Connecticut Quality Council
2024 Aligned Measure Set Annual Review
Measure Specifications for Measures to be Discussed During June 20th Quality Council Meeting

#	Measure Name	Page Number
2024 Aligned Measure Set Measures		
1	Patient-Centered Medical Home (PCMH) Consumer Assessment of Healthcare Providers and Systems (CAHPS)	3
Additional Measures for Discussion		
2	Back Pain After Lumbar Discectomy/Laminectomy	8
3	Cataracts: Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery	11
4	Cataracts: Patient Satisfaction within 90 Days Following Cataract Surgery	14
5	Dermatitis - Improvement in Patient-Reported Itch Severity	17
6	Functional Status After Lumbar Surgery	20
7	Functional Status After Primary Total Knee Replacement	23
8	Functional Status Change for Patients with Elbow, Wrist or Hand Impairments	26
9	Functional Status Change for Patients with Hip Impairment	29
10	Functional Status Change for Patients with Knee Impairments	32
11	Functional Status Change for Patients with Low Back Impairments	35
12	Functional Status Change for Patients with Lower Leg, Foot or Ankle Impairments	38
13	Functional Status Change for Patients with Neck Impairments	41
14	Functional Status Change for Patients with Shoulder Impairments	44
15	Informed, Patient-Centered Hip and Knee Replacement	47
16	Leg Pain After Lumbar Discectomy/Laminectomy	56
17	Person-Centered Primary Care Measure	59
20	Psoriasis - Improvement in Patient-Reported Itch Severity	66
21	Shared Decision-Making Process	69
22	Statin Therapy for Patients with Cardiovascular Disease	76
23	Statin Therapy for Patients with Diabetes	83

#	Measure Name	Page Number
24	Urinary Symptoms Score Change 6-12 Months After Diagnosis of Benign Prostatic Hyperplasia	93
25	Varicose Vein Treatment with Saphenous Ablation: Outcome Survey	96

Supplemental Patient-Centered Medical Home Items for the CAHPS® Clinician & Group Survey 3.0

Population Version: Adult
Language: English

Read about the Patient-Centered Medical Home Item Set.

Users of the CAHPS® Clinician & Group Survey are free to incorporate supplemental items in order to meet the needs of their organizations, local markets, and/or audiences. Some items cover events that occur with low frequency in the general population. You should include them only if your sample design is likely to yield a sufficient number of responses to those questions for statistical analysis and reporting.

Questions		Placement and Other Instructions
PCMH1.	Did this provider's office give you information about what to do if you needed care during evenings, weekends, or holidays? 1☐ Yes 2☐ No	After core question 8
PCMH2.	Specialists are doctors like surgeons, heart doctors, allergy doctors, skin doctors, and other doctors who specialize in one area of health care. In the last 6 months, did you see a specialist for a particular health problem? 1☐ Yes 2☐ No → **If No, go to PCMH4**	After core question 18
PCMH3.	In the last 6 months, how often did the provider named in Question 1 seem informed and up-to-date about the care you got from specialists? 1☐ Never 2☐ Sometimes 3☐ Usually 4☐ Always	After PCMH2 Note: Use with PCMH2
PCMH4.	Please answer these questions about the provider named in Question 1 of this survey. In the last 6 months, did someone from this provider's office talk with you about specific goals for your health? 1☐ Yes 2☐ No	After PCMH3
PCMH5.	In the last 6 months, did someone from this provider's office ask you if there are things that make it hard for you to take care of your health? 1☐ Yes 2☐ No	After PCMH4
PCMH6.	In the last 6 months, did you and someone from this provider's office talk about things in your life that worry you or cause you stress? 1☐ Yes 2☐ No	After PCMH5

Supplemental Patient-Centered Medical Home Items for the CAHPS® Clinician & Group Survey 3.0

Population Version: Child
Language: English

Read about the Patient-Centered Medical Home Item Set.

Users of the CAHPS® Clinician & Group Survey are free to incorporate supplemental items in order to meet the needs of their organizations, local markets, and/or audiences. Some items cover events that occur with low frequency in the general population. You should include them only if your sample design is likely to yield a sufficient number of responses to those questions for statistical analysis and reporting.

Questions	Placement and Other Instructions
PCMH1. Did this provider's office give you information about what to do if your child needed care during evenings, weekends, or holidays? 1☐ Yes 2☐ No	After core question 15
PCMH2. Specialists are doctors like surgeons, heart doctors, allergy doctors, skin doctors, and other doctors who specialize in one area of health care. In the last 6 months, did your child see a specialist for a particular health problem? 1☐ Yes 2☐ No → **If No, go to PCMH4**	After core question 25
PCMH3. In the last 6 months, how often did the provider named in Question 1 seem informed and up-to-date about the care your child got from specialists? 1☐ Never 2☐ Sometimes 3☐ Usually 4☐ Always	After PCMH2 Note: Use with PCMH2
PCMH4. Please answer these questions about the provider named in Question 1 of this survey. In the last 6 months, did you and someone from this provider's office talk about the kinds of behaviors that are normal for your child at this age? 1☐ Yes 2☐ No	After PCMH3
PCMH5. In the last 6 months, did you and someone from this provider's office talk about how your child's body is growing? 1☐ Yes 2☐ No	After PCMH4
PCMH6. In the last 6 months, did you and someone from this provider's office talk about your child's moods and emotions? 1☐ Yes 2☐ No	After PCMH5

Questions	Placement and Other Instructions
PCMH7. In the last 6 months, did you and someone from this provider's office talk about things you can do to keep your child from getting injured? 1☐ Yes 2☐ No	After PCMH6
PCMH8. In the last 6 months, did you and someone from this provider's office talk about how much or what kind of food your child eats? 1☐ Yes 2☐ No	After PCMH7
PCMH9. In the last 6 months, did you and someone from this provider's office talk about how much or what kind of exercise your child gets? 1☐ Yes 2☐ No	After PCMH8
PCMH10. In the last 6 months, did you and someone from this provider's office talk about how your child gets along with others? 1☐ Yes 2☐ No	After PCMH9

Back Pain After Lumbar Discectomy/Laminectomy

CMIT Measure ID: 85 **| CMIT ID:** 00085-01-C-MIPS **| Measure Type:** Patient-Reported Outcome-Based Performance Measure (PRO-PM)

Date of Information: 03/26/2024 **| Revision:** 3 **| Program:** Merit-Based Incentive Payment System Program

View Description

For patients 18 years of age or older who had a lumbar discectomy/laminectomy or fusion procedure, back pain is rated by the patients as less than or equal to 3.0 OR an improvement of 5.0 points or greater on the Visual Analog Scale (VAS) Pain scale or a numeric pain scale at three months (6 to 20 weeks) postoperatively for discectomy/laminectomy or at one year (9 to 15 months) postoperatively for lumbar fusion patients. Rates are stratified by procedure type; lumbar discectomy/laminectomy or fusion procedure.

Properties

Steward

Characteristics

Cascade of Meaningful Measures

Groups

Programs

Reporting Status

Milestones

Links

Similar Measures

Environmental Scan

Components

Properties

Date of Information

03/26/2024

Abbreviated Measure Title

Not Available

Description

For patients 18 years of age or older who had a lumbar discectomy/laminectomy or fusion procedure, back pain is rated by the patients as less than or equal to 3.0 OR an improvement of 5.0 points or greater on the Visual Analog Scale (VAS) Pain scale or a numeric pain scale at three months (6 to 20 weeks) postoperatively for discectomy/laminectomy or at one year (9 to 15 months) postoperatively for lumbar fusion patients. Rates are stratified by procedure type; lumbar discectomy/laminectomy or fusion procedure.

Numerator

Numerator 1: All eligible patients whose back pain is less than or equal to 3.0 OR an improvement of 5.0 points or greater on the VAS or Numeric Pain scale at three months (6 to 20 weeks) postoperatively Numerator 2: All eligible patients whose back pain is less than or equal to 3.0 OR an improvement of 5.0 points or greater on the Visual Analog Scale (VAS) or Numeric pain scale at one year (9 to 15 months) postoperatively.

Denominator

Denominator 1: Patients with lumbar discectomy/ laminectomy procedure Patients 18 years of age or older as of January 1 of the denominator identification period who had a lumbar discectomy/laminectomy procedure performed during the denominator identification period Denominator 2: Patients 18 years of age or older as of October 1 of the denominator identification period who had a lumbar fusion procedure performed during the denominator identification period.

Denominator Exclusions

DENOMINATOR EXCLUSIONS (SUBMISSION CRITERIA 1): Patient had a lumbar fusion on the same date as the discectomy/ laminectomy procedure Patient had cancer, acute fracture or infection related to the lumbar spine OR patient had neuromuscular, idiopathic, or congenital lumbar scoliosis DENOMINATOR EXCLUSIONS (SUBMISSION CRITERIA 2): Patient had cancer, acute fracture or infection related to the lumbar spine OR patient had neuromuscular, idiopathic, or congenital lumbar scoliosis.

Rationale

Mechanical low back pain (LBP) remains the second most common symptom-related reason for seeing a physician in the United States. Of the US population, 85% will experience an episode of mechanical LBP at some point during their lifetime. Fortunately, the LBP resolves for the vast majority within 2-4 weeks. For individuals younger than 45 years, mechanical LBP represents the most common cause of disability and is generally associated with a work-related injury. For individuals older than 45 years, mechanical LBP is the third most common cause of disability, and a careful history and physical examination are vital to evaluation, treatment, and management (Hills et al 2022). Overall, spine surgery rates have declined slightly from 2002-2007, but the rate of complex fusion procedures 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 fusions. After adjustment for age, comorbidity, previous spine surgery, and other features, the odds ratio (OR) of life-threatening complications for complex fusion compared with decompression alone was 2.95 (95% confidence interval [CI], 2.50- 3.49). A similar pattern was observed for rehospitalization within 30 days, which occurred for 7.8% of patients undergoing decompression and 13.0% having a complex fusion (adjusted OR, 1.94; 95% CI, 1.74-2.17). Adjusted mean hospital charges for complex fusion procedures were US $80,888 compared with US $23,724 for decompression alone (Deyo, R. JAMA 2010). The MNCM Spine Surgery Measure development workgroup developed patient reported outcome measures for two populations of patients undergoing different lumbar spine procedures, a more complex procedure (lumbar fusion) and a second procedure that represented the most common procedure CPT code 63030 for the most common diagnosis of disc herniation. In 2018, the development workgroup reconvened and redesigned the measure construct to a target-based measure and additionally expanded the denominator for this measure to include all lumbar discectomy laminectomy procedures.

Evidence

The measure result is the average change in back pain as rated on a 0 - 10 visual analog scale before and after lumbar discectomy/laminotomy by all eligible patients. Field testing was conducted with 11 practice groups, resulting in an overall average change in back pain of 3.0, with group level results ranging from 1.4 to 4.9. The distribution of results demonstrates significant variation in the magnitude of improvement in symptoms with surgery.

Denominator Exceptions

Not applicable

Numerator Exceptions

Not applicable

Risk Adjusted

No

Program Name Abbreviation

MIPS

Program Status

Active

Centers for Medicare & Medicaid Services **Measures Inventory Tool**

CMS Measures Management System (MMS) Hub

CMS Meaningful Measures

CMS Pre-Rulemaking

CMS Quality Measures

NQF Quality Position System

eCQI Resource Center

Login to CMIT

About this Site

Contact Us

How It Works

Privacy Policy

User Guide

Looking for U.S. government information and services? **Visit CMS.gov, HHS.gov, USA.gov**

Cataracts: Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery

CMIT Measure ID: 116 | **CMIT ID:** 00116-01-C-MIPS | **Measure Type:** Patient-Reported Outcome-Based Performance Measure (PRO-PM)

Date of Information: 07/27/2022 | **Revision:** 5 | **Program:** Merit-Based Incentive Payment System Program

View Description

Percentage of patients aged 18 years and older who had cataract surgery and had improvement in visual function achieved within 90 days following the cataract surgery,[based on completing a preoperative and post-operative visual function survey]

Properties

Steward

Characteristics

Cascade of Meaningful Measures

Groups

Programs

Reporting Status

Milestones

Links

Similar Measures

Environmental Scan

Components

Properties

Date of Information

07/27/2022

Abbreviated Measure Title

Not Available

Description

Percentage of patients aged 18 years and older who had cataract surgery and had improvement in visual function achieved within 90 days following the cataract surgery,[based on completing a preoperative and post-operative visual function survey]

Numerator

Return to Top

Patients 18 years and older who had improvement in visual function achieved within 90 days following cataract surgery, based on completing both a pre-operative and post-operative visual function survey.

Denominator

All patients aged 18 years and older who had cataract surgery

Denominator Exclusions

Not available

Rationale

1) Scientific Basis for Measuring Visual Function Outcomes after Cataract Surgery. Visual function has been described as having multiple components, including central near, intermediate, and distance visual acuity; peripheral vision; visual search; binocular vision; depth perception; contrast sensitivity; perception of color; adaptation; and visual processing speed. Visual function also can be measured in terms of functional disability caused by visual impairment. Many activities are affected by more than one of these visual components. Health services researchers have increasingly emphasized function and quality of life as the outcomes of treatment that are most critical and applicable to the patient. As previously stated, the primary purpose in managing a patient with cataract is to improve functional vision and the quality of life. In well-designed observational studies, cataract surgery consistently has been shown to have a significant impact on vision- dependent function. The Cataract Patient Outcomes R

Evidence

Several studies have reported an association between improved visual function after cataract surgery and improved health-related quality of life. The purpose of this measure is to evaluate if visual function has improved following cataract surgery. The Cataract Patient Outcomes Research Team (PORT) reported that almost 90% of patients under-going first-eye cataract surgery noted improvement in functional status and satisfaction with vision. (Steinberg, E. P., Tielsch, J. M., Schein, O. D., Javitt, J. C., Sharkey, P., Cassard, S. D., Legro, M. W., Diener-West, M., Bass, E. B., & Damiano, A. M. (1994). National study of cataract surgery outcomes. Variation in 4-month postoperative outcomes as reflected in multiple outcome measures. Ophthalmology, 101(6), 1131–1141. https://doi.org/10.1016/s0161-6420(94)31210-3).

Denominator Exceptions

Patient care survey was not completed by patient

Numerator Exceptions

Not applicable

Risk Adjusted

No

Program Name Abbreviation

MIPS

Program Status

Active

Looking for U.S. government information and services? **Visit CMS.gov, HHS.gov, USA.gov**

Cataracts: Patient Satisfaction within 90 Days Following Cataract Surgery

CMIT Measure ID: 117 **| CMIT ID:** 00117-01-C-MIPS **| Measure Type:** Patient-Reported Outcome-Based Performance Measure (PRO-PM)

Date of Information: 05/10/2019 **| Revision:** 1 **| Program:** Merit-Based Incentive Payment System Program

View Description

Percentage of patients aged 18 years and older who had cataract surgery and were satisfied with their care within 90 days following the cataract surgery, based on completion of the Consumer Assessment of Healthcare Providers and Systems Surgical Care Survey.

Properties

Steward

Characteristics

Cascade of Meaningful Measures

Groups

Programs

Reporting Status

Milestones

Links

Similar Measures

Environmental Scan

Components

Properties

Date of Information

05/10/2019

Abbreviated Measure Title

Not Available

Description

Percentage of patients aged 18 years and older who had cataract surgery and were satisfied with their care within 90 days following the cataract surgery, based on completion of the Consumer Assessment of Healthcare Providers and Systems Surgical Care Survey.

Numerator

Return to Top

Patients 18 years and older who were satisfied with their care within 90 days following cataract surgery, based on completion of the Consumer Assessment of Healthcare Providers and Systems Surgical Care Survey.

Denominator

All patients aged 18 years and older who had cataract surgery

Denominator Exclusions

Not available

Rationale

1) Scientific Basis for Measuring Patient Satisfaction after Cataract Surgery Patient satisfaction is a valuable performance indicator for measuring the quality of care delivered by ophthalmologists providing cataract surgery. In the broadest sense, patient satisfaction is an assessment of the patient s experience with the care process delivered by health plans, clinicians, health systems, hospitals, etc. This experience can cover domains as diverse as information/education, interpersonal manner, emotional support, accessibility, convenience, outcomes or results, environment, personalization, involvement in care, finances, etc. In 1996, The American Academy of Ophthalmology launched the National Eyecare Outcomes Network (NEON) database. From January 1, 1996 through March 30, 2001, 249 ophthalmologists at 114 different practice sites submitted data to the NEON cataract surgery database. Post-operative patient satisfaction responses were collected for 6,154 patients, or about 34.5% of all patients who had pre-operative forms submitted. This assessment was performed at a median of 4.1 weeks postoperatively for all patients enrolled in the database. A 12-item questionnaire was used to assess patient satisfaction. Patient satisfaction was associated with younger age and absence of ocular comorbidity. Other studies of patient satisfaction after cataract surgery were conducted in Austria and in Spain. The Austrian study found that patients with pre-existing eye disease, including those patients with improved visual acuity after surgery, were the least satisfied with the results of surgery. In these cases, improved patient education prior to surgery could be helpful in improving patient satisfaction. The Spanish study found that patient satisfaction was associated with expectations prior to surgery. Most patients are satisfied with their care and results after cataract surgery. This outcome is achieved consistently through careful attention through the patient selection process, accurate measurement of axial length and corneal power, appropriate selection of an IOL power calculation formula, etc. As such, it reflects the care and diligence with which the surgery is assessed, planned and executed. Failure to achieve this satisfaction after surgery would reflect patterns of patient selection or treatment that should be assessed for opportunities for improvement. Use of this indicator in Medicare Part B Claims reporting method would require some modification to the current reporting of post-operative care for patients undergoing cataract surgery, since this indicator would be operative during the 90-day global period. However, there is a strong and practical precedent for such modifications in that reporting arrangements have previously been made to accommodate co-management of care by different providers during the post-operative period. A similar adjustment to allow for filing of a claim of meeting this goal at one point in the 90-day global period would be sufficient, potentially drawing upon the methods to demarcate the onset of co-management transfer of post-operative care. Various patient satisfaction instruments exist, but an instrument developed by the program, Consumer Assessment of Healthcare Providers and Systems (CAHPS), Agency for Healthcare Research and Quality develops and supports the use of a comprehensive and evolving family of standardized surveys that ask consumers and patients to report on and evaluate their experiences with health care. These surveys cover topics that are important to consumers, such as the communication skills of providers and the accessibility off services. AHRQ first launched the CAHPS program in October 1995 in response to concerns about the lack of good information about the quality of health plans from the enrollees' perspective. At that time, numerous public and private organizations collected information on enrollee and patient satisfaction, but the surveys varied from sponsor to sponsor and

Evidence

Not Available

Denominator Exceptions

Patient care survey was not completed by patient

Numerator Exceptions

Not applicable

Risk Adjusted

No

Program Name Abbreviation

MIPS

Program Status

Active

Centers for Medicare & Medicaid Services **Measures Inventory Tool**

CMS Measures Management System (MMS) Hub

CMS Meaningful Measures

CMS Pre-Rulemaking

CMS Quality Measures

NQF Quality Position System

eCQI Resource Center

Login to CMIT

About this Site

Contact Us

How It Works

Privacy Policy

User Guide

Looking for U.S. government information and services? **Visit CMS.gov, HHS.gov, USA.gov**

Dermatitis - Improvement in Patient-Reported Itch Severity

CMIT Measure ID: 1663 **| CMIT ID:** 01663-01-C-MIPS **| Measure Type:** Patient-Reported Outcome-Based Performance Measure (PRO-PM)

Date of Information: 03/27/2023 **| Revision:** 6 **| Program:** Merit-Based Incentive Payment System Program

View Description

The percentage of patients, aged 18 years and older, with a diagnosis of dermatitis where at an initial (index) visit have a patient reported itch severity assessments performed, score greater than or equal to 4, and who achieve a score reduction of 2 or more points at a follow up visit.

Properties

Steward

Characteristics

Cascade of Meaningful Measures

Groups

Programs

Reporting Status

Milestones

Links

Similar Measures

Environmental Scan

Components

Properties

Date of Information

03/27/2023

Abbreviated Measure Title

Not Available

Description

The percentage of patients, aged 18 years and older, with a diagnosis of dermatitis where at an initial (index) visit have a patient reported itch severity assessments performed, score greater than or equal to 4, and who achieve a score reduction of 2 or more points at a follow up visit.

Numerator

Patients who achieve an assessment score that is reduced by 2 or more points (minimal clinically important difference) from the initial (index) assessment score.

Denominator

All patients aged 18 years and older, with a diagnosis of dermatitis with an initial (index visit) Numeric Rating Scale (NRS), Visual Rating Scale (VRS), or ItchyQuant assessment score of greater than or equal to 4 who are returning for a follow-up visit.

Denominator Exclusions

None

Rationale

Various types of dermatitis are chronically pruritic and are tremendously burdensome. Atopic dermatitis (AD) is a chronic skin disease in which pruritus is responsible for much of the disease burden and morbidity borne by patients. It is estimated that in the U.S. alone, 31.6 million people have symptoms of AD, with 17.8 million meeting the criteria for AD. The effects of this disease are substantial; with direct costs estimated to be between $1 and $4 billion. Other types of dermatitis, such as contact dermatitis and seborrheic dermatitis (SD) are also chronic, pruritic conditions which greatly affect patients. Approximately 6 million people in the U.S. have SD with direct and indirect costs estimated to be $230 million. These various forms of dermatitis also greatly impact the quality-of-life patients have. In one study looking at the patient burden in adults with moderate to severe AD, 85% reported problems with the frequency of their itch and 41.5% reported itching for 18 hours or more a day. With this persistence of itching, 55% of patients showed AD-related sleep disturbance 5 days a week or more and 21.8% showed clinically relevant anxiety or depression. In another study, investigators quantified pruritic burden in a cross-sectional analysis investigating chronic pruritus and pain. They demonstrated that the quality-of-life impact was due to the severity of the symptom, rather than whether the symptom was pain or pruritus. Moreover, they elucidated a mean health utility score of 0.87 from CP patients, meaning that on average, a patient would give up 13% of their life expectancy to live without pruritus. Additionally, studies of CP have shown patients to have a 17% higher mortality risk as well as being strongly associated with poorer general health. Moreover, data from the National Ambulatory Medical Care Survey (1999-2009) found that a total of 77 million patient visits for itch were made during the 11-year time period. This was an average of 7 million visits per year, which represented approximately 1% of all outpatient visits. Also, further analysis showed that although the majority visits (58.6%) were for new instances of itch, almost a third (32%) were for chronic pruritus. This measure aims to improve pruritus in patients who carry a large burden with this disease; by assessing itch and aiming to make the symptom more manageable.

Evidence

Various types of dermatitis are chronically pruritic and are tremendously burdensome. Atopic dermatitis (AD) is a chronic skin disease in which pruritus is responsible for much of the disease burden and morbidity borne by patients. It is estimated that in the U.S. alone, 31.6 million people have symptoms of AD, with 17.8 million meeting the criteria for AD. The effects of this disease are substantial; with direct costs estimated to be between $1 and $4 billion. Other types of dermatitis, such as contact dermatitis and seborrheic dermatitis (SD) are also chronic, pruritic conditions which greatly affect patients. Approximately 6 million people in the U.S. have SD with direct and indirect costs estimated to be $230 million.

Denominator Exceptions

None

Numerator Exceptions

Not Available

Risk Adjusted

No

Program Name Abbreviation

MIPS

Program Status

Active

Centers for Medicare & Medicaid Services **Measures Inventory Tool**

CMS Measures Management System (MMS) Hub

CMS Meaningful Measures

CMS Pre-Rulemaking

CMS Quality Measures

NQF Quality Position System

eCQI Resource Center

Login to CMIT

About this Site

Contact Us

How It Works

Privacy Policy

User Guide

Functional Status After Lumbar Surgery

CMIT Measure ID: 276 | **CMIT ID:** 00276-01-C-MIPS | **Measure Type:** Patient-Reported Outcome-Based Performance Measure (PRO-PM)

Date of Information: 03/26/2024 | **Revision:** 5 | **Program:** Merit-Based Incentive Payment System Program

View Description

For patients age 18 and older who had lumbar discectomy/laminectomy procedure, functional status is rated by the patient as less than or equal to 22 OR an improvement of 30 points or greater on the Oswestry Disability Index (ODI version 2. la) at three months (6 to 20 weeks) postoperatively

Properties

Steward

Characteristics

Cascade of Meaningful Measures

Groups

Programs

Reporting Status

Milestones

Links

Similar Measures

Environmental Scan

Components

Properties

Date of Information

03/26/2024

Abbreviated Measure Title

Not Available

Description

For patients age 18 and older who had lumbar discectomy/laminectomy procedure, functional status is rated by the patient as less than or equal to 22 OR an improvement of 30 points or greater on the Oswestry Disability Index (ODI version 2. la) at three months (6 to 20 weeks) postoperatively

Numerator

Return to Top

Numerator 1: All eligible patients whose functional status is less than or equal to 22 OR an improvement of 30 points or greater on the Oswestry Disability Index (ODI version 2.1a) at three months (6 to 20 weeks) postoperatively Numerator 2: All eligible patients whose functional status is less than or equal to 22 OR an improvement of 30 points or greater on the Oswestry Disability Index (ODI Version 2.1a) patient reported outcome tool at one year (9 to 15 months) postoperatively.

Denominator

Denominator 1: Patients with lumbar discectomy/laminectomy procedure Patients 18 years of age or older as of January 1 of the denominator identification period who had a lumbar discectomy/laminectomy procedure performed during the denominator identification period Denominator 2: Patients with lumbar fusion procedure Patients 18 years of age or older as of October 1 of the denominator identification period who had a lumbar fusion procedure performed during the denominator identification period.

Denominator Exclusions

DENOMINATOR 1 EXCLUSIONS: Patient had a lumbar fusion on the same date as the discectomy/laminectomy procedure AND NOT Patient had cancer, acute fracture or infection related to the lumbar spine OR patient had neuromuscular, idiopathic, or congenital lumbar scoliosis: - Patients with a diagnosis of lumbar spine region cancer at the time of the procedure - Patients with a diagnosis of acute lumbar spine region fracture at the time of the procedure - Patients with a diagnosis of lumbar spine region infection at the time of the procedure - Patients with a diagnosis of lumbar neuromuscular, idiopathic, or congenital scoliosis Denominator 2 Exclusions: Patient had cancer, acute fracture or infection related to the lumbar spine OR patient had neuromuscular, idiopathic, or congenital lumbar scoliosis: - Patients with a diagnosis of lumbar spine region cancer at the time of the procedure - Patients with a diagnosis of acute lumbar spine region fracture at the time of the procedure - Patients with a diagnosis of lumbar spine region infection at the time of the procedure - Patients with a diagnosis of lumbar neuromuscular, idiopathic, or congenital scoliosis

Rationale

Mechanical low back pain (LBP) remains the second most common symptom-related reason for seeing a physician in the United States. Of the US population, 85% will experience an episode of mechanical LBP at some point during their lifetime. Fortunately, the LBP resolves for the vast majority within 2-4 weeks. For individuals younger than 45 years, mechanical LBP represents the most common cause of disability and is generally associated with a work-related injury. For individuals older than 45 years, mechanical LBP is the third most common cause of disability, and a careful history and physical examination are vital to evaluation, treatment, and management (Hills et al 2022). Overall, spine surgery rates have declined slightly from 2002-2007, but the rate of complex fusion procedures 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 fusions. After adjustment for age, comorbidity, previous spine surgery, and other features, the odds ratio (OR) of life-threatening complications for complex fusion compared with decompression alone was 2.95 (95% confidence interval [CI], 2.50- 3.49). A similar pattern was observed for rehospitalization within 30 days, which occurred for 7.8% of patients undergoing decompression and 13.0% having a complex fusion (adjusted OR, 1.94; 95% CI, 1.74-2.17). Adjusted mean hospital charges for complex fusion procedures were US $80,888 compared with US $23,724 for decompression alone (Deyo, R. JAMA 2010). The MNCM Spine Surgery Measure development workgroup developed patient reported outcome measures for two populations of patients undergoing different lumbar spine procedures, a more complex procedure (lumbar fusion) and a second procedure that represented the most common procedure CPT code 63030 for the most common diagnosis of disc herniation. In 2018, the development workgroup reconvened and redesigned the measure construct to a target-based measure and additionally expanded the denominator for this measure to include all lumbar discectomy laminectomy procedures

Evidence

Not Available

Denominator Exceptions

Not applicable

Numerator Exceptions

Not applicable

Risk Adjusted

No

Program Name Abbreviation

MIPS

Program Status

Active

Centers for Medicare & Medicaid Services **Measures Inventory Tool**

CMS Measures Management System (MMS) Hub

CMS Meaningful Measures

CMS Pre-Rulemaking

CMS Quality Measures

NQF Quality Position System

eCQI Resource Center

Login to CMIT

About this Site

Contact Us

How It Works

Privacy Policy

User Guide

Looking for U.S. government information and services? **Visit CMS.gov, HHS.gov, USA.gov**

Functional Status After Primary Total Knee Replacement

CMIT Measure ID: 279 | **CMIT ID:** 00279-07-C-MIPS | **Measure Type:** Patient-Reported Outcome-Based Performance Measure (PRO-PM)

Date of Information: 09/20/2021 | **Revision:** 2 | **Program:** Merit-Based Incentive Payment System Program

View Description

For patients age 18 and older who had a primary total knee replacement procedure, functional status is rated by the patient as greater than or equal to 37 on the Oxford Knee Score (OKS) or a 71 or greater on the KOOS, JR tool at one year (9 to 15 months) postoperatively.

Properties

Steward

Characteristics

Cascade of Meaningful Measures

Groups

Programs

Reporting Status

Milestones

Links

Similar Measures

Environmental Scan

Components

Properties

Date of Information

09/20/2021

Abbreviated Measure Title

Not Available

Description

For patients age 18 and older who had a primary total knee replacement procedure, functional status is rated by the patient as greater than or equal to 37 on the Oxford Knee Score (OKS) or a 71 or greater on the KOOS, JR tool at one year (9 to 15 months) postoperatively.

Numerator

All eligible patients whose functional status is greater than or equal to 37 on the Oxford Knee Score (OKS) or greater than or equal to 71 on

Return to Top

the KOOS, JR patient reported outcome tool at one year (9 to 15 months) postoperatively.

Denominator

Patients 18 years of age or older as of October 1 of the denominator identification period who had a total knee replacement procedure performed during the denominator identification period.

Denominator Exclusions

None

Rationale

Annually there are over 500,000 total knee replacement (TKR) procedures performed in the United States. It is projected that by 2030 the volume of this procedure will increase to over 3.48 million per year due to the aging baby-boomers, increased obesity and indications for TKR that extend to both younger as well as older patients (AAOS 2006 Kurtz). From 2000 to 2006, the Medicare TKR rate overall in the United States increased 58%, from 5.5 to 8.7 per 1000 and TKR revisions currently represent 8.2% of all Medicare dollars spent (Ong 2006). It is estimated that annual hospital charges for TKR will approach 40.8 billion dollars annually by 2015 (Kaiser-Permanente 2007). For the Minnesota Medicare population in 2006, 9,856 patients underwent a primary hip or knee replacement procedure (DRG 544) and 1,174 patients had a hip or knee revision (DRG 545). Nationally, for DRG 544 the average charge per hospitalization was $38,447 with an average payment of $11,916 (Value driven health care 2008 CMS). Target was derived from a study Patient acceptable symptom states after total hip or knee replacement at mid-term follow-up [Kuerentjes JC, Van Tol FR Bone Joint Res 2014; 3:7 13]. Receiver operating characteristic (ROC) curves identified a PASS threshold of 42 for the Oxford Hip Score (OHS) after Total Hip Replacement (THR) and 37 for the OKS after TKR. THR patients with an OHS greater than or equal to 42 and TKR patients with an OKS greater than or equal to 37 had a higher NRS for satisfaction and a greater likelihood of being willing to undergo surgery again. The Patient Acceptable Symptom State (PASS), the highest level of symptom beyond which patients consider themselves well. PASS was compared to post-op OKS to determine an equivalent OKS threshold. OKS score greater than or equal to 37 indicates the achievement of an acceptable symptom state and correlates with a higher numeric rating scale for satisfaction [ROC curves PASS threshold of 37 with sensitivity of 76.3% and specificity of 76.5%]

Evidence

Not Available

Denominator Exceptions

Not applicable

Numerator Exceptions

Not applicable

Risk Adjusted

No

Program Name Abbreviation

MIPS

Program Status

Active

CMS Measures Management System (MMS) Hub

CMS Meaningful Measures

CMS Pre-Rulemaking

CMS Quality Measures

NQF Quality Position System

eCQI Resource Center

Login to CMIT

About this Site

Contact Us

How It Works

Privacy Policy

User Guide

Looking for U.S. government information and services? **Visit CMS.gov, HHS.gov, USA.gov**

Functional Status Change for Patients with Elbow, Wrist or Hand Impairments

CMIT Measure ID: 283 | **CMIT ID:** 00283-01-C-MIPS | **Measure Type:** Patient-Reported Outcome-Based Performance Measure (PRO-PM)

Date of Information: 06/16/2023 | **Revision:** 5 | **Program:** Merit-Based Incentive Payment System Program

View Description

A patient-reported outcome measure (PROM) of risk-adjusted change in functional status (FS) for patients 14 years+ with elbow, wrist, or hand impairments. The change in FS is assessed using the FOTO Elbow/Wrist/Hand FS PROM. The measure is adjusted to patient characteristics known to be associated with FS outcomes (risk adjusted) and used as a performance measure at the patient, individual clinician, and clinic levels to assess quality.

Properties

Steward

Characteristics

Cascade of Meaningful Measures

Groups

Programs

Reporting Status

Milestones

Links

Similar Measures

Environmental Scan

Components

Properties

Date of Information

06/16/2023

Abbreviated Measure Title

Not Available

Description

A patient-reported outcome measure (PROM) of risk-adjusted change in functional status (FS) for patients 14 years+ with elbow, wrist, or hand impairments. The change in FS is assessed using the FOTO Elbow/Wrist/Hand FS PROM. The measure is adjusted to patient

Return to Top

characteristics known to be associated with FS outcomes (risk adjusted) and used as a performance measure at the patient, individual clinician, and clinic levels to assess quality.

Numerator

Patients who were presented with the Elbow/Wrist/Hand FS PROM at Initial Evaluation (Intake) and at or near Discharge (Status) for the purpose of calculating the patient's Residual Score.

Denominator

All patients 14 years and older with elbow, wrist or hand impairments who have initiated a Treatment Episode.

Denominator Exclusions

Documentation stating patient has a diagnosis of a degenerative neurological condition such as ALS, MS, or Parkinson s diagnosed at any time before or during the episode of care Patient unable to complete the Elbow/Wrist/Hand FS PROM at Initial Evaluation and/or Discharge due to blindness, illiteracy, severe mental incapacity or language incompatibility and an adequate proxy is not available

Rationale

Functional deficits are common in the general population and are costly to the individual, their family, and society. Improved functional status has been associated with greater quality of life, self-efficacy, improved financial well-being, and lower future medical costs. Improving functional status in people seeking rehabilitation has become a goal of the American Physical Therapy Association (APTA). Therefore, measuring change in functional status is important for providers treating patients in rehabilitation and can be used to assess the success of treatment and direct modification of treatment. Change in functional status represents the Activities and Participation domain of the International Classification of Functioning, Disability and Health. If treatment is designed to improve the functional deficit, it is logical to assess functional status at discharge using a standardized score to determine if treatment improved the functional status of the patient over the treatment episode. The National Quality Measures Clearinghouse has approved the measurement of change in functional status, using this measure. (NQMC-1874)

Evidence

Not Available

Denominator Exceptions

Documentation of medical reason(s) for not screening for tobacco use (e.g., limited life expectancy, other medical reason) Documentation of medical reason(s) for not providing tobacco cessation intervention on the date of the encounter or within the previous 12 months if identified as a tobacco user (e.g., limited life expectancy, other medical reason)

Numerator Exceptions

Not applicable

Risk Adjusted

Yes

Program Name Abbreviation

MIPS

Program Status

Active

Centers for Medicare & Medicaid Services **Measures Inventory Tool**

CMS Measures Management System (MMS) Hub

CMS Meaningful Measures

CMS Pre-Rulemaking

CMS Quality Measures

NQF Quality Position System

eCQI Resource Center

Login to CMIT

About this Site

Contact Us

How It Works

Privacy Policy

User Guide

Functional Status Change for Patients with Hip Impairments

CMIT Measure ID: 285 | **CMIT ID:** 00285-01-C-MIPS | **Measure Type:** Patient-Reported Outcome-Based Performance Measure (PRO-PM)

Date of Information: 12/06/2022 | **Revision:** 4 | **Program:** Merit-Based Incentive Payment System Program

View Description

A patient-reported outcome measure (PROM) of risk-adjusted change in functional status (FS) for patients 14 years+ with hip impairments. The change in FS is assessed using the FOTO Lower Extremity Physical Function (LEPF) PROM. The measure is adjusted to patient characteristics known to be associated with FS outcomes (risk adjusted) and used as a performance measure at the patient, individual clinician, and clinic levels to assess quality.

Properties

Steward

Characteristics

Cascade of Meaningful Measures

Groups

Programs

Reporting Status

Milestones

Links

Similar Measures

Environmental Scan

Components

Properties

Date of Information

12/06/2022

Abbreviated Measure Title

Not Available

Description

A patient-reported outcome measure (PROM) of risk-adjusted change in functional status (FS) for patients 14 years+ with hip impairments. The change in FS is assessed using the FOTO Lower Extremity Physical Function (LEPF) PROM. The measure is adjusted to patient characteristics known to be associated with FS outcomes (risk adjusted) and used as a performance measure at the patient, individual clinician, and clinic levels to assess quality.

Return to Top

Numerator

Patients who were presented with the LEPF PROM at Initial Evaluation (Intake) and at or near Discharge (Status) for the purpose of calculating the patient's Residual Score.

Denominator

All patients 14 years and older with hip impairments who have initiated a Treatment Episode.

Denominator Exclusions

Documentation stating patient has a diagnosis of a degenerative neurological condition such as ALS, MS, or Parkinson s diagnosed at any time before or during the episode of care Patient unable to complete the LEPF PROM at Initial Evaluation and/or Discharge due to blindness, illiteracy, severe mental incapacity or language incompatibility and an adequate proxy is not available

Rationale

Functional deficits are common in the general population and are costly to the individual, their family and society. Improved functional status has been associated with greater quality of life, self-efficacy, improved financial well-being and lower future medical costs. Improving functional status in people seeking rehabilitation has become a goal of the American Physical Therapy Association. Therefore, measuring change in functional status is important for providers treating patients in rehabilitation and can be used to assess the success of treatment and direct modification of treatment. Change in functional status represents the Activities and Participation domain of the International Classification of Functioning, Disability and Health. If treatment is designed to improve the functional deficit, it is logical to assess functional status at discharge using a standardized score to determine if treatment improved the functional status of the patient over the treatment episode. The National Quality Measures Clearinghouse has approved the measurement of change in functional status, using this measure. (NQMC-1872)

Evidence

Not Available

Denominator Exceptions

Ongoing care not clinically indicated because the patient needed a home program only, referral to another provider or facility, or consultation only, as documented in the medical record Ongoing care not medically possible because the patient was discharged early due to specific medical events, documented in the medical record, such as the patient became hospitalized or scheduled for surgery Ongoing care not possible because the patient self-discharged early (e.g., financial or insurance reasons, transportation problems, or reason unknown) Patient refused to participate

Numerator Exceptions

Not applicable

Risk Adjusted

No

Program Name Abbreviation

MIPS

Program Status

Active

CMS Measures Management System (MMS) Hub

CMS Meaningful Measures

CMS Pre-Rulemaking

CMS Quality Measures

NQF Quality Position System

eCQI Resource Center

Login to CMIT

About this Site

Contact Us

How It Works

Privacy Policy

User Guide

Looking for U.S. government information and services? **Visit CMS.gov, HHS.gov, USA.gov**

Functional Status Change for Patients with Knee Impairments

CMIT Measure ID: 286 | **CMIT ID:** 00286-01-C-MIPS | **Measure Type:** Patient-Reported Outcome-Based Performance Measure (PRO-PM)

Date of Information: 12/06/2022 | **Revision:** 4 | **Program:** Merit-Based Incentive Payment System Program

View Description

A patient-reported outcome measure (PROM) of risk-adjusted change in functional status (FS) for patients 14 years+ with knee impairments. The change in FS is assessed using the FOTO Lower Extremity Physical Function (LEPF) PROM. The measure is adjusted to patient characteristics known to be associated with FS outcomes (risk adjusted) and used as a performance measure at the patient, individual clinician, and clinic levels to assess quality.

Properties

Steward

Characteristics

Cascade of Meaningful Measures

Groups

Programs

Reporting Status

Milestones

Links

Similar Measures

Environmental Scan

Components

Properties

Date of Information

12/06/2022

Abbreviated Measure Title

Not Available

Description

A patient-reported outcome measure (PROM) of risk-adjusted change in functional status (FS) for patients 14 years+ with knee impairments. The change in FS is assessed using the FOTO Lower Extremity Physical Function (LEPF) PROM. The measure is adjusted to patient characteristics known to be associated with FS outcomes (risk adjusted) and used as a performance measure at the patient, individual clinician, and clinic levels to assess quality.

Return to Top

Numerator

Patients who were presented with the LEPF PROM at Initial Evaluation (Intake) and at or near Discharge (Status) for the purpose of calculating the patient's Residual Score.

Denominator

All patients 14 years and older with knee impairments who have initiated a Treatment Episode.

Denominator Exclusions

Documentation stating patient has a diagnosis of a degenerative neurological condition such as ALS, MS, or Parkinson s diagnosed at any time before or during the episode of care. Patient unable to complete the LEPF PROM at Initial Evaluation and/or Discharge due to blindness, illiteracy, severe mental incapacity or language incompatibility and an adequate proxy is not available.

Rationale

Functional deficits are common in the general population and are costly to the individual, their family, and society. Improved functional status has been associated with greater quality of life, self-efficacy, improved financial well-being, and lower future medical costs. Improving functional status in people seeking rehabilitation has become a goal of the American Physical Therapy Association. Therefore, measuring change in functional status is important for providers treating patients in rehabilitation and can be used to assess the success of treatment and direct modification of treatment. Change in functional status represents the Activities and Participation domain of the International Classification of Functioning, Disability and Health. If treatment is designed to improve the functional deficit, it is logical to assess functional status at discharge using a standardized score to determine if treatment improved the functional status of the patient over the treatment episode. The National Quality Measures Clearinghouse has approved the measurement of change in functional status, using this measure. (NQMC-1873)

Evidence

Not Available

Denominator Exceptions

Ongoing care not clinically indicated because the patient needed a home program only, referral to another provider or facility, or consultation only, as documented in the medical record. Ongoing care not medically possible because the patient was discharged early due to specific medical events, documented in the medical record, such as the patient became hospitalized or scheduled for surgery. Ongoing care not possible because the patient self-discharged early (e.g., financial or insurance reasons, transportation problems, or reason unknown). Patient refused to participate

Numerator Exceptions

Not applicable

Risk Adjusted

No

Program Name Abbreviation

MIPS

Program Status

Active

CMS Measures Management System (MMS) Hub

CMS Meaningful Measures

CMS Pre-Rulemaking

CMS Quality Measures

NQF Quality Position System

eCQI Resource Center

Login to CMIT

About this Site

Contact Us

How It Works

Privacy Policy

User Guide

Looking for U.S. government information and services? **Visit CMS.gov, HHS.gov, USA.gov**

Functional Status Change for Patients with Low Back Impairments

CMIT Measure ID: 287 | **CMIT ID:** 00287-01-C-MIPS | **Measure Type:** Patient-Reported Outcome-Based Performance Measure (PRO-PM)

Date of Information: 12/06/2022 | **Revision:** 4 | **Program:** Merit-Based Incentive Payment System Program

View Description

A patient-reported outcome measure (PROM) of risk-adjusted change in functional status (FS) for patients 14 years+ with low back impairments. The change in FS is assessed using the FOTO Low Back FS PROM. The measure is adjusted to patient characteristics known to be associated with FS outcomes (risk adjusted) and used as a performance measure at the patient, individual clinician, and clinic levels to assess quality.

Properties

Steward

Characteristics

Cascade of Meaningful Measures

Groups

Programs

Reporting Status

Milestones

Links

Similar Measures

Environmental Scan

Components

Properties

Date of Information

12/06/2022

Abbreviated Measure Title

Not Available

Description

A patient-reported outcome measure (PROM) of risk-adjusted change in functional status (FS) for patients 14 years+ with low back impairments. The change in FS is assessed using the FOTO Low Back FS PROM. The measure is adjusted to patient characteristics known

Return to Top

to be associated with FS outcomes (risk adjusted) and used as a performance measure at the patient, individual clinician, and clinic levels to assess quality.

Numerator

Patients who were presented with the Low Back FS PROM at Initial Evaluation (Intake) and at or near Discharge (Status) for the purpose of calculating the patient's Residual Score.

Denominator

All patients 14 years and older with a low back impairment who have initiated a Treatment Episode

Denominator Exclusions

Documentation stating patient has a diagnosis of a degenerative neurological condition such as ALS, MS, or Parkinson s diagnosed at any time before or during the episode of care Patient unable to complete the Low Back FS PROM at Initial Evaluation and/or Discharge due to blindness, illiteracy, severe mental incapacity or language incompatibility and an adequate proxy is not available

Rationale

Functional deficits are common in the general population and are costly to the individual, their family, and society. Improved functional status has been associated with greater quality of life, self-efficacy, improved financial well-being, and lower future medical costs. Improving functional status in people seeking rehabilitation has become a goal of the American Physical Therapy Association (APTA). Therefore, measuring change in functional status is important for providers treating patients in rehabilitation and can be used to assess the success of treatment and direct modification of treatment. Change in functional status represents the Activities and Participation domain of the International Classification of Functioning, Disability and Health. If treatment is designed to improve the functional deficit, it is logical to assess functional status at discharge using a standardized score to determine if treatment improved the functional status of the patient over the treatment episode. The National Quality Measures Clearinghouse has approved the measurement of change in functional status, using this measure. (NQMC-2632)

Evidence

Not Available

Denominator Exceptions

Ongoing care not clinically indicated because the patient needed a home program only, referral to another provider or facility, or consultation only, as documented in the medical record Ongoing care not medically possible because the patient was discharged early due to specific medical events, documented in the medical record, such as the patient became hospitalized or scheduled for surgery Ongoing care not possible because the patient self-discharged early (e.g., financial or insurance reasons, transportation problems, or reason unknown) Patient refused to participate

Numerator Exceptions

Not applicable

Risk Adjusted

No

Program Name Abbreviation

MIPS

Program Status

Active

Centers for Medicare & Medicaid Services **Measures Inventory Tool**

CMS Measures Management System (MMS) Hub

CMS Meaningful Measures

CMS Pre-Rulemaking

CMS Quality Measures

NQF Quality Position System

eCQI Resource Center

Login to CMIT

About this Site

Contact Us

How It Works

Privacy Policy

User Guide

Functional Status Change for Patients with Lower Leg, Foot or Ankle Impairments

CMIT Measure ID: 288 | **CMIT ID:** 00288-01-C-MIPS | **Measure Type:** Patient-Reported Outcome-Based Performance Measure (PRO-PM)

Date of Information: 12/06/2022 | **Revision:** 5 | **Program:** Merit-Based Incentive Payment System Program

View Description

A patient-reported outcome measure (PROM) of risk-adjusted change in functional status (FS) for patients 14 years+ with foot, ankle or lower leg impairments. The change in FS is assessed using the FOTO Lower Extremity Physical Function (LEPF) PROM. The measure is adjusted to patient characteristics known to be associated with FS outcomes (risk adjusted) and used as a performance measure at the patient, individual clinician, and clinic levels to assess quality.

Properties

Steward

Characteristics

Cascade of Meaningful Measures

Groups

Programs

Reporting Status

Milestones

Links

Similar Measures

Environmental Scan

Components

Properties

Date of Information

12/06/2022

Abbreviated Measure Title

Not Available

Description

A patient-reported outcome measure (PROM) of risk-adjusted change in functional status (FS) for patients 14 years+ with foot, ankle or lower leg impairments. The change in FS is assessed using the FOTO Lower Extremity Physical Function (LEPF) PROM. The measure is

Return to Top

adjusted to patient characteristics known to be associated with FS outcomes (risk adjusted) and used as a performance measure at the patient, individual clinician, and clinic levels to assess quality.

Numerator

Patients who were presented with the LEPF PROM at Initial Evaluation (Intake) and at or near Discharge (Status) for the purpose of calculating the patient's Residual Score.

Denominator

All patients 14 years and older with foot, ankle or lower leg impairments who have initiated a Treatment Episode.

Denominator Exclusions

Documentation stating patient has a diagnosis of a degenerative neurological condition such as ALS, MS, or Parkinson s diagnosed at any time before or during the episode of care Patient unable to complete the LEPF PROM at Initial Evaluation and/or Discharge due to blindness, illiteracy, severe mental incapacity or language incompatibility and an adequate proxy is not available

Rationale

Functional deficits are common in the general population and are costly to the individual, their family and society. Improved functional status has been associated with greater quality of life, self-efficacy, improved financial well-being and lower future medical costs. Improving functional status in people seeking rehabilitation has become a goal of the American Physical Therapy Association. Therefore, measuring change in functional status is important for providers treating patients in rehabilitation and can be used to assess the success of treatment and direct modification of treatment. Change in functional status represents the Activities and Participation domain of the International Classification of Functioning, Disability and Health. If treatment is designed to improve the functional deficit, it is logical to assess functional status at discharge using a standardized score to determine if treatment improved the functional status of the patient over the treatment episode. The National Quality Measures Clearinghouse has approved the measurement of change in functional status, using this measure. (NQMC-1874)

Evidence

Not Available

Denominator Exceptions

Ongoing care not clinically indicated because the patient needed a home program only, referral to another provider or facility, or consultation only, as documented in the medical record Ongoing care not medically possible because the patient was discharged early due to specific medical events, documented in the medical record, such as the patient became hospitalized or scheduled for surgery Ongoing care not possible because the patient self-discharged early (e.g., financial or insurance reasons, transportation problems, or reason unknown) Patient refused to participate

Numerator Exceptions

Not applicable

Risk Adjusted

No

Program Name Abbreviation

MIPS

Program Status

Active

Centers for Medicare & Medicaid Services **Measures Inventory Tool**

CMS Measures Management System (MMS) Hub

CMS Meaningful Measures

CMS Pre-Rulemaking

CMS Quality Measures

NQF Quality Position System

eCQI Resource Center

Login to CMIT

About this Site

Contact Us

How It Works

Privacy Policy

User Guide

Functional Status Change for Patients with Neck Impairments

CMIT Measure ID: 289 | **CMIT ID:** 00289-01-C-MIPS | **Measure Type:** Patient-Reported Outcome-Based Performance Measure (PRO-PM)

Date of Information: 12/06/2022 | **Revision:** 5 | **Program:** Merit-Based Incentive Payment System Program

View Description

A patient-reported outcome measure (PROM) of risk-adjusted change in functional status (FS) for patients 14 years+ with neck impairments. The change in FS is assessed using the FOTO Neck FS PROM. The measure is adjusted to patient characteristics known to be associated with FS outcomes (risk-adjusted) and used as a performance measure at the patient, individual clinician, and clinic levels to assess quality.

Properties

Steward

Characteristics

Cascade of Meaningful Measures

Groups

Programs

Reporting Status

Milestones

Links

Similar Measures

Environmental Scan

Components

Properties

Date of Information

12/06/2022

Abbreviated Measure Title

Not Available

Description

A patient-reported outcome measure (PROM) of risk-adjusted change in functional status (FS) for patients 14 years+ with neck impairments. The change in FS is assessed using the FOTO Neck FS PROM. The measure is adjusted to patient characteristics known to be associated with FS outcomes (risk-adjusted) and used as a performance measure at the patient, individual clinician, and clinic levels to assess quality.

Numerator

Return to Top

Patients who were presented with the Neck FS PROM at Initial Evaluation (Intake) and at or near Discharge (Status) for the purpose of calculating the patient's Residual Score.

Denominator

All patients aged 14 years and older with neck impairments who initiated a Treatment Episode.

Denominator Exclusions

Documentation stating patient has a diagnosis of a degenerative neurological condition such as ALS, MS, or Parkinson s diagnosed at any time before or during the episode of care OR Patient unable to complete the Neck FS PROM at Initial Evaluation and/or Discharge due to blindness, illiteracy, severe mental incapacity or language incompatibility and an adequate proxy is not available.

Rationale

Neck impairments provide a common reason for patients seeking care in healthcare settings. During 2017, the FOTO database recorded 414,436 episodes of care across multiple healthcare systems and clinics throughout the United States. Prevalence estimates from epidemiologic studies on neck pain (defined as pain in the neck, with or without pain referred into one or both upper limbs, that lasts for at least 1 day) have a mean 1-year prevalence range of 23%1 to 37%2 and a mean lifetime prevalence of 49%.2 Consequently, neck pain is recognized as a global health care burden.3,4 Assessment of functional status using PROMs in patients with neck pain is an essential step in addressing this burden, provided the scores can be interpreted in clinically useful ways to inform patient-centered clinical decision making. The Neck FS PROM offers the advantages of modern scientific measurement methods like item response theory (IRT). IRT and related methods provide a number of measurement advantages including valid assumptions of interval scaling, superior scale coverage, uni-dimensionality for valid score change interpretations, and precise methods for evaluating components of the measures such as the functional questions and scales. IRT additionally forms the basis for computer adaptive testing (CAT) administration which reduces patient burden by minimizing the number of functional questions the patient must respond to in order to obtain a precise estimate of the patient s functional ability level. When combined with robust risk adjustment to provide for fair comparisons between providers, the Neck FS PROM forms the basis for a valuable patient reported outcome performance measure (PRO-PM). 1. Hoy DG, Protani M, De R, Buchbinder R. The epidemiology of neck pain. Best Pract Res Clin Rheumatol. 2010;24:783-792. https://doi. org/10.1016/j.berh.2011.01.019. 2. Fejer R, Kyvik KO, Hartvigsen J. The prevalence of neck pain in the world population: a systematic critical review of the literature. Eur Spine J. 2006;15:834-848. https://doi.org/10.1007/ s00586-004-0864-4 3. Hoy D, March L, Woolf A, et al. The global burden of neck pain: estimates from the Global Burden of Disease 2010 study. Ann Rheum Dis. 2014;73:1309-1315. https://doi.org/10.1136/ 4. Hurwitz EL, Randhawa K, Yu H, Cot P, Haldeman S. The Global Spine Care Initiative: a summary of the global burden of low back and neck pain studies. Eur Spine J. 2018;27:796-801. https:// doi.org/10.1007/s00586-017-5432-9

Evidence

Not Available

Denominator Exceptions

Ongoing care not clinically indicated because the patient needed a home program only, referral to another provider or facility, or consultation only, as documented in the medical record OR Ongoing care not medically possible because the patient was discharged early due to specific medical events, documented in the medical record, such as the patient became hospitalized or scheduled for surgery OR Ongoing care not possible because the patient self-discharged early (e.g., financial or insurance reasons, transportation problems, or reason unknown) OR Patient refused to participate

Numerator Exceptions

Not applicable

Risk Adjusted

No

Program Name Abbreviation

MIPS

Program Status

Active

Centers for Medicare & Medicaid Services **Measures Inventory Tool**

CMS Measures Management System (MMS) Hub

CMS Meaningful Measures

CMS Pre-Rulemaking

CMS Quality Measures

NQF Quality Position System

eCQI Resource Center

Login to CMIT

About this Site

Contact Us

How It Works

Privacy Policy

User Guide

Looking for U.S. government information and services? **Visit CMS.gov, HHS.gov, USA.gov**

Functional Status Change for Patients with Shoulder Impairments

CMIT Measure ID: 290 | **CMIT ID:** 00290-01-C-MIPS | **Measure Type:** Patient-Reported Outcome-Based Performance Measure (PRO-PM)

Date of Information: 12/06/2022 | **Revision:** 4 | **Program:** Merit-Based Incentive Payment System Program

View Description

A patient-reported outcome measure (PROM) of risk-adjusted change in functional status (FS) for patients 14 years+ with shoulder impairments. The change in FS is assessed using the FOTO Shoulder FS PROM. The measure is adjusted to patient characteristics known to be associated with FS outcomes (risk adjusted) and used as a performance measure at the patient, individual clinician, and clinic levels to assess quality.

Properties

Steward

Characteristics

Cascade of Meaningful Measures

Groups

Programs

Reporting Status

Milestones

Links

Similar Measures

Environmental Scan

Components

Properties

Date of Information

12/06/2022

Abbreviated Measure Title

Not Available

Description

A patient-reported outcome measure (PROM) of risk-adjusted change in functional status (FS) for patients 14 years+ with shoulder impairments. The change in FS is assessed using the FOTO Shoulder FS PROM. The measure is adjusted to patient characteristics known

Return to Top

to be associated with FS outcomes (risk adjusted) and used as a performance measure at the patient, individual clinician, and clinic levels to assess quality.

Numerator

Patients who were presented with the Shoulder FS PROM at Initial Evaluation (Intake) and at or near Discharge (Status) for the purpose of calculating the patient's Residual Score.

Denominator

All patients 14 years and older with shoulder impairments who have initiated a Treatment Episode.

Denominator Exclusions

Documentation stating patient has a diagnosis of a degenerative neurological condition such as ALS, MS, or Parkinson s diagnosed at any time before or during the episode of care Patient unable to complete the Shoulder FS PROM at Initial Evaluation and/or Discharge due to blindness, illiteracy, severe mental incapacity or language incompatibility and an adequate proxy is not available

Rationale

Functional deficits are common in the general population and are costly to the individual, their family, and society. Improved functional status has been associated with greater quality of life, self-efficacy, improved financial well-being, and lower future medical costs. Improving functional status in people seeking rehabilitation has become a goal of the American Physical Therapy Association (APTA). Therefore, measuring change in functional status is important for providers treating patients in rehabilitation and can be used to assess the success of treatment and direct modification of treatment. Change in functional status represents the Activities and Participation domain of the International Classification of Functioning, Disability and Health. If treatment is designed to improve the functional deficit, it is logical to assess functional status at discharge using a standardized score to determine if treatment improved the functional status of the patient over the treatment episode. The National Quality Measures Clearinghouse has approved the measurement of change in functional status, using this measure. (NQMC-2633)

Evidence

Not Available

Denominator Exceptions

Ongoing care not clinically indicated because the patient needed a home program only, referral to another provider or facility, or consultation only, as documented in the medical record Ongoing care not medically possible because the patient was discharged early due to specific medical events, documented in the medical record, such as the patient became hospitalized or scheduled for surgery Ongoing care not possible because the patient self-discharged early (e.g., financial or insurance reasons, transportation problems, or reason unknown) Patient refused to participate

Numerator Exceptions

Not applicable

Risk Adjusted

No

Program Name Abbreviation

MIPS

Program Status

Active

Centers for Medicare & Medicaid Services **Measures Inventory Tool**

CMS Measures Management System (MMS) Hub

CMS Meaningful Measures

CMS Pre-Rulemaking

CMS Quality Measures

NQF Quality Position System

eCQI Resource Center

Login to CMIT

About this Site

Contact Us

How It Works

Privacy Policy

User Guide

Hip and Knee Osteoarthritis
Informed, Patient-Centered Decision Measure
User Guide

I. Purpose:
To measure the extent to which patients are informed and receive treatments that match their goals and preferences.

II. Survey Versions:

- Decision Quality IPC Version: Treatments for Hip Osteoarthritis v2.0, ©2010 [updated 2012, 2016].
- Decision Quality IPC Version: Treatments for Knee Osteoarthritis v2.0, ©2010 [updated 2012, 2016].
- Hoja de Trabajo Sobre La Calidad de Decision en Tratamientos de Osteoartritis de Cadera v.2.0 ©2012 [updated 2016] [Spanish version of Hip].
- Hoja de Trabajo Sobre La Calidad de Decision en Tratamientos de Osteoartritis de Rodilla v.2.0 ©2012 [updated 2016] [Spanish version of Knee].

III. Timing
The decision quality instrument (DQI) is designed to be administered after a decision has been made. For the IPC measure, the DQI survey is administered up to 6 months after surgery.

IV. Scoring:
The surveys contain 5 knowledge items and one preference item and are scored as follows.

1. Knowledge Score: For each fact, a correct response receives one point (see Table 1). Missing responses receive 0 points. A total score is calculated for all patients who complete at least half of the items. Total scores are scaled from 0-100%.

Table 1: Knowledge items and correct responses

Question	Correct response
#1. Which treatment is most likely to provide relief from hip/knee pain caused by osteoarthritis?	Surgery
# 2. After hip/knee replacement surgery, about how many months does it take most people to get back to doing their usual activities?	2 to 6 months
# 3. If 100 people have hip/knee replacement surgery, about how many will need to have the same hip/knee replaced again in less than 15[knee]/20 [hip] years?	Less than half
# 4. If 100 people have hip/knee replacement surgery, about how many will have less hip/knee pain after the surgery?	90 (hip); 80 (knee)
# 5. Serious complications can happen after hip/knee replacement surgery including life threatening blood clots, infections, heart attacks, and even	4

death. If 100 people have hip/knee replacement surgery, about how many will have a serious complication within 3 months after surgery?	

Note: "I don't know" ("no estoy seguro" in Spanish version) can be added as a response to knowledge items. An "I don't know response" receives 0 points (see feasibility section for considerations with including this response option).

2. Concordance: We use patients' preferred treatment, assessed with a single item, "Which treatment did you want to do to treat your knee [hip] osteoarthritis?" with possible responses (Non surgical treatments, surgery, I am not sure). For the IPC measure, only patients who mark a preference for surgery are considered to be "matched."

V. Informed, Patient Centered Hip and Knee Replacement Surgery (NQF Measure #2958): In 2016, NQF endorse a measure that is derived from patient responses to the Hip or Knee Decision Quality Instruments. The target population is adult patients who had a primary hip or knee replacement surgery for treatment of hip or knee osteoarthritis within the past 6 months.

- **Numerator Statement:** The numerator is the number of respondents who have an adequate knowledge score (60% or greater) and a clear preference for surgery.
- **Denominator Statement:** The denominator includes the number of respondents from the target population of adults who have undergone primary knee or hip replacement surgery for treatment of knee or hip osteoarthritis.
- **Denominator Exclusions:** Respondents who are missing 3 or more knowledge items do not get a total knowledge score and are excluded. Similarly, respondents who do not indicate a preferred treatment are excluded. No other exclusions as long as the respondent has the procedure for the designated condition.

Sampling: Patients of a particular surgeon or at a particular clinical site (which could be a group of providers or a hospital or other surgical site) who had a primary knee or hip replacement surgery are identified from medical records, claims or in some other way. Sampling should allow time for immediate recovery, while attempting to survey shortly after the procedure, for example, by sampling eligible patients 1- 6 months after the procedure. Patients can be sampled sequentially, or a pool of such patients who had the procedure in a particular time period (e.g. in the last 3 months) can be created and sampled at a rate that produces the desired number of potential respondents. A list of ICD and CPT codes to identify patients with hip and knee osteoarthritis who are undergoing a primary joint replacement are available from the measure developer (decisions@partners.org).

The measure can also be calculated from a population-based sample, such as a sample of a population in a geographic area. Eligible respondents could be identified from claims (such as Medicare claims files) or based on patient self- reports of having had the procedures within some time frame.

A sample size of about 150 would be needed to detect differences in proportions of 15% for the measure (e.g. from 25% to 40%) with 80% power. This size difference is what we have observed between sites that do and do not make an effort to do shared decision making.

Proxy respondents are not permitted. The patients who receive the procedure should answer the survey questions.

VI. Development Process:
This has been described in detail in Sepucha et al (2008), briefly to generate the survey we:

- Conducted a review of the clinical evidence & of focus groups and interviews with patients to generate a candidate set of facts and goals salient to the decision
- Surveyed a convenience sample of patients (n=88) and a multidisciplinary group of clinical experts (n=51) to rate the facts and goals for importance, completeness, and accuracy.
- Drafted the instrument and then conducted cognitive interviews with patients who had knee or hip osteoarthritis (n=10) to evaluate items for acceptability and comprehension
- Conducted field test to evaluate the instruments

Three field tests were used to evaluate psychometric properties:

- A cross-sectional study with 382 adults with knee or hip osteoarthritis in the U.S.
- A survey of 45 primary care providers and specialists in the U.S.
- A randomized controlled trial comparing use of knee and hip osteoarthritis decision aids to control with 127 patients in Canada

Additional studies have used the measure and examined relationship to other constructs.

VII. Psychometric Properties:
These data are taken from Sepucha et al (2011).
Feasibility: The survey was feasible and had very low missing data. Note: "I am not sure" was a response category for the knowledge items in the field test. We took it out of the worksheet versions as we felt that it was better to force respondents to guess; however, removing this response may increase missing items.
Acceptability: The survey was acceptable with high response rates when administered by mail and by phone, and took less than 5 minutes to complete.
Reliability:

- Knowledge score: Short term (~4 week) retest reliability ICC=0.80 (95% CI 0.69 to 0.87), n=91
- The short term (~4 week) retest reliability for the treatment preference is ICC > 0.72.

Note: We did not calculate the internal consistency of the knowledge score because the items do not draw from a single underlying construct.

Validity

- Discriminant validity (Sepucha et al 2011):
    - The total knowledge score discriminated between patients and providers, mean differences of 19%, 95% CI (13%, 25%), p<0.001 for knee and 15%, 95% CI (9%, 21%), p<0.001 for hip
    - The total knowledge scores also discriminated between patients who had seen a decision aid and those who had not, (67% (SD 21.2%) vs. 51% (SD 24.9%), p<0.0001.)
    - The treatment preference item was able to discriminate among patients with different goals. For example, patients who stated a preference for surgery, those who were unsure and those who stated a preference for non-surgical options (model predicted probability of surgery 0.74 vs. 0.59 vs. 0.40, respectively, p<0.001 for all comparisons).
- Content validity was confirmed through the extensive feedback from patients and providers in the development process as well as in the field test. (Sepucha et al 2008)
- Predictive validity: Patients who made IPC decisions had higher better health outcomes (EQ-5D, KOOS and Harris Hip Scores) and less decision regret compared to those who did not have concordant care. (See Sepucha et al 2018).
- Construct validity: Patients who reported more shared decision making were more likely to have IPC decisions. (See Brodney et al 2019).

Reproducibility: The short knowledge score had high reproducibility when compared with the longer version, R=0.92 p <0.001

VIII. Appropriate Use

The DQIs are protected by copyright. They are available to use at no cost, provided that you:

- Cite the reference in any questionnaires or publications
- Do not charge for or profit from them
- Do not alter them except for customization for a specific condition and reformatting

Suggested Citations for the DQIs:

Sepucha KR. Knee [or Hip] Osteoarthritis Decision Quality Instrument v.2.0. ©Massachusetts General Hospital, 2010 [updated 2012, 2016].

Sepucha KR. Decision Quality Worksheet: Treatments for Knee [or Hip] Osteoarthritis. v.2.0. ©Massachusetts General Hospital, 2010 [updated 2012, 2016]. Downloaded from: http://www.massgeneral.org/decisionsciences/research/DQ_Instrument_List.aspx.

Suggested Citation of the User Guide:

Sepucha KR. Hip and Knee Osteoarthritis Decision Quality Instrument User Guide. © 2019. Available from: https://www.mghdecisionsciences.org.

IX. Selected References

1. Brodney S, Fowler FJ Jr, Barry MJ, Chang Y, Sepucha K. Comparison of Three Measures of Shared Decision Making: SDM Process_4, CollaboRATE, and SURE Scales. Med Decis Making. 2019 Jun 21:272989X19855951. doi: 10.1177/0272989X19855951.

2. Sepucha KR, Atlas SJ, Chang Y, Freiberg A, Malchau H, Mangla M, Rubash H, Simmons LH, Cha T. Informed, Patient-Centered Decisions Associated with Better Health Outcomes in Orthopedics: Prospective Cohort Study. Med Decis Making. 2018 Nov;38(8):1018-1026. doi: 10.1177/0272989X18801308. PubMed PMID: 30403575.

3. Sepucha K, Fowler F, Mulley A. Policy Support For Patient-Centered Care: The Need For Measurable Improvements In Decision Quality. *Health Affairs*. 2004 Oct 7 [web publication].

4. Sepucha K, Levin C, Uzogara E, Barry M, O'Connor A, Mulley A. Developing instruments to measure the quality of decisions: Early results for a set of symptom-driven decisions. *Patient Education and Counseling* 2008 73:504-510.

5. Sepucha K, Stacey D, Clay C, Chang Y, Cosenza C, Dervin G, Dorrwachter J, Feibelmann S, Katz JN, Kearing S, Malchau H, Taljaard M, Tomek I, Tugwell P, Levin C. Decision quality instrument for treatment of hip and knee osteoarthritis: a psychometric evaluation. *BMC Musculoskelet Disord*. 2011; 12(1):149.

6. Sepucha K, Feibelmann S, Chang Y, Clay CF, Kearing S, Tomek I, Yang TS, Katz JN. Factors associated with high decision quality for treatment of hip and knee osteoarthritis. J Am Coll Surg 2013 Oct;217(4):694-701. doi: 10.1016/j.jamcollsurg.2013.06.002.

7. Stacey D, Hawker G, Dervin G, Tugwell P, Boland L, Pomey MP, O'Connor AM, Taljaard M. Decision aid for patients considering total knee arthroplasty with preference report for surgeons: a pilot randomized controlled trial. BMC Musculoskelet Disord. 2014 Feb 24;15:54. doi: 10.1186/1471-2474-15-54.

X. Questions or comments? Please contact us at decisions@partners.org or visit our website at https://www.mghdecisionsciences.org

DECISION QUALITY WORKSHEET
TREATMENTS FOR HIP OSTEOARTHRITIS

Instructions

This survey has questions about what it was like for you to make decisions about treating your hip osteoarthritis.

Please check the box ☑ to answer each item.

Your answers will tell us two important things:

1. What matters most to you?
2. How well did we do our job of giving you information?

Thank you!

Section 1: What Matters Most to You

1.1. Which treatment did you want to have to treat your hip osteoarthritis?

- ☐ Hip replacement surgery
- ☐ Non-surgical treatment options
- ☐ I am not sure

Section 2: Facts About Hip Osteoarthritis

This set of questions asks about some facts doctors think are important for patients to know about hip osteoarthritis. The correct answer to each question is based on medical research. Please do your best to answer each question.

2.1. Which treatment is most likely to provide relief from hip pain caused by osteoarthritis?

- ☐ Surgery
- ☐ Non-surgical treatments
- ☐ Both are about the same

2.2. If 100 people have hip replacement surgery, about how many will need to have the same hip replaced again in less than 20 years?

- ☐ More than half
- ☐ About half
- ☐ Less than half

2.3. If 100 people have hip replacement surgery, about how many will have less hip pain after the surgery?

- ☐ 30
- ☐ 50
- ☐ 70
- ☐ 90

2.4. Serious complications happen after hip replacement surgery including life-threatening blood clots, infections, heart attacks, and even death.

If 100 people have hip replacement surgery, about how many will have a serious complication within 3 months after surgery?

- ☐ 4
- ☐ 10
- ☐ 14
- ☐ 20

2.5. After hip replacement surgery, about how many months does it take most people to get back to doing their usual activities?

- ☐ Less than 2 months
- ☐ 2 to 6 months
- ☐ 7 to 12 months
- ☐ More than 12 months

The End.
Thank you.

DECISION QUALITY WORKSHEET
TREATMENTS FOR KNEE OSTEOARTHRITIS

Instructions

This survey has questions about what it was like for you to make decisions about treating your knee osteoarthritis.

Please check the box ☑ to answer each item.

Your answers will tell us two important things:

1. What matters most to you?
2. How well did we do our job of giving you information?

Thank you!

Section 1: What Matters Most to You

1.1. Which treatment did you want to have to treat your knee osteoarthritis?

- ☐ Knee replacement surgery
- ☐ Non-surgical treatment options
- ☐ I am not sure

Section 2: Facts About Knee Osteoarthritis

This set of questions asks about some facts doctors think are important for patients to know about knee osteoarthritis. The correct answer to each question is based on medical research. Please do your best to answer each question.

2.1. Which treatment is most likely to provide relief from knee pain caused by osteoarthritis?

- ☐ Surgery
- ☐ Non-surgical treatments
- ☐ Both are about the same

2.2. If 100 people have knee replacement surgery, about how many will need to have the same knee replaced again in less than 15 years?

- ☐ More than half
- ☐ About half
- ☐ Less than half

2.3. If 100 people have knee replacement surgery, about how many will have less knee pain after the surgery?

- ☐ 20
- ☐ 40
- ☐ 60
- ☐ 80

2.4. Serious complications happen after knee replacement surgery including life-threatening blood clots, infections, heart attacks, and even death.

If 100 people have knee replacement surgery, about how many will have a serious complication within 3 months after surgery?

- ☐ 4
- ☐ 10
- ☐ 14
- ☐ 20

2.5. After knee replacement surgery, about how many months does it take most people to get back to doing their usual activities?

- ☐ Less than 2 months
- ☐ 2 to 6 months
- ☐ 7 to 12 months
- ☐ More than 12 months

The End.
Thank you.

Leg Pain After Lumbar Discectomy/Laminectomy

CMIT Measure ID: 411 | **CMIT ID:** 00411-01-C-MIPS | **Measure Type:** Patient-Reported Outcome-Based Performance Measure (PRO-PM)

Date of Information: 03/26/2024 | **Revision:** 3 | **Program:** Merit-Based Incentive Payment System Program

View Description

For patients 18 years of age or older who had a lumbar discectomy/laminectomy or fusion procedure, leg pain is rated by the patient as less than or equal to 3.0 OR an improvement of 5.0 points or greater on the Visual Analog Scale (VAS) Pain scale or a numeric pain scale at three months (6 to 20 weeks) for discectomy/laminectomy or at one year (9 to 15 months) postoperatively for lumbar fusion patients. Rates are stratified by procedure type; lumbar discectomy/laminectomy or fusion procedure.

Properties

Steward

Characteristics

Cascade of Meaningful Measures

Groups

Programs

Reporting Status

Milestones

Links

Similar Measures

Environmental Scan

Components

Properties

Date of Information

03/26/2024

Abbreviated Measure Title

Not Available

Description

For patients 18 years of age or older who had a lumbar discectomy/laminectomy or fusion procedure, leg pain is rated by the patient as less than or equal to 3.0 OR an improvement of 5.0 points or greater on the Visual Analog Scale (VAS) Pain scale or a numeric pain scale at three months (6 to 20 weeks) for discectomy/laminectomy or at one year (9 to 15 months) postoperatively for lumbar fusion patients. Rates are stratified by procedure type; lumbar discectomy/laminectomy or fusion procedure.

Return to Top

Numerator

Numerator 1: All eligible patients whose leg pain is less than or equal to 3.0 OR an improvement of 5.0 points or greater on the VAS or Numeric Pain scale at three months (6 to 20 weeks) postoperatively Numerator 2: All eligible patients whose leg pain is less than or equal to 3.0 OR an improvement of 5.0 points or greater on the Visual Analog Scale (VAS) or Numeric Pain scale at one year (9 to 15 months) postoperatively.

Denominator

Denominator 1: Patients with lumbar discectomy/laminectomy procedure Patients 18 years of age or older as of January 1 of the denominator identification period who had a lumbar discectomy/laminectomy procedure performed during the denominator identification period Denominator 2: Patients with lumbar fusion procedure Patients 18 years of age or older as of October 1 of the denominator identification period who had a lumbar fusion procedure performed during the denominator identification period.

Denominator Exclusions

DENOMINATOR EXCLUSIONS (SUBMISSION CRITERIA 1): Patient had a lumbar fusion on the same date as the discectomy/ laminectomy procedure Patient had cancer, acute fracture or infection related to the lumbar spine OR patient had neuromuscular, idiopathic, or congenital lumbar scoliosis DENOMINATOR EXCLUSIONS (SUBMISSION CRITERIA 2): Patient had cancer, acute fracture or infection related to the lumbar spine OR patient had neuromuscular, idiopathic, or congenital lumbar scoliosis.

Rationale

Mechanical low back pain (LBP) remains the second most common symptom-related reason for seeing a physician in the United States. Of the US population, 85% will experience an episode of mechanical LBP at some point during their lifetime. Fortunately, the LBP resolves for the vast majority within 2-4 weeks. For individuals younger than 45 years, mechanical LBP represents the most common cause of disability and is generally associated with a work-related injury. For individuals older than 45 years, mechanical LBP is the third most common cause of disability, and a careful history and physical examination are vital to evaluation, treatment, and management (Hills et al 2022). Overall, spine surgery rates have declined slightly from 2002-2007, but the rate of complex fusion procedures 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 fusions. After adjustment for age, comorbidity, previous spine surgery, and other features, the odds ratio (OR) of life- threatening complications for complex fusion compared with decompression alone was 2.95 (95% confidence interval [CI], 2.50-3.49). A similar pattern was observed for rehospitalization within 30 days, which occurred for 7.8% of patients undergoing decompression and 13.0% having a complex fusion (adjusted OR, 1.94; 95% CI, 1.74-2.17). Adjusted mean hospital charges for complex fusion procedures were US $80,888 compared with US $23,724 for decompression alone (Deyo, R. JAMA 2010). The MNCM Spine Surgery Measure development workgroup developed patient reported outcome measures for two populations of patients undergoing different lumbar spine procedures, a more complex procedure (lumbar fusion) and a second procedure that represented the most common procedure CPT code 63030 for the most common diagnosis of disc herniation. In 2018, the development workgroup reconvened and redesigned the measure construct to a target-based measure and additionally expanded the denominator for this measure to include all lumbar discectomy laminectomy procedures. Rationale for measure construct and calculation change: Target score based on 2016 study in the Spine Journal Fetke, TF et al "What level of pain are patients happy to live with after surgery for lumbar degenerative disorders?" This study compared the Core Outcomes Measures Index (COMI) and symptom well-being questions to two 0 to 10 graphic ratings scales for back and leg pain. Most spine interventions decrease pain but rarely do they totally eliminate it. Reporting of the percent of patients achieving a pain score equivalent to the ""acceptable symptom state"" may represent a more stringent target for denoting surgical success in the treatment of painful spinal disorders. For disc herniation, this is less than or equal to 2, and for other degenerative pathologies it is less than or equal to 3. The OR benchmark of change (5.0) derived from MNCM data (3 years); the average change in points of patients that did achieve the target of less than or equal to 3.0. Rationale for the expansion of the denominator and addition of exclusions: During the original development of this measure, the intent was to have a homogeneous population procedure that represented the most common procedure CPT code 63030 for the most common diagnosis of disc herniation. This strategy did not translate well from ICD-9 to ICD-10 diagnosis codes and the volume of eligible denominator patients dropped significantly. In 2018, the MNCM development workgroup reconvened for measure construct redesign and adopted a broader denominator population; all applicable discectomy laminectomy procedure codes and not limited by a type of diagnosis (includes all). With this decision, the workgroup decided to adopt the same exclusions for the spine fusion population and added exclusions for spine related cancer, acute fracture or infection, neuromuscular, idiopathic or congenital scoliosis.

Evidence

The measure result is the average change in leg pain as rated on a 0 - 10 visual analog scale before and after lumbar discectomy/laminotomy by all eligible patients. Field testing was conducted with 11 practice groups, resulting in an overall average change in leg pain of 4.3, with group level results ranging from 2.2 to 5.8. The distribution of results demonstrates significant variation in the magnitude of improvement in symptoms with surgery.

Denominator Exceptions

Not applicable

Numerator Exceptions

Not applicable

Risk Adjusted

No

Program Name Abbreviation

MIPS

Program Status

Active

Quality ID #483 (CBE 3568): Person-Centered Primary Care Measure Patient Reported Outcome Performance Measure (PCPCM PRO-PM)

2024 COLLECTION TYPE:
MIPS CLINICAL QUALITY MEASURES (CQMS)

MEASURE TYPE:
Patient-Reported Outcome-Based Performance Measure – High Priority

DESCRIPTION:
The Person-Centered Primary Care Measure Patient Reported Outcome Performance Measure (PCPCM PRO-PM) uses the PCPCM Patient Reported Outcome Measure (PROM) a comprehensive and parsimonious set of 11 patient-reported items - to assess the broad scope of primary care. Unlike other primary care measures, the PCPCM PRO-PM measures the high value aspects of primary care based on a patient's relationship with the clinician or practice.

INSTRUCTIONS:
This measure is to be submitted **once per performance period**. For each MIPS eligible clinician, group, subgroup*, virtual group, and APM Entity, a minimum of 30 PCPCM PRO instruments per clinician are needed for submission of this measure. All valid survey results (as defined in the specification) should be included in the aggregate score. For MIPS eligible groups, subgroups*, virtual groups, and APM entities with 5 or more clinicians, a minimum of 150 PCPCM PRO instruments per TIN for each site/location associated with the clinicians' part of the group, subgroups*, virtual groups, and APM entities are needed for submission of this measure. If the MIPS eligible group, subgroup*, virtual group, and APM entity with 5 or more clinicians encompasses multiple sites/locations, each site/location would need to meet the PCPCM PRO instruments requirements as stated.

NOTE: *Data for the measure are collected using the PCPCM PRO instrument. The target population is all active patients attributed to the clinician or practice. Every active patient receives an invitation to complete the PCPCM PROM during their birth month. A patient is defined as active if the patient has had a documented interaction with the practice within 12 months of their birth month during the measurement period.*

**Subgroups are only available through MVP reporting. All measure-specific criteria must be met by the subgroup.*

Measure Submission Type:
Measure data may be submitted by individual MIPS eligible clinicians, groups, or third-party intermediaries. The listed denominator criteria are used to identify the intended patient population. The numerator options included in this specification are used to submit the quality actions as allowed by the measure. The quality data codes listed do not need to be submitted by MIPS eligible clinicians, groups, or third-party intermediaries that utilize this modality for submissions; however, these codes may be submitted for those third-party intermediaries that utilize Medicare Part B claims data. For more information regarding Application Programming Interface (API), please refer to the Quality Payment Program (QPP) website.

DENOMINATOR:
Total number of completed PCPCM PRO instruments received in the reporting period

Definitions*:*
A completed PCPCM PRO instrument – A PCPCM PRO instrument for which the patient has responded to at least 8 of 11 items.
Active patient – The patient has had a documented interaction with the practice within 12 months of their birth month during the measurement period.

DENOMINATOR NOTE: *The target population is all active patients attributed to a clinician or practice during the performance reporting period who had a documented interaction within the 12 months prior to the patient's birth month. The target population is defined the same, regardless of unit of analysis (clinician, practice, or system).*

The PCPCM PRO is the same for all patients, regardless of age. Because the PCPCM PRO applies to all patients and is not particular to a clinical encounter, it is administered once a year to each patient during their birth month. All surveys received during the measurement period should be counted.

For each MIPS eligible clinician, group, subgroup, virtual group, and APM Entity, a minimum of 30 PCPCM PRO instruments per clinician are needed for submission of this measure. For MIPS eligible groups, subgroups*, virtual groups, and APM entities with 5 or more clinicians, a minimum of 150 PCPCM PRO instruments per TIN for each site/location associated with the clinicians' part of the group, subgroups*, virtual groups, and APM entities are needed for submission of this measure. If the MIPS eligible group, subgroup*, virtual group, and APM entity with 5 or more clinicians encompasses multiple sites/locations, each site/location would need to meet the PCPCM PRO instruments requirements as stated.*

**Subgroups are only available through MVP reporting. All measure-specific criteria must be met by the subgroup.*

Table 1- PCPCM PRO instrument questions

How would you assess your primary care experience?	Definitely = 4	Mostly = 3	Somewhat = 2	Not at all = 1
My practice makes it easy for me to get care.	Definitely	Mostly	Somewhat	Not at all
My practice is able to provide most of my care.	Definitely	Mostly	Somewhat	Not at all
In caring for me, my doctor considers all factors that affect my health.	Definitely	Mostly	Somewhat	Not at all
My practice coordinates the care I get from multiple places.	Definitely	Mostly	Somewhat	Not at all
My doctor or practice knows me as a person.	Definitely	Mostly	Somewhat	Not at all
My doctor and I have been through a lot together.	Definitely	Mostly	Somewhat	Not at all
My doctor or practice stands up for me.	Definitely	Mostly	Somewhat	Not at all
The care I get takes into account knowledge of my family.	Definitely	Mostly	Somewhat	Not at all
The care I get in this practice is informed by knowledge of my community.	Definitely	Mostly	Somewhat	Not at all
Over time, my practice helps me to stay healthy.	Definitely	Mostly	Somewhat	Not at all
Over time, my practice helps me to meet my goals.	Definitely	Mostly	Somewhat	Not at all

Denominator Criteria (Eligible Cases):
All patients with a completed PCPCM PRO instrument during the reporting period

NUMERATOR:
The calculated PCPCM PRO-PM performance score

NUMERATOR NOTE: *Scoring for the PCPCM PRO-PM is completed through a simple 4 step process using the PCPCM PRO to assess the broad scope of primary care from a patient's perspective.*

- ***Step One: Exclude incomplete patient responses.*** *Any PCPCM PRO instrument for which a patient failed to answer at least 8 of the 11 items is excluded from calculations.*
- ***Step Two: Calculate PCPCM PRO item specific mean scores.*** *Patients choose one of four response options for each item in the PCPCM PRO instrument. In scoring the PCPCM PRO, the first step requires determining an item mean score for each of the 11 items. Since the instrument scale is word based – Definitely, Mostly, Somewhat, Not At All – each response option must be assigned a value. Values are assigned as follows: Definitely = 4, Mostly = 3, Somewhat = 2, Not At All = 1.*

  Calculating the mean score for each item then requires looking across all PCPCM PRO instruments received for the entity being assessed during the analysis period. For example, if the entity is a clinician, then all completed (see Step One) PCPCM PRO instruments collected for that clinician are included in the calculation. If the entity is a practice, then all PCPCM PRO instruments collected for that practice are included in the analysis

  An entity's score for each PCPCM PRO item is calculated as a mean, i.e., the summary of all responses across PCPCM PRO instruments received for the entity, divided by the number of instruments received. This process leads to 11 item specific PCPCM PRO scores. Means should be reported to two decimal points.
- ***Step Three: Calculate the PCPCM PRO total score.*** *The PCPCM PRO total score for the entity is calculated by determining the mean of the 11 scored PRO items. This is done by adding the mean scores of all 11 PRO items and then dividing by 11. PRO means should be reported to two decimal points.*
- ***Step Four: Converting PCPCM PRO total scores and to PCPCM PRO-PM performance score.*** *In order to use the PCPCM PRO as a performance measure for reporting, the 4 point PCPCM PRO scale must be converted to a 0-100 performance scale. To do this, the PCPCM PRO total score for an entity, as calculated in Step Three, is divided by 4 and then multiplied by 100.*

RATIONALE:

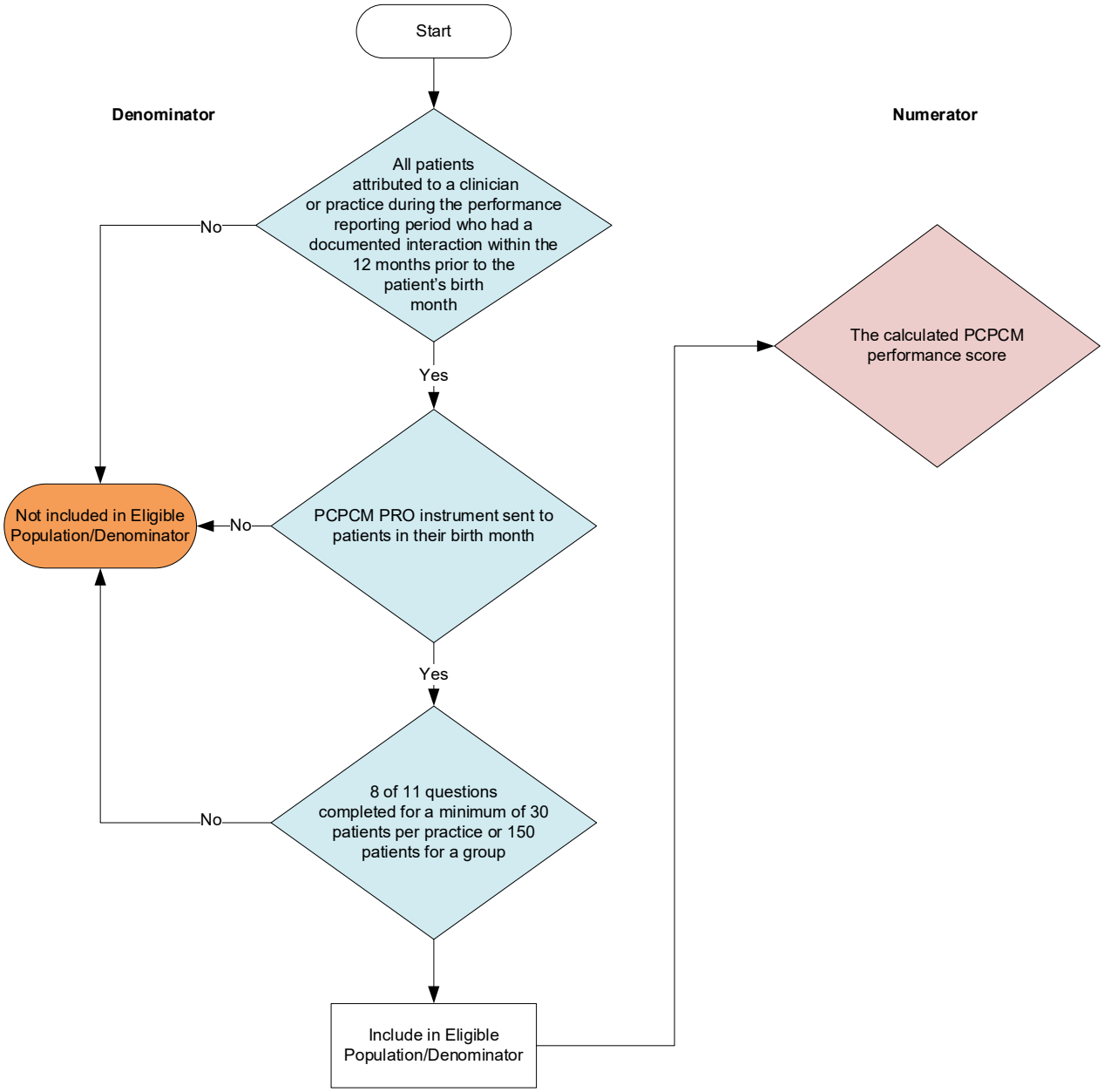
The Person-Centered Primary Care Measure Patient Reported Outcome Performance Measure (PCPCM PRO-PM) uses the PCPCM PROM - a comprehensive and parsimonious set of 11 patient-reported items - to assess the broad scope of primary care. Unlike other primary care measures, the PCPCM PRO-PM measures the high value aspects of primary care based on a patient's relationship with the clinician or practice. Patients identify the PCPCM PROM as meaningful and able to communicate the quality of their care to their clinicians and/or care team. The items within the PCPCM PROM are based on extensive stakeholder engagement and comprehensive reviews of the literature. It is not a consumer satisfaction survey – it is a patient assessment of whether the functions of primary care are being met by their clinician, or practice, and to what extent.

CLINICAL RECOMMENDATION STATEMENTS:

The IOM Report on Primary Care calls for care to be personalized at the patient level, with care integrated for whole people to overcome the many problems of fragmented and depersonalized care. The PCPCM-PM complements more narrow disease-specific quality measures, and can be used to integrate care for whole people. (Institute of Medicine. Donaldson MS, Yordy KD, Lohr KN, and Vanselow NA, editors. Committee on the Future of Primary Care, Division of Health Care Services. National Academy Press. Washington, D.C. 1996.)

2024 Clinical Quality Measure Flow for Quality ID #483 (CBE 3568): Person-Centered Primary Care Measure Patient Reported Outcome Performance Measure (PCPCM PRO-PM)

Disclaimer: *Refer to the measure specification for specific coding and instructions to submit this measure.*



PCPCM PRO-PM Sample Calculation

Step 1: Exclude incomplete patient responses

Any PCPCM PRO instrument for which a patient failed to answer at least 8 of the 11 items is excluded from calculations

Step 2: Calculate PCPCM PRO item specific mean scores*

How would you assess your primary care experience?	Patient 1	Patient 2	Patient 3	Patient 4	Patient 5	Patient 6	PCPCM PRO Instruments Mean Score
Item 1: My practice makes it easy for me to get care.	3	2	1	2	3	2	**2.17**
Item 2: My practice is able to provide most of my care.	4	2	1	N/A	4	2	**2.60**
Item 3: In caring for me, my doctor considers all factors that affect my health.	3	4	2	4	3	4	**3.33**
Item 4: My practice coordinates the care I get from multiple places.	4	4	4	4	4	4	**4.00**
Item 5: My doctor or practice knows me as a person.	1	1	1	3	1	1	**1.33**
Item 6: My doctor and I have been through a lot together.	3	1	1	1	3	1	**1.67**
Item 7: My doctor or practice stands up for me.	2	2	1	1	2	2	**1.67**
Item 8: The care I get takes into account knowledge of my family.	4	3	2	2	N/A	3	**2.80**
Item 9: The care I get in this practice is informed by knowledge of my community.	3	3	3	2	3	3	**2.83**
Item 10: Over time, my practice helps me to stay healthy.	2	1	3	2	2	1	**1.83**
Item 11: Over time, my practice helps me to meet my goals.	3	3	3	4	3	3	**3.17**

*For each MIPS eligible clinician, group, subgroup, virtual group, and APM Entity, a minimum of 30 PCPCM PRO instruments per clinician are needed for submission of this measure. All valid survey results (as defined in the specification) should be included in the aggregate score. For MIPS eligible groups, subgroups, virtual groups, and APM entities with 5 or more clinicians, a minimum of 150 PCPCM PRO instruments per TIN for each site/location associated with the clinicians part of the group, subgroups, virtual groups, and APM entities are needed for submission of this measure. If the MIPS eligible group, subgroup, virtual group, and APM entity with 5 or more clinicians encompasses multiple sites/locations, each site/location would need to meet the PCPCM PRO instruments requirements as stated.

Step 3: Calculate the PCPCM PRO total score

	Item 1	Item 2	Item 3	Item 4	Item 5	Item 6	Item 7	Item 8	Item 9	Item 10	Item 11	Total Mean Score
PCPCM PRO Instruments Mean Score	2.17	2.60	3.33	4.00	1.33	1.67	1.67	2.80	2.83	1.83	3.17	27.40

PCPCM PRO Total Score (27.40)/11= 2.49

Step 4: Converting PCPCM PRO total scores to PCPCM PRO-PM performance score

PCPCM PRO-PM Performance Score = (2.49/4)x100 = 62.27%

See the posted measure specification for specific coding and instructions to submit this measure.
NOTE: Submission Frequency: Procedure

2024 Clinical Quality Measure Flow Narrative for Quality ID #483 (CBE 3568): Person-Centered Primary Care Measure Patient Reported Outcome Performance Measure (PCPCM PRO-PM)

***Disclaimer**: Refer to the measure specification for specific coding and instructions to submit this measure*

1. Start with Denominator
2. Check *All patients attributed to a clinician or practice during the performance reporting period who had a documented interaction within the 12 months prior to the patient's birth month*:
    a. If *All patients attributed to a clinician or practice during the performance reporting period who had a documented interaction within the 12 months prior to the patient's birth month* equals No, do not include in *Eligible Population/Denominator*. Stop processing.
    b. If *All patients attributed to a clinician or practice during the performance reporting period who had a documented interaction within the 12 months prior to the patient's birth month* equals Yes, proceed to *PCPCM PRO instrument sent to patients in their birth month.*
3. Check *PCPCM PRO instrument sent to patients in their birth month.*
    a. If *PCPCM PRO instrument sent to patients in their birth month* equals No, do not include in *Eligible Population/Denominator*. Stop processing.
    b. If *PCPCM PRO instrument sent to patients in their birth month* equals Yes, proceed to *8 of 11 questions completed for a minimum of 30 patients per practice or 150 patients for a group*.
4. Check *8 of 11 questions completed for a minimum of 30 patients per practice or 150 patients for a group*.
    a. If *8 of 11 questions completed for a minimum of 30 patients per practice or 150 patients for a group* equals No, do not include in *Eligible Population/Denominator*. Stop processing.
    b. If *8 of 11 questions completed for a minimum of 30 patients per practice or 150 patients for a group* equals Yes, include in *Eligible Population/Denominator*.
5. Denominator Population:
    - Denominator Population is all Eligible Patients in the Denominator.
6. Start Numerator
7. Check *The calculated PCPCM performance score.*

PCPCM PRO-PM Sample Calculation:

Step One: Exclude incomplete patient responses. Any PCPCM PRO instrument for which a patient failed to answer at least 8 of the 11 items is excluded from calculations.

Step Two: Calculate PCPCM PRO item specific mean scores. Patients choose one of four response options for each item in the PCPCM PRO instrument. In scoring the PCPCM PRO, the first step requires determining an item mean score for each of the 11 items. Since the instrument scale is word based – Definitely, Mostly, Somewhat, Not At All – each response option must be assigned a value. Values are assigned as follows: Definitely = 4, Mostly = 3, Somewhat = 2, Not At All = 1.

Calculating the mean score for each item then requires looking across all PCPCM PRO instruments received for the entity being assessed during the analysis period. For example, if the entity is a clinician, then all completed (see Step One) PCPCM PRO instruments collected for that clinician are included in the calculation. If the entity is a practice, then all PCPCM PRO instruments collected for that practice are included in the analysis

An entity's score for each PCPCM PRO item is calculated as a mean, i.e., the summary of all responses across PCPCM PRO instruments received for the entity, divided by the number of instruments received. This process leads to 11 item specific PCPCM PRO scores. Means should be reported to two decimal points.

Step Three: Calculate the PCPCM PRO total score. The PCPCM PRO total score for the entity is calculated by determining the mean of the 11 scored PRO items. This is done by adding the mean scores of all 11 PRO items and then dividing by 11. PRO means should be reported to two decimal points.

Step Four: Converting PCPCM PRO total scores to PCPCM PRO-PM performance score. In order to use the PCPCM PRO as a performance measure for reporting, the 4 point PCPCM PRO scale must be converted to a 0-100 performance scale. To do this, the PCPCM PRO total score for an entity, as calculated in Step Three, is divided by 4 and then multiplied by 100.

*See the posted measure specification for specific coding and instructions to submit this measure.

NOTE: Submission Frequency: Procedure

The measure diagrams were developed by CMS as a supplemental resource to be used in conjunction with the measure specifications. They should not be used alone or as a substitution for the measure specification.

Psoriasis - Improvement in Patient-Reported Itch Severity

CMIT Measure ID: 1661 **| CMIT ID:** 01661-02-C-MIPS **| Measure Type:** Patient-Reported Outcome-Based Performance Measure (PRO-PM)

Date of Information: 03/26/2024 **| Revision:** 1 **| Program:** Merit-Based Incentive Payment System Program

View Description

The percentage of patients aged 8 years and older, with a diagnosis of psoriasis where at an initial (index) visit have a patient reported itch severity assessment performed, score greater than or equal to 4, and who achieve a score reduction of 3 or more points at a follow up visit.

Properties

Steward

Characteristics

Cascade of Meaningful Measures

Groups

Programs

Reporting Status

Milestones

Links

Similar Measures

Environmental Scan

Components

Properties

Date of Information

03/26/2024

Abbreviated Measure Title

Not Available

Description

The percentage of patients aged 8 years and older, with a diagnosis of psoriasis where at an initial (index) visit have a patient reported itch severity assessment performed, score greater than or equal to 4, and who achieve a score reduction of 3 or more points at a follow up visit.

Numerator

Patients who achieve an assessment score that is reduced by 3 or more points (minimal clinically important difference) from the initial

Return to Top

(index) assessment score.

Denominator

All patients aged 8 years and older, with a diagnosis of psoriasis with an initial (index visit) Numeric Rating Scale (NRS), Visual Rating Scale (VRS), or ItchyQuant assessment score of greater than or equal to 4 who are returning for a follow-up visit.

Denominator Exclusions

None

Rationale

Psoriasis is a chronic inflammatory disease in which pruritus is a frequent symptom. Approximately 7.4 million people in the United States have psoriasis. Direct costs of the disease are estimated between $51.7 and $63.2 billion, with the total economic burden estimated to be between $112 and $135 billion. Chronic inflammatory skin diseases, such as psoriasis, are pruritic and tremendously burdensome; with more than 70% of psoriasis patients suffering from itch. Itch has profound effects on patients, especially in geriatric populations, where there is increased incidence of pruritus. For those over 65 years old, itch is the most common skin complaint. The number of patients with pruritus is expected to increase as the elderly population grows - becoming 25% of the US population by 2025. Pruritus is a frequent and onerous symptom of psoriasis and, on its own, has significant effects on patients' quality of life. In a study, investigators quantified pruritic burden in a cross-sectional analysis investigating chronic pruritus and pain. They demonstrated that the quality-of-life impact was due to the severity of the symptom, rather than whether the symptom was pain or pruritus. Moreover, they elucidated a mean health utility score of 0.87 from chronic pruritus (CP) patients, meaning that on average, a patient would give up 13% of their life expectancy to live without pruritus.

Evidence

Psoriasis is a chronic inflammatory disease in which pruritus is a frequent symptom. Approximately 7.4 million people in the United States have psoriasis. Direct costs of the disease are estimated between $51.7 and $63.2 billion, with the total economic burden estimated to be between $112 and $135 billion. Chronic inflammatory skin diseases, such as psoriasis, are pruritic and tremendously burdensome; with more than 70% of psoriasis patients suffering from itch. Itch has profound effects on patients, especially in geriatric populations, where there is increased incidence of pruritus. For those over 65 years old, itch is the most common skin complaint. The number of patients with pruritus is expected to increase as the elderly population grows - becoming 25% of the US population by 2025. Pruritus is a frequent and onerous symptom of psoriasis and, on its own, has significant effects on patients' quality of life. In a study, investigators quantified pruritic burden in a cross-sectional analysis investigating chronic pruritus and pain. They demonstrated that the quality of life impact was due to the severity of the symptom, rather than whether the symptom was pain or pruritus. Moreover, they elucidated a mean health utility score of 0.87 from chronic pruritus (CP) patients, meaning that on average, a patient would give up 13% of their life expectancy to live without pruritus. An additional study showed the effects of CP on a population-based level. Researchers found that the point prevalence of pruritus was 13.5%. When looking at 12-months the prevalence rose to 16.4% and rose again to 22% when looking at lifetime prevalence. When studied again in 2013, the lifetime prevalence rose to 25.5%. Moreover, data from the National Ambulatory Medical Care Survey (1999-2009) found that a total of 77 million patient visits for itch were made during the 11-year time period. This was an average of 7 million visits per year, which represented approximately 1% of all outpatient visits. Also, further analysis showed that although the majority of visits (58.6%) were for new instances of itch, almost a third (32%) were for chronic pruritus. Pruritus is a subjective and multifaceted symptom that manifests in patients in various ways that affect quality-of-life by contributing to the development of depression, global distress, and sleep impairment. Additionally, studies of CP have shown patients to have a 17% higher mortality risk as well as being strongly associated with poorer general health. This measure aims to improve pruritus in patients who carry a large burden with this disease; by assessing itch and aiming to make the symptom more manageable. Furthermore, the use of itch will be a measure of overall disease improvement/response.

Denominator Exceptions

None

Numerator Exceptions

Not Available

Risk Adjusted

No

Program Name Abbreviation

MIPS

Program Status

Active

Centers for Medicare & Medicaid Services **Measures Inventory Tool**

CMS Measures Management System (MMS) Hub

CMS Meaningful Measures

CMS Pre-Rulemaking

CMS Quality Measures

NQF Quality Position System

eCQI Resource Center

Login to CMIT

About this Site

Contact Us

How It Works

Privacy Policy

User Guide

Looking for U.S. government information and services? **Visit CMS.gov, HHS.gov, USA.gov**

Shared Decision Making Process Survey
NQF Measure 2962
User Guide

I. Purpose:

To measure the extent to which patients are involved in the decision-making process.

II. Versions:

Shared Decision Making Process_4: 4 item version of the shared decision making process survey. The survey is able to be adapted to specific conditions and options. As shown in the Table, Item 3 varies depending on whether there are two options or more than two options.

III. Timing

The SDM Process_4 survey should be administered after a consult with a health care provider where a decision was discussed. The items were written assuming that the choice is known (e.g. that the patient is having or had surgery, taking medication, having the screening test, etc).

Modifications may be required if it is to be used before the choice is known.

IV. Scoring:

Each response is scored 0 or 1 according to the labels in the Table. Participants receive 1 point for a response of "yes" or "a lot" or "some." The total points are summed and result in total scores from 0 -4, with higher scores indicating more shared decision making. Surveys with one or more missing items do not get a total score.

Table: Shared Decision Making Process_4 survey

Instructions	**TALKING WITH YOUR HEALTH CARE PROVIDERS** Please answer these questions about what happened when you talked with health care providers including doctors, nurses and other health care professionals about [tests or treatments] for your [condition].
Items	1. How much did you and your health care providers talk about the reasons you might want to have [test/intervention]? ☐$_1$ A lot ☐$_1$ Some ☐$_0$ A little ☐$_0$ Not at all

	2. How much did you and your health care providers talk about the reasons you might **not** want to have [test/intervention]? ☐1 A lot ☐1 Some ☐0 A little ☐0 Not at all 3. Did any of your health care providers talk about [an alternative to intervention, e.g. non-surgical treatments/not testing] as something that you should seriously consider? [Version for situations with more than two options: Did any of your health care providers explain that there were choices in what you could do to treat your [condition]?] ☐1 Yes ☐0 No 4. Did any of your health care providers ask if you wanted to have [test/intervention]? ☐1 Yes ☐0 No

III. NQF PRO-PM Measure #2962 specifications:

The SDMP_4 is used as the basis for a patient-reported outcome performance measure (PRO-PM). The following describes calculation for that measure.

- **Numerator Statement:** The numerator is the sum of the total scores (0-4) for all those responding.
- **Denominator Statement:** The denominator includes the number of respondents from the target population of adults who have undergone a procedure for one of the target conditions and completed the survey.
- **Denominator Exclusions:** Respondents who are missing 1 or more items do not get a total score and are excluded. No other exclusions as long as the respondent has the procedure for the designated condition.
- **Sampling**: Patients of a particular surgeon or at a particular clinical site (which could be a group of providers or a hospital or other surgical site) who had a one of the procedures are identified from medical records, claims or in some other way. Sampling should allow time for immediate recovery, while attempting to survey shortly after the procedure, for example, by sampling eligible patients 1- 6 months after the procedure. Patients can be sampled sequentially, or a pool of such patients who had the procedure in a particular time period (e.g. in the last 3 months) can be created and sampled at a rate that produces the desired number of potential respondents.

The measure can also be calculated from a population-based sample, such as a sample of a population in a geographic area. Eligible respondents could be identified from claims (such as Medicare claims files) or based on patient self- reports of having had the procedures within some time frame.

- Proxy respondents are not permitted. The patients who receive the test or intervention for the target condition should answer the survey questions.

VI. Development Process:

In 2007, a team of researchers at the University of Michigan developed several items to be used in the DECISIONS survey, the first national survey of how common medical decisions were being made in the United States [1,2]. One key goal was to develop items that would assess the extent to which shared decision making happened across 10 different medical decisions. The SDM Process Survey is based on four questions from that survey.

The survey items were derived from the shared decision making model (SDM), a conceptual framework that was first outlined by Mulley in the late 1980s [3] and extended by Mulley and Sepucha [4-5]. The model takes a systems approach to understanding and improving clinical decision making that focuses on two key participants: patients (and family) and clinicians. The model emphasizes the fundamentally social nature of the decision making task, and the fact that it cannot be completed by the clinicians or patients alone, but rather requires interactions between them. The guiding principles behind the items included: 1) patients should have adequate knowledge and experience to answer; 2) minimize need for judgment or evaluation; 3) cover the key elements necessary for a shared decision process; 4) be short and easy to adapt to a variety of settings. Although the items do not cover all possible SDM behaviors, these four elements (discussion of options, pros, cons and preferences) are foundational components in widely accepted definitions [5-7].

VII. Psychometric Properties:

Feasibility: The survey is feasible and typically has very low missing data (1-3%). [e.g. see 8]

Acceptability: The survey is acceptable with high response rates when administered by mail, online or by phone, and takes < 2 minutes to complete.

Floor and ceiling effects: The SDMP_4 has not shown floor or ceiling effects. In a national study of 10 different medical conditions, mean scores varied widely, with lowest for mammography (mean = 1.5 out of 4), and the highest for surgery for low back pain (mean = 3.2 out of 4). [8]

Reliability:

- Internal consistency: the score is technically a composite and as a result, Cronbach's alpha may not be an appropriate measure of reliability, however we have calculated it for some samples and found Cronbach alphas of 0.77 for breast cancer surgery [9], 0.78 for hip and knee osteoarthritis [10], 0.54 for spine [11], 0. 87 for hip and knee osteoarthritis [11]
- Retest reliability: short term (~4 week) retest reliability ICC=0.64 (95% CI 0.67, 0.86) [9]
- Practice level reliability: When we drew random samples of patients from the same sites who had made decisions, the correlations of the SDMP_4 scores averaged .61 [13]

Validity

- Content validity was confirmed through the extensive feedback from patients and providers in the development process as well as in the field tests.
- Construct validity: Those who had higher SDMP scores reported
    - better decision quality, [10]
    - were less likely to think they made the wrong decision, [9] and
    - reported less dissonance (conflict between what was important to them and the decision that was made). [12]
    - clinical sites that made an effort to implement SDM (with patient decision aids and/or coaching) had higher scores than usual care sites [11, 13]

VIII. Sample size considerations

The standard deviations for the measure vary by topic and sample (ranging from 0.83-1.25). We have observed a 0.3SD-0.5SD difference between sites that do and do not make an effort to do shared decision making. A sample size of about 50-60 would be needed to detect differences in proportions of .5 SD for the measure with 80% power assuming standard deviation of about 1.

IX. Appropriate Use

The SDM Process_4 is protected by copyright. It is available to use at no cost, provided that you:

- Cite the reference in any questionnaires or publications
- Do not charge for or profit from it
- Do not alter items except for customization for a specific condition/interventions and reformatting

X. Suggested Citation for the SDM Process_4 User Guide:

Sepucha KR and Fowler FJ. Shared Decision Making Process_4 User Guide v.1.0. ©Massachusetts General Hospital, 2018.

XI. References:

1. Zikmund-Fisher BJ, Couper MP, Singer E, Levin C, Fowler Jr. FJ, Ziniel S, et al. The DECISIONS study: a nationwide survey of U.S. adults regarding nine common medical decisions. Medical Decision Making. September/October 2010; 30: 20S- 34S.
2. Zikmund-Fisher B, Couper M, Singer E, Ubel P, Fowler F, Levin C, Ziniel S, Fagerlin A. Deficits and variations in patients' experience with making 9 common medical decisions: The DECISIONS survey. Medical Decision Making. September/October 2010; 30: 85S-95S.
3. Mulley, A. J. (1990). Methodological issues in the application of effectiveness and outcomes research to clinical practice. Effectiveness and Outcomes in Health Care. Washington D.C., National Academy Press.
4. Sepucha K and Mulley A. Extending Decision Support: Preparation and Implementation. *Patient Education and Counseling* 2003; 50 (3):269-271.
5. Sepucha K and Mulley A. A Perspective on the Patient's Role in Treatment Decisions. *Medical Care Research and Review* 2009 66:54S-74S.

6. Charles, C, Gafni, A and Whelan, T. Decision- making in the physician-patient encounter: revising the shared decision –making model. Soc Sci and Med, 491 (1999) 65, 651-661.

7. Makoul, G and Clayman, ML An integrative model of shared decision making in medical encounters. Patient Educ and Couns. (2006), 60, 301-312.

8. Fowler, FJ, Gerstein, BS, Barry, MJ How patient centered are medical decisions? JAMA Internal Medicine 2013 173 (13) 1215-1221.

9. Sepucha K, Feibelmann S, Chang Y, Hewitt S, Ziogas A. Measuring the quality of surgical decisions for Latina breast cancer patients. Health Expect 2014 May 12 [Epub ahead of print].

10. Sepucha K, Feibelmann S, Chang Y, Clay CF, Kearing S, Tomek I, Yang TS, Katz JN. Factors associated with high decision quality for treatment of hip and knee osteoarthritis. J Am Coll Surg 2013 Oct;217(4):694-701. doi: 10.1016/j.jamcollsurg.2013.06.002. Epub 2013 Jul 25.

11. Sepucha K, Atlas SJ, Chang Y, Dorrwachter J, Freiberg A, Mangla M, Rubash HE, Simmons LH, Cha T. Patient Decision Aids Improve Decision Quality and Patient Experience and Reduce Surgical Rates in Routine Orthopaedic Care: A Prospective Cohort Study. J Bone Joint Surg Am. 2017 Aug 2;99(15):1253-1260. doi: 10.2106/JBJS.16.01045. PubMed PMID: 28763411.

12. Fowler FJ, Gallagher PM, Drake KM, Sepucha K. Decision Dissonance: Evaluation of an Approach to Measuring the Quality of Surgical Decision Making. Jt Comm J Qual Patient Saf 2013 Mar;39(3):136-44.

13. Fowler FJ and Sepucha K. National Quality Forum Measure Testing Attachment for Measure 2962. Available from http://www.qualityforum.org/ using the Find Measures application.

Shared Decision Making Process Survey: SDM Process_4

For situations with two main options insert condition (e.g. knee osteoarthritis) and chosen option (e.g. surgery) and alternative option (e.g. non surgical treatment):

TALKING WITH YOUR HEALTH CARE PROVIDERS

Please answer these questions about what happened when you talked with health care providers including doctors, nurses and other health care professionals about [tests or treatments] for your [condition].

1. How much did you and your health care providers talk about the reasons you might want to have [test/intervention]?

   ☐$_1$ A lot

   ☐$_1$ Some

   ☐$_0$ A little

   ☐$_0$ Not at all

2. How much did you and your health care providers talk about the reasons you might **not** want to have [test/intervention]?

   ☐$_1$ A lot

   ☐$_1$ Some

   ☐$_0$ A little

   ☐$_0$ Not at all

3. Did any of your health care providers talk about [an alternative to intervention, e.g. non-surgical treatments/not testing] as something that you should seriously consider?

   ☐$_1$ Yes

   ☐$_0$ No

4. Did any of your health care providers ask if you wanted to have [test/intervention]?

   ☐$_1$ Yes

   ☐$_0$ No

For situations with **more than** two main options insert condition (e.g. prostate cancer) and chosen option (e.g. surgery):

TALKING WITH YOUR HEALTH CARE PROVIDERS

Please answer these questions about what happened when you talked with health care providers including doctors, nurses and other health care professionals about [tests or treatments] for your [condition].

1. How much did you and your health care providers talk about the reasons you might want to have [test/intervention]?

   ☐$_1$ A lot

   ☐$_1$ Some

   ☐$_0$ A little

   ☐$_0$ Not at all

2. How much did you and your health care providers talk about the reasons you might **not** want to have [test/intervention]?

   ☐$_1$ A lot

   ☐$_1$ Some

   ☐$_0$ A little

   ☐$_0$ Not at all

3. Did any of your health care providers explain that there were choices in what you could do to treat your [condition]?

   ☐$_1$ Yes

   ☐$_0$ No

4. Did any of your health care providers ask if you wanted to have [test/intervention]?

   ☐$_1$ Yes

   ☐$_0$ No

Statin Therapy for Patients With Cardiovascular Disease (SPC)

SUMMARY OF CHANGES TO HEDIS MY 2024

- Added a laboratory claim exclusion to value sets for which laboratory claims should not be used.
- Revised the method for identifying advanced illness.
- Moved previously listed *Exclusions* to *Required exclusions.*
- Revised the "Denominator Exclusions" criteria in the Clinical Components table under *Rules for Allowable Adjustments of HEDIS*.

Description

The percentage of males 21–75 years of age and females 40–75 years of age during the measurement year who were identified as having clinical atherosclerotic cardiovascular disease (ASCVD) and met the following criteria. The following rates are reported:

1. *Received Statin Therapy.* Members who were dispensed at least one high-intensity or moderate-intensity statin medication during the measurement year.
2. *Statin Adherence 80%.* Members who remained on a high-intensity or moderate-intensity statin medication for at least 80% of the treatment period.

Definitions

IPSD	Index prescription start date. The earliest prescription dispensing date for any statin medication of at least moderate intensity during the measurement year.
Treatment period	The period of time beginning on the IPSD through the last day of the measurement year.
PDC	Proportion of days covered. The number of days the member is covered by at least one statin medication prescription of appropriate intensity, divided by the number of days in the treatment period.
Calculating number of days covered for multiple prescriptions	If multiple prescriptions for different medications are dispensed on the same day, calculate the number of days covered by a statin medication (for the numerator) using the prescriptions with the longest days supply. For multiple different prescriptions dispensed on different days with overlapping days supply, count each day in the treatment period only once toward the numerator. If multiple prescriptions for the same medication are dispensed on the same day or on different days, sum the days supply and use the total to calculate the number of days covered by a statin medication (for the numerator). For example, three prescriptions for the same medication are dispensed on the same day, each with a 30-days supply. Sum the days supply for a total of 90 days covered by a statin. Subtract any days supply that extends beyond December 31 of the measurement year.

Use the medication lists to determine if drugs are the same or different. Drugs in different medication lists are considered different drugs. For example, a dispensing event from the Amlodipine Atorvastatin High Intensity Medications List and a dispensing event from the Amlodipine Atorvastatin Moderate Intensity Medications List are dispensing events for different medications.

Eligible Population: *Rate 1*—Received Statin Therapy

Product line

Commercial, Medicaid, Medicare (report each product line separately).

Age

Report two age/gender stratifications and a total rate:

- Males 21–75 years as of December 31 of the measurement year.
- Females 40–75 years as of December 31 of the measurement year.
- Total.

Continuous enrollment

The measurement year and the year prior to the measurement year.

Allowable gap

No more than one gap in enrollment of up to 45 days during each year of continuous enrollment. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (i.e., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).

Anchor date

December 31 of the measurement year.

Benefit

Medical. Pharmacy during the measurement year.

Event/diagnosis

Members are identified for the eligible population in two ways: by event or by diagnosis. The organization must use *both* methods to identify the eligible population, but a member only needs to be identified by one method to be included in the measure.

Event. Any of the following during the year prior to the measurement year meet criteria:

- *MI.* Discharged from an inpatient setting with an MI (MI Value Set; Old Myocardial Infarction Value Set) on the discharge claim. To identify discharges:
  1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
  2. Identify the discharge date for the stay.
- *CABG.* Members who had CABG (CABG Value Set) in any setting.
- *PCI.* Members who had PCI (PCI Value Set) in any setting.
- *Other revascularization*. Members who had any other revascularization procedures (Other Revascularization Value Set) in any setting.

Diagnosis. Identify members who had at least one encounter with a diagnosis of IVD during both the measurement year and the year prior to the measurement year. The following encounters meet criteria:

- An outpatient visit, telephone visit, e-visit, virtual check-in or acute inpatient encounter (Outpatient, Telehealth and Acute Inpatient Value Set) with an IVD diagnosis (IVD Value Set).
- At least one acute inpatient discharge with an IVD diagnosis (IVD Value Set) on the discharge claim. To identify an acute inpatient discharge:
  1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
  2. Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set).
  3. Identify the discharge date for the stay.

Required exclusions

Exclude members who meet any of the following criteria:

- Members with a diagnosis of pregnancy (Pregnancy Value Set) during the measurement year or the year prior to the measurement year. Do not include laboratory claims (claims with POS code 81).
- In vitro fertilization (IVF Value Set) in the measurement year or the year prior to the measurement year.
- Dispensed at least one prescription for clomiphene (Estrogen Agonists Medications List) during the measurement year or the year prior to the measurement year.
- ESRD (ESRD Diagnosis Value Set) during the measurement year or the year prior to the measurement year. Do not include laboratory claims (claims with POS code 81).
- Dialysis (Dialysis Procedure Value Set) during the measurement year or the year prior to the measurement year.
- Cirrhosis (Cirrhosis Value Set) during the measurement year or the year prior to the measurement year. Do not include laboratory claims (claims with POS code 81).
- Myalgia, myositis, myopathy or rhabdomyolysis (Muscular Pain and Disease Value Set) during the measurement year. Do not include laboratory claims (claims with POS code 81).
- Members who use hospice services (Hospice Encounter Value Set; Hospice Intervention Value Set) or elect to use a hospice benefit any time during the measurement year. Organizations that use the Monthly Membership Detail Data File to identify these members must use only the run date of the file to determine if the member elected to use a hospice benefit during the measurement year.
- Members who die any time during the measurement year.
- Members receiving palliative care (Palliative Care Assessment Value Set; Palliative Care Encounter Value Set; Palliative Care Intervention Value Set) any time during the measurement year.
- Members who had an encounter for palliative care (ICD-10-CM code Z51.5) anytime during the measurement year. Do not include laboratory claims (claims with POS code 81).

- Medicare members 66 years of age and older as of December 31 of the measurement year who meet either of the following:
  - Enrolled in an Institutional SNP (I-SNP) any time during the measurement year.
  - Living long-term in an institution any time during the measurement year as identified by the LTI flag in the Monthly Membership Detail Data File. Use the run date of the file to determine if a member had an LTI flag during the measurement year.
- Members 66 years of age and older as of December 31 of the measurement year (all product lines) with frailty **and** advanced illness. Members must meet **both** frailty and advanced illness criteria to be excluded:
  1. **Frailty.** At least two indications of frailty (Frailty Device Value Set; Frailty Diagnosis Value Set; Frailty Encounter Value Set; Frailty Symptom Value Set) with different dates of service during the measurement year. Do not include laboratory claims (claims with POS code 81).
  2. **Advanced Illness.** Either of the following during the measurement year or the year prior to the measurement year:
     - Advanced illness (Advanced Illness Value Set) on at least two different dates of service. Do not include laboratory claims (claims with POS code 81).
     - Dispensed dementia medication (Dementia Medications List).

Estrogen Agonists Medications

Description	Prescription
Estrogen agonists	• Clomiphene

Dementia Medications

Description	Prescription
Cholinesterase inhibitors	• Donepezil • Galantamine • Rivastigmine
Miscellaneous central nervous system agents	• Memantine
Dementia combinations	• Donepezil-memantine

Administrative Specification: *Rate 1*—Received Statin Therapy

Denominator The Rate 1 eligible population.

Numerator The number of members who had at least one dispensing event for a high-intensity or moderate-intensity statin medication (High and Moderate Intensity Statin Medications List) during the measurement year.

High- and Moderate-Intensity Statin Medications

Description	Prescription	Medication Lists
High-intensity statin therapy	• Atorvastatin 40-80 mg	Atorvastatin High Intensity Medications List
High-intensity statin therapy	• Amlodipine-atorvastatin 40-80 mg	Amlodipine Atorvastatin High Intensity Medications List
High-intensity statin therapy	• Rosuvastatin 20-40 mg	Rosuvastatin High Intensity Medications List
High-intensity statin therapy	• Simvastatin 80 mg	Simvastatin High Intensity Medications List
High-intensity statin therapy	• Ezetimibe-simvastatin 80 mg	Ezetimibe Simvastatin High Intensity Medications List
Moderate-intensity statin therapy	• Atorvastatin 10-20 mg	Atorvastatin Moderate Intensity Medications List
Moderate-intensity statin therapy	• Amlodipine-atorvastatin 10-20 mg	Amlodipine Atorvastatin Moderate Intensity Medications List
Moderate-intensity statin therapy	• Rosuvastatin 5-10 mg	Rosuvastatin Moderate Intensity Medications List
Moderate-intensity statin therapy	• Simvastatin 20-40 mg	Simvastatin Moderate Intensity Medications List
Moderate-intensity statin therapy	• Ezetimibe-simvastatin 20-40 mg	Ezetimibe Simvastatin Moderate Intensity Medications List
Moderate-intensity statin therapy	• Pravastatin 40-80 mg	Pravastatin Moderate Intensity Medications List
Moderate-intensity statin therapy	• Lovastatin 40 mg	Lovastatin Moderate Intensity Medications List
Moderate-intensity statin therapy	• Fluvastatin 40-80 mg	Fluvastatin Moderate Intensity Medications List
Moderate-intensity statin therapy	• Pitavastatin 1-4 mg	Pitavastatin Moderate Intensity Medications List

Eligible Population: *Rate 2*—Statin Adherence 80%

Product line Commercial, Medicaid, Medicare (report each product line separately).

Age Report two age/gender stratifications and a total rate:

- Males 21–75 years as of December 31 of the measurement year.
- Females 40–75 years as of December 31 of the measurement year.
- Total.

Continuous enrollment The measurement year and the year prior to the measurement year.

Allowable gap No more than one gap in enrollment of up to 45 days during each year of continuous enrollment. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (e.g., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).

Anchor date December 31 of the measurement year.

Benefit Medical. Pharmacy during the measurement year.

Event/diagnosis All members who meet the numerator criteria for Rate 1.

Administrative Specification: *Rate 2*—Statin Adherence 80%

Denominator The Rate 2 eligible population.

Numerator The number of members who achieved a PDC of at least 80% during the treatment period.

Follow the steps below to identify numerator compliance.

Step 1 Identify the IPSD. The IPSD is the earliest dispensing event for any high-intensity or moderate-intensity statin medication during the measurement year. Use all the medications lists above to identify statin medication dispensing events.

Step 2 To determine the treatment period, calculate the number of days beginning on the IPSD through the end of the measurement year.

Step 3 Count the days covered by at least one prescription for any high-intensity or moderate-intensity statin medication during the treatment period. To ensure that days supply that extends beyond the measurement year is not counted, subtract any days supply that extends beyond December 31 of the measurement year.

Step 4 Calculate the member's PDC using the following equation. Multiply the equation by 100 and round (using the .5 rule) to the nearest whole number. For example, if a member has 291 total days covered by a medication during a 365-day treatment period, this calculates to 0.7972. Multiply this number by 100, convert it to 79.72% and round it to 80%, the nearest whole number.

$$\frac{\text{Total Days Covered by a Statin Medication in the Treatment Period (step 3)}}{\text{Total Days in Treatment Period (step 2)}}$$

Step 5 Sum the number of members whose PDC is ≥80% for the treatment period.

Note

- *All members who are numerator compliant for Rate 1 must be used as the eligible population for Rate 2 (regardless of the data source used to capture the Rate 1 numerator). For example, if supplemental data were used to identify compliance for the Rate 1 numerator, then supplemental data will be included in identifying the Rate 2 eligible population.*

Data Elements for Reporting

Organizations that submit HEDIS data to NCQA must provide the following data elements.

Table SPC-1/2/3: Data Elements for Statin Therapy for Patients With Cardiovascular Disease

Metric	Gender	Data Element	Reporting Instructions
ReceivedTherapy	F	Benefit	Metadata
Adherence	M	EligiblePopulation	For each Metric and Stratification
	Total	ExclusionAdminRequired	Only for ReceivedTherapy Metric
		NumeratorByAdmin	For each Metric and Stratification
		NumeratorBySupplemental	For each Metric and Stratification
		Rate	(Percent)

Rules for Allowable Adjustments of HEDIS

The "Rules for Allowable Adjustments of HEDIS" (the "Rules") describe how NCQA's HEDIS measure specifications can be adjusted for other populations, if applicable. The Rules, reviewed and approved by NCQA measure experts, provide for expanded use of HEDIS measures without changing their clinical intent.

Adjusted HEDIS measures may not be used for HEDIS health plan reporting.

Rules for Allowable Adjustments of Statin Therapy for Patients With Cardiovascular Disease

NONCLINICAL COMPONENTS		
Eligible Population	**Adjustments Allowed (Yes/No)**	**Notes**
Product lines	Yes	Using product line criteria is not required. Including any product line, combining product lines, or not including product line criteria is allowed.
Ages	Yes, with limits	Age determination dates may be changed (e.g., select, "age as of June 30"). The denominator age may be changed if the range is within the specified age range (ages 21–75 or 40–75 years). The denominator age may not be expanded.
Continuous enrollment, allowable gap, anchor date	Yes	Organizations are not required to use enrollment criteria; adjustments are allowed.
Benefits	Yes	Organizations are not required to use enrollment criteria; adjustments are allowed.
Other	Yes	Organizations may use additional eligible population criteria to focus on an area of interest defined by gender, race, ethnicity, socioeconomic or sociodemographic characteristics, geographic region or another characteristic.
CLINICAL COMPONENTS		
Eligible Population	**Adjustments Allowed (Yes/No)**	**Notes**
Event/diagnosis	No	Only events that contain (or map to) codes in the value sets may be used to identify discharges. Value sets and logic may not be changed.
Denominator Exclusions	**Adjustments Allowed (Yes/No)**	**Notes**
Required exclusions	Yes, with limits	Apply required exclusions according to specified value sets and medication lists. The hospice, deceased member, palliative care, I-SNP, LTI, frailty and advanced illness exclusions are not required. Refer to *Exclusions* in the *Guidelines for the Rules for Allowable Adjustments.*
Numerator Criteria	**Adjustments Allowed (Yes/No)**	**Notes**
• Rate 1: Received Statin Therapy • Rate 2: Statin Adherence 80%	No	Medication lists, value sets and logic may not be changed.

Statin Therapy for Patients With Diabetes (SPD)

SUMMARY OF CHANGES TO HEDIS MY 2024

- Updated the event/diagnosis criteria.
- Updated the Diabetes Medications table.
- Added a laboratory claim exclusion to value sets for which laboratory claims should not be used.
- Moved previously listed *Exclusions* to *Required exclusions.*
- Revised the method for identifying advanced illness.
- Revised the "Denominator Exclusions" criteria in the Clinical Components table under *Rules for Allowable Adjustments of HEDIS*.

Description

The percentage of members 40–75 years of age during the measurement year with diabetes who do not have clinical atherosclerotic cardiovascular disease (ASCVD) who met the following criteria. Two rates are reported:

1. *Received Statin Therapy.* Members who were dispensed at least one statin medication of any intensity during the measurement year.
2. *Statin Adherence 80%.* Members who remained on a statin medication of any intensity for at least 80% of the treatment period.

Definitions

IPSD	Index prescription start date. The earliest prescription dispensing date for any statin medication of any intensity during the measurement year.
Treatment period	The period of time beginning on the IPSD through the last day of the measurement year.
PDC	Proportion of days covered. The number of days the member is covered by at least one statin medication prescription of appropriate intensity, divided by the number of days in the treatment period.
Calculating number of days covered for multiple prescriptions	If multiple prescriptions for different medications are dispensed on the same day, calculate number of days covered by a statin medication (for the numerator) using the prescriptions with the longest days supply. For multiple different prescriptions dispensed on different days with overlapping days supply, count each day within the treatment period only once toward the numerator. If multiple prescriptions for the same medication are dispensed on the same or different day, sum the days supply and use the total to calculate the number of days covered by a statin medication (for the numerator). For example, three prescriptions for the same medication are dispensed on the same day, each with a 30-days supply, sum the days supply for a total of 90 days covered by a statin. Subtract any days supply that extends beyond December 31 of the measurement year.

Use the medication lists to determine if drugs are the same or different. Drugs in different lists are considered different drugs. For example, a dispensing event from the Amlodipine Atorvastatin High Intensity Medications List and a dispensing event from the Amlodipine Atorvastatin Moderate Intensity Medications List are dispensing events for different medications.

Eligible Population: *Rate 1*—Received Statin Therapy

Product lines Commercial, Medicaid, Medicare (report each product line separately).

Ages 40–75 years as of December 31 of the measurement year.

Continuous enrollment The measurement year and the year prior to the measurement year.

Allowable gap No more than one gap in enrollment of up to 45 days during each year of continuous enrollment. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (e.g., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).

Anchor date December 31 of the measurement year.

Benefit Medical. Pharmacy during the measurement year.

Event/diagnosis There are two ways to identify members with diabetes: by claim/encounter data and by pharmacy data. The organization must use both methods to identify the eligible population, but a member only needs to be identified by one method to be included in the measure. Members may be identified as having diabetes during the measurement year or the year prior to the measurement year.

Claim/encounter data. Members who had at least two diagnoses of diabetes (Diabetes Value Set) on different dates of service during the measurement year or the year prior to the measurement year. Do not include laboratory claims (claims with POS code 81).

Pharmacy data. Members who were dispensed insulin or hypoglycemics/ antihyperglycemics during the measurement year or the year prior to the measurement year (Diabetes Medications List) and have at least one diagnosis of diabetes (Diabetes Value Set) during the measurement year or the year prior to the measurement year. Do not include laboratory claims (claims with POS code 81).

Diabetes Medications

Description	Prescription		
Alpha-glucosidase inhibitors	• Acarbose	• Miglitol	
Amylin analogs	• Pramlintide		
Antidiabetic combinations	• Alogliptin-metformin • Alogliptin-pioglitazone • Canagliflozin-metformin • Dapagliflozin-metformin • Dapagliflozin-saxagliptin	• Empagliflozin-metformin • Ertugliflozin-metformin • Ertugliflozin-sitagliptin • Glimepiride-pioglitazone • Glipizide-metformin	• Metformin-pioglitazone • Metformin-repaglinide • Metformin-rosiglitazone • Metformin-saxagliptin • Metformin-sitagliptin

Description	Prescription		
	• Empagliflozin-linagliptin • Empagliflozin-linagliptin-metformin	• Glyburide-metformin • Linagliptin-metformin	
Insulin	• Insulin aspart • Insulin aspart-insulin aspart protamine • Insulin degludec • Insulin degludec-liraglutide • Insulin detemir • Insulin glargine • Insulin glargine-lixisenatide	• Insulin glulisine • Insulin isophane human • Insulin isophane-insulin regular • Insulin lispro • Insulin lispro-insulin lispro protamine • Insulin regular human • Insulin human inhaled	
Meglitinides	• Nateglinide	• Repaglinide	
Biguanides	• Metformin		
Glucagon-like peptide-1 (GLP1) agonists	• Albiglutide • Dulaglutide • Exenatide	• Liraglutide • Lixisenatide • Semaglutide	
Sodium glucose cotransporter 2 (SGLT2) inhibitor	• Canagliflozin • Dapagliflozin	• Empagliflozin • Ertugliflozin	
Sulfonylureas	• Chlorpropamide • Glimepiride	• Glipizide • Glyburide	• Tolazamide • Tolbutamide
Thiazolidinediones	• Pioglitazone	• Rosiglitazone	
Dipeptidyl peptidase-4 (DDP-4) inhibitors	• Alogliptin • Linagliptin	• Saxagliptin • Sitaglipin	

Required exclusions

Exclude members who meet any of the following criteria:

- Members with at least one of the following during the year prior to the measurement year:
  - *MI.* Discharged from an inpatient setting with an MI (MI Value Set; Old Myocardial Infarction Value Set) on the discharge claim. To identify discharges:
    1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
    2. Identify the discharge date for the stay.
  - *CABG.* Members who had CABG (CABG Value Set) in any setting.
  - *PCI.* Members who had PCI (PCI Value Set) in any setting.
  - *Other revascularization.* Members who had any other revascularization procedure (Other Revascularization Value Set) in any setting.
- Members who had at least one encounter with a diagnosis of IVD during both the measurement year and the year prior to the measurement year. The following encounters meet criteria:

  - An outpatient visit, telephone visit, e-visit, virtual check-in or acute inpatient encounter (Outpatient, Telehealth and Acute Inpatient Value Set) with an IVD diagnosis (IVD Value Set).
  - At least one acute inpatient discharge with an IVD diagnosis (IVD Value Set) on the discharge claim. To identify an acute inpatient discharge:
    1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
    2. Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set).
    3. Identify the discharge date for the stay.
- Members with a diagnosis of pregnancy (Pregnancy Value Set) during the measurement year or year prior to the measurement year. Do not include laboratory claims (claims with POS code 81).
- In vitro fertilization (IVF Value Set) in the measurement year or year prior to the measurement year.
- Dispensed at least one prescription for clomiphene (Estrogen Agonists Medications List) during the measurement year or the year prior to the measurement year.
- ESRD (ESRD Diagnosis Value Set) during the measurement year or the year prior to the measurement year. Do not include laboratory claims (claims with POS code 81).
- Dialysis (Dialysis Procedure Value Set) during the measurement year or the year prior to the measurement year.
- Cirrhosis (Cirrhosis Value Set) during the measurement year or the year prior to the measurement year. Do not include laboratory claims (claims with POS code 81).
- Myalgia, myositis, myopathy or rhabdomyolysis (Muscular Pain and Disease Value Set) during the measurement year. Do not include laboratory claims (claims with POS code 81).
- Members who use hospice services (Hospice Encounter Value Set; Hospice Intervention Value Set) or elect to use a hospice benefit any time during the measurement year. Organizations that use the Monthly Membership Detail Data File to identify these members must use only the run date of the file to determine if the member elected to use a hospice benefit during the measurement year.
- Members who die any time during the measurement year.
- Members receiving palliative care (Palliative Care Assessment Value Set; Palliative Care Encounter Value Set; Palliative Care Intervention Value Set) any time during the measurement year.
- Members who had an encounter for palliative care (ICD-10-CM code Z51.5) any time during the measurement year. Do not include laboratory claims (claims with POS code 81).
- Medicare members 66 years of age and older as of December 31 of the measurement year who meet either of the following:
  - Enrolled in an Institutional SNP (I-SNP) any time during the measurement year.

  - Living long-term in an institution any time during the measurement year as identified by the LTI flag in the Monthly Membership Detail Data File. Use the run date of the file to determine if a member had an LTI flag during the measurement year.

- Members 66 years of age and older as of December 31 of the measurement year (all product lines) with frailty **and** advanced illness. Members must meet **both** frailty and advanced illness criteria to be excluded:
  1. **Frailty.** At least two indications of frailty (Frailty Device Value Set; Frailty Diagnosis Value Set; Frailty Encounter Value Set; Frailty Symptom Value Set) with different dates of service during the measurement year. Do not include laboratory claims (claims with POS code 81).
  2. **Advanced Illness.** Either of the following during the measurement year or the year prior to the measurement year:
     - Advanced illness (Advanced Illness Value Set) on at least two different dates of service. Do not include laboratory claims (claims with POS code 81).
     - Dispensed dementia medication (Dementia Medications List).

Estrogen Agonists Medications

Description	Prescription
Estrogen agonists	• Clomiphene

Dementia Medications

Description	Prescription		
Cholinesterase inhibitors	• Donepezil	• Galantamine	• Rivastigmine
Miscellaneous central nervous system agents	• Memantine		
Dementia combinations	• Donepezil-memantine		

Administrative Specification: *Rate 1*—Received Statin Therapy

Denominator The Rate 1 eligible population.

Numerator The number of members who had at least one dispensing event for a high-intensity, moderate intensity, or low-intensity statin medication (High, Moderate and Low Intensity Statin Medications List) during the measurement year.

High, Moderate and Low-Intensity Statin Medications

Description	Prescription	Medication Lists
High-intensity statin therapy	Atorvastatin 40-80 mg	Atorvastatin High Intensity Medications List
High-intensity statin therapy	Amlodipine-atorvastatin 40-80 mg	Amlodipine Atorvastatin High Intensity Medications List
High-intensity statin therapy	Rosuvastatin 20-40 mg	Rosuvastatin High Intensity Medications List

Description	Prescription	Medication Lists
High-intensity statin therapy	Simvastatin 80 mg	Simvastatin High Intensity Medications List
High-intensity statin therapy	Ezetimibe-simvastatin 80 mg	Ezetimibe Simvastatin High Intensity Medications List
Moderate-intensity statin therapy	Atorvastatin 10-20 mg	Atorvastatin Moderate Intensity Medications List
Moderate-intensity statin therapy	Amlodipine-atorvastatin 10-20 mg	Amlodipine Atorvastatin Moderate Intensity Medications List
Moderate-intensity statin therapy	Rosuvastatin 5-10 mg	Rosuvastatin Moderate Intensity Medications List
Moderate-intensity statin therapy	Simvastatin 20-40 mg	Simvastatin Moderate Intensity Medications List
Moderate-intensity statin therapy	Ezetimibe-simvastatin 20-40 mg	Ezetimibe Simvastatin Moderate Intensity Medications List
Moderate-intensity statin therapy	Pravastatin 40-80 mg	Pravastatin Moderate Intensity Medications List
Moderate-intensity statin therapy	Lovastatin 40 mg	Lovastatin Moderate Intensity Medications List
Moderate-intensity statin therapy	Fluvastatin 40-80 mg	Fluvastatin Moderate Intensity Medications List
Moderate-intensity statin therapy	Pitavastatin 1–4 mg	Pitavastatin Moderate Intensity Medications List
Low-intensity statin therapy	Ezetimibe-simvastatin 10 mg	Ezetimibe Simvastatin Low Intensity Medications List
Low-intensity statin therapy	Fluvastatin 20 mg	Fluvastatin Low Intensity Medications List
Low-intensity statin therapy	Lovastatin 10-20 mg	Lovastatin Low Intensity Medications List
Low-intensity statin therapy	Pravastatin 10–20 mg	Pravastatin Low Intensity Medications List
Low-intensity statin therapy	Simvastatin 5-10 mg	Simvastatin Low Intensity Medications List

Eligible Population: *Rate 2*—Statin Adherence 80%

Product lines Commercial, Medicaid, Medicare (report each product line separately).

Age 40–75 years as of December 31 of the measurement year.

Continuous enrollment The measurement year and the year prior to the measurement year.

Allowable gap No more than one gap in enrollment of up to 45 days during the measurement year. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (e.g., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).

Anchor date December 31 of the measurement year.

Benefit Medical. Pharmacy during the measurement year.

Event/diagnosis All members who meet the numerator criteria for Rate 1.

Administrative Specification: *Rate 2*—Statin Adherence 80%

Denominator The Rate 2 eligible population.

Numerator The number of members who achieved a PDC of at least 80% during the treatment period.

Follow the steps below to identify numerator compliance.

Step 1 Identify the IPSD. The IPSD is the earliest dispensing event for any high-intensity, moderate-intensity or low-intensity statin medication during the measurement year. Use all the medication lists above to identify statin medication dispensing events.

Step 2 To determine the treatment period, calculate the number of days beginning on the IPSD through the end of the measurement year.

Step 3 Count the days covered by at least one prescription for any high-intensity, moderate-intensity or low-intensity statin medication during the treatment period. To ensure the measure does not give credit for supply that extends beyond the measurement year, subtract any days supply that extends beyond December 31 of the measurement year.

Step 4 Calculate the member's PDC using the following equation. Multiply the equation by 100 and round (using the .5 rule) to the nearest whole number. For example, if a member has 291 total days covered by a medication during a 365-day treatment period, this calculates to 0.7972. Multiply this number by 100, convert it to 79.72% and round it to 80%, the nearest whole number.

$$\frac{\text{Total Days Covered by a Statin Medication in the Treatment Period (step 3)}}{\text{Total Days in Treatment Period (step 2)}}$$

Step 5 Sum the number of members whose PDC is ≥80% for the treatment period.

Note

- *All members who are numerator compliant for Rate 1 must be used as the eligible population for Rate 2 (regardless of the data source used to capture the Rate 1 numerator). For example, if supplemental data were used to identify compliance for the Rate 1 numerator, then supplemental data will be included in identifying the Rate 2 eligible population.*

Data Elements for Reporting

Organizations that submit HEDIS data to NCQA must provide the following data elements.

Table SPD-1/2/3: Data Elements for Statin Therapy for Patients With Diabetes

Metric	Data Element	Reporting Instructions
ReceivedTherapy	Benefit	Metadata
Adherence	EligiblePopulation	For each Metric
	ExclusionAdminRequired	Only for ReceivedTherapy Metric
	NumeratorByAdmin	For each Metric
	NumeratorBySupplemental	For each Metric
	Rate	(Percent)

Rules for Allowable Adjustments of HEDIS

The "Rules for Allowable Adjustments of HEDIS" (the "Rules") describe how NCQA's HEDIS measure specifications can be adjusted for other populations, if applicable. The Rules, reviewed and approved by NCQA measure experts, provide for expanded use of HEDIS measures without changing their clinical intent.

Adjusted HEDIS measures *may not* be used for HEDIS health plan reporting.

Rules for Allowable Adjustments of Statin Therapy for Patients With Diabetes

NONCLINICAL COMPONENTS		
Eligible Population	**Adjustments Allowed (Yes/No)**	**Notes**
Product lines	Yes	Organizations are not required to use product line criteria; product lines may be combined and all (or no) product line criteria may be used.
Ages	Yes, with limits	Age determination dates may be changed (e.g., select, "age as of June 30"). Changing the denominator age range is allowed within the specified age range (ages 40–75 years). The denominator age may not be expanded.
Continuous enrollment, allowable gap, anchor date	Yes	Organizations are not required to use enrollment criteria; adjustments are allowed.
Benefits	Yes	Organizations are not required to use a benefit; adjustments are allowed.
Other	Yes	Organizations may use additional eligible population criteria to focus on an area of interest defined by gender, race, ethnicity, socioeconomic or sociodemographic characteristics, geographic region or another characteristic.
CLINICAL COMPONENTS		
Eligible Population	**Adjustments Allowed (Yes/No)**	**Notes**
Event/diagnosis	No	Only events or diagnoses that contain (or map to) codes in the medication lists and value sets may be used to identify visits. Medication lists, value sets and logic may not be changed.
Denominator Exclusions	**Adjustments Allowed (Yes/No)**	**Notes**
Required Exclusions	Yes, with limits	Apply required exclusions according to specified medication lists and value sets. The hospice, deceased member, palliative care, I-SNP, LTI, frailty and advanced illness exclusions are not required. Refer to *Exclusions* in the *Guidelines for the Rules for Allowable Adjustments.*

Numerator Criteria	Adjustments Allowed (Yes/No)	Notes
• Rate 1: Received Statin Therapy • Rate 2: Statin Adherence 80%	No	Medication lists, value sets and logic may not be changed.

Urinary Symptoms Score Change 6-12 Months After Diagnosis of Benign Prostatic Hyperplasia

CMIT Measure ID: 741 | **CMIT ID:** 00741-01-E-MIPS | **Measure Type:** Patient-Reported Outcome-Based Performance Measure (PRO-PM)

Date of Information: 12/06/2022 | **Revision:** 6 | **Program:** Merit-Based Incentive Payment System Program

View Description

Percentage of patients with an office visit within the measurement period and with a new diagnosis of clinically significant Benign Prostatic Hyperplasia who have International Prostate Symptoms Score (IPSS) or American Urological Association (AUA) Symptom Index (SI) documented at time of diagnosis and again 6-12 months later with an improvement of 3 points.

Properties

Steward

Characteristics

Cascade of Meaningful Measures

Groups

Programs

Reporting Status

Milestones

Links

Similar Measures

Environmental Scan

Components

Properties

Date of Information

12/06/2022

Abbreviated Measure Title

Not Available

Description

Percentage of patients with an office visit within the measurement period and with a new diagnosis of clinically significant Benign Prostatic Hyperplasia who have International Prostate Symptoms Score (IPSS) or American Urological Association (AUA) Symptom Index (SI) documented at time of diagnosis and again 6-12 months later with an improvement of 3 points.

Return to Top

Numerator

Patients with a documented improvement of at least 3 points in their urinary symptom score during the measurement period

Denominator

Male patients with an initial diagnosis of benign prostatic hyperplasia 6 months prior to, or during the measurement period, and a urinary symptom score assessment within 1 month of initial diagnosis and a follow-up urinary symptom score assessment within 6-12 months, who had a qualifying visit during the measurement period.

Denominator Exclusions

Patients with urinary retention that starts within 1 year of initial BPH diagnosis. Patients with an initial BPH diagnosis that starts during, or within 30 days of hospitalization. Patients with a diagnosis of morbid obesity, or with a BMI Exam => 40 before the follow up urinary symptom score.

Rationale

Benign prostatic hyperplasia (BPH) is one of the most common conditions affecting older men, with a prevalence of 50% by age 60 years and 90% by the ninth decade of life (Medina, Parra, & Moore, 1999).The enlarged gland had been proposed to contribute to the overall lower urinary tract symptoms (LUTS) complex (McVary et al., 2014). Although LUTS secondary to BPH is not often a life-threatening condition, the impact of LUTS/BPH on quality of life can be significant (Wei, Calhoun, & Jacobsen, 2005). The American Urological Association Symptom Index (AUA-SI) and the International Prostate Symptom Score (IPSS) were developed to measure outcomes in studies of different treatments for BPH (Wuerstle et al., 2011). The IPSS uses the same questions as the AUA-SI, but also adds a disease-specific quality of life question (OLeary, 2005). The IPSS was adopted in 1993 by the World Health Organization. It is a reproducible, validated index designed to determine disease severity and response to therapy (D Silva, Dahm, & Wong, 2014). It includes 3 storage symptom questions (frequency, nocturia, urgency) and four voiding symptoms (feeling of incomplete emptying, intermittency, straining, and a weak stream) as well as a B question: If you were to spend the rest of your life with your urinary condition just the way it is now, how would you feel about that A three-point improvement in the score is considered meaningful (McVary et al., 2014).

Evidence

Not Available

Denominator Exceptions

Not applicable

Numerator Exceptions

Not applicable

Risk Adjusted

No

Program Name Abbreviation

MIPS

Program Status

Active

CMS Measures Management System (MMS) Hub

CMS Meaningful Measures

CMS Pre-Rulemaking

CMS Quality Measures

NQF Quality Position System

eCQI Resource Center

Login to CMIT

About this Site

Contact Us

How It Works

Privacy Policy

User Guide

Looking for U.S. government information and services? **Visit CMS.gov, HHS.gov, USA.gov**

Varicose Vein Treatment with Saphenous Ablation: Outcome Survey

CMIT Measure ID: 752 **| CMIT ID:** 00752-01-C-MIPS **| Measure Type:** Patient-Reported Outcome-Based Performance Measure (PRO-PM)

Date of Information: 05/10/2019 **| Revision:** 1 **| Program:** Merit-Based Incentive Payment System Program

View Description

Percentage of patients treated for varicose veins (CEAP C2-S) who are treated with saphenous ablation (with or without adjunctive tributary treatment) that report an improvement on a disease specific patient reported outcome survey instrument after treatment.

Properties

Steward

Characteristics

Cascade of Meaningful Measures

Groups

Programs

Reporting Status

Milestones

Links

Similar Measures

Environmental Scan

Components

Properties

Date of Information

05/10/2019

Abbreviated Measure Title

Not Available

Description

Percentage of patients treated for varicose veins (CEAP C2-S) who are treated with saphenous ablation (with or without adjunctive tributary treatment) that report an improvement on a disease specific patient reported outcome survey instrument after treatment.

Numerator

Return to Top

Patients whose outcome survey score improved when assessed 3-6 months following treatment

Denominator

All patients who are treated for varicose veins with saphenous ablation and who receive an outcomes survey before and 3-6 months after treatment

Denominator Exclusions

Not available

Rationale

Surrogate measures to measure the success of varicose vein treatment with saphenous ablation have numerous flaws. The ultimate measure of success of saphenous ablation for varicose veins is an improved quality of life. This quality measure motivates physicians to assess changes in quality of life after as compared with before an ablation using one of several standardized survey instruments. This enables objective quantification of the improvement in quality of life that saphenous vein ablation provides patients with CEAP C2 disease.

Evidence

Not Available

Denominator Exceptions

Patient survey results not available

Numerator Exceptions

Not applicable

Risk Adjusted

No

Program Name Abbreviation

MIPS

Program Status

Active

Looking for U.S. government information and services? **Visit CMS.gov, HHS.gov, USA.gov**