List of Measures under Consideration for December 1, 2013

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OVERVIEW

Background

The Centers for Medicare & Medicaid Services (CMS) is issuing this List of Measures under Consideration (MUC) to comply with Section 1890A(a)(2) of the Social Security Act (the Act), which requires the Department of Health and Human Services (DHHS) to make publicly available a list of certain categories of 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 those measures and make them 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 on all potential measures. 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.

Statutory Requirement

Section 3014 of the Affordable Care Act (ACA) (P.L. 111-148) created a new Section 1890A of the Social Security Act, which requires that DHHS establish a federal pre-rulemaking process for the selection of certain categories of quality and efficiency measures for use by DHHS. These categories of measures are described in section 1890(b)(7)(B)(i)(I) of the Act . One of the steps in the pre-rulemaking process requires that DHHS make publicly available, not later than December 1st annually, a list of quality and efficiency measures DHHS is considering adopting, through the federal rulemaking process, for use in the Medicare program.

The pre-rulemaking process includes the following additional steps:

1. Providing the opportunity for multi-stakeholder groups to provide input not later than February 1st annually to DHHS on the selection of quality and efficiency measures;
2. Considering the multi-stakeholder groups' input in selecting quality and efficiency measures;
3. Publishing in the Federal Register the rationale for the use of any quality and efficiency measures that are not endorsed by the entity with a contract under Section 1890 of the Act, which is currently the National Quality Forum (NQF)[1]; and

[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

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 DHHS's Requirement to Make Its Measures under Consideration Publicly Available

The attached MUC List, which is compiled by CMS, will be posted for CMS on the NQF's website (www.qualityforum.org/MAP/). This posting will satisfy an important requirement of the pre-rulemaking process by making public the quality and efficiency measures DHHS is considering for use in the Medicare program. Additionally, CMS' website will indicate that the MUC list is being posted on NQF's website.

Included Measures

This MUC List identifies the quality and efficiency measures under consideration by the Secretary of DHHS for use under the Medicare program. Measures that appear on this List but are not selected for use under the Medicare program for the current rulemaking cycle will remain under consideration. They remain under consideration only for purposes of the particular program or other use that CMS was considering them for when they were placed on the MUC List. These measures can be selected for those previously considered purposes and programs/uses in future rulemaking cycles. The 2012 MUC list and the Measures Application

Partnership Report can be found at: http://www.qualityforum.org/Publications/2013/02/MAP_Pre-Rulemaking_Report_-_February_2013.aspx

Applicable Programs

The following programs that now implement or will implement quality and efficiency measures have been identified as meeting the criteria listed above. Accordingly, any quality and efficiency measures DHHS considers for these programs must be included in the List of Measures under Consideration:

1. Ambulatory Surgical Center Quality Reporting
2. End-Stage Renal Disease (ESRD) Quality Incentive Program
3. Home Health Quality Reporting
4. Hospice Quality Reporting
5. Hospital-Acquired Condition (HAC) Reduction Program
6. Hospital Inpatient Quality Reporting (IQR) Program
7. Hospital Outpatient Quality Reporting (OQR) Program
8. Hospital Readmission Reduction Program
9. Hospital Value-Based Purchasing

10. Inpatient Psychiatric Facility (IPF) Quality Reporting
11. Inpatient Rehabilitation Facility (IRF) Quality Reporting
12. Long-Term Care Hospital (LTCH) Quality Reporting
13. Medicare and Medicaid EHR Incentive Program for Eligible Professionals
14. Medicare and Medicaid EHR Incentive Program for Hospitals and Critical Access Hospitals (CAHs)
15. Medicare Shared Savings Program
16. Medicare Physician Quality Reporting System (PQRS)
17. Physician Compare
18. Physician Feedback/Quality and Resource Utilization Reports (QRUR)
19. Physician Value-Based Modifier Program
20. Prospective Payment System (PPS)-Exempt Cancer Hospital Quality Reporting

Measures List Highlights

Through publication of this List, CMS will make publicly available and seek the multi-stakeholder groups' input on 234 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, all programs contributed measures to this List except the Hospice Quality Reporting Program. All Hospice Quality Reporting measures that CMS is considering for possible future adoption have previously appeared on the MUC List and CMS has received MAP input on those measures. This Program has submitted no additional measures at this time for consideration for the current rulemaking cycle or subsequent rulemaking cycles.
- If CMS chooses not to adopt a measure under this List for the current rulemaking cycle, the measure remains under consideration by the Secretary and may be proposed and adopted in subsequent rulemaking cycles.
- The NQF already endorses many of the measures contained in this List with a number of 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 may choose whether to participate.
- CMS sought to be inclusive with respect to new measures on the MUC List. For example, three meetings were convened to obtain input and consensus on the MUC List from across the Department of Health and Human Services.

- CMS will continue aligning measures across programs whenever possible, 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 MUC List includes measures that CMS is currently considering for the Medicare program. Inclusion of a measure on this List does not require CMS to adopt the measure for the identified program.
- Measures contained on this List had to fill a quality and efficiency measurement need and were assessed for alignment amongst CMS programs when applicable.
- In an effort to provide a more meaningful List of Measures under Consideration, CMS included only measures that contain adequate specifications.
- The following components of the Department of Health and Human Services contributed to and supported CMS in a majority of measures on this List:
    1. Office of the Assistant Secretary for Health
    2. Office of the National Coordinator
    3. National Institutes of Health
    4. Agency for Healthcare Research and Quality
    5. Health Resources and Services Administration

6. Centers for Disease Control and Prevention
7. Substance Abuse and Mental Health Services Administration
8. Assistant Secretary for Planning and Evaluation
9. Indian Health Service

How to Navigate the Document

Headings in this document have been bookmarked to facilitate navigation. This document consists of three tables:

- List of Measures under Consideration (page 14)
  - This table contains the complete list of measures under consideration with basic information about each measure and the programs for which the measure is being considered.
- Appendix A: Measure Specifications (page 88)
  - This table details the numerator, denominator, and exclusions for each measure. It also includes the length of time the measure has been in use by any CMS quality reporting program if applicable.
- Appendix B: Measure Effectiveness (page 257)
  - This table describes the rationale for the measure and/or the impact the measure is anticipated to achieve.

Each table is preceded by a legend defining the contents of the columns.

If there are additional questions, please contact Julia.mikulla@cms.hhs.gov.

COUNT OF MEASURES UNDER CONSIDERATION BY PROGRAM[2]

CMS PROGRAM	NUMBER OF MEASURES UNDER CONSIDERATION
Ambulatory Surgical Center Quality Reporting	3
End Stage Renal Disease Quality Incentive Program	20
Home Health Quality Reporting	4
Hospice Quality Reporting	0
Hospital-Acquired Condition Reduction Program	4
Hospital Inpatient Quality Reporting	11
Hospital Outpatient Quality Reporting	6
Hospital Readmission Reduction Program	3
Hospital Value-Based Purchasing	14
Inpatient Psychiatric Facility Quality Reporting	10
Inpatient Rehabilitation Facility Quality Reporting	8
Long-Term Care Hospital Quality Reporting	3
Medicare and Medicaid EHR Incentive Program for Eligible Professionals	37
Medicare and Medicaid EHR Incentive Program for Hospitals and Critical Access Hospitals	6
Medicare Shared Savings Program	100

[2] A single measure may be under consideration for more than one program.

CMS PROGRAM	NUMBER OF MEASURES UNDER CONSIDERATION
Medicare Physician Quality Reporting System[3]	110
Physician Feedback/Quality and Resource Utilization Reports[4]	161
Physician Value-Based Payment Modifier[4]	161
Physician Compare [4]	110
Prospective Payment System-Exempt Cancer Hospital Quality Reporting	6

[3] Medicare Physician Quality Reporting System:

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 Feedback/QRUR, Physician Value-Based Payment Modifier, and Physician Compare programs.

[4] Physician Feedback/QRUR, Physician Value-Based Payment Modifier, and Physician Compare:

Measures that are already finalized and remain current for the Medicare Physician Quality Reporting System, Hospital Inpatient Quality Reporting, and Hospital Outpatient Quality Reporting programs that are not specifically included on this list may also be considered for the Physician Feedback/QRUR, Physician-Value Based Payment Modifier, and Physician Compare programs. Therefore, for future regulatory action for the Physician Feedback/QRUR, Physician Value-Based Payment Modifier, and Physician Compare programs, CMS may consider measures that were included in the 2011 and 2012 Lists of Measures under Consideration; and measures that have been finalized and remain current in the 2007–2014 Physician Fee Schedule Final Rules, 2002–2014 Inpatient Prospective Payment System Final Rules, and 2008–2014 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.

LIST OF MEASURES UNDER CONSIDERATION

Table Legend for the List of Measures under Consideration

CMS has included a list of terms used in the List of Measures under Consideration for clarity and consistency. They are presented below in the order in which they appear as headings in this List.

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

- An "E" prefix indicates a measure that is currently endorsed by the NQF.
- A "D" prefix indicates a measure that was once endorsed by the NQF but has subsequently been de-endorsed.
- An "F" prefix indicates a measure that was submitted to the NQF for endorsement but was not endorsed.
- An "S" prefix indicates a measure that is currently submitted to the NQF for endorsement.
- An all-lettered measure ID indicates a measure that has yet to be submitted to the NQF for endorsement.

Measure Title: Refers to the title of the measure.

- **DRAFT: Refers to a measure under development.**

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.

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

- Process: Refers to a measure that focuses on a process that 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 that are experienced by patients who have received health care.
- Intermediate Outcome: Refers to a measure that 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 and system wide (for example, staffing level).
- Efficiency: Refers to a measure concerning the cost of care associated with a specified level of health outcome.
- Patient Perspective: Refers to a measure that 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 that 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 measures and/or one or more outcome measures.

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

CMS Program(s): Refers to the applicable Medicare program(s) that may adopt the measure through rulemaking in the future.

List of Measures under Consideration Table

MUC ID	Measure Title	Description	Measure Type	Measure Steward	CMS Program(s)
XDEMB	High-Acuity Care Visits after Outpatient Cataract Procedure	Combined rate of unplanned admissions, emergency department visits, and observation stays among Medicare FFS beneficiaries within 7 days after receiving a cataract procedure at an ambulatory surgery center or other outpatient facility.	Outcome	Centers for Medicare & Medicaid Services (CMS)	Ambulatory Surgical Center Quality Reporting, Hospital Outpatient Quality Reporting, Medicare Shared Savings , Physician Compare, Physician Feedback/QRUR, Physician Value-Based Payment Modifier, Medicare Physician Quality Reporting System
XDEMA	High-Acuity Care Visits after Outpatient Colonoscopy Procedure	Combined rate of unplanned admissions, emergency department visits, and observation stays among Medicare FFS beneficiaries within 7 days after receiving a colonoscopy at an ambulatory surgery center or other outpatient facility.	Outcome	Centers for Medicare & Medicaid Services (CMS)	Ambulatory Surgical Center Quality Reporting, Hospital Outpatient Quality Reporting, Medicare Shared Savings , Physician Compare, Physician Feedback/QRUR, Physician Value-Based Payment Modifier, Medicare Physician Quality Reporting System

MUC ID	Measure Title	Description	Measure Type	Measure Steward	CMS Program(s)
XDELM	High-Acuity Care Visits after Outpatient Endoscopy Procedure	Combined rate of unplanned admissions, emergency department visits, and observation stays among Medicare FFS beneficiaries within 7 days after receiving an endoscopy at an ambulatory surgery center or other outpatient facility.	Outcome	Centers for Medicare & Medicaid Services (CMS)	Ambulatory Surgical Center Quality Reporting, Hospital Outpatient Quality Reporting, Medicare Shared Savings , Physician Compare, Physician Feedback/QRUR, Physician Value-Based Payment Modifier, Medicare Physician Quality Reporting System
E0260	Assessment of Health-related Quality of Life (Physical & Mental Functioning)	Percentage of dialysis patients who receive a quality of life assessment using the measure based on calculated results from a KDQOL-36 (36-question survey that assesses patients' functioning and well-being, which is conducted at least once per year, can be found at www.kdqol-complete.org).	Process	RAND Corporation	End-Stage Renal Disease Quality Incentive Program
E0029	Counseling on physical activity in older adults - a. Discussing Physical Activity, b. Advising Physical Activity	Discussing Physical Activity: Percentage patients 65 years of age and older who reported: discussing their level of exercise or physical activity with a doctor or other health provider in the last 12 months. Advising Physical Activity: Percentage patients 65 years of age and older who reported receiving advice to start, increase, or maintain their level	Process	National Committee for Quality Assurance (NCQA)	End-Stage Renal Disease Quality Incentive Program

MUC ID	Measure Title	Description	Measure Type	Measure Steward	CMS Program(s)
		of exercise or physical activity from a doctor or other health provider in the last 12 months.			
XDGBA	ESRD Vaccination – Lifetime Pneumococcal Vaccination	Percentage of ESRD patients ≥ 2 years of age at the start of the reporting period and on chronic dialysis ≥ 30 days in a facility at any point during the 12-month reporting period who either have ever received a pneumococcal vaccination (PPSV23 or PCV13), were offered and declined the vaccination, or were determined to have a medical contraindication.	Process	Centers for Medicare & Medicaid Services (CMS)	End-Stage Renal Disease Quality Incentive Program
XDEFL	ESRD Vaccination - Pneumococcal Vaccination (PPSV23)	Draft: Percentage of ESRD patients ≥ 2 years of age at the start of the reporting period and on chronic dialysis ≥ 30 days in a facility at any point during the 12-month reporting period who either had an up-to-date PPSV23 vaccine status or received PPSV23 vaccination during the reporting period, were offered but declined the vaccination, or were determined to have a medical contraindication.	Process	Centers for Medicare & Medicaid Services (CMS)	End-Stage Renal Disease Quality Incentive Program
XDEGA	ESRD Vaccination - Timely Influenza Vaccination	Draft: Percentage of ESRD patients ≥ 6 months of age on October 1 and on chronic dialysis ≥ 30 days in a facility at any point between October 1 and December 31 who either received an influenza vaccination, were offered but declined the vaccination, or were determined to have a medical contraindication.	Process	Centers for Medicare & Medicaid Services (CMS)	End-Stage Renal Disease Quality Incentive Program
XDEFM	Full-Season Influenza Vaccination (ESRD Patients)	Draft: Percentage of ESRD patients ≥ 6 months of age on October 1 and on chronic dialysis ≥ 30 days in a facility at any point between October 1 and March 31 who either received an influenza	Process	Centers for Medicare & Medicaid Services (CMS)	End-Stage Renal Disease Quality Incentive Program

MUC ID	Measure Title	Description	Measure Type	Measure Steward	CMS Program(s)
		vaccination, were offered but declined the vaccination, or were determined to have a medical contraindication.			
XDGAF	Hepatitis B vaccine coverage in hemodialysis patients	Percentage of hemodialysis patients who have ever received three or more doses of hepatitis B vaccine.	Process	Being developed by CMS	End-Stage Renal Disease Quality Incentive Program
E0393	Hepatitis C: Testing for Chronic Hepatitis C – Confirmation of Hepatitis C Viremia	Percentage of patients aged 18 years and older with a diagnosis of hepatitis C seen for an initial evaluation who had HCV RNA testing ordered or previously performed.	Process	American Medical Association - Physician Consortium for Performance Improvement (AMA-PCPI)	End-Stage Renal Disease Quality Incentive Program
E0004	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	The percentage of adolescent and adult members with a new episode of alcohol or other drug (AOD) dependence who received the following: a. Initiation of AOD Treatment. The percentage of members who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis. b. Engagement of AOD Treatment. The percentage of members who initiated treatment and who had two or more additional services with a diagnosis of AOD within 30 days of the initiation visit.	Process	National Committee for Quality Assurance (NCQA)	End-Stage Renal Disease Quality Incentive Program
XDEGC	Measurement of Plasma PTH	Percentage of all peritoneal dialysis and hemodialysis patients included in the sample for	Process	Centers for Medicare &	End-Stage Renal Disease Quality

MUC ID	Measure Title	Description	Measure Type	Measure Steward	CMS Program(s)
	Concentration	analysis with plasma PTH measured, together with documentation of the specific PTH assay utilized at least once within a 3 month period.		Medicaid Services (CMS)	Incentive Program
E0431	Influenza Vaccination Coverage Among Healthcare Personnel	Percentage of healthcare personnel (HCP) who receive the influenza vaccination.	Process	Centers for Disease Control and Prevention	End-Stage Renal Disease Quality Incentive Program, Inpatient Psychiatric Facility Quality Reporting
E0420	Pain Assessment and Follow-Up	Percentage of patients aged 18 years and older with documentation of a pain assessment through discussion with the patient including the use of a standardized tool(s) on each visit AND documentation of a follow-up plan when pain is present.	Process	Centers for Medicare & Medicaid Services (CMS)	End-Stage Renal Disease Quality Incentive Program
XCBMM	Pediatric Peritoneal Dialysis Adequacy: Achievement of Target Kt/V	The percent of pediatric peritoneal dialysis patient-months with Kt/V greater than or equal to 1.8 (dialytic + residual) during the six month reporting period. • If RRF is to be incorporated in the Kt/V calculation, this will be calculated using the mean of urea and creatinine clearances derived from 24 hour urine collection. • Total body water (V) should be estimated by one of the following pediatric specific V approximation methods: o Prediction equation based upon heavy water dilution § Males: TBW=0.10 (ht x wt)0.68 – 0.37 (wt) § Females: TBW=0.14 (ht x wt) 0.64 – 0.35 (wt)	Outcome	Centers for Medicare & Medicaid Services (CMS)	End-Stage Renal Disease Quality Incentive Program

MUC ID	Measure Title	Description	Measure Type	Measure Steward	CMS Program(s)
		o Simplified V estimating equations: § Males: TBW=20.88 x BSA – 4.29 § Females: TBW=16.92 x BSA – 1.81 o Sex specific normograms from the KDOQI PD guidelines for the pediatric population update from 2006			
XDGAM	Pediatric Peritoneal Dialysis Adequacy: Frequency of Measurement of Kt/V	Percent of pediatric peritoneal dialysis patient-months with Kt/V measured at least once in a six-month period.	Process	Centers for Medicare & Medicaid Services (CMS)	End-Stage Renal Disease Quality Incentive Program
XDEGB	Percentage of Dialysis Patients with Dietary Counseling	Percentage of all hemodialysis and peritoneal dialysis patients included in the sample for analysis with dietary counseling of the patient and/or caregiver on appropriate phosphorus sources and content as part of an overall healthy nutrition plan at least once within six months.	Process	Centers for Medicare & Medicaid Services (CMS)	End-Stage Renal Disease Quality Incentive Program
XDEFH	Pneumococcal Vaccination Measure (PCV13)	Draft: Percentage of ESRD patients ≥ 5 years of age at the start of the reporting period and on chronic dialysis ≥ 30 days in a facility at any point during the 12-month reporting period who have ever received a PCV13 pneumococcal vaccination, were offered but declined the vaccination, or were determined to have a medical contraindication.	Process	Centers for Medicare & Medicaid Services (CMS)	End-Stage Renal Disease Quality Incentive Program
E0418	Screening for Clinical Depression	Percentage of patients aged 18 years and older screened for clinical depression using a standardized tool and follow-up plan documented.	Process	Centers for Medicare & Medicaid Services (CMS)	End-Stage Renal Disease Quality Incentive Program

MUC ID	Measure Title	Description	Measure Type	Measure Steward	CMS Program(s)
XDEFF	Standardized Kt/V	Percent of adult HD patients in a facility with all necessary data elements reported to calculate the weekly Standard Kt/V, on a monthly basis.	Process	Centers for Medicare & Medicaid Services (CMS)	End-Stage Renal Disease Quality Incentive Program
XDEFE	Surface Area Normalized Kt/V	Percent of adult HD patients in a facility with all necessary data elements reported to calculate the weekly SAN Kt/V, on a monthly basis.	Process	Centers for Medicare & Medicaid Services (CMS)	End-Stage Renal Disease Quality Incentive Program
XAHMH	Ultrafiltration Rate (UFR)	Percent of patients with a UFR greater than 10 ml/kg/hr.	Process	Centers for Medicare & Medicaid Services (CMS)	End-Stage Renal Disease Quality Incentive Program
XDDLA	PSI 10:Postoperative Physiologic and Metabolic Derangement Rate	Postoperative physiologic and metabolic derangements (secondary diagnosis) or acute renal failures (secondary diagnosis) with dialysis per 1,000 elective surgical discharges for patients ages 18 years and older. Excludes cases with principal diagnosis for physiologic and metabolic derangement or acute renal failure; cases with secondary diagnosis for physiologic and metabolic derangement or acute renal failure present on admission; cases with secondary diagnosis of acute renal failure and dialysis before or on the same day as the first operating room procedure; cases with derangement.	Outcome	Agency for Healthcare Research & Quality (AHRQ)	Hospital-Acquired Condition Reduction Program
E0533	PSI 11: Post-Operative Respiratory Failure	Postoperative respiratory failure (secondary diagnosis), mechanical ventilation, or reintubation cases per 1,000 elective surgical discharges for patients ages 18 years and older.	Outcome	Agency for Healthcare Research & Quality (AHRQ)	Hospital-Acquired Condition Reduction Program

MUC ID	Measure Title	Description	Measure Type	Measure Steward	CMS Program(s)
		Excludes cases with principal diagnosis for acute respiratory failure; cases with secondary diagnosis for acute respiratory failure present on admission; cases in which tracheostomy is the only operating room procedure or in which tracheostomy occurs before the first operating room procedure; cases with neuromuscular disorders, laryngeal or pharyngeal surgery, craniofacial anomalies that had a procedure for the face, esophageal resection, lung cancer, or degenerative neurological disorders; cases with a procedure on the nose, mouth, or pharynx; cases with respiratory or circulatory diseases; and obstetric discharges.			
E0349	PSI 16: Transfusion Reaction	The number of medical and surgical discharges with a secondary diagnosis of transfusion reaction for patients ages 18 years and older or obstetric patients. Excludes cases with a principal diagnosis of transfusion reaction or cases with a secondary diagnosis of transfusion reaction that is present on admission.	Outcome	Agency for Healthcare Research & Quality (AHRQ)	Hospital-Acquired Condition Reduction Program
XAFLG	PSI 9: Perioperative Hemorrhage or Hematoma Rate	Perioperative hemorrhage or hematoma cases with control of perioperative hemorrhage, drainage of hematoma, or a miscellaneous hemorrhage- or hematoma-related procedure following surgery per 1,000 surgical discharges for patients ages 18 years and older. Excludes cases with a diagnosis of coagulation disorder; cases with a principal diagnosis of perioperative hemorrhage or hematoma; cases with a secondary diagnosis of perioperative	Outcome	Agency for Healthcare Research & Quality (AHRQ)	Hospital-Acquired Condition Reduction Program

MUC ID	Measure Title	Description	Measure Type	Measure Steward	CMS Program(s)
		hemorrhage or hematoma present on admission; cases where the only operating room procedure is control of perioperative hemorrhage, drainage of hematoma, or a miscellaneous hemorrhage- or hematoma-related procedure; and obstetric cases.			
XDFFA	Depression Screening Conducted and Follow-Up Plan Documented	Percentage of home health episodes of care in which patients were screened for depression (using a standardized depression screening tool) at start/resumption of care AND, if positive, the physician-ordered plan of care includes a depression intervention(s) AND/OR physician notified that the patient screened positive for depression.	Process	Centers for Medicare & Medicaid Services (CMS)	Home Health Quality Reporting
XDAEH	Emergency Department Use without Hospital Readmission During the 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 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.	Outcome	Centers for Medicare & Medicaid Services (CMS)	Home Health Quality Reporting
XDFGB	New or Worsened Pressure Ulcers	Percentage of home health episodes of care in which the patient is discharged from home health with one or more Stage 2 - 4 pressure ulcer(s) that are new or worsened since the start or resumption of care.	Outcome	Centers for Medicare & Medicaid Services (CMS)	Home Health Quality Reporting
XCHGG	Rehospitalization During the 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	Outcome	Centers for Medicare & Medicaid Services (CMS)	Home Health Quality Reporting

MUC ID	Measure Title	Description	Measure Type	Measure Steward	CMS Program(s)
		acute care hospital during the 30 days following the start of the home health stay.			
XBELG	Hospital 30-day, all-cause, unplanned, risk-standardized readmission rate (RSRR) following Coronary artery Bypass Graft (CABG) Surgery	The measure estimates a hospital-level risk-standardized readmission rate (RSRR), defined as unplanned readmission for any cause within 30 days from the date of discharge of the index CABG procedure, for patients 18 years and older discharged from the hospital after undergoing a qualifying isolated CABG procedure. The measure was developed using Medicare Fee-for-Service (FFS) patients 65 years and older and was tested in all-payer patients 18 years and older.	Outcome	Centers for Medicare & Medicaid Services (CMS)	Hospital Inpatient Quality Reporting, Hospital Readmission Reduction Program, Medicare Shared Savings, Physician Compare, Physician Feedback/QRUR, Physician Value-Based Payment Modifier, Medicare Physician Quality Reporting System
XDBCB	Adverse Drug Events - Hyperglycemia	Average percentage of hyperglycemic hospital days for individuals with a diagnosis of diabetes mellitus, anti-diabetic drugs (except metformin) administered, or at least one elevated glucose level during the hospital stay.	Intermediate Outcome	Centers for Medicare and Medicaid Services/Florida Medical Quality Assurance Incorporated	Hospital Inpatient Quality Reporting, Medicare Shared Savings, Medicare and Medicaid EHR Incentive Program for Hospitals and CAHs, Physician Compare, Physician Feedback/QRUR, Physician Value-Based Payment Modifier, Medicare Physician Quality Reporting System

MUC ID	Measure Title	Description	Measure Type	Measure Steward	CMS Program(s)
XDBGA	Adverse Drug Events - Hypoglycemia	The rate of hypoglycemic events following the administration of an anti-diabetic agent.	Intermediate Outcome	Centers for Medicare and Medicaid Services/Florida Medical Quality Assurance Incorporated	Hospital Inpatient Quality Reporting, Medicare Shared Savings, Medicare and Medicaid EHR Incentive Program for Hospitals and CAHs, Physician Compare, Physician Feedback/QRUR, Physician Value-Based Payment Modifier, Medicare Physician Quality Reporting System
XDEEL	Hospital 30-day Risk-standardized Acute Myocardial Infarction (AMI) Mortality eMeasure	This measure estimates hospital 30-day risk-standardized mortality rates following admission for acute myocardial infarction (AMI) using clinical information collected at presentation in an electronic health record (EHR).	Outcome	Centers for Medicare & Medicaid Services (CMS)	Hospital Inpatient Quality Reporting, Medicare Shared Savings, Medicare and Medicaid EHR Incentive Program for Hospitals and CAHs, Physician Compare, Physician Feedback/QRUR, Physician Value-Based Payment Modifier, Medicare Physician Quality Reporting System

MUC ID	Measure Title	Description	Measure Type	Measure Steward	CMS Program(s)
XDAEA	Appropriate Monitoring of patients receiving an Opioid via an IV Patient Controlled Analgesia Device	Patients receiving intravenous opioids via patient controlled analgesia who receive appropriate monitoring of their respiratory status (respiratory rate and pulse oximetry) and level of sedation	Process	Centers for Medicare & Medicaid Services (CMS)	Hospital Inpatient Quality Reporting, Medicare Shared Savings, Physician Compare, Physician Feedback/QRUR, Physician Value-Based Payment Modifier, Medicare Physician Quality Reporting System
XBGDL	Hospital 30-Day All-Cause Risk-Standardized Readmission Rate (RSRR) following Vascular Procedures	This measure estimates hospital risk-standardized 30-day readmission rates following hospital stays with one or more qualifying vascular procedure in patients who are 65 years of age or older and either admitted to the hospital (inpatients) for their vascular procedure(s) or receive their procedure at a hospital but are not admitted as an inpatient (outpatients). Both scenarios are hereafter referred to as "hospital stays."	Outcome	Centers for Medicare & Medicaid Services (CMS)	Hospital Inpatient Quality Reporting, Medicare Shared Savings, Physician Compare, Physician Feedback/QRUR, Physician Value-Based Payment Modifier, Medicare Physician Quality Reporting System
XDEEH	Hospital 30-day, all-cause, risk-standardized mortality rate (RSMR) following Coronary Artery Bypass Graft (CABG) surgery	The measure estimates a hospital-level, risk-standardized mortality rate (RSMR) for patients 18 years and older discharged from the hospital following a qualifying isolated CABG procedure. Mortality is defined as death from any cause within 30 days of the procedure date of an index CABG admission. The measure was developed using Medicare Fee-for-Service (FFS) patients 65	Outcome	Centers for Medicare & Medicaid Services (CMS)	Hospital Inpatient Quality Reporting, Medicare Shared Savings, Physician Compare, Physician Feedback/QRUR, Physician Value-Based Payment Modifier,

MUC ID	Measure Title	Description	Measure Type	Measure Steward	CMS Program(s)
		years and older and was tested in all-payer patients 18 years and older. An index admission is the hospitalization for a qualifying isolated CABG procedure considered for the mortality outcome.			Medicare Physician Quality Reporting System
XDELH	Hospital-level, risk-standardized 30-day episode-of-care payment measure for heart failure	The measure estimates a hospital-level risk-standardized 30-day episode-of-care payment measure for heart failure that begins at hospitalization and extends 30 days post-admission. Patients with a principal discharged diagnosis of heart failure were included. The measure was developed using Medicare Fee-for-Service (FFS) patients 65 years and older.	Outcome	Centers for Medicare & Medicaid Services (CMS)	Hospital Inpatient Quality Reporting, Medicare Shared Savings, Physician Compare, Physician Feedback/QRUR, Physician Value-Based Payment Modifier, Medicare Physician Quality Reporting System
XDELG	Hospital-level, risk-standardized 30-day episode-of-care payment measure for pneumonia	The measure estimates a hospital-level risk-standardized 30-day episode-of-care payment measure for pneumonia that begins at hospitalization and extends 30 days post-admission. Patients with a principal discharged diagnosis of pneumonia were included. The measure was developed using Medicare Fee-for-Service (FFS) patients 65 years and older.	Outcome	Centers for Medicare & Medicaid Services (CMS)	Hospital Inpatient Quality Reporting, Medicare Shared Savings, Physician Compare, Physician Feedback/QRUR, Physician Value-Based Payment Modifier, Medicare Physician Quality Reporting System
E0475	Hepatitis B Vaccine Coverage Among All Live Newborn	Percent of live newborn infants that receive hepatitis B vaccination before discharge at each single hospital/birthing facility during given time	Process	Centers for Disease Control and Prevention	Hospital Inpatient Quality Reporting, Medicare and

MUC ID	Measure Title	Description	Measure Type	Measure Steward	CMS Program(s)
	Infants Prior to Hospital or Birthing Facility Discharge	period (one year).			Medicaid EHR Incentive Program for Hospitals and CAHs, Physician Compare, Physician Feedback/QRUR, Physician Value-Based Payment Modifier, Medicare Physician Quality Reporting System
E0471	PC-02 Cesarean Section	This measure assesses the number of nulliparous women with a term, singleton baby in a vertex position delivered by cesarean section.	Outcome	The Joint Commission	Hospital Inpatient Quality Reporting, Physician Compare, Physician Feedback/QRUR, Physician Value-Based Payment Modifier, PQRS
XDFMH	30-Day Readmissions	Number of episodes of care with a resumption of care within 30 days to the same or to another HOD.	Outcome	Centers for Medicare & Medicaid Services (CMS)	Hospital Outpatient Quality Reporting, Physician Feedback/QRUR, Physician Value-Based Payment Modifier
XDFMG	Group Therapy	Number of episodes of care with only group therapy billed.	Outcome	Centers for Medicare & Medicaid Services (CMS)	Hospital Outpatient Quality Reporting, Physician Feedback/QRUR, Physician Value-Based

MUC ID	Measure Title	Description	Measure Type	Measure Steward	CMS Program(s)
					Payment Modifier
XDFMF	No Individual Psychotherapy	Number of episodes of care with no units of individual psychotherapy or psychiatric testing billed.	Outcome	Centers for Medicare & Medicaid Services (CMS)	Hospital Outpatient Quality Reporting, Physician Feedback/QRUR, Physician Value-Based Payment Modifier
F2027	Hospital 30-day, all-cause, risk-standardized readmission rate (RSRR) following an acute ischemic stroke hospitalization	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.	Outcome	Centers for Medicare & Medicaid Services (CMS)	Hospital Readmission Reduction Program
E1789	Hospital-Wide All-Cause Unplanned Readmission Measure (HWR)	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 cohorts (groups of discharge condition categories or procedure categories): surgery, gynecology, general medicine, cardiorespiratory, cardiovascular, and neurology. 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	Outcome	Centers for Medicare & Medicaid Services (CMS)	Hospital Readmission Reduction Program, Physician Feedback/QRUR, Physician Value-Based Payment Modifier

MUC ID	Measure Title	Description	Measure Type	Measure Steward	CMS Program(s)
		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.			
E0434	STK-1 Venous Thromboembolism (VTE) Prophylaxis	Ischemic stroke or hemorrhagic stroke patients who are non-ambulatory start receiving DVT prophylaxis by end of hospital day two.	Process	The Joint Commission	Hospital Value-Based Purchasing
E0441	STK-10 Assessed for Rehabilitation	Ischemic stroke or hemorrhagic stroke patients who were assessed for rehabilitation services.	Process	The Joint Commission	Hospital Value-Based Purchasing
E0435	STK-2 Antithrombotic therapy for ischemic stroke	Ischemic stroke patients prescribed antithrombotic therapy at hospital discharge.	Process	The Joint Commission	Hospital Value-Based Purchasing
E0436	STK-3 Anticoagulation therapy for Afib/flutter	Ischemic stroke patients with atrial fibrillation/flutter who are prescribed anticoagulation therapy at hospital discharge.	Process	The Joint Commission	Hospital Value-Based Purchasing
E0437	STK-4 Thrombolytic therapy for acute ischemic stroke	Acute ischemic stroke patients who arrive at the hospital within 120 minutes (2 hours) of time last known well and for whom IV t-PA was initiated at this hospital within 180 minutes (3 hours) of time last known well.	Process	The Joint Commission	Hospital Value-Based Purchasing
E0438	STK-5 Antithrombotic therapy by the end of hospital day 2	Patients with ischemic stroke who receive antithrombotic therapy by the end of hospital day two.	Process	The Joint Commission	Hospital Value-Based Purchasing

MUC ID	Measure Title	Description	Measure Type	Measure Steward	CMS Program(s)
E0439	STK-6 Discharged on Statin Medication	Ischemic stroke patients with LDL greater than or equal to 100 mg/dL, or LDL not measured, or who were on a lipid-lowering medication prior to hospital arrival are prescribed statin medication at hospital discharge.	Process	The Joint Commission	Hospital Value-Based Purchasing
D0440	STK-8 Stroke Education	Ischemic or hemorrhagic stroke patients or their caregivers who were given educational materials during the hospital stay addressing all of the following: activation of emergency medical system, need for follow-up after discharge, medications prescribed at discharge, risk factors for stroke, and warning signs and symptoms of stroke.	Process	CMS (The Joint Commission)	Hospital Value-Based Purchasing
E0371	VTE-1: Venous Thromboembolism Prophylaxis	Patients who received VTE prophylaxis or have documentation why no VTE prophylaxis was given: • the day of or the day after hospital admission • the day of or the day after surgery end date for surgeries that start the day of or the day after hospital	Process	The Joint Commission	Hospital Value-Based Purchasing
E0372	VTE-2: Intensive Care Unit Venous Thromboembolism Prophylaxis	Patients who received VTE prophylaxis or have documentation why no VTE prophylaxis was given: • the day of or the day after ICU admission (or transfer) • the day of or the day after surgery end date for surgeries that start the day of or the day after ICU admission (or transfer)	Process	The Joint Commission	Hospital Value-Based Purchasing

MUC ID	Measure Title	Description	Measure Type	Measure Steward	CMS Program(s)
E0373	VTE-3:VTE patients with anticoagulation overlap therapy	Patients who received overlap therapy: Included Populations: Patients who received warfarin and parenteral anticoagulation: • Five or more days, with an INR greater than or equal to 2 prior to discontinuation of parenteral therapy OR • Five or more days, with an INR less than 2 and discharged on overlap therapy OR • Less than five days and discharged on overlap therapy OR • With documentation of reason for discontinuation of overlap therapy OR • With documentation of a reason for no overlap therapy	Process	The Joint Commission	Hospital Value-Based Purchasing
D0374	VTE-4: Patients receiving un-fractionated Heparin with doses/labs monitored by protocol	This measure assesses the number of patients diagnosed with confirmed VTE who received intravenous (IV) unfractionated Heparin (UFH) therapy dosages AND had their platelet counts monitored using defined parameters such as a nomogram or protocol.	Process	CMS (The Joint Commission)	Hospital Value-Based Purchasing
D0375	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	Process	CMS (The Joint Commission)	Hospital Value-Based Purchasing

MUC ID	Measure Title	Description	Measure Type	Measure Steward	CMS Program(s)
		information about the potential for adverse drug reactions/interactions.			
D0376	VTE-6: Incidence of potentially preventable VTE	This measure assesses the number of patients diagnosed with confirmed VTE during hospitalization (not present at admission) who did not receive VTE prophylaxis between hospital admission and the day before the VTE diagnostic testing order date.	Outcome	CMS (The Joint Commission)	Hospital Value-Based Purchasing
XCAEA	IPF Metabolic Screening	Percent of Inpatient Psychiatric Facility inpatients who receive a comprehensive metabolic screening.	Process	Centers for Medicare & Medicaid Services (CMS)	Inpatient Psychiatric Facility Quality Reporting
XDCBA	IPF Suicide Risk Screening completed within one day of admission	Percentage of admissions to an IPF for which a detailed screening for risk of suicide was completed within one day of admission.	Process	Centers for Medicare & Medicaid Services (CMS)	Inpatient Psychiatric Facility Quality Reporting
XDEGE	IPF Use of an electronic health record meeting Stage 1 or Stage 2 Meaningful Use criteria	The facility will decide to use an electronic health record meeting Stage 1 or Stage 2 Meaningful Use criteria.	Structure	Centers for Medicare & Medicaid Services (CMS)	Inpatient Psychiatric Facility Quality Reporting
XDCFD	IPF Violence Risk Screening completed within one day of admission	Percentage of admissions for which a detailed screening for risk of violent behavior was completed within one day of admission.	Process	Centers for Medicare & Medicaid Services (CMS)	Inpatient Psychiatric Facility Quality Reporting
E0028	Preventive Care &	Percentage of patients aged 18 years and older	Process	American Medical	Inpatient Psychiatric

MUC ID	Measure Title	Description	Measure Type	Measure Steward	CMS Program(s)
	Screening: Tobacco Use: Screening & Cessation Intervention	who were screened for tobacco use at least once during the two-year measurement period AND who received cessation counseling intervention if identified as a tobacco user.		Association - convened Physician Consortium for Performance Improvement (AMA-convened PCPI)	Facility Quality Reporting
E1659	Influenza 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.	Process	Centers for Medicare & Medicaid Services (CMS)	Inpatient Psychiatric Facility Quality Reporting, Medicare and Medicaid EHR Incentive Program for Hospitals and CAHs
XDFGE	Inpatient Psychiatric Facility Routinely Assesses Patient Experience of Care	Yes/No -- Whether an IPF Routinely Assesses Patient Experience of Care using a standardized collection protocol and a structured instrument.	Structure	Centers for Medicare & Medicaid Services (CMS)	Inpatient Psychiatric Facility Quality Reporting, Physician Feedback/QRUR, Physician Value-Based Payment Modifier, Physician Quality Reporting System, Medicare Shared Savings, Physician

MUC ID	Measure Title	Description	Measure Type	Measure Steward	CMS Program(s)
					Compare
XDFGD	IPF Alcohol Use Screening completed within one day of admission	Alcohol Use Screening completed within one day of patient's admission to the IPF. This is a companion measure to MUC XDFGC -- IPF Drug Use Screening completed within one day of admission.	Process	Centers for Medicare & Medicaid Services (CMS)	Inpatient Psychiatric Facility Quality Reporting, Physician Feedback/QRUR, Physician Value-Based Payment Modifier, Physician Quality Reporting System, Medicare Shared Savings, Physician Compare
XDFGC	IPF Drug Use Screening completed within one day of admission	Drug Use Screening completed within one day of patient's admission to the IPF. This is a companion measure to MUC XDFGD -- IPF Alcohol Use Screening completed within one day of admission.	Process	Centers for Medicare & Medicaid Services (CMS)	Inpatient Psychiatric Facility Quality Reporting, Physician Feedback/QRUR, Physician Value-Based Payment Modifier, Physician Quality Reporting System, Medicare Shared Savings, Physician Compare
XCFFL	Functional Outcome Measure: Change in Mobility Score	This measure estimates the risk-adjusted mean change in mobility function between admission and discharge.	Intermediate Outcome	Centers for Medicare & Medicaid Services (CMS)	Inpatient Rehabilitation Facility Quality Reporting
XCFFM	Functional Outcome Measure: Change in Self-Care	This measure estimates the risk-adjusted mean change in self-care function between admission and discharge.	Intermediate Outcome	Centers for Medicare & Medicaid Services	Inpatient Rehabilitation Facility Quality Reporting

MUC ID	Measure Title	Description	Measure Type	Measure Steward	CMS Program(s)
	Score			(CMS)	
XDDCA	Functional Outcome Measure: Discharge mobility score	The percent of patients who meet or exceed an expected discharge mobility score.	Intermediate Outcome	Centers for Medicare & Medicaid Services (CMS)	Inpatient Rehabilitation Facility Quality Reporting
XDDCB	Functional Outcome Measure: Discharge self-care score	The percent of patients who meet or exceed an expected discharge self-care score.	Intermediate Outcome	Centers for Medicare & Medicaid Services (CMS)	Inpatient Rehabilitation Facility Quality Reporting
E1717	National Healthcare Safety Network (NHSN) Facility-Wide Inpatient Hospital-onset Clostridium difficile infection (CDI) Outcome Measure	Standardized infection ratio (SIR) of hospital-onset CDI Laboratory-identified events (LabID events) among all inpatients in the facility, excluding well-baby nurseries and neonatal intensive care units (NICUs)	Outcome	Centers for Disease Control and Prevention	Inpatient Rehabilitation Facility Quality Reporting
E1716	National Healthcare Safety Network (NHSN) Facility-Wide Inpatient Hospital-onset Methicillin-resistant Staphylococcus aureus (MRSA) Bacteremia Outcome Measure	Standardized infection ratio (SIR) of hospital-onset unique blood source MRSA Laboratory-identified events (LabID events) among all inpatients in the facility.	Outcome	Centers for Disease Control and Prevention	Inpatient Rehabilitation Facility Quality Reporting

MUC ID	Measure Title	Description	Measure Type	Measure Steward	CMS Program(s)
E0674	Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay)	This measure is based on data from all non-admission MDS 3.0 assessments of long-stay nursing facility residents or IRF patients, which may be annual, quarterly, significant change, significant correction, or discharge assessment. It reports the percent of residents or patients who experienced one or more falls with major injury (e.g., bone fractures, joint dislocations, closed head injuries with altered consciousness, and subdural hematoma) in the last year (12-month period). The measure is based on MDS 3.0 item J1900C, which indicates whether any falls that occurred were associated with major injury.	Outcome	Centers for Medicare & Medicaid Services (CMS)	Inpatient Rehabilitation Facility Quality Reporting
E0676	Percent of Residents Who Self-Report Moderate to Severe Pain (Short Stay)	This measure reports the percentage of short-stay residents or patients with a 14-day PPS assessment during a selected quarter (3 months) who have reported almost constant or frequent pain and at least one episode of moderate to severe pain, or any severe or horrible pain, in the 5 days prior to the 14-day PPS assessment.	Outcome	Centers for Medicare & Medicaid Services (CMS)	Inpatient Rehabilitation Facility Quality Reporting
XCFGB	Functional Outcome Measure: change in mobility among patients requiring ventilator support	Change in mobility score between admission and discharge among patients requiring ventilator support at admission.	Intermediate Outcome	Centers for Medicare & Medicaid Services (CMS)	Long-Term Care Hospital Quality Reporting
XCBBF	Percent of LTCH patients with an admission and discharge	Percent of LTCH patients with an admission and discharge functional assessment and a care plan that addresses function.	Process	Centers for Medicare & Medicaid Services (CMS)	Long-Term Care Hospital Quality Reporting

MUC ID	Measure Title	Description	Measure Type	Measure Steward	CMS Program(s)
	functional assessment and a care plan that addresses function				
XDDCC	Ventilator-Associated Event	The measures are two Standardized Incidence Ratios (SIR) for healthcare-associated, ventilator-associated events (VAEs) among adult patients, >=18 years old, in acute and long-term acute care hospitals and inpatient rehabilitation facilities, receiving conventional mechanical ventilator support for >=3 calendar days. Persons receiving rescue mechanical ventilation therapies are excluded. The two SIRS are for: 1. Ventilator-Associated Conditions (VAC). 2. Infection-related Ventilator-Associated Complications (IVAC).	Outcome	Centers for Disease Control and Prevention	Long-Term Care Hospital Quality Reporting
E0543	Adherence to Statin Therapy for Individuals with Coronary Artery Disease	The percentage of individuals with coronary artery disease (CAD) who are prescribed statin therapy that had a Proportion of Days Covered (PDC) for statin medications of at least 0.8 during the measurement period (12 consecutive months).	Intermediate Outcome	Centers for Medicare and Medicaid Services/Florida Medical Quality Assurance Incorporated	Medicare Shared Savings
E0576	Follow-up after hospitalization for a mental illness	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	Process	National Committee for Quality Assurance (NCQA)	Medicare Shared Savings

MUC ID	Measure Title	Description	Measure Type	Measure Steward	CMS Program(s)
		with a mental health practitioner within 30 days of discharge.			
E0556	INR for individuals taking warfarin and interacting anti-infective medications	Percentage of episodes with an International Normalized Ratio (INR) test performed 3 to 7 days after a newly started interacting anti-infective medication for individuals receiving warfarin.	Process	Centers for Medicare and Medicaid Services/Florida Medical Quality Assurance Incorporated	Medicare Shared Savings
E0555	Lack of Monthly INR Monitoring for Individuals on Warfarin	Average percentage of monthly intervals in which individuals with claims for warfarin do not receive an International Normalized Ratio (INR) test during the measurement period.	Process	Centers for Medicare and Medicaid Services/Florida Medical Quality Assurance Incorporated	Medicare Shared Savings
E0053	Osteoporosis management in women 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 fracture.	Process	National Committee for Quality Assurance (NCQA)	Medicare Shared Savings
E0046	Osteoporosis: Screening or Therapy for Women Aged 65 Years and Older	Percentage of female patients aged 65 years and older who had a central dual-energy X-ray absorptiometry (DXA) measurement ordered or performed at least once since age 60 or pharmacologic therapy prescribed within 12 months.	Process	National Committee for Quality Assurance (NCQA)	Medicare Shared Savings
XDAEB	Annual Wellness Assessment:	DRAFT: Percentage of patients 65 years and older with an annual wellness visit (AWV) during	Composite	Centers for Medicare &	Medicare Shared Savings, Medicare and

MUC ID	Measure Title	Description	Measure Type	Measure Steward	CMS Program(s)
	Assessment of Health Risks	the measurement period who received age- and sex-appropriate screenings: (Obesity, High Blood Pressure, Low HDL-C and High Total Cholesterol, Alcohol Misuse, Tobacco Use, Depression, Physical Inactivity, Falls, Colorectal Cancer, Breast Cancer, & Osteoporosis).		Medicaid Services (CMS)	Medicaid EHR Incentive Program for Eligible Professionals, Physician Compare, Physician Feedback/QRUR, Physician Value-Based Payment Modifier, Medicare Physician Quality Reporting System
XDBHA	Annual Wellness Assessment: Goal-Setting to Reduce Identified Risks	DRAFT: Percentage of patients 65 years of age and older with an annual wellness visit (AWV) during the measurement period who have established at least one risk-reduction goal during the AWV from among a set of identified risks.	Process	Centers for Medicare & Medicaid Services (CMS)	Medicare Shared Savings, Medicare and Medicaid EHR Incentive Program for Eligible Professionals, Physician Compare, Physician Feedback/QRUR, Physician Value-Based Payment Modifier, Medicare Physician Quality Reporting System
XDAEC	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 vaccinations: (Alcohol Misuse, Tobacco Use, Falls, Pneumococcal Vaccination, Influenza Vaccination).	Composite	Centers for Medicare & Medicaid Services (CMS)	Medicare Shared Savings, Medicare and Medicaid EHR Incentive Program for Eligible Professionals, Physician Compare, Physician

MUC ID	Measure Title	Description	Measure Type	Measure Steward	CMS Program(s)
					Feedback/QRUR, Physician Value-Based Payment Modifier, Medicare Physician Quality Reporting System
XDBGH	Annual Wellness Assessment: Reduction of Health Risks	DRAFT: Percentage of patients 66 years of age and older with an annual wellness visit (AWV) during the measurement period who set a goal to reduce a behavioral risk in the year prior and who achieved their risk reduction goal by the AWV during the measurement period.	Process	Centers for Medicare & Medicaid Services (CMS)	Medicare Shared Savings, Medicare and Medicaid EHR Incentive Program for Eligible Professionals, Physician Compare, Physician Feedback/QRUR, Physician Value-Based Payment Modifier, Medicare Physician Quality Reporting System
XDFHD	Assessment and Classification of Disease Activity	If a patient has rheumatoid arthritis, then disease activity using a standardized measurement tool should be assessed at >=50% of encounters for RA.	Patient Perspective	American College of Rheumatology	Medicare Shared Savings, Medicare and Medicaid EHR Incentive Program for Eligible Professionals, Physician Compare, Physician Feedback/QRUR, Physician Value-Based Payment Modifier, Medicare Physician Quality Reporting

MUC ID	Measure Title	Description	Measure Type	Measure Steward	CMS Program(s)
					System
XDFEH	Bone Mineral Density (BMD) & Fracture Risk	Percentage of patients >=50 years who have a documented BMD t-score of <=-2.5 or a history of fragility fracture or FRAX risk >=20% and are receiving any dose of glucocorticoids for >=90 days, who were treated with an anti-resorptive or anabolic agent, unless patient refusal or contraindications are noted.	Process	American College of Rheumatology	Medicare Shared Savings, Medicare and Medicaid EHR Incentive Program for Eligible Professionals, Physician Compare, Physician Feedback/QRUR, Physician Value-Based Payment Modifier, Medicare Physician Quality Reporting System
S1884	Depression Response at Six Months- Progress Towards Remission	Adult patients age 18 and older with major depression or dysthymia and an initial PHQ-9 score > 9 who demonstrate a response to treatment at six months defined as a PHQ-9 score that is reduced by 50% or greater from the initial PHQ-9 score. This measure applies to both patients with newly diagnosed and existing depression identified during the defined measurement period whose current PHQ-9 score indicates a need for treatment.	Outcome	Minnesota Community Measurement	Medicare Shared Savings, Medicare and Medicaid EHR Incentive Program for Eligible Professionals, Physician Compare, Physician Feedback/QRUR, Physician Value-Based Payment Modifier, Medicare Physician Quality Reporting System
S1885	Depression Response at Twelve Months- Progress	Adult patients age 18 and older with major depression or dysthymia and an initial PHQ-9 score > 9 who demonstrate a response to	Outcome	Minnesota Community Measurement	Medicare Shared Savings, Medicare and Medicaid EHR

MUC ID	Measure Title	Description	Measure Type	Measure Steward	CMS Program(s)
	Towards Remission	treatment at twelve months defined as a PHQ-9 score that is reduced by 50% or greater from the initial PHQ-9 score. This measure applies to both patients with newly diagnosed and existing depression identified during the defined measurement period whose current PHQ-9 score indicates a need for treatment.			Incentive Program for Eligible Professionals, Physician Compare, Physician Feedback/QRUR, Physician Value-Based Payment Modifier, Medicare Physician Quality Reporting System
XDELF	DRAFT: ADE Prevention and Monitoring: Minimum INR Monitoring for Patients with Atrial Fibrillation on Warfarin	DRAFT: Proportion of patients aged 18 and older with atrial fibrillation who are on chronic warfarin therapy and received minimum appropriate International Normalized Ratio (INR) monitoring.	Process	Centers for Medicare & Medicaid Services (CMS)	Medicare Shared Savings, Medicare and Medicaid EHR Incentive Program for Eligible Professionals, Physician Compare, Physician Feedback/QRUR, Physician Value-Based Payment Modifier, Medicare Physician Quality Reporting System
XDELE	DRAFT: ADE Prevention and Monitoring: Warfarin Time in Therapeutic Range	DRAFT: Average percentage of time in which patients aged 18 and older with atrial fibrillation who are on chronic warfarin therapy have International Normalized Ratio (INR) test results within the therapeutic range (i.e., TTR) during the measurement period.	Outcome	Centers for Medicare & Medicaid Services (CMS)	Medicare Shared Savings, Medicare and Medicaid EHR Incentive Program for Eligible Professionals, Physician Compare, Physician Feedback/QRUR,

MUC ID	Measure Title	Description	Measure Type	Measure Steward	CMS Program(s)
					Physician Value-Based Payment Modifier, Medicare Physician Quality Reporting System
XDCLD	DRAFT: Closing the Referral Loop - Critical Information Communicated with Request for Referral	DRAFT: Percentage of referrals sent by a referring clinician to another clinician for which the referring clinician sent relevant clinical information, including type of activity requested (i.e., referral, consultation, or co-management), preferred timing, problem list, medication list, medical history, and reason for referral.	Process	Centers for Medicare & Medicaid Services (CMS)	Medicare Shared Savings, Medicare and Medicaid EHR Incentive Program for Eligible Professionals, Physician Compare, Physician Feedback/QRUR, Physician Value-Based Payment Modifier, Medicare Physician Quality Reporting System
XDDAC	DRAFT: Closing the Referral Loop - Specialist Report Sent to Primary Care Physician	DRAFT: Percentage of referrals received for which the receiving provider sent a consultant report back to the referring provider.	Process	Centers for Medicare & Medicaid Services (CMS)	Medicare Shared Savings, Medicare and Medicaid EHR Incentive Program for Eligible Professionals, Physician Compare, Physician Feedback/QRUR, Physician Value-Based Payment Modifier, Medicare Physician Quality Reporting System

MUC ID	Measure Title	Description	Measure Type	Measure Steward	CMS Program(s)
XDELB	DRAFT: Functional Status Assessment and Goal Achievement for Patients with Congestive Heart Failure	DRAFT: Percentage of patients aged 65 years and older with congestive heart failure who had a target improvement goal defined after completing an initial patient-reported functional status assessment and met the goal after completing a follow-up functional status assessment.	Outcome	Centers for Medicare & Medicaid Services (CMS)	Medicare Shared Savings, Medicare and Medicaid EHR Incentive Program for Eligible Professionals, Physician Compare, Physician Feedback/QRUR, Physician Value-Based Payment Modifier, Medicare Physician Quality Reporting System
XDELD	DRAFT: Functional Status Assessment and Improvement for Patients who Received a Total Hip Replacement	DRAFT: Percentage of patients aged 18 years and older with primary total hip arthroplasty (THA) who achieved functional status improvement as assessed by a pre-and post-surgery patient-reported functional status assessment.	Outcome	Centers for Medicare & Medicaid Services (CMS)	Medicare Shared Savings, Medicare and Medicaid EHR Incentive Program for Eligible Professionals, Physician Compare, Physician Feedback/QRUR, Physician Value-Based Payment Modifier, Medicare Physician Quality Reporting System
XDELC	DRAFT: Functional Status Assessment and Improvement for Patients who	DRAFT: Percentage of patients aged 18 years and older with primary total knee arthroplasty (TKA) who achieved functional status improvement as assessed by a pre-and post-surgery patient-	Outcome	Centers for Medicare & Medicaid Services (CMS)	Medicare Shared Savings, Medicare and Medicaid EHR Incentive Program for

MUC ID	Measure Title	Description	Measure Type	Measure Steward	CMS Program(s)
	Received a Total Knee Replacement	reported functional status assessment.			Eligible Professionals, Physician Compare, Physician Feedback/QRUR, Physician Value-Based Payment Modifier, Medicare Physician Quality Reporting System
XDEHF	DRAFT: Substance Use Screening and Intervention Composite	DRAFT: Percentage of patients aged 18 years and older who were screened once within the last 24 months for tobacco use, unhealthy alcohol use, nonmedical prescription drug use, and illegal drug use AND who received an intervention for all positive screening results.	Process	Being developed by CMS	Medicare Shared Savings, Medicare and Medicaid EHR Incentive Program for Eligible Professionals, Physician Compare, Physician Feedback/QRUR, Physician Value-Based Payment Modifier, Medicare Physician Quality Reporting System
XDAFC	Functional Status Assessment and Goal Setting in Patients with Rheumatoid Arthritis	DRAFT: Percentage of patients with rheumatoid arthritis for whom a score on one of a select list of validated functional status tools (FSA) was recorded at least twice during the measurement period and for whom a goal was documented.	Process	Centers for Medicare & Medicaid Services (CMS)	Medicare Shared Savings, Medicare and Medicaid EHR Incentive Program for Eligible Professionals, Physician Compare, Physician Feedback/QRUR, Physician Value-Based

MUC ID	Measure Title	Description	Measure Type	Measure Steward	CMS Program(s)
					Payment Modifier, Medicare Physician Quality Reporting System
XDBGL	Functional Status Assessments and Goal Setting for Patients with Asthma	DRAFT: Percentage of patients 18 years of age and older with a diagnosis of persistent asthma for whom a score from one of a select list of validated functional status assessment (FSA) tools was recorded at least twice during the measurement period and for whom a care goal was documented during the initial assessment.	Process	Centers for Medicare & Medicaid Services (CMS)	Medicare Shared Savings, Medicare and Medicaid EHR Incentive Program for Eligible Professionals, Physician Compare, Physician Feedback/QRUR, Physician Value-Based Payment Modifier, Medicare Physician Quality Reporting System
XDBGM	Functional Status Assessments and Goal Setting for Patients with Chronic Obstructive Pulmonary Disease	DRAFT: Percentage of patients 18 years of age and older with a diagnosis of chronic obstructive pulmonary disease (COPD) for whom a score from one of a select list of validated functional status assessment (FSA) tools was recorded at least twice during the measurement period and for whom a care goal was documented during the initial assessment.	Process	Centers for Medicare & Medicaid Services (CMS)	Medicare Shared Savings, Medicare and Medicaid EHR Incentive Program for Eligible Professionals, Physician Compare, Physician Feedback/QRUR, Physician Value-Based Payment Modifier, Medicare Physician Quality Reporting System

MUC ID	Measure Title	Description	Measure Type	Measure Steward	CMS Program(s)
E2080	Gap in HIV 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.	Process	Health Resources and Services Administration (HRSA) - HIV/AIDS Bureau	Medicare Shared Savings, Medicare and Medicaid EHR Incentive Program for Eligible Professionals, Physician Compare, Physician Feedback/QRUR, Physician Value-Based Payment Modifier, Medicare Physician Quality Reporting System
E2079	HIV 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.	Intermediate Outcome	Health Resources and Services Administration (HRSA) - HIV/AIDS Bureau	Medicare Shared Savings, Medicare and Medicaid EHR Incentive Program for Eligible Professionals, Physician Compare, Physician Feedback/QRUR, Physician Value-Based Payment Modifier, Medicare Physician Quality Reporting System
E2082	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.	Outcome	Health Resources and Services Administration (HRSA) - HIV/AIDS	Medicare Shared Savings, Medicare and Medicaid EHR Incentive Program for

MUC ID	Measure Title	Description	Measure Type	Measure Steward	CMS Program(s)
				Bureau	Eligible Professionals, Physician Compare, Physician Feedback/QRUR, Physician Value-Based Payment Modifier, Medicare Physician Quality Reporting System
XDFEF	Osteoporotic Fracture Risk	IF a patient is receiving any dose of glucocorticoids for ≥ 90 days, THEN osteoporotic fracture risk (determined by validated composite fracture risk score AND/OR dual x-ray absorptiometry) should be recorded in the medical record in the measurement year or in the year prior to the measurement year.	Intermediate Outcome	American College of Rheumatology	Medicare Shared Savings, Medicare and Medicaid EHR Incentive Program for Eligible Professionals, Physician Compare, Physician Feedback/QRUR, Physician Value-Based Payment Modifier, Medicare Physician Quality Reporting System
XDAFA	Overuse of Diagnostic Imaging for Uncomplicated Headache	DRAFT: Percentage of all adult (>=18 years old) uncomplicated headache patients who received an order for a brain computed tomography (CT), computed tomography angiogram (CTA), magnetic resonance (MR), or magnetic resonance angiogram (MRA) study during the measurement period.	Efficiency	Centers for Medicare & Medicaid Services (CMS)	Medicare Shared Savings, Medicare and Medicaid EHR Incentive Program for Eligible Professionals, Physician Compare, Physician Feedback/QRUR, Physician Value-Based

MUC ID	Measure Title	Description	Measure Type	Measure Steward	CMS Program(s)
					Payment Modifier, Medicare Physician Quality Reporting System
XDFEG	Prednisone Use with Anabolic Agent	Percentage of patients >=50 years who are receiving >=7.5 mg/day of prednisone (or other glucocorticoid equivalent) for >=90 days, who are treated with an anti-resorptive or anabolic agent, unless patient refusal or contraindications are noted.	Process	American College of Rheumatology	Medicare Shared Savings, Medicare and Medicaid EHR Incentive Program for Eligible Professionals, Physician Compare, Physician Feedback/QRUR, Physician Value-Based Payment Modifier, Medicare Physician Quality Reporting System
E2083	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.	Process	Health Resources and Services Administration (HRSA) - HIV/AIDS Bureau	Medicare Shared Savings, Medicare and Medicaid EHR Incentive Program for Eligible Professionals, Physician Compare, Physician Feedback/QRUR, Physician Value-Based Payment Modifier, Medicare Physician Quality Reporting System

MUC ID	Measure Title	Description	Measure Type	Measure Steward	CMS Program(s)
XDFHE	Tuberculosis Screening Prior to First Course Biologic Disease Modifying Anti-Rheumatic Drug (DMARD) Therapy	If a patient with rheumatoid arthritis has been newly prescribed a biologic therapy, THEN the medical record should have TB testing or treatment recorded in the preceding 12-month period.	Intermediate Outcome	American College of Rheumatology	Medicare Shared Savings, Medicare and Medicaid EHR Incentive Program for Eligible Professionals, Physician Compare, Physician Feedback/QRUR, Physician Value-Based Payment Modifier, Medicare Physician Quality Reporting System
XDEMG	ACORN Adolescent (Youth) Outcome Questionnaire	ACORN is A Collaborative Outcomes Resource Network and they have developed a questionnaire intended to help clinicians rapidly assess the severity of the clients' symptoms, level of social support, readiness for change, and therapeutic alliance. These domains all have a bearing on the eventual outcome of treatment and therefore provide the clinician with a ready method to continuous monitor the clients' status and response to treatment. The questionnaire is intended to be used as a repeated measure during a treatment episode, and can be used to measure the magnitude of improvement experienced by the patient. Results are reported as an effect size reflecting pre-post change, or the difference between intake score and final score in the treatment episode.	Outcome	Center for Clinical Informatics	, Physician Compare, Physician Feedback/QRUR, Physician Value-Based Payment Modifier, Medicare Physician Quality Reporting System

MUC ID	Measure Title	Description	Measure Type	Measure Steward	CMS Program(s)
XDEMF	ACORN Adult Outcome Questionnaire	ACORN is A Collaborative Outcomes Resource Network and they have developed a questionnaire intended to help clinicians rapidly assess the severity of the clients' symptoms, level of social support, readiness for change, and therapeutic alliance. These domains all have a bearing on the eventual outcome of treatment and therefore provide the clinician with a ready method to continuous monitor the clients' status and response to treatment. The questionnaire is intended to be used as a repeated measure during a treatment episode, and can be used to measure the magnitude of improvement experienced by the patient. Results are reported as an effect size reflecting pre-post change, or the difference between intake score and final score in the treatment episode.	Outcome	Center for Clinical Informatics	Medicare Shared Savings, Physician Compare, Physician Feedback/QRUR, Physician Value-Based Payment Modifier, Medicare Physician Quality Reporting System
XAHDH	Adherence to Antiplatelet Treatment after Stent Implantation	The percentage of individuals with antiplatelet treatment who also have a proportion of days covered with antiplatelet treatment of at least 0.8 during the 12 months following implantation of a coronary artery drug-eluting stent (DES).	Intermediate Outcome	Centers for Medicare and Medicaid Services/Florida Medical Quality Assurance Incorporated CMS/FMQAI	Medicare Shared Savings, Physician Compare, Physician Feedback/QRUR, Physician Value-Based Payment Modifier, Medicare Physician Quality Reporting System
E1879	Adherence to Antipsychotic Medications for Individuals with	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	Intermediate Outcome	Centers for Medicare and Medicaid Services/Florida	Medicare Shared Savings, Physician Compare, Physician Feedback/QRUR,

MUC ID	Measure Title	Description	Measure Type	Measure Steward	CMS Program(s)
	Schizophrenia	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).		Medical Quality Assurance Incorporated	Physician Value-Based Payment Modifier, Medicare Physician Quality Reporting System
E0545	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 (ARBs) and oral hypoglycemic agents. The measure is divided into three sub-measures: Measure A: The percentage of eligible individuals who had at least two prescriptions for statins and who have a Proportion of Days Covered (PDC) of at least 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 of at least 0.8 during the measurement period (12 consecutive months). Measure C: The percentage of eligible individuals who had at least two prescriptions for a single oral hypoglycemic agent or at least two prescriptions for multiple agents within an anti-diabetic class and who have a PDC of at least 0.8 for at least 1 anti-diabetic class during the measurement period (12 consecutive months).	Intermediate Outcome	Centers for Medicare and Medicaid Services/Florida Medical Quality Assurance Incorporated	Medicare Shared Savings, Physician Compare, Physician Feedback/QRUR, Physician Value-Based Payment Modifier, Medicare Physician Quality Reporting System

MUC ID	Measure Title	Description	Measure Type	Measure Steward	CMS Program(s)
S1880	Adherence to Mood Stabilizers for Individuals with Bipolar I Disorder	The percentage of individuals with bipolar I disorder who received a mood stabilizer and had a Proportion of Days Covered (PDC) for mood stabilizer medications of at least 0.8 during the measurement period (12 consecutive months).	Intermediate Outcome	Centers for Medicare and Medicaid Services/Florida Medical Quality Assurance Incorporated	Medicare Shared Savings, Physician Compare, Physician Feedback/QRUR, Physician Value-Based Payment Modifier, Medicare Physician Quality Reporting System
XDFAL	Adult Primary Rhegmatogenous Retinal Detachment Reoperation Rate	Percentage of surgeries for primary rhegmatogenous retinal detachment where the retina remains attached after only one surgery.	Outcome	American Association of Eye and Ear Centers of Excellence and The Australian Council on Healthcare Standards	Medicare Shared Savings, Physician Compare, Physician Feedback/QRUR, Physician Value-Based Payment Modifier, Medicare Physician Quality Reporting System
XDFAH	Adult Primary Rhegmatogenous Retinal Detachment Surgery Success Rate	Percentage of Retinal Detachment cases achieving flat retinas six months post-surgery.	Outcome	American Association of Eye and Ear Centers of Excellence and The Australian Council on Healthcare Standards	Medicare Shared Savings, Physician Compare, Physician Feedback/QRUR, Physician Value-Based Payment Modifier, Medicare Physician Quality Reporting System
XDBBL	All-Cause Unplanned Admissions for	Measure of all-cause unplanned admissions among patients with diabetes.	Outcome	Centers for Medicare & Medicaid Services	Medicare Shared Savings, Physician Compare, Physician

MUC ID	Measure Title	Description	Measure Type	Measure Steward	CMS Program(s)
	Patients with Diabetes			(CMS)	Feedback/QRUR, Physician Value-Based Payment Modifier, Medicare Physician Quality Reporting System
XDBBG	All-Cause Unplanned Admissions for Patients with Heart Failure	Measure of all-cause unplanned admissions among patients with heart failure.	Outcome	Centers for Medicare & Medicaid Services (CMS)	Medicare Shared Savings, Physician Compare, Physician Feedback/QRUR, Physician Value-Based Payment Modifier, Medicare Physician Quality Reporting System
XDBBM	All-Cause Unplanned Admissions for Patients with Multiple Chronic Conditions	Measure of all-cause unplanned admissions among patients with multiple chronic conditions.	Outcome	Centers for Medicare & Medicaid Services (CMS)	Medicare Shared Savings, Physician Compare, Physician Feedback/QRUR, Physician Value-Based Payment Modifier, Medicare Physician Quality Reporting System
XCLAL	ALS Patient Care Preferences	Percentage of patients diagnosed with ALS who were offered assistance in care planning at least once annually (e.g. palliative care, invasive ventilation, hospice).	Process	American Academy of Neurology	Medicare Shared Savings, Physician Compare, Physician Feedback/QRUR, Physician Value-Based Payment Modifier,

MUC ID	Measure Title	Description	Measure Type	Measure Steward	CMS Program(s)
					Medicare Physician Quality Reporting System
XDFBD	Annual Hepatitis C Virus (HCV) Screening for Patients who are Active Injection Drug Users	Percentage of patients regardless of age who are active injection drug users who received a hepatitis C virus (HCV) antibody test or HCV ribonucleic acid (RNA) test within the 12-month reporting period.	Process	American Gastroenterological Association/American Association for the Study of Liver Disease/Physician Consortium for Performance Improvement	Medicare Shared Savings, Physician Compare, Physician Feedback/QRUR, Physician Value-Based Payment Modifier, Medicare Physician Quality Reporting System
XDFGM	Appropriate age for colorectal cancer screening colonoscopy	Percentage of patients aged 85 and older who receive a colonoscopy only for assessment of signs/symptoms of GI tract illness, in high-risk patients, and/or to follow up previously diagnosed advanced lesions.	Outcome	American College of Gastroenterology/ American Gastroenterological Association//American Society for Gastrointestinal Endoscopy	Medicare Shared Savings, Physician Compare, Physician Feedback/QRUR, Physician Value-Based Payment Modifier, Medicare Physician Quality Reporting System
XDFCL	Appropriate follow-up imaging for incidental simple ovarian cysts	Percentage of final reports for Ultrasound studies of the pelvis for pre-menopausal women aged 18 and older with no known ovarian disease with an ovarian cyst <5.0cm noted incidentally with documentation that no follow-up imaging is recommended.	Process	American College of Radiology/American Medical Association-Physician Consortium for Performance Improvement/Nati	Medicare Shared Savings, Physician Compare, Physician Feedback/QRUR, Physician Value-Based Payment Modifier, Medicare Physician Quality Reporting System

MUC ID	Measure Title	Description	Measure Type	Measure Steward	CMS Program(s)
				onal Committee for Quality Assurance	
XDFCE	Appropriate follow-up imaging for incidental thyroid nodules in patients	Percentage of final reports for CT or MRI studies of the chest or neck or ultrasound of the neck for patients aged 18 years and older with no known thyroid disease with a thyroid nodule < 1.0 cm noted incidentally with documentation that no follow-up imaging is recommended.	Process	American College of Radiology/American Medical Association Physician Consortium for Performance Improvement/National Committee for Quality Assurance	Medicare Shared Savings, Physician Compare, Physician Feedback/QRUR, Physician Value-Based Payment Modifier, Medicare Physician Quality Reporting System
XDFDA	Appropriate in vitro susceptibility testing - The agent(s) used for definitive therapy in invasive staphylococcal disease should be confirmed by in vitro susceptibility testing as interpreted by the Clinical Laboratory and Standards Institute (CLSI) to be active against the clinical isolate.	Percentage of adults 18 years of age and older with a diagnosis of invasive staphylococcal aureus (ISA) disease who were dispensed an antibiotic medication based on CLSI in vitro susceptibility testing for the isolate.	Process	Infectious Diseases Society of America	Medicare Shared Savings, Physician Compare, Physician Feedback/QRUR, Physician Value-Based Payment Modifier, Medicare Physician Quality Reporting System

MUC ID	Measure Title	Description	Measure Type	Measure Steward	CMS Program(s)
XDFHL	Appropriate Treatment of MSSA - For MSSA bacteremia, a β-lactam antibiotic is the drug of choice in the hospitalized patient in the absence of a documented allergy or drug intolerance.	Percentage of patients with MSSA bacteremia who received beta-lactam antibiotic (e.g. nafcillin or cefazolin) as definitive therapy.	Process	Infectious Diseases Society of America	Medicare Shared Savings, Physician Compare, Physician Feedback/QRUR, Physician Value-Based Payment Modifier, Medicare Physician Quality Reporting System
XDFCB	Appropriate use of imaging for non-traumatic knee pain	Percentage of patients aged 18 years and older with non-traumatic knee pain who undergo knee MR, MR arthrography with knee radiographs done within the preceding 3 months.	Process	American College of Radiology/American Medical Association-Physician Consortium for Performance Improvement/National Committee for Quality Assurance	Medicare Shared Savings, Physician Compare, Physician Feedback/QRUR, Physician Value-Based Payment Modifier, Medicare Physician Quality Reporting System
XDFCA	Appropriate use of imaging for non-traumatic shoulder pain	Percentage of patients aged 18 years and older with non-traumatic shoulder pain who undergo shoulder MR, MR arthrography, or a shoulder ultrasound with shoulder radiographs performed within the preceding 3 months.	Process	American College of Radiology/American Medical Association-Physician Consortium for	Medicare Shared Savings, Physician Compare, Physician Feedback/QRUR, Physician Value-Based Payment Modifier, Medicare Physician

MUC ID	Measure Title	Description	Measure Type	Measure Steward	CMS Program(s)
				Performance Improvement/National Committee for Quality Assurance	Quality Reporting System
XDFLD	Average change in functional status following lumbar spine fusion surgery	Average change from pre-operative functional status assessment to one year (nine to fifteen months) post-operative functional status using the Oswestry Disability Index (ODI version 2.1a) patient reported outcome tool.	Outcome	Minnesota Community Measurement	Medicare Shared Savings, Physician Compare, Physician Feedback/QRUR, Physician Value-Based Payment Modifier, Medicare Physician Quality Reporting System
XDFDL	Avoidance of inappropriate use of head CT in ED patients with minor head injury	Percentage of emergency department patients with minor head injury who received inappropriate imaging study (not clinically indicated)	Efficiency	American College of Emergency Physicians	Medicare Shared Savings, Physician Compare, Physician Feedback/QRUR, Physician Value-Based Payment Modifier, Medicare Physician Quality Reporting System
XDFGF	Avoidance of inappropriate use of imaging for adult ED patients with atraumatic low back pain	Percentage of emergency department patients aged >= 18 years with atraumatic low back pain who received an inappropriate imaging study (not clinically indicated)	Efficiency	American College of Emergency Physicians	Medicare Shared Savings, Physician Compare, Physician Feedback/QRUR, Physician Value-Based Payment Modifier, Medicare Physician Quality Reporting

MUC ID	Measure Title	Description	Measure Type	Measure Steward	CMS Program(s)
					System
XAHDG	Bleeding Outcomes Related to Oral Anticoagulants	The percentage of emergency department visits or hospitalizations for bleeding outcomes among users of oral anticoagulants.	Outcome	Centers for Medicare and Medicaid Services/Florida Medical Quality Assurance Incorporated	Medicare Shared Savings, Physician Compare, Physician Feedback/QRUR, Physician Value-Based Payment Modifier, Medicare Physician Quality Reporting System
XDFAG	Cataract Surgery with Intra-Operative Complications (Unplanned Rupture of Posterior Capsule requiring unplanned vitrectomy)	Rupture of the posterior capsule during anterior segment surgery requiring vitrectomy.	Outcome	American Association of Eye and Ear Centers of Excellence and The Australian Council on Healthcare Standards	Medicare Shared Savings, Physician Compare, Physician Feedback/QRUR, Physician Value-Based Payment Modifier, Medicare Physician Quality Reporting System
XDFAM	Cataract Surgery: Difference Between Planned and Final Refraction	Percentage of patients who achieve planned refraction within +-1,0 D.	Outcome	American Association of Eye and Ear Centers of Excellence and The Australian Council on Healthcare Standards	Medicare Shared Savings, Physician Compare, Physician Feedback/QRUR, Physician Value-Based Payment Modifier, Medicare Physician Quality Reporting System
E0005	CG CAHPS	Percentage of patients who got reminders from	Patient	Agency for	Medicare Shared

MUC ID	Measure Title	Description	Measure Type	Measure Steward	CMS Program(s)
	Supplemental and new Items : Between Visit Communication	provider's office between visits. Percentage of patients who got reminders from provider's office to make an appointment for tests or treatment.	Perspective	Healthcare Research & Quality (AHRQ)	Savings, Physician Compare, Physician Feedback/QRUR, Physician Value-Based Payment Modifier, Medicare Physician Quality Reporting System
E0005	CG CAHPS Supplemental Item : Educating Patient about Medication Adherence	Percentage of patients whose provider gave you easy to understand instructions about how to take prescription medicines. Percentage of patients whose provider gave you information in writing about how to take. Percentage of patients whose provider suggested ways to help you remember to take your medicines.	Patient Perspective	Agency for Healthcare Research & Quality (AHRQ)	Medicare Shared Savings, Physician Compare, Physician Feedback/QRUR, Physician Value-Based Payment Modifier, Medicare Physician Quality Reporting System
E0005	CG CAHPS: Courteous & Helpful Office Staff	Percentage of clerks and receptionists at this provider's office were helpful. Percentage of clerks and receptionists at this provider's office treated you with courtesy and respect.	Patient Perspective	Agency for Healthcare Research & Quality (AHRQ)	Medicare Shared Savings, Physician Compare, Physician Feedback/QRUR, Physician Value-Based Payment Modifier, Medicare Physician Quality Reporting System
E0005	CG CAHPS: Supplemental Item Care Coordination	Percentage of pProvider had medical records during your visits. Percentage of provider's office followed up to give you results of test or X-ray.	Patient Perspective	Agency for Healthcare Research & Quality (AHRQ)	Medicare Shared Savings, Physician Compare, Physician Feedback/QRUR,

MUC ID	Measure Title	Description	Measure Type	Measure Steward	CMS Program(s)
		Percentage of patient needed help from your care team to manage care, tests, or treatment from different providers. Percentage of patient 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.			Physician Value-Based Payment Modifier, Medicare Physician Quality Reporting System
E0005	CG CAHPS: Supplemental Item Stewardship of Patient Resources	Percentage of care team talked with you about cost of your prescription medicines.	Patient Perspective	Agency for Healthcare Research & Quality (AHRQ)	Medicare Shared Savings, Physician Compare, Physician Feedback/QRUR, Physician Value-Based Payment Modifier, Medicare Physician Quality Reporting System
XDFCF	Composite measure: 1) Appropriate follow-up imaging for incidental liver lesions	Percentage of final reports for abdominal imaging studies for asymptomatic patients aged 18 years and older with a liver lesion ≤ 1.5 cm noted incidentally with documentation that no follow-up imaging is recommended.	Process	American College of Radiology/American Medical Association Physician Consortium for Performance Improvement/National Committee for Quality Assurance	Medicare Shared Savings, Physician Compare, Physician Feedback/QRUR, Physician Value-Based Payment Modifier, Medicare Physician Quality Reporting System
XDFCG	Composite	Percentage of final reports for kidney imaging	Process	American College	Medicare Shared

MUC ID	Measure Title	Description	Measure Type	Measure Steward	CMS Program(s)
	measure: 2) Appropriate follow-up imaging for incidental kidney lesions composite measure	studies for patients aged 18 years and older who have a kidney lesion < 1.0 cm noted incidentally with documentation that no follow-up imaging is recommended.		of Radiology/American Medical Association-Physician Consortium for Performance Improvement/National Committee for Quality Assurance	Savings, Physician Compare, Physician Feedback/QRUR, Physician Value-Based Payment Modifier, Medicare Physician Quality Reporting System
XDFCH	Composite measure: 3) Appropriate follow-up imaging for incidental adrenal lesions composite measure	Percentage of final reports for abdominal imaging studies for patients aged 18 years and older with an adrenal lesion ≤4.0 cm noted incidentally with documentation that no follow-up imaging is recommended.	Process	American College of Radiology/American Medical Association-Physician Consortium for Performance Improvement/National Committee for Quality Assurance	Medicare Shared Savings, Physician Compare, Physician Feedback/QRUR, Physician Value-Based Payment Modifier, Medicare Physician Quality Reporting System
XDFBF	Discontinuation of Antiviral Therapy for Inadequate Viral Response	Percentage of patients aged 18 years and older with a diagnosis of hepatitis C genotype 1 who have an inadequate response to antiviral treatment for whom antiviral treatment was discontinued.	Process	American Gastroenterological Association/American Association for the Study of Liver Disease/Physician Consortium for Performance Improvement	Medicare Shared Savings, Physician Compare, Physician Feedback/QRUR, Physician Value-Based Payment Modifier, Medicare Physician Quality Reporting System

MUC ID	Measure Title	Description	Measure Type	Measure Steward	CMS Program(s)
XDFBG	Discussion and Shared Decision Making Surrounding Treatment Options	Percentage of patients aged 18 years and older with a diagnosis of hepatitis C with whom a physician or other clinician reviewed the range of treatment options appropriate to their genotype and demonstrated a shared decision making approach with the patient. To meet the measure, there must be documentation in the patient record of a discussion between the physician/clinician and the patient that includes all of the following: •Treatment choices appropriate to genotype •Risks and benefits. •Evidence of effectiveness. •Patient preferences toward the outcome of the treatment.	Process	American Gastroenterological Association/American Association for the Study of Liver Disease/Physician Consortium for Performance Improvement	Medicare Shared Savings, Physician Compare, Physician Feedback/QRUR, Physician Value-Based Payment Modifier, Medicare Physician Quality Reporting System
XDFDB	Head and Neck Cancer: Weight Loss Prevention	Percentage of patients with greater than 10% weight loss during radiotherapy for head and neck cancer.	Outcome	Academy of Nutrition and Dietetics	Medicare Shared Savings, Physician Compare, Physician Feedback/QRUR, Physician Value-Based Payment Modifier, Medicare Physician Quality Reporting System
XCLLL	HRS-12: Cardiac Tamponade and/or Pericardiocentesis Following Atrial Fibrillation Ablation	Rate of cardiac tamponade and/or pericardiocentesis following atrial fibrillation ablation.	Outcome	Heart Rhythm Society	Medicare Shared Savings, Physician Compare, Physician Feedback/QRUR, Physician Value-Based Payment Modifier,

MUC ID	Measure Title	Description	Measure Type	Measure Steward	CMS Program(s)
					Medicare Physician Quality Reporting System
XCLMD	HRS-9: Infection within 180 Days of Cardiac Implantable Electronic Device (CIED) Implantation, Replacement, or Revision	Infection rate following CIED device implantation, replacement, or revision.	Outcome	Heart Rhythm Society	Medicare Shared Savings, Physician Compare, Physician Feedback/QRUR, Physician Value-Based Payment Modifier, Medicare Physician Quality Reporting System
E0662	Median Time to Pain Management for Long Bone Fracture (OP-21/NQF-0662)	Median time from emergency department arrival to time of initial oral or parenteral pain medication administration for emergency department patients with a principal diagnosis of long bone fracture (LBF).	Intermediate Outcome	Centers for Medicare & Medicaid Services (CMS)	Medicare Shared Savings, Physician Compare, Physician Feedback/QRUR, Physician Value-Based Payment Modifier, Medicare Physician Quality Reporting System
XDFCM	Minimum antimicrobial therapy for Staph A. - For adult patients with Staphylococcus aureus bacteremia, the minimum duration of	Percentage of patients 18 years and older with one or more blood cultures positive for Staphylococcus aureus who receive 14 days or more of anti-staphylococcal antimicrobial therapy.	Process	Infectious Diseases Society of America	Medicare Shared Savings, Physician Compare, Physician Feedback/QRUR, Physician Value-Based Payment Modifier, Medicare Physician Quality Reporting System

MUC ID	Measure Title	Description	Measure Type	Measure Steward	CMS Program(s)
	antimicrobial therapy is 14 days				
XDFLL	National Institutes of Health Stroke Scale (NIHSS) for ED patients	Percentage of emergency department patients with suspected stroke &/or TIA in whom an NIHSS was performed.	Process	American Heart Association/American Society of Anesthesiologists/CDC Paul Coverdale National Acute Stroke Registry (PCNASR)	Medicare Shared Savings, Physician Compare, Physician Feedback/QRUR, Physician Value-Based Payment Modifier, Medicare Physician Quality Reporting System
E0465	Perioperative Anti-platelet Therapy for Patients undergoing Carotid Endarterectomy	Percentage of patients undergoing carotid endarterectomy (CEA) who are taking an anti-platelet agent (aspirin or clopidogrel) within 48 hours prior to surgery and are prescribed this medication at hospital discharge following surgery.	Process	Society for Vascular Surgery	Medicare Shared Savings, Physician Compare, Physician Feedback/QRUR, Physician Value-Based Payment Modifier, Medicare Physician Quality Reporting System
XDEME	Post-procedural Optimal medical therapy Composite (percutaneous coronary intervention)	Percentage of patients aged 18 years and older for whom PCI is performed who are prescribed optimal medical therapy at discharge.	Process	American College of Cardiology/American Heart Association	Medicare Shared Savings, Physician Compare, Physician Feedback/QRUR, Physician Value-Based Payment Modifier, Medicare Physician Quality Reporting System
XDFBM	Radiation	Percentage of final reports for patients aged 18	Process	American College	Medicare Shared

MUC ID	Measure Title	Description	Measure Type	Measure Steward	CMS Program(s)
	Consideration for Adult CT: Utilization of Dose Lowering Techniques	years and older undergoing CT with documentation that one or more of the following dose reduction techniques were used: • Automated exposure control. • Adjustment of the mA and/or kV according to patient size. • Use of iterative reconstruction technique.		of Radiology/American Medical Association-Physician Consortium for Performance Improvement/National Committee for Quality Assurance	Savings, Physician Compare, Physician Feedback/QRUR, Physician Value-Based Payment Modifier, Medicare Physician Quality Reporting System
XDFDH	Recurrence or amputation following endovascular infrainquinal lower extremity revascularization	Percentage of patients undergoing endovascular infrainguinal revascularization for non-limb threatening ischemia (claudication or asymptomatic) require repeat ipsilateral revascularization or any amputation within one year.	Outcome	Society for Vascular Surgery	Medicare Shared Savings, Physician Compare, Physician Feedback/QRUR, Physician Value-Based Payment Modifier, Medicare Physician Quality Reporting System
XDFDG	Recurrence or amputation following open infrainquinal lower extremity revascularization	Percentage of patients undergoing open infrainguinal revascularization for non-limb threatening ischemia (claudication or asymptomatic) who require ipsilateral repeat revascularization or any amputation within one year.	Outcome	Society for Vascular Surgery	Medicare Shared Savings, Physician Compare, Physician Feedback/QRUR, Physician Value-Based Payment Modifier, Medicare Physician Quality Reporting System
XCMDH	Reduction of complications	Percentage of stress urinary incontinence (SUI) surgeries for which cystoscopy was used during	Process	American Urological	Medicare Shared Savings, Physician

MUC ID	Measure Title	Description	Measure Type	Measure Steward	CMS Program(s)
	through the use of cystoscopy during surgery for stress urinary incontinence	the surgical procedure to reduce complications.		Association	Compare, Physician Feedback/QRUR, Physician Value-Based Payment Modifier, Medicare Physician Quality Reporting System
XDFBE	Referral to Treatment for Patients Identified with Hepatitis C Virus (HCV) Infection	Percentage of patients who were identified as having hepatitis C virus (HCV) infection through a screening process who were referred to treatment services for HCV infection within the 12 month reporting period.	Process	American Gastroenterological Association/American Association for the Study of Liver Disease/Physician Consortium for Performance Improvement	Medicare Shared Savings, Physician Compare, Physician Feedback/QRUR, Physician Value-Based Payment Modifier, Medicare Physician Quality Reporting System
XDFGL	Repeat Colonoscopy due to poor bowel preparation	Percentage of patient age 18 years and older undergoing colonoscopy who are recommended to have a follow-up examination earlier than standard intervals due to poor bowel preparation.	Outcome	American College of Gastroenterology/ American Gastroenterological Association/AGA/American Society for Gastrointestinal Endoscopy	Medicare Shared Savings, Physician Compare, Physician Feedback/QRUR, Physician Value-Based Payment Modifier, Medicare Physician Quality Reporting System
XDFBC	Screening for Hepatitis C Virus (HCV) for Patients at High Risk	Percentage of patients with one or more of the following: a history of injection drug use, patients who received blood transfusions prior to 1992, OR patients who were born in the years 1945–1965 who received a one-time hepatitis C	Process	American Gastroenterological Association/American Association for the Study of Liver	Medicare Shared Savings, Physician Compare, Physician Feedback/QRUR, Physician Value-Based

MUC ID	Measure Title	Description	Measure Type	Measure Steward	CMS Program(s)
		virus (HCV) antibody test.		Disease/Physician Consortium for Performance Improvement	Payment Modifier, Medicare Physician Quality Reporting System
XDFBH	Screening for Hepatocellular Carcinoma (HCC) in patients with Hepatitis C Cirrhosis	Percentage of patients aged 18 years and older with a diagnosis of chronic hepatitis C cirrhosis who were screened with either ultrasound, triple-contrast CT or triple-contrast MRI for hepatocellular carcinoma (HCC) at least once within the 12 month reporting period.	Process	American Gastroenterological Association/American Association for the Study of Liver Disease/Physician Consortium for Performance Improvement	Medicare Shared Savings, Physician Compare, Physician Feedback/QRUR, Physician Value-Based Payment Modifier, Medicare Physician Quality Reporting System
XDFCC	Use of premedication before contrast-enhanced imaging studies in patients with documented contrast allergy	Percentage of final reports for patients aged 18 years and older who had a previously documented contrast reaction following a prior imaging examination with intravascular iodinated contrast that include documentation that the patients underwent screening and were pre-medicated.	Process	American College of Radiology/American Medical Association-Physician Consortium for Performance Improvement/National Committee for Quality Assurance	Medicare Shared Savings, Physician Compare, Physician Feedback/QRUR, Physician Value-Based Payment Modifier, Medicare Physician Quality Reporting System
XDEGH	Appropriate Use of DXA Scans in Women Under 65 Who Do Not Meet the Risk Factor Profile	DRAFT: Percentage of women ages 18 to 64 without select risk factors for osteoporotic fracture who received an order for a dual-energy x-ray absorptiometry (DXA) scan.	Efficiency	Centers for Medicare & Medicaid Services (CMS)	Medicare and Medicaid EHR Incentive Program for Eligible Professionals, Physician Compare, Physician

MUC ID	Measure Title	Description	Measure Type	Measure Steward	CMS Program(s)
					Feedback/QRUR, Physician Value-Based Payment Modifier, Medicare Physician Quality Reporting System
E1399	Developmental Screening - Age 1	The percentage of children who had documentation in the medical record of a developmental screening by age 1.	Process	National Committee for Quality Assurance (NCQA)	Medicare and Medicaid EHR Incentive Program for Eligible Professionals, Physician Compare, Physician Feedback/QRUR, Physician Value-Based Payment Modifier, Medicare Physician Quality Reporting System
E1399	Developmental Screening - Age 2	The percentage of children who had documentation in the medical record of a developmental screening between 12 months and 2 years of life.	Process	National Committee for Quality Assurance (NCQA)	Medicare and Medicaid EHR Incentive Program for Eligible Professionals, Physician Compare, Physician Feedback/QRUR, Physician Value-Based Payment Modifier, Medicare Physician Quality Reporting System

MUC ID	Measure Title	Description	Measure Type	Measure Steward	CMS Program(s)
E1399	Developmental Screening - Age 3	The percentage of children who had documentation in the medical record of a developmental screening between 2 years and 3 years of life.	Process	National Committee for Quality Assurance (NCQA)	Medicare and Medicaid EHR Incentive Program for Eligible Professionals, Physician Compare, Physician Feedback/QRUR, Physician Value-Based Payment Modifier, Medicare Physician Quality Reporting System
XDEHE	DRAFT: Tobacco Use and Help with Quitting Among Adolescents	DRAFT: Percentage of adolescents 13 to 20 years of age with a primary care visit during the measurement period for whom tobacco use status was documented and received help quitting if identified as a tobacco user.	Process	National Committee for Quality Assurance (NCQA) on behalf of National Collaborative for Innovation in Quality Measurement (NCIQM)	Medicare and Medicaid EHR Incentive Program for Eligible Professionals, Physician Compare, Physician Feedback/QRUR, Physician Value-Based Payment Modifier, Medicare Physician Quality Reporting System
XDFHF	History of Fragility Fracture with Prednisone Use	Percentage of patients <50 years and have a history of fragility fracture and are receiving >=7.5 mg/day of prednisone (or other glucocorticoid equivalent) for >=90 days who are treated with an anti-resorptive or anabolic agent, unless risk of pregnancy, patient refusal or	Process	American College of Rheumatology	Medicare and Medicaid EHR Incentive Program for Eligible Professionals, Physician Compare, Physician

MUC ID	Measure Title	Description	Measure Type	Measure Steward	CMS Program(s)
		contraindications are noted.			Feedback/QRUR, Physician Value-Based Payment Modifier, Medicare Physician Quality Reporting System
E1959	Immunizations by 13 years of age - HPV	The percentage of adolescent girls 13 years of age who had three HPV vaccinations, with different dates of service on or before the 13th birthday.	Process	National Committee for Quality Assurance (NCQA)	Medicare and Medicaid EHR Incentive Program for Eligible Professionals, Physician Compare, Physician Feedback/QRUR, Physician Value-Based Payment Modifier, Medicare Physician Quality Reporting System
E1407	Immunizations by 13 years of age- Meningococcus, Tetanus, and Diphtheria	The percentage of adolescents 13 years of age who had one dose of meningococcal vaccine and one tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap) or one tetanus, diphtheria toxoids vaccine (Td) by their 13th birthday.	Process	National Committee for Quality Assurance (NCQA)	Medicare and Medicaid EHR Incentive Program for Eligible Professionals, Physician Compare, Physician Feedback/QRUR, Physician Value-Based Payment Modifier, Medicare Physician Quality Reporting System

MUC ID	Measure Title	Description	Measure Type	Measure Steward	CMS Program(s)
XDCMD	Oral Health: Children aged 6-9 years who receive sealants in the first permanent molar	Percentage of children between 6-9 years seen by the practitioner for an oral evaluation during the measurement period who are at elevated risk for caries who received a sealant on a one or more first permanent molar tooth within the measurement period.	Process	Dental Quality Alliance	Medicare and Medicaid EHR Incentive Program for Eligible Professionals, Physician Compare, Physician Feedback/QRUR, Physician Value-Based Payment Modifier, Medicare Physician Quality Reporting System
XDCME	Oral Health: Children who receive a comprehensive or periodic oral evaluation in two consecutive years	Percentage of children who were seen by a practitioner during the measurement period who received a comprehensive or periodic oral evaluation in the year prior to the measurement year who also received a comprehensive or periodic evaluation in the measurement year.	Process	Dental Quality Alliance	Medicare and Medicaid EHR Incentive Program for Eligible Professionals, Physician Compare, Physician Feedback/QRUR, Physician Value-Based Payment Modifier, Medicare Physician Quality Reporting System
E0500	Severe Sepsis/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.	Composite	Henry Ford Hospital	Medicare and Medicaid EHR Incentive Program for Hospitals and CAHs
XDFLE	Optimal Asthma	Percentage of patients ages 5-50 (pediatrics ages	Outcome	Minnesota	Physician Compare,

MUC ID	Measure Title	Description	Measure Type	Measure Steward	CMS Program(s)
	Care- Control Component	5-17) whose asthma is well-controlled as demonstrated by one of three age appropriate patient reported outcome tools.		Community Measurement	Physician Feedback/QRUR, Physician Value-Based Payment Modifier, Medicare Physician Quality Reporting System
E1507	Risky Behavior Assessment or Counseling by Age 18 Years	The percentage of adolescents with documentation of assessment or counseling for risky behavior by the age of 18 years. Four rates are reported: Risk Assessment or Counseling for Alcohol Use, Risk Assessment or Counseling for Tobacco Use, Risk Assessment or Counseling for Other Substance Use, and Risk Assessment or Counseling for Sexual Activity.	Process	National Committee for Quality Assurance (NCQA)	Physician Compare, Physician Feedback/QRUR, Physician Value-Based Payment Modifier, Medicare Physician Quality Reporting System
XDFBL	Utilization of ultrasonography in children with clinically suspected appendicitis	Percentage of patients aged 14 years and younger with clinically suspected appendicitis who undergo CT or MRI or Ultrasound of the abdomen or pelvis for whom Ultrasound was used as the initial imaging evaluation of the appendix.	Process	ACR/AMA-PCPI/NCQA	Physician Compare, Physician Feedback/QRUR, Physician Value-Based Payment Modifier, Medicare Physician Quality Reporting System
XDDMH	Draft: Acute Myocardial Infarction Condition Phase Episode for CMS Episode Grouper	Draft: Resources used in caring for the condition (duration TBD).	Cost/Resource Use	Centers for Medicare & Medicaid Services (CMS)	Physician Feedback/QRUR, Physician Value-Based Payment Modifier
XDEAM	Draft: Asthma	Draft: Resources used in caring for the condition	Cost/Resour	Centers for	Physician

MUC ID	Measure Title	Description	Measure Type	Measure Steward	CMS Program(s)
	Condition Episode for CMS Episode Grouper	(duration TBD).	ce Use	Medicare & Medicaid Services (CMS)	Feedback/QRUR, Physician Value-Based Payment Modifier
XDEEB	Draft: Back Pain Condition Episode for CMS Episode Grouper	Draft: Resources used in caring for the condition (duration TBD).	Cost/Resource Use	Centers for Medicare & Medicaid Services (CMS)	Physician Feedback/QRUR, Physician Value-Based Payment Modifier
XDEDC	Draft: Breast Cancer Condition Episode for CMS Episode Grouper	Draft: Resources used in caring for the condition (duration TBD).	Cost/Resource Use	Centers for Medicare & Medicaid Services (CMS)	Physician Feedback/QRUR, Physician Value-Based Payment Modifier
XDEDD	Draft: Breast Cancer Treatment Episode for CMS Episode Grouper	Draft: Resources used in caring for the condition (duration TBD).	Cost/Resource Use	Centers for Medicare & Medicaid Services (CMS)	Physician Feedback/QRUR, Physician Value-Based Payment Modifier
XDEBA	Draft: Bronchiectasis Condition Episode for CMS Episode Grouper	Draft: Resources used in caring for the condition (duration TBD).	Cost/Resource Use	Centers for Medicare & Medicaid Services (CMS)	Physician Feedback/QRUR, Physician Value-Based Payment Modifier
XDEBM	Draft: Cardiac Arrhythmia Condition Episode for CMS Episode Grouper	Draft: Resources used in caring for the condition (duration TBD).	Cost/Resource Use	Centers for Medicare & Medicaid Services (CMS)	Physician Feedback/QRUR, Physician Value-Based Payment Modifier
XDECB	Draft: Cardioversion Treatment Episode for CMS Episode	Draft: Resources used in caring for the condition (duration TBD).	Cost/Resource Use	Centers for Medicare & Medicaid Services (CMS)	Physician Feedback/QRUR, Physician Value-Based Payment Modifier

MUC ID	Measure Title	Description	Measure Type	Measure Steward	CMS Program(s)
	Grouper				
XDEDB	Draft: Carotid Artery Stenosis Treatment Episode for CMS Episode Grouper	Draft: Resources used in caring for the condition (duration TBD).	Cost/Resource Use	Centers for Medicare & Medicaid Services (CMS)	Physician Feedback/QRUR, Physician Value-Based Payment Modifier
XDEBC	Draft: Cataract Condition Episode for CMS Episode Grouper	Draft: Resources used in caring for the condition (duration TBD).	Cost/Resource Use	Centers for Medicare & Medicaid Services (CMS)	Physician Feedback/QRUR, Physician Value-Based Payment Modifier
XDEBD	Draft: Cataract Treatment Episode for CMS Episode Grouper	Draft: Resources used in caring for the condition (duration TBD).	Cost/Resource Use	Centers for Medicare & Medicaid Services (CMS)	Physician Feedback/QRUR, Physician Value-Based Payment Modifier
XDEBB	Draft: Chronic Bronchitis/Emphysema Condition Episode for CMS Episode Grouper	Draft: Resources used in caring for the condition (duration TBD).	Cost/Resource Use	Centers for Medicare & Medicaid Services (CMS)	Physician Feedback/QRUR, Physician Value-Based Payment Modifier
XDEDL	Draft: Colon Cancer Condition Episode for CMS Episode Grouper	Draft: Resources used in caring for the condition (duration TBD).	Cost/Resource Use	Centers for Medicare & Medicaid Services (CMS)	Physician Feedback/QRUR, Physician Value-Based Payment Modifier
XDEDM	Draft: Colon Cancer Treatment Episode for CMS Episode Grouper	Draft: Resources used in caring for the condition (duration TBD).	Cost/Resource Use	Centers for Medicare & Medicaid Services (CMS)	Physician Feedback/QRUR, Physician Value-Based Payment Modifier
XDDML	Draft: Coronary	Draft: Resources used in caring for the condition	Cost/Resour	Centers for	Physician

MUC ID	Measure Title	Description	Measure Type	Measure Steward	CMS Program(s)
	Artery Bypass Graft Treatment Episode for CMS Episode Grouper	(duration TBD).	ce Use	Medicare & Medicaid Services (CMS)	Feedback/QRUR, Physician Value-Based Payment Modifier
XDEEA	Draft: Dementia Condition Episode for CMS Episode Grouper	Draft: Resources used in caring for the condition (duration TBD).	Cost/Resource Use	Centers for Medicare & Medicaid Services (CMS)	Physician Feedback/QRUR, Physician Value-Based Payment Modifier
XDECL	Draft: Diabetes Condition Episode for CMS Episode Grouper	Draft: Resources used in caring for the condition (duration TBD).	Cost/Resource Use	Centers for Medicare & Medicaid Services (CMS)	Physician Feedback/QRUR, Physician Value-Based Payment Modifier
XDEBE	Draft: Glaucoma Condition Episode for CMS Episode Grouper	Draft: Resources used in caring for the condition (duration TBD).	Cost/Resource Use	Centers for Medicare & Medicaid Services (CMS)	Physician Feedback/QRUR, Physician Value-Based Payment Modifier
XDEBF	Draft: Glaucoma Treatment Episode for CMS Episode Grouper	Draft: Resources used in caring for the condition (duration TBD).	Cost/Resource Use	Centers for Medicare & Medicaid Services (CMS)	Physician Feedback/QRUR, Physician Value-Based Payment Modifier
XDECA	Draft: Heart Block Condition Episode for CMS Episode Grouper	Draft: Resources used in caring for the condition (duration TBD).	Cost/Resource Use	Centers for Medicare & Medicaid Services (CMS)	Physician Feedback/QRUR, Physician Value-Based Payment Modifier
XDDMM	Draft: Heart Catheterization Treatment Episode for CMS Episode Grouper	Draft: Resources used in caring for the condition (duration TBD).	Cost/Resource Use	Centers for Medicare & Medicaid Services (CMS)	Physician Feedback/QRUR, Physician Value-Based Payment Modifier

MUC ID	Measure Title	Description	Measure Type	Measure Steward	CMS Program(s)
XDEBL	Draft: Heart Failure Condition Episode for CMS Episode Grouper	Draft: Resources used in caring for the condition (duration TBD).	Cost/Resource Use	Centers for Medicare & Medicaid Services (CMS)	Physician Feedback/QRUR, Physician Value-Based Payment Modifier
XDEAB	Draft: Hip Osteoarthritis Condition Episode for CMS Episode Grouper	Draft: Resources used in caring for the condition (duration TBD).	Cost/Resource Use	Centers for Medicare & Medicaid Services (CMS)	Physician Feedback/QRUR, Physician Value-Based Payment Modifier
XDEAC	Draft: Hip Replacement/Revision Treatment Episode for CMS Episode Grouper	Draft: Resources used in caring for the condition (duration TBD).	Cost/Resource Use	Centers for Medicare & Medicaid Services (CMS)	Physician Feedback/QRUR, Physician Value-Based Payment Modifier
XDEAD	Draft: Hip/Femur Fracture Condition Episode for CMS Episode Grouper	Draft: Resources used in caring for the condition (duration TBD).	Cost/Resource Use	Centers for Medicare & Medicaid Services (CMS)	Physician Feedback/QRUR, Physician Value-Based Payment Modifier
XDEAE	Draft: Hip/Femur Fracture Repair Treatment Episode for CMS Episode Grouper	Draft: Resources used in caring for the condition (duration TBD).	Cost/Resource Use	Centers for Medicare & Medicaid Services (CMS)	Physician Feedback/QRUR, Physician Value-Based Payment Modifier
XDECF	Draft: Hypertension Condition Episode for CMS Episode Grouper	Draft: Resources used in caring for the condition (duration TBD).	Cost/Resource Use	Centers for Medicare & Medicaid Services (CMS)	Physician Feedback/QRUR, Physician Value-Based Payment Modifier

MUC ID	Measure Title	Description	Measure Type	Measure Steward	CMS Program(s)
XDEDA	Draft: Ischemic Cerebral Artery Disease Condition Episode for CMS Episode Grouper	Draft: Resources used in caring for the condition (duration TBD).	Cost/Resource Use	Centers for Medicare & Medicaid Services (CMS)	Physician Feedback/QRUR, Physician Value-Based Payment Modifier
XDDMG	Draft: Ischemic Heart Disease Condition Episode for CMS Episode Grouper	Draft: Resources used in caring for the condition (duration TBD).	Cost/Resource Use	Centers for Medicare & Medicaid Services (CMS)	Physician Feedback/QRUR, Physician Value-Based Payment Modifier
XDEAF	Draft: Knee Osteoarthritis Condition Episode for CMS Episode Grouper	Draft: Resources used in caring for the condition (duration TBD).	Cost/Resource Use	Centers for Medicare & Medicaid Services (CMS)	Physician Feedback/QRUR, Physician Value-Based Payment Modifier
XDEAG	Draft: Knee Replacement/Revision Treatment Episode for CMS Episode Grouper	Draft: Resources used in caring for the condition (duration TBD).	Cost/Resource Use	Centers for Medicare & Medicaid Services (CMS)	Physician Feedback/QRUR, Physician Value-Based Payment Modifier
XDEDE	Draft: Lung Cancer Condition Episode for CMS Episode Grouper	Draft: Resources used in caring for the condition (duration TBD).	Cost/Resource Use	Centers for Medicare & Medicaid Services (CMS)	Physician Feedback/QRUR, Physician Value-Based Payment Modifier
XDEDF	Draft: Lung Cancer Treatment Episode for CMS Episode Grouper	Draft: Resources used in caring for the condition (duration TBD).	Cost/Resource Use	Centers for Medicare & Medicaid Services (CMS)	Physician Feedback/QRUR, Physician Value-Based Payment Modifier

MUC ID	Measure Title	Description	Measure Type	Measure Steward	CMS Program(s)
XDECH	Draft: Nephropathy/Renal Failure Condition Episode for CMS Episode Grouper	Draft: Resources used in caring for the condition (duration TBD).	Cost/Resource Use	Centers for Medicare & Medicaid Services (CMS)	Physician Feedback/QRUR, Physician Value-Based Payment Modifier
XDECC	Draft: Pacemaker/AICD Implantation Treatment Episode for CMS Episode Grouper	Draft: Resources used in caring for the condition (duration TBD).	Cost/Resource Use	Centers for Medicare & Medicaid Services (CMS)	Physician Feedback/QRUR, Physician Value-Based Payment Modifier
XDEAA	Draft: Percutaneous Coronary Intervention Treatment Episode for CMS Episode Grouper	Draft: Resources used in caring for the condition (duration TBD).	Cost/Resource Use	Centers for Medicare & Medicaid Services (CMS)	Physician Feedback/QRUR, Physician Value-Based Payment Modifier
XDECD	Draft: Pneumonia Condition Episode for CMS Episode Grouper	Draft: Resources used in caring for the condition (duration TBD).	Cost/Resource Use	Centers for Medicare & Medicaid Services (CMS)	Physician Feedback/QRUR, Physician Value-Based Payment Modifier
XDEDH	Draft: Prostate Cancer Condition Episode for CMS Episode Grouper	Draft: Resources used in caring for the condition (duration TBD).	Cost/Resource Use	Centers for Medicare & Medicaid Services (CMS)	Physician Feedback/QRUR, Physician Value-Based Payment Modifier
XDEDG	Draft: Prostate Cancer Treatment Episode for CMS	Draft: Resources used in caring for the condition (duration TBD).	Cost/Resource Use	Centers for Medicare & Medicaid Services	Physician Feedback/QRUR, Physician Value-Based

MUC ID	Measure Title	Description	Measure Type	Measure Steward	CMS Program(s)
	Episode Grouper			(CMS)	Payment Modifier
XDECE	Draft: Respiratory Failure Condition Episode for CMS Episode Grouper	Draft: Resources used in caring for the condition (duration TBD).	Cost/Resource Use	Centers for Medicare & Medicaid Services (CMS)	Physician Feedback/QRUR, Physician Value-Based Payment Modifier
XDEBG	Draft: Retinal Disease Condition Episode for CMS Episode Grouper	Draft: Resources used in caring for the condition (duration TBD).	Cost/Resource Use	Centers for Medicare & Medicaid Services (CMS)	Physician Feedback/QRUR, Physician Value-Based Payment Modifier
XDEBH	Draft: Retinal Disease Treatment Episode for CMS Episode Grouper	Draft: Resources used in caring for the condition (duration TBD).	Cost/Resource Use	Centers for Medicare & Medicaid Services (CMS)	Physician Feedback/QRUR, Physician Value-Based Payment Modifier
XDECM	Draft: Sepsis/SIRS Condition Episode for CMS Episode Grouper	Draft: Resources used in caring for the condition (duration TBD).	Cost/Resource Use	Centers for Medicare & Medicaid Services (CMS)	Physician Feedback/QRUR, Physician Value-Based Payment Modifier
XDECG	Draft: Shock/Hypotension Condition Episode for CMS Episode Grouper	Draft: Resources used in caring for the condition (duration TBD).	Cost/Resource Use	Centers for Medicare & Medicaid Services (CMS)	Physician Feedback/QRUR, Physician Value-Based Payment Modifier
XDEAH	Draft: Shoulder Osteoarthritis Condition Episode for CMS Episode Grouper	Draft: Resources used in caring for the condition (duration TBD).	Cost/Resource Use	Centers for Medicare & Medicaid Services (CMS)	Physician Feedback/QRUR, Physician Value-Based Payment Modifier
XDEAL	Draft: Shoulder	Draft: Resources used in caring for the condition	Cost/Resour	Centers for	Physician

MUC ID	Measure Title	Description	Measure Type	Measure Steward	CMS Program(s)
	Replacement/Repair Treatment Episode for CMS Episode Grouper	(duration TBD).	ce Use	Medicare & Medicaid Services (CMS)	Feedback/QRUR, Physician Value-Based Payment Modifier
S2158	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.	Efficiency	Centers for Medicare & Medicaid Services (CMS)	Physician Feedback/QRUR, Physician Value-Based Payment Modifier
E1822	External Beam Radiotherapy for Bone Metastases	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	Process	American Society for Radiation Oncology (ASTRO)	PPS-Exempt Cancer Hospital
XDCFE	Initiation of Osteoclast Inhibitors for Patients with Multiple Myeloma or Bone Metastases Associated with Breast Cancer, Prostate Cancer, or Lung Cancer	DRAFT: Percent of patients aged 18 years and older with multiple myeloma or with bone metastases associated with breast cancer, prostate cancer, or non-small cell lung cancer who had two or more visits to the reporting facility during the measurement period and were administered appropriate osteoclast inhibitors within 60 days following diagnosis of multiple myeloma or bone metastases.	Process	Centers for Medicare & Medicaid Services (CMS)	PPS-Exempt Cancer Hospital

MUC ID	Measure Title	Description	Measure Type	Measure Steward	CMS Program(s)
XDBLG	Overuse of Imaging for Staging Breast Cancer at Low Risk of Metastasis	DRAFT: Percentage of women 18 years of age or older with stage 0, I, or II breast cancer who had a bone, CT, PET, or PET/CT scan anytime during the 120 days following the initial diagnosis of breast cancer.	Process	Centers for Medicare & Medicaid Services (CMS)	PPS-Exempt Cancer Hospital
E1628	Patients with Advanced Cancer Screened for Pain at Outpatient Visits	Adult patients with advanced cancer who are screened for the presence and intensity of pain at each outpatient visit.	Process	RAND Corporation	PPS-Exempt Cancer Hospital
E0450	Perioperative pulmonary embolism or deep vein thrombosis rate (PSI 12)	Perioperative pulmonary embolism or deep vein thrombosis (secondary diagnosis) per 1,000 surgical discharges for patients 18 years and older (version 4.5). Excludes cases with principal diagnosis for pulmonary embolism or deep vein thrombosis; cases with secondary diagnosis for pulmonary embolism or deep vein thrombosis present on admission; cases in which interruption of vena cava is the only operating room procedure or in which interruption of vena cava occurs before or on the same day as the first operating room procedure; and obstetric discharges.	Outcome	Agency for Healthcare Research & Quality (AHRQ)	PPS-Exempt Cancer Hospital
XDDAF	Potentially Avoidable Admissions and Emergency Department Visits Among Patients Receiving	DRAFT: Percentage of cancer patients 18 years of age or older receiving outpatient chemotherapy who have an admission or emergency department (ED) visit for nausea, emesis, anemia, neutropenic fever, diarrhea, dehydration, or pain. Two rates are calculated.	Outcome	Centers for Medicare & Medicaid Services (CMS)	PPS-Exempt Cancer Hospital

MUC ID	Measure Title	Description	Measure Type	Measure Steward	CMS Program(s)
	Outpatient Chemotherapy				

APPENDIX A: MEASURE SPECIFICATIONS

Table Legend for Measure Specifications.

CMS has included a list of terms used in the Table of Measure Specifications for clarity and consistency. They are presented below in the order in which they appear as headings in this Table.

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

- An "E" prefix indicates a measure that is currently endorsed by the NQF.
- A "D" prefix indicates a measure that was once endorsed by the NQF but has subsequently been de-endorsed.
- An "F" prefix indicates a measure that was submitted to the NQF for endorsement but was not endorsed.
- An "S" prefix indicates a measure that is currently submitted to the NQF for endorsement.
- An all-lettered measure ID indicates a measure that has yet to be submitted to the NQF for endorsement.

Measure Title: Refers to the title of the measure.

- DRAFT: Refers to a measure under development

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: 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.

Length of Time: Refers to the amount of time the measure has been utilized by a CMS program or any other agency.

Measure Specifications Table

MUC ID	Measure Title	Numerator	Denominator	Exclusions	Length of Time
XDEMB	High-Acuity Care Visits after Outpatient Cataract Procedure	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); rather, it is a risk-standardized outcome rate. Thus, we use this field to define the measure outcome. The outcome for this measure is the combined rate of unplanned admissions, emergency department visits, and observation stays among Medicare FFS beneficiaries within 7 days after receiving a cataract surgery at an ambulatory surgery center or other outpatient facility.	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); rather, it is a risk-standardized outcome rate. Thus, we use this field to define the measure cohort. The cohort for this measure is patients who receive a cataract surgery at an ambulatory surgery center or other outpatient facility.	TBD	N/A
XDEMA	High-Acuity Care Visits after Outpatient Colonoscopy Procedure	Note: This outcome measure does not have a traditional numerator and denominator like a core process measure (e.g., percentage of adult patients with	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	TBD	N/A

MUC ID	Measure Title	Numerator	Denominator	Exclusions	Length of Time
		diabetes aged 18-75 years receiving one or more hemoglobin A1c tests per year); rather, it is a risk-standardized outcome rate. Thus, we use this field to define the measure outcome. The outcome for this measure is the combined rate of unplanned admissions, emergency department visits, and observation stays among Medicare FFS beneficiaries within 7 days after receiving a colonoscopy at an ambulatory surgery center or other outpatient facility.	aged 18-75 years receiving one or more hemoglobin A1c tests per year); rather, it is a risk-standardized outcome rate. Thus, we use this field to define the measure cohort. The cohort for this measure is patients who receive a colonoscopy at an ambulatory surgery center or other outpatient facility.		
XDELM	High-Acuity Care Visits after Outpatient Endoscopy Procedure	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); rather, it is a risk-standardized outcome rate. Thus, we use this field to define the measure outcome.	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); rather, it is a risk-standardized outcome rate. Thus, we use this field to define the measure cohort.	TBD	N/A

MUC ID	Measure Title	Numerator	Denominator	Exclusions	Length of Time
		The outcome for this measure is one or more of the following events – unplanned admission, emergency department visit, or observation stay – among Medicare FFS beneficiaries within 7 days after receiving an endoscopy at an ambulatory surgery center or other outpatient facility.	The cohort for this measure is patients who receive an endoscopy at an ambulatory surgery center or other outpatient facility.		
E0260	Assessment of Health-related Quality of Life (Physical & Mental Functioning)	Number of patients who complete a KDQOL-36 with or without assistance at least once per year.	Number of eligible prevalent dialysis patients (peritoneal dialysis, in-center hemodialysis, home hemodialysis) in the facility during the year minus exclusions.	< Age 18; Unable to complete due to cognitive impairment, dementia, or active psychosis; Non-English speaking/reading (no native language translation or interpreter available); Patients under the facility's care for <3 months; Patients who refuse to complete the questionnaire	N/A
E0029	Counseling on physical activity in older adults - a. Discussing Physical Activity, b. Advising Physical Activity	This is a patient self-reported survey measure with two rates: a- Discussing physical activity: The number of patients in the denominator who responded "yes" to the question, "In the past 12 months, did you talk with a doctor or other health provider	a- Discussing physical activity: The number of Medicare members 65 years and older as of December 31st of the measurement year who responded "yes" or "no" to the question "In the past 12 months, did you talk with a doctor or other health provider about	None	1-2 years

MUC ID	Measure Title	Numerator	Denominator	Exclusions	Length of Time
		about your level of exercise or physical activity? For example, a doctor or other health provider may ask if you exercise regularly or take part in physical exercise." b- Advising physical activity: The number of patients in the denominator who responded "yes" to the question, "In the past 12 months, did a doctor or other health provider advise you to start, increase or maintain your level of exercise or physical activity? For example, in order to improve your health, your doctor or other health provider may advise you to start taking the stairs, increase walking from 10 to 20 minutes every day or to maintain your current exercise program."	your level of exercise or physical activity? For example, a doctor or other health provider may ask if you exercise regularly or take part in physical exercise." b- Advising Physical activity: The number of Medicare members 65 years and older as of December 31st of the measurement year who responded "yes" or "no" to the question, "In the past 12 months, did a doctor or other health provider advise you to start, increase or maintain your level of exercise or physical activity? For example, in order to improve your health, your doctor or other health provider may advise you to start taking the stairs, increase walking from 10 to 20 minutes every day or to maintain your current exercise program."		
XDGBA	ESRD Vaccination – Lifetime Pneumococcal Vaccination	Number of patients from the denominator who (to be calculated and reported separately): 1) Have ever received either the PPSV23 or PCV13 vaccine	All patients aged ≥ 2 years at the start of the reporting period and on chronic dialysis ≥ 30 days in a facility during the 12-month reporting period (in-center or home dialysis)	N/A	N/A

MUC ID	Measure Title	Numerator	Denominator	Exclusions	Length of Time
		(documented by the dialysis provider or documented off-site vaccination) 2) Were offered PPSV23 or PCV13 vaccination and declined 3) Were determined to have a medical contraindication			
XDEFL	ESRD Vaccination - Pneumococcal Vaccination (PPSV23)	Number of patients from the denominator who (to be calculated and reported separately): 1) Have up-to-date PPSV23 vaccine status or received the vaccine during the 12-month reporting period (documented by the dialysis provider or documented off-site vaccination) 2) Were offered PPSV23 vaccination and declined 3) Were determined to have a medical contraindication	All patients aged >=2 years at the start of the reporting period and on chronic dialysis >=30 days in a facility during the 12-month reporting period (in-center or home dialysis)		N/A
XDEGA	ESRD Vaccination - Timely Influenza Vaccination	Number of patients from the denominator who during the time from August 1 through December 31 (to be calculated and reported separately): 1) Received an influenza vaccination (documented by the dialysis provider, documented off-site vaccination, or patient	All patients alive and aged >= 6 months on October 1 and on chronic dialysis >= 30 days in a facility at any point between October 1 and December 31 (in-center or home dialysis)		N/A

MUC ID	Measure Title	Numerator	Denominator	Exclusions	Length of Time
		self-report) 2) Were offered an influenza vaccination and declined 3) Were determined to have a medical contraindication			
XDEFM	Full-Season Influenza Vaccination (ESRD Patients)	Number of patients from the denominator who during the time from August 1 through March 31 (to be calculated and reported separately): 1) Received an influenza vaccination (documented by the dialysis provider, documented off-site vaccination, or patient self-report) 2) Were offered an influenza vaccination and declined 3) Were determined to have a medical contraindication	All patients alive and aged >= 6 months on October 1 and on chronic dialysis >= 30 days in a facility at any point between October 1 and March 31 (in-center or home dialysis)		N/A
XDGAF	Hepatitis B vaccine coverage in hemodialysis patients	Number of hemodialysis patients who have ever received three or more hepatitis B vaccine.	All hemodialysis patients.	None.	N/A
E0393	Hepatitis C: Testing for Chronic Hepatitis C – Confirmation of	Patients for whom HCV RNA testing was ordered or previously performed	All patients aged 18 years and older with a diagnosis of hepatitis C seen for initial evaluation	Documentation of medical reason(s) for not ordering or performing HCV RNA testing Documentation of patient	1-2 years

MUC ID	Measure Title	Numerator	Denominator	Exclusions	Length of Time
	Hepatitis C Viremia			reason(s) for not ordering or performing HCV RNA testing	
E0004	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	a) Initiation of AOD Dependence Treatment: Initiation of AOD treatment through an inpatient admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of diagnosis. • If the Index Episode was an inpatient discharge, the inpatient stay is considered initiation of treatment and the member is compliant • If the Index Episode was an outpatient, intensive outpatient, partial hospitalization, detoxification or ED visit, the member must have an inpatient admission, outpatient visit, intensive outpatient encounter or partial hospitalization (Table IET-B) with an AOD diagnosis (Table IET-A) within 14 days of the IESD (inclusive) – If the initiation encounter is an inpatient admission, the admission date (not the discharge date) must be within 14 days of the IESD (inclusive)	Members age 13 years of age and older with a medical and chemical dependency benefit who were diagnosed with a new episode of alcohol and drug dependency (AOD) during the intake period of January 1-November 15 of the measurement year. The Intake Period is used to capture new episodes of AOD.	Exclude members who had a claim/encounter with a diagnosis of AOD (Table IET-A) during the 60 days (2 months) before the IESD. For an inpatient IESD, use the admission date to determine the Negative Diagnosis History. For an ED visit that results in an inpatient stay, use the ED date of service to determine the Negative Diagnosis History. Exclude from the denominator members whose initiation encounter is an inpatient stay with a discharge date after December 1 of the measurement year.	1-2 years

MUC ID	Measure Title	Numerator	Denominator	Exclusions	Length of Time
		• Do not count Index Episodes that include detoxification codes (including inpatient detoxification) as being initiation of treatment b) Engagement of AOD Treatment: Initiation of AOD treatment and two or more inpatient admissions, outpatient visits, intensive outpatient encounters or partial hospitalizations (Table IET-B) with any AOD diagnosis (Table IET-A) within 30 days after the date of the Initiation encounter (inclusive). Multiple engagement visits may occur on the same day, but they must be with different providers in order to be counted. For members who initiated treatment via an inpatient stay, use the discharge date as the start of the 30-day engagement period. • If the engagement encounter is an inpatient admission, the admission date (not the discharge date) must be within 30 days of the Initiation			

MUC ID	Measure Title	Numerator	Denominator	Exclusions	Length of Time
		encounter (inclusive). •Do not count engagement encounters that include detoxification codes (including inpatient detoxification)			
XDEGC	Measurement of Plasma PTH Concentration	Peritoneal dialysis and hemodialysis patients included in the sample for analysis with plasma PTH measured, together with documentation of the specific PTH assay utilized, at least once within a 3 month period	All hemodialysis and peritoneal dialysis patients included in the sample for analysis during the month of study.	Transient patients (in unit < 30 days)	N/A
E0431	Influenza Vaccination Coverage Among Healthcare Personnel	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	Number of HCP who are working in the healthcare facility for at least 1 working day between October 1 and March 31 of the following year, regardless of clinical responsibility or patient contact. Denominators are to be calculated separately for: (a) Employees: all persons who receive a direct paycheck from the reporting facility (i.e., on the facility's payroll). (b) Licensed independent practitioners: include physicians	None	>2 years

MUC ID	Measure Title	Numerator	Denominator	Exclusions	Length of Time
		(c) declined the vaccination (computed separately).	(MD, DO), advanced practice nurses, and physician assistants only who are affiliated with the reporting facility who do not receive a direct paycheck from the reporting facility. (c) Adult students/trainees and volunteers: include all adult students/trainees and volunteers who do not receive a direct paycheck from the reporting facility.		
E0420	Pain Assessment and Follow-Up	Patient's pain assessment is documented through discussion with the patient including the use of a standardized tool(s) AND a follow-up plan is documented when pain is present.	Patients 18 years of age and older on the date of the encounter	• Severe mental and/or physical incapacity where the person is unable to express himself/herself in a manner understood by others. For example, cases where pain cannot be accurately assessed through use of nationally recognized standardized pain assessment tools • 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	N/A
XCBMM	Pediatric Peritoneal Dialysis	Patients are included in the numerator if delivered PD was a weekly Kt/V urea (dialytic +	All pediatric (< 18 years old) peritoneal dialysis patients who have been on PD for at least 90	HD patients, adult patients, pediatric PD patients on dialysis < 90 days	N/A

MUC ID	Measure Title	Numerator	Denominator	Exclusions	Length of Time
	Adequacy: Achievement of Target Kt/V	residual) of at least 1.8 during the 6 month reporting period	days		
XDGAM	Pediatric Peritoneal Dialysis Adequacy: Frequency of Measurement of Kt/V	Patients are included in the numerator if weekly Kt/V urea (dialytic + residual) was measured at least once in a six month reporting period	All pediatric (< 18 years old) peritoneal dialysis patients who have been on PD for at least 90 days	HD patients, adult patients, pediatric PD patients on dialysis < 90 days	N/A
XDEGB	Percentage of Dialysis Patients with Dietary Counseling	Number of hemodialysis and peritoneal dialysis patients included in the denominator with dietary counseling of the patient and/or caregiver on appropriate phosphorus sources and content as part of an overall healthy nutrition plan at least once within six-months	All hemodialysis and peritoneal dialysis patients included in the sample for analysis during the month of study.	1. Transient patients (in unit < 30 days) 2. Patients exclusively on non-oral food sources (i.e., total parenteral or enteral nutrition).	N/A
XDEFH	Pneumococcal Vaccination Measure (PCV13)	Number of patients from the denominator who (to be calculated and reported separately): 1) Have ever received the PCV13 vaccine (documented by the dialysis provider or documented off-site vaccination) 2) Were offered PCV13 vaccination and declined	All patients aged >=5 years at the start of the reporting period and on chronic dialysis >=30 days in a facility during the 12-month reporting period (in-center or home dialysis)	Patients who received PPSV23 vaccination within 12 months prior to the start of the reporting period	N/A

MUC ID	Measure Title	Numerator	Denominator	Exclusions	Length of Time
		3) Were determined to have a medical contraindication			
E0418	Screening for Clinical Depression	Patient's screening for clinical depression is documented and follow up plan is documented.	Patient 18 years of age and older	A patient is not eligible if one or more of the following conditions exist: Patient refuses to participate Patient is in an urgent or emergent situation where time is of the essence and to delay treatment would jeopardize the patient's health status Situations where the patient's motivation to improve may impact the accuracy of results of nationally recognized standardized depression assessment tools. For example: certain court appointed cases Patient was referred with a diagnosis of depression Patient has been participating in ongoing treatment with screening of clinical depression in a preceding reporting period Severe mental and/or physical incapacity where the person is unable to express himself/herself in a manner understood by others. For example: cases such as delirium	1-2 years

MUC ID	Measure Title	Numerator	Denominator	Exclusions	Length of Time
				or severe cognitive impairment, where depression cannot be accurately assessed through use of nationally recognized standardized depression assessment tools.	
XDEFF	Standardized Kt/V	The number of patients with necessary data elements reported. The elements required for stdKt/V would include modality, birthdate, dialysis start date, prescribed sessions per week, spKt/V, spKt/V method, delivered minutes of BUN Hemodialysis session, Pre BUN, post BUN, pre dialysis weight and unit of measurement, post dialysis weight and unit of measurement, residual urea clearance (optional), and vascular access type.	(1) 18 or older (2) HD Patients (3) On Dialysis > 90 days (4) Same provider for 30 days.		N/A
XDEFE	Surface Area Normalized Kt/V	The number of patients with necessary data elements reported. The elements required to calculate SAN Kt/V include all elements required for stdKt/V as well as date of spKt/V measurement, Height and unit of Measurement, Sex, Race, Diabetes status.	1. 18 or older 2. HD Patients 3. On Dialysis > 90 days 4. Same provider for 30 days.		N/A

MUC ID	Measure Title	Numerator	Denominator	Exclusions	Length of Time
XAHMH	Ultrafiltration Rate (UFR)	Number of adult ESRD patients at a dialysis facility with a maximum ultrafiltration rate greater than 13 ml/kg/hr. Ultrafiltration rate is calculated for a single session per month (CROWNWeb generally records data from the last session) using data elements for pre-dialysis weight, post-dialysis weight, and delivered minutes of dialysis. The formula for UFR is: UFR = [(((Δ wt kg)*1000)/(delivered time/60))/post wt kg]	Total number of patients reported at a dialysis facility undergoing hemodialysis (HD). All adult (>=18 years old) hemodialysis patients with ESRD >=3 months and same provider for >= 30 days who have non-missing values for data elements necessary for calculating UFR (pre and post dialysis weight and delivered time per session) during the reporting period. Patients are excluded if (1) the patient is less than 18 years of age at the beginning of the reporting month; (2) Patient is not on hemodialysis during the reporting month; (3) the patient was on chronic dialysis for less than 90 days at the beginning of the reporting month; (4) the patient has been with the same provider for less than 30 days; (5) the pre dialysis weight (in kg) is missing during the reporting month; (6) the post dialysis weight (in kg) is missing during the reporting month; (7) the delivered time per		N/A

MUC ID	Measure Title	Numerator	Denominator	Exclusions	Length of Time
			session (in mins) is missing during the reporting month; (8) if the calculated UFR value was implausible, defined as less than 0 ml/kg/hr or greater than 50 ml/kg/hr;		
XDDLA	PSI 10:Postoperative Physiologic and Metabolic Derangement Rate	Discharges, among cases meeting the inclusion and exclusion rules for the denominator, with either: - any secondary ICD-9-CM diagnosis codes for physiologic and metabolic derangements; or -any secondary ICD-9-CM diagnosis codes for acute renal failure and any-listed ICD-9-CM procedure codes for dialysis	Elective surgical discharges, for patients ages 18 years and older, with any-listed ICD-9-CM procedure codes for an operating room procedure. Elective surgical discharges are defined by specific DRG or MS-DRG codes with admission type recorded as elective (SID ATYPE=3). See Patient Safety Indicators Appendices: - Appendix A – Operating Room Procedure Codes -Appendix D – Surgical Discharge DRGs -Appendix E – Surgical Discharge MS-DRGs	Exclude cases: with a principal ICD-9-CM diagnosis code (or secondary diagnosis present on admission) for physiologic and metabolic derangements (see above); with a principal ICD-9-CM diagnosis code (or secondary diagnosis present on admission†) for acute renal failure (see above); with any secondary ICD-9-CM diagnosis codes for acute renal failure (see above) and a dialysis procedure (see above) occurs before or on the same day as the first operating room procedure‡; with any secondary ICD-9-CM diagnosis codes for physiologic and metabolic derangements (see above) and a principal ICD-9-CM diagnosis code (or secondary diagnosis present on admission) for diabetes; with any secondary ICD-9-CM	N/A

MUC ID	Measure Title	Numerator	Denominator	Exclusions	Length of Time
				diagnosis codes for acute renal failure (see above) and a principal ICD-9-CM diagnosis code (or secondary diagnosis present on admission†) for acute myocardial infarction; with any secondary ICD-9-CM diagnosis codes for acute renal failure (see above) and a principal ICD-9-CM diagnosis code (or secondary diagnosis present on admission†) for cardiac arrhythmia; with any secondary ICD-9-CM diagnosis codes for acute renal failure (see above) and a principal ICD-9-CM diagnosis code (or secondary diagnosis present on admission†) for cardiac arrest; with any secondary ICD-9-CM diagnosis codes for acute renal failure (see above) and a principal ICD-9-CM diagnosis code (or secondary diagnosis present on admission†) for shock; with any secondary ICD-9-CM diagnosis codes for acute renal failure (see above) and a principal ICD-9-CM diagnosis code (or secondary diagnosis present on admission†) for	

MUC ID	Measure Title	Numerator	Denominator	Exclusions	Length of Time
				hemorrhage; with any secondary ICD-9-CM diagnosis codes for acute renal failure (see above) and a principal ICD-9-CM diagnosis code (or secondary diagnosis present on admission†) for gastrointestinal hemorrhage; with any secondary ICD-9-CM diagnosis codes for acute renal failure (see above) and a principal ICD-9-CM diagnosis code (or secondary diagnosis present on admission†) for chronic renal failure; MDC 14 (pregnancy, childbirth and the puerperium); with missing gender (SEX=missing), age (AGE=missing), quarter (DQTR=missing), year (YEAR=missing), or principal diagnosis (DX1=missing)	
E0533	PSI 11: Post-Operative Respiratory Failure	Discharges, among cases meeting the inclusion and exclusion rules for the denominator, with either: • any secondary ICD-9-CM diagnosis code for acute respiratory failure; or • any-listed ICD-9-CM procedure	Elective surgical discharges, for patients ages 18 years and older, with any-listed ICD-9-CM procedure codes for an operating room procedure. Elective surgical discharges are defined by specific DRG or MS-DRG codes with admission type recorded as	Exclude cases: • with a principal ICD-9-CM diagnosis code (or secondary diagnosis present on admission) for acute respiratory failure (see above) • where the only operating	>2 years

MUC ID	Measure Title	Numerator	Denominator	Exclusions	Length of Time
		codes for a mechanical ventilation for 96 consecutive hours or more that occurs zero or more days after the first major operating room procedure code (based on days from admission to procedure); or • any-listed ICD-9-CM procedure codes for a mechanical ventilation for less than 96 consecutive hours (or undetermined) that occurs two or more days after the first major operating room procedure code (based on days from admission to procedure); or • any-listed ICD-9-CM procedure codes for a reintubation that occurs one or more days after the first major operating room procedure code (based on days from admission to procedure)	elective (SID ATYPE=3). See Patient Safety Indicators Appendices: • Appendix A – Operating Room Procedure Codes • Appendix D – Surgical Discharge DRGs • Appendix E – Surgical Discharge MS-DRGs	room procedure is tracheostomy • where a procedure for tracheostomy occurs before the first operating room procedure • with any-listed ICD-9-CM diagnosis codes for neuromuscular disorder • with any-listed ICD-9-CM procedure codes for laryngeal or pharyngeal surgery • with any-listed ICD-9-CM procedure codes for the face and any-listed ICD-9-CM diagnosis codes for craniofacial anomalies • with any-listed ICD-9-CM procedure codes for esophageal resection • with any-listed ICD-9-CM procedure codes for lung cancer • with any-listed ICD-9-CM procedure codes for procedure on the nose, mouth and pharynx • any-listed ICD-9-CM diagnosis codes for degenerative neurological disorder	

MUC ID	Measure Title	Numerator	Denominator	Exclusions	Length of Time
				• MDC 4 (diseases/disorders of respiratory system) • MDC 5 (diseases/disorders of circulatory system) • 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)	
E0349	PSI 16: Transfusion Reaction	Surgical and medical discharges, for patients ages 18 years and older or MDC 14 (pregnancy, childbirth, and puerperium), with any secondary ICD-9-CM diagnosis codes for transfusion reaction. Surgical and medical discharges are defined by specific DRG or MS-DRG codes. See Patient Safety Indicators Appendices: Appendix B – Medical Discharge DRGs; Appendix C – Medical Discharge MS-DRGs; Appendix D – Surgical Discharge DRGs; Appendix E – Surgical Discharge MS-DRGs: For more info see:	N/A	Exclude cases: • with a principal ICD-9-CM diagnosis code (or secondary diagnosis present on admission) for transfusion reaction (see above) • with missing gender (SEX=missing), age (AGE=missing), quarter (DQTR=missing), year (YEAR=missing), or principal diagnosis (DX1=missing)	N/A

MUC ID	Measure Title	Numerator	Denominator	Exclusions	Length of Time
		http://www.qualityindicators.ahrq.gov/Modules/PSI_TechSpec.aspx			
XAFLG	PSI 9: Perioperative Hemorrhage or Hematoma Rate	Discharges, among cases meeting the inclusion and exclusion rules for the denominator, with either: -any secondary ICD-9-CM diagnosis codes for perioperative hemorrhage and any-listed ICD-9-CM procedure codes for control of perioperative hemorrhage; or -any secondary ICD-9-CM diagnosis codes for perioperative hemorrhage and any-listed ICD-9-CM procedure codes for drainage of hematoma; or -any secondary ICD-9-CM diagnosis codes for perioperative hemorrhage and any-listed ICD-9-CM procedure codes for miscellaneous hemorrhage- or hematoma-related procedure; or -any secondary ICD-9-CM diagnosis codes for perioperative hematoma and any-listed ICD-9-CM procedure codes for control of perioperative hemorrhage; or -any secondary ICD-9-CM diagnosis codes for perioperative hematoma and any-listed ICD-9-	Surgical discharges, for patients ages 18 years and older, with any-listed ICD-9-CM procedure codes for an operating room procedure. Surgical discharges are defined by specific DRG or MS-DRG codes.	Exclude cases: -with a principal ICD-9-CM diagnosis code (or secondary diagnosis present on admission†) for perioperative hemorrhage (see above) -with a principal ICD-9-CM diagnosis code (or secondary diagnosis present on admission†) for postoperative hematoma (see above) -where the only operating room procedure is control of postoperative hemorrhage (see above), drainage of hematoma (see above), or a miscellaneous hemorrhage- or hematoma-related procedure (see above) -with any secondary ICD-9-CM diagnosis codes for perioperative hemorrhage (see above) and any-listed ICD-9-CM procedure codes for control of perioperative hemorrhage (see above) occurring before the first operating room procedure‡ -with any secondary ICD-9-CM	N/A

MUC ID	Measure Title	Numerator	Denominator	Exclusions	Length of Time
		CM procedure codes for drainage of hematoma; or -any secondary ICD-9-CM diagnosis codes for perioperative hematoma and any-listed ICD-9-CM procedure codes for miscellaneous hemorrhage or hematoma-related procedure.		diagnosis codes for perioperative hemorrhage (see above) and any-listed ICD-9-CM procedure codes for drainage of hematoma (see above) occurring before the first operating room procedure‡ -with any secondary ICD-9-CM diagnosis codes for perioperative hemorrhage (see above) and any-listed ICD-9-CM procedure codes for miscellaneous hemorrhage- or hematoma-related procedure (see above) occurring before the first operating room procedure‡ -with any secondary ICD-9-CM diagnosis codes for perioperative hematoma (see above) and any-listed ICD-9-CM procedure codes for control of perioperative hemorrhage (see above) occurring before the first operating room procedure‡ -with any secondary ICD-9-CM diagnosis codes for perioperative hematoma (see above) and any-listed ICD-9-CM procedure codes for drainage of hematoma (see above) occurring before the first	

MUC ID	Measure Title	Numerator	Denominator	Exclusions	Length of Time
				operating room procedure‡ -with any secondary ICD-9-CM diagnosis codes for perioperative hematoma (see above) and any-listed ICD-9-CM procedure codes for miscellaneous hemorrhage- or hematoma-related procedure (see above) occurring before the first operating room procedure‡ -with any-listed ICD-9-CM diagnosis codes for coagulation disorder -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)	
XDFFA	Depression Screening Conducted and Follow-Up Plan Documented	Number of home health episodes of care in which patients were screened for depression (using a standardized depression screening tool) at start/resumption of care AND, if positive, the physician-ordered plan of care includes a depression intervention(s)	Number of home health episodes of care ending with discharge, death, or transfer to inpatient facility during the reporting period, other than those covered by generic or measure-specific exclusions.	Home health episodes for which the patient is nonresponsive.	N/A

MUC ID	Measure Title	Numerator	Denominator	Exclusions	Length of Time
		AND/OR physician notified that the patient screened positive for depression.			
XDAEH	Emergency Department Use without Hospital Readmission During the First 30 Days of Home Health	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 HH claim in the series of HH claims that comprise the HH stay. If the patient has any Medicare outpatient claims with any emergency department revenue center codes (0450-0459, 0981) during the 30 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	Number of home health stays that begin during the 12-month observation period for patients who had an acute inpatient hospitalization in the five days prior to the start of the HH stay. A home health stay is a sequence of home health payment episodes separated from other home health payment episodes by at least 60 days. Each home health payment episode is associated with a Medicare home health (HH) claim, so home health stays are constructed from claims data using the following procedure. 1. First, retrieve HH claims with a "from" date (FROM_DT) during the 12-month observation period or the 120 days prior to the beginning of the observation period and sequence these claims by "from" date for each beneficiary. 2. Second, drop claims with the	Numerator Exclusions: None Denominator Exclusions: The following are excluded: 1) HH stays for patients who are not continuously enrolled in fee-for-service Medicare for the 60 days following the start of the HH stay or until death. 2) HH stays that begin with a Low Utilization Payment Adjustment (LUPA) claim. 3) HH stays in which the patient receives service from multiple agencies during the first 60 days. 4) HH stays for patients who are not continuously enrolled in fee-for-service Medicare for the 6 months prior to the HH stay. 5) HH stays for patients who receive care during the window between hospital discharge and the start of HH care. In the first case, we lack full information about the patient's utilization of health care services and cannot determine if care was sought in	N/A

MUC ID	Measure Title	Numerator	Denominator	Exclusions	Length of Time
		measure numerator.	same "from" date and "through" date (THROUGH_DT) and claims listing no visits and no payment. Additionally, if multiple claims have the same "from" date, keep only the claim with the most recent process date. 3. Third, set Stay_Start_Date (1) equal to the "from" date on the beneficiary's first claim. Step through the claims sequentially to determine which claims begin new home health stays. If the claim "from" date is more than 60 days after the "through" date on the previous claim, then the claim begins a new stay. If the claim "from" date is within 60 days of the "through" date on the previous claim, then the claim continues the stay associated with the previous claim. 4. Fourth, for each stay, set Stay_Start_Date (n) equal to the "from" date of the first claim in the sequence of claims defining that stay. Set Stay_End_Date (n) equal to the "through" date on the last claim in that stay. Confirm that Stay_Start_Date (n+1) minus Stay_End_Date (n) is greater than	an emergency department during the numerator window. In the next two cases, it is unclear that the initial home health agency had an opportunity to impact the patient's health outcomes. In the fourth case, the stay is excluded because we lack information about the patient's health status prior to the beginning of home health that is needed for risk adjustment. In the final case, patients' health outcomes may be affected by the care they receive between hospital discharge and the start of home care. 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.	

MUC ID	Measure Title	Numerator	Denominator	Exclusions	Length of Time
			60 days for all adjacent stays. 5. Finally, drop stays that begin before the 12-month observation window. Note the examining claims from the 120 days before the beginning of the 12-month observation period is necessary to ensure that stays beginning during the observation period are in fact separated from previous home health claims by at least 60 days.	Admissions for cancer have very different mortality and readmission rates than the remainder of the population. Admissions for psychiatric diseases are treated in separate psychiatric facilities not comparable to treatment received in acute care hospitals, and admissions for rehabilitation care typically do not occur in an acute care setting. Finally, admissions that end in patient discharge against medical advice are excluded because the hospital did not have a full opportunity to treat the patient.	
XDFGB	New or Worsened Pressure Ulcers	Number of home health episodes of care in which the patient is discharged from home health with one or more Stage 2 - 4 pressure ulcer(s) that are new or have worsened since the start or resumption of care.	Number of home health episodes of care ending with a discharge during the reporting period, other than those covered by generic or measure-specific exclusions.	Home health episodes of care that end with inpatient facility transfer or death.	N/A
XCHGG	Rehospitalization During the First 30 Days of Home Health	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	Number of home health stays that begin during the 12-month observation period for patients who had an acute inpatient hospitalization in the five days	Numerator Exclusions: Inpatient claims for planned hospitalizations are excluded from the rehospitalization measure numerator. Planned	N/A

MUC ID	Measure Title	Numerator	Denominator	Exclusions	Length of Time
		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 at least one Medicare inpatient claim from short term or critical access hospitals (identified by the CMS Certification Number ending in 0001-0879, 0800-0899, or 1300-1399) during the 30 day window, then the stay is included in the measure numerator.	prior to the start of the HH stay. A home health stay is a sequence of home health payment episodes separated from other home health payment episodes by at least 60 days. Each home health payment episode is associated with a Medicare home health (HH) claim, so home health stays are constructed from claims data using the following procedure. 1. First, retrieve HH claims with a "from" date (FROM_DT) during the 12-month observation period or the 120 days prior to the beginning of the observation period and sequence these claims by "from" date for each beneficiary. 2. Second, drop claims with the same "from" date and "through" date (THROUGH_DT) and claims listing no visits and no payment. Additionally, if multiple claims have the same "from" date, keep only the claim with the most recent process date.	hospitalizations are defined using the same criteria as the Hospital-Wide All-Cause Unplanned Readmission Measure as of January 2013. Specifically, a small set of readmissions, defined using AHRQ Procedure and Diagnosis CCS, are always considered "planned." An additional set of admissions are categorized as "potentially planned" and are also excluded from being counted as unplanned admissions in the measure numerator unless they have a discharge condition category considered "acute or complication of care," which is defined using AHRQ Diagnosis CCS. Denominator Exclusions: The following are excluded: 1) HH stays for patients who are not continuously enrolled in fee-for-service Medicare for the 60 days following the start of the HH stay or until death. 2) HH stays that begin with a Low Utilization Payment Adjustment (LUPA)	

MUC ID	Measure Title	Numerator	Denominator	Exclusions	Length of Time
			3. Third, set Stay_Start_Date (1) equal to the "from" date on the beneficiary's first claim. Step through the claims sequentially to determine which claims begin new home health stays. If the claim "from" date is more than 60 days after the "through" date on the previous claim, then the claim begins a new stay. If the claim "from" date is within 60 days of the "through" date on the previous claim, then the claim continues the stay associated with the previous claim. 4. Fourth, for each stay, set Stay_Start_Date (n) equal to the "from" date of the first claim in the sequence of claims defining that stay. Set Stay_End_Date (n) equal to the "through" date on the last claim in that stay. Confirm that Stay_Start_Date (n+1) minus Stay_End_Date (n) is greater than 60 days for all adjacent stays. 5. Finally, drop stays that begin before the 12-month observation window.	claim. 3) HH stays in which the patient receives service from multiple agencies during the first 60 days. 4) HH stays for patients who are not continuously enrolled in fee-for-service Medicare for the 6 months prior to the HH stay. 5) HH stays for patients who receive care during the window between hospital discharge and the start of HH care. In the first case, we lack full information about the patient's utilization of health care services and cannot determine if care was sought in an emergency department during the numerator window. In the next two cases, it is unclear that the initial home health agency had an opportunity to impact the patient's health outcomes. In the fourth case, the stay is excluded because we lack information about the patient's health status prior to the beginning of home health that is needed for risk adjustment. In the final case, patients' health outcomes may be affected by	

MUC ID	Measure Title	Numerator	Denominator	Exclusions	Length of Time
			Note the examining claims from the 120 days before the beginning of the 12-month observation period is necessary to ensure that stays beginning during the observation period are in fact separated from previous home health claims by at least 60 days.	the care they receive between hospital discharge and the start of home care. 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. Admissions for cancer have very different mortality and readmission rates than the remainder of the population. Admissions for psychiatric diseases are treated in separate psychiatric facilities not comparable to treatment received in acute care hospitals, and admissions for rehabilitation care typically do not occur in an acute care setting. Finally, admissions that end in patient discharge against medical advice are excluded	

MUC ID	Measure Title	Numerator	Denominator	Exclusions	Length of Time
				because the hospital did not have a full opportunity to treat the patient.	
XBELG	Hospital 30-day, all-cause, unplanned, risk-standardized readmission rate (RSRR) following Coronary artery Bypass Graft (CABG) Surgery	The outcome for this measure is 30-day all-cause readmission. We define all-cause readmission as an unplanned inpatient admission for any cause within 30 days after the date of discharge from the index admission for patients 18 years and older discharged from the hospital after undergoing isolated CABG surgery. If a patient has one or more unplanned admissions (for any reason) within 30 days after discharge from the index admission, only one is counted as a readmission. (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 are using this field to define the outcome and to which	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). We therefore use this field to define the measure cohort. This claims-based measure can be used in either of two patient cohorts: (1) patients aged 65 years or older or (2) patients aged 18 years or older. We have tested the measure in both age groups. The cohort includes admissions for patients who receive a qualifying isolated CABG procedure (see codes below) and with a complete claims history for the 12 months prior to admission. For simplicity of implementation and as testing demonstrated closely correlated patient-level and hospital-level results using models with or	1) Patients who leave hospital against medical advice (AMA) are identified using the discharge disposition indicator in the Standard Analytic File (SAF). 2) Patients who die during the index hospitalization are identified using the discharge disposition vital status indicator in the SAF. 3) Subsequent qualifying CABG procedures during the measurement period is identified by the ICD-9 codes defining CABG mentioned in denominator details. 4) Patients undergoing non-isolated CABG procedures (CABG Surgeries that occur concomitantly with procedures that elevate patients' readmission risk).	N/A

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		hospital the outcome is attributed when there are multiple hospitalizations within a single episode of care.) This is an all-cause readmission measure and therefore any readmission within 30 days of discharge from the index hospitalization (hereafter referred to as discharge date) is included in the measure unless that readmission is deemed a "planned" readmission. The outcome is attributed to the hospital that provided the index CABG procedure. Planned Readmission Definition With this measure, CMS seeks to count only unplanned readmissions, as variation in "planned" readmissions does not typically reflect quality differences. Although clinical experts agree that planned readmissions are likely rare after isolated CABG, we have adapted an algorithm originally created to	without age interaction terms, the only recommended modification to the measure for application to all-payer data sets is replacement of the "Age-65" variable with a fully continuous age variable. 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). We therefore use this field to define the measure cohort.) The index cohort includes admissions for patients aged 18 years or older who received a qualifying "isolated" CABG procedure (CABG procedure without other concurrent major cardiac procedure such as a valve replacement). The measure was developed in a cohort of patients 65 years and older who were enrolled in Medicare FFS and admitted to non-federal hospitals. To be included in the Medicare FFS cohort, patients had to have a	Procedures that are occur concomitantly with a qualifying CABG procedure that exclude patients from the cohort are identified using the following ICD-9-CM procedure codes for: 0.61 Percutaneous angioplasty or atherectomy of precerebral (extracranial) vessel(s) 0.62 Percutaneous angioplasty or atherectomy of intracranial vessel(s) 0.62 Percutaneous angioplasty or atherectomy of intracranial vessel(s) 0.63 Percutaneous insertion of carotid artery stent(s) 0.64 Percutaneous insertion of other precerebral (extracranial) artery stent(s) 0.65 Percutaneous insertion of intracranial vascular stent(s) 32.4x Lobectomy with segmental resection of adjacent lobes of lung, excludes that with radical dissection [excision] of thoracic structures 33.5x Lung transplant 33.6 Combined heart-lung transplantation 35.00 Closed heart valvotomy,	

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		identify planned readmissions for a hospital-wide (i.e., not condition-specific) readmission measure to this CABG readmission measure. In brief, the algorithm identifies a short list of always planned readmissions (those where the principle discharge diagnosis is major organ transplant, obstetrical delivery, or maintenance chemotherapy) as well as those readmissions with a potentially planned procedure (e.g., total hip replacement or cholecystectomy) AND a non-acute principle discharge diagnosis code. For example, a readmission for colon resection is considered planned if the principal diagnosis is colon cancer but unplanned if the principal diagnosis is abdominal pain, as the latter might represent a complication of the CABG procedure or hospitalization. Readmissions that included potentially planned procedures with acute diagnoses or that might represent complications of CABG, such as PTCA or repeat	qualifying isolated CABG procedure AND had to be continuously enrolled in Medicare Fee-for-Service (FFS) one year prior to the first day of the index hospitalization and through 30 days post-discharge. This cohort is defined using the ICD-9 Clinical Modification (ICD-9-CM) procedure codes identified in Medicare Part A Inpatient claims data ICD-9-CM codes that define the cohort: 36.1x - Aortocoronary bypass for heart revascularization, not otherwise specified 36.11 - (Aorto) coronary bypass of one coronary artery 36.12 - (Aorto coronary bypass of two coronary arteries 36.13 - (Aorto) coronary bypass of three coronary arteries 36.14 - (Aorto) coronary bypass of four or more coronary arteries 36.15 - Single internal mammary-coronary artery bypass 36.16 - Double internal mammary-coronary artery bypass	unspecified valve 35.01 Closed heart valvotomy, aortic valve 35.02 Closed heart valvotomy, mitral valve 35.03 Closed heart valvotomy, pulmonary valve 35.04 Closed heart valvotomy, tricuspid valve 35.10 Open heart valvuloplasty without replacement, unspecified valve 35.11 Open heart valvuloplasty of aortic valve without replacement 35.12 Open heart valvuloplasty of mitral valve without replacement 35.13 Open heart valvuloplasty of pulmonary valve without replacement 35.14 Open heart valvuloplasty of tricuspid valve without replacement 35.20 Replacement of unspecified heart valve 35.21 Replacement of aortic valve with tissue graft 35.22 Other replacement of aortic valve 35.23 Replacement of mitral	

MUC ID	Measure Title	Numerator	Denominator	Exclusions	Length of Time
		CABG, are not considered planned. Overall, planned readmissions constituted < 3% of readmissions and only 0.3% of all index admissions were associated with a planned readmission (and not counted in the measure outcome). Outcome attribution Attribution of the outcome in situations where a patient has multiple contiguous admissions, at least one of which involves an index CABG procedure (i.e., the patient is either transferred into the hospital that performs the index CABG or is transferred out to another hospital following the index CABG) is as follows: - If a patient undergoes a CABG procedure in the first hospital and is then transferred to a second hospital where there is no CABG procedure, the readmission outcome is attributed to the first hospital performing the index CABG procedure and the 30-day window starts with the date of	36.17 - Abdominal- coronary artery bypass 36.19 - Other bypass anastomosis for heart revascularization	valve with tissue graft 35.24 Other replacement of mitral valve 35.25 Replacement of pulmonary valve with tissue graft 35.26 Other replacement of pulmonary valve 35.27 Replacement of tricuspid valve with tissue graft 35.28 Other replacement of tricuspid valve 35.31 Operations on papillary muscle 35.32 Operations on chordae tendineae 35.33 Annuloplasty 35.34 Infundibulectomy 35.35 Operations on trabeculae carneae cordis 35.39 Operations on other structures adjacent to valves of heart 35.41 Enlargement of existing atrial septal defect 35.42 Creation of septal defect in heart 35.50 Repair of unspecified septal defect of heart with prosthesis 35.51 Repair of atrial septal	

MUC ID	Measure Title	Numerator	Denominator	Exclusions	Length of Time
		discharge from the final hospital in the chain. Rationale: A transfer following CABG is most likely due to a complication of the index procedure and that care provided by the hospital performing the CABG procedure likely dominates readmission risk even among transferred patients. - If a patient is admitted to a first hospital but does not receive a CABG procedure there and is then transferred to a second hospital where a CABG is performed, the readmission outcome is attributed to the second hospital performing the index CABG procedure and the 30-day window starts with the date of discharge from the final hospital in the chain. Rationale: Care provided by the hospital performing the CABG procedure likely dominates readmission risk. -If a patient undergoes a CABG procedure in the first hospital and is transferred to a second		defect with prosthesis, open technique 35.52 Repair of atrial septal defect with prosthesis, closed technique 35.53 Repair of ventricular septal defect with prosthesis, open technique 35.54 Repair of endocardial cushion defect with prosthesis 35.55 Repair of ventricular septal defect with prosthesis, closed technique 35.60 Repair of unspecified septal defect of heart with tissue graft 35.61 Repair of atrial septal defect with tissue graft 35.62 Repair of ventricular septal defect with tissue graft 35.63 Repair of endocardial cushion defect with tissue graft 35.70 Other and unspecified repair of unspecified septal defect of heart 35.71 Other and unspecified repair of atrial septal defect 35.72 Other and unspecified repair of ventricular septal defect 35.73 Other and unspecified	

MUC ID	Measure Title	Numerator	Denominator	Exclusions	Length of Time
		hospital where another CABG procedure is performed, the readmission outcome is attributed to the first hospital performing the index (first) CABG procedure and the 30-day window starts with the date of discharge from the final hospital in the chain. Rationale: A transfer following CABG is most likely due to a complication of the index procedure, and care provided by the hospital performing the index CABG procedure likely dominates readmission risk even among transferred patients.		repair of endocardial cushion defect 35.81 Total repair of tetralogy of Fallot 35.82 Total repair of total anomalous pulmonary venous connection 35.83 Total repair of truncus arteriosus 35.84 Total correction of transposition of great vessels, not elsewhere classified 35.91 Interatrial transposition of venous return 35.92 Creation of conduit between right ventricle and pulmonary artery 35.93 Creation of conduit between left ventricle and aorta 35.94 Creation of conduit between atrium and pulmonary artery 35.95 Revision of corrective procedure on heart 35.96 Percutaneous valvuloplasty 35.98 Other operations on septa of heart 35.99 Other operations on valves of heart 37.31 Pericardiectomy	

MUC ID	Measure Title	Numerator	Denominator	Exclusions	Length of Time
				37.32 Excision of aneurysm of heart 37.33 Excision or destruction of other lesion or tissue of heart, open approach 37.35 Partial ventriculectomy 37.51 Heart transplantation 37.52 Implantation of total internal biventricular heart replacement system 37.53 Replacement or repair of thoracic unit of (total) replacement heart system 37.54 Replacement or repair of other implantable component of (total) replacement heart system 37.55 Removal of internal biventricular heart replacement system 37.63 Repair of heart assist system 37.67 Implantation of cardiomyostimulation system 38.12 Endarterectomy, other vessels of head and neck 38.11 Head and Neck Endarterectomy 38.14 Endarterectomy of Aorta 38.15 Thoracic Endarterectomy 38.16 Endarterectomy : Excision	

MUC ID	Measure Title	Numerator	Denominator	Exclusions	Length of Time
				of tunica intima of artery to relieve arterial walls thickened by plaque or chronic inflammation. Location includes abdominal arteries excluding abdominal aorta: Celiac, Gastric, Hepatic, Iliac, Mesenteric, Renal, Splenic, Umbi 38.17 Endarterectomy - abdominal veins: Iliac, Portal, Renal, Splenic, Vena cava. 38.34 Resection of vessel with replacement: Angiectomy, excision of aneurysm (arteriovenous), blood vessel (lesion) with anastomosis (4=aorta, abdominal) 38.42 Resection of vessel with replacement: Angiectomy, excision of aneurysm with replacement (2= other vessels of head and neck; carotid, jugular) 38.44 Resection of vessel with replacement, aorta, abdominal 38.45 Resection of vessel with replacement, thoracic vessels 39.21 Caval-pulmonary artery anastomosis 39.22 Aorta-subclavian-carotid bypass 39.23 Other intrathoracic	

MUC ID	Measure Title	Numerator	Denominator	Exclusions	Length of Time
				vascular shunt or bypass 39.24 Aorta-renal bypass 39.25 Aorta-iliac-femoral bypass 39.26 Other intra-abdominal vascular shunt or bypass 39.28 Extracranial-intracranial (EC-IC) vascular bypass 39.29 Other (peripheral) vascular shunt or bypass 39.71 Endovascular implantation of graft in abdominal aorta 39.72 Endovascular embolization or occlusion of head and neck vessels 39.73 Endovascular implantation of graft in thoracic aorta 39.74 Endovascular removal of obstruction from head and neck vessel(s) 39.75 Endovascular embolization or occlusion of vessel(s) of head or neck using bare coils 39.76 Endovascular embolization or occlusion of vessel(s) of head or neck using bioactive coils 39.79 Other endovascular procedures on other vessels 85.22 Resection of quadrant of breast	

MUC ID	Measure Title	Numerator	Denominator	Exclusions	Length of Time
				85.23 Subtotal Mastectomy, which excludes quadrant resection (85.22) 85.4x Mastectomy - includes simple/extended simple, unilateral/bilateral, radical/extended radical For Medicare FFS patients: 5) Patients younger than 65 years are identified using the age variable that is created based on patient admit date and birth date. 6) Patients without continuous enrollment in Medicare FFS for 12 months prior to index hospitalization. This is determined by patient enrollment status in both Part A and Part B and in FFS using CMS' EDB; the enrollment indicators must be appropriately marked for each of the 12 months prior to the index hospital stay. 7) Patients without at least 30 days post-discharge enrollment in FFS Medicare are identified using patient enrollment status	

MUC ID	Measure Title	Numerator	Denominator	Exclusions	Length of Time
				in the CMS' Enrollment Database (EDB).	
XDBCB	Adverse Drug Events - Hyperglycemia	Sum of the percentage of hospital days in hyperglycemia for all admissions in the denominator	Total number of admissions with a diagnosis of diabetes mellitus, at least one administration of insulin or any oral anti-diabetic medication except metformin, or at least one elevated blood glucose value (>200 mg/dL [11.1 mmol/L]) at any time during the entire hospital stay	1. Admissions with a diagnosis of diabetic ketoacidosis (DKA) or hyperglycemic hyperosmolar syndrome (HHS) 2. Admissions without any hospital days included in the analysis 3. Admissions with lengths of stay greater than 120 days	N/A
XDBGA	Adverse Drug Events - Hypoglycemia	Total number of hypoglycemic events (<40 mg/dL) that were preceded by administration of a short/rapid-acting insulin within 12 hours or an anti-diabetic agent other than a short/rapid-acting insulin within 24 hours, were not followed by another glucose value greater than 80 mg/dL within 5 minutes, and were at least 20 hours apart	Total number of hospital days with at least one anti-diabetic agent administered	Admissions with length of stay greater than 120 days	N/A
XDEEL	Hospital 30-day Risk-standardized Acute Myocardial Infarction (AMI)	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	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	1) Discharged against medical advice (AMA) 2) Transfer-in admissions: Among patients transferred from an inpatient admission at one acute care institution to	N/A

MUC ID	Measure Title	Numerator	Denominator	Exclusions	Length of Time
	Mortality eMeasure	more hemoglobin A1c tests per year); thus, we use this field to define mortality. The outcome for this measure is 30-day all-cause mortality. We define all-cause mortality as death from any cause within 30 calendar days after the date of the index admission. For example, if a patient were admitted on January 1, the last of the 30-day period would be January 31.	hemoglobin A1c tests per year); thus, we use this field to define patients included in the measure. Equals initial patient population	another, the second admission with an AMI is not eligible as an index admission 3) Admissions with unreliable data (age >115 years) 4) Multiple AMI admissions in measurement period: one admission should be randomly selected to retain and other admissions should be excluded for patients with multiple admissions for AMI within measurement period	
XDAEA	Appropriate Monitoring of patients receiving an Opioid via an IV Patient Controlled Analgesia Device	Hospitalizations during which the maximum time interval between documentation of each of the following parameters does not exceed 2.5 hours, starting at the beginning of the first episode of IV opioid administration via PCA, until either 24 hours later or discontinuation of the PCA, whichever occurs first: 1.Respiratory Rate 2.Pulse Oximetry 3.Sedation Score	All patients who receive an intravenous opioid via patient controlled analgesia in a hospital setting for more than 2.5 continuous hours	Patients with an order for "comfort measures only" or "allow natural death"	N/A
XBGDL	Hospital 30-Day All-Cause Risk-Standardized	This outcome measure does not have a traditional numerator and denominator like a core process	The target population for this measure includes inpatient and outpatient hospital stays for	Hospital stays are excluded from the cohort if they met any of the following criteria: (Brief	N/A

MUC ID	Measure Title	Numerator	Denominator	Exclusions	Length of Time
	Readmission Rate (RSRR) following Vascular Procedures	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 readmissions. The outcome for this measure is 30-day all-cause readmission following a qualifying index hospital stay (any stay with a vascular procedure). We define a readmission as a subsequent hospital inpatient admission within 30 days of either the discharge (for inpatients) or claim end date (for outpatients) following a qualifying hospital stay. We do not count as readmissions any outpatient procedures or any subsequent admissions which are identified as "staged" or planned. Readmissions captured in the measure include any inpatient hospitalization to an acute care hospital within 30 days of discharge or claim end (hereafter referred to as discharge) date from the index hospital stay,	patients at least 65 years of age who receive one or more qualifying vascular procedure. The time window can be specified from one to three years. We used Medicare claims data from one calendar year (2009) to develop this measure. 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 cohort. The index cohort includes inpatient or outpatient hospital stays for patients at least 65 years of age who received one or more qualifying vascular procedure at the hospital during 2009. Hospital stays are eligible for inclusion in the denominator if they contained a qualifying vascular procedure AND the patient had continuous enrollment in Medicare fee-for-	narrative description of exclusions from the target population) 1) Lack of continuous enrollment in Medicare FFS for 12 months prior to index hospital stay. Hospital stays for patients who lack continuous enrollment in Medicare FFS for 12 months prior to index hospital stay are excluded. Rationale: We exclude these hospital stays to ensure full data availability for risk-adjustment. 2) In-hospital deaths. Hospital stays for patients with in-hospital deaths are excluded. Rationale: Patients who die during the initial hospital stay are not at risk for readmission. 3) Transfers out. Hospitals stays in which patients receive a qualifying vascular procedure and are then transferred to another acute care facility are excluded. Rationale: In this instance, the	

MUC ID	Measure Title	Numerator	Denominator	Exclusions	Length of Time
		unless that readmission is identified as planned. To the extent possible, we do not count as readmissions hospital stays associated with planned procedures, as physicians caring for patients with vascular disease may opt to stage procedures across multiple hospital stays. We identified planned procedures in three ways: (1) same-procedure pairs, (2) different-procedure pairs, and (3) amputation procedures. Readmissions are considered planned and thus not counted as readmissions in the measure if they represent one of the procedure pairs below, are not associated with an acute diagnosis code listed below, and if they occur at the same hospital as the index procedure. Same-procedure pairs: Procedures that occur during the index hospital stay and are repeated in the readmission may represent a set of procedures planned, or staged, over two	service (FFS) one year prior to the first day of the index hospital stay and through 30 days post discharge. Procedures on veins, procedures on cardiac and intracranial arteries, and procedures addressing vascular access for hemodialysis, do not qualify for inclusion in the cohort as they represent hospital stays for patient populations distinct from those intended for inclusion in the measure, with differing risks for readmission. Additionally, hospital stays associated with a primary discharge diagnosis of ICD-9 code 996.73 (other complications due to renal dialysis device implant and graft) are not included in the cohort. This cohort is defined using the ICD-9 procedure codes identified in Medicare Part A inpatient and outpatient claims data and Medicare Part A outpatient Current Procedural Terminology (CPT) codes listed below. For purposes of risk adjustment, hospital stays are assigned to	hospital that performed the vascular procedure does not provide discharge care and cannot be fairly held responsible for outcomes following discharge. Of note, these stays are a part of a single acute episode of care and only the transfer-out admission is excluded from the index cohort (i.e., not the full episode of care; if a patient is transferred from one hospital to another and has a qualifying vascular procedure at the second hospital, which then discharges them to a non-acute setting, the second hospital stay is part of the index cohort and evaluated for readmission). The readmission is attributed to the hospital where the procedure was performed and where the patient received discharge care. 4) Lack of follow-up in Medicare FFS for at least 30 days post-discharge. Hospital stays for patients without at least 30-days of enrollment in Medicare FFS	

MUC ID	Measure Title	Numerator	Denominator	Exclusions	Length of Time
		hospital stays. For example, a set of stents which cross distinct anatomic areas within the body, such as the left and right extremities, may be placed over two hospital stays. Although some procedures that are repeated during a readmission may be the result of a complication of the first procedure, it is difficult to distinguish these scenarios from planned events using administrative claims data. We recognize that labeling all such procedure pairs as planned will inevitably capture some unplanned events. On balance, however, identifying the below same-procedure pairs as planned will avoid penalizing hospitals that opt to stage procedures over multiple hospital stays. This approach may be further refined with the implementation of International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10) codes which distinguish, for example, anatomic laterality. Unless the admitting diagnosis is for an	procedure groups based on anatomic location and whether an open surgical or endovascular procedure was performed, as described under section 2a1.13 below. Qualifying ICD-9 and CPT procedure codes listed by anatomic group and procedure type are as follows: Head/neck-endovascular: ICD-9 codes 00.61 Percutaneous angioplasty or atherectomy of precerebral (extracranial) vessel(s), basilar, carotid, vertebral 00.63 Percutaneous insertion of carotid artery stent(s), Includes: the use of any embolic protection device, distal protection device, filter device, or stent delivery system, Non-drug-eluting stent 39.72 Endovascular repair or occlusion of head and neck vessels 39.74 Endovascular removal of obstruction from head and neck vessel(s) 00.64 Percutaneous insertion of other precerebral (extracranial) artery stent(s) CPT codes	after the index stay are excluded. Rationale: We exclude these hospital stays because the 30-day readmission outcome cannot be assessed in this group. 5) Hospital stays for patients who leave hospital against medical advice (AMA). Hospital stays for patients who are discharged AMA are excluded. Rationale: We exclude hospital stays for patients who are discharged AMA because providers in these circumstances do not have the opportunity to deliver full care and prepare the patient for discharge. 6) Subsequent qualifying vascular procedures within 30 days of discharge. Any vascular hospital stay is either an index stay or a potential readmission, but not both. Rationale: Qualifying vascular procedures occurring within 30	

MUC ID	Measure Title	Numerator	Denominator	Exclusions	Length of Time
		acute illness as described below, a hospital stay for one of the following procedures that is followed by an inpatient admission for the same procedure at the same hospital is not counted as a readmission: Procedure code/description: 39.50 Angioplasty or atherectomy of other non-coronary vessel(s) 38.12 Endarterectomy-other vessels of head and neck 39.90 Insertion of non-drug-eluting, non-coronary artery stent(s) 39.29 Other (peripheral) vascular shunt or bypass 38.18 Endarterectomy-lower limb arteries 39.79 Other endovascular repair (of aneurysm) of other vessels 00.61 Percutaneous angioplasty or atherectomy of precerebral (extracranial) vessel(s), basilar, carotid, vertebral 00.63 Percutaneous insertion of carotid artery stent(s), Includes: the use of any embolic protection device, distal protection device,	37215 Transcatheter placement of intravascular stent(s), cervical carotid artery, percutaneous; with distal embolic protection 37216 Transcatheter placement of intravascular stent(s), cervical carotid artery, percutaneous; without distal embolic protection 0075T Transcatheter placement of extracranial vertebral or intrathoracic carotid artery stent(s), including radiologic supervision and interpretation, percutaneous; initial vessel Head/neck-open: ICD-9 codes 38.12 Endarterectomy-other vessels of head and neck 38.02 Incision of vessels-other vessels of head and neck 38.42 Resection of vessel with replacement-other vessels of head and neck 38.32 Resection of vessel with anastomosis-other vessels of head and neck CPT codes 35201 Repair blood vessel, direct; neck 35005 Direct repair of aneurysm,	days of discharge of an index hospital stay fall within the 30-day readmission assessment period during which no new hospital stay can be counted as an index hospital stay. They are considered readmissions.	

MUC ID	Measure Title	Numerator	Denominator	Exclusions	Length of Time
		filter device, or stent delivery system, Non-drug-eluting stent 38.08 Incision of vessels-lower limb arteries 39.52 Other repair of aneurysm 39.72 Endovascular repair or occlusion of head and neck vessels 38.03 Incision of vessels-upper limb vessels 39.59 Other repair of vessel 00.55 Insertion of drug-eluting stent(s) of other peripheral vessel(s), endograft(s), endovascular graft(s), stent grafts 39.57 Repair of blood vessel with synthetic patch graft 39.56 Repair of blood vessel with tissue patch graft 38.48 Resection of vessel with replacement-lower limb arteries 39.53 Repair of arteriovenous fistula 39.58 Repair of blood vessel with unspecified type of patch graft 38.68 Other excision of vessels-lower limb arteries 38.02 Incision of vessels-other vessels of head and neck 00.64 Percutaneous insertion of other precerebral (extracranial)	pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for aneurysm, pseudoaneurysm, and associated occlusive disease, vertebral artery 35231 Repair blood vessel with vein graft; neck 35301 Thromboendarterectomy, including patch graft, if performed; carotid, vertebral, subclavian, by neck incision 35701 Exploration (not followed by surgical repair), with or without lysis of artery; carotid artery 34001 Embolectomy of thrombectomy, with or without catheter; carotid, subclavian, or innominate artery, by neck incision Thoracic/abdominal-endovascular: ICD-9 codes 39.71 Endovascular repair of abdominal aortic aneurysm with graft 39.73 Endovascular implantation of graft in thoracic aorta CPT codes 35473 Transluminal balloon angioplasty, percutaneous; iliac		

MUC ID	Measure Title	Numerator	Denominator	Exclusions	Length of Time
		artery stent(s) 38.42 Resection of vessel with replacement-other vessels of head and neck 38.38 Resection of vessel with anastomosis-lower limb arteries 38.32 Resection of vessel with anastomosis-other vessels of head and neck 38.13 Endarterectomy-upper limb vessels 38.43 Resection of vessel with replacement-upper limb vessels 38.10 Endarterectomy-unspecified site 38.33 Resection of vessel with anastomosis-upper limb vessels 38.00 Incision of vessels-unspecified site 38.40 Resection of vessel with replacement-unspecified site 00.60 Insertion of drug-eluting stent(s) of superficial femoral artery 38.30 Resection of vessel with anastomosis-unspecified site Different-procedure pairs: We identified additional clinically sensible index-readmission different-procedure pairs that	35471 Transluminal balloon angioplasty, percutaneous; renal or visceral artery 35492 Transluminal peripheral atherectomy, percutaneous; iliac 35472 Transluminal balloon angioplasty, percutaneous; aortic 35490 Transluminal peripheral atherectomy, percutaneous; renal or other visceral artery 34808 Endovascular placement of iliac artery occlusion device (List separately in addition to code for primary procedure) 35491 Transluminal peripheral atherectomy, percutaneous; aortic 34825 Placement of proximal or distal extension prosthesis for endovascular repair of infrarenal abdominal aortic or iliac aneurysm false aneurysm, or dissection; initial vessel 34802 Endovascular repair of infrarenal abdominal aortic aneurysm or dissection; using modular bifurcated prosthesis (1 docking limb) 34800 Endovascular repair of infrarenal abdominal aortic aneurysm or dissection; using non-aortic tube prosthesis		

MUC ID	Measure Title	Numerator	Denominator	Exclusions	Length of Time
		may represent planned events. For example, a carotid endarterectomy is sometimes performed prior to a planned aortic aneurysm repair. Listed below are the different-procedure pairs which are likely planned across hospital stays and for which the second hospitalization is not counted as a readmission (unless the readmission is to a different hospital than that at which the index hospital stay occurred or is accompanied by an acute primary discharge diagnosis code listed below): Index procedure: 38.12 Endarterectomy-other vessels of head and neck Procedure at readmission: 38.44 Resection of abdominal aorta with replacement Index procedure: 39.22 Aorta-subclavian-carotid bypass Procedure at readmission: 39.73 Endovascular implantation of graft in thoracic aorta	34803 Endovascular repair of infrarenal abdominal aortic aneurysm or dissection; using modular bifurcated prosthesis (2 docking limb) 34805 Endovascular repair of infrarenal abdominal aortic aneurysm or dissection; using modular bifurcated prosthesis (1 docking limb), using aorto-iliac or aorto-unifemoral prosthesis 33880 Endovascular repair of descending thoracic aorta (e.g. aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption); involving coverage of left subclavian artery origin, initial endoprosthesis plus descending thoracic aortic extension(s), if required, to level of celiac artery origin 0078T Endovascular repair using prosthesis of abdominal aortic aneurysm, pseudoaneurysm or dissection, abdominal aorta involving visceral branches (superior mesenteric, celiac and/or renal arteries) 33881 Endovascular repair of descending thoracic aorta (e.g.,		

MUC ID	Measure Title	Numerator	Denominator	Exclusions	Length of Time
		Index procedure: 39.73 Endovascular implantation of graft in thoracic aorta Procedure at readmission: 39.22 Aorta-subclavian-carotic bypass Index procedure: 39.90 Insertion of non-drug-eluting, non-coronary artery stent(s) Procedure at readmission: 39.29 Other (peripheral) vascular shunt or bypass Index procedure: 39.90 Insertion of non-drug-eluting, non-coronary artery stent(s) Procedure at readmission: 39.50 Angioplasty or atherectomy of other non-coronary vessel(s) Index procedure: 39.25 Aorta-iliac-femoral bypass Procedure at readmission: 86.60 Free skin graft, not otherwise specified Index procedure: 39.29 Other (peripheral) vascular shunt or bypass Procedure at readmission: 86.60 Free skin graft, not otherwise	aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption); not involving coverage of left subclavian artery origin, initial endoprosthesis plus descending thoracic aortic extension(s), if required, to level of celiac artery origin 33886 Placement of distal extension prosthesis(s) delayed after endovascular repair of descending thoracic aorta 0080T Endovascular repair of abdominal aortic-aneurysm, pseudoaneurysm or abdominal aortic aneurysm involving visceral vessels (superior mesenteric, celiac or renal), using fenestrated modular bifurcated prosthesis (2 docking limbs), radiological supervision and interpretation 34804 Endovascular repair of infrarenal abdominal aortic aneurysm or dissection; using unibody bifurcated prosthesis 0081T Placement of visceral extension prosthesis for endovascular repair of abdominal aortic aneurysm involving visceral		

MUC ID	Measure Title	Numerator	Denominator	Exclusions	Length of Time
		specified Index procedure: 39.25 Aorta-iliac-femoral bypass Procedure at readmission: 86.22 Excisional debridement of wound, infection, or burn Index procedure: 39.29 Other (peripheral) vascular shunt or bypass Procedure at readmission: 86.22 Excisional debridement of wound, infection, or burn Index procedure: 39.23 Other intrathoracic vascular shunt or bypass Procedure at readmission: 39.73 Endovascular implantation of graft in thoracic aorta Index procedure: 39.24 Aorta-renal bypass Procedure at readmission: 39.71 Endovascular implantation of graft in abdominal aorta Index procedure: 39.26 Other intra-abdominal vascular shunt or bypass	vessels each visceral branch, radiological supervision and interpretation (Use separately in addition to code for primary procedure) 34900 Endovascular graft placement for repair of iliac artery (e.g., aneurysm, pseudoaneurysm, arteriovenous malformation, trauma) 35475 Transluminal balloon angioplasty, percutaneous; brachiocephalic trunk or branches, each vessel 35494 Transluminal peripheral atherectomy, percutaneous; brachiocephalic trunk or branches, each vessel Thoracic/abdominal-open: ICD-9 codes 38.44 Resection of abdominal aorta with replacement 39.25 Aorta-iliac-femoral bypass 38.45 Resection of vessel with replacement-thoracic vessel 38.16 Endarterectomy-abdominal arteries 39.22 Aorta-subclavian-carotid bypass 38.14 Endarterectomy-aorta		

MUC ID	Measure Title	Numerator	Denominator	Exclusions	Length of Time
		Procedure at readmission: 39.71 Endovascular implantation of graft in abdominal aorta Amputation procedures: In some cases readmissions which include amputations are likely planned follow-on care. Specifically, readmissions with toe or foot amputations may represent planned events, which may indicate good clinical practice and a prior vascular procedure's success at maximizing tissue preservation. Listed below are the procedure codes that, if occurring in the second hospital stay, will not be considered a readmission (unless the readmission is to a different hospital than that at which the index hospital stay occurred or is accompanied by an acute primary discharge diagnosis code listed below). Again, the index vascular procedure(s) must be performed on patients who were admitted for a subsequent amputation to be considered planned.	39.26 Other intra-abdominal vascular shunt or bypass 38.46 Resection of vessel with replacement-abdominal arteries 38.34 Resection of Abdominal Aorta with anastomosis 39.24 Aorta-renal bypass 38.66 Other excision of vessels-abdominal arteries 39.55 Reimplantation of aberrant renal vessel 38.36 Resection of vessel with anastomosis-abdominal arteries 38.15 Endarterectomy-other thoracic vessels 38.35 Resection of vessel with anastomosis-other thoracic vessels 39.23 Other intrathoracic vascular shunt or bypass 39.54 Re-entry operation (aorta) CPT codes 35226 Repair blood vessel, direct; lower extremity 35903 Excision of infected graft; extremity 35206 Repair blood vessel, direct; upper extremity 35190 Repair, acquired or traumatic arteriovenous fistula; extremities		

MUC ID	Measure Title	Numerator	Denominator	Exclusions	Length of Time
		84.11 Amputation toe 84.12 Amputation through foot Identifying acute readmissions that are not planned: If a planned readmission is identified as described above it will not be counted as a readmission unless it is associated with a common acute diagnosis which would suggest that the readmission was not planned. Any readmissions associated with the following acute International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM, hereafter referred to as ICD-9) primary discharge diagnosis codes will not be considered planned, regardless of procedure(s) performed at readmission: 038.xx, 785.52, 785.59, 790.7, 995.91, 995.92, 998.0, 998.59 (Sepsis) 410.xx (excluding 410.x2) (Acute Myocardial Infarction (AMI)) 996.xx, 997.xx, 998.xx (Complication of prior procedure)	35011 Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for aneurysm and associated occlusive disease, axillary-brachial artery, by arm incision 35860 Exploration for postoperative hemorrhage, thrombosis or infection; extremity 35207 Repair blood vessel, direct; hand, finger 35236 Repair blood vessel with vein graft; upper extremity 35371 Thromboendarterectomy, including patch graft, if performed; common femoral 35266 Repair blood vessel with graft other than vein; upper extremity 35879 Revision, lower extremity arterial bypass, without thrombectomy, open; With vein patch angioplasty 35045 Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for aneurysm, pseudoaneurysm, and associated occlusive disease, radial or ulnar		

MUC ID	Measure Title	Numerator	Denominator	Exclusions	Length of Time
		Readmissions that are associated with these primary discharge diagnoses are likely unplanned. These diagnoses were identified as the most common discharge diagnoses that follow hospital stays for vascular procedures and that represent specific and clearly acute conditions.	artery 35883 Revision, femoral anastomosis of synthetic arterial bypass graft in groin, open; with nonautogenous patch graft (e.g., Dacron, ePTFE, bovine pericardium) 35302 Thromboendarterectomy, including patch graft, if performed; superficial femoral artery 35372 Thromboendarterectomy, including patch graft, if performed; deep (profunda) femoral 35556 Bypass graft, with vein; femoral-popliteal 35656 Bypass graft, with other than vein; femoral-popliteal 35881 Revision, lower extremity arterial bypass, without thrombectomy, open; with segmental vein interposition 35141 Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for aneurysm, pseudoaneurysm, and associated occlusive disease, common femoral artery (profunda femoris,		

MUC ID	Measure Title	Numerator	Denominator	Exclusions	Length of Time
			superficial femoral) 35286 Repair blood vessel with graft other than vein; lower extremity 35355 Thromboendarterectomy, including patch graft, if performed, iliofemoral 35256 Repair blood vessel with vein graft; lower extremity 35303 Thromboendarterectomy, including patch graft, if performed; popliteal artery 35142 Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for ruptured aneurysm, common femoral artery (profunda femoris, superficial femoral) 35184 Repair, congenital alteriovenous fistula; extremities 35151 Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for aneurysm, pseudoaneurysm, and associated occlusive disease, popliteal artery 35525 Bypass graft, with vein; brachial-brachial 35566 Bypass graft, with vein;		

MUC ID	Measure Title	Numerator	Denominator	Exclusions	Length of Time
			femoral-anterior tibial, posterior tibial, peroneal artery or other distal vessels 35570 Bypass graft, with vein; tibial-tibial, peroneal-tibial, or tibial/peroneal trunk-tibial 34813 Placement of femoral-femoral prosthetic graft during endovascular aortic aneurysm repair (list separately in addition to code for primary procedure) 35013 Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for ruptured aneurysm, axillary-brachial artery, by arm incision 35304 Thromboendarterectomy, including patch graft, if performed; tibioperoneal trunk artery 35305 Thromboendarterectomy, including patch graft, if performed; tibial or peroneal artery, initial vessel 35306 Thromboendarterectomy, including patch graft, if performed; each additional tibial or peroneal artery (List separately in addition to code for primary		

MUC ID	Measure Title	Numerator	Denominator	Exclusions	Length of Time
			procedure) 35523 Bypass graft, with vein; brachial-ulnar or radial 35585 In-situ vein bypass; femoral-anterior tibial, posterior tibial, or peroneal artery 35661 Bypass graft, with other than vein; femoral-femoral 35884 Revision, femoral anastomosis of synthetic arterial bypass graft in groin, open; with autogenous vein patch graft 35518 Bypass graft, with vein; axillary-axillary 35521 Bypass graft, with vein; axillary-femoral 35558 Bypass graft, with vein; femoral-femoral 35571 Bypass graft, with vein; popliteal-tibial, -peroneal artery or other distal vessels 35650 Bypass graft, with other than vein; axillary-axillary 34101 Embolectomy or thrombectomy, with or without catheter; axillary, brachial, innominate, subclavian artery, by arm incision 35459 Transluminal balloon angioplasty, open; tibioperoneal trunk and branches		

MUC ID	Measure Title	Numerator	Denominator	Exclusions	Length of Time
			34111 Embolectomy or thrombectomy, with or without catheter; radial or ulnar artery, by arm incision 35485 Transluminal peripheral atherectomy, open; tibioperoneal trunk and branches 35483 Transluminal peripheral atherectomy, open; femoral-popliteal 34812 Open femoral artery exposure for delivery of endovascular prosthesis, by groin incision, unilateral Limb-endovascular: ICD-9 codes 00.60 Insertion of drug-eluting stent(s) of superficial femoral artery CPT codes 35474 Transluminal balloon angioplasty, percutaneous; femoral-popliteal 35493 Transluminal peripheral atherectomy, percutaneous; femoral-popliteal 35470 Transluminal balloon angioplasty, percutaneous; tibioperoneal trunk or branches, each vessel		

MUC ID	Measure Title	Numerator	Denominator	Exclusions	Length of Time
			35495 Transluminal peripheral atherectomy, percutaneous; tibioperoneal trunk and branches 35456 Transluminal balloon angioplasty, open; femoral-popliteal Limb-open: ICD-9 codes 38.18 Endarterectomy-lower limb arteries 38.08 Incision of vessels-lower limb arteries 38.48 Resection of vessel with replacement-lower limb arteries 38.68 Other excision of vessels-lower limb arteries 38.38 Resection of vessel with anastomosis-lower limb arteries 38.03 Incision of vessels-upper limb vessels 38.13 Endarterectomy-upper limb vessels 38.43 Resection of vessel with replacement-upper limb vessels 38.33 Resection of vessel with anastomosis-upper limb vessels CPT codes 35226 Repair blood vessel, direct; lower extremity 35903 Excision of infected graft;		

MUC ID	Measure Title	Numerator	Denominator	Exclusions	Length of Time
			extremity 35206 Repair blood vessel, direct; upper extremity 35190 Repair, acquired or traumatic arteriovenous fistula; extremities 35011 Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for aneurysm and associated occlusive disease, axillary-brachial artery, by arm incision 35207 Repair blood vessel, direct; hand, finger 35236 Repair blood vessel with vein graft; upper extremity 35371 Thromboendarterectomy, including patch graft, if performed; common femoral 35266 Repair blood vessel with graft other than vein; upper extremity 35879 Revision, lower extremity arterial bypass, without thrombectomy, open; With vein patch angioplasty 35045 Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch		

MUC ID	Measure Title	Numerator	Denominator	Exclusions	Length of Time
			graft; for aneurysm, pseudoaneurysm, and associated occlusive disease, radial or ulnar artery 35883 Revision, femoral anastomosis of synthetic arterial bypass graft in groin, open; with nonautogenous patch graft (e.g., Dacron, ePTFE, bovine pericardium) 35302 Thromboendarterectomy, including patch graft, if performed; superficial femoral artery 35372 Thromboendarterectomy, including patch graft, if performed; deep (profunda) femoral 35556 Bypass graft, with vein; femoral-popliteal 35656 Bypass graft, with other than vein; femoral-popliteal 35881 Revision, lower extremity arterial bypass, without thrombectomy, open; with segmental vein interposition 35141 Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for aneurysm,		

MUC ID	Measure Title	Numerator	Denominator	Exclusions	Length of Time
			pseudoaneurysm, and associated occlusive disease, common femoral artery (profunda femoris, superficial femoral) 35286 Repair blood vessel with graft other than vein; lower extremity 35355 Thromboendarterectomy, including patch graft, if performed, iliofemoral 35256 Repair blood vessel with vein graft; lower extremity 35303 Thromboendarterectomy, including patch graft, if performed; popliteal artery 35142 Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for ruptured aneurysm, common femoral artery (profunda femoris, superficial femoral) 35184 Repair, congenital alteriovenous fistula; extremities 35151 Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for aneurysm, pseudoaneurysm, and associated occlusive disease, popliteal artery		

MUC ID	Measure Title	Numerator	Denominator	Exclusions	Length of Time
			35525 Bypass graft, with vein; brachial-brachial 35566 Bypass graft, with vein; femoral-anterior tibial, posterior tibial, peroneal artery or other distal vessels 35570 Bypass graft, with vein; tibial-tibial, peroneal-tibial, or tibial/peroneal trunk-tibial 34813 Placement of femoral-femoral prosthetic graft during endovascular aortic aneurysm repair (list separately in addition to code for primary procedure) 35013 Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for ruptured aneurysm, axillary-brachial artery, by arm incision 35304 Thromboendarterectomy, including patch graft, if performed; tibioperoneal trunk artery 35305 Thromboendarterectomy, including patch graft, if performed; tibial or peroneal artery, initial vessel 35306 Thromboendarterectomy, including patch graft, if		

MUC ID	Measure Title	Numerator	Denominator	Exclusions	Length of Time
			performed; each additional tibial or peroneal artery (List separately in addition to code for primary procedure) 35523 Bypass graft, with vein; brachial-ulnar or radial 35585 In-situ vein bypass; femoral-anterior tibial, posterior tibial, or peroneal artery 35661 Bypass graft, with other than vein; femoral-femoral 35884 Revision, femoral anastomosis of synthetic arterial bypass graft in groin, open; with autogenous vein patch graft 35518 Bypass graft, with vein; axillary-axillary 35521 Bypass graft, with vein; axillary-femoral 35558 Bypass graft, with vein; femoral-femoral 35571 Bypass graft, with vein; popliteal-tibial, -peroneal artery or other distal vessels 35650 Bypass graft, with other than vein; axillary-axillary 34101 Embolectomy or thrombectomy, with or without catheter; axillary, brachial, innominate, subclavian artery, by arm incision		

MUC ID	Measure Title	Numerator	Denominator	Exclusions	Length of Time
			35459 Transluminal balloon angioplasty, open; tibioperoneal trunk and branches 34111 Embolectomy or thrombectomy, with or without catheter; radial or ulnar artery, by arm incision 35485 Transluminal peripheral atherectomy, open; tibioperoneal trunk and branches 35483 Transluminal peripheral atherectomy, open; femoral-popliteal 34812 Open femoral artery exposure for delivery of endovascular prosthesis, by groin incision, unilateral Unspecified-endovascular: ICD-9 codes 39.50 Angioplasty or atherectomy of other non-coronary vessel(s) 39.90 Insertion of non-drug-eluting, non-coronary artery stent(s) 39.79 Other endovascular repair (of aneurysm) of other vessels 00.55 Insertion of drug-eluting stent(s) of other peripheral vessel(s), endograft(s), endovascular graft(s), stent grafts		

MUC ID	Measure Title	Numerator	Denominator	Exclusions	Length of Time
			CPT codes 37205 Transcatheter placement of an intravascular stent(s) (except coronary, carotid, and vertebral vessel), percutaneous; initial vessel 37206 Transcatheter placement of an intravascular stent(s) (except coronary, carotid, and vertebral vessel), percutaneous; each additional vessel (List separately in addition to code for primary procedure) 37204 Transcatheter occlusion or embolization (e.g., for tumor destruction, to achieve hemostasis, to occlude a vascular malformation), percutaneous, any method, non-central nervous system, non-head or neck 37184 Primary percutaneous transluminal mechanical thrombectomy, noncoronary, arterial or arterial bypass graft, including fluoroscopic guidance and intraprocedural pharmacological thrombolytic injection(s); initial vessel 37186 Secondary percutaneous transluminal thrombectomy (e.g., nonprimary mechanical, snare		

MUC ID	Measure Title	Numerator	Denominator	Exclusions	Length of Time
			basket, suction technique), noncoronary, arterial or arterial bypass graft, including fluoroscopic guidance and intraprocedural pharmacological thrombolytic injections, provided in conjunction with another percutaneous intervention other than primary mechanical thrombectomy (List separately in addition to code for primary procedure) 37187 Percutaneous transluminal mechanical thrombectomy, vein(s), including intraprocedural pharmacological thrombolytic injections and fluoroscopic guidance 37185 Primary percutaneous transluminal mechanical thrombectomy, noncoronary, arterial or arterial bypass graft, including fluoroscopic guidance and intraprocedural pharmacological thrombolytic injection(s); second and all subsequent vessel(s) within the same vascular family (List separately in addition to code for primary mechanical thrombectomy procedure)		

MUC ID	Measure Title	Numerator	Denominator	Exclusions	Length of Time
			37208 Transcatheter placement of an intravascular stent(s) (non-coronary vessel), open; each additional vessel (List separately in addition to code for primary procedure) Unspecified-open: ICD-9 codes 39.29 Other (peripheral) vascular shunt or bypass 39.49 Other revision of vascular procedure 39.52 Other repair of aneurysm 39.59 Other repair of vessel 39.57 Repair of blood vessel with synthetic patch graft 39.56 Repair of blood vessel with tissue patch graft 39.58 Repair of blood vessel with unspecified type of patch graft 39.53 Repair of arteriovenous fistula 38.10 Endarterectomy-unspecified site 38.00 Incision of vessels-unspecified site 38.40 Resection of vessel with replacement-unspecified site 38.30 Resection of vessel with anastomosis-unspecified site		

MUC ID	Measure Title	Numerator	Denominator	Exclusions	Length of Time
			CPT codes 35761 Exploration (not followed by surgical repair), with or without lysis of artery; other vessels 35685 Placement of vein patch or cuff at distal anastomosis of bypass graft, synthetic conduit (list separately in addition to code for primary procedure) 35681 Bypass graft; composite, prosthetic and vein (List separately in addition to code for primary procedure) 35506 Bypass graft, with vein; carotid-subclavian or subclavian-carotid 37799 Unlisted procedure, vascular surgery 37207 Transcatheter placement of an intravascular stent(s) (non-coronary vessel), open; initial vessel 35875 Thrombectomy of arterial or venous graft (other than hemodialysis graft or fistula) 35876 Thrombectomy of arterial or venous graft (other than hemodialysis graft or fistula); with revision of arterial or venous graft		
XDEEH	Hospital 30-day,	This outcome measure does not	Note: This outcome measure does	For all cohorts:	N/A

MUC ID	Measure Title	Numerator	Denominator	Exclusions	Length of Time
	all-cause, risk-standardized mortality rate (RSMR) following Coronary Artery Bypass Graft (CABG) surgery	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 and to which hospital the outcome is attributed when there are multiple hospitalizations within a single episode of care. This is an all-cause mortality measure and therefore any death within 30 days of the index procedure date from the index hospitalization s included in the measure. Deaths are identified in the Medicare Enrollment Database. Outcome Attribution Attribution of the outcome in situations where a patient has multiple contiguous admissions, at least one of which involves an index CABG procedure (i.e., the patient is either transferred into the hospital that performs the index CABG or is transferred out	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). We therefore use this field to define the measure cohort. This claims-based measure can be used in either of two patient cohorts: (1) patients aged 65 years or older or (2) patients aged 18 years or older. We have tested the measure in both age groups. The index cohort includes admissions for patients aged 18 years or older who received a qualifying "isolated" CABG procedure (CABG procedure without other concurrent major cardiac procedure such as valve replacement). The measure was developed in a cohort of patients 65 years and older who were enrolled in Medicare FFS and admitted to non-federal hospitals. To be included in the Medicare FFS cohort, patients had to have a qualifying isolated CABG	1) Patients who leave hospital against medical advice (AMA) are identified using the discharge disposition indicator in the Standard Analytic File (SAF). 2) Patients with inconsistent or unknown vital status or other unreliable data are identified if any of the following conditions are met 1) the patient's age is greater than 115 years: 2) if the discharge date for a hospitalization is before the admission date; 3) if the patient has a sex other than 'male' or 'female'. 3) Subsequent qualifying CABG procedures during the measurement period are identified by the ICD-9 codes defining CABG listed in denominator details. 4) Non-isolated CABG procedures (CABG Surgeries that occur concomitantly with excluded procedures and	

MUC ID	Measure Title	Numerator	Denominator	Exclusions	Length of Time
		to another hospital following the index CABG) is as follows: - If a patient undergoes a CABG procedure in the first hospital and is then transferred to a second hospital where there is no CABG procedure, the mortality outcome is attributed to the first hospital performing the index CABG procedure and the 30-day window starts with the date of index CABG procedure. Rationale: A transfer following CABG is most likely due to a complication of the index procedure and that care provided by the hospital performing the CABG procedure likely dominates mortality risk even among transferred patients. - If a patient is admitted to a first hospital but does not receive a CABG procedure there and is then transferred to a second hospital where a CABG is performed, the mortality outcome is attributed to the second hospital performing the index CABG procedure and the	procedure AND had to be continuously enrolled in Medicare Fee-for-Service (FFS) one year prior to the first day of the index hospitalization and through 30 days post procedure. This cohort is defined using the ICD-9 Clinical Modification (ICD-9-CM) procedure codes identified in Medicare Part A Inpatient claims data. ICD-9-CM codes that define the cohort: 36.1x - Aortocoronary bypass for heart revascularization, not otherwise specified 36.11 - (Aorto) coronary bypass of one coronary artery 36.12 - (Aorto) coronary bypass of two coronary arteries 36.13 - (Aorto) coronary bypass of three coronary arteries 36.14 - (Aorto) coronary bypass of four or more coronary arteries 36.15 - Single internal mammary-coronary artery bypass 36.16 - Double internal mammary-coronary artery bypass 36.17 - Abdominal- coronary	procedure groups). Procedures that occur concomitantly with a qualifying CABG procedure that exclude patients from the cohort are identified using the following ICD-9-CM procedure codes: 0.61 Percutaneous angioplasty or atherectomy of precerebral (extracranial) vessel(s) 0.62 Percutaneous angioplasty or atherectomy of intracranial vessel(s) 0.62 Percutaneous angioplasty or atherectomy of intracranial vessel(s) 0.63 Percutaneous insertion of carotid artery stent(s) 0.64 Percutaneous insertion of other precerebral (extracranial) artery stent(s) 0.65 Percutaneous insertion of intracranial vascular stent(s) 32.4x Lobectomy with segmental resection of adjacent lobes of lung, excludes that with radical dissection [excision] of thoracic structures 33.5x Lung transplant 33.6 Combined heart-lung transplantation	

MUC ID	Measure Title	Numerator	Denominator	Exclusions	Length of Time
		30-day window starts with the date of index CABG procedure. Rationale: Care provided by the hospital performing the CABG procedure likely dominates mortality risk. -If a patient undergoes a CABG procedure in the first hospital and is transferred to a second hospital where another CABG procedure is performed, the mortality outcome is attributed to the first hospital performing the index (first) CABG procedure and the 30-day window starts with the date of index CABG procedure. Rationale: A transfer following CABG is most likely due to a complication of the index procedure, and care provided by the hospital performing the index CABG procedure likely dominates mortality risk even among transferred patients.	artery bypass 36.19 - Other bypass anastomosis for heart revascularization	35.00 Closed heart valvotomy, unspecified valve 35.01 Closed heart valvotomy, aortic valve 35.02 Closed heart valvotomy, mitral valve 35.03 Closed heart valvotomy, pulmonary valve 35.04 Closed heart valvotomy, tricuspid valve 35.10 Open heart valvuloplasty without replacement, unspecified valve 35.11 Open heart valvuloplasty of aortic valve without replacement 35.12 Open heart valvuloplasty of mitral valve without replacement 35.13 Open heart valvuloplasty of pulmonary valve without replacement 35.14 Open heart valvuloplasty of tricuspid valve without replacement 35.20 Replacement of unspecified heart valve 35.21 Replacement of aortic valve with tissue graft 35.22 Other replacement of aortic valve	

MUC ID	Measure Title	Numerator	Denominator	Exclusions	Length of Time
				35.23 Replacement of mitral valve with tissue graft 35.24 Other replacement of mitral valve 35.25 Replacement of pulmonary valve with tissue graft 35.26 Other replacement of pulmonary valve 35.27 Replacement of tricuspid valve with tissue graft 35.28 Other replacement of tricuspid valve 35.31 Operations on papillary muscle 35.32 Operations on chordae tendineae 35.33 Annuloplasty 35.34 Infundibulectomy 35.35 Operations on trabeculae carneae cordis 35.39 Operations on other structures adjacent to valves of heart 35.41 Enlargement of existing atrial septal defect 35.42 Creation of septal defect in heart 35.50 Repair of unspecified septal defect of heart with prosthesis	

MUC ID	Measure Title	Numerator	Denominator	Exclusions	Length of Time
				35.51 Repair of atrial septal defect with prosthesis, open technique 35.52 Repair of atrial septal defect with prosthesis, closed technique 35.53 Repair of ventricular septal defect with prosthesis, open technique 35.54 Repair of endocardial cushion defect with prosthesis 35.55 Repair of ventricular septal defect with prosthesis, closed technique 35.60 Repair of unspecified septal defect of heart with tissue graft 35.61 Repair of atrial septal defect with tissue graft 35.62 Repair of ventricular septal defect with tissue graft 35.63 Repair of endocardial cushion defect with tissue graft 35.70 Other and unspecified repair of unspecified septal defect of heart 35.71 Other and unspecified repair of atrial septal defect 35.72 Other and unspecified repair of ventricular septal defect	

MUC ID	Measure Title	Numerator	Denominator	Exclusions	Length of Time
				35.73 Other and unspecified repair of endocardial cushion defect 35.81 Total repair of tetralogy of Fallot 35.82 Total repair of total anomalous pulmonary venous connection 35.83 Total repair of truncus arteriosus 35.84 Total correction of transposition of great vessels, not elsewhere classified 35.91 Interatrial transposition of venous return 35.92 Creation of conduit between right ventricle and pulmonary artery 35.93 Creation of conduit between left ventricle and aorta 35.94 Creation of conduit between atrium and pulmonary artery 35.95 Revision of corrective procedure on heart 35.96 Percutaneous valvuloplasty 35.98 Other operations on septa of heart 35.99 Other operations on valves of heart	

MUC ID	Measure Title	Numerator	Denominator	Exclusions	Length of Time
				37.31 Pericardiectomy 37.32 Excision of aneurysm of heart 37.33 Excision or destruction of other lesion or tissue of heart, open approach 37.35 Partial ventriculectomy 37.51 Heart transplantation 37.52 Implantation of total internal biventricular heart replacement system 37.53 Replacement or repair of thoracic unit of (total) replacement heart system 37.54 Replacement or repair of other implantable component of (total) replacement heart system 37.55 Removal of internal biventricular heart replacement system 37.63 Repair of heart assist system 37.67 Implantation of cardiomyostimulation system 38.12 Endarterectomy, other vessels of head and neck 38.11 Head and Neck Endarterectomy 38.14 Endarterectomy of Aorta 38.15 Thoracic Endarterectomy	

MUC ID	Measure Title	Numerator	Denominator	Exclusions	Length of Time
				38.16 Endarterectomy : Excision of tunica intima of artery to relieve arterial walls thickened by plaque or chronic inflammation. Location includes abdominal arteries excluding abdominal aorta: Celiac, Gastric, Hepatic, Iliac, Mesenteric, Renal, Splenic, Umbi 38.17 Endarterectomy - abdominal veins: Iliac, Portal, Renal, Splenic, Vena cava. 38.34 Resection of vessel with replacement: Angiectomy, excision of aneurysm (arteriovenous), blood vessel (lesion) with anastomosis (4=aorta, abdominal) 38.42 Resection of vessel with replacement: Angiectomy, excision of aneurysm with replacement (2= other vessels of head and neck; carotid, jugular) 38.44 Resection of vessel with replacement, aorta, abdominal 38.45 Resection of vessel with replacement, thoracic vessels 39.21 Caval-pulmonary artery anastomosis 39.22 Aorta-subclavian-carotid bypass	

MUC ID	Measure Title	Numerator	Denominator	Exclusions	Length of Time
				39.23 Other intrathoracic vascular shunt or bypass 39.24 Aorta-renal bypass 39.25 Aorta-iliac-femoral bypass 39.26 Other intra-abdominal vascular shunt or bypass 39.28 Extracranial-intracranial (EC-IC) vascular bypass 39.29 Other (peripheral) vascular shunt or bypass 39.71 Endovascular implantation of graft in abdominal aorta 39.72 Endovascular embolization or occlusion of head and neck vessels 39.73 Endovascular implantation of graft in thoracic aorta 39.74 Endovascular removal of obstruction from head and neck vessel(s) 39.75 Endovascular embolization or occlusion of vessel(s) of head or neck using bare coils 39.76 Endovascular embolization or occlusion of vessel(s) of head or neck using bioactive coils 39.79 Other endovascular procedures on other vessels 85.22 Resection of quadrant of	

MUC ID	Measure Title	Numerator	Denominator	Exclusions	Length of Time
				breast 85.23 Subtotal Mastectomy, which excludes quadrant resection (85.22) 85.4x Mastectomy - includes simple/extended simple, unilateral/bilateral, radical/extended radical For Medicare FFS patients: 5) Patients younger than 65 years are identified using the age variable that is created based on patient admit date and birth date. 6) Patients without continuous enrollment in Medicare FFS for 12 months prior to index hospitalization. This is determined by patient enrollment status in both Part A and Part B and in FFS using CMS' Enrollment Database (EDB); the enrollment indicators must be appropriately marked for each of the 12 months prior to the index hospital stay.	
XDELH	Hospital-level, risk-	*Note: This outcome measure does not have a traditional	Note: This outcome measure does not have a traditional numerator	Patients younger than 65 years Rationale: Younger Medicare	N/A

MUC ID	Measure Title	Numerator	Denominator	Exclusions	Length of Time
	standardized 30-day episode-of-care payment measure for heart failure	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. The outcome for this measure is a hospital-level, risk-standardized payment for Medicare patients for a heart failure episode-of-care. The payment timeframe starts from the admission date of an index hospitalization through 30 days post-admission. We include payments for the index admission, as well as payments for subsequent inpatient, outpatient, skilled nursing facility, home health, hospice, physician/clinical laboratory/ambulance services, supplier Part B items, and durable medical equipment, prosthetics/orthotics, and supplies. In order to compare payments for Medicare patients related to	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). We therefore use this field to define the measure cohort. The denominator includes admissions to non-federal, short-stay, acute-care hospitals for Medicare FFS patients age 65 years and older with a principal discharge diagnosis of heart failure and continuous enrollment in Medicare Part A and Part B benefits for the 12 months prior to the index admission and 30 days post- admission. Principal diagnosis of heart failure is defined by the following ICD-9-CM codes: 402.01-Malignant hypertensive heart disease with congestive heart failure (CHF) 402.11-Benign hypertensive heart disease with CHF 402.91-Hypertensive heart disease with CHF	patients represent a distinct population with dissimilar characteristics and outcomes. Patients not continuously enrolled in FFS Medicare for the 12 months prior to the index admission Rationale: This is necessary to ensure full historical data for risk adjustment. Patients without at least 30 days of post-admission enrollment in FFS Medicare Rationale: This is necessary in order to identify the outcome (payments) in the dataset over the analytic period. Patients who were admitted and discharged on the same day (and not transferred or deceased) Rationale: These patients likely did not suffer clinically significant HF. Patients transferred into the hospital Rationale: The episode of care	

MUC ID	Measure Title	Numerator	Denominator	Exclusions	Length of Time
		clinical care, we remove geography and policy adjustments from our payment calculation whenever possible. If the data for a specific care setting do not allow for the removal of these adjustments, we calculate an average payment for each item across all geographic areas and replace the claim payment amount in the data with the average payment amount for that item.	404.01-Malignant hypertensive heart and renal disease with CHF 404.03-Malignant hypertensive heart and renal disease with CHF & renal failure (RF) 404.11-Benign hypertensive heart and renal disease with CHF 404.13-Benign hypertensive heart and renal disease with CHF & RF 404.91-Unspecified hypertensive heart and renal disease with CHF 404.93-Hypertension and non-specified heart and renal disease with CHF & RF 428.0-Congestive heart failure, unspecified 428.1-Left heart failure 428.20-Systolic heart failure, unspecified 428.21-Systolic heart failure, acute 428.22-Systolic heart failure, chronic 428.23-Systolic heart failure, acute or chronic 428.30-Diastolic heart failure, unspecified 428.31-Diastolic heart failure, acute 428.32-Diastolic heart failure, chronic 428.33-Diastolic heart failure,	begins with the first admitting hospital. If a patient is transferred, the payments for that second hospitalization are counted as part of the full episode payment associated with the first admitting hospital. That is to say, transferred patients are included in the measure but the accepting hospital is not considered an index stay. Patients with claims that contain inconsistent or unknown vital status Rationale: We exclude stays for patients that include inconsistent data (e.g., date of death precedes date of admission). Patients with claims that contain unreliable data Rationale: We exclude stays for patients that include unreliable data (e.g., age is greater than 115 or more than one gender is included in a claim). Patients discharged against	

MUC ID	Measure Title	Numerator	Denominator	Exclusions	Length of Time
			acute or chronic 428.40-Combined systolic and diastolic heart failure, unspecified 428.41-Combined systolic and diastolic heart failure, acute 428.42-Combined systolic and diastolic heart failure, chronic 428.43-Combined systolic and diastolic heart failure, acute or chronic 428.9-Heart failure, unspecified	medical advice (AMA) Rationale: Hospitals had limited opportunity to implement high quality care. Patients with hospice enrollment within one year prior to or on the date of an index admission Rationale: This exclusion is made for CMS's 30-day HF mortality measure and allows the cohort to be as closely aligned with this measure as possible. Patients transferred to federal hospitals Rationale: We do not have claims data for these hospitals, so including these patients would cause payments to be underestimated. Patients without a DRG or DRG weight for their index hospitalization Rationale: We cannot calculate a payment for these patients' index admission; this would make the entire episode of care appear significantly less	

MUC ID	Measure Title	Numerator	Denominator	Exclusions	Length of Time
				expensive. Patients who receive a heart transplant during the episode of care Rationale: These patients are clinically distinct, are generally very high payment cases, and are not representative of the typical heart failure patient that this measure aims to capture. Patients who receive a Left Ventricular Assist Device (LVAD) during the episode of care Rationale: These patients are clinically distinct, are generally very high payment cases, and are not representative of the typical heart failure patient that this measure aims to capture.	
XDELG	Hospital-level, risk-standardized 30-day episode-of-care payment measure for pneumonia	*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 are using this field to	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). We therefore use this field to define the measure cohort.	Patients younger than 65 years Rationale: Younger Medicare patients represent a distinct population with dissimilar characteristics and outcomes. Patients not continuously enrolled in FFS Medicare for the 12 months prior to the index	N/A

MUC ID	Measure Title	Numerator	Denominator	Exclusions	Length of Time
		define the outcome. The outcome for this measure is a hospital-level, risk-standardized payment for Medicare patients for a pneumonia episode-of-care. The payment timeframe starts from the admission date of an index hospitalization through 30 days post-admission. We include payments for the index admission, as well as payments for subsequent inpatient, outpatient, skilled nursing facility, home health, hospice, physician/clinical laboratory/ambulance services, supplier Part B items, and durable medical equipment, prosthetics/orthotics, and supplies. In order to compare payments for Medicare patients related to clinical care, we remove geography and policy adjustment from our payment calculation whenever possible. If the data for a specific care setting do not allow for the removal of these adjustments, we calculate an	The denominator includes admissions to non-federal, short-stay, acute-care hospitals for Medicare FFS patients age 65 years and older with a principal discharge diagnosis of pneumonia and continuous enrollment in Medicare Part A and Part B benefits for the 12 months prior to the index admission and 30 days post- admission. Principal diagnosis of pneumonia is defined by the following ICD-9-CM codes: 480.0-Pneumonia due to adenovirus 480.1 -Pneumonia due to respiratory syncytial virus 480.2-Pneumonia due to parainfluenza virus 480.3- Pneumonia due to SARS-associated coronavirus 480.8-Viral pneumonia: pneumonia due to other virus not elsewhere classified 480.9-Viral pneumonia unspecified 481-Pneumococcal pneumonia [streptococcus pneumoniae pneumonia]	admission Rationale: This is necessary to ensure full historical data for risk adjustment. Patients without at least 30 days of post-admission enrollment in FFS Medicare Rationale: This is necessary in order to identify the outcome (payments) in the dataset over the analytic period. Patients who were admitted and discharged on the same day (and not transferred or deceased) Rationale: These patients likely did not suffer clinically significant pneumonia. Patients transferred into the hospital Rationale: The episode of care begins with the first admitting hospital. If a patient is transferred, the payments for that second hospitalization are counted as part of the full episode payment that is associated with the first	

MUC ID	Measure Title	Numerator	Denominator	Exclusions	Length of Time
		average payment for each item across all geographic areas and replace the claim payment amount in the data with the average payment amount for that item.	482.0-Pneumonia due to klebsiella pneumoniae 482.1-Pneumonia due to pseudomonas 482.2-Pneumonia due to hemophilus influenzae (h. influenzae) 482.30-Pneumonia due to streptococcus unspecified 482.31-Pneumonia due to streptococcus group a 482.32-Pneumonia due to streptococcus group b 482.39-Pneumonia due to other streptococcus 482.40-Pneumonia due to staphylococcus unspecified 482.41-Pneumonia due to staphylococcus aureus 482.42-Methicillin resistant pneumonia due to Staphylococcus aureus 482.49-Other staphylococcus pneumonia 482.81-Pneumonia due to anaerobes 482.82-Pneumonia due to escherichia coli [e.coli] 482.83-Pneumonia due to other gram-negative bacteria 482.84-Pneumonia due to	admitting hospital. That is to say, transferred patients are included in the measure but the accepting hospital is not considered an index stay. Patients with claims that contain inconsistent or unknown vital status Rationale: We exclude stays for patients that include inconsistent data (e.g., date of death precedes date of admission). Patients with claims that contain unreliable data Rationale: We exclude stays for patients that include unreliable data (e.g., age is greater than 115 or more than one gender is included in a claim). Patients discharged against medical advice (AMA) Rationale: Hospitals had limited opportunity to implement high quality care. Patients with hospice enrollment within one year prior	

MUC ID	Measure Title	Numerator	Denominator	Exclusions	Length of Time
			legionnaires' disease 482.89-Pneumonia due to other specified bacteria 482.9-Bacterial pneumonia unspecified 483.0-Pneumonia due to mycoplasma pneumoniae 483.1-Pneumonia due to chlamydia 483.8-Pneumonia due to other specified organism 485-Bronchopneumonia organism unspecified 486-Pneumonia organism unspecified 487.0-Influenza with pneumonia 488.11-Influenza due to identified novel H1N1 influenza virus with pneumonia	to or on the date of an index admission Rationale: This exclusion is made for CMS's 30-day pneumonia mortality measure and allows the cohort to be as closely aligned with this measure as possible. Patients transferred to federal hospitals Rationale: We do not have claims data for these hospitals, so including these patients would cause payments to be underestimated. Patients without a DRG or DRG weight for their index hospitalization Rationale: We cannot calculate a payment for these patients' index admission; this would make the entire episode of care appear significantly less expensive.	
E0475	Hepatitis B Vaccine Coverage Among All Live Newborn	The number of live newborn infants administered hepatitis B vaccine prior to discharge from the hospital/birthing facility ("birth dose" of hepatitis B	The number of live newborn infants born at the hospital/birthing facility, during the reporting window (one calendar year).	Denominator Exception: The number of live newborn infants born at the hospital/birthing facility whose parent/guardian refused	N/A

MUC ID	Measure Title	Numerator	Denominator	Exclusions	Length of Time
	Infants Prior to Hospital or Birthing Facility Discharge	vaccine).		hepatitis B birth dose.	
E0471	PC-02 Cesarean Section	Patients with cesarean sections with ICB-9-CM principal procedure code or ICD-9-CM other procedure codes for cesarean section as defined in TJC Manual	Nulliparous patients delivered of a live term singleton newborn in vertex presentation	ICD-9-CM principal diagnosis code or IC-9-CM other diagnosis code for contraindications to vaginal delivery. < 8 years of age >= 65 years of age LOS > 120 days	1-2 years
XDFMH	30-Day Readmissions	Count of all index episodes of care ending in the report period from which a resumption of care occurred within 30 days to the same or to another HOD. Any episode of care that begins (from date) more than 30 days after a previous episode of care ends (through date) becomes a new index episode of care.	Count of all episodes of care ending in the report period	None	N/A
XDFMG	Group Therapy	Count of episodes of care ending in the report period with only group therapy (revenue code 0915) billed	Count of all episodes of care ending in the reporting period	None	N/A
XDFMF	No Individual Psychotherapy	Count of episodes of care ending in the report period with no units of individual psychotherapy (revenue code 0914) or	Count of all episodes of care ending in the report period	None	N/A

MUC ID	Measure Title	Numerator	Denominator	Exclusions	Length of Time
		psychiatric testing (revenue codes 0900 or 0918)			
F2027	Hospital 30-day, all-cause, risk-standardized readmission rate (RSRR) following an acute ischemic stroke hospitalization	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 are using this field to define the outcome and to which hospital the outcome is attributed when there are multiple hospitalizations within a single episode of care.) The outcome for this measure is 30-day all-cause readmission. We define all-cause readmission as readmission for any cause within 30 days from the date of discharge of the index stroke for patients 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.	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). We therefore use this field to define the measure cohort. The denominator includes patients 65 years and older who were admitted to non-federal acute care hospitals for an ischemic stroke as defined by the following ICD-9-CM codes and with a complete claims history for the 12 months prior to admission: ICD-9-CM codes used to define ischemic stroke: 433.01 Occlusion and stenosis of precerebral arteries, Basilar artery with cerebral infarction 433.11 Occlusion and stenosis of precerebral arteries, Carotid artery with cerebral infarction 433.21 Occlusion and stenosis of precerebral arteries, Vertebral artery with cerebral infarction	Exclusions: 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).	N/A

MUC ID	Measure Title	Numerator	Denominator	Exclusions	Length of Time
		Measure includes unplanned readmissions to any acute care hospital for any cause within 30 days from the date of discharge of the index admission. Planned Readmissions: With this measure, CMS seeks to count only unplanned readmissions, as "planned" readmissions generally are not a signal of quality of care. We have adapted an algorithm originally created to identify planned readmissions for a hospital-wide (i.e., not condition-specific) readmission measure to this stroke readmission measure. In brief, the algorithm identifies a short list of always planned readmissions (those where the principle discharge diagnosis is major organ transplant, obstetrical delivery, or maintenance chemotherapy) as well as those readmissions with a potentially planned procedure (e.g., total hip replacement or cholecystectomy) AND a non-acute principle discharge	433.31 Occlusion and stenosis of precerebral arteries, Multiple and bilateral with cerebral infarction 433.81 Occlusion and stenosis of precerebral arteries, Other specified precerebral artery with cerebral infarction 433.91 Occlusion and stenosis of precerebral arteries, Unspecified precerebral artery with cerebral infarction, Precerebral artery NOS 434.01 Occlusion of cerebral arteries, Cerebral thrombosis with cerebral infarction, thrombosis of cerebral arteries 434.11 Occlusion of cerebral arteries, Cerebral embolism with cerebral infarction 434.91 Occlusion of cerebral arteries, Cerebral artery occlusion, unspecified, with cerebral infarction	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.	

MUC ID	Measure Title	Numerator	Denominator	Exclusions	Length of Time
		diagnosis code. For example, a readmission for colon resection is considered planned if the principal diagnosis is colon cancer but unplanned if the principal diagnosis is abdominal pain, as the latter might represent a complication of the stroke hospitalization. Readmissions that included potentially planned procedures with acute diagnoses or that might represent complications of stroke are not considered planned. Overall, only 0.6% of all index admissions were associated with a planned readmission (and not counted in the measure outcome). More details about the planned readmission algorithm can be found on the CMS website at: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/Measure-Methodology.html.			
E1789	Hospital-Wide All-Cause Unplanned	Note: This outcome measure does not have a traditional numerator and denominator like	Note: This outcome measure does not have a traditional numerator and denominator like a core	The HWR measure excludes admissions for patients:	< 1 year

MUC ID	Measure Title	Numerator	Denominator	Exclusions	Length of Time
	Readmission Measure (HWR)	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. Planned Readmission Definition With this measure, CMS seeks to count only unplanned readmissions, as variation in "planned" readmissions does not typically reflect quality differences. In brief, the algorithm identifies a short list of always planned readmissions (those where the principle	process measure (e.g., percentage of adult patients with diabetes aged 18-75 years receiving one or more hemoglobin A1c tests per year). We therefore use this field to define the measure cohort. 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.	1) Who were admitted to Prospective Payment System (PPS)-exempt cancer hospitals, because these hospitals care for a unique population of patients that cannot reasonably be compared to the patients admitted to other hospitals; 2) Without at least 30 days post-discharge enrollment in FFS Medicare, because the 30-day readmission outcome cannot be assessed in this group; 3) Who were not enrolled in Part A Medicare for the 12 months prior to and including the date of the index admission, which ensures a full year of administrative data for risk adjustment; 4) Who were discharged against medical advice (AMA), because providers did not have the opportunity to deliver full care and prepare the patient for discharge; 5) Who were admitted for	

MUC ID	Measure Title	Numerator	Denominator	Exclusions	Length of Time
		discharge diagnosis is major organ transplant, obstetrical delivery, or maintenance chemotherapy) as well as those readmissions with a potentially planned procedure (e.g., total hip replacement or cholecystectomy) AND a non-acute principal discharge diagnosis code. For example, a readmission for colon resection is considered planned if the principal diagnosis is colon cancer but unplanned if the principal diagnosis is abdominal pain, as the latter might represent a complication of the initial index admission. Unplanned readmissions within 30 days of discharge from an index admission that occur after a planned readmission will not be counted in the outcome. This is because it is not clear whether such readmissions are appropriately attributed to the original index admission or the intervening planned readmission.		primary psychiatric diagnoses, because these patients are typically cared for in separate psychiatric or rehabilitation centers that are not comparable to acute care hospitals; 6) Who were admitted for rehabilitation, because these patients are not typically admitted to an acute care hospital and are not for acute care; and 7) Who were admitted for medical treatment of cancer, because these admissions have a very different readmission profile than the rest of the Medicare population, and outcomes for these admissions do not correlate well with outcomes for other admissions.	
E0434	STK-1 Venous	Ischemic or hemorrhagic stroke	Ischemic or hemorrhagic stroke	Patients less than 18 years of	1-2

MUC ID	Measure Title	Numerator	Denominator	Exclusions	Length of Time
	Thromboembolism (VTE) Prophylaxis	patients who received VTE prophylaxis or have documentation why no VTE prophylaxis was given on the day of or the day after hospital admission.	patients	age; Patients who have a Length of Stay less than 2 days; Patients who have a Length of Stay greater than 120 days Patients with Comfort Measures Only documented on day of or day after hospital arrival; Patients enrolled in clinical trials; Patients admitted for Elective Carotid Intervention	years
E0441	STK-10 Assessed for Rehabilitation	Ischemic or hemorrhagic stroke patients assessed for or who received rehabilitation services.	Ischemic or hemorrhagic stroke patients.	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 admitted for Elective Carotid Intervention; Patients discharged to another hospital; Patients who left against medical advice; Patients who expired; Patients discharged to home for hospice care; Patients discharged to a health care facility for hospice care	1-2 years
E0435	STK-2 Antithrombotic therapy for ischemic stroke	Ischemic stroke patients prescribed antithrombotic therapy at hospital discharge	Ischemic stroke patients.	Patients less than 18 years of age; Patients who have a Length of Stay greater than 120 days; Patients with Comfort Measures	1-2 years

MUC ID	Measure Title	Numerator	Denominator	Exclusions	Length of Time
				Only documented; Patients enrolled in clinical trials; Patients admitted for Elective Carotid Intervention; Patients discharged to another hospital; Patients who left against medical advice; Patients who expired; Patients discharged to home for hospice care; Patients discharged to a health care facility for hospice care; Patients with a documented Reason For Not Prescribing Antithrombotic Therapy at Discharge	
E0436	STK-3 Anticoagulation therapy for Afib/flutter	Ischemic stroke patients prescribed anticoagulation therapy at hospital discharge.	Ischemic stroke patients with documented atrial fibrillation/flutter.	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 admitted for Elective Carotid Intervention; Patients discharged to another hospital; Patients who left against medical advice; Patients who expired; Patients discharged to home for hospice care; Patients discharged to a health care facility for hospice care; Patients with a documented Reason For	1-2 years

MUC ID	Measure Title	Numerator	Denominator	Exclusions	Length of Time
				Not Prescribing Anticoagulation Therapy	
E0437	STK-4 Thrombolytic therapy for acute ischemic stroke	Acute ischemic stroke patients for whom IV thrombolytic therapy was initiated at this hospital within 3 hours (less than or equal to 180 minutes) of time last known well.	Acute ischemic stroke patients whose time of arrival is within 2 hours (less than or equal to 120 minutes) of time last known well.	Patients less than 18 years of age; Patients who have a Length of Stay greater than 120 days; Patients enrolled in clinical trials; Patients admitted for Elective Carotid Intervention; Time Last Known Well to arrival in the emergency department greater than 2 hours; Patients with a documented Reason For Not Initiating IV Thrombolytic	1-2 years
E0438	STK-5 Antithrombotic therapy by the end of hospital day 2	Ischemic stroke patients who had antithrombotic therapy administered by end of hospital day 2.	Ischemic stroke patients.	Patients less than 18 years of age; Patients who have a Duration of Stay less than 2 days; Patients who have a Length of Stay greater than 120 days; Patients with Comfort Measures Only documented on day of or day after arrival; Patients enrolled in clinical trials; Patients admitted for Elective Carotid Intervention; Patients discharged prior to the end of hospital day 2; Patients with IV OR IA Thrombolytic (t-PA) Therapy Administered at This Hospital or Within 24 Hours Prior to Arrival; Patients with a	1-2 years

MUC ID	Measure Title	Numerator	Denominator	Exclusions	Length of Time
				documented Reason For Not Administering Antithrombotic Therapy By End Of Hospital Day 2	
E0439	STK-6 Discharged on Statin Medication	Ischemic stroke patients prescribed statin medication at hospital discharge.	Ischemic stroke patients with an LDL greater than or equal to 100 mg/dL, OR LDL not measured, OR who were on a lipid-lowering medication prior to hospital arrival.	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 admitted for Elective Carotid Intervention; Patients discharged to another hospital; Patients who left against medical advice; Patients who expired; Patients discharged to home for hospice care; Patients discharged to a health care facility for hospice care; Patients with a Reason For Not Prescribing Statin Medication at Discharge	1-2 years
D0440	STK-8 Stroke Education	Ischemic or hemorrhagic stroke patients with documentation that they or their caregivers were given educational material addressing all of the following: 1. Activation of emergency medical system; 2. Follow-up after discharge; 3. Medications	Ischemic stroke or hemorrhagic stroke patients discharged home.	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 admitted for Elective Carotid Intervention	1-2 years

MUC ID	Measure Title	Numerator	Denominator	Exclusions	Length of Time
		prescribed at discharge; 4. Risk factors for stroke; 5. Warning signs and symptoms of stroke			
E0371	VTE-1: Venous Thromboembolism Prophylaxis	Patients who received VTE prophylaxis or have documentation why no VTE prophylaxis was given: - the day of or the day after hospital admission - 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) less than two days and greater than 120 days Patients with Comfort Measures Only documented on day of or day after hospital arrival 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 greater than or equal to 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	1-2 years

MUC ID	Measure Title	Numerator	Denominator	Exclusions	Length of Time
				Patients with ICD-9-CM Principal Procedure Code of Surgical Care Improvement Project (SCIP) VTE selected surgeries	
E0372	VTE-2: Intensive Care Unit Venous Thromboembolism Prophylaxis	Patients who received VTE prophylaxis or have documentation why no VTE prophylaxis was given: - the day of or the day after ICU admission (or transfer) - the day of or the day after surgery end date for surgeries that start the day of or the day after ICU admission (or transfer)	Patients directly admitted or transferred to ICU.	Patients less than 18 years of age Patients who have a hospital length of stay (LOS) less than two days and greater than 120 days Patients with Comfort Measures Only documented on day of or day after hospital arrival Patients enrolled in clinical trials Patients with ICU LOS less than one day without VTE prophylaxis administered and documentation for no VTE prophylaxis Patients with ICD-9-CM Principal or Other Diagnosis Code of Obstetrics or VTE Patients with ICD-9-CM Principal	1-2 years

MUC ID	Measure Title	Numerator	Denominator	Exclusions	Length of Time
				Procedure Code of Surgical Care Improvement Project (SCIP) VTE selected surgeries	
E0373	VTE-3:VTE patients with anticoagulation overlap therapy	Patients who received overlap therapy	Patients with confirmed VTE who received warfarin.	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 discharged to a health care facility for hospice care; Patients discharged to home for hospice care; Patients who expired; Patients who left against medical advice; Patients discharged to another hospital; Patients without warfarin therapy during hospitalization; Patients without VTE confirmed by diagnostic testing	1-2 years
D0374	VTE-4: Patients receiving un-fractionated Heparin with doses/labs monitored by protocol	Patients who have their IV UFH therapy dosages AND platelet counts monitored according to defined parameters such as a nomogram or protocol.	Patients with confirmed VTE receiving IV UFH therapy.	Patients less than 18 years of age; Patients who have a length of stay greater than 120 days; Patients with Comfort Measure Only documented; Patients enrolled in clinical trials; Patients discharged to a health care facility for hospice care; Patients discharged to home for hospice care; Patients who	1-2 years

MUC ID	Measure Title	Numerator	Denominator	Exclusions	Length of Time
				expired; Patients who left against medical advice; Patients discharged to another hospital; Patients without UFH Therapy Administration; Patients without VTE confirmed by diagnostic testing	
D0375	VTE-5: VTE discharge instructions	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	1-2 years
D0376	VTE-6: Incidence of potentially preventable VTE	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	1-2 years

MUC ID	Measure Title	Numerator	Denominator	Exclusions	Length of Time
				pharmacologic prophylaxis; Patients without VTE confirmed by diagnostic testing	
XCAEA	IPF Metabolic Screening	Number of inpatients who received a comprehensive metabolic screening for metabolic disorders during the measurement year. Comprehensive screening currently defined to include: Body mass index A1C or glucose test Blood pressure Lipid panel Total cholesterol Low density lipoprotein High density lipoprotein Triglycerides	Total number of psychiatric inpatients admitted during the measurement period.	As currently defined: * Patients for whom there was an inability for the facility to complete a screening during all inpatient stays during the year. * Patients with a length of stay greater than or equal to 365 days. * Patients with documentation in the medical record of a metabolic screen conducted within 12 months of their first admission during the measurement year. * Patients with a diagnosis of cardiovascular disease (CVD) or diabetes.	N/A
XDCBA	IPF Suicide Risk Screening completed within one day of admission	Number of admissions with a detailed screening of suicide risk within the first day of admission	All individuals discharged from hospital-based IPFs during the measurement year.	Admissions corresponding to assessments that could not be completed within the first day of admission due to the patient's unstable medical or psychological condition. (The chart must provide documentation regarding why the assessment could not be completed.)	N/A

MUC ID	Measure Title	Numerator	Denominator	Exclusions	Length of Time
XDEGE	IPF Use of an electronic health record meeting Stage 1 or Stage 2 Meaningful Use criteria	To be determined	To be determined	To be determined	N/A
XDCFD	IPF Violence Risk Screening completed within one day of admission	Number of admissions with a documented assessment for violence risk within the first day of admission.	Total number of psychiatric inpatient discharges during the measurement period.	* Admissions corresponding to) assessments that could not be completed within the first day of admission due to the patient's unstable medical or psychological condition. (The chart must provide documentation regarding why the assessment could not be completed.) * Admissions involving a length of stay equal to or greater than 365 days, or less than one day. * Additional admissions to psychiatric units during a single hospitalization.	N/A
E0028	Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention	Patients who were screened for tobacco use* at least once during the two-year measurement period AND who received tobacco cessation counseling intervention** if identified as a	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 two year measurement period	Documentation of medical reason(s) for not screening for tobacco use (e.g., limited life expectancy)	1-2 years

MUC ID	Measure Title	Numerator	Denominator	Exclusions	Length of Time
		tobacco user *Includes use of any type of tobacco ** Cessation counseling intervention includes brief counseling (3 minutes or less), and/or pharmacotherapy			
E1659	Influenza Immunization	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 (Appendix A, Table12.10); 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; Patients who have a Length of Stay greater than 120 days; Patients who leave Against Medical Advice (AMA).	>2 years
XDFGE	Inpatient Psychiatric Facility Routinely Assesses Patient Experience of Care	Number of admissions with a detailed assessment of patient experience of care	Total number of psychiatric inpatient discharges during the measurement period	* Admissions corresponding to) assessments that could not be completed within the first day of admission due to the patient's unstable medical or psychological condition. (The chart must provide	N/A

MUC ID	Measure Title	Numerator	Denominator	Exclusions	Length of Time
				documentation regarding why the assessment could not be completed.) * Admissions involving a length of stay equal to or greater than 365 days, or less than one day. * Additional admissions to psychiatric units during a single hospitalization.	
XDFGD	IPF Alcohol Use Screening completed within one day of admission	Number of admissions with a detailed screening of alcohol use within the first day of admission.	Total number of psychiatric inpatient discharges during the measurement period.	* Admissions corresponding to) assessments that could not be completed within the first day of admission due to the patient's unstable medical or psychological condition. (The chart must provide documentation regarding why the assessment could not be completed.) * Admissions involving a length of stay equal to or greater than 365 days, or less than one day. * Additional admissions to psychiatric units during a single hospitalization.	N/A
XDFGC	IPF Drug Use Screening completed within one day of admission	Number of admissions with a detailed screening for drug use within the first day of admission.	Total number of psychiatric inpatient discharges during the measurement period.	* Admissions corresponding to) assessments that could not be completed within the first day of admission due to the patient's unstable medical or	N/A

MUC ID	Measure Title	Numerator	Denominator	Exclusions	Length of Time
				psychological condition. (The chart must provide documentation regarding why the assessment could not be completed.) * Admissions involving a length of stay equal to or greater than 365 days, or less than one day. * Additional admissions to psychiatric units during a single hospitalization.	
XCFFL	Functional Outcome Measure: Change in Mobility Score	The mean change in mobility function	Patients discharged during the selected time period	Patients with incomplete stays, including patients who died in the facility, patients discharged to acute care, patients discharged against medical advice	N/A
XCFFM	Functional Outcome Measure: Change in Self-Care Score	The mean change in self-care function	Patients discharged during the selected time period	Patients with incomplete stays, including patients who died in the facility, patients discharged to acute care, patients discharged against medical advice	N/A
XDDCA	Functional Outcome Measure: Discharge mobility score	The number of patients who meet or exceed an expected discharge mobility score	Patients discharged during the selected time period	Patients with incomplete stays, including patients who died in the facility, patients discharged to acute care, patients discharged against medical advice	N/A

MUC ID	Measure Title	Numerator	Denominator	Exclusions	Length of Time
XDDCB	Functional Outcome Measure: Discharge self-care score	The number of patients who meet or exceed an expected discharge self-care score	Patients discharged during the selected time period	Patients with incomplete stays, including patients who died in the facility, patients discharged to acute care, patients discharged against medical advice	N/A
E1717	National Healthcare Safety Network (NHSN) Facility-Wide Inpatient Hospital-onset Clostridium difficile infection (CDI) Outcome Measure	Total number of observed hospital-onset CDI LabID events among all inpatients in the facility, excluding well baby-nurseries and NICUs	Total number of expected hospital-onset CDI LabID events, calculated by multiplying the number of inpatient days for the facility by the hospital-onset CDI LabID event rate for the same types of facilities (obtained from the standard population).	None	< 1 year
E1716	National Healthcare Safety Network (NHSN) Facility-Wide Inpatient Hospital-onset Methicillin-resistant Staphylococcus aureus (MRSA) Bacteremia Outcome	Total number of observed hospital-onset unique blood source MRSA LabID events among all inpatients in the facility	Total number of expected hospital-onset unique blood source MRSA LabID events, calculated by multiplying the number of inpatient days for the facility by the hospital-onset MRSA LabID event rate for the same types of facilities (obtained from the standard population).	None	< 1 year

MUC ID	Measure Title	Numerator	Denominator	Exclusions	Length of Time
	Measure				
E0674	Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay)	The numerator is the number of short-stay residents or patients who are able to self-report with a selected target assessment (IRF: numbers to be assigned; MDS: assessments may be OBRA admission quarterly, annual or significant change/correction assessment.	The denominator is the total number of long-stay residents in the nursing facility or IRF patients who were assessed during the selected time window and who did not meet the exclusion criteria.	Residents with MDS admission assessments (OBRA or a 5-day PPS assessment) from the current quarter are excluded. Also excluded are residents for whom data from the relevant section of the MDS are missing. Residents must be present for at least 100 days to be included in long-stay measures. IRF exclusion items TBD. Long-stay facilities or IRFs are excluded from the public reporting if their sample includes fewer than 30 residents.	>2 years
E0676	Percent of Residents Who Self-Report Moderate to Severe Pain (Short Stay)	The numerator is the number of short-stay residents or patients who are able to self-report with a selected target assessment (IRF: numbers to be assigned; MDS: assessments may be OBRA admission quarterly, annual or significant change/correction assessments (A0310A = 01, 02, 03, 04, 05, 06) or PPS 5-, 14-, 30-, 60-, 90-day, or readmission/return assessments	The denominator is: IRF- to be determined; MDS- the total of all short-stay residents in the nursing facility who have received an MDS 3.0 14-day PPS assessment during the preceding 6 months from the selected quarter and who do not meet the exclusion criteria.	A patient or resident is excluded they did not meet the pain symptom conditions for the numerator AND any of the following conditions are true: IRF- to be determined; MDS- 1) the patient or resident cannot self-report; 2) there are missing data in the responses to the relevant questions in the MDS assessment; OR 3) the assessment indicates that the	>2 years

MUC ID	Measure Title	Numerator	Denominator	Exclusions	Length of Time
		(A0310B = 01, 02, 03, 04, 05, 06) or discharge assessment with or without return anticipated (A0310F = 10, 11)) who report almost constant or frequent pain (item J0400 = 01 or 02) AND at least one episode of moderate to severe pain (item J0600A = 05, 06, 07, 08, or 09 on a scale of 01-10 with 10 being the worst pain you can imagine, OR item J0600B = 02 or 03 on a scale of 0 – 04, with 04 being very severe, horrible pain) OR very severe/horrible pain of any frequency (item J0600A = 10 on a scale of 01 to 10 OR item J0600B = 04 on a scale of 0 to 04) in the 5 days prior to the assessment)		resident had pain or hurting at any time in the last 5 days (J0300 = 1), but the numeric pain intensity item indicates no pain (J0600A = 00). Nursing homes or IRFs with fewer than 20 residents in the sample are excluded from public reporting because of small sample size.	
XCFGB	Functional Outcome Measure: change in mobility among patients requiring ventilator support	The risk-adjusted change in the mobility score between admission and discharge	All patients discharged from the LTCH during the time period who required ventilator support at admission	TBD	N/A
XCBBF	Percent of LTCH patients with an	Patients with an admission and discharge functional assessment	All patients discharged from the LTCH during the time period	TBD	N/A

MUC ID	Measure Title	Numerator	Denominator	Exclusions	Length of Time
	admission and discharge functional assessment and a care plan that addresses function	and a care plan that addresses function			
XDDCC	Ventilator-Associated Event	VAC: Total number of expected VACs, calculated by multiplying the number of ventilator days for each location under surveillance for VAEs during the period by the VAC rate for the same types of locations obtained from the standard population. IVAC: Total number of expected IVACs, calculated by multiplying the number of ventilator days for each location under surveillance for VAEs during the period by the IVAC rate for the same types of locations obtained from the standard population.	VAC: Total number of observed healthcare-associated VACs among adult patients in acute and long-term acute care hospitals and inpatient rehabilitation facilities IVAC: Total number of observed healthcare-associated IVACs among adult patients in acute and long-term acute care hospitals and inpatient rehabilitation facilities	Patients receiving non-conventional (rescue) mechanical ventilation therapies are excluded. Rescue mechanical ventilation therapies that are excluded from VAC and IVAC surveillance include (but are not limited to) the following: high-frequency mechanical ventilation, mechanical ventilation in the prone position, and extracorporeal membrane oxygenation.	1-2 years
E0543	Adherence to Statin Therapy for Individuals with Coronary Artery Disease	Individuals with CAD who filled at least two prescriptions for a statin and have a Proportion of Days Covered (PDC) for statin medications of at least 0.8	Individuals at least 18 years and older as of the beginning of the measurement period with CAD and at least two claims for statins during the measurement period (12 consecutive months).	None	1-2 years

MUC ID	Measure Title	Numerator	Denominator	Exclusions	Length of Time
E0576	Follow-up after hospitalization for a mental illness	An outpatient visit, intensive outpatient encounter, or partial hospitalization (refer to Table FUH-C in the original measure documentation for codes to identify visits) 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.	Discharges for members 6 years of age and older as of the date of discharge who were hospitalized for treatment of selected mental health disorders. Must be 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.	•Mental Health Readmission or Direct Transfer: 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. •Mental Health Readmission or Direct Transfer: Exclude discharges followed by readmission or direct transfer to a non-acute facility for a mental health principal diagnosis (refer to Tables MPT-A and MPT-B in the original measure documentation for codes to identify additional mental health diagnosis and inpatient services, respectively) 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 in the original measure documentation for codes to identify non-acute	1-2 years

MUC ID	Measure Title	Numerator	Denominator	Exclusions	Length of Time
				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 non-acute facility for a non-mental health principal diagnosis. This includes any International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) Diagnosis or Diagnosis Related Group (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.	
E0556	INR for individuals taking warfarin and interacting anti-infective medications	Number of episodes in the denominator with an INR test performed 3 to 7 days after the start date of an anti-infective medication	Number of episodes with a newly started interacting anti-infective medication with an overlapping days' supply of warfarin.	Individuals with a diagnosis of cancer Individuals who are monitoring INR at home identified by HCPCS (G0248-G0250)	1-2 years
E0555	Lack of Monthly INR Monitoring	Sum of the percentage of monthly intervals without an INR	Individuals with warfarin claims for at least 40 days.	Individuals that are monitoring INR at home identified by HCPCS	1-2 years

MUC ID	Measure Title	Numerator	Denominator	Exclusions	Length of Time
	for Individuals on Warfarin	test for each individual in the denominator.		(G0248-G0250)	
E0053	Osteoporosis management in women who had a fracture	Appropriate testing or treatment for osteoporosis after the fracture defined by any one of the following criteria: •A bone mineral density (BMD) test on the Index Episode Start Date (IESD) or in the 180-day period after the IESD or •A BMD test during the inpatient stay for the fracture (applies only to fractures requiring hospitalization) or •A dispensed prescription to treat osteoporosis on the IESD or in the 180-day period after the IESD See the related "Numerator Inclusions/Exclusions" field.	Women 67 years of age and older as of December 31 of the measurement year, with a Negative Diagnosis History, who had an outpatient, emergency department (ED), nonacute inpatient or acute inpatient encounter for a fracture during the 12 months beginning July 1 of the year prior to the measurement year and ending June 30 of the measurement year. If the member had more than one fracture, include only the first fracture (see the related "Denominator Inclusions/Exclusions" field).	Denominator Exclusions •Exclude members with an outpatient, ED, nonacute inpatient or acute inpatient encounter (refer to Table OMW-D in the original measure documentation for codes to identify visit type) for a fracture (refer to Table OMW-A in the original measure documentation for codes to identify fractures) during the 60 days prior to the IESD. •Exclude members who had a bone mineral density (BMD) test (refer to Table OMW-B in the original measure documentation for codes to identify BMD test) or who received any osteoporosis treatment (refer to Table OMW-C in the original measure documentation for U.S. Food and Drug Administration [FDA]-approved osteoporosis therapies) during the 365 days prior to the IESD. •Fractures of finger, toe, face	1-2 years

MUC ID	Measure Title	Numerator	Denominator	Exclusions	Length of Time
				and skull are not included in this measure. Exclusions/Exceptions Medical factors addressed	
E0046	Osteoporosis: Screening or Therapy for Women Aged 65 Years and Older	Patients who had a central DXA measurement ordered or performed at least once since age 60 or pharmacologic therapy prescribed within 12 months	Women 65 and older as of December 31 of the measurement year.	Exclude patients for whom central DXA measurement was not ordered or performed and pharmacologic therapy was not prescribed by reason of appropriate denominator exception, including: Documentation of medical reason(s) for not ordering or performing a central DXA measurement or not prescribing pharmacologic therapy Documentation of patient reason(s) for not ordering or performing a central DXA measurement or not prescribing pharmacologic therapy Documentation of system reason(s) for not ordering or performing a central DXA measurement or not prescribing pharmacologic therapy	1-2 years
XDAEB	Annual Wellness	DRAFT: Patients who received	DRAFT: Patients 65 years and	DRAFT: Patients with a condition	N/A

MUC ID	Measure Title	Numerator	Denominator	Exclusions	Length of Time
	Assessment: Assessment of Health Risks	age- and sex-appropriate screenings	older with an AWV during the measurement period	diagnosed prior to the AWV (for example, depression) will be excluded from screening for that condition.	
XDBHA	Annual Wellness Assessment: Goal-Setting to Reduce Identified Risks	DRAFT: Patients who have accepted and documented at least one goal in one of their risk areas during the AWV. Risk reduction goals can be set for the following risks: obesity, tobacco use, alcohol misuse	DRAFT: Patients with an AWV during the measurement period and an identified risk. A patient is eligible for the denominator if he or she has the following risks: obesity, tobacco use, alcohol misuse	DRAFT: None	N/A
XDAEC	Annual Wellness Assessment: Management of Health Risks	DRAFT: Patients who received management of identified risks and age-appropriate immunizations	DRAFT: Patients 65 years and older with an AWV during the measurement period and at least one identified risk (patients are eligible for immunizations even if they do not have risks)	DRAFT: None	N/A
XDBGH	Annual Wellness Assessment: Reduction of Health Risks	DRAFT: Patients who have achieved a reduction in risk by the AWV during the measurement period. Reductions can be in the following areas: obesity, tobacco use, alcohol misuse	DRAFT: Patients 66 years and older who set a goal to reduce their health risk during an AWV in the year prior to the measurement period. A patient is eligible for the denominator if he or she has one of the following goals: obesity, tobacco use, alcohol misuse	DRAFT: None	N/A
XDFHD	Assessment and Classification of Disease Activity	Number of patients with 50% of total number of outpatient RA encounters in the measurement	Patients with two or more face-to-face encounters with the same clinician for rheumatoid arthritis		N/A

MUC ID	Measure Title	Numerator	Denominator	Exclusions	Length of Time
		year with assessment of disease activity using a standardized measure. ACR recommended measures include: RAPID3, DAS28, PASI or II, CDAI or SDAI.[i]	in the measurement year.		
XDFEH	Bone Mineral Density (BMD) & Fracture Risk	Number of patients during the measurement year with documentation in the medical record of: 1) recommendation for any anti-resorptive or anabolic agent, 2) prescription for any anti-resorptive or anabolic agent, or 3) taking any anti-resorptive or anabolic agent	Number of patients during the measurement year with documentation in the medical record of: 1) recommendation for any anti-resorptive or anabolic agent, 2) prescription for any anti-resorptive or anabolic agent, or 3) taking any anti-resorptive or anabolic agent	Contraindications or patient refusal or documentation in the medical record during the measurement year that the patient is on a "drug holiday"	N/A
S1884	Depression Response at Six Months-Progress Towards Remission	Adults age 18 and older with a diagnosis of major depression or dysthymia and an initial PHQ-9 score greater than nine who achieve a response at six months as demonstrated by a six month (+/- 30 days) PHQ-9 score that is reduced by 50% or greater from the initial PHQ-9 score.	Adults age 18 and older; no upper age limit Have the diagnosis of major depression or dysthymia defined by any of the following ICD-9* codes: 296.2x Major depressive disorder, single episode 296.3x Major depressive disorder, recurrent episode 300.4 Dysthymic disorder AND PHQ-9 Score is greater than nine. * For primary care providers the diagnosis codes can be in any	Denominator exclusions include death, permanent nursing home resident or receiving hospice or palliative care any time during the measurement period. Bipolar Disorder or Personality Disorder (in any position), ICD-9 Codes include: 296.00, 296.01, 296.02, 296.03, 296.04, 296.05, 296.06, 296.10, 296.11, 296.12, 296.13, 296.14, 296.15, 296.16, 296.40, 296.41, 296.42, 296.43, 296.44, 296.45, 296.46, 296.50, 296.51, 296.52, 296.53, 296.54 , 296.55, 296.56,	N/A

MUC ID	Measure Title	Numerator	Denominator	Exclusions	Length of Time
			position (primary or secondary). For behavioral health providers the diagnosis codes need to be in the primary position. This is to more accurately define major depression and exclude patients who may have other more serious mental health diagnoses (e.g. schizophrenia, psychosis) with a secondary diagnosis of depression.	296.60, 296.61, 296.62, 296.63, 296.64, 296.65, 296.66, 296.7, 296.80, 296.81, 296.82, 296.89, 301.0, 301.1, 301.10, 301.11, 301.12, 301.1 , 301.2, 301.20, 301.21, 301.22, 301.3, 301.4, 301.5, 301.50, 301.51, 301.59, 301.6, 301.7, 301.8, 301.81, 301.82, 301.83, 301.84, 301.89, 301.9	
S1885	Depression Response at Twelve Months-Progress Towards Remission	Adults age 18 and older with a diagnosis of major depression or dysthymia and an initial PHQ-9 score greater than nine who achieve a response at twelve months as demonstrated by a twelve month (+/- 30 days) PHQ-9 score that is reduced by 50% or greater from the initial PHQ-9 score.	Adults age 18 and older; no upper age limit Have the diagnosis of major depression or dysthymia defined by any of the following ICD-9* codes: 296.2x Major depressive disorder, single episode 296.3x Major depressive disorder, recurrent episode 300.4 Dysthymic disorder AND PHQ-9 Score is greater than nine. * For primary care providers the diagnosis codes can be in any position (primary or secondary). For behavioral health providers the diagnosis codes need to be in the primary position. This is to	Denominator exclusions include death, permanent nursing home resident or receiving hospice or palliative care any time during the measurement period. Bipolar Disorder or Personality Disorder (in any position), ICD-9 Codes include: 296.00, 296.01, 296.02, 296.03, 296.04, 296.05, 296.06, 296.10, 296.11, 296.12, 296.13, 296.14, 296.15, 296.16, 296.40, 296.41, 296.42, 296.43, 296.44, 296.45, 296.46, 296.50, 296.51, 296.52, 296.53, 296.54, 296.55, 296.56, 296.60, 296.61, 296.62, 296.63, 296.64, 296.65, 296.66, 296.7, 296.80, 296.81, 296.82, 296.89, 301.0, 301.1, 301.10, 301.11,	N/A

MUC ID	Measure Title	Numerator	Denominator	Exclusions	Length of Time
			more accurately define major depression and exclude patients who may have other more serious mental health diagnoses (e.g. schizophrenia, psychosis) with a secondary diagnosis of depression.	301.12, 301.1 , 301.2, 301.20, 301.21, 301.22, 301.3, 301.4, 301.5, 301.50, 301.51, 301.59, 301.6, 301.7, 301.8, 301.81, 301.82, 301.83, 301.84, 301.89, 301.9	
XDELF	DRAFT: ADE Prevention and Monitoring: Minimum INR Monitoring for Patients with Atrial Fibrillation on Warfarin	DRAFT: Patients who had at least 1 INR in each 90-day interval of the measurement period during which they are on warfarin therapy	DRAFT: Patients aged 18 and older with atrial fibrillation without valvular heart disease and on chronic warfarin therapy who had been on chronic warfarin therapy for at least 180 days before the start of the measurement period. Patient should have at least one outpatient visit during the measurement period.	DRAFT: To be excluded from the denominator, patient must have an active diagnosis of valvular heart disease during the measurement period.	N/A
XDELE	DRAFT: ADE Prevention and Monitoring: Warfarin Time in Therapeutic Range	DRAFT: Continuous Variable Measure Measure Observation: Average percentage of time that patients in the measure population have INR results within the therapeutic range (i.e., TTR)	DRAFT: Continuous Variable Measure Initial Patient Population: Patients aged 18 and older with atrial fibrillation without valvular heart disease who had been on chronic warfarin therapy for at least 180 days before the start of the measurement period. Patient should have at least one outpatient visit during the measurement period.	N/A	N/A

MUC ID	Measure Title	Numerator	Denominator	Exclusions	Length of Time
			Measure Population: Equals All in Initial Patient Population with sufficient international normalized ratio (INR) results to calculate a warfarin time in therapeutic range (TTR).		
XDCLD	DRAFT: Closing the Referral Loop - Critical Information Communicated with Request for Referral	DRAFT: Referrals for which the referring clinician sent the following relevant clinical information. • Type of activity requested (i.e., referral, consultation, co-management) • Reason for referral • Preferred timing • Problem list • Medication list • Medical history	DRAFT: Referrals sent by a referring clinician to another clinician.	DRAFT: None	N/A
XDDAC	DRAFT: Closing the Referral Loop - Specialist Report Sent to Primary Care Physician	DRAFT: Referrals received for which a consultant report is sent back to the referring provider	DRAFT: Referrals received by a provider.	DRAFT: None	N/A
XDELB	DRAFT: Functional Status	DRAFT: Patients who completed initial and follow-up functional status assessments using a	DRAFT: Adults aged 65 years and older who had at least one outpatient encounter during the	DRAFT: Patients with severe cognitive impairment	N/A

MUC ID	Measure Title	Numerator	Denominator	Exclusions	Length of Time
	Assessment and Goal Achievement for Patients with Congestive Heart Failure	qualifying tool, set a goal with their provider for a change in functional status score and who met the target goal by the follow-up functional status assessment	measurement year and an active diagnosis of heart failure		
XDELD	DRAFT: Functional Status Assessment and Improvement for Patients who Received a Total Hip Replacement	DRAFT: Patients who completed pre- and post-surgery functional status assessments using a qualifying general or condition-specific tool, and whose functional status improved	DRAFT: Adults aged 18 and older with a primary total hip arthroplasty (THA) and at least one outpatient encounter during the measurement year	DRAFT: Patients with multiple trauma at the time of the total hip arthroplasty or patients with severe cognitive impairment	N/A
XDELC	DRAFT: Functional Status Assessment and Improvement for Patients who Received a Total Knee Replacement	DRAFT: Patients who completed pre- and post-surgery functional status assessments using a qualifying general or condition-specific tool, and whose functional status improved	DRAFT: Adults aged 18 and older with a primary total knee arthroplasty (TKA) and at least one outpatient encounter during the measurement year	DRAFT: Patients with multiple traumas at the time of the total knee arthroplasty or patients with severe cognitive impairment	N/A
XDEHF	DRAFT: Substance Use Screening and Intervention Composite	DRAFT: Patients who received the following substance use screenings once within the last 24 months AND who received an intervention for all positive	DRAFT: 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 12 month measurement period	DRAFT: Documentation of medical reason(s) for not screening for substance use (e.g., limited life expectancy, other medical reasons)	N/A

MUC ID	Measure Title	Numerator	Denominator	Exclusions	Length of Time
		screening results: Tobacco use component Patients who were screened for tobacco use at least once within the last 24 months AND who received tobacco cessation intervention if identified as a tobacco user Unhealthy alcohol use component Patients who were screened for unhealthy alcohol use using a systematic screening method at least once within the last 24 months AND who received brief counseling if identified as an unhealthy alcohol user Drug use component (nonmedical prescription drug use and illicit drug use) Patients who were screened for nonmedical prescription drug use and illicit drug use using a systematic screening method at least once within the last 24 months AND who received brief counseling if identified as a nonmedical prescription drug			

MUC ID	Measure Title	Numerator	Denominator	Exclusions	Length of Time
		user or illicit drug user			
XDAFC	Functional Status Assessment and Goal Setting in Patients with Rheumatoid Arthritis	DRAFT: Patients for whom a score on one of a select list of functional status assessment (FSA) tools was recorded at least twice during the measurement period and a goal was documented during the initial assessment.	DRAFT: Patients 18 years of age and older with a diagnosis of rheumatoid arthritis and an encounter during the measurement period	DRAFT: None	N/A
XDBGL	Functional Status Assessments and Goal Setting for Patients with Asthma	DRAFT: Patients for whom a score from one of a select list of functional status assessment (FSA) tools was recorded at least twice and for whom a care goal was documented during the initial assessment.	DRAFT: Patients 18 years of age and older with persistent asthma and an encounter during the measurement period.	DRAFT: Patients with an active diagnosis of COPD before or during the measurement period	N/A
XDBGM	Functional Status Assessments and Goal Setting for Patients with Chronic Obstructive Pulmonary Disease	DRAFT: Patients for whom a score on one of a select list of functional status assessment (FSA) tools was recorded at least twice and for whom a care goal was documented during the initial assessment.	DRAFT: Patients 18 years of age and older with COPD and an encounter during the measurement period.	DRAFT: None	N/A
E2080	Gap in HIV medical visits	Number of patients in the denominator who did not have a medical visit in the last 6 months of the measurement year	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	Patients who died at any time during the measurement year.	1-2 years

MUC ID	Measure Title	Numerator	Denominator	Exclusions	Length of Time
		(Measurement year is a consecutive 12-month period of time)	measurement year. (The measurement year can be any consecutive 12-month period.)		
E2079	HIV medical visit frequency	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 the subsequent 6-month period. (Measurement period is a consecutive 24-month period of time	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.	1-2 years
E2082	HIV viral load suppression	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	1-2 years
XDFEF	Osteoporotic Fracture Risk	Number of patients who have documentation of osteoporotic fracture risk assessment* OR dual X-ray absorptiometry testing results during the measurement year or in the year prior to the measurement year.	Number of adults aged 18 and older taking GCC at any dose for ≥ 90 days continuously prior to a face-to-face office visit with the provider; excluding patients taking an anti-resorptive or anabolic therapy.		N/A
XDAFA	Overuse of Diagnostic	DRAFT: Patients in the denominator who have received	DRAFT: Patients, aged >=18 years, who present to an office or	DRAFT: Patients in the denominator who have an	N/A

MUC ID	Measure Title	Numerator	Denominator	Exclusions	Length of Time
	Imaging for Uncomplicated Headache	an order from an eligible provider for an outpatient brain CT, CTA, MR, or MRA during the measurement period.	preventive visit with an eligible provider with an uncomplicated headache during the measurement period.	additional diagnosis or diagnoses for which diagnostic imaging is clinically warranted (i.e., "red flags" such as recent trauma, HIV status, history of cancer, anticoagulant use, abnormal neurologic signs/symptoms, etc.)	
XDFEG	Prednisone Use with Anabolic Agent	Number of patients during the measurement year with documentation in the medical record of: 1) recommendation for any anti-resorptive or anabolic agent, 2) prescription for any anti-resorptive or anabolic agent, or 3) taking any anti-resorptive or anabolic agent	Number of patients >=50 years of age taking >=7.5 mg/day of prednisone (or other glucocorticoid equivalent) for >= 90 days continuously prior to a face-to-face office visit with the provider	Contraindications or patient refusal or documentation in the medical record during the measurement year that the patient is on a "drug holiday"	N/A
E2083	Prescription of HIV antiretroviral therapy	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	< 1 year
XDFHE	Tuberculosis Screening Prior to First Course Biologic Disease Modifying Anti-Rheumatic Drug (DMARD) Therapy	Any record of TB testing documented or performed (PPD, IFN-gamma release assays, or other appropriate method) OR treatment prescribed or documented (prescription for INH or other appropriate medication) in the medical record	All patients with RA newly started on biologic therapy during the measurement year (defined as no biologic in the year preceding the measurement year).		N/A

MUC ID	Measure Title	Numerator	Denominator	Exclusions	Length of Time
		in the 12 months preceding the biologic prescription.			
XDEMG	ACORN Adolescent (Youth) Outcome Questionnaire	Pre-post change score	Standard deviation of questionnaire at intake	Patients seen only once	N/A
XDEMF	ACORN Adult Outcome Questionnaire	Pre-post change score	Standard deviation of questionnaire at intake	Patients seen only once	N/A
XAHDH	Adherence to Antiplatelet Treatment after Stent Implantation	The count of individuals in the denominator with an antiplatelet PDC of at least 0.8	Individuals undergoing coronary artery drug-eluting stent (DES) placement at any time during the first 12 months of the 24-month measurement period	Individuals with a history of contraindication(s) to antiplatelet therapy. Contraindications include peptic ulcer disease, intracranial hemorrhage, and GI bleed.	N/A
E1879	Adherence to Antipsychotic Medications for Individuals with Schizophrenia	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)	Individuals with any diagnosis of dementia during the measurement period	< 1 year
E0545	Adherence to Chronic Medications for Individuals with	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	1-2 years

MUC ID	Measure Title	Numerator	Denominator	Exclusions	Length of Time
	Diabetes Mellitus	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.	with a diagnosis of diabetes in any setting during the measurement period	
S1880	Adherence to Mood Stabilizers for Individuals with Bipolar I Disorder	Individuals with bipolar I disorder who fill at least two prescriptions for a mood stabilizer and have a Proportion of Days Covered (PDC) for mood stabilizer medication of at least 0.8	Individuals at least 18 years of age as of the beginning of the measurement period with bipolar I disorder and at least two claims for a mood stabilizer during the measurement period (12 consecutive months)	None	N/A
XDFAL	Adult Primary Rhegmatogenous Retinal Detachment Reoperation Rate	Number of successful rhegmatogenous retinal detachment surgeries with one surgery	Number of Adult Primary Rhegmatogenous Retinal Detachment cases with 6 month follow up	Excluded from Numerator and Denominator (1) patients with a history of prior retinal surgery (2) non-rhematogenous retinal detachments (3) retinal detachments of an unclear mechanism (4) rhegmatogenous retinal detachments in the setting of open globe injuries (5)	N/A

MUC ID	Measure Title	Numerator	Denominator	Exclusions	Length of Time
				eyes with prior vitreoretinal surgery (6) eyes with proliferative vitreoretinopathy (7) patients < 18 years old (8) Patients with first retinal detachment surgery done at another facility	
XDFAH	Adult Primary Rhegmatogenous Retinal Detachment Surgery Success Rate	Number of Adult Primary Rhegmatogenous Retinal Detachment cases achieving flat retinas six months post-surgery	Number of Adult Primary Rhegmatogenous Retinal Detachment cases with 6 month follow up	Excluded from Numerator and Denominator (1) patients with a history of prior retinal surgery (2) non-rhematogenous retinal detachments (3) retinal detachments of an unclear mechanism (4) rhegmatogenous retinal detachments in the setting of open globe injuries (5) eyes with prior vitreoretinal surgery (6) eyes with proliferative vitreoretinopathy (7) patients < 18 years old (8) Patients with first retinal detachment surgery done at another facility	N/A
XDBBL	All-Cause Unplanned Admissions for Patients with Diabetes	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	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	TBD	N/A

MUC ID	Measure Title	Numerator	Denominator	Exclusions	Length of Time
		hemoglobin A1c tests per year); rather, it is a risk-standardized outcome rate. Thus, we use this field to define the measure outcome. The outcome for this measure is all-cause unplanned admissions among patients with diabetes.	year); rather, it is a risk-standardized outcome rate. Thus, we use this field to define the measure cohort. The cohort for this measure is patients with a diagnosis of diabetes.		
XDBBG	All-Cause Unplanned Admissions for Patients with Heart Failure	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); rather, it is a risk-standardized outcome rate. Thus, we use this field to define the measure outcome. The outcome for this measure is all-cause unplanned admissions among patients with heart failure.	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); rather, it is a risk-standardized outcome rate. Thus, we use this field to define the measure cohort.	TBD	N/A
XDBBM	All-Cause Unplanned Admissions for Patients with	Note: This outcome measure does not have a traditional numerator and denominator like a core process measure (e.g.,	Note: This outcome measure does not have a traditional numerator and denominator like a core process measure (e.g., percentage	TBD	N/A

MUC ID	Measure Title	Numerator	Denominator	Exclusions	Length of Time
	Multiple Chronic Conditions	percentage of adult patients with diabetes aged 18-75 years receiving one or more hemoglobin A1c tests per year); rather, it is a risk-standardized outcome rate. Thus, we use this field to define the measure outcome. The outcome for this measure is all-cause unplanned admissions among patients with multiple chronic conditions.	of adult patients with diabetes aged 18-75 years receiving one or more hemoglobin A1c tests per year); rather, it is a risk-standardized outcome rate. Thus, we use this field to define the measure cohort. The cohort for this measure is patients diagnosed with multiple chronic conditions.		
XCLAL	ALS Patient Care Preferences	Patients who were offered at least once annually assistance in care planning (e.g. palliative care, invasive ventilation, or hospice).	All patients with a diagnosis of amyotrophic lateral sclerosis.	Documentation of a medical reason for not offering at least once annually assistance in care planning (e.g. patient in hospice and already in terminal phase)	N/A
XDFBD	Annual Hepatitis C Virus (HCV) Screening for Patients who are Active Injection Drug Users	Patients who received an HCV antibody test or HCV RNA test within the 12 month reporting period	All patients regardless of age who are active* injection drug users who were seen twice for any visits or who had at least one preventive care visit within the 12 month reporting period *Active means within the past 12 months.	Exclusions: Patients with a diagnosis of chronic hepatitis C Exceptions: Documentation of medical reason(s) for not receiving annual screening for HCV (e.g., advanced disease, limited life expectancy, patient diagnosed with chronic hepatitis C [untreated], other medical reasons) Documentation of patient	N/A

MUC ID	Measure Title	Numerator	Denominator	Exclusions	Length of Time
				reason(s) for not receiving annual screening for HCV (e.g., patient declined, other patient reasons)	
XDFGM	Appropriate age for colorectal cancer screening colonoscopy	Patients aged 85 and older who received a routine colonoscopy screening for CRC	All patients aged 50 and older who receive a routine colonoscopy screening for CRC	Not applicable	N/A
XDFCL	Appropriate follow-up imaging for incidental simple ovarian cysts	Final reports of Ultrasound studies of the pelvis with documentation that no follow up imaging is recommended Instructions: For performance, a lower percentage, with a definitional target approaching 0%, indicates appropriate evaluation simple ovarian cysts incidentally noted on CT/MRI in patients with no known ovarian disease	All final reports for Ultrasound studies of the pelvis for pre-menopausal women aged 18 and older with no known ovarian disease that demonstrate an ovarian cyst <5.0cm noted incidentally	None	N/A
XDFCE	Appropriate follow-up imaging for incidental thyroid nodules in patients	Final reports of a CT or MRI of the chest or neck OR ultrasound of the neck with documentation that no follow up imaging is recommended	All final reports for CT or MRI studies of the chest or neck or ultrasound of the neck for patients aged 18 and older with no known thyroid disease with a thyroid nodule < 1.0 cm noted incidentally	Documentation of medical reason(s) for not including documentation that follow up imaging is not needed (e.g., patient has multiple endocrine neoplasia, patient has cervical lymphadenopathy, other medical reason(s))	N/A

MUC ID	Measure Title	Numerator	Denominator	Exclusions	Length of Time
XDFDA	Appropriate in vitro susceptibility testing - The agent(s) used for definitive therapy in invasive staphylococcal disease should be confirmed by in vitro susceptibility testing as interpreted by the Clinical Laboratory and Standards Institute (CLSI) to be active against the clinical isolate.	Patients who were dispensed antibiotic medication on or within 3 days after an inpatient or Emergency Department encounter for invasive staphylococcus aureus (ISA) disease.	All adults age 18 of age and above as of July 1 of the year prior to the measurement year to 18 years as of June 30 of the measurement year who had an ED or inpatient admission with a diagnosis of invasive staphylococcal aureus (ISA) disease during the intake period (July 1st of the year prior to the measurement year to June 30th of the measurement year).	1. Formulary restriction (cascade reporting) 2. AST blood test not reported by lab in a timely manner 3. Inadequate reporting of AST blood test for sites where not effective 4. Patients who are transferred to another inpatient facility	N/A
XDFHL	Appropriate Treatment of MSSA - For MSSA bacteremia, a β-lactam antibiotic is the drug of choice in	All hospitalized patients with MSSA bacteremia who are treated with a beta-lactam antibiotic (e.g. nafcillin or cefazolin) as definitive therapy	All hospitalized patients with MSSA bacteremia	1. Patients with a documented allergy to b-lactam antibiotics 2. Patients with a documented intolerance to a b-lactam antibiotics Documentation of patient reason(s) for no consultation with a nephrologist (e.g.,	N/A

MUC ID	Measure Title	Numerator	Denominator	Exclusions	Length of Time
	the hospitalized patient in the absence of a documented allergy or drug intolerance.			nephrology specialist not available within 60 minutes of travel time from patient's home, other patient reasons)	
XDFCB	Appropriate use of imaging for non-traumatic knee pain	Patients with knee radiographs done within the preceding 3 months.	All patients aged 18 years and older with non-traumatic knee pain who undergo knee MR, MR arthrography	None	N/A
XDFCA	Appropriate use of imaging for non-traumatic shoulder pain	Patients with shoulder radiographs performed within the preceding 3 months.	All patients aged 18 years and older with non-traumatic shoulder pain who undergo shoulder MR, MR arthrography, or a shoulder ultrasound	None	N/A
XDFLD	Average change in functional status following lumbar spine fusion surgery	Adults age 18 and older; no upper age limit who undergo lumbar spine surgery during the measurement period and complete both a pre-operative and post-operative ODI functional status assessment.	Adults age 18 and older; no upper age limit who undergo lumbar spine fusion surgery during the measurement year. CPT Codes: 22533, 22534, 22558, 22612, 22630, 22633	Cancer, fracture or infection related to the spine. Idiopathic and congenital scoliosis. ICD-9 Diagnosis Codes: 70.2, 170.6, 198.5, 213.2, 213.6, 238.0, 239.2, 805.4, 805.5, 805.6 ,805.7, 806.4, 806.5, 806.60, 806.61, 806.62, 806.69, 806.70, 806.71, 806.72, 806.79, 733.13, 905.1 730.0x*, 730.1x*, 730.2x*, 730.3x*, 730.7x*, 730.8x*, 730.9x* [x = 5 pelvic region & thigh, 8 = other specified site, 9	N/A

MUC ID	Measure Title	Numerator	Denominator	Exclusions	Length of Time
				= multiple sites)], 733.82, 737.30, 737.31, 737.32, 737.33, 737.34, 737.39, 754.2	
XDFDL	Avoidance of inappropriate use of head CT in ED patients with minor head injury	Patients with an inappropriate imaging study (not clinically indicated)	Emergency department patients with minor head injury	Clinically indicated head CT (numerator and denominator exclusions to be further defined)	N/A
XDFGF	Avoidance of inappropriate use of imaging for adult ED patients with atraumatic low back pain	Patients with an inappropriate imaging study (not clinically indicated)	Emergency department patients aged >= 18 years with atraumatic low back pain	Patients with clinical indications for imaging including but not limited to neurological deficits, malignancy, underlying condition, or suspected vertebral infection, suspected cauda equina syndrome, or suspected spinal cord compression	N/A
XAHDG	Bleeding Outcomes Related to Oral Anticoagulants	Total number of individuals in the denominator with the admission date of an inpatient stay or an emergency department visit for a bleeding outcome occurring during a period covered by oral anticoagulant therapy	Individuals with one or more claims for oral anticoagulants during the measurement period that have been continuously enrolled during both the previous year and the measurement year or until they died (if they died during the measurement year) Note: a separate sub measure will be added to the specifications that	None	N/A

MUC ID	Measure Title	Numerator	Denominator	Exclusions	Length of Time
			will report the percentage of ED visits or hospitalizations for bleeding outcomes among users of dabigatran separately from warfarin.		
XDFAG	Cataract Surgery with Intra-Operative Complications (Unplanned Rupture of Posterior Capsule requiring unplanned vitrectomy)	Number of Cataract Surgery cases with unplanned rupture of the posterior capsule requiring vitrectomy	Total number of cataract surgery cases	Excluded from the numerator and the denominator (1) Cases with preoperative posterior capsule rupture (2) Cases that did not require vitrectomy	N/A
XDFAM	Cataract Surgery: Difference Between Planned and Final Refraction	Number of uncomplicated cataracts in patients without other eye diseases who achieve refraction +-1 D, measured at the one month follow up visit	Total number of uncomplicated cataract surgeries with one month follow up/ number of cases reviewed.	Excluded from Numerator and Denominator: Patients with other eye diseases than cataract.	N/A
E0005	CG CAHPS Supplemental and new Items : Between Visit Communication	This is an NQF-endorsed measure and does not have a numerator, denominator, or exclusion.	This is an NQF-endorsed measure and does not have a numerator, denominator, or exclusion.	This is an NQF-endorsed measure and does not have a numerator, denominator, or exclusion.	1-2 years
E0005	CG CAHPS Supplemental	This is an NQF-endorsed measure and does not have a numerator,	This is an NQF-endorsed measure and does not have a numerator,	This is an NQF-endorsed measure and does not have a	1-2 years

MUC ID	Measure Title	Numerator	Denominator	Exclusions	Length of Time
	Item : Educating Patient about Medication Adherence	denominator, or exclusion.	denominator, or exclusion.	numerator, denominator, or exclusion.	
E0005	CG CAHPS: Courteous & Helpful Office Staff	This is an NQF-endorsed measure and does not have a numerator, denominator, or exclusion.	This is an NQF-endorsed measure and does not have a numerator, denominator, or exclusion.	This is an NQF-endorsed measure and does not have a numerator, denominator, or exclusion.	1-2 years
E0005	CG CAHPS: Supplemental Item Care Coordination	This is an NQF-endorsed measure and does not have a numerator, denominator, or exclusion.	This is an NQF-endorsed measure and does not have a numerator, denominator, or exclusion.	This is an NQF-endorsed measure and does not have a numerator, denominator, or exclusion.	1-2 years
E0005	CG CAHPS: Supplemental Item Stewardship of Patient Resources	This is an NQF-endorsed measure and does not have a numerator, denominator, or exclusion.	This is an NQF-endorsed measure and does not have a numerator, denominator, or exclusion.	This is an NQF-endorsed measure and does not have a numerator, denominator, or exclusion.	1-2 years
XDFCF	Composite measure: 1) Appropriate follow-up imaging for incidental liver lesions	Final reports abdominal imaging studies with documentation that no follow up imaging is recommended	All final reports for abdominal imaging studies for asymptomatic patients aged 18 years and older with a liver lesion ≤ 1.5 cm noted incidentally	Documentation of medical reason(s) for not including documentation that follow up imaging is not needed (e.g. patient has a known malignancy that can metastasize to the liver, other medical reason(s))	N/A
XDFCG	Composite measure: 2) Appropriate	Final reports of kidney imaging studies with documentation that no follow up imaging is	All final reports for kidney imaging studies for patients aged 18 and older who have a kidney lesion <	Documentation of medical reason(s) for not including documentation that follow-up is	N/A

MUC ID	Measure Title	Numerator	Denominator	Exclusions	Length of Time
	follow-up imaging for incidental kidney lesions composite measure	recommended	1.0 cm noted incidentally	not needed, (e.g., patient has a known malignancy that can metastasize to the kidney, other medical reason(s))	
XDFCH	Composite measure: 3) Appropriate follow-up imaging for incidental adrenal lesions composite measure	Final reports of abdominal imaging studies with documentation that no follow up imaging is recommended	All final reports for abdominal imaging studies for patients aged 18 and older with an adrenal lesion ≤4.0 cm noted incidentally.	Documentation of medical reason(s) for not including documentation that follow up imaging is not needed, (e.g., including patient has a known malignancy such as lung cancer that can metastasize to the adrenal glands, other medical reason(s))	N/A
XDFBF	Discontinuation of Antiviral Therapy for Inadequate Viral Response	Boceprevir Patients for whom peginterferon alfa, ribavirin and boceprevir was discontinued Telaprevir Patients for whom peginterferon alfa, ribavirin and telaprevir was discontinued Numerator Note: Date treatment was discontinued may be up to 4 weeks after week 12 or week 24 The foregoing list of medications/drug names is based on clinical guidelines and other evidence. The specified drugs were selected based on the strength of evidence for their	All patients aged 18 years and older with a diagnosis of hepatitis C genotype 1 who are treatment naïve* and receiving peginterferon, ribavirin and boceprevir who have HCV RNA >100 IU/mL at week 12 or detectable HCV RNA at treatment week 24 All patients aged 18 years and older with a diagnosis of hepatitis C genotype 1 who are treatment naïve and receiving peginterferon, ribavirin and telaprevir who have HCV RNA >1000 IU/mL at treatment weeks	None	N/A

MUC ID	Measure Title	Numerator	Denominator	Exclusions	Length of Time
		clinical effectiveness. This list of selected drugs may not be current. Physicians and other health care professionals should refer to the FDA's web site page entitled "Drug Safety Communications" for up-to-date drug recall and alert information when prescribing medications.	4 or 12 and/or detectable at treatment week 24 *Treatment naïve is defined as no prior antiviral treatment for acute or chronic hepatitis C infection.		
XDFBG	Discussion and Shared Decision Making Surrounding Treatment Options	Patients with whom a physician or other clinician reviewed the range of treatment options appropriate to their genotype and demonstrated a shared decision making approach with the patient. To meet the measure, there must be documentation in the patient record of a discussion between the physician/clinician and the patient that includes all of the following. •Treatment choices appropriate to genotype •Risks and benefits •Evidence of effectiveness •Patient preferences toward the outcome of the treatment	All patients aged 18 years and older with a diagnosis of chronic hepatitis C	None	N/A
XDFDB	Head and Neck Cancer: Weight	Patients whose post radiotherapy weight is less than 90% of their	Patients for whom radiation therapy for head or neck cancer	Patients with a body mass index greater than 30 prior to surgery	N/A

MUC ID	Measure Title	Numerator	Denominator	Exclusions	Length of Time
	Loss Prevention	pre-surgical and pre-radiotherapy weight	was completed	and radiotherapy	
XCLLL	HRS-12: Cardiac Tamponade and/or Pericardiocentesis Following Atrial Fibrillation Ablation	The number of patients from the denominator with cardiac tamponade and/or pericardiocentesis occurring within 30 days following atrial fibrillation ablation.	All patients aged 18 years and older with atrial fibrillation ablation performed during the reporting period.	N/A	N/A
XCLMD	HRS-9: Infection within 180 Days of Cardiac Implantable Electronic Device (CIED) Implantation, Replacement, or Revision	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-defibrillators (ICDs, single or dual chamber); • Cardiac resynchronization devices (pacemaker or ICD); and • Implantable loop recorders (ILRs).	N/A	N/A
E0662	Median Time to Pain Management for Long Bone Fracture (OP-	Time (in minutes) from emergency department arrival to time of initial oral or parenteral pain medication administration for emergency department	N/A Continuous variable	N/A Continuous variable	N/A

MUC ID	Measure Title	Numerator	Denominator	Exclusions	Length of Time
	21/NQF-0662)	patients with a diagnosis of a (long bone) fracture.			
XDFCM	Minimum antimicrobial therapy for Staph A. - For adult patients with Staphylococcus aureus bacteremia, the minimum duration of antimicrobial therapy is 14 days.	All hospitalized patients of 18 years age and older with Staphylococcus aureus on one or more blood cultures receiving 14 days or more of an anti-staphylococcal antimicrobial	All hospitalized patients of 18 years of age and older with Staphylococcus aureus on one or more blood cultures	1. Patients who expire less than 14 days from initial dose of anti-staphylococcal antimicrobial 2. Patients who are transferred to another inpatient facility	N/A
XDFLL	National Institutes of Health Stroke Scale (NIHSS) for ED patients	ED patients with suspected Stroke/TIA in whom an NIHSS was performed	ED patients with suspected Stroke/TIA	Numerator and denominator exclusions to be determined	N/A
E0465	Perioperative Anti-platelet Therapy for Patients undergoing Carotid Endarterectomy	Patients over age 18 undergoing carotid endarterectomy who received ASA and/or clopidogrel within 48 hours prior to the initiation of surgery AND are prescribed this medication at hospital discharge following surgery	Patients over age 18 undergoing carotid endarterectomy	Patients with known intolerance to ASA and clopidogrel, or those on heparin; patients with active bleeding or undergoing urgent or emergent operations or endarterectomy combined with cardiac surgery	N/A

MUC ID	Measure Title	Numerator	Denominator	Exclusions	Length of Time
XDEME	Post-procedural Optimal medical therapy Composite (percutaneous coronary intervention)	Percentage of patients aged 18 years and older for whom PCI is performed who are prescribed optimal medical therapy at discharge	All patients aged 18 years and older for whom PCI is performed	Patients who expired, Patients who left against medical advice, Patient discharged to hospice or for whom comfort care measures only is documented, Patient discharged to other acute care hospital	N/A
XDFBM	Radiation Consideration for Adult CT: Utilization of Dose Lowering Techniques	Final reports with documentation that one or more of the following dose reduction techniques were used: • Automated exposure control • Adjustment of the mA and/or kV according to patient size • Use of iterative reconstruction technique	All final reports for patients aged 18 years and older undergoing CT	None	N/A
XDFDH	Recurrence or amputation following endovascular infrainquinal lower extremity revascularizatio n	Patients over 18 undergoing endovascular infrainguinal revascularization for non-limb threatening ischemia (claudication or asymptomatic) who require ipsilateral repeat revascularization or any amputation within one year.	Patients over 18 undergoing endovascular infrainguinal revascularization for non-limb threatening ischemia (claudication or asymptomatic)	Patients with limb-threatening ischemia (rest pain or tissue loss)	N/A
XDFDG	Recurrence or amputation following open infrainquinal lower extremity	Patients over 18 undergoing open infrainguinal revascularization for non-limb threatening ischemia (claudication or asymptomatic)	Patients over 18 undergoing open infrainguinal revascularization for non-limb threatening ischemia (claudication or asymptomatic)	Patients with limb-threatening ischemia (rest pain or tissue loss)	N/A

MUC ID	Measure Title	Numerator	Denominator	Exclusions	Length of Time
	revascularization	who require ipsilateral repeat revascularization or any amputation within one year.			
XCMDH	Reduction of complications through the use of cystoscopy during surgery for stress urinary incontinence	Surgeries for which cystoscopy was used during the surgical procedure	All SUI surgeries done in female patients, aged 18 and older	Documentation of medical reason(s) for not using cystoscopy during SUI surgery (patients for whom the use of a cystoscope may not be appropriate, such as the presence of a new cystostomy repair). The panel noted that endoscopy after a new repair should be cautiously used. Documentation of patient reason(s) for not using cystoscopy during SUI surgery (patients who might prefer that a cystoscope not be used).	N/A
XDFBE	Referral to Treatment for Patients Identified with Hepatitis C Virus (HCV) Infection	Patients who were referred to treatment services for HCV infection within the 12 month reporting period	All patients who were identified as having HCV infection through a screening process	Exceptions: Documentation of medical reason(s) for not being referred to treatment services for HCV infection (e.g., advanced disease, limited life expectancy, other medical reasons) Documentation of patient reason(s) for not being referred to treatment services for HCV infection (e.g., patient declined, other patient reasons)	N/A

MUC ID	Measure Title	Numerator	Denominator	Exclusions	Length of Time
XDFGL	Repeat Colonoscopy due to poor bowel preparation	Patients aged 18 years and older who are recommended to have a repeat colonoscopy due to poor bowel preparation	Patients aged 18 years and older for whom a screening or surveillance colonoscopy was performed	Medical reasons: 1) Anatomic reasons for incomplete procedure (e.g. tortuous colon, previous surgery, adhesions, large lesion). 2) Colonoscopies with a 52 or 53 modifier on Medicare claims forms are also excluded from this measure.	N/A
XDFBC	Screening for Hepatitis C Virus (HCV) for Patients at High Risk	Patients who received a one-time HCV antibody test* *Prior receipt of HCV RNA test or RIBA test will meet the numerator	All patients with one or more of the following: a history of injection drug use, patients who received blood transfusions prior to 1992, OR patients who were born in the years 1945–1965 who were seen twice for any visits or who had at least one preventive care visit within the 12 month reporting period	Exclusions: Patients with a diagnosis of chronic hepatitis C Exceptions: Documentation of medical reason(s) for not receiving one-time HCV antibody test (e.g., advanced disease, limited life expectancy, other medical reasons) Documentation of patient reason(s) for not receiving one-time HCV antibody test (e.g., patient declined, other patient reasons)	N/A
XDFBH	Screening for Hepatocellular Carcinoma (HCC) in patients with Hepatitis C	Patients who were screened with either ultrasound, triple-contrast CT or triple-contrast MRI for HCC at least once within the 12 month reporting period	All patients aged 18 years and older with a diagnosis of chronic hepatitis C cirrhosis	None	N/A

MUC ID	Measure Title	Numerator	Denominator	Exclusions	Length of Time
	Cirrhosis				
XDFCC	Use of premedication before contrast-enhanced imaging studies in patients with documented contrast allergy	Final reports for patients that include documentation that patients underwent screening and were pre-medicated	All final reports for patients aged 18 years and older who are at risk for a contrast reaction following a prior imaging examination with intravascular iodinated contrast Definitions: At risk-for the purposes of this measure, patients are considered at risk if they have had a previously documented contrast reaction Intravascular – mode of contrast given previously	None	N/A
XDEGH	Appropriate Use of DXA Scans in Women Under 65 Who Do Not Meet the Risk Factor Profile	DRAFT: Female patients who received an order for at least one DXA scan in the measurement period or the prior year	DRAFT: Female patients ages 18 to 64 years with an encounter during the measurement period.	DRAFT: Women with specific risk factors for osteoporotic fractures TBD through testing, but potentially: Having two or more of the following: BMI<=21 kg/m2, current smoker, alcohol consumption (>2 units/day), family history of osteoporotic fracture (maternal hip fracture); OR having one or more of the following within the past two years: diagnosis of osteoporosis, rheumatoid arthritis, type 1 diabetes, thyroid disease	N/A

MUC ID	Measure Title	Numerator	Denominator	Exclusions	Length of Time
				(hypothyroidism, hyperthyroidism), malabsorption syndromes (celiac disease, inflammatory bowel disease, cystic fibrosis, malabsorption), chronic renal failure, hyperparathyroidism; OR having had prior osteoporotic fracture or a gastric bypass surgery anytime; OR high risk medications which involve cumulative medication duration >=90 days of corticosteroids (>=5 mg/day) or immunosuppressive drugs (>=5 mg/day)] within the past 2 years	
E1399	Developmental Screening - Age 1	Children who had documentation in the medical record of a developmental screening (screening for risk of developmental, behavioral, and social delays) using a standardized screening tool by their first birthday	Children with a visit who turned 1 year of age during the measurement period and who had documentation of a face-to-face visit between the clinician and the child that predates the child's birthday	None	N/A
E1399	Developmental Screening - Age 2	Children who had documentation in the medical record of a developmental screening (screening for risk of developmental, behavioral, and social delays) using a	Children who turned 2 years of age during the measurement period and who had documentation of a face-to-face visit between the clinician and the child that predates the child's	None	N/A

MUC ID	Measure Title	Numerator	Denominator	Exclusions	Length of Time
		standardized screening tool after their first and before or on their second birthday	birthday by at least 12 months		
E1399	Developmental Screening - Age 3	Children who had documentation in the medical record of a developmental screening (screening for risk of developmental, behavioral, and social delays) using a standardized screening tool after their second and before or on their third birthday	Children who turned 3 years of age during the measurement period and who had documentation of a face-to-face visit between the clinician and the child that predates the child's birthday by at least 12 months	None	N/A
XDEHE	DRAFT: Tobacco Use and Help with Quitting Among Adolescents	DRAFT: Documentation of the following within 18 months of the measurement period end date: 1) that the adolescent is not a tobacco user OR 2) that the adolescent is a tobacco user AND any of the following: • Advice given to quit smoking or tobacco use; • Counseling on the benefits of quitting smoking or tobacco use (e.g. "5-A" Framework) • Assistance with or referral to external smoking or tobacco cessation support programs (e.g.	DRAFT: Adolescents who turn 13 through 20 years during the measurement period and have documentation of a face-to-face visit to the primary care practice during the 12 months prior to the measurement period	DRAFT: None	N/A

MUC ID	Measure Title	Numerator	Denominator	Exclusions	Length of Time
		telephone counseling 'quit line')			
XDFHF	History of Fragility Fracture with Prednisone Use	Number of patients during the measurement year with documentation in the medical record of: 1) recommendation for any anti-resorptive or anabolic agent, 2) prescription for any anti-resorptive or anabolic agent, or 3) taking any anti-resorptive or anabolic agent	Number of adults under age 50 years and with a history of fragility fracture (fracture of the humerus, hip, spine or distal radius) and currently taking >=7.5 mg/day of prednisone (or other glucocorticoid equivalent) for >=90 days	Contraindications, patient refusal, documentation of current or future pregnancy risk in women, or documentation in the medical record that the patient is on a "drug holiday"	N/A
E1959	Immunizations by 13 years of age - HPV	Female adolescents who receive at least three HPV vaccinations, with different dates of service, between their 9th and 13th birthdays	Female adolescents who turn 13 years of age during the measurement year and who had documentation of a face-to-face visit between the clinician and the child that predates the child's birthday by at least 12 months	Denominator Exception: Adolescents with an anaphylactic reaction to the HPV vaccine documented before their 13th birthday	N/A
E1407	Immunizations by 13 years of age- Meningococcus, Tetanus, and Diphtheria	Adolescents who receive either one meningococcal conjugate or one meningococcal polysaccharide vaccine on or between the adolescent's 11th and 13th birthdays and either one tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap) or one tetanus, diphtheria toxoids vaccine (Td) on or between the adolescent's 10th and 13th birthdays	Adolescents who turn 13 years of age during the measurement period and who had documentation of a face-to-face visit between the clinician and the child that predates the child's birthday by at least 12 months	Denominator Exception: Adolescents who had an anaphylactic reaction for a specific vaccine documented before their 13th birthday	N/A

MUC ID	Measure Title	Numerator	Denominator	Exclusions	Length of Time
XDCMD	Oral Health: Children aged 6-9 years who receive sealants in the first permanent molar	Unique number of children aged 6-9 at elevated risk who received a sealant on one or more first permanent molar tooth in the measurement period	Unique number of children between 6-9 years seen by a practitioner for an oral evaluation during the measurement period who are at elevated risk	Medical reason (e.g. non-sealable surface) Patient reasons (e.g., refusal of treatment, did not return for treatment)	N/A
XDCME	Oral Health: Children who receive a comprehensive or periodic oral evaluation in two consecutive years	Unique number of children under age 21 who received a comprehensive or periodic oral evaluation in the measurement year and in the year prior to the measurement year.	Unique number of children under age 21 who received a comprehensive or periodic oral evaluation in the measurement year.	None	N/A
E0500	Severe Sepsis/Septic Shock: Management Bundle	If: A. measure lactate level B. obtain blood cultures prior to antibiotics C. administer broad spectrum antibiotics D. administer 30 ml/kg crystalloid for hypotension or lactate >=4 mmol/L E. apply vasopressors (for hypotension that does not respond to initial fluid resuscitation to maintain a mean arterial pressure >= 65)	Number of patients presenting with severe sepsis or septic shock.	A) Patients with advanced directives for comfort care are excluded. B) Clinical conditions that preclude total measure completion should be excluded (e.g. mortality within the first 6 hours of presentation). C) Patients for whom a central line is clinically contraindicated (e.g. coagulopathy that cannot be corrected, inadequate internal jugular or subclavian central venous access due to	>2 years

MUC ID	Measure Title	Numerator	Denominator	Exclusions	Length of Time
		F. In the event of persistent arterial hypotension despite volume resuscitation (septic shock) or initial lactate >=4mmol/L (36 mg/dl) measure central venous pressure and central venous oxygen saturation G. remeasure lactate if initial lactate is elevated represent processes of care: Numerator statement: Patients from the denominator who received all the following: A, B, and C within 3 hours of time of presentation† AND IF septic shock is present (as either defined as hypotension* or lactate >=4 mmol/L) who also received D and E and F and G within 6 hours of time of presentation. †"time of presentation" is defined as the time of triage in the Emergency Department or, if presenting from another care venue, from the earliest chart annotation consistent with all elements severe sepsis or septic shock ascertained through chart		repeated cannulations). D) Patients for whom a central line was attempted but could not be successfully inserted. E) Patient or surrogate decision maker declined or is unwilling to consent to such therapies or central line placement.	

MUC ID	Measure Title	Numerator	Denominator	Exclusions	Length of Time
		review. * "hypotension" is defined as systolic blood pressure (SBP) <90 mm Hg or mean arterial pressure (MAP) <70 mm Hg or a SBP decrease >40 mm Hg or <2 SD below normal for age or known baseline.			
XDFLE	Optimal Asthma Care- Control Component	Asthma well-controlled (take the most recent asthma control tool available); any of the following tools below: • Asthma Control Test (ACT) score of 20 or above - ages 12 and older • Childhood Asthma Control Test (C-ACT) score of 20 or above - ages 11 and younger • Asthma Control Questionnaire (ACQ) score of 0.75 or lower - ages 17 and older • Asthma Therapy Assessment Questionnaire (ATAQ) score of 0 – only applicable for children and adolescents	Patients ages 5 to 50 with asthma who have at least two visits for this condition over the last two years (established patient) with at least one visit in the last 12 months. Extrinsic asthma: 493.00, 493.01, 493.02 Intrinsic asthma: 493.10, 493.11, 493.12 Other forms of asthma: 493.80, 493.81, 493.82 Asthma, unspecified: 493.90, 493.91, 493.92	Exclusions: Death, hospice and permanent nursing home resident and the following conditions: COPD (491.2, 493.2, 496, 506.4) Emphysema (492, 506.4, 518.1, 518.2) Cystic fibrosis (277.0) Acute respiratory failure (518.81)	N/A
E1507	Risky Behavior Assessment or Counseling by Age 18 Years	Adolescents who had documentation of a Risky Behavior Assessment or Counseling By Age 18 Years.	Adolescents with a visit who turned 18 years of age in the measurement year.	None	N/A

MUC ID	Measure Title	Numerator	Denominator	Exclusions	Length of Time
XDFBL	Utilization of ultrasonography in children with clinically suspected appendicitis	Patients for whom Ultrasound was used as the initial imaging evaluation of the appendix.	All patients aged 14 years and younger with clinically suspected appendicitis who undergo CT or MRI or Ultrasound of the abdomen or pelvis Definitions: Clinically suspected appendicitis- for the purposes of this measure, clinically suspected appendicitis includes right lower quadrant pain.	Medical reason(s) for not using ultrasound as the initial imaging evaluation of the appendix (e.g., patient is obese, other medical reason(s))	N/A
XDDMH	Draft: Acute Myocardial Infarction Condition Phase Episode for CMS Episode Grouper	Draft: Resources used in the episodes attributed to the provider[5]	Draft: Number of episodes attributed to the provider[5]	Determined by specific code sets of diagnoses and interventions	N/A
XDEAM	Draft: Asthma	Draft: Resources used in the	Draft: Number of episodes	Determined by specific code	N/A

[5] These measures are episode groupers, which are different from traditional quality metrics. CMMI is developing (as required by the ACA) an episode grouper for use in Medicare programs. Episode groupers are resource use measures. We develop software code for the basic grouper logic that is condition-agnostic. Then we develop condition- or procedure-specific groupers in a relatively quick fashion by including ICD-10 codes, CPT codes, and by defining the episode length. Most acute conditions will likely have an episode length of 30 days, and most chronic conditions will likely have a length of a year, but this is not yet solidified. We have developed the basic grouper logic and have about 6 grouper measures developed that are undergoing testing. The majority of the episode groupers on this list are not yet developed, but may be by next year in time for proposal in a rule. It is not yet possible to put in specifics of the numerator, denominator or episode length, and we do not yet have the specific code sets. These will be more fully defined over the course of the next several months.

MUC ID	Measure Title	Numerator	Denominator	Exclusions	Length of Time
	Condition Episode for CMS Episode Grouper	episodes attributed to the provider[5]	attributed to the provider[5]	sets of diagnoses and interventions	
XDEEB	Draft: Back Pain Condition Episode for CMS Episode Grouper	Draft: Resources used in the episodes attributed to the provider[5]	Draft: Number of episodes attributed to the provider[5]	Determined by specific code sets of diagnoses and interventions	N/A
XDEDC	Draft: Breast Cancer Condition Episode for CMS Episode Grouper	Draft: Resources used in the episodes attributed to the provider[5]	Draft: Number of episodes attributed to the provider[5]	Determined by specific code sets of diagnoses and interventions	N/A
XDEDD	Draft: Breast Cancer Treatment Episode for CMS Episode Grouper	Draft: Resources used in the episodes attributed to the provider[5]	Draft: Number of episodes attributed to the provider[5]	Determined by specific code sets of diagnoses and interventions	N/A
XDEBA	Draft: Bronchiectasis Condition Episode for CMS Episode Grouper	Draft: Resources used in the episodes attributed to the provider[5]	Draft: Number of episodes attributed to the provider[5]	Determined by specific code sets of diagnoses and interventions	N/A
XDEBM	Draft: Cardiac	Draft: Resources used in the	Draft: Number of episodes	Determined by specific code	N/A

MUC ID	Measure Title	Numerator	Denominator	Exclusions	Length of Time
	Arrhythmia Condition Episode for CMS Episode Grouper	episodes attributed to the provider[5]	attributed to the provider[5]	sets of diagnoses and interventions	
XDECB	Draft: Cardioversion Treatment Episode for CMS Episode Grouper	Draft: Resources used in the episodes attributed to the provider[5]	Draft: Number of episodes attributed to the provider[5]	Determined by specific code sets of diagnoses and interventions	N/A
XDEDB	Draft: Carotid Artery Stenosis Treatment Episode for CMS Episode Grouper	Draft: Resources used in the episodes attributed to the provider[5]	Draft: Number of episodes attributed to the provider[5]	Determined by specific code sets of diagnoses and interventions	N/A
XDEBC	Draft: Cataract Condition Episode for CMS Episode Grouper	Draft: Resources used in the episodes attributed to the provider[5]	Draft: Number of episodes attributed to the provider[5]	Determined by specific code sets of diagnoses and interventions	N/A
XDEBD	Draft: Cataract Treatment Episode for CMS Episode Grouper	Draft: Resources used in the episodes attributed to the provider[5]	Draft: Number of episodes attributed to the provider[5]	Determined by specific code sets of diagnoses and interventions	N/A
XDEBB	Draft: Chronic	Draft: Resources used in the	Draft: Number of episodes	Determined by specific code	N/A

MUC ID	Measure Title	Numerator	Denominator	Exclusions	Length of Time
	Bronchitis/Emphysema Condition Episode for CMS Episode Grouper	episodes attributed to the provider[5]	attributed to the provider[5]	sets of diagnoses and interventions	
XDEDL	Draft: Colon Cancer Condition Episode for CMS Episode Grouper	Draft: Resources used in the episodes attributed to the provider[5]	Draft: Number of episodes attributed to the provider[5]	Determined by specific code sets of diagnoses and interventions	N/A
XDEDM	Draft: Colon Cancer Treatment Episode for CMS Episode Grouper	Draft: Resources used in the episodes attributed to the provider[5]	Draft: Number of episodes attributed to the provider[5]	Determined by specific code sets of diagnoses and interventions	N/A
XDDML	Draft: Coronary Artery Bypass Graft Treatment Episode for CMS Episode Grouper	Draft: Resources used in the episodes attributed to the provider[5]	Draft: Number of episodes attributed to the provider[5]	Determined by specific code sets of diagnoses and interventions	N/A
XDEEA	Draft: Dementia Condition Episode for CMS Episode Grouper	Draft: Resources used in the episodes attributed to the provider[5]	Draft: Number of episodes attributed to the provider[5]	Determined by specific code sets of diagnoses and interventions	N/A

MUC ID	Measure Title	Numerator	Denominator	Exclusions	Length of Time
XDECL	Draft: Diabetes Condition Episode for CMS Episode Grouper	Draft: Resources used in the episodes attributed to the provider[5]	Draft: Number of episodes attributed to the provider[5]	Determined by specific code sets of diagnoses and interventions	N/A
XDEBE	Draft: Glaucoma Condition Episode for CMS Episode Grouper	Draft: Resources used in the episodes attributed to the provider[5]	Draft: Number of episodes attributed to the provider[5]	Determined by specific code sets of diagnoses and interventions	N/A
XDEBF	Draft: Glaucoma Treatment Episode for CMS Episode Grouper	Draft: Resources used in the episodes attributed to the provider[5]	Draft: Number of episodes attributed to the provider[5]	Determined by specific code sets of diagnoses and interventions	N/A
XDECA	Draft: Heart Block Condition Episode for CMS Episode Grouper	Draft: Resources used in the episodes attributed to the provider[5]	Draft: Number of episodes attributed to the provider[5]	Determined by specific code sets of diagnoses and interventions	N/A
XDDMM	Draft: Heart Catheterization Treatment Episode for CMS Episode Grouper	Draft: Resources used in the episodes attributed to the provider[5]	Draft: Number of episodes attributed to the provider[5]	Determined by specific code sets of diagnoses and interventions	N/A
XDEBL	Draft: Heart Failure	Draft: Resources used in the episodes attributed to the	Draft: Number of episodes attributed to the provider[5]	Determined by specific code sets of diagnoses and	N/A

MUC ID	Measure Title	Numerator	Denominator	Exclusions	Length of Time
	Condition Episode for CMS Episode Grouper	provider[5]		interventions	
XDEAB	Draft: Hip Osteoarthritis Condition Episode for CMS Episode Grouper	Draft: Resources used in the episodes attributed to the provider[5]	Draft: Number of episodes attributed to the provider[5]	Determined by specific code sets of diagnoses and interventions	N/A
XDEAC	Draft: Hip Replacement/Revision Treatment Episode for CMS Episode Grouper	Draft: Resources used in the episodes attributed to the provider[5]	Draft: Number of episodes attributed to the provider[5]	Determined by specific code sets of diagnoses and interventions	N/A
XDEAD	Draft: Hip/Femur Fracture Condition Episode for CMS Episode Grouper	Draft: Resources used in the episodes attributed to the provider[5]	Draft: Number of episodes attributed to the provider[5]	Determined by specific code sets of diagnoses and interventions	N/A
XDEAE	Draft: Hip/Femur Fracture Repair Treatment Episode for CMS	Draft: Resources used in the episodes attributed to the provider[5]	Draft: Number of episodes attributed to the provider[5]	Determined by specific code sets of diagnoses and interventions	N/A

MUC ID	Measure Title	Numerator	Denominator	Exclusions	Length of Time
	Episode Grouper				
XDECF	Draft: Hypertension Condition Episode for CMS Episode Grouper	Draft: Resources used in the episodes attributed to the provider[5]	Draft: Number of episodes attributed to the provider[5]	Determined by specific code sets of diagnoses and interventions	N/A
XDEDA	Draft: Ischemic Cerebral Artery Disease Condition Episode for CMS Episode Grouper	Draft: Resources used in the episodes attributed to the provider[5]	Draft: Number of episodes attributed to the provider[5]	Determined by specific code sets of diagnoses and interventions	N/A
XDDMG	Draft: Ischemic Heart Disease Condition Episode for CMS Episode Grouper	Draft: Resources used in the episodes attributed to the provider[5]	Draft: Number of episodes attributed to the provider[5]	Determined by specific code sets of diagnoses and interventions	N/A
XDEAF	Draft: Knee Osteoarthritis Condition Episode for CMS Episode Grouper	Draft: Resources used in the episodes attributed to the provider[55]	Draft: Number of episodes attributed to the provider[5]	Determined by specific code sets of diagnoses and interventions	N/A
XDEAG	Draft: Knee	Draft: Resources used in the	Draft: Number of episodes	Determined by specific code	N/A

MUC ID	Measure Title	Numerator	Denominator	Exclusions	Length of Time
	Replacement/Revision Treatment Episode for CMS Episode Grouper	episodes attributed to the provider[5]	attributed to the provider[5]	sets of diagnoses and interventions	
XDEDE	Draft: Lung Cancer Condition Episode for CMS Episode Grouper	Draft: Resources used in the episodes attributed to the provider[5]	Draft: Number of episodes attributed to the provider[5]	Determined by specific code sets of diagnoses and interventions	N/A
XDEDF	Draft: Lung Cancer Treatment Episode for CMS Episode Grouper	Draft: Resources used in the episodes attributed to the provider[5]	Draft: Number of episodes attributed to the provider[5]	Determined by specific code sets of diagnoses and interventions	N/A
XDECH	Draft: Nephropathy/Renal Failure Condition Episode for CMS Episode Grouper	Draft: Resources used in the episodes attributed to the provider[5]	Draft: Number of episodes attributed to the provider[5]	Determined by specific code sets of diagnoses and interventions	N/A
XDECC	Draft: Pacemaker/AICD Implantation Treatment	Draft: Resources used in the episodes attributed to the provider[5]	Draft: Number of episodes attributed to the provider[5]	Determined by specific code sets of diagnoses and interventions	N/A

MUC ID	Measure Title	Numerator	Denominator	Exclusions	Length of Time
	Episode for CMS Episode Grouper				
XDEAA	Draft: Percutaneous Coronary Intervention Treatment Episode for CMS Episode Grouper	Draft: Resources used in the episodes attributed to the provider[5]	Draft: Number of episodes attributed to the provider[5]	Determined by specific code sets of diagnoses and interventions	N/A
XDECD	Draft: Pneumonia Condition Episode for CMS Episode Grouper	Draft: Resources used in the episodes attributed to the provider[5]	Draft: Number of episodes attributed to the provider[5]	Determined by specific code sets of diagnoses and interventions	N/A
XDEDH	Draft: Prostate Cancer Condition Episode for CMS Episode Grouper	Draft: Resources used in the episodes attributed to the provider[5]	Draft: Number of episodes attributed to the provider[5]	Determined by specific code sets of diagnoses and interventions	N/A
XDEDG	Draft: Prostate Cancer Treatment Episode for CMS Episode Grouper	Draft: Resources used in the episodes attributed to the provider[5]	Draft: Number of episodes attributed to the provider[5]	Determined by specific code sets of diagnoses and interventions	N/A

MUC ID	Measure Title	Numerator	Denominator	Exclusions	Length of Time
XDECE	Draft: Respiratory Failure Condition Episode for CMS Episode Grouper	Draft: Resources used in the episodes attributed to the provider[5]	Draft: Number of episodes attributed to the provider[55]	Determined by specific code sets of diagnoses and interventions	N/A
XDEBG	Draft: Retinal Disease Condition Episode for CMS Episode Grouper	Draft: Resources used in the episodes attributed to the provider[5]	Draft: Number of episodes attributed to the provider[5]	Determined by specific code sets of diagnoses and interventions	N/A
XDEBH	Draft: Retinal Disease Treatment Episode for CMS Episode Grouper	Draft: Resources used in the episodes attributed to the provider[5]	Draft: Number of episodes attributed to the provider[5]	Determined by specific code sets of diagnoses and interventions	N/A
XDECM	Draft: Sepsis/SIRS Condition Episode for CMS Episode Grouper	Draft: Resources used in the episodes attributed to the provider[5]	Draft: Number of episodes attributed to the provider[5]	Determined by specific code sets of diagnoses and interventions	N/A
XDECG	Draft: Shock/Hypotension Condition	Draft: Resources used in the episodes attributed to the provider[5]	Draft: Number of episodes attributed to the provider[5]	Determined by specific code sets of diagnoses and interventions	N/A

MUC ID	Measure Title	Numerator	Denominator	Exclusions	Length of Time
	Episode for CMS Episode Grouper				
XDEAH	Draft: Shoulder Osteoarthritis Condition Episode for CMS Episode Grouper	Draft: Resources used in the episodes attributed to the provider[5]	Draft: Number of episodes attributed to the provider[5]	Determined by specific code sets of diagnoses and interventions	N/A
XDEAL	Draft: Shoulder Replacement/Repair Treatment Episode for CMS Episode Grouper	Draft: Resources used in the episodes attributed to the provider[5]	Draft: Number of episodes attributed to the provider[5]	Determined by specific code sets of diagnoses and interventions	N/A
S2158	Medicare Spending Per Beneficiary	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	1-2 years

MUC ID	Measure Title	Numerator	Denominator	Exclusions	Length of Time
				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.	
E1822	External Beam Radiotherapy for Bone Metastases	All patients, regardless of age, with painful bone metastases, and no previous radiation to the same anatomic site who receive	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 2) Patients with femoral axis cortical involvement greater	N/A

MUC ID	Measure Title	Numerator	Denominator	Exclusions	Length of Time
		EBRT with any of the following recommended fractionation schemes: 30Gy/10fxns, 24Gy/6fxns, Gy/1fxn. Screening may be completed using verbal, numeric, visual analog rating scales designed for use with non-verbal patients, or other standardized tools		than 3 cm in length 3) Patients who have undergone a surgical stabilization procedure4) Patients with spinal cord compression, cauda equina compression or radicular pain	
XDCFE	Initiation of Osteoclast Inhibitors for Patients with Multiple Myeloma or Bone Metastases Associated with Breast Cancer, Prostate Cancer, or Lung Cancer	DRAFT: Patients who were administered appropriate OI therapy at the reporting facility within 60 days of the first diagnosis of multiple myeloma or bone metastases indicated at the reporting facility during the measurement period. Appropriate osteoclast inhibitor therapy varies by cancer and includes intravenous bisphosphonates pamidronate disodium pentahydrate or zoledronate or osteoclast inhibitor denosumab (subcutaneous).	DRAFT: Patients aged 18 years and older with an initial diagnosis of multiple myeloma or bone metastases associated with one of the following primary cancers: breast cancer, prostate cancer, or non-small cell lung cancer who had two or more visits to the reporting facility during the measurement period.	DRAFT: Patients who meet any of the following criteria at any time during the measurement period: (1) Patients with dental disease (2) Patients with renal insufficiency (3) Patients receiving palliative care (4) Patients who died Exceptions: Multiple myeloma patients without indication of active bone disease	N/A
XDBLG	Overuse of Imaging for Staging Breast Cancer at Low Risk of	DRAFT: Women who received an order from their provider for a bone, CT, PET, or PET/CT scan anytime during the 120 days following the initial diagnosis of	DRAFT: Women aged 18 or older with stage 0, I, or II breast cancer.	DRAFT: 1. Any patient who received an order for a Bone, CT, PET, or PET/CT scan after the initiation of systemic chemotherapy or radiation	N/A

MUC ID	Measure Title	Numerator	Denominator	Exclusions	Length of Time
	Metastasis	breast cancer.		therapy. 2. Any patient who received an order for an: (a) bone scan due to localized bone pain or elevated alkaline phosphatase; (b) abdominal or pelvic CT due to elevated alkaline phosphatase, an abnormal liver function test, or abdominal or pelvic symptoms; or (c) chest CT due to abnormal pulmonary symptoms.	
E1628	Patients with Advanced Cancer Screened for Pain at Outpatient Visits	Patients who are screened for the presence of absence of pain (and if present, rating of severity noted) using a quantitative standardized tool during primary or cancer-related/specialty outpatient visit(s) Screening may be completed using verbal, numeric, visual analog rating scales designed for use with non-verbal patients, or other standardized tools	Adult patients with Stage IV cancer who are alive 30 days or more after diagnosis and who have at least 1 primary care or cancer-related/specialty outpatient visit	None (other than those patients are not alive at least 30 days after cancer diagnosis)	>2 years
E0450	Perioperative pulmonary embolism or deep vein thrombosis rate	Discharges, among cases meeting the inclusion and exclusion rules for the denominator, with a secondary ICD-9-CM diagnosis code for deep vein thrombosis or	Surgical discharges, for patients ages 18 years and older, with any-listed ICD-9-CM procedure codes for an operating room procedure. Surgical discharges are defined by	Exclude cases: • with a principal ICD-9-CM diagnosis code (or secondary diagnosis present on admission)	>2 years

MUC ID	Measure Title	Numerator	Denominator	Exclusions	Length of Time
	(PSI 12)	a secondary ICD-9-CM diagnosis code for pulmonary embolism.	specific DRGs or MS-DRG codes. See Patient Safety Indicators Appendices: • Appendix A – Operating Room Procedure Codes • Appendix D – Surgical Discharge DRGs • Appendix E – Surgical Discharge MS-DRGs	for deep vein thrombosis (see above) • with a principal ICD-9-CM diagnosis code (or secondary diagnosis present on admission) for pulmonary embolism (see above) • where the only operating room procedure is interruption of vena cava • where a procedure for interruption of vena cava occurs before or on the same day as the first operating room procedure† • 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)	
XDDAF	Potentially Avoidable Admissions and Emergency Department	DRAFT: Cancer patients 18 years of age or older undergoing outpatient chemotherapy treatment who were admitted to an inpatient setting or ED with	DRAFT: Patients aged 18 years and older as of the start of the measurement period with a principal diagnosis of cancer who received at least one outpatient	DRAFT: Patients with hematologic cancer during the intake period. Patients receiving inpatient chemotherapy during the intake	N/A

MUC ID	Measure Title	Numerator	Denominator	Exclusions	Length of Time
	Visits Among Patients Receiving Outpatient Chemotherapy	one of the following principal diagnoses during the course of treatment: Nausea Emesis Anemia Neutropenic fever Diarrhea Dehydration Pain Two rates are reported for this measure: 1) Percent of patients admitted to the ED 2) Percent of patients admitted to the inpatient hospital setting	chemotherapy treatment at the reporting facility during the intake period.	period.	

APPENDIX B: MEASURE EFFECTIVENESS

Measure Effectiveness Table Legend

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

- An "E" prefix indicates a measure that is currently endorsed by the NQF.
- A "D" prefix indicates a measure that was once endorsed by the NQF but has subsequently been de-endorsed.
- An "F" prefix indicates a measure that was submitted to the NQF for endorsement but was not endorsed.
- An "S" prefix indicates a measure that is currently submitted to the NQF for endorsement.
- An all-lettered measure ID indicates a measure that has yet to be submitted to the NQF for endorsement.

Measure Title: Refers to the title of the measure.

- DRAFT: Refers to measures under development.

Effectiveness: Refers to the rationale and/or impact the measure is anticipated to achieve.

Measure Effectiveness Table

MUC ID	Measure Title	Effectiveness
XDEMB	High-Acuity Care Visits after Outpatient Cataract Procedure	Cataract procedures are common and costly. There is wide variation in high-acuity care utilization post-discharge across facilities providing ambulatory surgery.
XDEMA	High-Acuity Care Visits after Outpatient Colonoscopy Procedure	Colonoscopy procedures are common and costly. There is wide variation in high-acuity care utilization post-discharge across facilities providing ambulatory surgery.
XDELM	High-Acuity Care Visits after Outpatient Endoscopy Procedure	Endoscopy procedures are common and costly. There is wide variation in high-acuity care utilization post-discharge across facilities providing ambulatory surgery.
E0260	Assessment of Health-related Quality of Life (Physical & Mental Functioning)	Measure requires reporting of the provision of the KDQOL assessment of quality of life issues in dialysis patients.
E0029	Counseling on physical activity in older adults - a. Discussing Physical Activity, b. Advising Physical Activity	Lack of physical activity and health conditions such as obesity, diabetes and cardiovascular disease interact dynamically to diminish the health of patients with ESRD. Studies have found that patients on dialysis therapy are inactive, are at high risk for conditions that can be prevented or ameliorated by exercise, and often receive most of their care from their nephrologist. Other studies have found that the adoption of routine counseling and encouragement for physical activity has the potential to improve outcomes, improve physical functioning, and optimize quality of life and overall health of dialysis patients. And clinicians have demonstrated that particular types of physical therapy and exercise regimes improve health outcomes in patients with ESRD. Therefore, regularly discussing patients' level of physical activity, and counseling them on the importance of regular exercise, offers the possibility of improving the health and wellbeing of patients with ESRD.
XDGBA	ESRD Vaccination – Lifetime Pneumococcal Vaccination	1. According to the CDC, Streptococcus pneumoniae (pneumococcus) remains a leading cause of serious illness in the United States, with the highest incidence rates occurring among high-risk and immunocompromised groups (which includes ESRD patients). 2. Recent studies have demonstrated a lower risk of mortality and hospitalization among dialysis patients who received the pneumococcal vaccine (Bond 2012; Gilbertson 2011). 3. Evidence suggests that pneumococcal vaccination is underutilized among dialysis patients.

MUC ID	Measure Title	Effectiveness
		For example, in a survey-based study of dialysis facilities across three ESRD networks, Bond et al (2012) found that only 45.3% of the 34,502 surveyed patients had ever received the pneumococcal vaccine. This suggests a performance gap when compared to the Healthy People 2010 goals of 60% for non-institutionalized high-risk adults aged 18-64 and 90% for adults aged 65 years or older and the CDC vaccination guidelines.
XDEFL	ESRD Vaccination - Pneumococcal Vaccination (PPSV23)	1. According to the CDC, Streptococcus pneumoniae (pneumococcus) remains a leading cause of serious illness in the United States, with the highest incidence rates occurring among high-risk and immunocompromised groups (which includes ESRD patients). 2. Recent studies have demonstrated a lower risk of mortality and hospitalization among dialysis patients who received the pneumococcal vaccine (Bond 2012; Gilbertson 2011). 3. Evidence suggests that pneumococcal vaccination is underutilized among dialysis patients. For example, in a survey-based study of dialysis facilities across three ESRD networks, Bond et al (2012) found that only 45.3% of the 34,502 surveyed patients had ever received the pneumococcal vaccine. This suggests a performance gap when compared to the Healthy People 2010 goals of 60% for non-institutionalized high-risk adults aged 18-64 and 90% for adults aged 65 years or older and the CDC vaccination guidelines.
XDEGA	ESRD Vaccination - Timely Influenza Vaccination	1. According to the CDC, seasonal influenza is associated with approximately 36,000 deaths and 226,000 hospitalizations annually. 2. Recent studies have demonstrated a lower risk of mortality and hospitalization among dialysis patients who received the pneumococcal vaccine (Bond 2012; Gilbertson 2011). 3. Evidence suggests that influenza vaccination is underutilized among dialysis patients. Annual vaccination rates range from 40-80% depending on the source of data (Medicare claims vs. survey-based). This suggests a performance gap when compared to the Healthy People 2010 goal of 90% and the CDC vaccination guidelines.
XDEFM	Full-Season Influenza Vaccination (ESRD Patients)	1. According to the CDC, seasonal influenza is associated with approximately 36,000 deaths and 226,000 hospitalizations annually. 2. Recent studies have demonstrated a lower risk of mortality and hospitalization among dialysis patients who received the pneumococcal vaccine (Bond 2012; Gilbertson 2011). 3. Evidence suggests that influenza vaccination is underutilized among dialysis patients. Annual vaccination rates range from 40-80% depending on the source of data (Medicare claims vs. survey-based). This suggests a performance gap when compared to the Healthy People 2010

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		goal of 90% and the CDC vaccination guidelines.
XDGAF	Hepatitis B vaccine coverage in hemodialysis patients	In line with Healthy People 2020 goal for hepatitis B vaccination rates.
E0393	Hepatitis C: Testing for Chronic Hepatitis C – Confirmation of Hepatitis C Viremia	Intended to avoid unnecessary and potentially dangerous treatment application to patients with false-positive HCV serologies.
E0004	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	Substance abuse has been shown to be significant issue in the ESRD patient population and nephrotoxins such as those found in recreational drugs like heroin and cocaine, alcohol, tobacco and overuse of analgesics (e.g. aspirin or ibuprofen) can act as important contributors to kidney failure. Moreover, patients abusing or dependent upon psychoactive substances are less likely to be placed on kidney transplant lists, or to be selected for transplantation. This means that the treatment of substance abuse can be an important component in the treatment of ESRD, yet few facilities actively screen patients for alcohol, tobacco and other drug disorders. Therefore, regular screening for substance use and abuse, and referrals to substance abuse treatment programs, promises to improve health outcomes for a significant proportion of the ESRD patient population.
XDEGC	Measurement of Plasma PTH Concentration	Elevations in PTH are associated with increased morbidity and mortality. Commonly used therapies in dialysis patients are prescribed to affect PTH and hence PTH should be monitored. Recent evidence in the EVOLVE and ADVANCE studies demonstrate efficacy of strategies to lower PTH in a priori secondary analyses.
E0431	Influenza Vaccination Coverage Among Healthcare Personnel	The CDC recommends universal vaccination among healthcare personnel. These guidelines state: 1. Annual influenza vaccinations should be administered to all healthcare personnel. 2. Live attenuated vaccine (LAIV) can be used for healthcare personnel in any setting, except those who care for severely immunocompromised hospitalized persons who require care in a protective environment. 3. Vaccination efforts should begin as soon as vaccine is available and continue through the influenza season. • CDC, the Advisory Committee on Immunization Practices (ACIP), and the Healthcare Infection Control Practices Advisory Committee (HICPAC) recommend that all U.S. health care workers

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		get vaccinated annually against influenza. • Health care workers include (but are 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, laundry, security, maintenance, administrative, billing, and volunteers) not directly involved in patient care but potentially exposed to infectious agents that can be transmitted to and from health care workers and patients. • Influenza (the flu) can be a serious disease that can lead to hospitalization and sometimes even death. Anyone can get sick from the flu. • You can get the flu from anyone, including patients and coworkers who are sick with the flu. • If you get the flu, you can spread it to others even if you don't feel sick. • By getting vaccinated, you can help protect yourself, your family at home, and also your patients at work from getting the flu. • Health care workers who get vaccinated help to reduce the following: ◦ transmission of influenza ◦ staff illness and absenteeism ◦ influenza-related illness and death, especially among people at increased risk for severe influenza illness • Higher vaccination levels among staff have been associated with a lower risk of nosocomial (hospital-acquired) influenza cases. • Influenza outbreaks in hospitals and long-term care facilities have been attributed to low influenza vaccination coverage among health care workers in those facilities. • Higher influenza vaccination levels among health care workers can reduce influenza-related illness, and even deaths, in settings like nursing homes. • During the 2010-2011 influenza season, coverage for influenza vaccination among health care workers was estimated at 63.5%. • Coverage was 98.1% among health care workers who had an employer requirement for vaccination. • In the absence of requirements, increased vaccination coverage was associated with

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		employers offering vaccination onsite, free of charge, for multiple days. • During the 2009-2010 influenza season, an estimated 61.9% of health care workers received seasonal influenza vaccine.
E0420	Pain Assessment and Follow-Up	Studies have shown that pain is a significant problem for more than 50% of patients with ESRD, that pain is commonly associated with patients' quality of life in early- and late-stage chronic kidney disease patients, that pain is not effectively managed in the ESRD patient population, and that chronic pain often goes untreated. Pain is a frequent experience often with a debilitating impact on the daily lives of patients with ESRD, and research has shown dialysis facilities have not paid sufficient attention to this critical area of health and well-being. Therefore regular pain assessments and follow-ups offer the best possibility of improving the health and well-being of patients with ESRD.
XCBMM	Pediatric Peritoneal Dialysis Adequacy: Achievement of Target Kt/V	1. In considering potential measures, it should be recognized that large-scale clinical trials evaluating target peritoneal dialysis (PD) adequacy for the pediatric population do not exist. Due to the low prevalence of stage 5 CKD among pediatric patients, high renal transplantation rate, and difficulty of determining measurable study end points, longitudinal studies on pediatric peritoneal dialysis adequacy have not been performed and clinical evidence regarding PD adequacy are primarily based on observational studies. 2. Currently there are no NQF endorsed measures for pediatric patients (age<18 years old) on peritoneal dialysis (PD) and studies have shown a weekly PD Kt/V target of 1.8 is associated with better clinical outcomes. 3. Pediatric PD adequacy targets should be no lower than existing adult PD adequacy targets since generally, pediatric patients' greater metabolic demands require higher adequacy targets in terms of small solute clearance. 4. Recognizing that limited evidence in the pediatric population exists, clinical practice guidelines and clinical opinion support the recommendation that target clearance in pediatric patients should meet or exceed adult standards. This is because pediatric patients have greater metabolic demands and therefore require higher adequacy targets in terms of small solute clearance. 5. Kt/V of 1.8/week or greater in adult PD patients was associated with better serum albumin

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		levels (a predictor of survival) (Paniagua, 2002). 6. ADEMEX did not show clinical benefit with Kt/V>1.7/week in adult CAPD patients (JASN, 2002); however, in a study of adult CAPD patients, Kt/V>1.8/week may be optimal based on survival analysis (Lo, 2005). 7. In small studies, pediatric data suggest a positive relationship between clinical outcomes, including growth and total solute clearance (Warady, 2001; Hotta, 2000). 8. Kt/V of 1.8 is the generally accepted target in the community and there may be a potential for confusion if the measure target is not the target recommended by clinical practice guidelines.
XDGAM	Pediatric Peritoneal Dialysis Adequacy: Frequency of Measurement of Kt/V	1. For pediatric patients, the interval of measurement should take into consideration the practicality of performing adequacy measurements where collection of PD effluent fluid and residual urine may be more challenging. This is the reason behind the difference in the interval of measurement proposed in the pediatric measure as compared to the corresponding adult PD measure which requires assessment of Kt/V at four month intervals. 2. This measure assumes that standard practice of monthly clinical assessment of pediatric PD patients is conducted. This assumption will be documented in the measure submission forms. 3. Clinical practice guidelines indicate measurement of Kt/V at least once every six months in this population, and preliminary analyses suggest that this is currently practiced by the community. Deviating from this practice may be confusing to the nephrology community. 4. There is no clear evidence that supports the need to increase the frequency of measurement to four-month intervals. 5. The TEP also noted that although Kt/V should be measured a minimum of every 6 months, this may be more frequent depending on the occurrence of events that may reduce solute clearance such as peritonitis.
XDEGB	Percentage of Dialysis Patients	1. Hyperphosphatemia and severe hypophosphatemia are associated with increased morbidity

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	with Dietary Counseling	and mortality. 2. Dietary counseling has been shown to improve phosphorus levels (Shi, 2013) 3. Recent studies have shown that reducing foods high in phosphate additives may result in reduction of serum phosphorus (Sullivan, 2009 and Mayne, 2012). 4. Expert counseling will limit potential adverse effects of unmonitored diets.
XDEFH	Pneumococcal Vaccination Measure (PCV13)	1. According to the CDC, Streptococcus pneumoniae (pneumococcus) remains a leading cause of serious illness in the United States, with the highest incidence rates occurring among high-risk and immunocompromised groups (which includes ESRD patients). 2. Recent studies have demonstrated a lower risk of mortality and hospitalization among dialysis patients who received the pneumococcal vaccine (Bond 2012; Gilbertson 2011). 3. Evidence suggests that pneumococcal vaccination is underutilized among dialysis patients. For example, in a survey-based study of dialysis facilities across three ESRD networks, Bond et al (2012) found that only 45.3% of the 34,502 surveyed patients had ever received the pneumococcal vaccine. This suggests a performance gap when compared to the Healthy People 2010 goals of 60% for non-institutionalized high-risk adults aged 18-64 and 90% for adults aged 65 years or older and the CDC vaccination guidelines.
E0418	Screening for Clinical Depression	Studies have shown that depression and anxiety are the most common comorbid illnesses in patients with ESRD. Moreover, depressive affect and decreased perception of social support have been associated with higher rates of mortality in the ESRD population, and some studies suggest that this association is as strong as the association between medical risk factors and mortality. Nevertheless, depression and anxiety remain under-recognized and under-treated, despite the availability of reliable screening instruments. Therefore, screening for depression offers an important opportunity to improve the health of patients with ESRD.
XDEFF	Standardized Kt/V	The TEP discussed the literature review to assess scientific importance. Standardized stdKt/V is an important metric to consider since the minimum spKt/V targets for different dialysis schedules should logically be different from a thrice times per week schedule. stdKt/V better reflects a continuous weekly clearance equivalent across different numbers of sessions per week, akin to continuous weekly Kt/V use in PD. Using a formula for stdKt/V, it was possible to predict outcomes from PD as well as outcomes from HD based on frequency of sessions [Gotch 1998]. The Leypoldt equation is based on a fixed volume model [Leypoldt 2004]. The use of stdKt/V is in line with justifications needed to propose a measure. There is clinical significance

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		and proven usability. StdKt/V is a good compromise between frequency and dosage. However, it's not certain if a universal threshold for stdKt/V would be linked to outcomes as presumably the purpose of providing higher frequency of dialysis is to increase the total delivered dose of dialysis. The KDOQI 2006 guidelines suggest that in the absence of dose-ranging outcomes data, minimum spKt/V targets for different schedules can be based on achieving a minimum stdKt/V of 2.0 per week. However, the TEP felt that this threshold was too low. The target for Stdkt/V is not clear, and more data are needed for its justification in routine clinical use.
XDEFE	Surface Area Normalized Kt/V	The TEP discussed the literature review to assess scientific importance. Surface area normalized SAN Kt/V could be another potentially useful metric. The rationale for choosing volume (V) as a denominator for spKt/V was mostly out of 'convenience'. SAN Kt/V is superior to spKt/V in that it uses surface area (SA) as the denominator instead of V. SA is important for a number of reasons. Women tend to have a higher surface area relative to their volume, and a study has shown that women are actually receiving a lower dosing when adjusting for SA [Ramirez 2012]. This was not seen when using either spKt/V or stdKt/V. In a study by Daugirdas [Daugirdas 2010], measurements of stdKt/V are shown by both women and men in the high dose arm of the HEMO study appeared to receive similar doses. When measured by surface area normalized stdKt/V (SANKt/V), women and men in each of the study's arms appeared to be receiving different doses - "The lowest surface-area-normalized dose was received by women randomized to the conventional dose arm, possibly explaining the sex-specific response to higher dialysis dose."
XAHMH	Ultrafiltration Rate (UFR)	This measure is intended to guard against risks associated with high ultrafiltration (i.e., rapid fluid removal) rates for adult dialysis patient undergoing hemodialysis (HD). Despite majority of dialysis patients achieving targets for urea removal, the mortality rate among hemodialysis patients has remained unacceptably high. Published literature suggests that higher UFR is an independent predictor of mortality. Faster UFR (depending on the magnitude of interdialytic fluid loss and the duration of dialysis session) may lead to higher frequency of intradialytic hypotension (IDH), which currently occurs at high frequency and has been associated with higher mortality. Phenomena, such as repetitive 'myocardial stunning', recurrent central nervous system, bowel, and other organ-perfusion related damage could result if large volumes of fluid are removed rapidly during each dialysis session, with deleterious consequences for the patient both in the short and longer term.

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XDDLA	PSI 10:Postoperative Physiologic and Metabolic Derangement Rate	This measure is intended to reduce the number of postoperative physiological and metabolic derangement rates.
E0533	PSI 11: Post-Operative Respiratory Failure	This measure is intended to reduce the number of post-op respiratory failure discharges.
E0349	PSI 16: Transfusion Reaction	This measure is intended to reduce the number of transfusion reactions after surgery.
XAFLG	PSI 9: Perioperative Hemorrhage or Hematoma Rate	This measure is intended to reduce Perioperative Hemorrhage or Hematoma Rates at discharge.
XDFFA	Depression Screening Conducted and Follow-Up Plan Documented	Depression causes suffering and impairment in social and occupational functioning, and decreases the quality of life. It is also associated with higher health care costs as well as with increased rates of chronic medical conditions. Studies have shown that a higher number of depression symptoms are associated with poor health and impaired functioning, whether or not the criteria for a diagnosis of major depression are met. Additionally, studies focused on depression assessment in home health care patients indicate that the condition is frequently underreported, thus there is room for improvement. It is envisioned that this measure will improve the assessment of depression in home care patients, providing information to home care agencies and consumers that will enable them to address and monitor the care received by patients with depression.
XDAEH	Emergency Department Use without Hospital Readmission During the First 30 Days of Home Health	The emergency department (ED) serves an important function in post-acute care that has not been recognized with reports that one third of hospital revisits are missed if ED visits are not included. ED visits have described as gateway encounters for hospital re-admissions. A recent study highlighted the importance of measuring both emergency department visits and inpatient readmissions after a hospital discharge. In this study, focused on a single hospital, measures which evaluate readmission to the inpatient setting and do not include a return to the ED would miss 54 percent of all ED use after an inpatient stay. Thus, measuring ED use as well as inpatient readmission can help identify potential areas to improve care. There is evidence that there are strategies that can be undertaken to reduce emergency use without readmission among community dwelling elderly including care coordination, primary care access (i.e. physician follow up), telehealth and a variety of home health care specific

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		evidence-based strategies from the Quality Improvement Organizations (medication reconciliation, care provision [frontloading visits], patient education strategies, falls prevention and other topics).
XDFGB	New or Worsened Pressure Ulcers	Studies have demonstrated that while pressure ulcers may be relatively rare, they have a substantial adverse impact on patient quality of life and have a predictive risk with mortality. They are a national focus because they are widely seen as preventable with sufficient risk assessment and quality care provision. This measure are envisioned to encourage agencies to conduct a risk assessment, include pressure ulcer prevention in the plan of care, and implement pressure ulcer prevention during short term episodes of care, which could significantly reduce the incidence of pressure ulcers in the home health care patient population. Additionally, these measures would provide home health agencies and consumers with information that will enable them to monitor the quality of care received by all patients at risk of developing pressure ulcers.
XCHGG	Rehospitalization During the First 30 Days of Home Health	Hospital readmissions are a national priority for Medicare recipients, based on evidence that 20% of all Medicare beneficiaries who were hospitalized had a return hospital stay within 30 days. In 2004, this cost the Medicare program $17.4 billion. Within home health care, an analysis of Medicare claims shows that 14 percent of home health patients are rehospitalized within 30 days of the start of home health care. There is limited research on the extent to which these hospital readmissions are avoidable within home health care: one study reporting on patients with heart failure found that more than 40% of the 30 day rehospitalizations may have been avoidable. In addition, there is evidence from studies of Medicare patients in general that there are interventions to reduce the need for hospital care within a substantial proportion of these Medicare beneficiaries. Moreover, there are a number of national initiatives, both governmental (e.g., Quality Improvement Organizations, National Priorities Partnership, and CMS) and through private foundations (e.g., Institute for Healthcare Improvement), addressing this issue. Thus there is room for improvement and this is a national priority issue. There is evidence that there are strategies that can be undertaken to rehospitalization including care coordination, physician follow up, hospital discharge planning and a variety of home health care specific evidence-based strategies from the Quality Improvement Organizations (medication management, care provision [frontloading visits], patient education

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		strategies, falls prevention and other topics).
XBELG	Hospital 30-day, all-cause, unplanned, risk-standardized readmission rate (RSRR) following Coronary artery Bypass Graft (CABG) Surgery	A hospital-level, 30-day all-cause unplanned readmission measure will inform healthcare providers about opportunities to improve care and strengthen incentives for quality improvement, particularly for care at the time of transitions (e.g., discharge to home or a skilled nursing facility). Improvements in inpatient care and care transitions for this common, costly procedure are likely to reduce costly readmissions. CABG is a priority area for outcomes measure development because it is a common procedure associated with considerable morbidity, mortality, and health care spending. In 2007, there were 114,028 hospitalizations for CABG surgery and 137,721 hospitalizations for combined surgeries for CABG and valve procedures ("CABG plus valve" surgeries) in the U.S. [1] Readmission rates following CABG surgery are high and vary across hospitals. The CABG unadjusted mean hospital readmission rate calculated in the 2009 Medicare FFS patients undergoing isolated CABG surgery is 17.1% and ranges from 0-100% with a median of 16.6% (25th and 75th percentiles are 13.2% and 20%, respectively). The variation persists after risk adjustment. Our mean RSRR is 17.0% with a range from 14.0%-21.5%. The median risk-standardized rate is 16.9% (25th and 75th percentiles are 16.1% and 17.8%, respectively). Similarly, published data also demonstrate variation in readmission rates. The average 30-day all-cause, hospital-level readmission rate was 16.5% and ranged from 8.3% to 21.1% among patients who underwent CABG surgery in New York between January 1, 2005 and November 30, 2007. [2] Among patients readmitted within 30 days, 87.3% of readmissions were for reasons related to CABG surgery, with a 30-day rate of readmissions due to complications of CABG surgery of 14.4%. Patients readmitted within 30 days also experienced a 2.8% in-hospital mortality rate during their readmission(s), three-fold higher than the 30-day mortality rate for patients without readmissions. [2] 1. Drye E, Krumholz H, Vellanky S, Wang Y. Probing New Conditions and Procedures for New Measure Development: Yale New Haven Health Systems Corporation; Center for Outcomes Research and Evaluation.; 2009:1-7. 2. Hannan EL, Zhong Y, Lahey SJ, et al. 30-day readmissions after coronary artery bypass graft surgery in New York State. JACC Cardiovasc Interv. 2011; 4(5):569-576.

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XDBCB	Adverse Drug Events - Hyperglycemia	Hyperglycemia in the inpatient setting has been associated with a substantial increase in hospital mortality and has been a predictor of complications and serious infections. Furthermore, anti-diabetic drugs have consistently been identified as one of the primary drug classes causing Adverse Drug Events and Diabetes was ranked fourth in the top 20 high impact conditions by NQF. This measure, along with the companion balancing measure (hypoglycemia), would ensure that hospitals are monitoring blood glucose and developing interventions to promote appropriate blood glucose control to improve outcomes.
XDBGA	Adverse Drug Events - Hypoglycemia	Hypoglycemia is associated with increased in-hospital mortality, morbidity, longer hospital stay, and higher medical costs. Furthermore, anti-diabetic drugs have consistently been identified as one of the primary drug classes causing Adverse Drug Events and Diabetes was ranked fourth in the top 20 high impact conditions by NQF. This measure, along with the companion balancing measure (hyperglycemia), would ensure that hospitals are monitoring blood glucose and developing interventions to promote appropriate blood glucose control to improve outcomes.
XDEEL	Hospital 30-day Risk-standardized Acute Myocardial Infarction (AMI) Mortality eMeasure	Acute myocardial infarction (AMI) is one of the most common principal hospital discharge diagnoses among older adults and is associated with high mortality. The high prevalence and considerable morbidity and mortality associated with AMI create an economic burden on the healthcare system (American Heart Association 2010). In 2008, AMI was the sixth most expensive condition treated in US hospitals, accounting for 3.3% of the national hospital bill. It was also the sixth most expensive condition billed to Medicare that year, accounting for 4.8% of Medicare's hospital bill (Wier and Andrews 2011). Many current hospital interventions are known to decrease the risk of death within 30 days of hospital admission (Krumholz et al. 1995; Krumholz et al. 1996; Krumholz et al. 1998; Krumholz et al. 1999; Rathore et al. 2009). Current process-based performance measures, however, cannot capture all the ways that care within the hospital might influence outcomes (Bradley et al. 2006; Werner and Bradlow 2006). As a result, many stakeholders are interested in outcome measures that advance transparency and quality assessment for the public and health care professionals (Krumholz et al. 2007). The implementation of electronic health records (EHRs) offers opportunities for the

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		advancement of quality measurement. Performance measures developed for use in EHRs will utilize detailed clinical data without requiring the investment of resources currently needed to collect registry or medical record-abstracted data. An EHR-based measure of AMI mortality will respond to stakeholders' interest in using medical record data for risk adjustment in outcome measures.
XDAEA	Appropriate Monitoring of patients receiving an Opioid via an IV Patient Controlled Analgesia Device	Appropriate monitoring of patients receiving an opioid via IV PCA Device
XBGDL	Hospital 30-Day All-Cause Risk-Standardized Readmission Rate (RSRR) following Vascular Procedures	Vascular procedures are commonly performed procedures. They are often performed on older, sicker patients and have a high rate of readmission. The MedPAC 2007 Report to Congress identified "other vascular" as one of the seven conditions which account for nearly 30 percent of potentially preventable readmissions within 15 days following discharge. These conditions were responsible for $182,000,000 spending on readmissions. Research has shown that readmission rates are influenced by the quality of inpatient and outpatient care, as well as hospital system characteristics, such as the bed capacity of the local health care system (Fisher et al. 1994). It is envisioned that this measure will improve quality and coordination of care, thus reducing readmission rates. Fisher ES, Wennberg JE, Stukel TA, Sharp SM. Hospital readmission rates for cohorts of Medicare beneficiaries in Boston and New Haven. N Engl J Med. 1994; 331(15):989-995. Report to the Congress: Promoting Greater Efficiency in Medicare: Medicare Payment Advisory Commission (MedPAC); 2007.
XDEEH	Hospital 30-day, all-cause, risk-standardized mortality rate (RSMR) following Coronary Artery Bypass Graft (CABG) surgery	It is envisioned that this measure will provide hospitals with procedure-specific information to help improve patient safety and quality of care, thus reducing mortality rates. CABG is a priority area for outcomes measure development because it is a common procedure associated with considerable morbidity, mortality, and health care spending. In 2007, there were 114,028 hospitalizations for CABG surgery and 137,721 hospitalizations for combined surgeries for CABG and valve procedures ("CABG plus valve" surgeries) among Medicare FFS patients in the U.S. [1]

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		CABG surgeries are costly procedures that account for the majority of major cardiac surgeries performed nationally. In fiscal year 2009, isolated CABG surgeries accounted for almost half (47.6%) of all cardiac surgery hospital admissions in Massachusetts. [2] In 2008, the average Medicare payment was $30,546 for CABG without valve and $47,669 for CABG plus valve surgeries. [3] Mortality rates following CABG surgery vary widely across hospitals. The unadjusted mean hospital mortality rate in 2009 Medicare FFS patients undergoing isolated CABG surgery is 3.2% and ranges from 0-50% with a median of 2.7% (25th and 75th percentiles are 1.4% and 4.4%, respectively). The variation persists after risk adjustment. Our mean RSMR is 3.2% with a range from 1.5%-7.9%. The median risk-standardized rate is 3.0% (25th and 75th percentiles are 2.6% and 3.6%, respectively). Similarly, published data also demonstrate variation in mortality rates. The observed operative (i.e., in-hospital or within 30-days of surgery) all-cause, hospital-level mortality rate was 1.81% and ranged from 0.0% to 5.6% among patients who were discharged after CABG surgery (without any other major heart surgery) in New York in 2008 [4]. 1. Drye E, Krumholz H, Vellanky S, Wang Y. Probing New Conditions and Procedures for New Measure Development: Yale New Haven Health Systems Corporation; Center for Outcomes Research and Evaluation.; 2009:1-7. 2. Massachusetts Data Analysis Center. Adult Coronary Artery Bypass Graft Surgery in the Commonwealth of Massachusetts: Hospital and Surgeons Risk-Standardized 30-Day Mortality Rates. In: Health MDoP, ed. Boston2009:77. 3. Pennsylvania Health Care Cost Containment Council. Cardiac Surgery in Pennsylvania 2008-2009. Harrisburg2011:60. 4. American New York State Department of Health. Adult Cardiac Surgery in New York State 2006-20082010:54.
XDELH	Hospital-level, risk-standardized 30-day episode-of-care payment measure for heart failure	Medicare spending is estimated to have been $525.0 billion in 2010 with annual growth rates projected to be 6.3% for 2013 through 2020 due to both an increase in the Medicare population as well as Medicare spending on each beneficiary [1]. Further projections anticipate an exhaustion of Medicare's Hospital Insurance Trust Fund (Part A) by 2024 [2]. The growth in

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		spending is unsustainable and highlights the need to understand the value of care Medicare buys with every dollar spent. Given the urgency of the state of the Medicare Hospital Insurance Trust Fund and the fact that Medicare pays for 40-50% of hospitalizations nationally [3], hospital costs are a natural venue in which to deconstruct payments for Medicare patients. Yet payments to hospitals are difficult to interpret in isolation. Some high payment hospitals may have better clinical outcomes when compared with low payment hospitals; other high payment hospitals may not. For this reason, the value of hospital care is more clearly assessed when pairing hospital payments with hospital quality. A measure of payments for Medicare patients to hospitals that is aligned with current quality of care measures will facilitate profiling hospital value (payments and quality). This measure will reflect differences in the management of care for patients with heart failure both during hospitalization and immediately post-discharge. Heart failure is a condition with substantial range in costs of care and for which there are well-established publicly reported quality measures and is therefore an ideal condition for assessing relative value for an episode-of-care that begins with an acute hospitalization. By focusing on one specific condition, value assessments may provide actionable feedback to hospitals and incentivize targeted improvements in care. 1. Ash AS, Byrne-Logan S. How Well Do Models Work? Predicting Health Care Costs. Proceedings of the Section on Statistics in Epidemiology. American Statistical Association. 1998. 2. Medpac. Report to the Congress: Medicare Payment Policy 9/17/12 2012. 3. National Hospital Discharge Survey. http://www.cdc.gov/nchs/nhds.htm. Accessed 08/07/2012.
XDELG	Hospital-level, risk-standardized 30-day episode-of-care payment measure for pneumonia	Medicare spending is estimated to have been $525.0 billion in 2010 with annual growth rates projected to be 6.3% for 2013 through 2020 due to both an increase in the Medicare population as well as Medicare spending on each beneficiary [1]. Further projections anticipate an exhaustion of Medicare's Hospital Insurance Trust Fund (Part A) by 2024 [2]. The growth in spending is unsustainable and highlights the need to understand the value of care Medicare

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		buys with every dollar spent. Given the urgency of the state of the Medicare Hospital Insurance Trust Fund and the fact that Medicare pays for 40-50% of hospitalizations nationally [3], hospital costs are a natural venue in which to deconstruct payments for Medicare patients. Yet payments to hospitals are difficult to interpret in isolation. Some high payment hospitals may have better clinical outcomes when compared with low payment hospitals; other high payment hospitals may not. For this reason, the value of hospital care is more clearly assessed when pairing hospital payments with hospital quality. A measure of payments for Medicare patients to hospitals that is aligned with current quality of care measures will facilitate profiling hospital value (payments and quality). This measure will reflect differences in the management of care for patients with pneumonia both during hospitalization and immediately post-discharge. Pneumonia is a condition with substantial range in costs of care and for which there are well-established publicly reported quality measures and is therefore an ideal condition for assessing relative value for an episode-of-care that begins with an acute hospitalization. By focusing on one specific condition, value assessments may provide actionable feedback to hospitals and incentivize targeted improvements in care. 1. Ash AS, Byrne-Logan S. How Well Do Models Work? Predicting Health Care Costs. Proceedings of the Section on Statistics in Epidemiology. American Statistical Association. 1998. 2. Medpac. Report to the Congress: Medicare Payment Policy 9/17/12 2012. 3. National Hospital Discharge Survey. http://www.cdc.gov/nchs/nhds.htm. Accessed 08/07/2012.
E0475	Hepatitis B Vaccine Coverage Among All Live Newborn Infants Prior to Hospital or Birthing Facility Discharge	Hepatitis B infection is largely asymptomatic until complications develop (accompanied by decreased life expectancy and productivity, and with ballooning healthcare costs), the universal hepatitis B birth dose will become an even more critical safety net. The purpose of this measure is to encourage administration of the birth dose of hepatitis B vaccine and to

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		provide a safety-net for infants who would not receive post-exposure prophylaxis because their mother's chronic hepatitis B infection is not determined or detected, is misinterpreted or incorrectly recorded, or who return to a household with risk of transmission from family members with chronic hepatitis B infection (often unknown). Infants have a 90% chance of chronic hepatitis B if infected. The first dose of hepatitis B vaccine provides the initial step for prevention of almost certain life-long chronic hepatitis B infection with ~25% risk of cirrhosis, liver failure, and liver cancer. This is the critical "window" for prevention since chronic hepatitis B infection is not "curable". A universal birth dose measure will be critical in measuring the quality of this important disease prevention activity.
E0471	PC-02 Cesarean Section	This measure assesses the number of nulliparous women with a term, singleton baby in a vertex position delivered by cesarean section
XDFMH	30-Day Readmissions	See measure description for the 30-Day Readmissions measure (XDFMH) in the List of Measures under Consideration Table
XDFMG	Group Therapy	See measure description for the Group Therapy measure (XDFMG) in the List of Measures under Consideration Table
XDFMF	No Individual Psychotherapy	See measure description for the No Individual Psychotherapy measure (XDFMF) in the List of Measures under Consideration Table
F2027	Hospital 30-day, all-cause, risk-standardized readmission rate (RSRR) following an acute ischemic stroke hospitalization	Stroke is a leading cause of morbidity for patients. It increases patients' likelihood of dependence on the healthcare system and is a condition that contributes greatly to the cost of healthcare in the U.S. There is good evidence of variation in readmission rates for stroke patients. For these reasons stroke is an important target for quality measurement and improvement initiatives. Stroke is a priority area for outcomes measure development as it is a relatively common condition with potentially debilitating effects. Approximately 7 million Americans have experienced and survived a stroke (AHA, 2012). Stroke affects approximately 795,000 people each year in the US, and of these strokes, about 610,000 are first attacks and 185,000 are recurrent attacks (AHA, 2012). By 2030, it is projected than an additional 4 million people will have had a stroke, a 24.9% increase in prevalence from 2010 (AHA, 2012). Stroke is a disease associated with high rates of preventable complications and discharge to settings with substantial requirements for ongoing care, e.g. home health or rehabilitation

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		settings. Both of these factors provide numerous opportunities for potential readmissions, and, consequently, opportunities to reduce readmission rates with appropriate interventions and care decisions. The goal of this measure is to improve patient outcomes by providing patients, physicians, and hospitals with information about hospital-level, risk-standardized readmission rates following hospitalization for stroke. Measurement of patient outcomes allows for a broad view of quality of care that encompasses more than what can be captured by individual process-of-care measures. Complex and critical aspects of care, such as communication between providers, prevention of, and response to, complications, patient safety and coordinated transitions to the outpatient environment, all contribute to patient outcomes but are difficult to measure by individual process measures. The goal of outcomes measurement is to risk-adjust for patients' conditions at the time of hospital admission and then evaluate patient outcomes. This readmission measure was developed to identify institutions, whose performance is better or worse than would be expected based on their patient case-mix, and therefore promote hospital quality improvement and better inform consumers about care quality. --- American Heart Association, Heart Disease and Stroke Statistics - 2012 Update. American Heart Association, Circulation 2012, 125:e2-e220.
E1789	Hospital-Wide All-Cause Unplanned Readmission Measure (HWR)	The Hospital-wide All-Cause Unplanned Readmission Measure reports the hospital-level, risk-standardized rate of unplanned all-cause readmission within 30 days of hospital discharge. A hospital's readmission rate is related to complex and critical aspects of care such as communication between providers; prevention of, and response to, complications; patient safety; and coordinated transitions to the outpatient environment. These are of importance to patients, physicians, hospitals and policymakers. While disease-specific measures of readmission are helpful to identify deficiencies in care for specific groups of patients, they account for only a small minority of total readmissions [1]. By contrast, a hospital-wide, all-condition readmission measure could provide a broad sense of the quality of care at hospitals. In this way, the measure can promote hospital quality improvement and better inform consumers about care quality. Studies have estimated the rate of preventable readmissions to be as low as 12% and as high

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		as 76% [2, 3]. Some readmissions are unavoidable and result from inevitable progression of disease or worsening of chronic conditions. However, readmissions may also result from poor quality of care or inadequate transitional care. Randomized controlled trials have shown that improvement in the following areas can directly reduce readmission rates: quality of care during the initial admission; improvement in communication with patients, their caregivers and their clinicians; patient education; predischarge assessment; and coordination of care after discharge. Evidence that hospitals have been able to reduce readmission rates through these quality-of-care initiatives illustrates the degree to which hospital practices can affect readmission rates. Successful randomized trials have reduced 30-day readmission rates by 20-40% [4-14]. Since 2008, 14 Medicare Quality Improvement Organizations have been funded to focus on care transitions, applying lessons learned from clinical trials. Several have been notably successful in reducing readmissions. The strongest evidence supporting the efficacy of improved discharge processes and enhanced care at transitions is a randomized controlled trial by Project RED (Re-Engineered Discharge), which demonstrated a 30% reduction in 30-day readmissions. In this intervention, a nurse was assigned to each patient as a discharge advocate, responsible for patient education, follow-up, medication reconciliation, and preparing individualized discharge instructions sent to the patient's primary care provider. A follow-up phone call from a pharmacist within 4 days of discharge was also part of the intervention [4]. Given that studies have shown readmissions to be related to quality of care, and that interventions have been able to reduce 30-day readmission rates, it is reasonable to consider an all-condition readmission rate as an effective quality measure. References: 1. Jencks SF, Williams MV, Coleman EA. Rehospitalizations among patients in the Medicare fee-for-service program. New England Journal of Medicine 2009; 360(14):1418-28. 2. Benbassat J, Taragin M. Hospital readmissions as a measure of quality of health care: advantages and limitations. Archives of Internal Medicine 2000; 160(8):1074-81. 3. Medicare Payment Advisory Commission (U.S.). Report to the Congress promoting greater efficiency in Medicare. Washington, DC: Medicare Payment Advisory Commission, 2007. 4. Jack BW, Chetty VK, Anthony D, Greenwald JL, Sanchez GM, Johnson AE, et al. A

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		reengineered hospital discharge program to decrease rehospitalization: a randomized trial. Ann Intern Med 2009; 150(3):178-87. 5. Coleman EA, Smith JD, Frank JC, Min SJ, Parry C, Kramer AM. Preparing patients and caregivers to participate in care delivered across settings: the Care Transitions Intervention. J Am Geriatr Soc 2004; 52(11):1817-25. 6. Courtney M, Edwards H, Chang A, Parker A, Finlayson K, Hamilton K. Fewer emergency readmissions and better quality of life for older adults at risk of hospital readmission: a randomized controlled trial to determine the effectiveness of a 24-week exercise and telephone follow-up program. J Am Geriatr Soc 2009; 57(3):395-402. 7. Garasen H, Windspoll R, Johnsen R. Intermediate care at a community hospital as an alternative to prolonged general hospital care for elderly patients: a randomized controlled trial. BMC Public Health 2007; 7:68. 8. Koehler BE, Richter KM, Youngblood L, Cohen BA, Prengler ID, Cheng D, et al. Reduction of 30-day postdischarge hospital readmission or emergency department (ED) visit rates in high-risk elderly medical patients through delivery of a targeted care bundle. J Hosp Med 2009;4(4):211-218. 9. Mistiaen P, Francke AL, Poot E. Interventions aimed at reducing problems in adult patients discharged from hospital to home: a systematic metareview. BMC Health Serv Res 2007;7:47. 10. Naylor M, Brooten D, Jones R, Lavizzo-Mourey R, Mezey M, Pauly M. Comprehensive discharge planning for the hospitalized elderly. A randomized clinical trial. Ann Intern Med 1994;120(12):999-1006. 11. Naylor MD, Brooten D, Campbell R, Jacobsen BS, Mezey MD, Pauly MV, et al. Comprehensive discharge planning and home follow-up of hospitalized elders: a randomized clinical trial. Jama 1999;281(7):613-20. 12. van Walraven C, Seth R, Austin PC, Laupacis A. Effect of discharge summary availability during post-discharge visits on hospital readmission. J Gen Intern Med 2002;17(3):186-92. 13. Weiss M, Yakusheva O, Bobay K. Nurse and patient perceptions of discharge readiness in relation to postdischarge utilization. Med Care 2010;48(5):482-6. 14. Krumholz HM, Amatruda J, Smith GL, et al. Randomized trial of an education and support intervention to prevent readmission of patients with heart failure. J Am Coll Cardiol. Jan 2 2002;39(1):83-89.
E0434	STK-1 Venous	Stroke is the third leading cause of death in the United States with approximately 795,000 new

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	Thromboembolism (VTE) Prophylaxis	or recurrent strokes each year. About 610,000 of these are first attacks and 185,000 are recurrent attacks (1). The high incidence of stroke worldwide highlights the need for stroke performance improvement and efficiency. This measure is part of a set of eight nationally implemented measures that address stroke care. References: American Heart Association (AHA). Heart Disease and Stroke Statistics-2009 Update (AHA Website). Dallas, TX; American Heart Association; 2009. Available at: » http://www.americanheart.org/downloadable/heart/1240250946756LS-1982%20Heart%20and%20Stroke%20Update.042009.pdf
E0441	STK-10 Assessed for Rehabilitation	Stroke is the third leading cause of death in the United States with approximately 795,000 new or recurrent strokes each year. About 610,000 of these are first attacks and 185,000 are recurrent attacks (1). The high incidence of stroke worldwide highlights the need for stroke performance improvement and efficiency. This measure is part of a set of eight nationally implemented measures that address stroke care. References: American Heart Association (AHA). Heart Disease and Stroke Statistics-2009 Update (AHA Website). Dallas, TX; American Heart Association; 2009. Available at: » http://www.americanheart.org/downloadable/heart/1240250946756LS-1982%20Heart%20and%20Stroke%20Update.042009.pdf
E0435	STK-2 Antithrombotic therapy for ischemic stroke	Stroke is the third leading cause of death in the United States with approximately 795,000 new or recurrent strokes each year. About 610,000 of these are first attacks and 185,000 are recurrent attacks (1). The high incidence of stroke worldwide highlights the need for stroke performance improvement and efficiency. This measure is part of a set of eight nationally implemented measures that address stroke care. References: American Heart Association (AHA). Heart Disease and Stroke Statistics-2009 Update (AHA Website). Dallas, TX; American Heart Association; 2009. Available at: » http://www.americanheart.org/downloadable/heart/1240250946756LS-1982%20Heart%20and%20Stroke%20Update.042009.pdf

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E0436	STK-3 Anticoagulation therapy for Afib/flutter	Stroke is the third leading cause of death in the United States with approximately 795,000 new or recurrent strokes each year. About 610,000 of these are first attacks and 185,000 are recurrent attacks (1). The high incidence of stroke worldwide highlights the need for stroke performance improvement and efficiency. This measure is part of a set of eight nationally implemented measures that address stroke care. References: American Heart Association (AHA). Heart Disease and Stroke Statistics-2009 Update (AHA Website). Dallas, TX; American Heart Association; 2009. Available at: » http://www.americanheart.org/downloadable/heart/1240250946756LS-1982%20Heart%20and%20Stroke%20Update.042009.pdf
E0437	STK-4 Thrombolytic therapy for acute ischemic stroke	Stroke is the third leading cause of death in the United States with approximately 795,000 new or recurrent strokes each year. About 610,000 of these are first attacks and 185,000 are recurrent attacks (1). The high incidence of stroke worldwide highlights the need for stroke performance improvement and efficiency. This measure is part of a set of eight nationally implemented measures that address stroke care. References: American Heart Association (AHA). Heart Disease and Stroke Statistics-2009 Update (AHA Website). Dallas, TX; American Heart Association; 2009. Available at: » http://www.americanheart.org/downloadable/heart/1240250946756LS-1982%20Heart%20and%20Stroke%20Update.042009.pdf
E0438	STK-5 Antithrombotic therapy by the end of hospital day 2	Stroke is the third leading cause of death in the United States with approximately 795,000 new or recurrent strokes each year. About 610,000 of these are first attacks and 185,000 are recurrent attacks (1). The high incidence of stroke worldwide highlights the need for stroke performance improvement and efficiency. This measure is part of a set of eight nationally implemented measures that address stroke care. References: American Heart Association (AHA). Heart Disease and Stroke Statistics-2009 Update (AHA Website). Dallas, TX; American Heart Association; 2009. Available at: » http://www.americanheart.org/downloadable/heart/1240250946756LS-

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		1982%20Heart%20and%20Stroke%20Update.042009.pdf
E0439	STK-6 Discharged on Statin Medication	Stroke is the third leading cause of death in the United States with approximately 795,000 new or recurrent strokes each year. About 610,000 of these are first attacks and 185,000 are recurrent attacks (1). The high incidence of stroke worldwide highlights the need for stroke performance improvement and efficiency. This measure is part of a set of eight nationally implemented measures that address stroke care. References: American Heart Association (AHA). Heart Disease and Stroke Statistics-2009 Update (AHA Website). Dallas, TX; American Heart Association; 2009. Available at: » http://www.americanheart.org/downloadable/heart/1240250946756LS-1982%20Heart%20and%20Stroke%20Update.042009.pdf
D0440	STK-8 Stroke Education	Stroke is the third leading cause of death in the United States with approximately 795,000 new or recurrent strokes each year. About 610,000 of these are first attacks and 185,000 are recurrent attacks (1). The high incidence of stroke worldwide highlights the need for stroke performance improvement and efficiency. This measure is part of a set of eight nationally implemented measures that address stroke care. References: American Heart Association (AHA). Heart Disease and Stroke Statistics-2009 Update (AHA Website). Dallas, TX; American Heart Association; 2009. Available at: » http://www.americanheart.org/downloadable/heart/1240250946756LS-1982%20Heart%20and%20Stroke%20Update.042009.pdf
E0371	VTE-1: Venous Thromboembolism Prophylaxis	Each year, 600,000 patients will experience venous thromboembolism. Each year, at least 50,000 and perhaps as many as 200,000 patients will die from blood clots that obstruct blood flow to their lungs (pulmonary embolism). The tragedy is that most of these problems could be avoided by simple, cost-effective measures. Use of modern methods of DVT prophylaxis will reduce the incidence of DVT during the postoperative period by two-thirds and will prevent death from pulmonary embolism in 1 patient out of every 200 major operations (1). This measure is part of a set of six nationally implemented prevention and treatment measures that address VTE.

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		References: Best Practices: Preventing Deep Vein Thrombosis and Pulmonary Embolism. A Practical Guide to Evaluation and Improvement. UMass Medical School Center for Outcomes Research. http://www.outcomes-umassmed.org/dvt/best_practice/
E0372	VTE-2: Intensive Care Unit Venous Thromboembolism Prophylaxis	Each year, 600,000 patients will experience venous thromboembolism. Each year, at least 50,000 and perhaps as many as 200,000 patients will die from blood clots that obstruct blood flow to their lungs (pulmonary embolism). The tragedy is that most of these problems could be avoided by simple, cost-effective measures. Use of modern methods of DVT prophylaxis will reduce the incidence of DVT during the postoperative period by two-thirds and will prevent death from pulmonary embolism in 1 patient out of every 200 major operations (1). This measure is part of a set of six nationally implemented prevention and treatment measures that address VTE. References: Best Practices: Preventing Deep Vein Thrombosis and Pulmonary Embolism. A Practical Guide to Evaluation and Improvement. UMass Medical School Center for Outcomes Research. http://www.outcomes-umassmed.org/dvt/best_practice/
E0373	VTE-3:VTE patients with anticoagulation overlap therapy	Each year, 600,000 patients will experience venous thromboembolism. Each year, at least 50,000 and perhaps as many as 200,000 patients will die from blood clots that obstruct blood flow to their lungs (pulmonary embolism). The tragedy is that most of these problems could be avoided by simple, cost-effective measures. Use of modern methods of DVT prophylaxis will reduce the incidence of DVT during the postoperative period by two-thirds and will prevent death from pulmonary embolism in 1 patient out of every 200 major operations (1). This measure is part of a set of six nationally implemented prevention and treatment measures that address VTE. References: Best Practices: Preventing Deep Vein Thrombosis and Pulmonary Embolism. A Practical Guide to Evaluation and Improvement. UMass Medical School Center for Outcomes Research. http://www.outcomes-umassmed.org/dvt/best_practice/

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D0374	VTE-4: Patients receiving un-fractionated Heparin with doses/labs monitored by protocol	Each year, 600,000 patients will experience venous thromboembolism. Each year, at least 50,000 and perhaps as many as 200,000 patients will die from blood clots that obstruct blood flow to their lungs (pulmonary embolism). The tragedy is that most of these problems could be avoided by simple, cost-effective measures. Use of modern methods of DVT prophylaxis will reduce the incidence of DVT during the postoperative period by two-thirds and will prevent death from pulmonary embolism in 1 patient out of every 200 major operations (1). This measure is part of a set of six nationally implemented prevention and treatment measures that address VTE. References: Best Practices: Preventing Deep Vein Thrombosis and Pulmonary Embolism. A Practical Guide to Evaluation and Improvement. UMass Medical School Center for Outcomes Research. http://www.outcomes-umassmed.org/dvt/best_practice/
D0375	VTE-5: VTE discharge instructions	Each year, 600,000 patients will experience venous thromboembolism. Each year, at least 50,000 and perhaps as many as 200,000 patients will die from blood clots that obstruct blood flow to their lungs (pulmonary embolism). The tragedy is that most of these problems could be avoided by simple, cost-effective measures. Use of modern methods of DVT prophylaxis will reduce the incidence of DVT during the postoperative period by two-thirds and will prevent death from pulmonary embolism in 1 patient out of every 200 major operations (1). This measure is part of a set of six nationally implemented prevention and treatment measures that address VTE. References: Best Practices: Preventing Deep Vein Thrombosis and Pulmonary Embolism. A Practical Guide to Evaluation and Improvement. UMass Medical School Center for Outcomes Research. http://www.outcomes-umassmed.org/dvt/best_practice/
D0376	VTE-6: Incidence of potentially preventable VTE	Each year, 600,000 patients will experience venous thromboembolism. Each year, at least 50,000 and perhaps as many as 200,000 patients will die from blood clots that obstruct blood flow to their lungs (pulmonary embolism). The tragedy is that most of these problems could be avoided by simple, cost-effective measures. Use of modern methods of DVT prophylaxis will reduce the incidence of DVT during the postoperative period by two-thirds and will prevent

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		death from pulmonary embolism in 1 patient out of every 200 major operations (1). This measure is part of a set of six nationally implemented prevention and treatment measures that address VTE. References: Best Practices: Preventing Deep Vein Thrombosis and Pulmonary Embolism. A Practical Guide to Evaluation and Improvement. UMass Medical School Center for Outcomes Research. http://www.outcomes-umassmed.org/dvt/best_practice/
XCAEA	IPF Metabolic Screening	Although patients with psychiatric disorders have a high prevalence of metabolic syndrome and cardiometabolic risk factors, such as hypertension, glucose abnormalities, dyslipidemia, and obesity, these conditions are frequently untreated. Recent mortality statistics for patients with schizophrenia and bipolar disorder indicate a 1.2- to 4.9-fold increase in mortality relative to age- and sex-matched individuals in the general population resulting from coronary heart disease, diabetes, stroke, and other cardiovascular conditions. Moreover, the lifespan of public mental health patients is approximately 25 years shorter than that of the general population. Smoking, a lack of physical activity, poor diet, and use of some second-generation antipsychotics are all possible contributors to increased health risks. Past studies have found that patients with mental illness also have elevated rates of metabolic syndrome, which is one of the most widely used markers for cardiometabolic risk in the general population. Although cardiometabolic screening has been widely recommended for patients given prescriptions for second-generation antipsychotics, prevalence estimates of cardiovascular risk and metabolic syndrome have generally not been obtained outside of clinical trials, and data are lacking among psychiatric patients treated in routine clinical settings.
XDCBA	IPF Suicide Risk Screening completed within one day of admission	Suicide is the 10th leading cause of death in the United States, taking the lives of 37,793 people in 2010.1 In 2003, the American Psychiatric Association reported that 1,500 suicides take place in inpatient hospital units in the United States each year. Suicide has ranked in the top five most frequently reported events to The Joint Commission (TJC) since 1995. From 1995 through the first quarter of 2012, TJC Sentinel Event Database includes 1007 reports of inpatient suicides. In 1998, TJC issued a Sentinel Event Alert on inpatient suicides with

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		recommendations for prevention. This alert dealt broadly with inpatient suicides with most of those occurring in psychiatric hospitals. When it became apparent that 14% of the suicides were occurring in medical/surgical units and 8% occurred in the emergency department, a follow-up Sentinel Event Alert urging greater attention was issued on November 17, 2010. In an effort to address the issue of suicide risk, TJC implemented NPSG.15.01.01, a National Patient Safety Goal (NPSG) starting in 2007 requiring all accredited behavioral health care organizations, psychiatric hospitals and general hospitals treating individuals for emotional or behavioral disorders to identify individuals at risk for suicide. Implementation expectations include the following: • Conduct a risk assessment that identifies specific characteristics of the individual served and environmental features that may increase or decrease the risk of suicide. • Address the immediate safety needs and most appropriate setting for treatment of the individual served. • When an individual at risk for suicide leaves the care of the organization, provide suicide prevention information (such as a crisis hotline) to the individual and his or her family. Data from recent studies in Veterans Health Association hospitals indicate that about 50% of completed suicides and serious suicide attempts occur on mental health units, and 50% occur in other areas of the hospital. The Emergency Department (ED) and acute care or medical units are the second and third most common location. While psychiatric providers and staff are well aware of the risk of suicide among their patients, other hospital departments are not designed to prevent suicides and their staff may not have received education about suicide risks and prevention. It is important that staff training supports the notion of suicide detection and having a high index of suspicion. A two-page summary guide to suicide risks from hospital patients is available from the Suicide Prevention Resource Center. One in 10 suicides are by people seen in an emergency department within 2 months of dying. The guide notes: “Many were never assessed for suicide risk. Look for evidence of risk in all patients.” According to TJC, the top five groups at high risk for suicide include the young, medically ill, specific populations groups (such as Native Americans, Alaskan Natives, and African American

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		males ages 15-19), persons with mental and substance abuse disorders, and the elderly. A critical first step in any suicide prevention effort is an effective risk assessment that identifies specific individual characteristics and environmental features that may increase or decrease the risk for suicide. Assessment of patients for suicide risk is a process, rather than an isolated event. Because the ED may serve as the entry point for patients at risk for suicide, initial risk assessment should begin in the emergency care unit. All patients should be screened for depression as part of the inpatient admission process. Emphasis should be placed on the need for ongoing evaluation particularly at clinically significant points during inpatient care including transitions between units, levels of care, and before discharge. If it is determined that a patient is at risk for suicide, findings from the suicide risk assessment will drive the elements of the patient's treatment plan including the setting for treatment, therapeutic interventions, and necessary measures to ensure patient safety.
XDEGE	IPF Use of an electronic health record meeting Stage 1 or Stage 2 Meaningful Use criteria	Freestanding IPFs are not eligible for MU incentives. The reasons behind using such a measure are that 1) EHRs have benefits in the coordination of care, and their employment is one indication of effectiveness in that area, 2) EHR adoption in healthcare is a federal policy priority, 3) information about EHR use among facilities not receiving incentive payments is essential in our planning related to e-measures, and 4) to the extent that IPFs employ EHRs meeting Phase 1 and 2 standards, we probably don't need to separately solicit BH measures already contained in such standards.
XDCFD	IPF Violence Risk Screening completed within one day of admission	Inpatient violence is of critical concern to mental health professionals and other individuals affected by psychiatric inpatients who engage in assaultive behavior. During acute psychiatric hospitalization, about 18 percent of civilly committed patients physically assault other individuals, and another 30 to 35 percent engage in fear-inducing behavior. More than two-thirds of the patients committed as a danger to others are likely to engage in some type of violence within 72 hours after admission. Violent acts by inpatients are a common cause of injury to staff in emergency and inpatient settings, with nursing staff sustaining the most injuries. Staff injuries range from bites and bruises to head injuries. One study found that more than 90 percent of physicians and nurses working in psychiatric hospitals have been subjected to violence from patients at some time during their careers. Lost work days resulting from patient assault are not uncommon. In addition to causing bodily harm, inpatient violence has

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		the potential to affect the therapeutic climate negatively, to upset other patients, and to demoralize staff. Effective risk assessments help clinicians detect patients who are at high risk of violence, take appropriate steps in the hospital to manage the risk, and ultimately reduce the number of injuries incurred by staff and other patients.
E0028	Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention	Measure Policy Council-recommended tobacco use and cessation intervention measure: This measure has been widely used in other programs and has been shown to reduce the use of tobacco.
E1659	Influenza Immunization	Influenza (flu) is an acute, contagious, viral infection of the nose, throat and lungs (respiratory illness) caused by influenza viruses. Outbreaks of seasonal influenza occur annually during late autumn and winter months although the timing and severity of outbreaks can vary substantially from year to year and community to community. Influenza activity most often peaks in February, but can peak rarely as early as November and as late as April. In order to protect as many people as possible before influenza activity increases, most flu-vaccine is administered in September through November, but vaccine is recommended to be administered throughout the influenza season as well. Because the flu vaccine usually first becomes available in September, health systems can usually meet public and patient needs for vaccination in advance of widespread influenza circulation. Up to 1 in 5 people in the United States get influenza every season (CDC, Key Facts). Each year an average of approximately 226,000 people in the US are hospitalized with complications from influenza and between 3,000 and 49,000 die from the disease and its complications (Thompson WW, JAMA). Combined with pneumonia, influenza is the nation's 8th leading cause of death (Minino, 2004 National Center for Health Statistics). Up to two-thirds of all deaths attributable to pneumonia and influenza occur in the population of patients that have been hospitalized during flu season regardless of age (Fedson). The Advisory Committee on Immunization Practices (ACIP) recommends seasonal influenza vaccination for all persons 6 months of age and older to highlight the importance of preventing influenza. Vaccination is associated with reductions in influenza among all age groups (CDC Press Release February 24, 2010). The influenza vaccination is the most effective method for preventing influenza virus infection

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		and its potentially severe complications. Screening and vaccination of inpatients is recommended, but hospitalization is an underutilized opportunity to provide vaccination to persons 6 months of age or older.
XDFGE	Inpatient Psychiatric Facility Routinely Assesses Patient Experience of Care	The Centers for Medicare & Medicaid Services (CMS) QIG wishes to assess whether the Inpatient Psychiatric Facilities routinely assess patient experience of care using a standardized collection protocol and a structured instrument.
XDFGD	IPF Alcohol Use Screening completed within one day of admission	Doctors routinely screen patients for an increasing number of conditions. The term "screening" refers to the testing of members of a certain population (such as all the patients in a physician's practice) to estimate the likelihood that they have a specific disorder, such as alcohol or drug abuse or dependence. Screening is not the same as diagnostic testing, which establishes a definite diagnosis of a disorder. Instead, screening is used to identify people who are likely to have a disorder, as determined by their responses to certain key questions. People with positive screening results may be advised to undergo more detailed diagnostic testing to definitively confirm or rule out the disorder. A clinician might initiate further assessment, provide a brief intervention, and/or arrange for clinical follow-up when a screening test indicates that a patient may have a problem with alcohol or drugs. There is good evidence that even patients who do not meet the criteria for alcohol or drug dependence or abuse, but who are drinking or using drugs at levels that place them at risk for increased problems, can be helped through screening and brief intervention. There is a high rate of excessive alcohol and drug consumption and abuse in people with psychiatric disorders, especially males. Such individuals may be particularly vulnerable to complications of alcohol and drug misuse such as suicide and exacerbation of their disorder. The potential for decreased severity of psychiatric symptoms and a reduction in the number of hospital admissions following cessation or reduction in alcohol and drug consumption is considerable. Screening for drug and alcohol use and dependence, and offers a means of initiating intervention in the psychiatric inpatient population.
XDFGC	IPF Drug Use Screening completed within one day of	Doctors routinely screen patients for an increasing number of conditions. The term "screening" refers to the testing of members of a certain population (such as all the patients in a

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	admission	physician's practice) to estimate the likelihood that they have a specific disorder, such as alcohol or drug abuse or dependence. Screening is not the same as diagnostic testing, which establishes a definite diagnosis of a disorder. Instead, screening is used to identify people who are likely to have a disorder, as determined by their responses to certain key questions. People with positive screening results may be advised to undergo more detailed diagnostic testing to definitively confirm or rule out the disorder. A clinician might initiate further assessment, provide a brief intervention, and/or arrange for clinical follow-up when a screening test indicates that a patient may have a problem with alcohol or drug use. There is good evidence that even patients who do not meet the criteria for alcohol or drug dependence or abuse, but who are drinking or using drugs at levels that place them at risk for increased problems, can be helped through screening and brief intervention. There is a high rate of excessive alcohol and drug consumption and abuse in people with psychiatric disorders, especially males. Such individuals may be particularly vulnerable to complications of alcohol and drug misuse such as suicide and exacerbation of their disorder. The potential for decreased severity of psychiatric symptoms and a reduction in the number of hospital admissions following cessation or reduction in alcohol and drug consumption is considerable. Screening for drug and alcohol use and dependence offers a means of initiating intervention in the psychiatric inpatient population.
XCFFL	Functional Outcome Measure: Change in Mobility Score	Functional improvement is a major goal of rehabilitation care
XCFFM	Functional Outcome Measure: Change in Self-Care Score	Functional improvement is a major goal of rehabilitation care
XDDCA	Functional Outcome Measure: Discharge mobility score	Maximizing patients' functional status is a major goal of rehabilitation care
XDDCB	Functional Outcome Measure: Discharge self-care score	Maximizing patients' functional status is a major goal of rehabilitation care
E1717	National Healthcare Safety	C.difficile is a dangerous infection that has the potential to spread rapidly in healthcare

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	Network (NHSN) Facility-Wide Inpatient Hospital-onset Clostridium difficile infection (CDI) Outcome Measure	settings when proper infection control procedures are not in place.
E1716	National Healthcare Safety Network (NHSN) Facility-Wide Inpatient Hospital-onset Methicillin-resistant Staphylococcus aureus (MRSA) Bacteremia Outcome Measure	MRSA is a dangerous infection that has the potential to spread rapidly in healthcare settings when proper infection control procedures are not in place.
E0674	Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay)	Injuries from falls are a dangerous and potentially life-threatening event for which IRF patients are at high risk.
E0676	Percent of Residents Who Self-Report Moderate to Severe Pain (Short Stay)	Adequate pain management is an important aspect of care. Patients should not have moderate to severe pain at the time of discharge.
XCFGB	Functional Outcome Measure: change in mobility among patients requiring ventilator support	While rehabilitation is not the primary goal of LTCH care, function remains an important indicator of LTCH quality, as well as key to LTCH care trajectories.
XCBBF	Percent of LTCH patients with an admission and discharge functional assessment and a care plan that addresses function	While rehabilitation is not the primary goal of LTCH care, function remains an important indicator of LTCH quality, as well as key to LTCH care trajectories.
XDDCC	Ventilator-Associated Event	Ventilator use is very common in LTCHs, and having a measure related to ventilator use is a high priority for CMS. Further, MedPAC has identified measures to improve care for ventilator patients a high priority for the LTCH setting.
E0543	Adherence to Statin Therapy for	The prevalence of CHD increases rapidly with age, even among the elderly. Recommendations

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	Individuals with Coronary Artery Disease	from clinical practice guidelines support the use of lipid-lowering therapy in general for patients with CAD, and randomized controlled trials have shown that a reduction in LDL level is associated with a decrease in CAD events. There is evidence supporting a higher adherence to statins improves CAD outcomes and decreases risk for all-cause mortality. This measure complies with the clinical recommendations and evidence and promotes the continuous use of statin therapy for patients with CAD.
E0576	Follow-up after hospitalization for a mental illness	Proper follow-up treatment for psychiatric hospitalization can lead to improved quality of life for patients, families and society as a whole.
E0556	INR for individuals taking warfarin and interacting anti-infective medications	Warfarin is frequently used in the elderly to avoid thrombosis and embolic events, such as stroke. However, its narrow range of therapeutic control, along with the likelihood for adverse interactions when taken with other drugs, necessitate the careful monitoring of patients taking warfarin. Studies have found that patients with poor international normalized ratio (INR) control experienced higher rates of mortality and major bleeding episodes when compared to those with good or moderate INR control. This measure has the potential to reduce the number of significant adverse drug events through appropriate and timely monitoring of INR for patients taking warfarin and interacting anti-infective medications.
E0555	Lack of Monthly INR Monitoring for Individuals on Warfarin	Despite the extensive use of warfarin, it remains one of the primary drugs responsible for adverse drug events (ADEs), particularly among the elderly. Warfarin's narrow range of therapeutic control necessitates the careful monitoring of patients taking the drug. An important consideration for avoiding adverse events is maintaining patients within the therapeutic range through appropriate and timely monitoring. Studies have found that patients with poor international normalized ratio (INR) control experienced higher rates of mortality and major bleeding episodes when compared to those with good or moderate INR control. This measure has the potential to reduce the number of significant adverse drug events through promoting routine monitoring of INR for patients taking warfarin.
E0053	Osteoporosis management in women who had a fracture	Evidence-based management of osteoporosis in older women who have had a previous fracture has been shown to reduce the risk of recurrent fractures.
E0046	Osteoporosis: Screening or Therapy for Women Aged 65 Years and Older	Currently in the US, the estimated national direct expenditures for osteoporosis and related fractures total approximately $14 billion annually (NIAMS, 2010). Experts predict that by 2025 osteoporosis will cost approximately $25.3 billion each year (NOF, 2010).

MUC ID	Measure Title	Effectiveness
XDAEB	Annual Wellness Assessment: Assessment of Health Risks	Approximately 70% of the total burden of disease is related to preventable causes (Mokdad 2004), and risky health behaviors may account for 70% of medical spending. As part of a set of four Annual Wellness Assessment measures (Assessment, Management, Goal Setting and Risk Reduction), this measure will encourage providers to identify patients' health risks, which will help them to collaborate with patients on reducing risk.
XDBHA	Annual Wellness Assessment: Goal-Setting to Reduce Identified Risks	Providers rarely work with patients to set goals for behavioral risk reduction (California Healthcare Foundation 2005), yet evidence suggests that using goal-setting as a component of patient-centered care can improve health outcomes (CDC 2011) and may control costs. Goal-setting, by promoting patient engagement, is also a priority of the National Quality Strategy and CMS. As part of a set of four Annual Wellness Assessment measures (Assessment, Management, Goal Setting and Risk Reduction), this measure will encourage providers to identify patients' health risks and set goals that can improve health outcomes.
XDAEC	Annual Wellness Assessment: Management of Health Risks	Approximately 70% of the total burden of disease is related to preventable causes (Mokdad 2004), and risky health behaviors may account for 70% of medical spending. As part of a set of four Annual Wellness Assessment measures (Assessment, Management, Goal Setting and Risk Reduction), this measure will encourage providers to identify patients' health risks and collaborate with them to reduce risk.
XDBGH	Annual Wellness Assessment: Reduction of Health Risks	Providers rarely work with patients to set goals for behavioral risk reduction (California Healthcare Foundation 2005), yet evidence suggests that using goal-setting as a component of patient-centered care can improve health outcomes (CDC 2011) and may control costs. Goal-setting, by promoting patient engagement, is also a priority of the National Quality Strategy and CMS. As part of a set of four Annual Wellness Assessment measures (Assessment, Management, Goal Setting and Risk Reduction), this measure will encourage providers to identify patients' health risks, set goals that can improve health outcomes, and collaborate with patients in reducing their risks.
XDFHD	Assessment and Classification of Disease Activity	Based on available evidence, the use of a standardized, reproducible measures of RA disease activity to guide therapy facilitates care and may improve patient outcomes. Use of standardized disease activity measures is currently inconsistent in rheumatology practice.[] Data from the ACR's Rheumatology Clinical Registry (RCR) in 2011 found performance on the PQRS disease activity measure was 43.4% among participating rheumatologists.

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XDFEH	Bone Mineral Density (BMD) & Fracture Risk	Literature suggests a significant gap in quality, with only about one-quarter of patients receiving appropriate treatment. In a systematic review which included 18 studies examining treatment rates in patients who had sustained fractures, the weighted average for appropriate treatment was only 22% (Solomon 2005).
S1884	Depression Response at Six Months- Progress Towards Remission	The Centers for Disease Control and Prevention states that nationally 15.7% of people report being told by a health care professional that they had depression at some point in their lifetime. Persons with a current diagnosis of depression and a lifetime diagnosis of depression or anxiety were significantly more likely than persons without these conditions to have cardiovascular disease, diabetes, asthma and obesity and to be a current smoker, to be physically inactive and to drink heavily. According to National Institute of Mental Health (NIMH), 6.7 percent of the U.S. population ages 18 and older (14.8 million people) in any given year have a diagnosis of a major depressive disorder. Major depression is the leading cause of disability in the U.S. for ages 15 - 44. Additionally, dysthymia accounts for an additional 3.3 million Americans. In Minnesota, the rates for current depression are 6-7.9% and the percent of Minnesotans who have a lifetime diagnosis of depression is between 13 and 15%. Suicide rates for Minnesotans are 10.4 per 100,000 or 1.3 suicides per day, with the highest rates among the following groups: males (4 times greater than females), ages 30 to 49 years, and non-Hispanic whites.
S1885	Depression Response at Twelve Months- Progress Towards Remission	The Centers for Disease Control and Prevention states that nationally 15.7% of people report being told by a health care professional that they had depression at some point in their lifetime. Persons with a current diagnosis of depression and a lifetime diagnosis of depression or anxiety were significantly more likely than persons without these conditions to have cardiovascular disease, diabetes, asthma and obesity and to be a current smoker, to be physically inactive and to drink heavily. According to National Institute of Mental Health (NIMH), 6.7 percent of the U.S. population ages 18 and older (14.8 million people) in any given year have a diagnosis of a major depressive disorder. Major depression is the leading cause of disability in the U.S. for ages 15 - 44. Additionally, dysthymia accounts for an additional 3.3 million Americans. In Minnesota, the rates for current depression are 6-7.9% and the percent of Minnesotans who have a lifetime diagnosis of depression is between 13 and 15%. Suicide rates for Minnesotans are 10.4 per 100,000 or 1.3 suicides per day, with the highest rates among the following groups: males (4 times greater than females), ages 30 to 49 years,

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		and non-Hispanic whites.
XDELF	DRAFT: ADE Prevention and Monitoring: Minimum INR Monitoring for Patients with Atrial Fibrillation on Warfarin	Millions of patients in the United States use warfarin to prevent strokes or to prevent or treat venous thromboembolism. Warfarin is highly effective, and has been in clinical use for over 50 years. However, warfarin is difficult to manage because it has many possible interactions with diet, other drugs, and comorbid conditions that may destabilize anticoagulation control. The possible consequences of insufficient or excessive anticoagulation are extremely serious and often fatal, making it imperative to pursue good control. The international normalized ratio (INR) test is the laboratory test used to determine the degree to which the patient's coagulation has been successfully suppressed by the vitamin K antagonist (VKA). For most patients, the goal is to keep the INR between 2 and 3, which roughly corresponds to the blood taking 2 to 3 times as long to clot as would a normal person's blood. This level of anticoagulation has been shown to maximize benefit (i.e., protect patients from blood clots) while minimizing risk (i.e., risk of hemorrhage attributable to excessive anticoagulation). The 2012 ACCP anticoagulation clinical practice guidelines recommend a routine INR testing frequency of up to 12 weeks for patients on stable warfarin dosing. Therefore, all patients who are on chronic warfarin should have at least 4 INR tests during a 12-month period or at least 1 INR test during each 12-week period of a measurement year. Any patient that does not have at least one INR test result in each 12-week period while on chronic warfarin therapy is not undergoing minimum appropriate monitoring.
XDELE	DRAFT: ADE Prevention and Monitoring: Warfarin Time in Therapeutic Range	Millions of patients in the United States use warfarin to prevent strokes or to prevent or treat venous thromboembolism. Warfarin is highly effective, and has been in clinical use for over 50 years. However, warfarin is difficult to manage because it has many possible interactions with diet, other drugs, and comorbid conditions that may destabilize anticoagulation control. The possible consequences of insufficient or excessive anticoagulation are extremely serious and often fatal, making it imperative to pursue good control. The international normalized ratio (INR) test is the laboratory test used to determine the degree to which the patient's coagulation has been successfully suppressed by the vitamin K antagonist (VKA). For most patients, the goal is to keep the INR between 2 and 3, which

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		roughly corresponds to the blood taking 2 to 3 times as long to clot as would a normal person's blood. This level of anticoagulation has been shown to maximize benefit (i.e., protect patients from blood clots) while minimizing risk (i.e., risk of hemorrhage attributable to excessive anticoagulation). Therapeutic INR range (TTR) is a way of summarizing INR control over time. TTR has been followed before, mostly in the setting of clinical trials where it is used to evaluate the effectiveness of warfarin therapy, particularly when warfarin is being compared to some other strategy. However, TTR has not previously been used as a quality measure – in fact, there has been a general lack of quality measurement in oral anticoagulation. There is much evidence that better anticoagulation control (i.e., higher TTR) can protect patients from severe or even fatal adverse events. The 2012 ACCP anticoagulation clinical practice guidelines recommend a routine INR testing frequency of up to 12 weeks for patients on stable warfarin dosing. Therefore, all patients who are on chronic warfarin should have at least 4 INR tests during a 12-month period or at least 1 INR test during each 12-week period of a measurement year. Any patient that does not have at least one INR test result in each 12-week period while on chronic warfarin therapy is not undergoing minimum appropriate monitoring. This quality measure is not intended to differentiate between stable versus unstable warfarin dosing for the following reasons. There is no prevailing definition of "stable" warfarin dosing and a valid, reliable method for determining the status of patients' warfarin dosing is not available. In 2012, the ACCP anticoagulation guidelines suggest a definition for "very stable" – defined as a warfarin dose that has not changed in 6 months. Because the measurement period is set to only one year, it would be impossible to fully implement criteria for identifying patients whose dose has not changed in 6 months. Also, because dose information is not consistently found in EHRs, building measure logic that is dependent on the availability of dose and dose adjustments was determined to not be currently feasible by a panel of subject matter experts. Because the target therapeutic range for patients with atrial flutter is the same as that for atrial fibrillation without valvular heart disease, patients with atrial flutter are also included in the denominator of this measure.

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XDCLD	DRAFT: Closing the Referral Loop - Critical Information Communicated with Request for Referral	There is evidence that the communication between primary care physicians and specialists is inadequate. This measure intends to improve the communication between primary and specialty care and enhance care continuity.
XDDAC	DRAFT: Closing the Referral Loop - Specialist Report Sent to Primary Care Physician	There is evidence that the communication between primary care physicians and specialists is inadequate. This measure intends to improve the communication between primary and specialty care and enhance care continuity.
XDELB	DRAFT: Functional Status Assessment and Goal Achievement for Patients with Congestive Heart Failure	Goal-setting addresses patient engagement, a high priority of the National Quality Strategy and CMS. Only 4 of 64 measures in the 2014 measure set address this domain. Evidence suggests that physicians rarely conduct functional status assessments for patients with congestive heart failure.
XDELD	DRAFT: Functional Status Assessment and Improvement for Patients who Received a Total Hip Replacement	Measuring functional status for patient undergoing total hip replacement permits longitudinal assessment - from the patient's perspective - of the impact of surgical intervention on pain, physical function, as well as health-related quality of life.
XDELC	DRAFT: Functional Status Assessment and Improvement for Patients who Received a Total Knee Replacement	Measuring functional status for patient undergoing total knee replacement permits longitudinal assessment - from the patient's perspective - of the impact of surgical intervention on pain, physical function, as well as health-related quality of life.
XDEHF	DRAFT: Substance Use Screening and Intervention Composite	Substance use problems and illnesses have substantial impact on health and societal costs, and often are linked to catastrophic personal consequences. In 2010, an estimated 19.3% (45.3 million) of U.S. adults were current cigarette smokers; of these, 78.2% smoked every day, and 21.8% smoked some days. 30% of the U.S. population misuse alcohol, with most engaging in what is considered risky drinking. In 2010, an estimated 22.6 million Americans aged 12 or older (~8.9 percent of the population) were current illicit drug users, which means they had used an illicit drug during the month prior to the survey. About 1 in 5 Americans aged 18–25 used illicit drugs in the past. Because many patients will not self-identify or have not yet developed detectable problems associated with substance use, screening can identify patients for whom intervention may be indicated. Brief motivational counseling for these various substances has been shown to be an effective treatment for reducing problem use, particularly

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		in primary care settings. The 2011 National Survey on Drug Use and Health found that 1 in 20 persons in the U.S. aged 12 or older reported nonmedical use of prescription painkillers in the past year. Prescription drug overdose is now the leading cause of accidental death in the United States - surpassing motor vehicle accidents. Many scientific studies have also shown there are dire health consequences from untreated substance use disorders on medical complications of diabetes mellitus and other co-occurring chronic conditions. HHS recognized the need for including essential services for substance use disorders (SUD) in primary care as an essential health benefit in its recently published (February, 2013) Final Rule on standards related to essential health benefits (EHBs) to be covered by these insurance exchanges as one of the 10 categories of essential health benefits, in a manner complying with the Mental Health Parity and Addiction Equity Act of 2008. Consequently, due to this looming vast expansion of SUD service EHBs in primary care, it is necessary that health care providers in general medical settings be equipped with an appropriate training and resources as well as CMS 'meaningful use' reimbursement incentives, to support and guide science-based screening and counseling for substance use disorders in primary care, utilizing relevant electronic-health-record-based performance measures and accompanying evidence-based clinical decision support tools.
XDAFC	Functional Status Assessment and Goal Setting in Patients with Rheumatoid Arthritis	Measures by PHEMUR. Specialty of intended use: Primary care physicians and specialists Although the lifetime risk of rheumatoid arthritis is 3-4% (Crowson 2011), the disease and its related complications cause a disproportionate societal burden estimated between $20-$40 billion annual (Birnbaum 2009). Anecdotal evidence suggests that physicians rarely conduct functional status assessments for patients with rheumatoid arthritis, but in research settings, assessing the status of disease and basing treatment on these assessments has improved outcomes. Goal-setting addresses patient engagement, one of the primary objectives of CMS and the National Quality Strategy. Only 4 of the 64 (6.25%) measures in the 2014 EHR Incentive Program for Eligible Professionals (encompassing both Meaningful Use 1 and Meaningful Use 2 measures) address patient engagement.
XDBGL	Functional Status Assessments and Goal Setting for Patients with Asthma	Asthma affects a large proportion of the population, accounting for 480,000 hospitalizations, 1.9 million emergency department visits, and 8.9 million physician visits annually. Research indicates that patients living with asthma across the country are not receiving care according to clinical best practice guidelines (which include regular functional status assessment) and

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		that performance is low across geographic regions and socioeconomic status (Meng 1999). Many patients with asthma may not receive functional status assessments, but evidence suggests that tracking functional status may help patients to self-manage and feel in control of their condition. Providers may also use the data to identify at-risk patients and guide treatment. Goal-setting addresses patient engagement, a high priority of the National Quality Strategy and CMS. Only 4 of the 64 measures in the 2014 EHR Incentive Program for Eligible Professionals (encompassing both Meaningful Use 1 and Meaningful Use 2 measures) address patient engagement.
XDBGM	Functional Status Assessments and Goal Setting for Patients with Chronic Obstructive Pulmonary Disease	COPD continues to be the fourth-leading cause of mortality (5.3% of all deaths) in the United States (Centers for Disease Control and Prevention 2011). Excess health care expenditures are estimated at nearly $6,000 annually for every COPD patient in the U.S. (Miller et al. 2005) and the annual inpatient days for the Medicare population in 2005 for COPD (8.18 days) was second only to chronic kidney disease (9.51 days) (Schneider et al. 2009). Evidence suggests that tracking functional status can improve patient self-management of their condition, which can reduce hospital admissions. Providers may also be better able to provide care through use of the information provided in a functional status assessment. Goal-setting addresses patient engagement, a high priority of the National Quality Strategy and CMS. Only 4 of the 64 measures in the 2014 EHR Incentive Program for Eligible Professionals (encompassing both Meaningful Use 1 and Meaningful Use 2 measures) address patient engagement.
E2080	Gap in HIV medical visits	Retention is a critical component of the HIV care continuum. Although HIV viral suppression is the ultimate outcome of HIV care/treatment, retention is a strongly associated with viral suppression and is the outcome for the care completion services within HIV care.
E2079	HIV medical visit frequency	Retention is a critical component of the HIV care continuum. Although HIV viral suppression is the ultimate outcome of HIV care/treatment, retention is strongly associated with viral suppression and is the outcome for care completion services within HIV care.
E2082	HIV viral load suppression	Viral load suppression is a critical component of the HIV care continuum and the ultimate outcome of HIV care/treatment.
XDFEF	Osteoporotic Fracture Risk	Literature suggests a significant gap in quality, with only between 1 and 47% of glucocorticoid users receiving screening for GIOP. A systematic review examining osteoporosis screening in glucocorticoid users found that in a vast majority of studies, less than one-third of eligible

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		patients underwent dual x-ray absorptiometry (Morris, 2004).
XDAFA	Overuse of Diagnostic Imaging for Uncomplicated Headache	There is evidence that diagnostic imaging for headaches is overused, with only 2% of patient scans yielding pathology. Unnecessary imaging is costly and needlessly exposes patients to radiation. Development of efficiency measures is one of the primary objectives highlighted by both the 2012 report on the National Quality Strategy and CMS. Only 4 of the 64 measures in the 2014 EHR Incentive Program for Eligible Professionals (encompassing both Meaningful Use 1 and Meaningful Use 2 measures) address efficiency. This measure concept was also identified in the Choosing Wisely campaign recommendations as an area of concern.
XDFEG	Prednisone Use with Anabolic Agent	Literature suggests a significant gap in quality, with very few patients receiving appropriate treatment. In a systematic review that included 11 studies examining treatment rates in patients using glucocorticoids, the weighted average for receiving appropriate treatment was only 12% (Solomon 2005).
E2083	Prescription of HIV antiretroviral therapy	Prescription of HIV antiretroviral therapy is a critical component of the HIV care continuum. Although HIV viral suppression is the ultimate outcome of HIV care/treatment, retention is a strongly associated with viral suppression and is the outcome for the care completion services within HIV care.
XDFHE	Tuberculosis Screening Prior to First Course Biologic Disease Modifying Anti-Rheumatic Drug (DMARD) Therapy	Data from the ACR's Rheumatology Clinical Registry (RCR) in 2011 found performance on the PQRS TB measure was 73.6% among participating rheumatologists.
XDEMG	ACORN Adolescent (Youth) Outcome Questionnaire	This is a brief, reliable and valid questionnaire assessing symptoms of depression, anxiety, behavior problems, attention problems, social isolation and conflict, and drug/alcohol use. It is designed to be easily administered and regular intervals within an episode of care, and measures the magnitude of improvement within the episode of care.
XDEMF	ACORN Adult Outcome Questionnaire	This is a brief, reliable and valid questionnaire assessing symptoms of depression, anxiety, social isolation and conflict, functionality and work place productivity, drug/alcohol use, and suicidal/self-harm ideation. It is designed to be easily administered and regular intervals within an episode of care, and measures the magnitude of improvement within the episode of care.
XAHDH	Adherence to Antiplatelet	This measure relates to coronary artery disease (CAD), which is listed as a priority area by the

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	Treatment after Stent Implantation	Institute of Medicine and a priority area for future effectiveness metrics by the Agency for Healthcare Research and Quality. Drug-eluting stents (DES) implantation is a common procedure in the Medicare population for treatment of angina and heart attacks. Appropriate antiplatelet therapy (clopidogrel or prasugrel) is required after DES placement to reduce the risk of stent thrombosis, a complication with severe mortality consequences. Dual antiplatelet therapy, consisting of the use of aspirin combined with clopidogrel, for 12 months following DES placement significantly reduces the risk of sub-acute stent thrombosis (within 1 month of implantation) and late stent thrombosis (after 1 month of implantation). However, evidence suggests that this recommendation is not followed in up to 25% of cases. This measure can help improve the safety and effectiveness of DES implantation in regard to gaps in adherence to clopidogrel or prasugrel.
E1879	Adherence to Antipsychotic Medications for Individuals with Schizophrenia	This measure relates to mental disorders that have been identified by AHRQ as a priority area for future effectiveness metrics and by the Institute of Medicine as a priority area. A large body of evidence has shown that antipsychotic medications are effective in treating acute psychotic exacerbations of schizophrenia and in reducing the likelihood of relapse. According to the American Psychiatric Association Clinical Practice Guidelines, "antipsychotic medications substantially reduce the risk of relapse in the stable phase of illness and are strongly recommended." This measure describes the degree of compliance or non-compliance with the clinical recommendations. By providing information on the percentage of schizophrenic individuals with appropriate long-term use of antipsychotic medications, this measure has the potential to improve management of schizophrenia.
E0545	Adherence to Chronic Medications for Individuals with Diabetes Mellitus	Diabetic patients often require chronic treatment with oral anti-diabetics, statins, and/or ACEIs/ARBs. However, adherence to chronic medication regimens has been documented in the literature to be less than optimal. Furthermore, treatment with certain drugs among diabetics is underutilized. The leading cause of mortality among diabetic patients is heart disease, and the rate of mortality due to heart disease and stroke are 2 to 4 times higher among diabetics than among non-diabetics. Lipid-lowering drugs, in particular statins, have been shown to be effective at reducing adverse cardiovascular events in patients with diabetes. This measure aims to ensure the effectiveness of treatment through improving medication adherence, and hence, improves overall health outcomes.
S1880	Adherence to Mood Stabilizers	This measure relates to mental disorders, which have been identified by the Agency for

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	for Individuals with Bipolar I Disorder	Healthcare Research and Quality (AHRQ) as a priority area for future effectiveness metrics and by the Institute of Medicine as a priority area. Bipolar disorder is associated with increased morbidity and high health care costs. Randomized, placebo-controlled trials have demonstrated the effectiveness of mood stabilizer medications in reducing the symptoms and probability of relapse for patients diagnosed with bipolar I disorder. This measure describes the degree to which providers utilize mood stabilizer medications in treating this disorder and subsequent patient adherence.
XDFAL	Adult Primary Rhegmatogenous Retinal Detachment Reoperation Rate	Achieving success with the initial surgery is the most favorable outcome. In a study published in 2011, Schall and colleagues studied the success rate with 4 surgical techniques. Initial success rate for retinal reattachment was 86% for scleral buckling only, 90% for vitrectomy only, 94% for the combination of scleral buckling and vitrectomy, and 63% for pneumatic retinopexy surgery. Patients undergoing pneumatic retinopexy had a lower initial success rate, however there was no statistically significant difference in initial reattachment rates between the other three groups. In a 2002 study Ling and colleagues reported an 85% success rate with a single procedure. Of the 15% that initially failed 97 % were successful with one additional surgery. References: 1. Schall S, Sherman MP, Barr CC, Kaplan HJ, Primary retinal detachment repair: comparison of 1-year outcomes of four surgical techniques. Retina 2011 Sep;31(8):1500-4. 2. Ling,et al, Retinal detachment surgery in district general hospitals: An Audit of Changing Practice, Br J Ophthalmology 2002; 86:827-833
XDFAH	Adult Primary Rhegmatogenous Retinal Detachment Surgery Success Rate	Studies demonstrate that the success rate increases with the recognition of risk factors and the practice of retina subspecialization. International studies report primary rhegmatogenous retinal surgery success rates ranging from 64 to 91%. References: 1. MEEI Quality and Outcomes Report 2011, 2. Wickham,BC, Wong, D, Charteris, DG, Retinal detachment repair by vitrectomy: simplified formulae to estimate the risk of failure, Br J Ophthalmology 2011 Feb 16
XDBBL	All-Cause Unplanned Admissions for Patients with Diabetes	Diabetes has high prevalence among Medicare recipients and is a leading cause of morbidity/mortality. Diabetes can generally be successfully managed in the ambulatory care setting; high-quality primary care could be expected to prevent unnecessary admissions
XDBBG	All-Cause Unplanned Admissions for Patients with Heart Failure	Heart failure has high prevalence among Medicare recipients and is a leading cause of morbidity/mortality. Heart failure can generally be successfully managed in the ambulatory care setting; high-quality primary care could be expected to prevent unnecessary admissions

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XDBBM	All-Cause Unplanned Admissions for Patients with Multiple Chronic Conditions	As of 2008, two-thirds of Medicare beneficiaries had two or more chronic conditions, and beneficiaries with multiple chronic conditions required significantly more healthcare resources. Many chronic conditions can generally be successfully managed in the ambulatory care setting; high-quality primary care could be expected to prevent unnecessary admissions
XCLAL	ALS Patient Care Preferences	Palliative care should be adopted from the time of diagnosis. Many patients are not adequately informed treatment options and many hospice workers are not familiar with ALS. Management of the terminal phase of ALS is unsatisfactory in 33% - 61% of cases in Europe and only 8% of palliative care units are involved from the time of diagnosis. The current system of palliative care in the USA is highly decentralized. Between 60-88% of patients die in a medical facility in some countries and not at home, while over 58% of seriously ill ALS patients do not have hospice care. J Neurol Neurosurg Psychiatry 2011; 82(4):413-8 Neuron Disord 2001;2(4):203-208 Ann Neurol 2009; 65:S1:S24-8 Amyotroph Lateral Scler Other Motor Neuron Disord 2004; 5:240 -244 Amyotroph Lateral Scler 2001; 2:159 Palliat Med 2000; 14:42 National Hospice and Palliative Care Organization (NHPCO).
XDFBD	Annual Hepatitis C Virus (HCV) Screening for Patients who are Active Injection Drug Users	The U.S. Preventive Services Task Force (USPSTF) recommends screening for hepatitis C virus (HCV) infection in adults at high risk, including those with any history of intravenous drug use or blood transfusions prior to 1992. Grade B recommendation. Assessment of Risk: Established high-risk factors for HCV infection include blood transfusion prior to 1992 and past or current intravenous drug use. Because of screening programs for donated blood, blood transfusions are no longer an important source of HCV infection. In contrast, 60% of new HCV infections occur in individuals who report injecting drugs within the last 6 months. Other risk factors include chronic hemodialysis, being born to an HCV-infected mother, incarceration, intranasal drug use, getting an unregulated tattoo, and other percutaneous exposures (e.g., in health care workers, having surgery prior to the implementation of universal precautions). Evidence on tattoos and other percutaneous exposures as risk factors for HCV infection is limited. In the United States, an estimated 2.7–3.9 million persons (1.0%–1.5%) are living with hepatitis C virus (HCV) infection, and an estimated 17,000 persons were newly infected in 2010, the most recent year that data are available. With an HCV antibody prevalence of 3.25%, persons born

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		during 1945–1965 account for approximately three fourths of all chronic HCV infections among adults in the United States. Although effective treatments are available to clear HCV infection from the body, most persons with HCV do not know they are infected do not receive needed care (e.g., education, counseling, and medical monitoring), and are not evaluated for treatment. Since 1998, routine HCV testing has been recommended by CDC for persons most likely to be infected with HCV. These recommendations were made on the basis of a known epidemiologic association between a risk factor and acquiring HCV infection. HCV testing is the first step toward improving health outcomes for persons infected with HCV. In a recent analysis of data from a national health survey, 55% of persons ever infected with HCV reported an exposure risk (e.g., injection-drug use or blood transfusion before July 1992), and the remaining 45% reported no known exposure risk (CDC, unpublished data, 2012). Current risk-based testing strategies have had limited success, as evidenced by the substantial number of HCV-infected persons who remain unaware of their infection. Of the estimated 2.7–3.9 million persons living with HCV infection in the United States, 45%–85% are unaware of their infection status; this proportion varies by setting, risk level in the population, and site-specific testing practices. Studies indicate that even among high-risk populations for whom routine HCV testing is recommended, prevalence of testing for HCV seromarkers varies from 17%–87%; according to one study, 72% of persons with a history of injection-drug use who are infected with HCV remain unaware of their infection status.
XDFGM	Appropriate age for colorectal cancer screening colonoscopy	Colonoscopy is considered to be the most effective screening option for colorectal cancer. Colonoscopy permits immediate polypectomy and removal of macroscopically abnormal tissue in contrast to tests based on radiographic imaging or detection of occult blood or exfoliated DNA in stool. Following removal, the polyp is sent to pathology for histologic confirmation of cancer. Colonoscopy directly visualizes the entire extent of the colon and rectum, including segments of the colon that are beyond the reach of flexible sigmoidoscopy. Colonoscopy therefore has become either the primary screening method or a follow-up modality for all colorectal cancer screening methods and is one of the most widely performed procedures in the United States. Given that, appropriate use of colonoscopy is crucial. The U.S. Preventive Services Task Force (USPSTF) recommends screening for colorectal cancer in adults using fecal occult blood test (FOBT), sigmoidoscopy, or colonoscopy, beginning at 50 years of age and continuing until 75 years of age. The risks and benefits of these screening methods vary. A

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		recommendation. However, the USPSTF recommends against screening for colorectal cancer in adults older than 85 years. D recommendation (http://www.uspreventiveservicestaskforce.org/uspstf08/colocancer/colors.htm). In a cohort study of Medicare enrollees from 2000-2008, the authors concluded that one-third of patients 80 years or older at their initial negative screening examination result underwent a repeated screening examination within 7 years. In addition the authors also stated that use of colonoscopy outside the scope of the recommendations, can not only cause overuse that exposes patients to unnecessary procedures but also increases costs. Identifying and decreasing overuse of screening colonoscopy is important to free up resources to increase appropriate colonoscopy in inadequately screened populations.(Goodwin JS, Singh A, Reddy N, Riall TS, Kuo, Y). Overuse of Screening Colonoscopy in the Medicare Population. Arch Intern Med. 2011;171(15):1335-1343. doi:10.1001/archinternmed.2011.212). This is of special concern, given the increased potential for complications, decreased completion rate and decreased benefit of this examination in the very elderly. In addition, even though the prevalence of colonic neoplasia increases with age, screening colonoscopy in very elderly patients results in smaller gains in life expectancy compared with younger patients, even when adjusted for life expectancy (Lin OS, Kozarek RA, Schembre DB, et al. Screening colonoscopy in very elderly patients: prevalence of neoplasia and estimated impact on life expectancy. JAMA. 2006;295(20):2357-2365).
XDFCL	Appropriate follow-up imaging for incidental simple ovarian cysts	The following evidence statements are quoted verbatim from the referenced clinical guidelines and other references: In women of reproductive age: 1. Cysts ≤ 3cm: Normal physiologic findings; at the discretion of the interpreting physician whether or not to describe them in the imaging report; do not need follow up. 2. Cysts >3 and ≤ 5cm: Should be described in the imaging report with a statement that they are almost certainly benign; do not need follow up Simple cysts and hemorrhagic cysts in women of reproductive age are almost always physiologic. Small simple cysts in postmenopausal women are common, and clinically inconsequential. Ovarian cancer, while typically cystic, does not arise from these benign-

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		appearing cysts. After a good quality ultrasound in women of reproductive age, DON'T recommend follow-up for a classic corpus luteum or simple cyst <5 cm in greatest diameter. Use 1 cm as a threshold for simple cysts in postmenopausal women. (USSRU, 2010) Characterization of an adnexal mass as a cyst is important for management. US identification of a simple cystic mass establishes a benign process in 100% of premenopausal women and in 95% of postmenopausal women. There are no firm data to support recommendations for specific follow-up intervals. Most cysts in premenopausal women are functional in nature and will resolve spontaneously. Most nonfunctional cysts in premenopausal women with benign US features (such as endometriomas, simple cysts, dermoid cysts, and hydrosalpinges) measuring <6 cm in diameter have been shown to remain unchanged during long-term follow-up. Therefore, it is possible to manage these lesions safely by US follow-up rather than surgical intervention in asymptomatic women. (ACR, 2009) Simple cysts up to 10 cm in diameter on ultrasound findings are almost universally benign and may safely be followed without intervention, even in postmenopausal patients. (Level B) (ACOG, 2007) In asymptomatic women with pelvic masses, whether premenopausal or postmenopausal, transvaginal ultrasonography is the imaging modality of choice. No alternative imaging modality has demonstrated sufficient superiority to transvaginal ultrasonography to justify its routine use. (Level B) (ACOG, 2007)
XDFCE	Appropriate follow-up imaging for incidental thyroid nodules in patients	The following evidence statements are quoted verbatim from the referenced clinical guidelines and other references: Nonpalpable nodules detected on US or other anatomic imaging studies are termed incidentally discovered nodules or ''incidentalomas." Nonpalpable nodules have the same risk of malignancy as palpable nodules with the same size. Generally, only nodules >1 cm should be evaluated, since they have a greater potential to be clinically significant cancers.
XDFDA	Appropriate in vitro susceptibility testing - The agent(s) used for definitive therapy in invasive staphylococcal disease should be confirmed by in vitro	With vancomycin being the predominant antibiotic used to treat Staphylococcus aureus infections, treatment failures have increased among the S. aureus infected patient population due to the emergence of resistant strains. Failure of vancomycin therapy to cure infections have led to increased patient mortality, healthcare costs, and spread of resistant S. aureus infectious conditions. Prudent measures to confirm the susceptibility of the infecting S. aureus isolate to the antimicrobial agent of interest has been shown to improve cure rates and

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	susceptibility testing as interpreted by the Clinical Laboratory and Standards Institute (CLSI) to be active against the clinical isolate.	impede the spread resistant strains.
XDFHL	Appropriate Treatment of MSSA - For MSSA bacteremia, a β-lactam antibiotic is the drug of choice in the hospitalized patient in the absence of a documented allergy or drug intolerance.	With the increase of methicillin-resistant Staphylococcus aureus (MRSA) infections, clinicians have responded by choosing antibiotics that are effective against MRSA, typically vancomycin, for empiric therapy for suspected staphylococcal infections. Clinicians frequently start vancomycin therapy for cases of suspected staphylococcal infection and continue treatment with vancomycin despite the identification of methicillin-susceptible S. aureus (MSSA) as being the infecting pathogen, which can be more effectively treated with a beta-lactam antibiotic. Studies have shown that vancomycin is inferior to beta-lactam to treat MSSA and vancomycin-use leads to higher infection-related mortalities and recurrence of infections in patients with MSSA as well as leading to potential antibiotic resistance.
XDFCB	Appropriate use of imaging for non-traumatic knee pain	The rationale for this measure is to promote the appropriate use of imaging for non-traumatic knee pain. The mandatory initial imaging examination for nontraumatic knee pain is AP and lateral radiography. • In patients with anterior patellofemoral knee pain, an axial view should be included in the initial radiographic study. • An MRI examination for nontraumatic knee pain is indicated when the pain is persistent and conventional radiographs are nondiagnostic or when additional information is necessary before instituting treatment or surgical intervention. • An MRI is not indicated before a physical examination or routine conventional radiographs, or when there is diagnostic radiographic evidence of severe degenerative joint diseases, inflammatory arthritis, stress fracture, osteonecrosis, or reflex sympathetic dystrophy, for which additional imaging is not going to alter the treatment plan. (ACR, 2008) Because most patients with knee pain have soft tissue injuries, plain-film radiographs generally are not indicated. (AFP, 2003)

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		Adult patients with nontraumatic knee pain of <4 wk of duration Radiographs not initially indicated [C] (Journal of Manipulative and Physiological Therapeutics, 2007) General indications for knee radiographs include: • History of noninvestigated trauma (with signs from the OKR) • Complex history • Significant unexplained effusion with no radiographs • Loss of mobility in undiagnosed condition • Acute/subacute onset • Intermittent locking • Unrelieved by 4 wk of conservative care • Palpable enlarging mass • Painful prosthesis (JMPT, 2007) Presence of one red flag alone may not necessarily indicate the need for radiography. (JMPT, 2007) Critical exclusionary dx include: • Occult fracture • Septic arthritis • Osteonecrosis • Infection • Tumor (JMPT, 2007)
XDFCA	Appropriate use of imaging for non-traumatic shoulder pain	Acute (<2 weeks) shoulder pain can be attributable to structures related to the glenohumeral articulation and joint capsule, the rotator cuff, acromioclavicular joint, and scapula. Radiography is a safe, fast, low-cost imaging modality that effectively demonstrates many forms of shoulder pathology. However, a multimodal approach may be required to accurately assess shoulder pathology. Radiography is a useful initial screening modality for acute shoulder pain of all

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		causes. Radiography is useful in the evaluation of fractures of the shoulder girdle. .(ACR, 2010) The mainstay in initial imaging of shoulder trauma is the radiograph. Radiography provides a quick, inexpensive evaluation for fracture and dislocation. .(ACR, 2010) A good shoulder trauma radiography protocol includes: AP, Grashey, axillary, and/or scapular Y projections. Special projections include the Rockwood view for evaluation of shoulder impingement, the Westpoint view for Bankart fractures, and the Stryker notch view for Hill-Sachs fractures. .(ACR, 2010) MRI is currently the procedure of choice for evaluation of occult fractures and the shoulder soft tissues, including the tendons, ligaments, muscles, and labrocapsular structures. The shoulder MRI protocol may or may not include Gadolinium, depending on the clinical question. MRI and MRA are the modalities of choice in evaluation of patients ACR, 2010) Shoulder pain is defined as chronic when it has been present for longer than six months, regardless of whether the patient has previously sought treatment. It can be divided into six diagnostic categories: (1) rotator cuff disorders, including tendinosis, full or partial thickness tears, or calcific tendinitis; (2) adhesive capsulitis; (3) glenohumeral osteoarthritis; (4) glenohumeral instability; (5) acromioclavicular joint pathology; and (6) other chronic pain, including less common shoulder problems and non-shoulder problems. All patients should receive radiographs as part of the initial work-up for chronic shoulder pain. Further testing of chronic shoulder pain, using imaging should be performed when the diagnosis remains unclear or the outcome would change management. (AFP, 2008)
XDFLD	Average change in functional status following lumbar spine fusion surgery	Overall, spine surgery rates have declined slightly from 2002-2007, but the rate of complex spinal fusion procedures has increased 15-fold, from 1.3 to 19.9 per 100,000 Medicare beneficiaries. Complications increased with increasing surgical invasiveness, from 2.3% among patients having decompression alone to 5.6% among those having complex spinal fusions. After adjustment for age, comorbidity, previous spine surgery, and other features, the odds ratio (OR) of life-threatening complications for complex spinal fusion compared with decompression alone was 2.95 (95% confidence interval [CI], 2.50-3.49). Minnesota, as

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		compared to national Medicare statistics, demonstrates a lumbar spinal fusion rate that is four times the national average [0.84 per 1000 enrollees as compared to 0.2 per 1000]. Spinal fusion has become one of medicine's most controversial procedures. Some surgeons argue that spinal fusion is appropriate only for a small number of conditions, such as spinal instability, spinal fracture or severe curvature of the spine and that the financial incentives have caused the procedure to become overused. Others say that it is a useful tool to treat patients who have debilitating back pain and have tried other options like physical therapy to no avail. For consumers, there is a lack of publicly reported information that would provide patients with an understanding of potentially how well they will function after having lumbar spinal surgery. These measures are cutting edge and will provide outcome data for patients that currently do not exist.
XDFDL	Avoidance of inappropriate use of head CT in ED patients with minor head injury	Efficiency (Overuse) Domain: The rationale for this measure is to promote the appropriate use of imaging services and avoid unnecessary exposure to radiation. A noncontrast head CT is indicated in head trauma patients with loss of consciousness or posttraumatic amnesia only if one or more of the following is present: headache, vomiting, age greater than 60 years, drug or alcohol intoxication, deficits in short-term memory, physical evidence of trauma above the clavicle, posttraumatic seizure, GCS score less than 15, focal neurologic deficit, or coagulopathy (ACEP/CDC Clinical Policy 2008). A noncontrast head CT should be considered in head trauma patients with no loss of consciousness or posttraumatic amnesia if there is a focal neurologic deficit, vomiting, severe headache, age 65 years or greater, physical signs of a basilar skull fracture, GCS score less than 15, coagulopathy, or a dangerous mechanism of injury.* *Dangerous mechanism of injury includes ejection from a motor vehicle, a pedestrian struck, and a fall from a height of more than 3 feet or 5 stairs.(ACEP/CDC 2008)
XDFGF	Avoidance of inappropriate use of imaging for adult ED patients with atraumatic low back pain	Efficiency (Overuse) Domain: The rationale for this measure is to promote the appropriate use of imaging services and avoid unnecessary exposure to radiation. These strategies have the potential to improve both the quality and affordability of healthcare. Because the cost of outpatient imaging studies is approximately $14 billion annually for Medicare beneficiaries. This proposed measure for ED patients is similar to both NQF #0052 (NCQA measure on low back pain) and NQF#0514 (CMS MRI for low back pain). ACEP will confer with the measure stewards on the development of this measure. ACR appropriateness criteria, American College of Physicians, American Pain Society, and Michigan Quality Improvement Consortium, &

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		American College of Occupational and Environmental Medicine all have guidelines to support the rationale for this measure.
XAHDG	Bleeding Outcomes Related to Oral Anticoagulants	This measure relates to patient safety, which is listed as a priority area by the National Priority Partnership. Warfarin is a widely used drug with a narrow therapeutic range and thus has potential for serious adverse drug events, especially among elderly patients. Regular monitoring and dose adjustment are needed for safe use, but do not always occur, and there is significant opportunity for improvement in regard to identification of the frequency of warfarin-related adverse events. This measure provides much-needed information on the frequency of serious warfarin-related adverse events in this high-risk group and identifies opportunities to make warfarin use safer.
XDFAG	Cataract Surgery with Intra-Operative Complications (Unplanned Rupture of Posterior Capsule requiring unplanned vitrectomy)	Unplanned anterior vitrectomies are performed following cataract surgery when vitreous inadvertently prolapses into the anterior segment of the eye. This may result in poor visual outcome and additional complications, including retinal detachment. Studies have shown unplanned Vitrectomy Rates ranging from 1% to 4%. The literature states that this complication occurs more commonly for inexperienced surgeons. References: 1. D.F Chang, Cataract Surgery Complication Rates, How are we doing? Cataract and Refractive Surgery Feb 2012 2. Australasian Clinical Indicator Report 2004-2011, Summary of Results; Ophthalmology; 3. Chan, FM, Au Eong, KG, Phacoemulsification Cataract Surgery and Unplanned Anterior Vitrectomy - it can be bad news, Eye (2003)17, 679
XDFAM	Cataract Surgery: Difference Between Planned and Final Refraction	Refractive Outcome is important to the patient and to the surgeon. Planned refraction is something the surgeon and patient discuss at the time of assessment for cataract surgery and is a way to align patient and surgeon expectations of the outcome. Comparing actual outcome to predicted outcome is a valuable measure of success. Kugelberg and Lundstrom published outcomes data from the Swedish registry and found in routine cataract surgeries 75% to 90% of patients ended up with refraction within 1 Diopter of the target refraction. The study describes factors that influenced refractive outcome as older age and use of a clear corneal incision. High volume ophthalmology departments showed a significant difference in absolute prediction error. Another 2009 study by Gale and colleagues reported outcomes improving from 79.7% to 87% within 3 measurement cycles and the authors suggested that a benchmark standard of 85% be established. References: 1. Kugelberg, M.A. and Lundstrom, M, Refractive Outcome After Cataract Surgery, Cataract & Refractive Surgery Today Europe, May 2009: 2.

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		Gale, RP, Johnston, RL, Zuberbuhler, B, McKibbin, M, Benchmark Standards for refractive Outcomes After Cataract Surgery, Eye (London) 2009 Jan;23 (1) 149-52
E0005	CG CAHPS Supplemental and new Items : Between Visit Communication	These summary survey measures enhance the experience of care quality domain and are being considered by VM and PQRS GPRO reporting option.
E0005	CG CAHPS Supplemental Item : Educating Patient about Medication Adherence	These summary survey measures enhance the experience of care quality domain and are being considered by VM and PQRS GPRO reporting option.
E0005	CG CAHPS: Courteous & Helpful Office Staff	These summary survey measures enhance the experience of care quality domain and are being considered by VM and PQRS GPRO reporting option.
E0005	CG CAHPS: Supplemental Item Care Coordination	These summary survey measures enhance the experience of care quality domain and are being considered by VM and PQRS GPRO reporting option.
E0005	CG CAHPS: Supplemental Item Stewardship of Patient Resources	These summary survey measures enhance the experience of care quality domain and are being considered by VM and PQRS GPRO reporting option.
XDFCF	Composite measure: 1) Appropriate follow-up imaging for incidental liver lesions	The following evidence statements are quoted verbatim from the referenced clinical guidelines and other references: The Incidental Findings Committee recommends the following for low-dose unenhanced CT examinations for liver masses: 1. In low-risk and average-risk patients, sharply marginated, low-attenuation (_20 HU) solitary or multiple masses may typically not need further evaluation. 2. Small, solitary masses_1.5 cm that are not cystic and are discovered on unenhanced or standard-dose or low-dose scans in low-risk and average-risk patients may typically not need further evaluation. (ACR, 2010)
XDFCG	Composite measure: 2) Appropriate follow-up imaging for incidental kidney lesions composite measure	The following evidence statements are quoted verbatim from the referenced clinical guidelines and other references: The Incidental Findings Committee recommends the following for low-dose unenhanced CT

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		examination for renal masses: 1. It may be appropriate to interpret incidental renal masses as simple cysts unless suspicious features noted [earlier within the document] are convincingly present. The argument for adopting this approach is even stronger when considering small (<3 cm) masses, particularly those <1 cm. The smaller the mass (even when solid), the more likely it is benign. Furthermore, masses <1 cm may not be able to be fully characterized, even if renal mass-protocol CT or MRI was performed. Although this represents a consensus opinion of the committee, no data are yet available to support this approach. 2. If a renal mass is small (<3 cm), homogenous, any >70 HU, recent data suggest that the mass can be confidently diagnosed as a benign hyperattentuating cyst (Bosniak category II). (ACR, 2010)
XDFCH	Composite measure: 3) Appropriate follow-up imaging for incidental adrenal lesions composite measure	The following evidence statements are quoted verbatim from the referenced clinical guidelines and other references: The Incidental Findings Committee recommends the following for low-dose unenhanced CT examinations for adrenal masses: 1. Because attenuation should not be altered by a low dose technique, if the mean attenuation of an adrenal mass is_10 HU on a low-dose CT examination, one may conclude that the adrenal mass is likely to be a benign adenoma. 2. If a lesion is_10 HU and 1 to 4 cm in an asymptomatic patient without cancer, 1-year follow-up CT or MRI may be considered, if no prior studies for comparison are available. Prior examinations that show stability for_1 year can eliminate the need for further workup, so every effort should be made to obtain prior CT or MRI examinations in these situations. 3. For adrenal masses_4 cm, dedicated adrenal MRI or CT should be considered to further characterize. (ACR, 2010)
XDFBF	Discontinuation of Antiviral Therapy for Inadequate Viral Response	Treatment with all three drugs (boceprevir, peginterferon alfa, and ribavirin) should be stopped if the HCV RNA level is >100 IU/mL at treatment week 12 or detectable at treatment week 24 (Class 2a, Level B). (AASLD, 2011). Treatment with all three drugs (telaprevir, peginterferon alfa, and ribavirin) should be stopped if the HCV RNA level is >1,000 IU/mL at treatment weeks 4 or 12 and/or detectable at treatment week 24 (Class 2a, Level B). (AASLD, 2011). The absence of an early virological response (EVR) is the most robust means of identifying non-responders. Data from two retrospective analyses of multicenter trials

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		indicated that failure to decrease serum HCV RNA by 2 logs or more at treatment week 12 correlated strongly with non-response in treatment-naive subjects with genotype 1 infection. , Ninety-seven to 100% of treatment-naive patients with HCV genotype 1 infection who did not reach an EVR failed to achieve an SVR. Thus, patients who do not have an EVR can discontinue therapy early without compromising their chance to achieve an SVR. In contrast, an EVR is less accurate in predicting an SVR since only 65% to 72% of subjects who achieved an EVR ultimately attained an SVR.29 A completely negative test for HCV RNA at week 12 (complete EVR) is a better predictor of an SVR than a 2-log reduction in HCV RNA, 83% versus 21%. It is important to understand the current state of treatment effectiveness so we can identify the gaps along the spectrum of care and the magnitude with which each of these gaps contributes to the drop in effectiveness. Such knowledge is essential for a rational and efficient approach to ensuring that more patients get access to treatment and ultimately, achieve SVR. In addition, with the anticipated release of newer, more efficacious therapies, addressing the gaps of effectiveness in clinical practice is very timely. Almost all patients treated with peginterferon and ribavirin experience one or more adverse events during the course of therapy. Adverse events are a major reason that patients decline or stop therapy altogether. In the registration trials of peginterferon alfa-2a and 2b plus ribavirin, 10% to 14% of patients had to discontinue therapy due to an adverse event. , The most common adverse events in these trials were influenza-like side effects such as fatigue, headache, fever and rigors, which occurred in more than half of the patients, and psychiatric side effects (depression, irritability, and insomnia), which occurred in 22% to 31% of patients. Using the nationwide Veterans Administration (VA) HCV Clinical Case Registry (CCR), researchers examined a cohort of veterans who had HCV viremia between 2000 and 2005 and identified patients who received pegylated-interferon (PEG-INF) and ribavirin; based on the entire cohort, for every 100 patients with chronic HCV, 60 had a genotype test; 12 received PEG-INF and ribavirin; six completed treatment; and only three achieved SVR. This is one of the largest studies examining HCV treatment effectiveness in a community practice setting. Researchers showed that, compared to efficacy estimates obtained in RCTs, PEG-INF and ribavirin treatment effectiveness was low in a national sample of veterans with chronic HCV.28 Overall effectiveness for HCV treatment in achieving SVR was only 3.6% for the entire study population. Thus, nearly 96,000 of the 99,166 veterans with HCV diagnosed between FY2000 and FY2005 have either not been treated or have not cleared the virus.28 Since the benefits of

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		treatment are limited to patients with SVR, our data show that antiviral treatment has been minimally effective in reducing the burden of HCV-related chronic liver disease. Most of the drop in effectiveness resulted from low treatment rates (12.7%); high treatment discontinuation rates (16.3%); and low response to therapy (23.6% and 50.6%).
XDFBG	Discussion and Shared Decision Making Surrounding Treatment Options	Treatment decisions should be individualized based on the severity of liver disease, the potential for serious side effects, the likelihood of treatment response, the presence of comorbid conditions, and the patient's readiness for treatment (Class IIa, Level C). (AASLD, 2009). The decision to treat is based on many factors, including the degree of fibrosis and patient preferences, particularly with the new treatments coming out. Treatment improves health outcomes in more patients infected with hepatitis C virus. Ideally, physicians would discuss treatment options with patients and the potential harms and benefits, particularly in the context of the patients' current degree of liver fibrosis and the rapidly developing new oral drugs that will be available over the next several years. It must be re-emphasized that the recommendations on the selection of patients for treatment are guidelines and not fixed rules; management and treatment considerations should be made on a case-by-case basis, taking into consideration the experience of the practitioner together with the acceptance of risk by the patient. Attaining treatment-related SVR among persons with HCV is associated with a reduction in the relative risk for hepatocellular carcinoma (HCC). A systematic review published in 2013 summarized the evidence from 30 observational studies examining the risk for HCC among HCV-infected persons who have been treated and either achieved an SVR or did not respond to therapy. Findings showed a protective effect of treatment-related SVR on the development of HCC among HCV-infected persons at all stages of fibrosis and among those with advanced liver disease. With the availability of newer and more effective therapies, SVR rates can be increased and HCC incidence rates can be reduced in HCV-infected persons. The association between SVR and HCC should be considered when weighing the benefits and harms of identifying and treating HCV-infected persons. Current recommendations for treatment of persons with chronic HCV infection derive from data collected in the randomized registration trials. However these trials have usually been restrictive in their exclusion criteria and thus have not reflected the general population who require therapy. More data are needed in certain groups such as those with renal disease, depression and active substance abuse, children, and those with HIV/HCV co-infection.29 As with all decisions in medicine, a balance must be struck between the benefit and risk related to therapy. Application of these

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		principles can be challenging and the relative strength of a recommendation will need to vary accordingly.
XDFDB	Head and Neck Cancer: Weight Loss Prevention	Medical Nutrition Therapy (MNT) that consists of nutrition assessment, intensive intervention, and ongoing monitoring and evaluation by an RDN should be provided for patients with head/neck cancer being considered for radiation therapy. MNT has been shown to improve calorie and protein intake, maintain anthropometric measurements and improve quality of life (QOL). Three positive quality studies and one neutral study found routine, nutrition intervention is beneficial and may prevent nutritional deterioration, improve calorie and protein intake, maintain anthropometric measurements and improve quality of life in patients receiving radiation therapy for head and neck cancers. One randomized controlled trial (RCT) found patients who received regular nutrition counseling from a Registered Dietitian (RD) based on the Academy of Nutrition and Dietetics Medical Nutrition Therapy protocol for cancer (radiation oncology) lost significantly less weight and fat-free mass (FFM) than controls. Another RCT found nutrition counseling improves outcomes for patients with counseling having an equal or greater benefit than supplementation; and that at 3 months post-treatment, only counseling significantly impacted patient outcomes. The prospective nonrandomized trial found that intensive nutrition intervention, including instruction to maintain caloric intake of 40 kcals/kg body weight, provided beneficial effects for head and neck cancer patients by minimizing weight loss, preserving FFM, and promoting maintenance of nutrition parameters. A two-group comparison showed that increased interaction or visits by a RD help decrease post-surgery and post-radiation therapy weight loss in patients with squamous cell cancer of the oral cavity. References: Dawson ER, Morley SE, Robertson AG, Soutar DS. Increasing Dietary Supervision Can Reduce Weight Loss in Oral Cancer Patients. Nutrition and Cancer. 2001;41(1&2):70-74. Goncalves Dias MC, de Fatima Nunes Marucci, Nadalin W, Waitberg DL. (2005). Nutritional intervention improves the caloric and protein ingestion of head and neck cancer patients under radiotherapy. Nutr. Hosp. 20:320-325. Isenring E, Capra S, Bauer J, Davies PS. The impact of nutrition support on body composition in cancer outpatients receiving radiotherapy. Acta Diabetol. 2003 Oct; 40 Suppl 1: S162-S164. Ravasco P, Monteiro-Grillo I, Vidal PM, Camilo ME. Impact of nutrition on outcome: A prospective randomized controlled trial in patients with head and neck cancer undergoing radiotherapy. Head and Neck. 2005 Aug; 659-668.

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XCLLL	HRS-12: Cardiac Tamponade and/or Pericardiocentesis Following Atrial Fibrillation Ablation	Research suggests that tamponade results in 6 percent of patients within 30 days following an atrial fibrillation ablation. Moreover, evidence suggests that tamponade is often a direct result of the procedure and is preventable.
XCLMD	HRS-9: Infection within 180 Days of Cardiac Implantable Electronic Device (CIED) Implantation, Replacement, or Revision	The rate of implantable cardioverter-defibrillator (ICD) infections has been increasing faster than that of device implantation and is associated with substantial morbidity, mortality, and financial cost. A recent study including over 200,000 ICD implant patients found 2 percent of patients undergoing ICD implantation experienced a device-related infection. Patients who developed an ICD infection were likely to have more comorbidity burden, warfarin use, coronary sinus lead, device upgrade/malfunction as the last surgery, peri-ICD implant complications, and non-EP trained operator. The evidence demonstrates the need to measure performance in this area.
E0662	Median Time to Pain Management for Long Bone Fracture (OP-21/NQF-0662)	Patient Centered Outcome Domain: Pain management in patients with long bone fractures is undertreated in emergency departments (Ritsema, Kelen, Pronovost, & Pham, 2007). Emergency department pain management has room for improvement (Ritsema, Kelen, Pronovost, & Pham, 2007). Patients with bone fractures continue to lack administration of pain medication as part of treatment regimens (Brown, 2003). When performance measures are implemented for pain management of these patients administration and treatment rates for pain improve (Titler, 2009). Disparities continue to exist in the administration of pain medication for minorities (Epps, 2008 and Todd, 1993) and children as well (Brown, 2003 and Friedland, 1994). ACEP will confer with the measure steward to consider adapting or adopting this hospital outpatient measure as a clinician and/or clinician group level measure.
XDFCM	Minimum antimicrobial therapy for Staph A. - For adult patients with Staphylococcus aureus bacteremia, the minimum duration of antimicrobial therapy is 14 days.	Staphylococcus aureus bacteremia (SAB) is among the most prevalent infections within the healthcare setting. Associated with higher morbidity and mortality in comparison with bacteremia caused by other pathogens, SAB places substantial cost and resource burden on health care systems. SAB is difficult to treat and can lead to life-threatening complications, including endocarditis and metastatic infections. In combination with appropriate choice and dosage of antibiotic, a minimum of 14 days of therapy has been shown to prevent relapse of patients infected with SAB. The appropriate length of therapy can improve patient outcomes and reduce healthcare costs.

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XDFLL	National Institutes of Health Stroke Scale (NIHSS) for ED patients	Effectiveness of Clinical Care Domain: The NIHSS is a validated tool for assessing the initial stroke severity. An objective, standardized assessment of stroke severity is essential for determining eligibility for thrombolytic therapy, is the main determinant of short-term and long-term prognosis from stroke, and facilitates communication of stroke severity between health care providers.
E0465	Perioperative Anti-platelet Therapy for Patients undergoing Carotid Endarterectomy	The Vascular Study Group of Northern New England (VSGNNE) has published validated registry data from 48 surgeons in 9 hospitals concerning more than 3000 patients undergoing CEA (Cronenwett, 2007). This demonstrated initially that only 82% of patients were taking ASA or clopidogrel preoperatively before CEA in 2004. Through quality improvement efforts, this percentage has increased to 91% during the first 6 months of 2007. Further, a recent study from Austria found that 37% of 206 patients undergoing CEA were not on preoperative antiplatelet therapy, and concluded that this practice does not meet current guidelines and provides substantial opportunity for improvement (Assadian, 2006).
XDEME	Post-procedural Optimal medical therapy Composite (percutaneous coronary intervention)	The rate of prescribed optimal medical statin therapy after PCI is suboptimal. Only 84% of patients are prescribed a statin upon discharge after PCI. Additionally, only 86% of patients with a prior diagnosis of cardiovascular disease are prescribed statin therapy after PCI.
XDFBM	Radiation Consideration for Adult CT: Utilization of Dose Lowering Techniques	The following evidence statements are quoted verbatim from the referenced clinical guidelines and other references: CT examinations should be performed only for a valid medical reason and with the minimum exposure that provides the image quality necessary for adequate diagnostic information. (ACR, 2011) Radiologists, medical physicists, radiologic technologists, and all supervising physicians have a responsibility to minimize radiation dose to individual patients, to staff, and to society as a whole, while maintaining the necessary diagnostic image quality. This concept is known as "as low as reasonably achievable (ALARA)." (ACR, 2011) Facilities, in consultation with the medical physicist, should have in place and should adhere to policies and procedures, in accordance with ALARA, to vary examination protocols to take into account patient body habitus, such as height and/or weight, body mass index or lateral width.

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		The dose reduction devices that are available on imaging equipment should be active; if not; manual techniques should be used to moderate the exposure while maintaining the necessary diagnostic image quality. Periodically, radiation exposures should be measured and patient radiation doses estimated by a medical physicist in accordance with the appropriate ACR Technical Standard. (ACR, 2011)
XDFDH	Recurrence or amputation following endovascular infrainquinal lower extremity revascularization	Patients with lower extremity ischemia but with no symptoms or claudication alone are at very low risk of amputation without intervention. Any amputation or requirement of repeat intervention within a year should be considered a procedural adverse outcome. This measure will serve as an indicator of both appropriateness and outcome.
XDFDG	Recurrence or amputation following open infrainquinal lower extremity revascularization	Patients with lower extremity ischemia but with no symptoms or claudication alone are at very low risk of amputation without intervention. Any amputation or requirement of repeat intervention within a year should be considered a procedural adverse outcome. This measure will serve as an indicator of both appropriateness and outcome.
XCMDH	Reduction of complications through the use of cystoscopy during surgery for stress urinary incontinence	Variation in surgical complication rates suggests potential for improvement in use of cystoscopy to identify and guide repair at the time of the surgery. The proposed measure is expected to encourage practitioners to utilize cystoscopy during surgery for SUI. This safety precaution will enable surgeons to immediately repair areas damaged during SUI surgery, thereby reducing the post-surgical complication rate, and minimizing patient recovery time.
XDFBE	Referral to Treatment for Patients Identified with Hepatitis C Virus (HCV) Infection	In addition to testing adults of all ages at risk for HCV infection, CDC7 recommends that: • Adults born during 1945–1965 should receive one-time testing for HCV without prior ascertainment of HCV risk (Strong Recommendation, Moderate Quality of Evidence), and • All persons identified with HCV infection should receive a brief alcohol screening and intervention as clinically indicated, followed by referral to appropriate care and treatment services for HCV infection and related conditions (Strong Recommendation, Moderate Quality of Evidence). Providers and patients can discuss HCV testing as part of an individual's preventive health care. For persons identified with HCV infection, CDC recommends that they receive appropriate care, including HCV-directed clinical preventive services (e.g., screening for alcohol use, hepatitis A and hepatitis B vaccination as appropriate, and medical monitoring of disease). Recommendations are available to guide treatment decisions. Treatment decisions should be made by the patient and provider after several factors are considered, including stage of

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		disease, hepatitis C genotype, comorbidities, therapy-related adverse events, and benefits of treatment. (CDC, 2012) Clinical preventive services, regular medical monitoring, and behavioral changes can improve health outcomes for persons with HCV infection. HCV care and treatment recommendations have been issued by AASLD and endorsed by the Infectious Disease Society of America and the American Gastroenterological Association. Routine testing of persons born during 1945–1965 is expected to lead to more HCV-infected persons being identified earlier in the course of disease. To improve health outcomes, persons testing positive for HCV must be provided with appropriate treatment. Linking patients to care and treatment is a critical component of the strategy to reduce the burden of disease. Attaining treatment-related SVR among persons with HCV is associated with a reduction in the relative risk for hepatocellular carcinoma (HCC). A systematic review published in 2013 summarized the evidence from 30 observational studies examining the risk for HCC among HCV-infected persons who have been treated and either achieved an SVR or did not respond to therapy. Findings showed a protective effect of treatment-related SVR on the development of HCC among HCV-infected persons at all stages of fibrosis and among those with advanced liver disease. With the availability of newer and more effective therapies, SVR rates can be increased and HCC incidence rates can be reduced in HCV-infected persons.38 The association between SVR and HCC should be considered when weighing the benefits and harms of identifying and treating HCV-infected persons. Many persons identified as HCV-infected do not receive recommended medical evaluation and care after the diagnosis of HCV infection; this gap in linkage to care can be attributed to several factors, including being uninsured or underinsured, failure of providers to provide a referral, failure of patients to follow up on a referral, drug or alcohol use, and other barriers.7 The lack of such care, or substantial delays before care is received, negatively impacts the health outcomes of infected persons.
XDFGL	Repeat Colonoscopy due to poor bowel preparation	Poor bowel preparation is a major impediment to the effectiveness of colonoscopy. Poor preparation prolongs cecal intubation time and withdrawal time and reduces detection of both small and large polyps. Some colonoscopies must be repeated at intervals shorter than those recommended in guidelines because of inadequate preparation. The economic burden of repeating examinations because of inadequate bowel preparation is substantial. An individual practitioners' percentage of examinations requiring repeat because of preparation is

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		recommended. Individual endoscopists may compare their percentages to others within the same practice or to other endoscopists practicing in the same hospital. This can allow identification of outliers within that hospital for whom corrective measures should be taken. (ASGE/ACG Taskforce on Quality in Endoscopy. Am J Gastroenterol 2006;101:873–885). Other studies have demonstrated that bowel preparation has significant impact on the quality of a colonoscopy exam. (Cohen L., Kastenberg D, Lottes SR et al. Polyp detection rate during colonoscopy is correlated with quality of bowel preparation. Am J Gastroenterol 2006;101:S556) (Parra-Blanco A, Nicolas-Perez D, Gimeno-Garcia A et al. The timing of bowel preparation before colonoscopy determines the quality of cleansing, and is a significant factor contributing to the detection of flat lesions: a randomized study. World J Gastroenterol 2006;12:6161–6).
XDFBC	Screening for Hepatitis C Virus (HCV) for Patients at High Risk	In addition to testing adults of all ages at risk for HCV infection, CDC7 recommends that: • Adults born during 1945–1965 should receive one-time testing for HCV without prior ascertainment of HCV risk (Strong Recommendation, Moderate Quality of Evidence), and • All persons identified with HCV infection should receive a brief alcohol screening and intervention as clinically indicated, followed by referral to appropriate care and treatment services for HCV infection and related conditions (Strong Recommendation, Moderate Quality of Evidence). Providers and patients can discuss HCV testing as part of an individual's preventive health care. For persons identified with HCV infection, CDC recommends that they receive appropriate care, including HCV-directed clinical preventive services (e.g., screening for alcohol use, hepatitis A and hepatitis B vaccination as appropriate, and medical monitoring of disease). Recommendations are available to guide treatment decisions. Treatment decisions should be made by the patient and provider after several factors are considered, including stage of disease, hepatitis C genotype, comorbidities, therapy-related adverse events, and benefits of treatment. (CDC, 2012). The U.S. Preventive Services Task Force (USPSTF) recommends screening for hepatitis C virus (HCV) infection in adults at high risk, including those with any history of intravenous drug use or blood transfusions prior to 1992. Grade B recommendation. Assessment of Risk: Established high-risk factors for HCV infection include blood transfusion prior to 1992 and past or current intravenous drug use. Because of screening programs for donated blood, blood transfusions are no longer an important source of HCV infection. In contrast, 60% of new HCV

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		infections occur in individuals who report injecting drugs within the last 6 months. Other risk factors include chronic hemodialysis, being born to an HCV-infected mother, incarceration, intranasal drug use, getting an unregulated tattoo, and other percutaneous exposures (e.g., in health care workers, having surgery prior to the implementation of universal precautions). Evidence on tattoos and other percutaneous exposures as risk factors for HCV infection is limited. The USPSTF recommends that clinicians consider offering screening for HCV infection in adults born between 1945 and 1965. Grade B recommendation. The USPSTF concludes with moderate certainty that screening for HCV infection in the 1945–1965 birth cohort has at least a moderate net benefit. The USPSTF concluded that screening is of moderate benefit for populations at high risk. The USPSTF concluded that the benefit of screening all adults in the birth cohort born between 1945 and 1965 is moderate. The benefit is smaller given the lower. Birth-cohort screening is probably less efficient than risk-based screening, meaning more persons will need to be screened to identify 1 patient with HCV infection. Nevertheless, the overall number of Americans who will probably benefit from birth-cohort screening is greater than the number who will benefit from risk-based screening. A risk-based approach may miss detection of a substantial proportion of HCV-infected individuals in the birth cohort, due to either lack of patient disclosure or knowledge about prior risk status. As a result, clinicians should consider a birth cohort–based screening approach for patients born between 1945 and 1965 who have no other known HCV risk factors. Screening in the birth cohort for HCV infection will identify infected patients at earlier stages of disease, before they develop complications from liver damage. In the United States, an estimated 2.7–3.9 million persons (1.0%–1.5%) are living with hepatitis C virus (HCV) infection, and an estimated 17,000 persons were newly infected in 2010, the most recent year that data are available. With an HCV antibody prevalence of 3.25%, persons born during 1945–1965 account for approximately three fourths of all chronic HCV infections among adults in the United States. Although effective treatments are available to clear HCV infection from the body, most persons with HCV do not know they are infected, do not receive needed care (e.g., education, counseling, and medical monitoring), and are not evaluated for

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		treatment. HCV causes acute infection, which can be characterized by mild to severe illness but is usually asymptomatic. In approximately 75%–85% of persons, HCV persists as a chronic infection, placing infected persons at risk for liver cirrhosis, hepatocellular carcinoma (HCC), and extrahepatic complications that develop over the decades following onset of infection.29 HCV testing is the first step toward improving health outcomes for persons infected with HCV. In a recent analysis of data from a national health survey, 55% of persons ever infected with HCV reported an exposure risk (e.g., injection-drug use or blood transfusion before July 1992), and the remaining 45% reported no known exposure risk (CDC, unpublished data, 2012). Current risk-based testing strategies have had limited success, as evidenced by the substantial number of HCV-infected persons who remain unaware of their infection. Of the estimated 2.7–3.9 million persons living with HCV infection in the United States, 45%–85% are unaware of their infection; this proportion varies by setting, risk level in the population, and site-specific testing practices. Studies indicate that even among high-risk populations for whom routine HCV testing is recommended, prevalence of testing for HCV seromarkers varies from 17%–87%; according to one study, 72% of persons with a history of injection-drug use who are infected with HCV remain unaware of their infection status. Barriers to testing include inadequate health insurance coverage and limited access to regular health care47; however, risk-based testing practices have not been successful in identifying most HCV-infected persons, even those covered by health insurance.
XDFBH	Screening for Hepatocellular Carcinoma (HCC) in patients with Hepatitis C Cirrhosis	Identifying patients with cirrhosis is of particular importance, as their prognosis and likelihood to respond to therapy are altered, and they require surveillance for HCC. (A1) (EASL, 2011) Patients with HCV-related cirrhosis who achieve an SVR, regardless of the genotype, should continue to be monitored at 6 to 12 month intervals for the development of HCC (Class IIa, Level C) (AASLD, 2009) Patients at high risk for developing HCC [including patients with Hepatitis C cirrhosis] should be entered into surveillance programs (Level I). (AASLD, 2011) Surveillance for HCC should be performed using ultrasonography (level II). Patients should be screened at 6 month intervals (level II). (AASLD, 2011). Hepatitis C virus (HCV) is a leading cause of hepatocellular carcinoma (HCC). In the United States, this form of cancer occurs in

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		approximately 15,000 person's annually.38 Rates of HCC in the United States have more than tripled, from 1.6 per 100,000 persons to 4.9 per 100,000 persons, over the past quarter century, and an estimated 15,000 cases of HCC occur annually. Chronic HCV infection is the most commonly reported risk factor for HCC, and approximately half of all patients with HCC have serologic evidence of HCV infection. The risk of HCC in patients with chronic hepatitis C is highest among patients who have established cirrhosis, where the incidence of HCC is between 2%-8% per year. Surveillance for HCC has become widely applied despite, until recently, the absence of evidence of benefit. There is now a single randomized controlled trial of surveillance versus no surveillance that has shown a survival benefit to a strategy of 6-monthly surveillance with alphafetoprotein (AFP) and ultrasound. In addition, several studies have shown that surveillance does indeed detect earlier disease (stage migration). Uncontrolled studies, all subject to lead-time bias, have also suggested that survival is improved after surveillance. There is now a single randomized controlled trial of surveillance versus no surveillance that has shown a survival benefit to a strategy of 6-monthly surveillance with alphafetoprotein (AFP) and ultrasound. This study, which was performed in China, recruited 18,816 patients who had markers of current or prior hepatitis B infection. Adherence to surveillance was suboptimal (less than 60%) but in the subjects in the surveillance arm the HCC related mortality was reduced by 37%.. Because of poor compliance these results probably represent the minimum benefit that can be expected from surveillance. Ideally, these results should be validated in other geographical areas and therefore, additional randomized controlled trials (RCT) assessing the benefits of surveillance are still considered necessary. However, in the West it is unlikely that such trials will ever be conducted.
XDFCC	Use of premedication before contrast-enhanced imaging studies in patients with documented contrast allergy	The following evidence statements are quoted verbatim from the referenced clinical guidelines and other references: Frequency The reported incidence of intravenous (IV) contrast media extravasation related to power injection for CT has ranged from 0.1% to 0.9% (1/1,000 patients to 1/106 patients). The primary indication for premedication is pre-treatment of "at-risk" patients who require contrast media. In this context, "at-risk" means at higher risk for an acute allergic-like reaction.

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		Before deciding to premedicate an "at-risk" patient, some consideration should be given to the goals of such premedication. Ideally, one would like to prevent all contrast reactions, including minor, moderate, and severe ones. However, it is most important to target premedication to those who, in the past, have had moderately severe or severe reactions requiring treatment. No premedication strategy should be a substitute for the preadministration preparedness discussed in this manual. Contrast reactions occur despite premedication prophylaxis. The radiologist must be prepared and able to treat these reactions. Most commonly, a repeat reaction will be similar to the patients' intial reaction; however, there is a chance that a recurrent reaction will be more or less severe. Risk factors for Adverse Intravenous Contrast Material Reactions include allergy, asthma, renal insufficiency, cardiac status, anxiety, and miscellaneous risk factors. (ACR, 2010)
XDEGH	Appropriate Use of DXA Scans in Women Under 65 Who Do Not Meet the Risk Factor Profile	This measure is expected to benefit patients by reducing the use of DXA scans that are not indicated by clinical guidelines. Evidence suggests that the frequent use of DXA scans among women who do not meet the risk factor profile may contribute to over $500 million in health care costs (Kale et al. 2011) and expose patients to the burden of unnecessary radiation and/or treatment (Lim, Hoeksema, and Sherin 2009). Development of efficiency measures is one of the primary objectives of CMS and the National Quality Strategy.Only 4 of the 64 (6.25%) measures in the 2014 EHR Incentive Program for Eligible Professionals (encompassing both Meaningful Use 1 and Meaningful Use 2 measures) address efficiency. This measure concept was also identified in the Choosing Wisely campaign recommendations as an area of concern.
E1399	Developmental Screening - Age 1	Pediatricians are not usually successful in identifying children with developmental delays without use of a standardized tool (Hix-Small, 2007). This measure will encourage the use of standardized tools for developmental screening, as delineated by guidelines. Children who are identified earlier are more likely to have developmental promotion activities, that can further improve the likelihood that they will be able to start school ready to learn
E1399	Developmental Screening - Age 2	Pediatricians are not usually successful in identifying children with developmental delays without use of a standardized tool (Hix-Small, 2007). This measure will encourage the use of standardized tools for developmental screening, as delineated by guidelines. Children who are identified earlier are more likely to have developmental promotion activities that can further improve the likelihood that they will be able to start school ready to learn.
E1399	Developmental Screening - Age	Pediatricians are not usually successful in identifying children with developmental delays

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	3	without use of a standardized tool (Hix-Small, 2007). This measure will encourage the use of standardized tools for developmental screening, as delineated by guidelines. Children who are identified earlier are more likely to have developmental promotion activities, that can further improve the likelihood that they will be able to start school ready to learn
XDEHE	DRAFT: Tobacco Use and Help with Quitting Among Adolescents	Over 2.6 million adolescents 18 years of age and younger are current tobacco users, with nearly one-fifth of all adolescents becoming current smokers before finishing high school. This issue is important, as early onset of tobacco use is correlated to tobacco use in adulthood. Of adults that smoke on a daily basis, 82 percent reported trying their first cigarette before the age of 18, and 53 percent reported becoming daily smokers before the age of 18. Tobacco use is associated with some of the most serious and costly diseases, including lung cancer, heart disease and emphysema. Tobacco use can affect an individual's reproductive health and damage almost every organ in the body. In addition to these long-term complications, there are also a number of health concerns that can appear immediately in otherwise young and healthy adolescents, such as increased heart rate, increased blood pressure and shortness of breath. Effective cessation assistance options for adolescents include counseling (individual or group, cognitive-behavioral, family, and motivational) and forms of behavior therapy
XDFHF	History of Fragility Fracture with Prednisone Use	A few existing studies suggest that bisphosphonate use among premenospausal women with osteoporosis is relatively low (43% among those with a fracture in Cohen 2009).
E1959	Immunizations by 13 years of age - HPV	The most common sexually transmitted virus in the U.S. is genital human papillomavirus (HPV). It is contracted through genital contact, such as vaginal and anal sex. According to the CDC, at least 50 percent of all sexually active people will have genital HPV at some point during their lifetime (CDC, 2011). Preventing disease through vaccination eliminates direct costs associated with treating the disease, including doctor visits and hospital stays, as well as indirect costs, including time lost from work
E1407	Immunizations by 13 years of age- Meningococcus, Tetanus, and Diphtheria	Preventing disease through vaccination eliminates the costs associated with treating that disease including doctor visits and hospital stays, as well as time lost from work for parents. A study analyzing a cohort of 4.1 million children estimated that 2.87 million pertussis cases would occur, resulting in 1,131 deaths; 276,750 diphtheria cases, resulting in 27,675 deaths; and 165 tetanus cases, resulting in 25 deaths. From the societal perspective, these cases would

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		cost $23,536.5 million, with approximately $18,772.4 million (80%) for diphtheria and $4,770.1 million (20%) for pertussis (Ekwueme et al., 2000). With the use of the Tdap vaccine, the number of diphtheria, tetanus and pertussis cases has been reduced by 99%, 93% and 96%, respectively (Ekwueme et al., 2000)
XDCMD	Oral Health: Children aged 6-9 years who receive sealants in the first permanent molar	Evidence-based Clinical Recommendations recommend that sealants should be placed on pits and fissures of children's primary and permanent teeth when it is determined that the tooth, or the patient, is at risk of experiencing caries. The evidence for sealant effectiveness in permanent molars is stronger than evidence for primary molars. In addition to these guidelines based on prospective clinical studies, retrospective analysis of treatment outcomes based on health services research also supports the effectiveness of sealant use.
XDCME	Oral Health: Children who receive a comprehensive or periodic oral evaluation in two consecutive years	Dental caries is the most common chronic childhood disease—five times more common than asthma. According to evidence-based guidelines at least an annual oral exam is desirable for all children. Ensuring continuity of care is imperative in achieving and maintaining optimum oral health.
E0500	Severe Sepsis/Septic Shock: Management Bundle	The purpose of Henry Ford Hospital's severe sepsis and septic shock early management bundle is to support the efficient, effective, and timely delivery of high quality sepsis care in support of the IOM's aims for improvement. This is consistent with the HHS National Quality Strategy's priorities directed at one of the leading causes of mortality. By providing timely patient-centered care, and making sepsis care more affordable through early intervention, reduced resource use and complication rates can result. The Severe Sepsis and Septic Shock Early Management Bundle provide a standard operating procedure for the early risk stratification and management of a patient with severe infection. Through applying this standard operating procedure a clinically and statistically significant decrease in organ failure, mortality, and the utilization of health care resources has been demonstrated for over ten years. The current measure project aimed to review and update the existing NQF #0500 Severe Sepsis and Septic Shock Management Bundle to ensure it reflects the latest guideline recommendations, address areas most in need of performance improvement, and incorporate results of worldwide data collection and quality improvement initiatives. Henry Ford Hospital consulted with leadership and representatives from critical care medicine (Society of Critical Care Medicine), infectious diseases (Infectious Diseases Society of America), and emergency physicians to review and update the Severe Sepsis and Septic Shock Early Management Bundle.

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XDFLE	Optimal Asthma Care- Control Component	Roughly 7% of adults and children in Minnesota are currently living with asthma. Asthma is a chronic disease associated with familial, infectious, allergenic, socioeconomic, psychosocial and environmental factors. It is not curable but is treatable. Despite improvements in diagnosis and management, and an increased understanding of the epidemiology, immunology, and biology of the disease, asthma prevalence has progressively increased over the past 15 years. In addition, variation in practice from recommended clinical guidelines is evident with only 33% of adult asthma patients in Minnesota reporting in 2005 to having an action plan and 75% reporting instruction on what to do when having an asthma attack. It is up to providers to assess patients, prescribe medications, educate about self-management, help patients identify and mitigate triggers so patients can prevent their exacerbations.
E1507	Risky Behavior Assessment or Counseling by Age 18 Years	NQF measures 1406 and 1507 assess the percentage of children with documentation of a risk assessment or counseling for risky behaviors by the age of 13 or 18 years (respectively). Four rates are reported: Risk Assessment or Counseling for Alcohol Use, for Tobacco Use, for Other Substance Use, and for Sexual Activity. Early alcohol and drug use (pre-adolescent/early adolescent) is a predictor of later dependence. In the 2003 National Survey on Drug Use and Health (NSDUH), individuals who stated that they began drinking prior to age 15 were over 5 times more likely to report alcohol dependence or abuse at some point in their lives. Approximately 58% of Americans begin drinking alcohol before age 18 and heavy alcohol use spikes in the late teens and early 20's. Because there is strong evidence for the utility of preventive counseling at both ages, the Behavioral Health Coordinating Committee (BHCC) at HHS recommends combining these measures into one measure that reports separate rates for counseling provided at age13 and 18. If this is not possible in the time frame for MU Stage 3 the BHCC prioritizes NQF 1507 (age 18). Age 18 is an important transitional year and by this age the patient is more likely to see their doctor without their parent, which promotes more honest conversations.
XDFBL	Utilization of ultrasonography in children with clinically suspected appendicitis	The following evidence statements are quoted verbatim from the referenced clinical guidelines and other references: Although CT is more accurate, US is nearly as good in experienced hands, and given the lack of ionizing radiation, is the preferred examination in children, particularly if equivocal results are

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		followed up by CT. Thus the CT – after US – approach appears to have excellent accuracy, with reported sensitivity and specificity of 94%. A single retrospective study showed that in intermediate-to-high pretest probability children, US followed by CT is most cost-effective, whereas, in low pretest probability patients, US alone is the most effective and least costly strategy. (ACR, 2010) In children, US is the preferred intial examination, as it is nearly as accurate as CT for diagnosis of appendicitis without exposure to ionizing radiation. (ACR, 2010) In children, use ultrasound to confirm acute appendicitis but not to definitively exclude acute appendicitis. (Level B) (ACEP, 2010) In children, use an abdominal and pelvic CT to confirm or exclude acute appendicitis. (Level B) (ACEP, 2010)
XDDMH	Draft: Acute Myocardial Infarction Condition Phase Episode for CMS Episode Grouper	This measure would help CMS compare resource use for similar clinical situations (Condition or Treatment) in order to achieve the best outcome while lowering costs.
XDEAM	Draft: Asthma Condition Episode for CMS Episode Grouper	This measure would help CMS compare resource use for similar clinical situations (Condition or Treatment) in order to achieve the best outcome while lowering costs.
XDEEB	Draft: Back Pain Condition Episode for CMS Episode Grouper	This measure would help CMS compare resource use for similar clinical situations (Condition or Treatment) in order to achieve the best outcome while lowering costs.
XDEDC	Draft: Breast Cancer Condition Episode for CMS Episode Grouper	This measure would help CMS compare resource use for similar clinical situations (Condition or Treatment) in order to achieve the best outcome while lowering costs.
XDEDD	Draft: Breast Cancer Treatment Episode for CMS Episode Grouper	This measure would help CMS compare resource use for similar clinical situations (Condition or Treatment) in order to achieve the best outcome while lowering costs.
XDEBA	Draft: Bronchiectasis Condition Episode for CMS Episode Grouper	This measure would help CMS compare resource use for similar clinical situations (Condition or Treatment) in order to achieve the best outcome while lowering costs.

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XDEBM	Draft: Cardiac Arrhythmia Condition Episode for CMS Episode Grouper	This measure would help CMS compare resource use for similar clinical situations (Condition or Treatment) in order to achieve the best outcome while lowering costs.
XDECB	Draft: Cardioversion Treatment Episode for CMS Episode Grouper	This measure would help CMS compare resource use for similar clinical situations (Condition or Treatment) in order to achieve the best outcome while lowering costs.
XDEDB	Draft: Carotid Artery Stenosis Treatment Episode for CMS Episode Grouper	This measure would help CMS compare resource use for similar clinical situations (Condition or Treatment) in order to achieve the best outcome while lowering costs.
XDEBC	Draft: Cataract Condition Episode for CMS Episode Grouper	This measure would help CMS compare resource use for similar clinical situations (Condition or Treatment) in order to achieve the best outcome while lowering costs.
XDEBD	Draft: Cataract Treatment Episode for CMS Episode Grouper	This measure would help CMS compare resource use for similar clinical situations (Condition or Treatment) in order to achieve the best outcome while lowering costs.
XDEBB	Draft: Chronic Bronchitis/Emphysema Condition Episode for CMS Episode Grouper	This measure would help CMS compare resource use for similar clinical situations (Condition or Treatment) in order to achieve the best outcome while lowering costs.
XDEDL	Draft: Colon Cancer Condition Episode for CMS Episode Grouper	This measure would help CMS compare resource use for similar clinical situations (Condition or Treatment) in order to achieve the best outcome while lowering costs.
XDEDM	Draft: Colon Cancer Treatment Episode for CMS Episode Grouper	This measure would help CMS compare resource use for similar clinical situations (Condition or Treatment) in order to achieve the best outcome while lowering costs.
XDDML	Draft: Coronary Artery Bypass Graft Treatment Episode for CMS Episode Grouper	This measure would help CMS compare resource use for similar clinical situations (Condition or Treatment) in order to achieve the best outcome while lowering costs.

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XDEEA	Draft: Dementia Condition Episode for CMS Episode Grouper	This measure would help CMS compare resource use for similar clinical situations (Condition or Treatment) in order to achieve the best outcome while lowering costs.
XDECL	Draft: Diabetes Condition Episode for CMS Episode Grouper	This measure would help CMS compare resource use for similar clinical situations (Condition or Treatment) in order to achieve the best outcome while lowering costs.
XDEBE	Draft: Glaucoma Condition Episode for CMS Episode Grouper	This measure would help CMS compare resource use for similar clinical situations (Condition or Treatment) in order to achieve the best outcome while lowering costs.
XDEBF	Draft: Glaucoma Treatment Episode for CMS Episode Grouper	This measure would help CMS compare resource use for similar clinical situations (Condition or Treatment) in order to achieve the best outcome while lowering costs.
XDECA	Draft: Heart Block Condition Episode for CMS Episode Grouper	This measure would help CMS compare resource use for similar clinical situations (Condition or Treatment) in order to achieve the best outcome while lowering costs.
XDDMM	Draft: Heart Catheterization Treatment Episode for CMS Episode Grouper	This measure would help CMS compare resource use for similar clinical situations (Condition or Treatment) in order to achieve the best outcome while lowering costs.
XDEBL	Draft: Heart Failure Condition Episode for CMS Episode Grouper	This measure would help CMS compare resource use for similar clinical situations (Condition or Treatment) in order to achieve the best outcome while lowering costs.
XDEAB	Draft: Hip Osteoarthritis Condition Episode for CMS Episode Grouper	This measure would help CMS compare resource use for similar clinical situations (Condition or Treatment) in order to achieve the best outcome while lowering costs.
XDEAC	Draft: Hip Replacement/Revision Treatment Episode for CMS Episode Grouper	This measure would help CMS compare resource use for similar clinical situations (Condition or Treatment) in order to achieve the best outcome while lowering costs.

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XDEAD	Draft: Hip/Femur Fracture Condition Episode for CMS Episode Grouper	This measure would help CMS compare resource use for similar clinical situations (Condition or Treatment) in order to achieve the best outcome while lowering costs.
XDEAE	Draft: Hip/Femur Fracture Repair Treatment Episode for CMS Episode Grouper	This measure would help CMS compare resource use for similar clinical situations (Condition or Treatment) in order to achieve the best outcome while lowering costs.
XDECF	Draft: Hypertension Condition Episode for CMS Episode Grouper	This measure would help CMS compare resource use for similar clinical situations (Condition or Treatment) in order to achieve the best outcome while lowering costs.
XDEDA	Draft: Ischemic Cerebral Artery Disease Condition Episode for CMS Episode Grouper	This measure would help CMS compare resource use for similar clinical situations (Condition or Treatment) in order to achieve the best outcome while lowering costs.
XDDMG	Draft: Ischemic Heart Disease Condition Episode for CMS Episode Grouper	This measure would help CMS compare resource use for similar clinical situations (Condition or Treatment) in order to achieve the best outcome while lowering costs.
XDEAF	Draft: Knee Osteoarthritis Condition Episode for CMS Episode Grouper	This measure would help CMS compare resource use for similar clinical situations (Condition or Treatment) in order to achieve the best outcome while lowering costs.
XDEAG	Draft: Knee Replacement/Revision Treatment Episode for CMS Episode Grouper	This measure would help CMS compare resource use for similar clinical situations (Condition or Treatment) in order to achieve the best outcome while lowering costs.
XDEDE	Draft: Lung Cancer Condition Episode for CMS Episode Grouper	This measure would help CMS compare resource use for similar clinical situations (Condition or Treatment) in order to achieve the best outcome while lowering costs.
XDEDF	Draft: Lung Cancer Treatment Episode for CMS Episode Grouper	This measure would help CMS compare resource use for similar clinical situations (Condition or Treatment) in order to achieve the best outcome while lowering costs.

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XDECH	Draft: Nephropathy/Renal Failure Condition Episode for CMS Episode Grouper	This measure would help CMS compare resource use for similar clinical situations (Condition or Treatment) in order to achieve the best outcome while lowering costs.
XDECC	Draft: Pacemaker/AICD Implantation Treatment Episode for CMS Episode Grouper	This measure would help CMS compare resource use for similar clinical situations (Condition or Treatment) in order to achieve the best outcome while lowering costs.
XDEAA	Draft: Percutaneous Coronary Intervention Treatment Episode for CMS Episode Grouper	This measure would help CMS compare resource use for similar clinical situations (Condition or Treatment) in order to achieve the best outcome while lowering costs.
XDECD	Draft: Pneumonia Condition Episode for CMS Episode Grouper	This measure would help CMS compare resource use for similar clinical situations (Condition or Treatment) in order to achieve the best outcome while lowering costs.
XDEDH	Draft: Prostate Cancer Condition Episode for CMS Episode Grouper	This measure would help CMS compare resource use for similar clinical situations (Condition or Treatment) in order to achieve the best outcome while lowering costs.
XDEDG	Draft: Prostate Cancer Treatment Episode for CMS Episode Grouper	This measure would help CMS compare resource use for similar clinical situations (Condition or Treatment) in order to achieve the best outcome while lowering costs.
XDECE	Draft: Respiratory Failure Condition Episode for CMS Episode Grouper	This measure would help CMS compare resource use for similar clinical situations (Condition or Treatment) in order to achieve the best outcome while lowering costs.
XDEBG	Draft: Retinal Disease Condition Episode for CMS Episode Grouper	This measure would help CMS compare resource use for similar clinical situations (Condition or Treatment) in order to achieve the best outcome while lowering costs.
XDEBH	Draft: Retinal Disease Treatment Episode for CMS Episode Grouper	This measure would help CMS compare resource use for similar clinical situations (Condition or Treatment) in order to achieve the best outcome while lowering costs.

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XDECM	Draft: Sepsis/SIRS Condition Episode for CMS Episode Grouper	This measure would help CMS compare resource use for similar clinical situations (Condition or Treatment) in order to achieve the best outcome while lowering costs.
XDECG	Draft: Shock/Hypotension Condition Episode for CMS Episode Grouper	This measure would help CMS compare resource use for similar clinical situations (Condition or Treatment) in order to achieve the best outcome while lowering costs.
XDEAH	Draft: Shoulder Osteoarthritis Condition Episode for CMS Episode Grouper	This measure would help CMS compare resource use for similar clinical situations (Condition or Treatment) in order to achieve the best outcome while lowering costs.
XDEAL	Draft: Shoulder Replacement/Repair Treatment Episode for CMS Episode Grouper	This measure would help CMS compare resource use for similar clinical situations (Condition or Treatment) in order to achieve the best outcome while lowering costs.
S2158	Medicare Spending Per Beneficiary	Provide data to enable improved efficiency and avoidance of unnecessary services
E1822	External Beam Radiotherapy for Bone Metastases	This measure addresses the MAP priority of palliative care for cancer patients, a gap in the PCHQR Program. The measure also promotes the CMS domains of safety and efficiency. Bone metastases are common among cancer patients and often cause pain that reduces quality of life. EBRT is known to relieve the pain of bone metastases, but there are wide variations in the doses and number of fractions used, including doses that are higher than recommended. This measure encourages the appropriate use of EBRT for palliation.
XDCFE	Initiation of Osteoclast Inhibitors for Patients with Multiple Myeloma or Bone Metastases Associated with Breast Cancer, Prostate Cancer, or Lung Cancer	This measure addresses the CMS domains of clinical care and patient-centered care. OIs reduce pain and bone fractures in people with bone metastases and multiple myeloma, thereby improving quality of life and reducing health costs associated with treating pain and fractures. This measure is intended to encourage appropriate administration of OIs to patients with multiple myeloma and bone disease and patients with bone metastases and one of the following primary cancers: multiple myeloma, NSCLC, breast cancer or CRPC. Studies have demonstrated that as few as half of eligible patients receive OIs.
XDBLG	Overuse of Imaging for Staging	This measure addresses the CMS and MAP priorities of patient safety and efficiency. There is

MUC ID	Measure Title	Effectiveness
	Breast Cancer at Low Risk of Metastasis	known, growing overuse of imaging (bone, CT, PET, and PET/CT scans) among women with breast cancer at low risk of metastasis. This measure is designed to curb the use of inappropriate imaging tests and the resulting unnecessary exposure to radiation and associated health care costs.
E1628	Patients with Advanced Cancer Screened for Pain at Outpatient Visits	This measure addresses the MAP priorities of palliative care and patient-reported symptoms. Pain is a symptom commonly associated with cancer. At least one study has found a disparity in the assessment of pain among cancer outpatients relative to inpatients. Screening for pain at each outpatient visit will promote the effective management of pain over time.
E0450	Perioperative pulmonary embolism or deep vein thrombosis rate (PSI 12)	The measure addresses the MAP and CMS priorities of patient safety and clinical outcomes. Pulmonary embolism (PE) and deep vein thrombosis (DVT) are common yet preventable complications that lead to higher costs and increased risk of death. It is especially important to measure PE/DVT outcomes among cancer patients, who may be more likely to develop PE/DVT relative to non-cancer patients. An outcomes measure encourages providers to take providers to take preventive measures tailored to each patient's situation.
XDDAF	Potentially Avoidable Admissions and Emergency Department Visits Among Patients Receiving Outpatient Chemotherapy	This measure addresses the MAP priority of clinical outcomes, and matches the CMS domains of clinical care, efficiency, and care coordination. This measure is intended to promote appropriate symptom prevention and management in the outpatient setting. Appropriate management of cancer-related symptoms, such as nausea and vomiting, anemia, neutropenic fever, diarrhea, dehydration, and pain, in the outpatient setting should curb admissions and ED visits for side effects and complications of either the disease itself or its treatment.

List of Measures under Consideration for December 1, 2013

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Ambulatory Surgical Center Quality Reporting MUC 2013

MUC ID	CMS Program	Measure Title	CMS Domain
XDEMB	Ambulatory Surgical Center Quality Reporting	High-Acuity Care Visits after Outpatient Cataract Procedure	Patient Safety
XDEMA	Ambulatory Surgical Center Quality Reporting	High-Acuity Care Visits after Outpatient Colonoscopy Procedure	Patient Safety
XDELM	Ambulatory Surgical Center Quality Reporting	High-Acuity Care Visits after Outpatient Endoscopy Procedure	Patient Safety

End-Stage Renal Disease Quality Incentive Program MUC 2013

MUC ID	CMS Program	Measure Title	CMS Domain
E0260	End Stage Renal Disease Quality Improvement Program	Assessment of Health-related Quality of Life (Physical & Mental Functioning)	Communication and Care Coordination
E0029	End Stage Renal Disease Quality Improvement Program	Counseling on physical activity in older adults - a. Discussing Physical Activity, b. Advising Physical Activity	Communication and Care Coordination
XDGBA	End Stage Renal Disease Quality Improvement Program	ESRD Vaccination – Lifetime Pneumococcal Vaccination	Effective Clinical Care
XDEFL	End Stage Renal Disease Quality Improvement Program	ESRD Vaccination - Pneumococcal Vaccination (PPSV23)	Effective Clinical Care
XDEGA	End Stage Renal Disease Quality Improvement Program	ESRD Vaccination - Timely Influenza Vaccination	Effective Clinical Care
XDEFM	End Stage Renal Disease Quality Improvement Program	Full-Season Influenza Vaccination (ESRD Patients)	Effective Clinical Care
XDGAF	End Stage Renal Disease Quality Improvement Program	Hepatitis B vaccine coverage in hemodialysis patients	Effective Clinical Care
E0393	End Stage Renal Disease Quality Improvement Program	Hepatitis C: Testing for Chronic Hepatitis C – Confirmation of Hepatitis C Viremia	Effective Clinical Care
E0004	End Stage Renal Disease Quality Improvement Program	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	Community/Population Health
XDEGC	End Stage Renal Disease Quality Improvement Program	Measurement of Plasma PTH Concentration	Effective Clinical Care
E0431	End Stage Renal Disease Quality Improvement	Influenza Vaccination Coverage Among Healthcare Personnel	Effective Clinical Care

MUC ID	CMS Program	Measure Title	CMS Domain
	Program		
E0420	End Stage Renal Disease Quality Improvement Program	Pain Assessment and Follow-Up	Person and Caregiver-Centered Experience
XCBMM	End Stage Renal Disease Quality Improvement Program	Pediatric Peritoneal Dialysis Adequacy: Achievement of Target Kt/V	Effective Clinical Care
XDGAM	End Stage Renal Disease Quality Improvement Program	Pediatric Peritoneal Dialysis Adequacy: Frequency of Measurement of Kt/V	Effective Clinical Care
XDEGB	End Stage Renal Disease Quality Improvement Program	Percentage of Dialysis Patients with Dietary Counseling	Effective Clinical Care
XDEFH	End Stage Renal Disease Quality Improvement Program	Pneumococcal Vaccination Measure (PCV13)	Effective Clinical Care
E0418	End Stage Renal Disease Quality Improvement Program	Screening for Clinical Depression	Effective Clinical Care
XDEFF	End Stage Renal Disease Quality Improvement Program	Standardized Kt/V	Effective Clinical Care
XDEFE	End Stage Renal Disease Quality Improvement Program	Surface Area Normalized Kt/V	Effective Clinical Care
XAHMH	End Stage Renal Disease Quality Improvement Program	Ultrafiltration Rate (UFR)	Effective Clinical Care

Home Health Quality Reporting MUC 2013

MUC ID	CMS Program	Measure Title	CMS Domain
XDFFA	Home Health Quality Reporting	Depression Screening Conducted and Follow-Up Plan Documented	Effective Clinical Care
XDAEH	Home Health Quality Reporting	Emergency Department Use without Hospital Readmission During the First 30 Days of Home Health	Communication and Care Coordination
XDFGB	Home Health Quality Reporting	New or Worsened Pressure Ulcers	Effective Clinical Care
XCHGG	Home Health Quality Reporting	Rehospitalization During the First 30 Days of Home Health	Communication and Care Coordination

Hospital Acquired Condition Reduction Program MUC 2013

MUC ID	CMS Program	Measure Title	CMS Domain
XDDLA	Hospital Acquired Condition Reduction Program	PSI 10:Postoperative Physiologic and Metabolic Derangement Rate	Patient Safety
E0533	Hospital Acquired Condition Reduction Program	PSI 11: Post Operative Respiratory Failure	Patient Safety
E0349	Hospital Acquired Condition Reduction Program	PSI 16: Transfusion Reaction	Patient Safety
XAFLG	Hospital Acquired Condition Reduction Program	PSI 9: Perioperative Hemorrhage or Hematoma Rate	Patient Safety

Hospital Inpatient Quality Reporting MUC 2013

MUC ID	CMS Program	Measure Title	CMS Domain
XDBCB	Hospital Inpatient Quality Reporting	Adverse Drug Events - Hyperglycemia	Patient Safety
XDBGA	Hospital Inpatient Quality Reporting	Adverse Drug Events - Hypoglycemia	Patient Safety
XDAEA	Hospital Inpatient Quality Reporting	Appropriate Monitoring of patients receiving an Opioid via an IV Patient Controlled Analgesia Device	Patient Safety
E0475	Hospital Inpatient Quality Reporting	Hepatitis B Vaccine Coverage Among All Live Newborn Infants Prior to Hospital or Birthing Facility Discharge	Effective Clinical Care
XBGDL	Hospital Inpatient Quality Reporting	Hospital 30-Day All-Cause Risk-Standardized Readmission Rate (RSRR) following Vascular Procedures	Communication and Care Coordination
XDEEL	Hospital Inpatient Quality Reporting	Hospital 30-day Risk-standardized Acute Myocardial Infarction (AMI) Mortality eMeasure	Patient Safety
XDEEH	Hospital Inpatient Quality Reporting	Hospital 30-day, all-cause, risk-standardized mortality rate (RSMR) following Coronary Artery Bypass Graft (CABG) surgery	Patient Safety
XBELG	Hospital Inpatient Quality Reporting	Hospital 30-day, all-cause, unplanned, risk-standardized readmission rate (RSRR) following Coronary artery Bypass Graft (CABG) Surgery	Communication and Care Coordination
XDELH	Hospital Inpatient Quality Reporting	Hospital-level, risk-standardized 30-day episode-of-care payment measure for heart failure	Efficiency and Cost Reduction
XDELG	Hospital Inpatient Quality Reporting	Hospital-level, risk-standardized 30-day episode-of-care payment measure for pneumonia	Efficiency and Cost Reduction
E0471	Hospital Inpatient Quality Reporting	PC-02 Cesarean Section	Community/Population Health

Hospital Outpatient Quality Reporting MUC 2013

MUC ID	CMS Program	Measure Title	CMS Domain
XDFMH	Hospital Outpatient Quality Reporting	30-Day Readmissions	Communication and Care Coordination
XDFMG	Hospital Outpatient Quality Reporting	Group Therapy	Efficiency and Cost Reduction
XDEMB	Hospital Outpatient Quality Reporting	High-Acuity Care Visits after Outpatient Cataract Procedure	Patient Safety
XDEMA	Hospital Outpatient Quality Reporting	High-Acuity Care Visits after Outpatient Colonoscopy Procedure	Patient Safety
XDELM	Hospital Outpatient Quality Reporting	High-Acuity Care Visits after Outpatient Endoscopy Procedure	Patient Safety
XDFMF	Hospital Outpatient Quality Reporting	No Individual Psychotherapy	Efficiency and Cost Reduction

Hospital Readmission Reduction Program MUC 2013

MUC ID	CMS Program	Measure Title	CMS Domain
F2027	Hospital Readmission Reduction Program	Hospital 30-day, all-cause, risk-standardized readmission rate (RSRR) following an acute ischemic stroke hospitalization	Communication and Care Coordination
XBELG	Hospital Readmission Reduction Program	Hospital 30-day, all-cause, unplanned, risk-standardized readmission rate (RSRR) following Coronary artery Bypass Graft (CABG) Surgery	Communication and Care Coordination
E1789	Hospital Readmission Reduction Program	Hospital-Wide All-Cause Unplanned Readmission Measure (HWR)	Communication and Care Coordination

Hospital Value-Based Purchasing MUC 2013

MUC ID	CMS Program	Measure Title	CMS Domain
E0434	Hospital Value-Based Purchasing	STK-1 Venous Thromboembolism (VTE) Prophylaxis	Effective Clinical Care
E0441	Hospital Value-Based Purchasing	STK-10 Assessed for Rehabilitation	Effective Clinical Care
E0435	Hospital Value-Based Purchasing	STK-2 Antithrombotic therapy for ischemic stroke	Effective Clinical Care
E0436	Hospital Value-Based Purchasing	STK-3 Anticoagulation therapy for Afib/flutter	Effective Clinical Care
E0437	Hospital Value-Based Purchasing	STK-4 Thrombolytic therapy for acute ischemic stroke	Effective Clinical Care
E0438	Hospital Value-Based Purchasing	STK-5 Antithrombotic therapy by the end of hospital day 2	Effective Clinical Care
E0439	Hospital Value-Based Purchasing	STK-6 Discharged on Statin Medication	Effective Clinical Care
D0440	Hospital Value-Based Purchasing	STK-8 Stroke Education	Community/Population Health
E0371	Hospital Value-Based Purchasing	VTE-1: Venous Thromboembolism Prophylaxis	Effective Clinical Care
E0372	Hospital Value-Based Purchasing	VTE-2: Intensive Care Unit Venous Thromboembolism Prophylaxis	Effective Clinical Care
E0373	Hospital Value-Based Purchasing	VTE-3:VTE patients with anticoagulation overlap therapy	Effective Clinical Care
D0374	Hospital Value-Based Purchasing	VTE-4: Patients receiving un-fractionated Heparin with doses/labs monitored by protocol	Effective Clinical Care
D0375	Hospital Value-Based Purchasing	VTE-5: VTE discharge instructions	Patient Safety
D0376	Hospital Value-Based Purchasing	VTE-6: Incidence of potentially preventable VTE	Patient Safety

Inpatient Psychiatric Facility Quality Reporting MUC 2013

MUC ID	CMS Program	Measure Title	CMS Domain
E1659	Inpatient Psychiatric Facility Quality Reporting	Influenza Immunization	Effective Clinical Care
E0431	Inpatient Psychiatric Facility Quality Reporting	Influenza Vaccination Coverage Among Healthcare Personnel	Effective Clinical Care
XDFGE	Inpatient Psychiatric Facility Quality Reporting	Inpatient Psychiatric Facility Routinely Assesses Patient Experience of Care	Person and Caregiver-Centered Experience
XDFGD	Inpatient Psychiatric Facility Quality Reporting	IPF Alcohol Use Screening completed within one day of admission	Effective Clinical Care
XDFGC	Inpatient Psychiatric Facility Quality Reporting	IPF Drug Use Screening completed within one day of admission	Effective Clinical Care
XCAEA	Inpatient Psychiatric Facility Quality Reporting	IPF Metabolic Screening	Effective Clinical Care
XDCBA	Inpatient Psychiatric Facility Quality Reporting	IPF Suicide Risk Screening completed within one day of admission	Effective Clinical Care
XDEGE	Inpatient Psychiatric Facility Quality Reporting	IPF Use of an electronic health record meeting Stage 1 or Stage 2 Meaningful Use criteria	Communication and Care Coordination
XDCFD	Inpatient Psychiatric Facility Quality Reporting	IPF Violence Risk Screening completed within one day of admission	Effective Clinical Care
E0028	Inpatient Psychiatric Facility Quality Reporting	Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention	Effective Clinical Care

Inpatient Rehabilitation Facility Quality Reporting MUC 3013

MUC ID	CMS Program	Measure Title	CMS Domain
XCFFL	Inpatient Rehabilitation Facilitiy Quality Reporting	Functional Outcome Measure: Change in Mobility Score	Effective Clinical Care
XCFFM	Inpatient Rehabilitation Facilitiy Quality Reporting	Functional Outcome Measure: Change in Self-Care Score	Effective Clinical Care
XDDCA	Inpatient Rehabilitation Facilitiy Quality Reporting	Functional Outcome Measure: Discharge mobility score	Effective Clinical Care
XDDCB	Inpatient Rehabilitation Facilitiy Quality Reporting	Functional Outcome Measure: Discharge self-care score	Effective Clinical Care
E1717	Inpatient Rehabilitation Facilitiy Quality Reporting	National Healthcare Safety Network (NHSN) Facility-Wide Inpatient Hospital-onset Clostridium difficile infection (CDI) Outcome Measure	Patient Safety
E1716	Inpatient Rehabilitation Facilitiy Quality Reporting	National Healthcare Safety Network (NHSN) Facility-Wide Inpatient Hospital-onset Methicillin-resistant Staphylococcus aureus (MRSA) Bacteremia Outcome Measure	Patient Safety
E0674	Inpatient Rehabilitation Facilitiy Quality Reporting	Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay)	Patient Safety
E0676	Inpatient Rehabilitation Facilitiy Quality Reporting	Percent of Residents Who Self-Report Moderate to Severe Pain (Short Stay)	Effective Clinical Care

Long-Term Care Hospital Quality Reporting

MUC ID	CMS Program	Measure Title	CMS Domain
XCFGB	Long-Term Care Hospital Quality Reporting	Functional Outcome Measure: change in mobility among patients requiring ventilator support	Effective Clinical Care
XCBBF	Long-Term Care Hospital Quality Reporting	Percent of LTCH patients with an admission and discharge functional assessment and a care plan that addresses function	Person and Caregiver-Centered Experience
XDDCC	Long-Term Care Hospital Quality Reporting	Ventilator-Associated Event	Patient Safety

Medicare and Medicaid EHR Incentive Program for Eligible Professionals MUC 2013

MUC ID	CMS Program	Measure Title	CMS Domain
XDAEB	Medicare and Medicaid EHR Incentive Program for Eligible Professionals	Annual Wellness Assessment: Assessment of Health Risks	Effective Clinical Care
XDBHA	Medicare and Medicaid EHR Incentive Program for Eligible Professionals	Annual Wellness Assessment: Goal-Setting to Reduce Identified Risks	Person and Caregiver-Centered Experience
XDAEC	Medicare and Medicaid EHR Incentive Program for Eligible Professionals	Annual Wellness Assessment: Management of Health Risks	Effective Clinical Care
XDBGH	Medicare and Medicaid EHR Incentive Program for Eligible Professionals	Annual Wellness Assessment: Reduction of Health Risks	Effective Clinical Care
XDEGH	Medicare and Medicaid EHR Incentive Program for Eligible Professionals	Appropriate Use of DXA Scans in Women Under 65 Who Do Not Meet the Risk Factor Profile	Efficiency and Cost Reduction
XDFHD	Medicare and Medicaid EHR Incentive Program for Eligible Professionals	Assessment and Classification of Disease Activity	Effective Clinical Care
XDFEH	Medicare and Medicaid EHR Incentive Program for Eligible Professionals	Bone Mineral Density (BMD) & Fracture Risk	Effective Clinical Care
S1884	Medicare and Medicaid EHR Incentive Program for Eligible Professionals	Depression Response at Six Months- Progress Towards Remission	Effective Clinical Care
S1885	Medicare and Medicaid EHR Incentive Program for Eligible Professionals	Depression Response at Twelve Months- Progress Towards Remission	Effective Clinical Care
E1399	Medicare and Medicaid EHR Incentive Program for Eligible Professionals	Developmental Screening - Age 1	Effective Clinical Care
E1399	Medicare and Medicaid EHR Incentive Program for	Developmental Screening - Age 2	Effective Clinical Care

MUC ID	CMS Program	Measure Title	CMS Domain
	Eligible Professionals		
E1399	Medicare and Medicaid EHR Incentive Program for Eligible Professionals	Developmental Screening - Age 3	Effective Clinical Care
XDELF	Medicare and Medicaid EHR Incentive Program for Eligible Professionals	DRAFT: ADE Prevention and Monitoring: Minimum INR Monitoring for Patients with Atrial Fibrillation on Warfarin	Patient Safety
XDELE	Medicare and Medicaid EHR Incentive Program for Eligible Professionals	DRAFT: ADE Prevention and Monitoring: Warfarin Time in Therapeutic Range	Patient Safety
XDCLD	Medicare and Medicaid EHR Incentive Program for Eligible Professionals	DRAFT: Closing the Referral Loop - Critical Information Communicated with Request for Referral	Communication and Care Coordination
XDDAC	dicare and Medicaid EHR Incentive Program for Eligible Professionals	DRAFT: Closing the Referral Loop - Specialist Report Sent to Primary Care Physician	Communication and Care Coordination
XDELB	Medicare and Medicaid EHR Incentive Program for Eligible Professionals	DRAFT: Functional Status Assessment and Goal Achievement for Patients with Congestive Heart Failure	Person and Caregiver-Centered Experience
XDELD	Medicare and Medicaid EHR Incentive Program for Eligible Professionals	DRAFT: Functional Status Assessment and Improvement for Patients who Received a Total Hip Replacement	Effective Clinical Care
XDELC	Medicare and Medicaid EHR Incentive Program for Eligible Professionals	DRAFT: Functional Status Assessment and Improvement for Patients who Received a Total Knee Replacement	Effective Clinical Care
XDEHF	Medicare and Medicaid EHR	DRAFT: Substance Use Screening and	Effective Clinical Care

MUC ID	CMS Program	Measure Title	CMS Domain
	Incentive Program for Eligible Professionals	Intervention Composite	
XDEHE	Medicare and Medicaid EHR Incentive Program for Eligible Professionals	DRAFT: Tobacco Use and Help with Quitting Among Adolescents	Effective Clinical Care
XDAFC	Medicare and Medicaid EHR Incentive Program for Eligible Professionals	Functional Status Assessment and Goal Setting in Patients with Rheumatoid Arthritis	Person and Caregiver-Centered Experience
XDBGL	Medicare and Medicaid EHR Incentive Program for Eligible Professionals	Functional Status Assessments and Goal Setting for Patients with Asthma	Person and Caregiver-Centered Experience
XDBGM	Medicare and Medicaid EHR Incentive Program for Eligible Professionals	Functional Status Assessments and Goal Setting for Patients with Chronic Obstructive Pulmonary Disease	Person and Caregiver-Centered Experience
E2080	Medicare and Medicaid EHR Incentive Program for Eligible Professionals	Gap in HIV medical visits	Community/Population Health
XDFHF	Medicare and Medicaid EHR Incentive Program for Eligible Professionals	History of Fragility Fracture with Prednisone Use	Effective Clinical Care
E2079	Medicare and Medicaid EHR Incentive Program for Eligible Professionals	HIV medical visit frequency	Community/Population Health
E2082	Medicare and Medicaid EHR Incentive Program for Eligible Professionals	HIV viral load suppression	Effective Clinical Care
E1959	Medicare and Medicaid EHR Incentive Program for Eligible Professionals	Immunizations by 13 years of age - HPV	Effective Clinical Care
E1407	Medicare and Medicaid EHR Incentive Program for Eligible Professionals	Immunizations by 13 years of age- Meningococcus, Tetanus, and Diphtheria	Effective Clinical Care
XDCMD	Medicare and Medicaid EHR	Oral Health: Children aged 6-9 years who	Effective Clinical Care

MUC ID	CMS Program	Measure Title	CMS Domain
	Incentive Program for Eligible Professionals	receive sealants in the first permanent molar	
XDCME	Medicare and Medicaid EHR Incentive Program for Eligible Professionals	Oral Health: Children who receive a comprehensive or periodic oral evaluation in two consecutive years	Community/Population Health
XDFEF	Medicare and Medicaid EHR Incentive Program for Eligible Professionals	Osteoporotic Fracture Risk	Effective Clinical Care
XDAFA	Medicare and Medicaid EHR Incentive Program for Eligible Professionals	Overuse of Diagnostic Imaging for Uncomplicated Headache	Efficiency and Cost Reduction
XDFEG	Medicare and Medicaid EHR Incentive Program for Eligible Professionals	Prednisone Use with Anabolic Agent	Effective Clinical Care
E2083	Medicare and Medicaid EHR Incentive Program for Eligible Professionals	Prescription of HIV antiretroviral therapy	Effective Clinical Care
XDFHE	Medicare and Medicaid EHR Incentive Program for Eligible Professionals	Tuberculosis Screening Prior to First Course Biologic Disease Modifying Anti-Rheumatic Drug (DMARD) Therapy	Patient Safety

Medicare and Medicaid EHR Incentive Program for Hospitals/Critical Access Hospitals MUC 2013

MUC ID	CMS Program	Measure Title	CMS Domain
XDBCB	Medicare and Medicaid EHR Incentive Program for Hospitals and CAHs	Adverse Drug Events - Hyperglycemia	Patient Safety
XDBGA	Medicare and Medicaid EHR Incentive Program for Hospitals and CAHs	Adverse Drug Events - Hypoglycemia	Patient Safety
E0475	Medicare and Medicaid EHR Incentive Program for Hospitals and CAHs	Hepatitis B Vaccine Coverage Among All Live Newborn Infants Prior to Hospital or Birthing Facility Discharge	Effective Clinical Care
XDEEL	Medicare and Medicaid EHR Incentive Program for Hospitals and CAHs	Hospital 30-day Risk-standardized Acute Myocardial Infarction (AMI) Mortality eMeasure	Patient Safety
E1659	Medicare and Medicaid EHR Incentive Program for Hospitals and CAHs	Influenza Immunization	Effective Clinical Care
E0500	Medicare and Medicaid EHR Incentive Program for Hospitals and CAHs	Severe Sepsis/Septic Shock: Management Bundle	Effective Clinical Care

Medicare Physician Quality Reporting System MUC 2013

MUC ID	CMS Program	Measure Title	CMS Domain
XDEMG	Medicare Physician Quality Reporting System	ACORN Adolescent (Youth) Outcome Questionnaire	Effective Clinical Care
XDEMF	Medicare Physician Quality Reporting System	ACORN Adult Outcome Questionnaire	Effective Clinical Care
XAHDH	Medicare Physician Quality Reporting System	Adherence to Antiplatelet Treatment after Stent Implantation	Effective Clinical Care
E1879	Medicare Physician Quality Reporting System	Adherence to Antipsychotic Medications for Individuals with Schizophrenia	Effective Clinical Care
E0545	Medicare Physician Quality Reporting System	Adherence to Chronic Medications for Individuals with Diabetes Mellitus	Effective Clinical Care
S1880	Medicare Physician Quality Reporting System	Adherence to Mood Stabilizers for Individuals with Bipolar I Disorder	Effective Clinical Care
XDFAL	Medicare Physician Quality Reporting System	Adult Primary Rhegmatogenous Retinal Detachment Reoperation Rate	Effective Clinical Care
XDFAH	Medicare Physician Quality Reporting System	Adult Primary Rhegmatogenous Retinal Detachment Surgery Success Rate	Effective Clinical Care
XDBCB	Medicare Physician Quality Reporting System	Adverse Drug Events - Hyperglycemia	Patient Safety
XDBGA	Medicare Physician Quality Reporting System	Adverse Drug Events - Hypoglycemia	Patient Safety
XDBBL	Medicare Physician Quality Reporting System	All-Cause Unplanned Admissions for Patients with Diabetes	Communication and Care Coordination
XDBBG	Medicare Physician Quality Reporting System	All-Cause Unplanned Admissions for Patients with Heart Failure	Communication and Care Coordination
XDBBM	Medicare Physician Quality Reporting	All-Cause Unplanned Admissions for Patients	Communication and Care Coordination

MUC ID	CMS Program	Measure Title	CMS Domain
	System	with Multiple Chronic Conditions	
XCLAL	Medicare Physician Quality Reporting System	ALS Patient Care Preferences	Person and Caregiver-Centered Experience
XDFBD	Medicare Physician Quality Reporting System	Annual Hepatitis C Virus (HCV) Screening for Patients who are Active Injection Drug Users	Effective Clinical Care
XDAEB	Medicare Physician Quality Reporting System	Annual Wellness Assessment: Assessment of Health Risks	Effective Clinical Care
XDBHA	Medicare Physician Quality Reporting System	Annual Wellness Assessment: Goal-Setting to Reduce Identified Risks	Person and Caregiver-Centered Experience
XDAEC	Medicare Physician Quality Reporting System	Annual Wellness Assessment: Management of Health Risks	Effective Clinical Care
XDBGH	Medicare Physician Quality Reporting System	Annual Wellness Assessment: Reduction of Health Risks	Effective Clinical Care
XDFGM	Medicare Physician Quality Reporting System	Appropriate age for colorectal cancer screening colonoscopy	Efficiency and Cost Reduction
XDFCL	Medicare Physician Quality Reporting System	Appropriate follow-up imaging for incidental simple ovarian cysts	Efficiency and Cost Reduction
XDFCE	Medicare Physician Quality Reporting System	Appropriate follow-up imaging for incidental thyroid nodules in patients	Communication and Care Coordination
XDFDA	Medicare Physician Quality Reporting System	Appropriate in vitro susceptibility testing - The agent(s) used for definitive therapy in invasive staphylococcal disease should be confirmed by in vitro susceptibility testing as interpreted by the Clinical Laboratory and Standards Institute (CLSI) to be active	Effective Clinical Care

MUC ID	CMS Program	Measure Title	CMS Domain
		against the clinical isolate.	
XDAEA	Medicare Physician Quality Reporting System	Appropriate Monitoring of patients receiving an Opioid via an IV Patient Controlled Analgesia Device	Patient Safety
XDFHL	Medicare Physician Quality Reporting System	Appropriate Treatment of MSSA - For MSSA bacteremia, a β-lactam antibiotic is the drug of choice in the hospitalized patient in the absence of a documented allergy or drug intolerance.	Effective Clinical Care
XDEGH	Medicare Physician Quality Reporting System	Appropriate Use of DXA Scans in Women Under 65 Who Do Not Meet the Risk Factor Profile	Efficiency and Cost Reduction
XDFCB	Medicare Physician Quality Reporting System	Appropriate use of imaging for non-traumatic knee pain	Efficiency and Cost Reduction
XDFCA	Medicare Physician Quality Reporting System	Appropriate use of imaging for non-traumatic shoulder pain	Efficiency and Cost Reduction
XDFHD	Medicare Physician Quality Reporting System	Assessment and Classification of Disease Activity	Effective Clinical Care
XDFLD	Medicare Physician Quality Reporting System	Average change in functional status following lumbar spine fusion surgery	Effective Clinical Care
XDFDL	Medicare Physician Quality Reporting System	Avoidance of inappropriate use of head CT in ED patients with minor head injury	Efficiency and Cost Reduction
XDFGF	Medicare Physician Quality Reporting System	Avoidance of inappropriate use of imaging for adult ED patients with atraumatic low back pain	Efficiency and Cost Reduction
XAHDG	Medicare Physician Quality Reporting System	Bleeding Outcomes Related to Oral Anticoagulants	Patient Safety

MUC ID	CMS Program	Measure Title	CMS Domain
XDFEH	Medicare Physician Quality Reporting System	Bone Mineral Density (BMD) & Fracture Risk	Effective Clinical Care
XDFAG	Medicare Physician Quality Reporting System	Cataract Surgery with Intra-Operative Complications (Unplanned Rupture of Posterior Capsule requiring unplanned vitrectomy)	Patient Safety
XDFAM	Medicare Physician Quality Reporting System	Cataract Surgery: Difference Between Planned and Final Refraction	Effective Clinical Care
E0005	Medicare Physician Quality Reporting System	CG CAHPS Supplemental and new Items : Between Visit Communication	Communication and Care Coordination
E0005	Medicare Physician Quality Reporting System	CG CAHPS Supplemental Item : Educating Patient about Medication Adherence	Communication and Care Coordination
E0005	Medicare Physician Quality Reporting System	CG CAHPS: Courteous & Helpful Office Staff	Communication and Care Coordination
E0005	Medicare Physician Quality Reporting System	CG CAHPS: Supplemental Item Care Coordination	Communication and Care Coordination
E0005	Medicare Physician Quality Reporting System	CG CAHPS: Supplemental Item Stewardship of Patient Resources	Communication and Care Coordination
XDFCF	Medicare Physician Quality Reporting System	Composite measure: 1) Appropriate follow-up imaging for incidental liver lesions	Communication and Care Coordination
XDFCG	Medicare Physician Quality Reporting System	Composite measure: 2) Appropriate follow-up imaging for incidental kidney lesions composite measure	Communication and Care Coordination
XDFCH	Medicare Physician Quality Reporting System	Composite measure: 3) Appropriate follow-up imaging for incidental adrenal lesions composite measure	Communication and Care Coordination

MUC ID	CMS Program	Measure Title	CMS Domain
S1884	Medicare Physician Quality Reporting System	Depression Response at Six Months- Progress Towards Remission	Effective Clinical Care
S1885	Medicare Physician Quality Reporting System	Depression Response at Twelve Months- Progress Towards Remission	Effective Clinical Care
E1399	Medicare Physician Quality Reporting System	Developmental Screening - Age 1	Effective Clinical Care
E1399	Medicare Physician Quality Reporting System	Developmental Screening - Age 2	Effective Clinical Care
E1399	Medicare Physician Quality Reporting System	Developmental Screening - Age 3	Effective Clinical Care
XDFBF	Medicare Physician Quality Reporting System	Discontinuation of Antiviral Therapy for Inadequate Viral Response	Efficiency and Cost Reduction
XDFBG	Medicare Physician Quality Reporting System	Discussion and Shared Decision Making Surrounding Treatment Options	Person and Caregiver-Centered Experience
XDELF	Medicare Physician Quality Reporting System	DRAFT: ADE Prevention and Monitoring: Minimum INR Monitoring for Patients with Atrial Fibrillation on Warfarin	Patient Safety
XDELE	Medicare Physician Quality Reporting System	DRAFT: ADE Prevention and Monitoring: Warfarin Time in Therapeutic Range	Patient Safety
XDCLD	Medicare Physician Quality Reporting System	DRAFT: Closing the Referral Loop - Critical Information Communicated with Request for Referral	Communication and Care Coordination
XDDAC	Medicare Physician Quality Reporting System	DRAFT: Closing the Referral Loop - Specialist Report Sent to Primary Care Physician	Communication and Care Coordination
XDELB	Medicare Physician Quality Reporting System	DRAFT: Functional Status Assessment and Goal Achievement for	Person and Caregiver-Centered Experience

MUC ID	CMS Program	Measure Title	CMS Domain
		Patients with Congestive Heart Failure	
XDELD	Medicare Physician Quality Reporting System	DRAFT: Functional Status Assessment and Improvement for Patients who Received a Total Hip Replacement	Effective Clinical Care
XDELC	Medicare Physician Quality Reporting System	DRAFT: Functional Status Assessment and Improvement for Patients who Received a Total Knee Replacement	Effective Clinical Care
XDEHF	Medicare Physician Quality Reporting System	DRAFT: Substance Use Screening and Intervention Composite	Effective Clinical Care
XDEHE	Medicare Physician Quality Reporting System	DRAFT: Tobacco Use and Help with Quitting Among Adolescents	Effective Clinical Care
XDAFC	Medicare Physician Quality Reporting System	Functional Status Assessment and Goal Setting in Patients with Rheumatoid Arthritis	Person and Caregiver-Centered Experience
XDBGL	Medicare Physician Quality Reporting System	Functional Status Assessments and Goal Setting for Patients with Asthma	Person and Caregiver-Centered Experience
XDBGM	Medicare Physician Quality Reporting System	Functional Status Assessments and Goal Setting for Patients with Chronic Obstructive Pulmonary Disease	Person and Caregiver-Centered Experience
E2080	Medicare Physician Quality Reporting System	Gap in HIV medical visits	Community/Population Health
XDFDB	Medicare Physician Quality Reporting System	Head and Neck Cancer: Weight Loss Prevention	Effective Clinical Care
E0475	Medicare Physician Quality Reporting System	Hepatitis B Vaccine Coverage Among All Live Newborn Infants Prior to Hospital or Birthing Facility Discharge	Effective Clinical Care
XDEMB	Medicare Physician Quality Reporting System	High-Acuity Care Visits after Outpatient Cataract Procedure	Patient Safety

MUC ID	CMS Program	Measure Title	CMS Domain
XDEMA	Medicare Physician Quality Reporting System	High-Acuity Care Visits after Outpatient Colonoscopy Procedure	Patient Safety
XDELM	Medicare Physician Quality Reporting System	High-Acuity Care Visits after Outpatient Endoscopy Procedure	Patient Safety
XDFHF	Medicare Physician Quality Reporting System	History of Fragility Fracture with Prednisone Use	Effective Clinical Care
E2079	Medicare Physician Quality Reporting System	HIV medical visit frequency	Community/Population Health
E2082	Medicare Physician Quality Reporting System	HIV viral load suppression	Effective Clinical Care
XBGDL	Medicare Physician Quality Reporting System	Hospital 30-Day All-Cause Risk-Standardized Readmission Rate (RSRR) following Vascular Procedures	Communication and Care Coordination
XDEEL	Medicare Physician Quality Reporting System	Hospital 30-day Risk-standardized Acute Myocardial Infarction (AMI) Mortality eMeasure	Patient Safety
XDEEH	Medicare Physician Quality Reporting System	Hospital 30-day, all-cause, risk-standardized mortality rate (RSMR) following Coronary Artery Bypass Graft (CABG) surgery	Patient Safety
XBELG	Medicare Physician Quality Reporting System	Hospital 30-day, all-cause, unplanned, risk-standardized readmission rate (RSRR) following Coronary artery Bypass Graft (CABG) Surgery	Communication and Care Coordination
XDELH	Medicare Physician Quality Reporting System	Hospital-level, risk-standardized 30-day episode-of-care payment measure for heart failure	Efficiency and Cost Reduction
XDELG	Medicare Physician Quality Reporting System	Hospital-level, risk-standardized 30-day episode-of-care	Efficiency and Cost Reduction

MUC ID	CMS Program	Measure Title	CMS Domain
		payment measure for pneumonia	
XCLLL	Medicare Physician Quality Reporting System	HRS-12: Cardiac Tamponade and/or Pericardiocentesis Following Atrial Fibrillation Ablation	Patient Safety
XCLMD	Medicare Physician Quality Reporting System	HRS-9: Infection within 180 Days of Cardiac Implantable Electronic Device (CIED) Implantation, Replacement, or Revision	Patient Safety
E1959	Medicare Physician Quality Reporting System	Immunizations by 13 years of age - HPV	Effective Clinical Care
E1407	Medicare Physician Quality Reporting System	Immunizations by 13 years of age- Meningococcus, Tetanus, and Diphtheria	Effective Clinical Care
XDFGE	Medicare Physician Quality Reporting System	Inpatient Psychiatric Facility Routinely Assesses Patient Experience of Care	Person and Caregiver-Centered Experience
XDFGD	Medicare Physician Quality Reporting System	IPF Alcohol Use Screening completed within one day of admission	Effective Clinical Care
XDFGC	Medicare Physician Quality Reporting System	IPF Drug Use Screening completed within one day of admission	Effective Clinical Care
E0662	Medicare Physician Quality Reporting System	Median Time to Pain Management for Long Bone Fracture (OP-21/NQF-0662)	Effective Clinical Care
XDFCM	Medicare Physician Quality Reporting System	Minimum antimicrobial therapy for Staph A. - For adult patients with Staphylococcus aureus bacteremia, the minimum duration of antimicrobial therapy is 14 days.	Efficiency and Cost Reduction
XDFLL	Medicare Physician Quality Reporting	National Institutes of Health Stroke Scale	Effective Clinical Care

MUC ID	CMS Program	Measure Title	CMS Domain
	System	(NIHSS) for ED patients	
XDFLE	Medicare Physician Quality Reporting System	Optimal Asthma Care-Control Component	Effective Clinical Care
XDCMD	Medicare Physician Quality Reporting System	Oral Health: Children aged 6-9 years who receive sealants in the first permanent molar	Effective Clinical Care
XDCME	Medicare Physician Quality Reporting System	Oral Health: Children who receive a comprehensive or periodic oral evaluation in two consecutive years	Community/Population Health
XDFEF	Medicare Physician Quality Reporting System	Osteoporotic Fracture Risk	Effective Clinical Care
XDAFA	Medicare Physician Quality Reporting System	Overuse of Diagnostic Imaging for Uncomplicated Headache	Efficiency and Cost Reduction
E0471	Medicare Physician Quality Reporting System	PC-02 Cesarean Section	Community/Population Health
E0465	Medicare Physician Quality Reporting System	Perioperative Anti-platelet Therapy for Patients undergoing Carotid Endarterectomy	Effective Clinical Care
XDEME	Medicare Physician Quality Reporting System	Post-procedural Optimal medical therapy Composite (percutaneous coronary intervention)	Effective Clinical Care
XDFEG	Medicare Physician Quality Reporting System	Prednisone Use with Anabolic Agent	Effective Clinical Care
E2083	Medicare Physician Quality Reporting System	Prescription of HIV antiretroviral therapy	Effective Clinical Care
XDFBM	Medicare Physician Quality Reporting System	Radiation Consideration for Adult CT: Utilization of Dose Lowering Techniques	Patient Safety
XDFDH	Medicare Physician Quality Reporting System	Recurrence or amputation following endovascular	Effective Clinical Care

MUC ID	CMS Program	Measure Title	CMS Domain
		infrainquinal lower extremity revascularization	
XDFDG	Medicare Physician Quality Reporting System	Recurrence or amputation following open infrainquinal lower extremity revascularization	Effective Clinical Care
XCMDH	Medicare Physician Quality Reporting System	Reduction of complications through the use of cystoscopy during surgery for stress urinary incontinence	Patient Safety
XDFBE	Medicare Physician Quality Reporting System	Referral to Treatment for Patients Identified with Hepatitis C Virus (HCV) Infection	Effective Clinical Care
XDFGL	Medicare Physician Quality Reporting System	Repeat Colonoscopy due to poor bowel preparation	Efficiency and Cost Reduction
E1507	Medicare Physician Quality Reporting System	Risky Behavior Assessment or Counseling by Age 18 Years	Effective Clinical Care
XDFBC	Medicare Physician Quality Reporting System	Screening for Hepatitis C Virus (HCV) for Patients at High Risk	Effective Clinical Care
XDFBH	Medicare Physician Quality Reporting System	Screening for Hepatocellular Carcinoma (HCC) in patients with Hepatitis C Cirrhosis	Effective Clinical Care
XDFHE	Medicare Physician Quality Reporting System	Tuberculosis Screening Prior to First Course Biologic Disease Modifying Anti-Rheumatic Drug (DMARD) Therapy	Patient Safety
XDFCC	Medicare Physician Quality Reporting System	Use of premedication before contrast-enhanced imaging studies in patients with documented contrast allergy	Effective Clinical Care
XDFBL	Medicare Physician Quality Reporting	Utilization of ultrasonography in	Efficiency and Cost Reduction

MUC ID	CMS Program	Measure Title	CMS Domain
	System	children with clinically suspected appendicitis	

Medicare Shared Savings MUC 2013

MUC ID	CMS Program	Measure Title	CMS Domain
XDEMF	Medicare Shared Savings	ACORN Adult Outcome Questionnaire	Effective Clinical Care
XAHDH	Medicare Shared Savings	Adherence to Antiplatelet Treatment after Stent Implantation	Effective Clinical Care
E1879	Medicare Shared Savings	Adherence to Antipsychotic Medications for Individuals with Schizophrenia	Effective Clinical Care
E0545	Medicare Shared Savings	Adherence to Chronic Medications for Individuals with Diabetes Mellitus	Effective Clinical Care
S1880	Medicare Shared Savings	Adherence to Mood Stabilizers for Individuals with Bipolar I Disorder	Effective Clinical Care
E0543	Medicare Shared Savings	Adherence to Statin Therapy for Individuals with Coronary Artery Disease	Effective Clinical Care
XDFAL	Medicare Shared Savings	Adult Primary Rhegmatogenous Retinal Detachment Reoperation Rate	Effective Clinical Care
XDFAH	Medicare Shared Savings	Adult Primary Rhegmatogenous Retinal Detachment Surgery Success Rate	Effective Clinical Care
XDBCB	Medicare Shared Savings	Adverse Drug Events - Hyperglycemia	Patient Safety
XDBGA	Medicare Shared Savings	Adverse Drug Events - Hypoglycemia	Patient Safety
XDBBL	Medicare Shared Savings	All-Cause Unplanned Admissions for Patients with Diabetes	Communication and Care Coordination

MUC ID	CMS Program	Measure Title	CMS Domain
XDBBG	Medicare Shared Savings	All-Cause Unplanned Admissions for Patients with Heart Failure	Communication and Care Coordination
XDBBM	Medicare Shared Savings	All-Cause Unplanned Admissions for Patients with Multiple Chronic Conditions	Communication and Care Coordination
XCLAL	Medicare Shared Savings	ALS Patient Care Preferences	Person and Caregiver-Centered Experience
XDFBD	Medicare Shared Savings	Annual Hepatitis C Virus (HCV) Screening for Patients who are Active Injection Drug Users	Effective Clinical Care
XDAEB	Medicare Shared Savings	Annual Wellness Assessment: Assessment of Health Risks	Effective Clinical Care
XDBHA	Medicare Shared Savings	Annual Wellness Assessment: Goal-Setting to Reduce Identified Risks	Person and Caregiver-Centered Experience
XDAEC	Medicare Shared Savings	Annual Wellness Assessment: Management of Health Risks	Effective Clinical Care
XDBGH	Medicare Shared Savings	Annual Wellness Assessment: Reduction of Health Risks	Effective Clinical Care
XDFGM	Medicare Shared Savings	Appropriate age for colorectal cancer screening colonoscopy	Efficiency and Cost Reduction
XDFCL	Medicare Shared Savings	Appropriate follow-up imaging for incidental simple ovarian cysts	Efficiency and Cost Reduction
XDFCE	Medicare Shared Savings	Appropriate follow-up imaging for incidental thyroid nodules in patients	Communication and Care Coordination
XDFDA	Medicare Shared	Appropriate in vitro susceptibility testing -	Effective Clinical Care

MUC ID	CMS Program	Measure Title	CMS Domain
	Savings	The agent(s) used for definitive therapy in invasive staphylococcal disease should be confirmed by in vitro susceptibility testing as interpreted by the Clinical Laboratory and Standards Institute (CLSI) to be active against the clinical isolate.	
XDAEA	Medicare Shared Savings	Appropriate Monitoring of patients receiving an Opioid via an IV Patient Controlled Analgesia Device	Patient Safety
XDFHL	Medicare Shared Savings	Appropriate Treatment of MSSA - For MSSA bacteremia, a β-lactam antibiotic is the drug of choice in the hospitalized patient in the absence of a documented allergy or drug intolerance.	Effective Clinical Care
XDFCB	Medicare Shared Savings	Appropriate use of imaging for non-traumatic knee pain	Efficiency and Cost Reduction
XDFCA	Medicare Shared Savings	Appropriate use of imaging for non-traumatic shoulder pain	Efficiency and Cost Reduction
XDFHD	Medicare Shared Savings	Assessment and Classification of Disease Activity	Effective Clinical Care
XDFLD	Medicare Shared Savings	Average change in functional status following lumbar spine fusion surgery	Effective Clinical Care
XDFDL	Medicare Shared	Avoidance of inappropriate use of	Efficiency and Cost Reduction

MUC ID	CMS Program	Measure Title	CMS Domain
	Savings	head CT in ED patients with minor head injury	
XDFGF	Medicare Shared Savings	Avoidance of inappropriate use of imaging for adult ED patients with atraumatic low back pain	Efficiency and Cost Reduction
XAHDG	Medicare Shared Savings	Bleeding Outcomes Related to Oral Anticoagulants	Patient Safety
XDFEH	Medicare Shared Savings	Bone Mineral Density (BMD) & Fracture Risk	Effective Clinical Care
XDFAG	Medicare Shared Savings	Cataract Surgery with Intra-Operative Complications (Unplanned Rupture of Posterior Capsule requiring unplanned vitrectomy)	Patient Safety
XDFAM	Medicare Shared Savings	Cataract Surgery: Difference Between Planned and Final Refraction	Effective Clinical Care
E0005	Medicare Shared Savings	CG CAHPS Supplemental and new Items : Between Visit Communication	Communication and Care Coordination
E0005	Medicare Shared Savings	CG CAHPS Supplemental Item : Educating Patient about Medication Adherence	Communication and Care Coordination
E0005	Medicare Shared Savings	CG CAHPS: Courteous & Helpful Office Staff	Communication and Care Coordination
E0005	Medicare Shared Savings	CG CAHPS: Supplemental Item Care Coordination	Communication and Care Coordination
E0005	Medicare Shared Savings	CG CAHPS: Supplemental Item Stewardship of Patient Resources	Communication and Care Coordination

MUC ID	CMS Program	Measure Title	CMS Domain
XDFCF	Medicare Shared Savings	Composite measure: 1) Appropriate follow-up imaging for incidental liver lesions	Communication and Care Coordination
XDFCG	Medicare Shared Savings	Composite measure: 2) Appropriate follow-up imaging for incidental kidney lesions composite measure	Communication and Care Coordination
XDFCH	Medicare Shared Savings	Composite measure: 3) Appropriate follow-up imaging for incidental adrenal lesions composite measure	Communication and Care Coordination
S1884	Medicare Shared Savings	Depression Response at Six Months-Progress Towards Remission	Effective Clinical Care
S1885	Medicare Shared Savings	Depression Response at Twelve Months-Progress Towards Remission	Effective Clinical Care
XDFBF	Medicare Shared Savings	Discontinuation of Antiviral Therapy for Inadequate Viral Response	Efficiency and Cost Reduction
XDFBG	Medicare Shared Savings	Discussion and Shared Decision Making Surrounding Treatment Options	Person and Caregiver-Centered Experience
XDELF	Medicare Shared Savings	DRAFT: ADE Prevention and Monitoring: Minimum INR Monitoring for Patients with Atrial Fibrillation on Warfarin	Patient Safety
XDELE	Medicare Shared Savings	DRAFT: ADE Prevention and Monitoring: Warfarin Time in Therapeutic Range	Patient Safety
XDCLD	Medicare	DRAFT: Closing the	Communication and Care Coordination

MUC ID	CMS Program	Measure Title	CMS Domain
	Shared Savings	Referral Loop - Critical Information Communicated with Request for Referral	
XDDAC	Medicare Shared Savings	DRAFT: Closing the Referral Loop - Specialist Report Sent to Primary Care Physician	Communication and Care Coordination
XDELB	Medicare Shared Savings	DRAFT: Functional Status Assessment and Goal Achievement for Patients with Congestive Heart Failure	Person and Caregiver-Centered Experience
XDELD	Medicare Shared Savings	DRAFT: Functional Status Assessment and Improvement for Patients who Received a Total Hip Replacement	Effective Clinical Care
XDELC	Medicare Shared Savings	DRAFT: Functional Status Assessment and Improvement for Patients who Received a Total Knee Replacement	Effective Clinical Care
XDEHF	Medicare Shared Savings	DRAFT: Substance Use Screening and Intervention Composite	Effective Clinical Care
E0576	Medicare Shared Savings	Follow-up after hospitalization for a mental illness	Effective Clinical Care
XDAFC	Medicare Shared Savings	Functional Status Assessment and Goal Setting in Patients with Rheumatoid Arthritis	Person and Caregiver-Centered Experience
XDBGL	Medicare Shared Savings	Functional Status Assessments and Goal Setting for Patients with Asthma	Person and Caregiver-Centered Experience
XDBGM	Medicare	Functional Status	Person and Caregiver-Centered Experience

MUC ID	CMS Program	Measure Title	CMS Domain
	Shared Savings	Assessments and Goal Setting for Patients with Chronic Obstructive Pulmonary Disease	
E2080	Medicare Shared Savings	Gap in HIV medical visits	Community/Population Health
XDFDB	Medicare Shared Savings	Head and Neck Cancer: Weight Loss Prevention	Effective Clinical Care
XDEMB	Medicare Shared Savings	High-Acuity Care Visits after Outpatient Cataract Procedure	Patient Safety
XDEMA	Medicare Shared Savings	High-Acuity Care Visits after Outpatient Colonoscopy Procedure	Patient Safety
XDELM	Medicare Shared Savings	High-Acuity Care Visits after Outpatient Endoscopy Procedure	Patient Safety
E2079	Medicare Shared Savings	HIV medical visit frequency	Community/Population Health
E2082	Medicare Shared Savings	HIV viral load suppression	Effective Clinical Care
XBGDL	Medicare Shared Savings	Hospital 30-Day All-Cause Risk-Standardized Readmission Rate (RSRR) following Vascular Procedures	Communication and Care Coordination
XDEEL	Medicare Shared Savings	Hospital 30-day Risk-standardized Acute Myocardial Infarction (AMI) Mortality eMeasure	Patient Safety
XDEEH	Medicare Shared Savings	Hospital 30-day, all-cause, risk-standardized mortality rate (RSMR) following Coronary Artery Bypass Graft (CABG) surgery	Patient Safety

MUC ID	CMS Program	Measure Title	CMS Domain
XBELG	Medicare Shared Savings	Hospital 30-day, all-cause, unplanned, risk-standardized readmission rate (RSRR) following Coronary artery Bypass Graft (CABG) Surgery	Communication and Care Coordination
XDELH	Medicare Shared Savings	Hospital-level, risk-standardized 30-day episode-of-care payment measure for heart failure	Efficiency and Cost Reduction
XDELG	Medicare Shared Savings	Hospital-level, risk-standardized 30-day episode-of-care payment measure for pneumonia	Efficiency and Cost Reduction
XCLLL	Medicare Shared Savings	HRS-12: Cardiac Tamponade and/or Pericardiocentesis Following Atrial Fibrillation Ablation	Patient Safety
XCLMD	Medicare Shared Savings	HRS-9: Infection within 180 Days of Cardiac Implantable Electronic Device (CIED) Implantation, Replacement, or Revision	Patient Safety
XDFGE	Medicare Shared Savings	Inpatient Psychiatric Facility Routinely Assesses Patient Experience of Care	Person and Caregiver-Centered Experience
E0556	Medicare Shared Savings	INR for individuals taking warfarin and interacting anti-infective medications	Patient Safety
XDFGD	Medicare Shared Savings	IPF Alcohol Use Screening completed within one day of admission	Effective Clinical Care
XDFGC	Medicare Shared	IPF Drug Use Screening completed	Effective Clinical Care

MUC ID	CMS Program	Measure Title	CMS Domain
	Savings	within one day of admission	
E0555	Medicare Shared Savings	Lack of Monthly INR Monitoring for Individuals on Warfarin	Patient Safety
E0662	Medicare Shared Savings	Median Time to Pain Management for Long Bone Fracture (OP-21/NQF-0662)	Effective Clinical Care
XDFCM	Medicare Shared Savings	Minimum antimicrobial therapy for Staph A. - For adult patients with Staphylococcus aureus bacteremia, the minimum duration of antimicrobial therapy is 14 days.	Efficiency and Cost Reduction
XDFLL	Medicare Shared Savings	National Institutes of Health Stroke Scale (NIHSS) for ED patients	Effective Clinical Care
E0053	Medicare Shared Savings	Osteoporosis management in women who had a fracture	Effective Clinical Care
E0046	Medicare Shared Savings	Osteoporosis: Screening or Therapy for Women Aged 65 Years and Older	Effective Clinical Care
XDFEF	Medicare Shared Savings	Osteoporotic Fracture Risk	Effective Clinical Care
XDAFA	Medicare Shared Savings	Overuse of Diagnostic Imaging for Uncomplicated Headache	Efficiency and Cost Reduction
E0465	Medicare Shared Savings	Perioperative Anti-platelet Therapy for Patients undergoing Carotid Endarterectomy	Effective Clinical Care
XDEME	Medicare	Post-procedural	Effective Clinical Care

MUC ID	CMS Program	Measure Title	CMS Domain
	Shared Savings	Optimal medical therapy Composite (percutaneous coronary intervention)	
XDFEG	Medicare Shared Savings	Prednisone Use with Anabolic Agent	Effective Clinical Care
E2083	Medicare Shared Savings	Prescription of HIV antiretroviral therapy	Effective Clinical Care
XDFBM	Medicare Shared Savings	Radiation Consideration for Adult CT: Utilization of Dose Lowering Techniques	Patient Safety
XDFDH	Medicare Shared Savings	Recurrence or amputation following endovascular infrainquinal lower extremity revascularization	Effective Clinical Care
XDFDG	Medicare Shared Savings	Recurrence or amputation following open infrainquinal lower extremity revascularization	Effective Clinical Care
XCMDH	Medicare Shared Savings	Reduction of complications through the use of cystoscopy during surgery for stress urinary incontinence	Patient Safety
XDFBE	Medicare Shared Savings	Referral to Treatment for Patients Identified with Hepatitis C Virus (HCV) Infection	Effective Clinical Care
XDFGL	Medicare Shared Savings	Repeat Colonoscopy due to poor bowel preparation	Efficiency and Cost Reduction
XDFBC	Medicare Shared Savings	Screening for Hepatitis C Virus (HCV) for Patients at High Risk	Effective Clinical Care
XDFBH	Medicare	Screening for	Effective Clinical Care

MUC ID	CMS Program	Measure Title	CMS Domain
	Shared Savings	Hepatocellular Carcinoma (HCC) in patients with Hepatitis C Cirrhosis	
XDFHE	Medicare Shared Savings	Tuberculosis Screening Prior to First Course Biologic Disease Modifying Anti-Rheumatic Drug (DMARD) Therapy	Patient Safety
XDFCC	Medicare Shared Savings	Use of premedication before contrast-enhanced imaging studies in patients with documented contrast allergy	Effective Clinical Care

Physician Compare MUC 2013

MUC ID	CMS Program	Measure Title	CMS Domain
XDEMG	Physician Compare	ACORN Adolescent (Youth) Outcome Questionnaire	Effective Clinical Care
XDEMF	Physician Compare	ACORN Adult Outcome Questionnaire	Effective Clinical Care
XAHDH	Physician Compare	Adherence to Antiplatelet Treatment after Stent Implantation	Effective Clinical Care
E1879	Physician Compare	Adherence to Antipsychotic Medications for Individuals with Schizophrenia	Effective Clinical Care
E0545	Physician Compare	Adherence to Chronic Medications for Individuals with Diabetes Mellitus	Effective Clinical Care
S1880	Physician Compare	Adherence to Mood Stabilizers for Individuals with Bipolar I Disorder	Effective Clinical Care
XDFAL	Physician Compare	Adult Primary Rhegmatogenous Retinal Detachment Reoperation Rate	Effective Clinical Care
XDFAH	Physician Compare	Adult Primary Rhegmatogenous Retinal Detachment Surgery Success Rate	Effective Clinical Care
XDBCB	Physician Compare	Adverse Drug Events - Hyperglycemia	Patient Safety
XDBGA	Physician Compare	Adverse Drug Events - Hypoglycemia	Patient Safety
XDBBL	Physician Compare	All-Cause Unplanned Admissions for Patients with Diabetes	Communication and Care Coordination
XDBBG	Physician Compare	All-Cause Unplanned Admissions for Patients with Heart Failure	Communication and Care Coordination
XDBBM	Physician Compare	All-Cause Unplanned Admissions for Patients with Multiple Chronic Conditions	Communication and Care Coordination
XCLAL	Physician Compare	ALS Patient Care	Person and Caregiver-Centered Experience

MUC ID	CMS Program	Measure Title	CMS Domain
		Preferences	
XDFBD	Physician Compare	Annual Hepatitis C Virus (HCV) Screening for Patients who are Active Injection Drug Users	Effective Clinical Care
XDAEB	Physician Compare	Annual Wellness Assessment: Assessment of Health Risks	Effective Clinical Care
XDBHA	Physician Compare	Annual Wellness Assessment: Goal-Setting to Reduce Identified Risks	Person and Caregiver-Centered Experience
XDAEC	Physician Compare	Annual Wellness Assessment: Management of Health Risks	Effective Clinical Care
XDBGH	Physician Compare	Annual Wellness Assessment: Reduction of Health Risks	Effective Clinical Care
XDFGM	Physician Compare	Appropriate age for colorectal cancer screening colonoscopy	Efficiency and Cost Reduction
XDFCL	Physician Compare	Appropriate follow-up imaging for incidental simple ovarian cysts	Efficiency and Cost Reduction
XDFCE	Physician Compare	Appropriate follow-up imaging for incidental thyroid nodules in patients	Communication and Care Coordination
XDFDA	Physician Compare	Appropriate in vitro susceptibility testing - The agent(s) used for definitive therapy in invasive staphylococcal disease should be confirmed by in vitro susceptibility testing as interpreted by the Clinical Laboratory and Standards Institute (CLSI) to be active against the clinical isolate.	Effective Clinical Care
XDAEA	Physician Compare	Appropriate Monitoring of patients receiving an	Patient Safety

MUC ID	CMS Program	Measure Title	CMS Domain
		Opioid via an IV Patient Controlled Analgesia Device	
XDFHL	Physician Compare	Appropriate Treatment of MSSA - For MSSA bacteremia, a β-lactam antibiotic is the drug of choice in the hospitalized patient in the absence of a documented allergy or drug intolerance.	Effective Clinical Care
XDEGH	Physician Compare	Appropriate Use of DXA Scans in Women Under 65 Who Do Not Meet the Risk Factor Profile	Efficiency and Cost Reduction
XDFCB	Physician Compare	Appropriate use of imaging for non-traumatic knee pain	Efficiency and Cost Reduction
XDFCA	Physician Compare	Appropriate use of imaging for non-traumatic shoulder pain	Efficiency and Cost Reduction
XDFHD	Physician Compare	Assessment and Classification of Disease Activity	Effective Clinical Care
XDFLD	Physician Compare	Average change in functional status following lumbar spine fusion surgery	Effective Clinical Care
XDFDL	Physician Compare	Avoidance of inappropriate use of head CT in ED patients with minor head injury	Efficiency and Cost Reduction
XDFGF	Physician Compare	Avoidance of inappropriate use of imaging for adult ED patients with atraumatic low back pain	Efficiency and Cost Reduction
XAHDG	Physician Compare	Bleeding Outcomes Related to Oral Anticoagulants	Patient Safety
XDFEH	Physician Compare	Bone Mineral Density (BMD) & Fracture Risk	Effective Clinical Care
XDFAG	Physician Compare	Cataract Surgery with Intra-Operative Complications	Patient Safety

MUC ID	CMS Program	Measure Title	CMS Domain
		(Unplanned Rupture of Posterior Capsule requiring unplanned vitrectomy)	
XDFAM	Physician Compare	Cataract Surgery: Difference Between Planned and Final Refraction	Effective Clinical Care
E0005	Physician Compare	CG CAHPS Supplemental and new Items : Between Visit Communication	Communication and Care Coordination
E0005	Physician Compare	CG CAHPS Supplemental Item : Educating Patient about Medication Adherence	Communication and Care Coordination
E0005	Physician Compare	CG CAHPS: Courteous & Helpful Office Staff	Communication and Care Coordination
E0005	Physician Compare	CG CAHPS: Supplemental Item Care Coordination	Communication and Care Coordination
E0005	Physician Compare	CG CAHPS: Supplemental Item Stewardship of Patient Resources	Communication and Care Coordination
XDFCF	Physician Compare	Composite measure: 1) Appropriate follow-up imaging for incidental liver lesions	Communication and Care Coordination
XDFCG	Physician Compare	Composite measure: 2) Appropriate follow-up imaging for incidental kidney lesions composite measure	Communication and Care Coordination
XDFCH	Physician Compare	Composite measure: 3) Appropriate follow-up imaging for incidental adrenal lesions composite measure	Communication and Care Coordination
S1884	Physician Compare	Depression Response at Six Months- Progress Towards Remission	Effective Clinical Care
S1885	Physician Compare	Depression Response at Twelve Months- Progress Towards Remission	Effective Clinical Care

MUC ID	CMS Program	Measure Title	CMS Domain
E1399	Physician Compare	Developmental Screening - Age 1	Effective Clinical Care
E1399	Physician Compare	Developmental Screening - Age 2	Effective Clinical Care
E1399	Physician Compare	Developmental Screening - Age 3	Effective Clinical Care
XDFBF	Physician Compare	Discontinuation of Antiviral Therapy for Inadequate Viral Response	Efficiency and Cost Reduction
XDFBG	Physician Compare	Discussion and Shared Decision Making Surrounding Treatment Options	Person and Caregiver-Centered Experience
XDELF	Physician Compare	DRAFT: ADE Prevention and Monitoring: Minimum INR Monitoring for Patients with Atrial Fibrillation on Warfarin	Patient Safety
XDELE	Physician Compare	DRAFT: ADE Prevention and Monitoring: Warfarin Time in Therapeutic Range	Patient Safety
XDCLD	Physician Compare	DRAFT: Closing the Referral Loop - Critical Information Communicated with Request for Referral	Communication and Care Coordination
XDDAC	Physician Compare	DRAFT: Closing the Referral Loop - Specialist Report Sent to Primary Care Physician	Communication and Care Coordination
XDELB	Physician Compare	DRAFT: Functional Status Assessment and Goal Achievement for Patients with Congestive Heart Failure	Person and Caregiver-Centered Experience
XDELD	Physician Compare	DRAFT: Functional Status Assessment and Improvement for Patients who Received a Total Hip Replacement	Effective Clinical Care
XDELC	Physician Compare	DRAFT: Functional Status Assessment and Improvement for	Effective Clinical Care

MUC ID	CMS Program	Measure Title	CMS Domain
		Patients who Received a Total Knee Replacement	
XDEHF	Physician Compare	DRAFT: Substance Use Screening and Intervention Composite	Effective Clinical Care
XDEHE	Physician Compare	DRAFT: Tobacco Use and Help with Quitting Among Adolescents	Effective Clinical Care
XDAFC	Physician Compare	Functional Status Assessment and Goal Setting in Patients with Rheumatoid Arthritis	Person and Caregiver-Centered Experience
XDBGL	Physician Compare	Functional Status Assessments and Goal Setting for Patients with Asthma	Person and Caregiver-Centered Experience
XDBGM	Physician Compare	Functional Status Assessments and Goal Setting for Patients with Chronic Obstructive Pulmonary Disease	Person and Caregiver-Centered Experience
E2080	Physician Compare	Gap in HIV medical visits	Community/Population Health
XDFDB	Physician Compare	Head and Neck Cancer: Weight Loss Prevention	Effective Clinical Care
E0475	Physician Compare	Hepatitis B Vaccine Coverage Among All Live Newborn Infants Prior to Hospital or Birthing Facility Discharge	Effective Clinical Care
XDEMB	Physician Compare	High-Acuity Care Visits after Outpatient Cataract Procedure	Patient Safety
XDEMA	Physician Compare	High-Acuity Care Visits after Outpatient Colonoscopy Procedure	Patient Safety
XDELM	Physician Compare	High-Acuity Care Visits after Outpatient Endoscopy Procedure	Patient Safety
XDFHF	Physician Compare	History of Fragility Fracture with Prednisone Use	Effective Clinical Care
E2079	Physician Compare	HIV medical visit frequency	Community/Population Health
E2082	Physician Compare	HIV viral load suppression	Effective Clinical Care

MUC ID	CMS Program	Measure Title	CMS Domain
XBGDL	Physician Compare	Hospital 30-Day All-Cause Risk-Standardized Readmission Rate (RSRR) following Vascular Procedures	Communication and Care Coordination
XDEEL	Physician Compare	Hospital 30-day Risk-standardized Acute Myocardial Infarction (AMI) Mortality eMeasure	Patient Safety
XDEEH	Physician Compare	Hospital 30-day, all-cause, risk-standardized mortality rate (RSMR) following Coronary Artery Bypass Graft (CABG) surgery	Patient Safety
XBELG	Physician Compare	Hospital 30-day, all-cause, unplanned, risk-standardized readmission rate (RSRR) following Coronary artery Bypass Graft (CABG) Surgery	Communication and Care Coordination
XDELH	Physician Compare	Hospital-level, risk-standardized 30-day episode-of-care payment measure for heart failure	Efficiency and Cost Reduction
XDELG	Physician Compare	Hospital-level, risk-standardized 30-day episode-of-care payment measure for pneumonia	Efficiency and Cost Reduction
XCLLL	Physician Compare	HRS-12: Cardiac Tamponade and/or Pericardiocentesis Following Atrial Fibrillation Ablation	Patient Safety
XCLMD	Physician Compare	HRS-9: Infection within 180 Days of Cardiac Implantable Electronic Device (CIED) Implantation, Replacement, or Revision	Patient Safety

MUC ID	CMS Program	Measure Title	CMS Domain
E1959	Physician Compare	Immunizations by 13 years of age - HPV	Effective Clinical Care
E1407	Physician Compare	Immunizations by 13 years of age-Meningococcus, Tetanus, and Diphtheria	Effective Clinical Care
XDFGE	Physician Compare	Inpatient Psychiatric Facility Routinely Assesses Patient Experience of Care	Person and Caregiver-Centered Experience
XDFGD	Physician Compare	IPF Alcohol Use Screening completed within one day of admission	Effective Clinical Care
XDFGC	Physician Compare	IPF Drug Use Screening completed within one day of admission	Effective Clinical Care
E0662	Physician Compare	Median Time to Pain Management for Long Bone Fracture (OP-21/NQF-0662)	Effective Clinical Care
XDFCM	Physician Compare	Minimum antimicrobial therapy for Staph A. - For adult patients with Staphylococcus aureus bacteremia, the minimum duration of antimicrobial therapy is 14 days.	Efficiency and Cost Reduction
XDFLL	Physician Compare	National Institutes of Health Stroke Scale (NIHSS) for ED patients	Effective Clinical Care
XDFLE	Physician Compare	Optimal Asthma Care-Control Component	Effective Clinical Care
XDCMD	Physician Compare	Oral Health: Children aged 6-9 years who receive sealants in the first permanent molar	Effective Clinical Care
XDCME	Physician Compare	Oral Health: Children who receive a comprehensive or periodic oral evaluation in two consecutive years	Community/Population Health
XDFEF	Physician Compare	Osteoporotic Fracture Risk	Effective Clinical Care

MUC ID	CMS Program	Measure Title	CMS Domain
XDAFA	Physician Compare	Overuse of Diagnostic Imaging for Uncomplicated Headache	Efficiency and Cost Reduction
E0471	Physician Compare	PC-02 Cesarean Section	Community/Population Health
E0465	Physician Compare	Perioperative Anti-platelet Therapy for Patients undergoing Carotid Endarterectomy	Effective Clinical Care
XDEME	Physician Compare	Post-procedural Optimal medical therapy Composite (percutaneous coronary intervention)	Effective Clinical Care
XDFEG	Physician Compare	Prednisone Use with Anabolic Agent	Effective Clinical Care
E2083	Physician Compare	Prescription of HIV antiretroviral therapy	Effective Clinical Care
XDFBM	Physician Compare	Radiation Consideration for Adult CT: Utilization of Dose Lowering Techniques	Patient Safety
XDFDH	Physician Compare	Recurrence or amputation following endovascular infrainquinal lower extremity revascularization	Effective Clinical Care
XDFDG	Physician Compare	Recurrence or amputation following open infrainquinal lower extremity revascularization	Effective Clinical Care
XCMDH	Physician Compare	Reduction of complications through the use of cystoscopy during surgery for stress urinary incontinence	Patient Safety
XDFBE	Physician Compare	Referral to Treatment for Patients Identified with Hepatitis C Virus (HCV) Infection	Effective Clinical Care
XDFGL	Physician Compare	Repeat Colonoscopy due to poor bowel preparation	Efficiency and Cost Reduction

MUC ID	CMS Program	Measure Title	CMS Domain
E1507	Physician Compare	Risky Behavior Assessment or Counseling by Age 18 Years	Effective Clinical Care
XDFBC	Physician Compare	Screening for Hepatitis C Virus (HCV) for Patients at High Risk	Effective Clinical Care
XDFBH	Physician Compare	Screening for Hepatocellular Carcinoma (HCC) in patients with Hepatitis C Cirrhosis	Effective Clinical Care
XDFHE	Physician Compare	Tuberculosis Screening Prior to First Course Biologic Disease Modifying Anti-Rheumatic Drug (DMARD) Therapy	Patient Safety
XDFCC	Physician Compare	Use of premedication before contrast-enhanced imaging studies in patients with documented contrast allergy	Effective Clinical Care
XDFBL	Physician Compare	Utilization of ultrasonography in children with clinically suspected appendicitis	Efficiency and Cost Reduction

Physician Feedback/QRUR MUC 2013

MUC ID	CMS Program	Measure Title	CMS Domain
XDFMH	Physician Feedback/QRUR	30-Day Readmissions	Communication and Care Coordination
XDEMG	Physician Feedback/QRUR	ACORN Adolescent (Youth) Outcome Questionnaire	Effective Clinical Care
XDEMF	Physician Feedback/QRUR	ACORN Adult Outcome Questionnaire	Effective Clinical Care
XAHDH	Physician Feedback/QRUR	Adherence to Antiplatelet Treatment after Stent Implantation	Effective Clinical Care
E1879	Physician Feedback/QRUR	Adherence to Antipsychotic Medications for Individuals with Schizophrenia	Effective Clinical Care
E0545	Physician Feedback/QRUR	Adherence to Chronic Medications for Individuals with Diabetes Mellitus	Effective Clinical Care
S1880	Physician Feedback/QRUR	Adherence to Mood Stabilizers for Individuals with Bipolar I Disorder	Effective Clinical Care
XDFAL	Physician Feedback/QRUR	Adult Primary Rhegmatogenous Retinal Detachment Reoperation Rate	Effective Clinical Care
XDFAH	Physician Feedback/QRUR	Adult Primary Rhegmatogenous Retinal Detachment Surgery Success Rate	Effective Clinical Care
XDBCB	Physician Feedback/QRUR	Adverse Drug Events - Hyperglycemia	Patient Safety
XDBGA	Physician Feedback/QRUR	Adverse Drug Events - Hypoglycemia	Patient Safety
XDBBL	Physician Feedback/QRUR	All-Cause Unplanned Admissions for Patients with Diabetes	Communication and Care Coordination
XDBBG	Physician Feedback/QRUR	All-Cause Unplanned Admissions for Patients with Heart Failure	Communication and Care Coordination
XDBBM	Physician Feedback/QRUR	All-Cause Unplanned Admissions for Patients with Multiple Chronic	Communication and Care Coordination

MUC ID	CMS Program	Measure Title	CMS Domain
		Conditions	
XCLAL	Physician Feedback/QRUR	ALS Patient Care Preferences	Person and Caregiver-Centered Experience
XDFBD	Physician Feedback/QRUR	Annual Hepatitis C Virus (HCV) Screening for Patients who are Active Injection Drug Users	Effective Clinical Care
XDAEB	Physician Feedback/QRUR	Annual Wellness Assessment: Assessment of Health Risks	Effective Clinical Care
XDBHA	Physician Feedback/QRUR	Annual Wellness Assessment: Goal-Setting to Reduce Identified Risks	Person and Caregiver-Centered Experience
XDAEC	Physician Feedback/QRUR	Annual Wellness Assessment: Management of Health Risks	Effective Clinical Care
XDBGH	Physician Feedback/QRUR	Annual Wellness Assessment: Reduction of Health Risks	Effective Clinical Care
XDFGM	Physician Feedback/QRUR	Appropriate age for colorectal cancer screening colonoscopy	Efficiency and Cost Reduction
XDFCL	Physician Feedback/QRUR	Appropriate follow-up imaging for incidental simple ovarian cysts	Efficiency and Cost Reduction
XDFCE	Physician Feedback/QRUR	Appropriate follow-up imaging for incidental thyroid nodules in patients	Communication and Care Coordination
XDFDA	Physician Feedback/QRUR	Appropriate in vitro susceptibility testing - The agent(s) used for definitive therapy in invasive staphylococcal disease should be confirmed by in vitro susceptibility testing as interpreted by the Clinical Laboratory and Standards Institute (CLSI) to be active against the clinical	Effective Clinical Care

MUC ID	CMS Program	Measure Title	CMS Domain
		isolate.	
XDAEA	Physician Feedback/QRUR	Appropriate Monitoring of patients receiving an Opioid via an IV Patient Controlled Analgesia Device	Patient Safety
XDFHL	Physician Feedback/QRUR	Appropriate Treatment of MSSA - For MSSA bacteremia, a β-lactam antibiotic is the drug of choice in the hospitalized patient in the absence of a documented allergy or drug intolerance.	Effective Clinical Care
XDEGH	Physician Feedback/QRUR	Appropriate Use of DXA Scans in Women Under 65 Who Do Not Meet the Risk Factor Profile	Efficiency and Cost Reduction
XDFCB	Physician Feedback/QRUR	Appropriate use of imaging for non-traumatic knee pain	Efficiency and Cost Reduction
XDFCA	Physician Feedback/QRUR	Appropriate use of imaging for non-traumatic shoulder pain	Efficiency and Cost Reduction
XDFHD	Physician Feedback/QRUR	Assessment and Classification of Disease Activity	Effective Clinical Care
XDFLD	Physician Feedback/QRUR	Average change in functional status following lumbar spine fusion surgery	Effective Clinical Care
XDFDL	Physician Feedback/QRUR	Avoidance of inappropriate use of head CT in ED patients with minor head injury	Efficiency and Cost Reduction
XDFGF	Physician Feedback/QRUR	Avoidance of inappropriate use of imaging for adult ED patients with atraumatic low back pain	Efficiency and Cost Reduction
XAHDG	Physician Feedback/QRUR	Bleeding Outcomes Related to Oral Anticoagulants	Patient Safety
XDFEH	Physician	Bone Mineral Density	Effective Clinical Care

MUC ID	CMS Program	Measure Title	CMS Domain
	Feedback/QRUR	(BMD) & Fracture Risk	
XDFAG	Physician Feedback/QRUR	Cataract Surgery with Intra-Operative Complications (Unplanned Rupture of Posterior Capsule requiring unplanned vitrectomy)	Patient Safety
XDFAM	Physician Feedback/QRUR	Cataract Surgery: Difference Between Planned and Final Refraction	Effective Clinical Care
E0005	Physician Feedback/QRUR	CG CAHPS Supplemental and new Items : Between Visit Communication	Communication and Care Coordination
E0005	Physician Feedback/QRUR	CG CAHPS Supplemental Item : Educating Patient about Medication Adherence	Communication and Care Coordination
E0005	Physician Feedback/QRUR	CG CAHPS: Courteous & Helpful Office Staff	Communication and Care Coordination
E0005	Physician Feedback/QRUR	CG CAHPS: Supplemental Item Care Coordination	Communication and Care Coordination
E0005	Physician Feedback/QRUR	CG CAHPS: Supplemental Item Stewardship of Patient Resources	Communication and Care Coordination
XDFCF	Physician Feedback/QRUR	Composite measure: 1) Appropriate follow-up imaging for incidental liver lesions	Communication and Care Coordination
XDFCG	Physician Feedback/QRUR	Composite measure: 2) Appropriate follow-up imaging for incidental kidney lesions composite measure	Communication and Care Coordination
XDFCH	Physician Feedback/QRUR	Composite measure: 3) Appropriate follow-up imaging for incidental adrenal lesions composite measure	Communication and Care Coordination
S1884	Physician Feedback/QRUR	Depression Response at Six Months- Progress	Effective Clinical Care

MUC ID	CMS Program	Measure Title	CMS Domain
		Towards Remission	
S1885	Physician Feedback/QRUR	Depression Response at Twelve Months-Progress Towards Remission	Effective Clinical Care
E1399	Physician Feedback/QRUR	Developmental Screening - Age 1	Effective Clinical Care
E1399	Physician Feedback/QRUR	Developmental Screening - Age 2	Effective Clinical Care
E1399	Physician Feedback/QRUR	Developmental Screening - Age 3	Effective Clinical Care
XDFBF	Physician Feedback/QRUR	Discontinuation of Antiviral Therapy for Inadequate Viral Response	Efficiency and Cost Reduction
XDFBG	Physician Feedback/QRUR	Discussion and Shared Decision Making Surrounding Treatment Options	Person and Caregiver-Centered Experience
XDDMH	Physician Feedback/QRUR	Draft: Acute Myocardial Infarction Condition Phase Episode for CMS Episode Grouper	Efficiency and Cost Reduction
XDELF	Physician Feedback/QRUR	DRAFT: ADE Prevention and Monitoring: Minimum INR Monitoring for Patients with Atrial Fibrillation on Warfarin	Patient Safety
XDELE	Physician Feedback/QRUR	DRAFT: ADE Prevention and Monitoring: Warfarin Time in Therapeutic Range	Patient Safety
XDEAM	Physician Feedback/QRUR	Draft: Asthma Condition Episode for CMS Episode Grouper	Efficiency and Cost Reduction
XDEEB	Physician Feedback/QRUR	Draft: Back Pain Condition Episode for CMS Episode Grouper	Efficiency and Cost Reduction
XDEDC	Physician Feedback/QRUR	Draft: Breast Cancer Condition Episode for CMS Episode Grouper	Efficiency and Cost Reduction
XDEDD	Physician Feedback/QRUR	Draft: Breast Cancer Treatment Episode for CMS Episode Grouper	Efficiency and Cost Reduction

MUC ID	CMS Program	Measure Title	CMS Domain
XDEBA	Physician Feedback/QRUR	Draft: Bronchiectasis Condition Episode for CMS Episode Grouper	Efficiency and Cost Reduction
XDEBM	Physician Feedback/QRUR	Draft: Cardiac Arrhythmia Condition Episode for CMS Episode Grouper	Efficiency and Cost Reduction
XDECB	Physician Feedback/QRUR	Draft: Cardioversion Treatment Episode for CMS Episode Grouper	Efficiency and Cost Reduction
XDEDB	Physician Feedback/QRUR	Draft: Carotid Artery Stenosis Treatment Episode for CMS Episode Grouper	Efficiency and Cost Reduction
XDEBC	Physician Feedback/QRUR	Draft: Cataract Condition Episode for CMS Episode Grouper	Efficiency and Cost Reduction
XDEBD	Physician Feedback/QRUR	Draft: Cataract Treatment Episode for CMS Episode Grouper	Efficiency and Cost Reduction
XDEBB	Physician Feedback/QRUR	Draft: Chronic Bronchitis/Emphysema Condition Episode for CMS Episode Grouper	Efficiency and Cost Reduction
XDCLD	Physician Feedback/QRUR	DRAFT: Closing the Referral Loop - Critical Information Communicated with Request for Referral	Communication and Care Coordination
XDDAC	Physician Feedback/QRUR	DRAFT: Closing the Referral Loop - Specialist Report Sent to Primary Care Physician	Communication and Care Coordination
XDEDL	Physician Feedback/QRUR	Draft: Colon Cancer Condition Episode for CMS Episode Grouper	Efficiency and Cost Reduction
XDEDM	Physician Feedback/QRUR	Draft: Colon Cancer Treatment Episode for CMS Episode Grouper	Efficiency and Cost Reduction
XDDML	Physician Feedback/QRUR	Draft: Coronary Artery Bypass Graft Treatment Episode for CMS Episode Grouper	Efficiency and Cost Reduction
XDEEA	Physician Feedback/QRUR	Draft: Dementia Condition Episode for CMS Episode Grouper	Efficiency and Cost Reduction

MUC ID	CMS Program	Measure Title	CMS Domain
XDECL	Physician Feedback/QRUR	Draft: Diabetes Condition Episode for CMS Episode Grouper	Efficiency and Cost Reduction
XDELB	Physician Feedback/QRUR	DRAFT: Functional Status Assessment and Goal Achievement for Patients with Congestive Heart Failure	Person and Caregiver-Centered Experience
XDELD	Physician Feedback/QRUR	DRAFT: Functional Status Assessment and Improvement for Patients who Received a Total Hip Replacement	Effective Clinical Care
XDELC	Physician Feedback/QRUR	DRAFT: Functional Status Assessment and Improvement for Patients who Received a Total Knee Replacement	Effective Clinical Care
XDEBE	Physician Feedback/QRUR	Draft: Glaucoma Condition Episode for CMS Episode Grouper	Efficiency and Cost Reduction
XDEBF	Physician Feedback/QRUR	Draft: Glaucoma Treatment Episode for CMS Episode Grouper	Efficiency and Cost Reduction
XDECA	Physician Feedback/QRUR	Draft: Heart Block Condition Episode for CMS Episode Grouper	Efficiency and Cost Reduction
XDDMM	Physician Feedback/QRUR	Draft: Heart Catheterization Treatment Episode for CMS Episode Grouper	Efficiency and Cost Reduction
XDEBL	Physician Feedback/QRUR	Draft: Heart Failure Condition Episode for CMS Episode Grouper	Efficiency and Cost Reduction
XDEAB	Physician Feedback/QRUR	Draft: Hip Osteoarthritis Condition Episode for CMS Episode Grouper	Efficiency and Cost Reduction
XDEAC	Physician Feedback/QRUR	Draft: Hip Replacement/Revision Treatment Episode for CMS Episode Grouper	Efficiency and Cost Reduction
XDEAD	Physician Feedback/QRUR	Draft: Hip/Femur Fracture Condition Episode for CMS Episode Grouper	Efficiency and Cost Reduction

MUC ID	CMS Program	Measure Title	CMS Domain
XDEAE	Physician Feedback/QRUR	Draft: Hip/Femur Fracture Repair Treatment Episode for CMS Episode Grouper	Efficiency and Cost Reduction
XDECF	Physician Feedback/QRUR	Draft: Hypertension Condition Episode for CMS Episode Grouper	Efficiency and Cost Reduction
XDEDA	Physician Feedback/QRUR	Draft: Ischemic Cerebral Artery Disease Condition Episode for CMS Episode Grouper	Efficiency and Cost Reduction
XDDMG	Physician Feedback/QRUR	Draft: Ischemic Heart Disease Condition Episode for CMS Episode Grouper	Efficiency and Cost Reduction
XDEAF	Physician Feedback/QRUR	Draft: Knee Osteoarthritis Condition Episode for CMS Episode Grouper	Efficiency and Cost Reduction
XDEAG	Physician Feedback/QRUR	Draft: Knee Replacement/Revision Treatment Episode for CMS Episode Grouper	Efficiency and Cost Reduction
XDEDE	Physician Feedback/QRUR	Draft: Lung Cancer Condition Episode for CMS Episode Grouper	Efficiency and Cost Reduction
XDEDF	Physician Feedback/QRUR	Draft: Lung Cancer Treatment Episode for CMS Episode Grouper	Efficiency and Cost Reduction
XDECH	Physician Feedback/QRUR	Draft: Nephropathy/Renal Failure Condition Episode for CMS Episode Grouper	Efficiency and Cost Reduction
XDECC	Physician Feedback/QRUR	Draft: Pacemaker/AICD Implantation Treatment Episode for CMS Episode Grouper	Efficiency and Cost Reduction
XDEAA	Physician Feedback/QRUR	Draft: Percutaneous Coronary Intervention Treatment Episode for CMS Episode Grouper	Efficiency and Cost Reduction
XDECD	Physician Feedback/QRUR	Draft: Pneumonia Condition Episode for CMS Episode Grouper	Efficiency and Cost Reduction

MUC ID	CMS Program	Measure Title	CMS Domain
XDEDH	Physician Feedback/QRUR	Draft: Prostate Cancer Condition Episode for CMS Episode Grouper	Efficiency and Cost Reduction
XDEDG	Physician Feedback/QRUR	Draft: Prostate Cancer Treatment Episode for CMS Episode Grouper	Efficiency and Cost Reduction
XDECE	Physician Feedback/QRUR	Draft: Respiratory Failure Condition Episode for CMS Episode Grouper	Efficiency and Cost Reduction
XDEBG	Physician Feedback/QRUR	Draft: Retinal Disease Condition Episode for CMS Episode Grouper	Efficiency and Cost Reduction
XDEBH	Physician Feedback/QRUR	Draft: Retinal Disease Treatment Episode for CMS Episode Grouper	Efficiency and Cost Reduction
XDECM	Physician Feedback/QRUR	Draft: Sepsis/SIRS Condition Episode for CMS Episode Grouper	Efficiency and Cost Reduction
XDECG	Physician Feedback/QRUR	Draft: Shock/Hypotension Condition Episode for CMS Episode Grouper	Efficiency and Cost Reduction
XDEAH	Physician Feedback/QRUR	Draft: Shoulder Osteoarthritis Condition Episode for CMS Episode Grouper	Efficiency and Cost Reduction
XDEAL	Physician Feedback/QRUR	Draft: Shoulder Replacement/Repair Treatment Episode for CMS Episode Grouper	Efficiency and Cost Reduction
XDEHF	Physician Feedback/QRUR	DRAFT: Substance Use Screening and Intervention Composite	Effective Clinical Care
XDEHE	Physician Feedback/QRUR	DRAFT: Tobacco Use and Help with Quitting Among Adolescents	Effective Clinical Care
XDAFC	Physician Feedback/QRUR	Functional Status Assessment and Goal Setting in Patients with Rheumatoid Arthritis	Person and Caregiver-Centered Experience
XDBGL	Physician Feedback/QRUR	Functional Status Assessments and Goal Setting for Patients with Asthma	Person and Caregiver-Centered Experience

MUC ID	CMS Program	Measure Title	CMS Domain
XDBGM	Physician Feedback/QRUR	Functional Status Assessments and Goal Setting for Patients with Chronic Obstructive Pulmonary Disease	Person and Caregiver-Centered Experience
E2080	Physician Feedback/QRUR	Gap in HIV medical visits	Community/Population Health
XDFMG	Physician Feedback/QRUR	Group Therapy	Efficiency and Cost Reduction
XDFDB	Physician Feedback/QRUR	Head and Neck Cancer: Weight Loss Prevention	Effective Clinical Care
E0475	Physician Feedback/QRUR	Hepatitis B Vaccine Coverage Among All Live Newborn Infants Prior to Hospital or Birthing Facility Discharge	Effective Clinical Care
XDEMB	Physician Feedback/QRUR	High-Acuity Care Visits after Outpatient Cataract Procedure	Patient Safety
XDEMA	Physician Feedback/QRUR	High-Acuity Care Visits after Outpatient Colonoscopy Procedure	Patient Safety
XDELM	Physician Feedback/QRUR	High-Acuity Care Visits after Outpatient Endoscopy Procedure	Patient Safety
XDFHF	Physician Feedback/QRUR	History of Fragility Fracture with Prednisone Use	Effective Clinical Care
E2079	Physician Feedback/QRUR	HIV medical visit frequency	Community/Population Health
E2082	Physician Feedback/QRUR	HIV viral load suppression	Effective Clinical Care
XBGDL	Physician Feedback/QRUR	Hospital 30-Day All-Cause Risk-Standardized Readmission Rate (RSRR) following Vascular Procedures	Communication and Care Coordination
XDEEL	Physician Feedback/QRUR	Hospital 30-day Risk-standardized Acute Myocardial Infarction (AMI) Mortality eMeasure	Patient Safety
XDEEH	Physician Feedback/QRUR	Hospital 30-day, all-cause, risk-standardized mortality rate (RSMR) following Coronary	Patient Safety

MUC ID	CMS Program	Measure Title	CMS Domain
		Artery Bypass Graft (CABG) surgery	
XBELG	Physician Feedback/QRUR	Hospital 30-day, all-cause, unplanned, risk-standardized readmission rate (RSRR) following Coronary artery Bypass Graft (CABG) Surgery	Communication and Care Coordination
XDELH	Physician Feedback/QRUR	Hospital-level, risk-standardized 30-day episode-of-care payment measure for heart failure	Efficiency and Cost Reduction
XDELG	Physician Feedback/QRUR	Hospital-level, risk-standardized 30-day episode-of-care payment measure for pneumonia	Efficiency and Cost Reduction
E1789	Physician Feedback/QRUR	Hospital-Wide All-Cause Unplanned Readmission Measure (HWR)	Communication and Care Coordination
XCLLL	Physician Feedback/QRUR	HRS-12: Cardiac Tamponade and/or Pericardiocentesis Following Atrial Fibrillation Ablation	Patient Safety
XCLMD	Physician Feedback/QRUR	HRS-9: Infection within 180 Days of Cardiac Implantable Electronic Device (CIED) Implantation, Replacement, or Revision	Patient Safety
E1959	Physician Feedback/QRUR	Immunizations by 13 years of age - HPV	Effective Clinical Care
E1407	Physician Feedback/QRUR	Immunizations by 13 years of age-Meningococcus, Tetanus, and Diphtheria	Effective Clinical Care
XDFGE	Physician Feedback/QRUR	Inpatient Psychiatric Facility Routinely Assesses Patient Experience of Care	Person and Caregiver-Centered Experience
XDFGD	Physician Feedback/QRUR	IPF Alcohol Use Screening completed	Effective Clinical Care

MUC ID	CMS Program	Measure Title	CMS Domain
		within one day of admission	
XDFGC	Physician Feedback/QRUR	IPF Drug Use Screening completed within one day of admission	Effective Clinical Care
E0662	Physician Feedback/QRUR	Median Time to Pain Management for Long Bone Fracture (OP-21/NQF-0662)	Effective Clinical Care
S2158	Physician Feedback/QRUR	Medicare Spending Per Beneficiary	Efficiency and Cost Reduction
XDFCM	Physician Feedback/QRUR	Minimum antimicrobial therapy for Staph A. - For adult patients with Staphylococcus aureus bacteremia, the minimum duration of antimicrobial therapy is 14 days.	Efficiency and Cost Reduction
XDFLL	Physician Feedback/QRUR	National Institutes of Health Stroke Scale (NIHSS) for ED patients	Effective Clinical Care
XDFMF	Physician Feedback/QRUR	No Individual Psychotherapy	Efficiency and Cost Reduction
XDFLE	Physician Feedback/QRUR	Optimal Asthma Care-Control Component	Effective Clinical Care
XDCMD	Physician Feedback/QRUR	Oral Health: Children aged 6-9 years who receive sealants in the first permanent molar	Effective Clinical Care
XDCME	Physician Feedback/QRUR	Oral Health: Children who receive a comprehensive or periodic oral evaluation in two consecutive years	Community/Population Health
XDFEF	Physician Feedback/QRUR	Osteoporotic Fracture Risk	Effective Clinical Care
XDAFA	Physician Feedback/QRUR	Overuse of Diagnostic Imaging for Uncomplicated Headache	Efficiency and Cost Reduction
E0471	Physician Feedback/QRUR	PC-02 Cesarean Section	Community/Population Health
E0465	Physician Feedback/QRUR	Perioperative Anti-platelet Therapy for Patients undergoing	Effective Clinical Care

MUC ID	CMS Program	Measure Title	CMS Domain
		Carotid Endarterectomy	
XDEME	Physician Feedback/QRUR	Post-procedural Optimal medical therapy Composite (percutaneous coronary intervention)	Effective Clinical Care
XDFEG	Physician Feedback/QRUR	Prednisone Use with Anabolic Agent	Effective Clinical Care
E2083	Physician Feedback/QRUR	Prescription of HIV antiretroviral therapy	Effective Clinical Care
XDFBM	Physician Feedback/QRUR	Radiation Consideration for Adult CT: Utilization of Dose Lowering Techniques	Patient Safety
XDFDH	Physician Feedback/QRUR	Recurrence or amputation following endovascular infrainquinal lower extremity revascularization	Effective Clinical Care
XDFDG	Physician Feedback/QRUR	Recurrence or amputation following open infrainquinal lower extremity revascularization	Effective Clinical Care
XCMDH	Physician Feedback/QRUR	Reduction of complications through the use of cystoscopy during surgery for stress urinary incontinence	Patient Safety
XDFBE	Physician Feedback/QRUR	Referral to Treatment for Patients Identified with Hepatitis C Virus (HCV) Infection	Effective Clinical Care
XDFGL	Physician Feedback/QRUR	Repeat Colonoscopy due to poor bowel preparation	Efficiency and Cost Reduction
E1507	Physician Feedback/QRUR	Risky Behavior Assessment or Counseling by Age 18 Years	Effective Clinical Care
XDFBC	Physician Feedback/QRUR	Screening for Hepatitis C Virus (HCV) for Patients at High Risk	Effective Clinical Care
XDFBH	Physician	Screening for	Effective Clinical Care

MUC ID	CMS Program	Measure Title	CMS Domain
	Feedback/QRUR	Hepatocellular Carcinoma (HCC) in patients with Hepatitis C Cirrhosis	
XDFHE	Physician Feedback/QRUR	Tuberculosis Screening Prior to First Course Biologic Disease Modifying Anti-Rheumatic Drug (DMARD) Therapy	Patient Safety
XDFCC	Physician Feedback/QRUR	Use of premedication before contrast-enhanced imaging studies in patients with documented contrast allergy	Effective Clinical Care
XDFBL	Physician Feedback/QRUR	Utilization of ultrasonography in children with clinically suspected appendicitis	Efficiency and Cost Reduction

Physician Value-Based Payment Modifier MUC 2013

MUC ID	CMS Program	Measure Title	CMS Domain
XDFMH	Physician Value-Based Payment Modifier	30-Day Readmissions	Communication and Care Coordination
XDEMG	Physician Value-Based Payment Modifier	ACORN Adolescent (Youth) Outcome Questionnaire	Effective Clinical Care
XDEMF	Physician Value-Based Payment Modifier	ACORN Adult Outcome Questionnaire	Effective Clinical Care
XAHDH	Physician Value-Based Payment Modifier	Adherence to Antiplatelet Treatment after Stent Implantation	Effective Clinical Care
E1879	Physician Value-Based Payment Modifier	Adherence to Antipsychotic Medications for Individuals with Schizophrenia	Effective Clinical Care
E0545	Physician Value-Based Payment Modifier	Adherence to Chronic Medications for Individuals with Diabetes Mellitus	Effective Clinical Care
S1880	Physician Value-Based Payment Modifier	Adherence to Mood Stabilizers for Individuals with Bipolar I Disorder	Effective Clinical Care
XDFAL	Physician Value-Based Payment Modifier	Adult Primary Rhegmatogenous Retinal Detachment Reoperation Rate	Effective Clinical Care
XDFAH	Physician Value-Based Payment Modifier	Adult Primary Rhegmatogenous Retinal Detachment Surgery Success Rate	Effective Clinical Care
XDBCB	Physician Value-Based Payment Modifier	Adverse Drug Events - Hyperglycemia	Patient Safety
XDBGA	Physician Value-Based Payment Modifier	Adverse Drug Events - Hypoglycemia	Patient Safety
XDBBL	Physician Value-Based Payment Modifier	All-Cause Unplanned Admissions for Patients with Diabetes	Communication and Care Coordination
XDBBG	Physician Value-Based Payment Modifier	All-Cause Unplanned Admissions for Patients with Heart Failure	Communication and Care Coordination

MUC ID	CMS Program	Measure Title	CMS Domain
XDBBM	Physician Value-Based Payment Modifier	All-Cause Unplanned Admissions for Patients with Multiple Chronic Conditions	Communication and Care Coordination
XCLAL	Physician Value-Based Payment Modifier	ALS Patient Care Preferences	Person and Caregiver-Centered Experience
XDFBD	Physician Value-Based Payment Modifier	Annual Hepatitis C Virus (HCV) Screening for Patients who are Active Injection Drug Users	Effective Clinical Care
XDAEB	Physician Value-Based Payment Modifier	Annual Wellness Assessment: Assessment of Health Risks	Effective Clinical Care
XDBHA	Physician Value-Based Payment Modifier	Annual Wellness Assessment: Goal-Setting to Reduce Identified Risks	Person and Caregiver-Centered Experience
XDAEC	Physician Value-Based Payment Modifier	Annual Wellness Assessment: Management of Health Risks	Effective Clinical Care
XDBGH	Physician Value-Based Payment Modifier	Annual Wellness Assessment: Reduction of Health Risks	Effective Clinical Care
XDFGM	Physician Value-Based Payment Modifier	Appropriate age for colorectal cancer screening colonoscopy	Efficiency and Cost Reduction
XDFCL	Physician Value-Based Payment Modifier	Appropriate follow-up imaging for incidental simple ovarian cysts	Efficiency and Cost Reduction
XDFCE	Physician Value-Based Payment Modifier	Appropriate follow-up imaging for incidental thyroid nodules in patients	Communication and Care Coordination
XDFDA	Physician Value-Based Payment Modifier	Appropriate in vitro susceptibility testing - The agent(s) used for definitive therapy in invasive staphylococcal disease should be confirmed by in vitro susceptibility testing as interpreted by the Clinical Laboratory and Standards Institute (CLSI)	Effective Clinical Care

MUC ID	CMS Program	Measure Title	CMS Domain
		to be active against the clinical isolate.	
XDAEA	Physician Value-Based Payment Modifier	Appropriate Monitoring of patients receiving an Opioid via an IV Patient Controlled Analgesia Device	Patient Safety
XDFHL	Physician Value-Based Payment Modifier	Appropriate Treatment of MSSA - For MSSA bacteremia, a β-lactam antibiotic is the drug of choice in the hospitalized patient in the absence of a documented allergy or drug intolerance.	Effective Clinical Care
XDEGH	Physician Value-Based Payment Modifier	Appropriate Use of DXA Scans in Women Under 65 Who Do Not Meet the Risk Factor Profile	Efficiency and Cost Reduction
XDFCB	Physician Value-Based Payment Modifier	Appropriate use of imaging for non-traumatic knee pain	Efficiency and Cost Reduction
XDFCA	Physician Value-Based Payment Modifier	Appropriate use of imaging for non-traumatic shoulder pain	Efficiency and Cost Reduction
XDFHD	Physician Value-Based Payment Modifier	Assessment and Classification of Disease Activity	Effective Clinical Care
XDFLD	Physician Value-Based Payment Modifier	Average change in functional status following lumbar spine fusion surgery	Effective Clinical Care
XDFDL	Physician Value-Based Payment Modifier	Avoidance of inappropriate use of head CT in ED patients with minor head injury	Efficiency and Cost Reduction
XDFGF	Physician Value-Based Payment Modifier	Avoidance of inappropriate use of imaging for adult ED patients with atraumatic low back pain	Efficiency and Cost Reduction
XAHDG	Physician Value-Based Payment Modifier	Bleeding Outcomes Related to Oral Anticoagulants	Patient Safety
XDFEH	Physician Value-Based Payment	Bone Mineral Density (BMD) & Fracture Risk	Effective Clinical Care

MUC ID	CMS Program	Measure Title	CMS Domain
	Modifier		
XDFAG	Physician Value-Based Payment Modifier	Cataract Surgery with Intra-Operative Complications (Unplanned Rupture of Posterior Capsule requiring unplanned vitrectomy)	Patient Safety
XDFAM	Physician Value-Based Payment Modifier	Cataract Surgery: Difference Between Planned and Final Refraction	Effective Clinical Care
E0005	Physician Value-Based Payment Modifier	CG CAHPS Supplemental and new Items : Between Visit Communication	Communication and Care Coordination
E0005	Physician Value-Based Payment Modifier	CG CAHPS Supplemental Item : Educating Patient about Medication Adherence	Communication and Care Coordination
E0005	Physician Value-Based Payment Modifier	CG CAHPS: Courteous & Helpful Office Staff	Communication and Care Coordination
E0005	Physician Value-Based Payment Modifier	CG CAHPS: Supplemental Item Care Coordination	Communication and Care Coordination
E0005	Physician Value-Based Payment Modifier	CG CAHPS: Supplemental Item Stewardship of Patient Resources	Communication and Care Coordination
XDFCF	Physician Value-Based Payment Modifier	Composite measure: 1) Appropriate follow-up imaging for incidental liver lesions	Communication and Care Coordination
XDFCG	Physician Value-Based Payment Modifier	Composite measure: 2) Appropriate follow-up imaging for incidental kidney lesions composite measure	Communication and Care Coordination
XDFCH	Physician Value-Based Payment Modifier	Composite measure: 3) Appropriate follow-up imaging for incidental adrenal lesions composite measure	Communication and Care Coordination
S1884	Physician Value-Based Payment Modifier	Depression Response at Six Months- Progress Towards Remission	Effective Clinical Care

MUC ID	CMS Program	Measure Title	CMS Domain
S1885	Physician Value-Based Payment Modifier	Depression Response at Twelve Months- Progress Towards Remission	Effective Clinical Care
E1399	Physician Value-Based Payment Modifier	Developmental Screening - Age 1	Effective Clinical Care
E1399	Physician Value-Based Payment Modifier	Developmental Screening - Age 2	Effective Clinical Care
E1399	Physician Value-Based Payment Modifier	Developmental Screening - Age 3	Effective Clinical Care
XDFBF	Physician Value-Based Payment Modifier	Discontinuation of Antiviral Therapy for Inadequate Viral Response	Efficiency and Cost Reduction
XDFBG	Physician Value-Based Payment Modifier	Discussion and Shared Decision Making Surrounding Treatment Options	Person and Caregiver-Centered Experience
XDDMH	Physician Value-Based Payment Modifier	Draft: Acute Myocardial Infarction Condition Phase Episode for CMS Episode Grouper	Efficiency and Cost Reduction
XDELF	Physician Value-Based Payment Modifier	DRAFT: ADE Prevention and Monitoring: Minimum INR Monitoring for Patients with Atrial Fibrillation on Warfarin	Patient Safety
XDELE	Physician Value-Based Payment Modifier	DRAFT: ADE Prevention and Monitoring: Warfarin Time in Therapeutic Range	Patient Safety
XDEAM	Physician Value-Based Payment Modifier	Draft: Asthma Condition Episode for CMS Episode Grouper	Efficiency and Cost Reduction
XDEEB	Physician Value-Based Payment Modifier	Draft: Back Pain Condition Episode for CMS Episode Grouper	Efficiency and Cost Reduction
XDEDC	Physician Value-Based Payment Modifier	Draft: Breast Cancer Condition Episode for CMS Episode Grouper	Efficiency and Cost Reduction
XDEDD	Physician Value-Based Payment Modifier	Draft: Breast Cancer Treatment Episode for CMS Episode Grouper	Efficiency and Cost Reduction

MUC ID	CMS Program	Measure Title	CMS Domain
XDEBA	Physician Value-Based Payment Modifier	Draft: Bronchiectasis Condition Episode for CMS Episode Grouper	Efficiency and Cost Reduction
XDEBM	Physician Value-Based Payment Modifier	Draft: Cardiac Arrhythmia Condition Episode for CMS Episode Grouper	Efficiency and Cost Reduction
XDECB	Physician Value-Based Payment Modifier	Draft: Cardioversion Treatment Episode for CMS Episode Grouper	Efficiency and Cost Reduction
XDEDB	Physician Value-Based Payment Modifier	Draft: Carotid Artery Stenosis Treatment Episode for CMS Episode Grouper	Efficiency and Cost Reduction
XDEBC	Physician Value-Based Payment Modifier	Draft: Cataract Condition Episode for CMS Episode Grouper	Efficiency and Cost Reduction
XDEBD	Physician Value-Based Payment Modifier	Draft: Cataract Treatment Episode for CMS Episode Grouper	Efficiency and Cost Reduction
XDEBB	Physician Value-Based Payment Modifier	Draft: Chronic Bronchitis/Emphysema Condition Episode for CMS Episode Grouper	Efficiency and Cost Reduction
XDCLD	Physician Value-Based Payment Modifier	DRAFT: Closing the Referral Loop - Critical Information Communicated with Request for Referral	Communication and Care Coordination
XDDAC	Physician Value-Based Payment Modifier	DRAFT: Closing the Referral Loop - Specialist Report Sent to Primary Care Physician	Communication and Care Coordination
XDEDL	Physician Value-Based Payment Modifier	Draft: Colon Cancer Condition Episode for CMS Episode Grouper	Efficiency and Cost Reduction
XDEDM	Physician Value-Based Payment Modifier	Draft: Colon Cancer Treatment Episode for CMS Episode Grouper	Efficiency and Cost Reduction
XDDML	Physician Value-Based Payment Modifier	Draft: Coronary Artery Bypass Graft Treatment Episode for CMS Episode Grouper	Efficiency and Cost Reduction
XDEEA	Physician Value-Based Payment Modifier	Draft: Dementia Condition Episode for CMS Episode Grouper	Efficiency and Cost Reduction

MUC ID	CMS Program	Measure Title	CMS Domain
XDECL	Physician Value-Based Payment Modifier	Draft: Diabetes Condition Episode for CMS Episode Grouper	Efficiency and Cost Reduction
XDELB	Physician Value-Based Payment Modifier	DRAFT: Functional Status Assessment and Goal Achievement for Patients with Congestive Heart Failure	Person and Caregiver-Centered Experience
XDELD	Physician Value-Based Payment Modifier	DRAFT: Functional Status Assessment and Improvement for Patients who Received a Total Hip Replacement	Effective Clinical Care
XDELC	Physician Value-Based Payment Modifier	DRAFT: Functional Status Assessment and Improvement for Patients who Received a Total Knee Replacement	Effective Clinical Care
XDEBE	Physician Value-Based Payment Modifier	Draft: Glaucoma Condition Episode for CMS Episode Grouper	Efficiency and Cost Reduction
XDEBF	Physician Value-Based Payment Modifier	Draft: Glaucoma Treatment Episode for CMS Episode Grouper	Efficiency and Cost Reduction
XDECA	Physician Value-Based Payment Modifier	Draft: Heart Block Condition Episode for CMS Episode Grouper	Efficiency and Cost Reduction
XDDMM	Physician Value-Based Payment Modifier	Draft: Heart Catheterization Treatment Episode for CMS Episode Grouper	Efficiency and Cost Reduction
XDEBL	Physician Value-Based Payment Modifier	Draft: Heart Failure Condition Episode for CMS Episode Grouper	Efficiency and Cost Reduction
XDEAB	Physician Value-Based Payment Modifier	Draft: Hip Osteoarthritis Condition Episode for CMS Episode Grouper	Efficiency and Cost Reduction
XDEAC	Physician Value-Based Payment Modifier	Draft: Hip Replacement/Revision Treatment Episode for CMS Episode Grouper	Efficiency and Cost Reduction
XDEAD	Physician Value-Based Payment Modifier	Draft: Hip/Femur Fracture Condition Episode for CMS Episode Grouper	Efficiency and Cost Reduction

MUC ID	CMS Program	Measure Title	CMS Domain
XDEAE	Physician Value-Based Payment Modifier	Draft: Hip/Femur Fracture Repair Treatment Episode for CMS Episode Grouper	Efficiency and Cost Reduction
XDECF	Physician Value-Based Payment Modifier	Draft: Hypertension Condition Episode for CMS Episode Grouper	Efficiency and Cost Reduction
XDEDA	Physician Value-Based Payment Modifier	Draft: Ischemic Cerebral Artery Disease Condition Episode for CMS Episode Grouper	Efficiency and Cost Reduction
XDDMG	Physician Value-Based Payment Modifier	Draft: Ischemic Heart Disease Condition Episode for CMS Episode Grouper	Efficiency and Cost Reduction
XDEAF	Physician Value-Based Payment Modifier	Draft: Knee Osteoarthritis Condition Episode for CMS Episode Grouper	Efficiency and Cost Reduction
XDEAG	Physician Value-Based Payment Modifier	Draft: Knee Replacement/Revision Treatment Episode for CMS Episode Grouper	Efficiency and Cost Reduction
XDEDE	Physician Value-Based Payment Modifier	Draft: Lung Cancer Condition Episode for CMS Episode Grouper	Efficiency and Cost Reduction
XDEDF	Physician Value-Based Payment Modifier	Draft: Lung Cancer Treatment Episode for CMS Episode Grouper	Efficiency and Cost Reduction
XDECH	Physician Value-Based Payment Modifier	Draft: Nephropathy/Renal Failure Condition Episode for CMS Episode Grouper	Efficiency and Cost Reduction
XDECC	Physician Value-Based Payment Modifier	Draft: Pacemaker/AICD Implantation Treatment Episode for CMS Episode Grouper	Efficiency and Cost Reduction
XDEAA	Physician Value-Based Payment Modifier	Draft: Percutaneous Coronary Intervention Treatment Episode for CMS Episode Grouper	Efficiency and Cost Reduction
XDECD	Physician Value-Based Payment Modifier	Draft: Pneumonia Condition Episode for CMS Episode Grouper	Efficiency and Cost Reduction
XDEDH	Physician Value-Based Payment	Draft: Prostate Cancer Condition Episode for	Efficiency and Cost Reduction

MUC ID	CMS Program	Measure Title	CMS Domain
	Modifier	CMS Episode Grouper	
XDEDG	Physician Value-Based Payment Modifier	Draft: Prostate Cancer Treatment Episode for CMS Episode Grouper	Efficiency and Cost Reduction
XDECE	Physician Value-Based Payment Modifier	Draft: Respiratory Failure Condition Episode for CMS Episode Grouper	Efficiency and Cost Reduction
XDEBG	Physician Value-Based Payment Modifier	Draft: Retinal Disease Condition Episode for CMS Episode Grouper	Efficiency and Cost Reduction
XDEBH	Physician Value-Based Payment Modifier	Draft: Retinal Disease Treatment Episode for CMS Episode Grouper	Efficiency and Cost Reduction
XDECM	Physician Value-Based Payment Modifier	Draft: Sepsis/SIRS Condition Episode for CMS Episode Grouper	Efficiency and Cost Reduction
XDECG	Physician Value-Based Payment Modifier	Draft: Shock/Hypotension Condition Episode for CMS Episode Grouper	Efficiency and Cost Reduction
XDEAH	Physician Value-Based Payment Modifier	Draft: Shoulder Osteoarthritis Condition Episode for CMS Episode Grouper	Efficiency and Cost Reduction
XDEAL	Physician Value-Based Payment Modifier	Draft: Shoulder Replacement/Repair Treatment Episode for CMS Episode Grouper	Efficiency and Cost Reduction
XDEHF	Physician Value-Based Payment Modifier	DRAFT: Substance Use Screening and Intervention Composite	Effective Clinical Care
XDEHE	Physician Value-Based Payment Modifier	DRAFT: Tobacco Use and Help with Quitting Among Adolescents	Effective Clinical Care
XDAFC	Physician Value-Based Payment Modifier	Functional Status Assessment and Goal Setting in Patients with Rheumatoid Arthritis	Person and Caregiver-Centered Experience
XDBGL	Physician Value-Based Payment Modifier	Functional Status Assessments and Goal Setting for Patients with Asthma	Person and Caregiver-Centered Experience
XDBGM	Physician Value-Based Payment Modifier	Functional Status Assessments and Goal Setting for Patients with	Person and Caregiver-Centered Experience

MUC ID	CMS Program	Measure Title	CMS Domain
		Chronic Obstructive Pulmonary Disease	
E2080	Physician Value-Based Payment Modifier	Gap in HIV medical visits	Community/Population Health
XDFMG	Physician Value-Based Payment Modifier	Group Therapy	Efficiency and Cost Reduction
XDFDB	Physician Value-Based Payment Modifier	Head and Neck Cancer: Weight Loss Prevention	Effective Clinical Care
E0475	Physician Value-Based Payment Modifier	Hepatitis B Vaccine Coverage Among All Live Newborn Infants Prior to Hospital or Birthing Facility Discharge	Effective Clinical Care
XDEMB	Physician Value-Based Payment Modifier	High-Acuity Care Visits after Outpatient Cataract Procedure	Patient Safety
XDEMA	Physician Value-Based Payment Modifier	High-Acuity Care Visits after Outpatient Colonoscopy Procedure	Patient Safety
XDELM	Physician Value-Based Payment Modifier	High-Acuity Care Visits after Outpatient Endoscopy Procedure	Patient Safety
XDFHF	Physician Value-Based Payment Modifier	History of Fragility Fracture with Prednisone Use	Effective Clinical Care
E2079	Physician Value-Based Payment Modifier	HIV medical visit frequency	Community/Population Health
E2082	Physician Value-Based Payment Modifier	HIV viral load suppression	Effective Clinical Care
XBGDL	Physician Value-Based Payment Modifier	Hospital 30-Day All-Cause Risk-Standardized Readmission Rate (RSRR) following Vascular Procedures	Communication and Care Coordination
XDEEL	Physician Value-Based Payment Modifier	Hospital 30-day Risk-standardized Acute Myocardial Infarction (AMI) Mortality eMeasure	Patient Safety
XDEEH	Physician Value-Based Payment	Hospital 30-day, all-cause, risk-standardized	Patient Safety

MUC ID	CMS Program	Measure Title	CMS Domain
	Modifier	mortality rate (RSMR) following Coronary Artery Bypass Graft (CABG) surgery	
XBELG	Physician Value-Based Payment Modifier	Hospital 30-day, all-cause, unplanned, risk-standardized readmission rate (RSRR) following Coronary artery Bypass Graft (CABG) Surgery	Communication and Care Coordination
XDELH	Physician Value-Based Payment Modifier	Hospital-level, risk-standardized 30-day episode-of-care payment measure for heart failure	Efficiency and Cost Reduction
XDELG	Physician Value-Based Payment Modifier	Hospital-level, risk-standardized 30-day episode-of-care payment measure for pneumonia	Efficiency and Cost Reduction
E1789	Physician Value-Based Payment Modifier	Hospital-Wide All-Cause Unplanned Readmission Measure (HWR)	Communication and Care Coordination
XCLLL	Physician Value-Based Payment Modifier	HRS-12: Cardiac Tamponade and/or Pericardiocentesis Following Atrial Fibrillation Ablation	Patient Safety
XCLMD	Physician Value-Based Payment Modifier	HRS-9: Infection within 180 Days of Cardiac Implantable Electronic Device (CIED) Implantation, Replacement, or Revision	Patient Safety
E1959	Physician Value-Based Payment Modifier	Immunizations by 13 years of age - HPV	Effective Clinical Care
E1407	Physician Value-Based Payment Modifier	Immunizations by 13 years of age-Meningococcus, Tetanus, and Diphtheria	Effective Clinical Care
XDFGE	Physician Value-Based Payment Modifier	Inpatient Psychiatric Facility Routinely Assesses Patient Experience of Care	Person and Caregiver-Centered Experience
XDFGD	Physician Value-Based Payment	IPF Alcohol Use Screening completed	Effective Clinical Care

MUC ID	CMS Program	Measure Title	CMS Domain
	Modifier	within one day of admission	
XDFGC	Physician Value-Based Payment Modifier	IPF Drug Use Screening completed within one day of admission	Effective Clinical Care
E0662	Physician Value-Based Payment Modifier	Median Time to Pain Management for Long Bone Fracture (OP-21/NQF-0662)	Effective Clinical Care
S2158	Physician Value-Based Payment Modifier	Medicare Spending Per Beneficiary	Efficiency and Cost Reduction
XDFCM	Physician Value-Based Payment Modifier	Minimum antimicrobial therapy for Staph A. - For adult patients with Staphylococcus aureus bacteremia, the minimum duration of antimicrobial therapy is 14 days.	Efficiency and Cost Reduction
XDFLL	Physician Value-Based Payment Modifier	National Institutes of Health Stroke Scale (NIHSS) for ED patients	Effective Clinical Care
XDFMF	Physician Value-Based Payment Modifier	No Individual Psychotherapy	Efficiency and Cost Reduction
XDFLE	Physician Value-Based Payment Modifier	Optimal Asthma Care-Control Component	Effective Clinical Care
XDCMD	Physician Value-Based Payment Modifier	Oral Health: Children aged 6-9 years who receive sealants in the first permanent molar	Effective Clinical Care
XDCME	Physician Value-Based Payment Modifier	Oral Health: Children who receive a comprehensive or periodic oral evaluation in two consecutive years	Community/Population Health
XDFEF	Physician Value-Based Payment Modifier	Osteoporotic Fracture Risk	Effective Clinical Care
XDAFA	Physician Value-Based Payment Modifier	Overuse of Diagnostic Imaging for Uncomplicated Headache	Efficiency and Cost Reduction

MUC ID	CMS Program	Measure Title	CMS Domain
E0471	Physician Value-Based Payment Modifier	PC-02 Cesarean Section	Community/Population Health
E0465	Physician Value-Based Payment Modifier	Perioperative Anti-platelet Therapy for Patients undergoing Carotid Endarterectomy	Effective Clinical Care
XDEME	Physician Value-Based Payment Modifier	Post-procedural Optimal medical therapy Composite (percutaneous coronary intervention)	Effective Clinical Care
XDFEG	Physician Value-Based Payment Modifier	Prednisone Use with Anabolic Agent	Effective Clinical Care
E2083	Physician Value-Based Payment Modifier	Prescription of HIV antiretroviral therapy	Effective Clinical Care
XDFBM	Physician Value-Based Payment Modifier	Radiation Consideration for Adult CT: Utilization of Dose Lowering Techniques	Patient Safety
XDFDH	Physician Value-Based Payment Modifier	Recurrence or amputation following endovascular infrainquinal lower extremity revascularization	Effective Clinical Care
XDFDG	Physician Value-Based Payment Modifier	Recurrence or amputation following open infrainquinal lower extremity revascularization	Effective Clinical Care
XCMDH	Physician Value-Based Payment Modifier	Reduction of complications through the use of cystoscopy during surgery for stress urinary incontinence	Patient Safety
XDFBE	Physician Value-Based Payment Modifier	Referral to Treatment for Patients Identified with Hepatitis C Virus (HCV) Infection	Effective Clinical Care
XDFGL	Physician Value-Based Payment Modifier	Repeat Colonoscopy due to poor bowel preparation	Efficiency and Cost Reduction

MUC ID	CMS Program	Measure Title	CMS Domain
E1507	Physician Value-Based Payment Modifier	Risky Behavior Assessment or Counseling by Age 18 Years	Effective Clinical Care
XDFBC	Physician Value-Based Payment Modifier	Screening for Hepatitis C Virus (HCV) for Patients at High Risk	Effective Clinical Care
XDFBH	Physician Value-Based Payment Modifier	Screening for Hepatocellular Carcinoma (HCC) in patients with Hepatitis C Cirrhosis	Effective Clinical Care
XDFHE	Physician Value-Based Payment Modifier	Tuberculosis Screening Prior to First Course Biologic Disease Modifying Anti-Rheumatic Drug (DMARD) Therapy	Patient Safety
XDFCC	Physician Value-Based Payment Modifier	Use of premedication before contrast-enhanced imaging studies in patients with documented contrast allergy	Effective Clinical Care
XDFBL	Physician Value-Based Payment Modifier	Utilization of ultrasonography in children with clinically suspected appendicitis	Efficiency and Cost Reduction

PPS-Exempt Cancer MUC 2013

MUC ID	CMS Program	Measure Title	CMS Domain
E1822	PPS-Exempt Cancer Hospital	External Beam Radiotherapy for Bone Metastases	Effective Clinical Care
XDCFE	PPS-Exempt Cancer Hospital	Initiation of Osteoclast Inhibitors for Patients with Multiple Myeloma or Bone Metastases Associated with Breast Cancer, Prostate Cancer, or Lung Cancer	Effective Clinical Care
XDBLG	PPS-Exempt Cancer Hospital	Overuse of Imaging for Staging Breast Cancer at Low Risk of Metastasis	Efficiency and Cost Reduction
E1628	PPS-Exempt Cancer Hospital	Patients with Advanced Cancer Screened for Pain at Outpatient Visits	Effective Clinical Care
E0450	PPS-Exempt Cancer Hospital	Perioperative pulmonary embolism or deep vein thrombosis rate (PSI 12)	Patient Safety
XDDAF	PPS-Exempt Cancer Hospital	Potentially Avoidable Admissions and Emergency Department Visits Among Patients Receiving Outpatient Chemotherapy	Communication and Care Coordination