



Measure Information

This document contains the information submitted by measure developers/stewards, but is organized according to NQF's measure evaluation criteria and process. The item numbers refer to those in the submission form but may be in a slightly different order here. In general, the item numbers also reference the related criteria (e.g., item 1b.1 relates to sub criterion 1b).

Brief Measure Information
<p>NQF #: 0088e</p> <p>Corresponding Measures: 0088</p> <p>De.2. Measure Title: Diabetic Retinopathy: Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy</p> <p>Co.1.1. Measure Steward: American Academy of Ophthalmology (AAO)</p> <p>De.3. Brief Description of Measure: Percentage of patients aged 18 years and older with a diagnosis of diabetic retinopathy who had a dilated macular or fundus exam performed which included documentation of the level of severity of retinopathy and the presence or absence of macular edema during one or more office visits within 12 months</p> <p>1b.1. Developer Rationale: Several level 1 RCT studies demonstrate the ability of timely treatment to reduce the rate and severity of vision loss from diabetes (Diabetic Retinopathy Study – DRS, Early Treatment Diabetic Retinopathy Study – ETDRS). Necessary examination prerequisites to applying the study results are that the presence and severity of both peripheral diabetic retinopathy and macular edema be accurately documented. In the RAND chronic disease quality project, while administrative data indicated that roughly half of the patients had an eye exam in the recommended time period, chart review data indicated that only 19% had documented evidence of a dilated examination. Thus, ensuring timely treatment that could prevent 95% of the blindness due to diabetes requires the performance and documentation of key examination parameters. The documented level of severity of retinopathy and the documented presence or absence of macular edema assists with the on-going plan of care for the patient with diabetic retinopathy.</p>
<p>S.4. Numerator Statement: Patients who had a dilated macular or fundus exam performed which included documentation of the level of severity of retinopathy AND the presence or absence of macular edema during one or more office visits within 12 months</p> <p>S.6. Denominator Statement: All patients aged 18 years and older with a diagnosis of diabetic retinopathy</p> <p>S.8. Denominator Exclusions: Denominator Exceptions:</p> <p>Documentation of medical reason(s) for not performing a dilated macular or fundus examination</p> <p>Documentation of patient reason(s) for not performing a dilated macular or fundus examination</p> <p>Denominator Exclusions: not applicable</p>
<p>De.1. Measure Type: Process</p> <p>S.17. Data Source: Electronic Health Records</p> <p>S.20. Level of Analysis: Clinician : Group/Practice, Clinician : Individual</p>
<p>IF Endorsement Maintenance – Original Endorsement Date: Nov 04, 2015 Most Recent Endorsement Date: Nov 04, 2015</p>
<p>IF this measure is included in a composite, NQF Composite#/title:</p> <p>IF this measure is paired/grouped, NQF#/title:</p> <p>De.4. IF PAIRED/GROUPED, what is the reason this measure must be reported with other measures to appropriately interpret results?</p>

1. Evidence, Performance Gap, Priority – Importance to Measure and Report

Extent to which the specific measure focus is evidence-based, important to making significant gains in healthcare quality, and improving health outcomes for a specific high-priority (high-impact) aspect of healthcare where there is variation in or overall less-than-optimal performance. ***Measures must be judged to meet all sub criteria to pass this criterion and be evaluated against the remaining criteria.***

1a. Evidence to Support the Measure Focus – See attached Evidence Submission Form

[DR_Macular_Edema_0088_Evidence_2013-08-20-635936460055101298.docx](#)

1a.1 For Maintenance of Endorsement: Is there new evidence about the measure since the last update/submission?

Do not remove any existing information. If there have been any changes to evidence, the Committee will consider the new evidence. Please use the most current version of the evidence attachment (v7.1). Please use red font to indicate updated evidence.

1b. Performance Gap

Demonstration of quality problems and opportunity for improvement, i.e., data demonstrating:

- considerable variation, or overall less-than-optimal performance, in the quality of care across providers; and/or
- Disparities in care across population groups.

1b.1. Briefly explain the rationale for this measure (e.g., how the measure will improve the quality of care, the benefits or improvements in quality envisioned by use of this measure)

If a COMPOSITE (e.g., combination of component measure scores, all-or-none, any-or-none), SKIP this question and answer the composite questions.

Several level 1 RCT studies demonstrate the ability of timely treatment to reduce the rate and severity of vision loss from diabetes (Diabetic Retinopathy Study – DRS, Early Treatment Diabetic Retinopathy Study – ETDRS). Necessary examination prerequisites to applying the study results are that the presence and severity of both peripheral diabetic retinopathy and macular edema be accurately documented. In the RAND chronic disease quality project, while administrative data indicated that roughly half of the patients had an eye exam in the recommended time period, chart review data indicated that only 19% had documented evidence of a dilated examination. Thus, ensuring timely treatment that could prevent 95% of the blindness due to diabetes requires the performance and documentation of key examination parameters. The documented level of severity of retinopathy and the documented presence or absence of macular edema assists with the on-going plan of care for the patient with diabetic retinopathy.

1b.2. Provide performance scores on the measure as specified (current and over time) at the specified level of analysis. (This is required for maintenance of endorsement. Include mean, std dev, min, max, interquartile range, scores by decile. Describe the data source including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities include.) This information also will be used to address the sub-criterion on improvement (4b1) under Usability and Use.

2012 Reporting Experience Including Trends (2009-2013)

Physician Quality Reporting System and Electronic Prescribing (eRx) Incentive Program

2012 is the most recent year for which PQRS Experience Report measure data is available. The average performance rates on Diabetic Retinopathy- Documentation of Screening for Macular Edema and Severity of Diabetic Retinopathy, over the last several years are as follows:

Average Performance Rate in 2009: 96.8%

Average Performance Rate in 2010: 97.0%

Average Performance Rate in 2011: 96.3%

Average Performance Rate in 2012: 96.0%

It is important to note that PQRS was a voluntary reporting program, with approximately 36.3% of eligible professionals participating using any reporting option in 2012, and performance rates may not be nationally representative.

Center for Medicare and Medicaid Services. 2012 Reporting Experience Including Trends. Available:

<http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/index.html?redirect=/PQRS/>

1b.3. If no or limited performance data on the measure as specified is reported in 1b2, then provide a summary of data from the

literature that indicates opportunity for improvement or overall less than optimal performance on the specific focus of measurement.

Sloan, Yashkin, and Chen (2014) looked at 2151 Medicare beneficiaries who responded to the Health and Retirement Study. Medicare beneficiaries with ≥ 1 of the 3 study diagnoses (glaucoma, age-related macular degeneration, or diabetes mellitus (DM)) were identified by diagnosis codes and merged with survey information. The same individuals were followed for 5 years divided into four 15-month periods. The primary outcome measure was the number of 15-month periods with an eye examination.

One third of beneficiaries with the study's chronic diseases saw an eye care provider in all 4 follow-up periods despite having Medicare. One quarter only obtained an eye examination at most during 1 of the four 15-month follow-up periods. Among the 3 groups of patients studied, utilization was particularly low for persons with diagnosed DM and no eye complications. Rates of eye examinations for elderly persons with DM or frequently occurring eye diseases, especially for DM, remain far below recommended levels in a nationally representative sample of persons with health insurance coverage. Several factors, including limited physical and cognitive function and greater distance to an ophthalmologist, but not health insurance coverage, account for variation in regular use.

Although effective treatment is available, fewer patients with diabetes are referred by their primary care physicians for ophthalmic care than would be expected according to guidelines by the American Diabetes Association and the American Academy of Ophthalmology (Kraft, Marrero, Lazaridis et al 1997). In two community-based studies, 43% to 65% of participants had not received a dilated eye examination at the time of enrollment (NCQA 2013; Paz, Varma, Klein et al 2006).

Kraft SK, Marrero DG, Lazaridis EN, et al. Primary care physicians' practice patterns and diabetic retinopathy: current levels of care. Arch Fam Med 1997;6:29-37.

National Committee for Quality Assurance. Improving quality and patient experience: the state of health care quality 2013. 2013:53. Available at: www.ncqa.org/Portals/0/Newsroom/SOHC/2013/SOHC-web_version_report.pdf. Accessed June 11, 2014.

Paz SH, Varma R, Klein R, et al, Los Angeles Latino Eye Study Group. Noncompliance with vision care guidelines in Latinos with type 2 diabetes mellitus: the Los Angeles Latino Eye Study. Ophthalmology 2006;113:1372-7.

Sloan FA, Yashkin AP, Chen Y. Gaps in Receipt of Regular Eye Examinations among Medicare Beneficiaries Diagnosed with Diabetes or Chronic Eye Diseases. Ophthalmology. December 2014; Volume 121, Issue 12, Pages 2452–2460 Received: April 30, 2014; Received in revised form: June 24, 2014; Accepted: July 14, 2014; Published Online: September 07, 2014. <http://dx.doi.org/10.1016/j.optha.2014.07.020>.

1b.4. Provide disparities data from the measure as specified (current and over time) by population group, e.g., by race/ethnicity, gender, age, insurance status, socioeconomic status, and/or disability. *(This is required for maintenance of endorsement. Describe the data source including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities included.) For measures that show high levels of performance, i.e., "topped out", disparities data may demonstrate an opportunity for improvement/gap in care for certain sub-populations. This information also will be used to address the sub-criterion on improvement (4b1) under Usability and Use.*

As described in question 1.b2, the PQRS program periodically provides us with confidential performance data for this measure. However, this data does not include the information on race/ethnicity, gender, age or any other population groups that would be required to evaluate disparities.

1b.5. If no or limited data on disparities from the measure as specified is reported in 1b.4, then provide a summary of data from the literature that addresses disparities in care on the specific focus of measurement. Include citations. Not necessary if performance data provided in 1b.4

Age, marriage, education, and a higher score on the Charlson index were associated with more periods with an eye examination of the four 15-month periods studied. Male gender, being limited in instrumental activities of daily living at baseline, distance to the nearest ophthalmologist, and low cognitive function were associated with a reduction in frequency of eye examinations.

Sloan FA, Yashkin AP, Chen Y. Gaps in Receipt of Regular Eye Examinations among Medicare Beneficiaries Diagnosed with Diabetes

or Chronic Eye Diseases. Ophthalmology. December 2014 Volume 121, Issue 12, Pages 2452–2460 Received: April 30, 2014; Received in revised form: June 24, 2014; Accepted: July 14, 2014; Published Online: September 07, 2014.
<http://dx.doi.org/10.1016/j.ophtha.2014.07.020>.

2. Reliability and Validity—Scientific Acceptability of Measure Properties

Extent to which the measure, as specified, produces consistent (reliable) and credible (valid) results about the quality of care when implemented. **Measures must be judged to meet the sub criteria for both reliability and validity to pass this criterion and be evaluated against the remaining criteria.**

2a.1. Specifications The measure is well defined and precisely specified so it can be implemented consistently within and across organizations and allows for comparability. eMeasures should be specified in the Health Quality Measures Format (HQMF) and the Quality Data Model (QDM).

De.5. Subject/Topic Area (check all the areas that apply):

Ears, Nose, Throat (ENT), Endocrine, Endocrine : Diabetes, Eye Care

De.6. Non-Condition Specific(check all the areas that apply):

Health and Functional Status : Change

De.7. Target Population Category (Check all the populations for which the measure is specified and tested if any):

Elderly

S.1. Measure-specific Web Page (Provide a URL link to a web page specific for this measure that contains current detailed specifications including code lists, risk model details, and supplemental materials. Do not enter a URL linking to a home page or to general information.)

Additional measure details at: eCQI Resource Center webpage <https://ecqi.healthit.gov/eligible-professional-eligible-clinician-ecqms>
 . Value set details at VSAC webpage: <https://vsac.nlm.nih.gov/>

S.2a. If this is an eMeasure, HQMF specifications must be attached. Attach the zipped output from the eMeasure authoring tool (MAT) - if the MAT was not used, contact staff. (Use the specification fields in this online form for the plain-language description of the specifications)

This is an eMeasure Attachment: CMS167v7.zip

S.2b. Data Dictionary, Code Table, or Value Sets (and risk model codes and coefficients when applicable) must be attached. (Excel or csv file in the suggested format preferred - if not, contact staff)

Attachment Attachment: CMS167v7_NQF0088_ValueSets_20180504.xlsx

S.2c. Is this an instrument-based measure (i.e., data collected via instruments, surveys, tools, questionnaires, scales, etc.)? Attach copy of instrument if available.

No, this is not an instrument-based measure Attachment:

S.2d. Is this an instrument-based measure (i.e., data collected via instruments, surveys, tools, questionnaires, scales, etc.)? Attach copy of instrument if available.

Not an instrument-based measure

S.3.1. For maintenance of endorsement: Are there changes to the specifications since the last updates/submission. If yes, update the specifications for S1-2 and S4-22 and explain reasons for the changes in S3.2.

S.3.2. For maintenance of endorsement, please briefly describe any important changes to the measure specifications since last measure update and explain the reasons.

S.4. Numerator Statement (Brief, narrative description of the measure focus or what is being measured about the target population, i.e., cases from the target population with the target process, condition, event, or outcome) DO NOT include the rationale for the measure.

IF an OUTCOME MEASURE, state the outcome being measured. Calculation of the risk-adjusted outcome should be described in the calculation algorithm (S.14).

Patients who had a dilated macular or fundus exam performed which included documentation of the level of severity of retinopathy AND the presence or absence of macular edema during one or more office visits within 12 months

S.5. Numerator Details (All information required to identify and calculate the cases from the target population with the target process, condition, event, or outcome such as definitions, time period for data collection, specific data collection items/responses, code/value sets – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format at S.2b)

IF an OUTCOME MEASURE, describe how the observed outcome is identified/counted. Calculation of the risk-adjusted outcome should be described in the calculation algorithm (S.14).

Time Period for Data Collection: At least once during the measurement period

DEFINITIONS:

Documentation – The medical record must include: documentation of the level of severity of retinopathy AND documentation of whether macular edema was present or absent

Macular Edema – Acceptable synonyms for macular edema include: macular thickening, intraretinal thickening, serous detachment of the retina, or pigment epithelial detachment

Severity of Retinopathy – Mild nonproliferative, moderate nonproliferative, severe nonproliferative, very severe nonproliferative, proliferative

HQMF eCQM developed and is included in this submission.

S.6. Denominator Statement (Brief, narrative description of the target population being measured)

All patients aged 18 years and older with a diagnosis of diabetic retinopathy

S.7. Denominator Details (All information required to identify and calculate the target population/denominator such as definitions, time period for data collection, specific data collection items/responses, code/value sets – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format at S.2b.)

IF an OUTCOME MEASURE, describe how the target population is identified. Calculation of the risk-adjusted outcome should be described in the calculation algorithm (S.14).

Time Period for Data Collection: 12 consecutive months

HQMF eCQM developed and is included in this submission.

S.8. Denominator Exclusions (Brief narrative description of exclusions from the target population)

Denominator Exceptions:

Documentation of medical reason(s) for not performing a dilated macular or fundus examination

Documentation of patient reason(s) for not performing a dilated macular or fundus examination

Denominator Exclusions: not applicable

S.9. Denominator Exclusion Details (All information required to identify and calculate exclusions from the denominator such as definitions, time period for data collection, specific data collection items/responses, code/value sets – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format at S.2b.)

Time Period for Data Collection: At the time of the denominator eligible encounter

Exceptions are used to remove a patient from the denominator of a performance measure when the patient does not receive a therapy or service AND that therapy or service would not be appropriate due to patient-specific reasons. The patient would otherwise meet the denominator criteria. Exceptions are not absolute, and are based on clinical judgment, individual patient characteristics, or patient preferences. The PCPI exception methodology uses three categories of reasons for which a patient may be removed from the denominator of an individual measure. These measure exception categories are not uniformly relevant across all measures; for each measure, there must be a clear rationale to permit an exception for a medical, patient, or system reason. For measure Diabetic Retinopathy: Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy, exceptions may include medical or patient reasons for not performing a dilated macular or fundus exam. Although this methodology does not require the external reporting of more detailed exception data, the PCPI recommends that physicians document the specific reasons for exception in patients' medical records for purposes of optimal patient management and audit-readiness. The PCPI also advocates the systematic review and analysis of each physician's exceptions data to identify practice patterns and opportunities for quality improvement.

HQMF eCQM developed and is included in this submission.

S.10. Stratification Information (Provide all information required to stratify the measure results, if necessary, including the stratification variables, definitions, specific data collection items/responses, code/value sets, and the risk-model covariates and coefficients for the clinically-adjusted version of the measure when appropriate – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format with at S.2b.)

Consistent with CMS' Measures Management System Blueprint and recent national recommendations put forth by the IOM and NQF to standardize the collection of race and ethnicity data, we encourage the results of this measure to be stratified by race, ethnicity, administrative sex, and payer and have included these variables as recommended data elements to be collected.

S.11. Risk Adjustment Type (Select type. Provide specifications for risk stratification in measure testing attachment)

No risk adjustment or risk stratification

If other:

S.12. Type of score:

Rate/proportion

If other:

S.13. Interpretation of Score (Classifies interpretation of score according to whether better quality is associated with a higher score, a lower score, a score falling within a defined interval, or a passing score)

Better quality = Higher score

S.14. Calculation Algorithm/Measure Logic (Diagram or describe the calculation of the measure score as an ordered sequence of steps including identifying the target population; exclusions; cases meeting the target process, condition, event, or outcome; time period for data, aggregating data; risk adjustment; etc.)

To calculate performance rates:

1. Find the patients who meet the initial population (ie, the general group of patients that a set of performance measures is designed to address).
2. From the patients within the initial population criteria, find the patients who qualify for the denominator (ie, the specific group of patients for inclusion in a specific performance measure based on defined criteria). Note: in some cases the initial population and denominator are identical.
3. From the patients within the denominator, find the patients who meet the numerator criteria (ie, the group of patients in the denominator for whom a process or outcome of care occurs). Validate that the number of patients in the numerator is less than or equal to the number of patients in the denominator
4. From the patients who did not meet the numerator criteria, determine if the provider has documented that the patient meets any criteria for exception when denominator exceptions have been specified [for this measure: (medical or patient reasons for not performing dilated macular or fundus exam)]. If the patient meets any exception criteria, they should be removed from the denominator for performance calculation. --Although the exception cases are removed from the denominator population for the performance calculation, the exception rate (ie, percentage with valid exceptions) should be calculated and reported along with performance rates to track variations in care and highlight possible areas of focus for QI.

If the patient does not meet the numerator and a valid exception is not present, this case represents a quality failure.

S.15. Sampling (If measure is based on a sample, provide instructions for obtaining the sample and guidance on minimum sample size.)

IF an instrument-based performance measure (e.g., PRO-PM), identify whether (and how) proxy responses are allowed.
not applicable- the measure is not based on a sample.

S.16. Survey/Patient-reported data (If measure is based on a survey or instrument, provide instructions for data collection and guidance on minimum response rate.)

Specify calculation of response rates to be reported with performance measure results.
not applicable- the measure is not based on a survey.

S.17. Data Source (Check ONLY the sources for which the measure is SPECIFIED AND TESTED).

If other, please describe in S.18.

Electronic Health Records

S.18. Data Source or Collection Instrument (Identify the specific data source/data collection instrument (e.g. name of database, clinical registry, collection instrument, etc., and describe how data are collected.)

IF instrument-based, identify the specific instrument(s) and standard methods, modes, and languages of administration.
not applicable

S.19. Data Source or Collection Instrument (available at measure-specific Web page URL identified in S.1 OR in attached appendix at A.1)

No data collection instrument provided

S.20. Level of Analysis (Check ONLY the levels of analysis for which the measure is SPECIFIED AND TESTED)

Clinician : Group/Practice, Clinician : Individual

S.21. Care Setting (Check ONLY the settings for which the measure is SPECIFIED AND TESTED)

Other, Outpatient Services, Post-Acute Care

If other: Domiciliary

S.22. COMPOSITE Performance Measure - Additional Specifications (Use this section as needed for aggregation and weighting rules, or calculation of individual performance measures if not individually endorsed.)

Not applicable. The measure is not a composite.

2. Validity – See attached Measure Testing Submission Form

[DR_Macular_Edema_0088_Testing_2013-08-20_-1-_updated_5-4-15-635936460060717514.docx](#), [EENT_Bonnie_Testing_Results-635998825161371449.pdf](#)

2.1 For maintenance of endorsement

Reliability testing: If testing of reliability of the measure score was not presented in prior submission(s), has reliability testing of the measure score been conducted? If yes, please provide results in the Testing attachment. Please use the most current version of the testing attachment (v7.1). Include information on all testing conducted (prior testing as well as any new testing); use red font to indicate updated testing.

2.2 For maintenance of endorsement

Has additional empirical validity testing of the measure score been conducted? If yes, please provide results in the Testing attachment. Please use the most current version of the testing attachment (v7.1). Include information on all testing conducted (prior testing as well as any new testing); use red font to indicate updated testing.

2.3 For maintenance of endorsement

Risk adjustment: For outcome, resource use, cost, and some process measures, risk-adjustment that includes social risk factors is not prohibited at present. Please update sections 1.8, 2a2, 2b1, 2b4.3 and 2b5 in the Testing attachment and S.140 and S.11 in the online submission form. NOTE: These sections must be updated even if social risk factors are not included in the risk-adjustment strategy.

You MUST use the most current version of the Testing Attachment (v7.1) -- older versions of the form will not have all required questions.

3. Feasibility

Extent to which the specifications including measure logic, require data that are readily available or could be captured without undue burden and can be implemented for performance measurement.

3a. Byproduct of Care Processes

For clinical measures, the required data elements are routinely generated and used during care delivery (e.g., blood pressure, lab test, diagnosis, medication order).

3a.1. Data Elements Generated as Byproduct of Care Processes.

Generated or collected by and used by healthcare personnel during the provision of care (e.g., blood pressure, lab value, diagnosis, depression score)

If other:

3b. Electronic Sources

The required data elements are available in electronic health records or other electronic sources. If the required data are not in electronic health records or existing electronic sources, a credible, near-term path to electronic collection is specified.

3b.1. To what extent are the specified data elements available electronically in defined fields (i.e., data elements that are needed to compute the performance measure score are in defined, computer-readable fields) Update this field for maintenance of endorsement.

ALL data elements are in defined fields in electronic health records (EHRs)

3b.2. If ALL the data elements needed to compute the performance measure score are not from electronic sources, specify a credible, near-term path to electronic capture, OR provide a rationale for using other than electronic sources. For maintenance of endorsement, if this measure is not an eMeasure (eCQM), please describe any efforts to develop an eMeasure (eCQM).

3b.3. If this is an eMeasure, provide a summary of the feasibility assessment in an attached file or make available at a measure-specific URL. Please also complete and attach the NQF Feasibility Score Card.

Attachment: [NQF_0088_Feasibility-635660058466975992-635936460066177724.docx](#)

3c. Data Collection Strategy

Demonstration that the data collection strategy (e.g., source, timing, frequency, sampling, patient confidentiality, costs associated with fees/licensing of proprietary measures) can be implemented (e.g., already in operational use, or testing demonstrates that it is ready to put into operational use). For eMeasures, a feasibility assessment addresses the data elements and measure logic and demonstrates the eMeasure can be implemented or feasibility concerns can be adequately addressed.

3c.1. Required for maintenance of endorsement. Describe difficulties (as a result of testing and/or operational use of the measure) regarding data collection, availability of data, missing data, timing and frequency of data collection, sampling, patient confidentiality, time and cost of data collection, other feasibility/implementation issues.

IF instrument-based, consider implications for both individuals providing data (patients, service recipients, respondents) and those whose performance is being measured.

We have not identified any areas of concern or made any modifications as a result of testing and operational use of the measure in relation to data collection, availability of data, missing data, timing and frequency of data collection, sampling, patient confidentiality, time and cost of data collection, and other feasibility issues unless otherwise noted.

3c.2. Describe any fees, licensing, or other requirements to use any aspect of the measure as specified (e.g., value/code set, risk model, programming code, algorithm).

not applicable

4. Usability and Use

Extent to which potential audiences (e.g., consumers, purchasers, providers, policy makers) are using or could use performance results for both accountability and performance improvement to achieve the goal of high-quality, efficient healthcare for individuals or populations.

4a. Accountability and Transparency

Performance results are used in at least one accountability application within three years after initial endorsement and are publicly reported within six years after initial endorsement (or the data on performance results are available). If not in use at the time of initial endorsement, then a credible plan for implementation within the specified timeframes is provided.

4.1. Current and Planned Use

NQF-endorsed measures are expected to be used in at least one accountability application within 3 years and publicly reported within 6 years of initial endorsement in addition to performance improvement.

Specific Plan for Use	Current Use (for current use provide URL)
	<p>Public Reporting Physician Quality Rating System http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-</p> <p>Payment Program Meaningful Use Stage II http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Stage_2.html</p> <p>Quality Improvement (Internal to the specific organization) Intelligent Research in Sight (IRIS) http://www.aao.org/iris-registry/</p>

4a1.1 For each CURRENT use, checked above (update for maintenance of endorsement), provide:

- Name of program and sponsor
- Purpose
- Geographic area and number and percentage of accountable entities and patients included
- Level of measurement and setting

1) [Physician Quality Reporting System \(PQRS\)](#)-Sponsored by the Centers for Medicare and Medicaid Services (CMS)
Purpose: PQRS is a national reporting program that uses a combination of incentive payments and payment adjustments to promote reporting of quality information by eligible professionals (EPs). The program provides an incentive payment to practices with EPs (identified on claims by their individual National Provider Identifier [NPI] and Tax Identification Number [TIN]). Eps satisfactorily report data on quality measures for covered Physician Fee Schedule (PFS) services furnished to Medicare Part B Fee-for-Service (FFS) beneficiaries (including Railroad Retirement Board and Medicare Secondary Payer). Beginning in 2015, the program also applies a payment adjustment to EPs who do not satisfactorily report data on quality measures for covered professional services. Source: <http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/index.html> It is our understanding that CMS is also planning to move towards publicly reporting physician data via Physician Compare.

2) [Meaningful Use Stage 2 \(EHR Incentive Program\)](#) – Sponsored by the Centers for Medicare and Medicaid Services (CMS)
The Medicare and Medicaid EHR Incentive Programs provide incentive payments to eligible professionals, eligible hospitals, and critical access hospitals (CAHs) as they adopt, implement, upgrade or demonstrate meaningful use of certified EHR technology.

These professionals are eligible for incentive payments for the “meaningful use” of certified EHR technology, if all program requirements are met, including successful implementation and reporting of program measures, which include this measure, to demonstrate meaningful use of EHR technology.

3) [The IRIS\(TM\) Registry \(Intelligent Research in Sight\)](#) is the nation’s first EHR-based (electronic health record) comprehensive

eye disease and condition registry. It is a centralized data repository and reporting tool that uses observational study methods to collect and perform statistical analysis of patient data to produce easy-to-interpret, national and inter-practice benchmark reports. The reports can validate the quality of care ophthalmologists provide and pinpoint opportunities for improvement. Eligible physicians who sign up and meet the reporting requirements can use the IRIS(TM) Registry to report clinical quality data to the Physician Quality Reporting System (PQRS) and the Medicare Electronic Health Record Incentive Program. The IRIS(TM) Registry will automatically extract and submit data for PQRS measures to the Center for Medicare and Medicaid Services (CMS) on a practice's behalf.

4a1.2. If not currently publicly reported OR used in at least one other accountability application (e.g., payment program, certification, licensing) what are the reasons? (e.g., Do policies or actions of the developer/steward or accountable entities restrict access to performance results or impede implementation?)

not applicable

4a1.3. If not currently publicly reported OR used in at least one other accountability application, provide a credible plan for implementation within the expected timeframes -- any accountability application within 3 years and publicly reported within 6 years of initial endorsement. (Credible plan includes the specific program, purpose, intended audience, and timeline for implementing the measure within the specified timeframes. A plan for accountability applications addresses mechanisms for data aggregation and reporting.)

not applicable

4a2.1.1. Describe how performance results, data, and assistance with interpretation have been provided to those being measured or other users during development or implementation.

How many and which types of measured entities and/or others were included? If only a sample of measured entities were included, describe the full population and how the sample was selected.

4a2.1.2. Describe the process(es) involved, including when/how often results were provided, what data were provided, what educational/explanatory efforts were made, etc.

4a2.2.1. Summarize the feedback on measure performance and implementation from the measured entities and others described in 4d.1.

Describe how feedback was obtained.

4a2.2.2. Summarize the feedback obtained from those being measured.

4a2.2.3. Summarize the feedback obtained from other users

4a2.3. Describe how the feedback described in 4a2.2.1 has been considered when developing or revising the measure specifications or implementation, including whether the measure was modified and why or why not.

Improvement

Progress toward achieving the goal of high-quality, efficient healthcare for individuals or populations is demonstrated. If not in use for performance improvement at the time of initial endorsement, then a credible rationale describes how the performance results could be used to further the goal of high-quality, efficient healthcare for individuals or populations.

4b1. Refer to data provided in 1b but do not repeat here. Discuss any progress on improvement (trends in performance results, number and percentage of people receiving high-quality healthcare; Geographic area and number and percentage of accountable entities and patients included.)

If no improvement was demonstrated, what are the reasons? If not in use for performance improvement at the time of initial

endorsement, provide a credible rationale that describes how the performance results could be used to further the goal of high-quality, efficient healthcare for individuals or populations.

While the PCPI creates measures with an ultimate goal of improving the quality of care, measurement is a mechanism to drive improvement but does not equate with improvement. Measurement can help identify opportunities for improvement with actual improvement requiring making changes to health care processes and structure. In order to promote improvement, quality measurement systems need to provide feedback to front-line clinical staff in as close to real time as possible and at the point of care whenever possible. (1)

1. Conway PH, Mostashari F, Clancy C. The future of quality measurement for improvement and accountability. JAMA. 2013 Jun 5;309(21):2215-6.

4b2. Unintended Consequences

The benefits of the performance measure in facilitating progress toward achieving high-quality, efficient healthcare for individuals or populations outweigh evidence of unintended negative consequences to individuals or populations (if such evidence exists).

4b2.1. Please explain any unexpected findings (positive or negative) during implementation of this measure including unintended impacts on patients.

We are not aware of any unintended consequences at this time, but we take unintended consequences very seriously and therefore continuously monitor to identify actions that can be taken to mitigate them.

4b2.2. Please explain any unexpected benefits from implementation of this measure.

5. Comparison to Related or Competing Measures

If a measure meets the above criteria and there are endorsed or new related measures (either the same measure focus or the same target population) or competing measures (both the same measure focus and the same target population), the measures are compared to address harmonization and/or selection of the best measure.

5. Relation to Other NQF-endorsed Measures

Are there related measures (conceptually, either same measure focus or target population) or competing measures (conceptually both the same measure focus and same target population)? If yes, list the NQF # and title of all related and/or competing measures.
Yes

5.1a. List of related or competing measures (selected from NQF-endorsed measures)

5.1b. If related or competing measures are not NQF endorsed please indicate measure title and steward.

This is the eMeasure version of NQF#0088.

5a. Harmonization of Related Measures

The measure specifications are harmonized with related measures;

OR

The differences in specifications are justified

5a.1. If this measure conceptually addresses EITHER the same measure focus OR the same target population as NQF-endorsed measure(s):

Are the measure specifications harmonized to the extent possible?

5a.2. If the measure specifications are not completely harmonized, identify the differences, rationale, and impact on interpretability and data collection burden.

not applicable

5b. Competing Measures

The measure is superior to competing measures (e.g., is a more valid or efficient way to measure);

OR

Multiple measures are justified.

5b.1. If this measure conceptually addresses both the same measure focus and the same target population as NQF-endorsed measure(s):

Describe why this measure is superior to competing measures (e.g., a more valid or efficient way to measure quality); OR provide a rationale for the additive value of endorsing an additional measure. (Provide analyses when possible.)

not applicable

Appendix

A.1 Supplemental materials may be provided in an appendix. All supplemental materials (such as data collection instrument or methodology reports) should be organized in one file with a table of contents or bookmarks. If material pertains to a specific submission form number, that should be indicated. Requested information should be provided in the submission form and required attachments. There is no guarantee that supplemental materials will be reviewed.

No appendix Attachment:

Contact Information

Co.1 Measure Steward (Intellectual Property Owner): American Academy of Ophthalmology (AAO)

Co.2 Point of Contact: Flora, Lum, flum@aao.org, 415-561-8500-

Co.3 Measure Developer if different from Measure Steward: American Academy of Ophthalmology

Co.4 Point of Contact: Flora, Lum, flum@aao.org, 415-561-8500-

Additional Information

Ad.1 Workgroup/Expert Panel involved in measure development

Provide a list of sponsoring organizations and workgroup/panel members' names and organizations. Describe the members' role in measure development.

PCPI measures are developed through cross-specialty, multi-disciplinary work groups. All medical specialties and other health care professional disciplines participating in patient care for the clinical condition or topic under study are invited to participate as equal contributors to the measure development process. In addition, the PCPI strives to include on its work groups individuals representing the perspectives of patients, consumers, private health plans, and employers. This broad-based approach to measure development ensures buy-in on the measures from all stakeholders and minimizes bias toward any individual specialty or stakeholder group. All work groups have at least two co-chairs who have relevant clinical and/or measure development expertise and who are responsible for ensuring that consensus is achieved and that all perspectives are voiced.

Work Group members:

Paul P. Lee, MD, JD (Co-Chair)

Jinnet B. Fowles, PhD (Co-Chair)

Richard L. Abbott, MD Jeffrey S. Karlik, MD

Lloyd P. Aiello, MD PhD Mathew W. MacCumber, MD, PhD

Priscilla P. Arnold, MD Mildred M. G. Olivier, MD

Richard Hellman, MD, FACP, FACE James L. Rosenzweig, MD, FACE

Leon W. Herndon, MD Sam J. W. Romeo, MD, MBA

Kenneth J. Hoffer, MD John T. Thompson, MD

Health Plan Representative- Andrea Gelzer, MD MS FACP

American Academy of Ophthalmology- Flora Lum, MD

Facilitators- Timothy F. Kresowik, MD; Rebecca A. Kresowik

American Medical Association- Karen S. Kmetik, PhD, Heidi Bossley, MSN, MBA, Stephen Havas, MD, MPH, MS

#0088e Diabetic Retinopathy: Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy, Last Updated: Apr 28, 2021

National Committee for Quality Assurance- Donna Pillittere
<p>Measure Developer/Steward Updates and Ongoing Maintenance</p> <p>Ad.2 Year the measure was first released: 2006</p> <p>Ad.3 Month and Year of most recent revision: 07, 2014</p> <p>Ad.4 What is your frequency for review/update of this measure? Supporting Guidelines/Coding/Specifications are reviewed annually and updated as needed.</p> <p>Ad.5 When is the next scheduled review/update for this measure? 12, 2015</p>
<p>Ad.6 Copyright statement: Copyright 2014 American Medical Association. All Rights Reserved.</p> <p>Ad.7 Disclaimers: Physician Performance Measures (Measures) and related data specifications have been developed by the American Medical Association (AMA) - convened Physician Consortium for Performance Improvement® (PCPI®). These Measures are not clinical guidelines and do not establish a standard of medical care, and have not been tested for all potential applications. The Measures, while copyrighted, can be reproduced and distributed, without modification, for noncommercial purposes, eg, use by health care providers in connection with their practices. Commercial use is defined as the sale, license, or distribution of the Measures for commercial gain, or incorporation of the Measures into a product or service that is sold, licensed or distributed for commercial gain. Commercial uses of the Measures require a license agreement between the user and the AMA, (on behalf of the PCPI). Neither the AMA, PCPI nor its members shall be responsible for any use of the Measures.</p> <p>THE MEASURES AND SPECIFICATIONS ARE PROVIDED "AS IS" WITHOUT WARRANTY OF ANY KIND.</p> <p>Limited proprietary coding is contained in the Measure specifications for convenience. Users of the proprietary code sets should obtain all necessary licenses from the owners of these code sets. The AMA, the PCPI and its members disclaim all liability for use or accuracy of any Current Procedural Terminology (CPT®) or other coding contained in the specifications.</p> <p>CPT® contained in the Measure specifications is copyright 2004-2014 American Medical Association. LOINC® copyright 2004-2014 Regenstrief Institute, Inc. This material contains SNOMED Clinical Terms® (SNOMED CT®) copyright 2004-2014 International Health Terminology Standards Development Organisation. ICD-10 copyright 2014 World Health Organization. All Rights Reserved.</p>
Ad.8 Additional Information/Comments: