



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 subcriterion 1b).

Brief Measure Information

NQF #: 0268

Corresponding Measures:

De.2. Measure Title: Perioperative Care: Selection of Prophylactic Antibiotic: First OR Second Generation Cephalosporin

Co.1.1. Measure Steward: American Society of Plastic Surgeons

De.3. Brief Description of Measure: Percentage of surgical patients aged 18 years and older undergoing procedures with the indications for a first OR second generation cephalosporin prophylactic antibiotic who had an order for first OR second generation cephalosporin for antimicrobial prophylaxis

1b.1. Developer Rationale: Presence of antibiotics in the blood and tissue during and after surgery can prevent infection. Cephalosporins are currently the drug of choice for antimicrobial prophylaxis due to their broad-spectrum effect and low occurrence of adverse reactions.

S.4. Numerator Statement: Surgical patients who had an order for first OR second generation cephalosporin for antimicrobial prophylaxis

S.7. Denominator Statement: All surgical patients aged 18 years and older undergoing procedures with the indications for a first OR second generation cephalosporin prophylactic antibiotic

S.10. Denominator Exclusions: Denominator Exceptions:

Documentation of medical reason(s) for not ordering a first OR second generation cephalosporin for antimicrobial prophylaxis (eg, patients enrolled in clinical trials, patients with documented infection prior to surgical procedure of interest, patients who were receiving antibiotics more than 24 hours prior to surgery [except colon surgery patients taking oral prophylactic antibiotics], patients who were receiving antibiotics within 24 hours prior to arrival [except colon surgery patients taking oral prophylactic antibiotics], other medical reason(s))

De.1. Measure Type: Process

S.23. Data Source: Claims

S.26. Level of Analysis: Clinician : Group/Practice, Clinician : Individual

IF Endorsement Maintenance – Original Endorsement Date: Jul 31, 2008 **Most Recent Endorsement Date:** Jul 17, 2015

IF this measure is included in a composite, NQF Composite#/title:

IF this measure is paired/grouped, NQF#/title:

De.4. IF PAIRED/GROUPED, what is the reason this measure must be reported with other measures to appropriately interpret results? Not applicable.

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 subcriteria to pass this criterion and be evaluated against the remaining criteria.**

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

[0268_Evidence_Attachment.pdf](#)

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., the benefits or improvements in quality envisioned by use of this measure)
Presence of antibiotics in the blood and tissue during and after surgery can prevent infection. Cephalosporins are currently the drug of choice for antimicrobial prophylaxis due to their broad-spectrum effect and low occurrence of adverse reactions.

1b.2. Provide performance scores on the measure as specified (current and over time) at the specified level of analysis. (This is required for endorsement maintenance. 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 included). This information also will be used to address the subcriterion on improvement (4b.1) under Usability and Use.
[Confidential CMS PQRI 2010 Performance Information by Measure. Jan-Sept TAP file.](#)

CMS Physician Quality Reporting Initiative:

Data Source: This measure was used in the 2010 CMS Physician Quality Reporting Initiative/System. There is a gap in care as shown by this data; 96.40% is the aggregate performance rate in the total patient population and 93.53% is the mean performance rate of TIN/NPI's. A total of 69,130 NPI's submitted PQRS information for this measure.

10th percentile: 85.29%
25th percentile: 100%
50th percentile: 100%
75th percentile: 100%
90th percentile: 100%

Exception Rate: 4.96%
Maximum Performance Score: 100%
Interquartile Range: 0%

[2Confidential CMS PQRI 2008 Performance Information by Measure. Jan-Sept TAP file.](#)

CMS Physician Quality Reporting Initiative:

Data Source: This measure was used in the 2008 CMS Physician Quality Reporting Initiative/System. There is a gap in care as shown by this data; 62.66% is the aggregate performance rate in the total patient population. A total of 90,563 NPI's submitted PQRS information for this measure. 2

10th percentile: 9.09%
25th percentile: 33.33%
50th percentile: 68.69%
75th percentile: 91.67%
90th percentile: 100%

Exception Rate: 3.16%
Maximum Performance Score: 100%
Interquartile Range: 58.34%

It is important to note that PQRS is currently a voluntary reporting program, with about 29% of eligible professionals participating

using any reporting option in 2011, and performance rates may not be nationally representative. For all measures groups in the PQRS program, including the perioperative care measure group, eligible professionals are able to select which cases are submitted. This has the potential to inflate performance scores.

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.

In a 2013 article, Goede et al analyzed facility-level data from the Surgical Care Improvement Project (SCIP). In this study they found that 75% of cases were non-compliant with at least one aspect of antibiotic prophylaxis and nearly 11% of cases were noncompliant with antibiotic selection protocols.

Goede WJ, Lovely JK, Thompson RL, Cima RR. Assessment of prophylactic antibiotic use in patients with surgical site infections. *Hosp Pharm.* 2013;48(7):560-567.

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 endorsement maintenance. 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 subcriterion on improvement (4b.1) 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 1b4, then provide a summary of data from the literature that addresses disparities in care on the specific focus of measurement. Include citations.

We are not aware of any studies that address disparities in selection of a first or second generation cephalosporin as antimicrobial prophylaxis for surgical patients.

1c. High Priority (previously referred to as High Impact)

The measure addresses:

- a specific national health goal/priority identified by DHHS or the National Priorities Partnership convened by NQF; OR
- a demonstrated high-priority (high-impact) aspect of healthcare (e.g., affects large numbers of patients and/or has a substantial impact for a smaller population; leading cause of morbidity/mortality; high resource use (current and/or future); severity of illness; and severity of patient/societal consequences of poor quality).

1c.1. Demonstrated high priority aspect of healthcare

Affects large numbers, Frequently performed procedure, Patient/societal consequences of poor quality

1c.2. If Other:

1c.3. Provide epidemiologic or resource use data that demonstrates the measure addresses a high priority aspect of healthcare.

List citations in 1c.4.

A 2013 meta-analysis by Zimlichman et al found that surgical site infections (SSIs) are the most frequent healthcare-associated infections (HAIs) and account for more than a third of costs associated with HAIs. SSIs caused by methicillin-resistant staphylococcus aureus (MRSA) are associated with highest attributable excess length of stay (LOS) at 23 days. An estimated 158,639 SSIs occur annually, which account for 36% of HAIs. Incidence rate of SSIs is nearly 2 per 100 patient procedures. SSIs were responsible for an estimated \$3.3 billion in costs in 2009 for inpatients at acute care hospitals.

1c.4. Citations for data demonstrating high priority provided in 1a.3

Zimlichman E, Henderson D, Tamir O, et al. Health care-associated infections: a meta-analysis of costs and financial impact on the US health care system. *JAMA Intern Med.* 2013;173(22):2039-2046

1c.5. If a PRO-PM (e.g. HRQoL/functional status, symptom/burden, experience with care, health-related behaviors), provide evidence that the target population values the measured PRO and finds it meaningful. (Describe how and from whom their input was obtained.)

Not applicable. Not a PRO-PM.

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 subcriteria 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):
Infectious Diseases (ID), Surgery, Surgery : Perioperative and Anesthesia

De.6. Non-Condition Specific (check all the areas that apply):
Safety, Safety : Healthcare Associated Infections, Safety : Medication

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.)
The specifications for this measure are attached with this form. Additional measure information can be found at <http://www.ama-assn.org/apps/listserv/x-check/qmeasure.cgi?submit=PCPI>.

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 not an eMeasure Attachment:

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: 0268_CPT_Procedure_Codes_Mar2014-635306625656505387.xls

S.3. For endorsement maintenance, please briefly describe any changes to the measure specifications since last endorsement date and explain the reasons.
Measure numerator language was broadened to include all first and second generation cephalosporins instead of being restricted to cefazolin or cefuroxime.
The denominator exceptions list was broadened to better harmonize with an existing facility-level measure.
The list of Current Procedural Terminology® (CPT) procedure codes included in this measure has undergone thorough review by surgical specialty societies to determine appropriate procedures in their respective fields where evidence supports the use of a first or second generation cephalosporin for the prevention of surgical site infections. Additionally, the CPT code book undergoes annual review for additions and deletions of coding, which impacts the codes included in the denominator coding for this measure.

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)
IF an OUTCOME MEASURE, state the outcome being measured. Calculation of the risk-adjusted outcome should be described in the calculation algorithm.
Surgical patients who had an order for first OR second generation cephalosporin for antimicrobial prophylaxis

S.5. Time Period for Data (What is the time period in which data will be aggregated for the measure, e.g., 12 mo, 3 years, look back to August for flu vaccination? Note if there are different time periods for the numerator and denominator.)
Once for each surgical procedure performed during the measurement period.

S.6. 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, 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.

Numerator Instructions: There must be documentation of an order (written order, verbal order, or standing order/protocol) for a first OR second generation cephalosporin for antimicrobial prophylaxis OR documentation that a first OR second generation cephalosporin was given. In the event surgery is delayed, as long as the patient is redosed (if clinically appropriate) the numerator coding should be applied.

For Claims: Currently, G-Code G9197 is used for prospective claims reporting. However, a new CPT Category II code is under development to reflect the updated numerator language for this measure.

(CPT Category II code under development): Documentation of medical reason(s) for not ordering a first OR second generation cephalosporin for antimicrobial prophylaxis

Note: This code is provided for antibiotic ordered or antibiotic given. Report if a first or second generation cephalosporin was given for antimicrobial prophylaxis.

S.7. Denominator Statement *(Brief, narrative description of the target population being measured)*

All surgical patients aged 18 years and older undergoing procedures with the indications for a first OR second generation cephalosporin prophylactic antibiotic

S.8. Target Population Category *(Check all the populations for which the measure is specified and tested if any):*

S.9. Denominator Details *(All information required to identify and calculate the target population/denominator such as definitions, 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)*

For Claims:

Patients aged ≥ 18 years

AND

CPT procedure code: See attachment for applicable CPT codes (including procedures in the following families: abdomen, peritoneum, and omentum; bariatric; biliary tract; breast; cardiothoracic surgery; colon; endocrine; esophagus; foot and ankle; general surgery; general thoracic surgery; gynecologic surgery; hip reconstruction; integumentary – repair; knee reconstruction; laryngectomy; liver; Meckel's diverticulum and appendix; mediastinum and diaphragm; neurological surgery; pancreas; rectum; renal transplantation; small intestine; spine; spleen and lymphatic; stomach (other than bariatric); trauma (fractures)/hip fracture surgery; vascular)

S.10. Denominator Exclusions *(Brief narrative description of exclusions from the target population)*

Denominator Exceptions:

Documentation of medical reason(s) for not ordering a first OR second generation cephalosporin for antimicrobial prophylaxis (eg, patients enrolled in clinical trials, patients with documented infection prior to surgical procedure of interest, patients who were receiving antibiotics more than 24 hours prior to surgery [except colon surgery patients taking oral prophylactic antibiotics], patients who were receiving antibiotics within 24 hours prior to arrival [except colon surgery patients taking oral prophylactic antibiotics], other medical reason(s))

S.11. Denominator Exclusion Details *(All information required to identify and calculate exclusions from the denominator such as definitions, 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)*

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. Examples are provided in the measure exception language of instances that may constitute an exception and are intended to serve as a guide to clinicians. For measure 0268: Perioperative Care: Selection of Prophylactic Antibiotic: First OR Second Generation Cephalosporin, exceptions may include medical reason(s) (eg, contraindication) for not ordering a first or second generation cephalosporin. 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. Additional details by data source are as follows:

Currently, G-Code G9196 is used for prospective claims reporting. However, a new CPT Category II code is under development to reflect the updated numerator language for this measure.

(CPT Category II code under development): Documentation of medical reason(s) for not ordering a first OR second generation cephalosporin for antimicrobial prophylaxis

S.12. Stratification Details/Variables *(All information required to stratify the measure results including the stratification variables, definitions, 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 with at S.2b)*

We encourage the results of this measure to be stratified by race, ethnicity, primary language, and administrative sex.

S.13. Risk Adjustment Type (Select type. Provide specifications for risk stratification in S.12 and for statistical model in S.14-15)

No risk adjustment or risk stratification

If other:

S.14. Identify the statistical risk model method and variables *(Name the statistical method - e.g., logistic regression and list all the risk factor variables. Note - risk model development and testing should be addressed with measure testing under Scientific Acceptability)*

Not applicable. No risk adjustment or risk stratification.

S.15. Detailed risk model specifications *(must be in attached data dictionary/code list Excel or csv file. Also indicate if available at measure-specific URL identified in S.1.)*

Note: Risk model details (including coefficients, equations, codes with descriptors, definitions), should be provided on a separate worksheet in the suggested format in the Excel or csv file with data dictionary/code lists at S.2b.

S.15a. Detailed risk model specifications *(if not provided in excel or csv file at S.2b)*

S.16. Type of score:

Rate/proportion

If other:

S.17. 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.18. Calculation Algorithm/Measure Logic *(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; aggregating data; risk adjustment; etc.)*

To calculate performance rates:

- 1) Find the patients who meet the initial patient population (ie, the general group of patients that a set of performance measures is designed to address).
- 2) From the patients within the initial patient 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 patient population and denominator are identical.
- 3) From the patients within the denominator, find the patients who qualify for the Numerator (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 physician has documented that the patient

meets any criteria for exception when exceptions have been specified [for this measure: medical reason(s) (eg, contraindication)]. 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.19. Calculation Algorithm/Measure Logic Diagram URL or Attachment (You also may provide a diagram of the Calculation Algorithm/Measure Logic described above at measure-specific Web page URL identified in S.1 OR in attached appendix at A.1)
No diagram provided

S.20. Sampling (If measure is based on a sample, provide instructions for obtaining the sample and guidance on minimum sample size.)

IF a PRO-PM, identify whether (and how) proxy responses are allowed.

Not applicable. The measure is not based on a sample.

S.21. Survey/Patient-reported data (If measure is based on a survey, provide instructions for conducting the survey and guidance on minimum response rate.)

IF a PRO-PM, specify calculation of response rates to be reported with performance measure results.

Not applicable. The measure is not based on a survey.

S.22. Missing data (specify how missing data are handled, e.g., imputation, delete case.)

Required for Composites and PRO-PMs.

If data required to determine if an individual patient should be included in a specific performance measure based on defined criteria is missing, those cases would be ineligible for inclusion in the denominator and therefore the case would be deleted.

If data required to determine if a denominator eligible patient qualifies for the numerator (or has a valid exclusion/exception) is missing, this case would represent a quality failure.

S.23. Data Source (Check ONLY the sources for which the measure is SPECIFIED AND TESTED).

If other, please describe in S.24.

Claims

S.24. Data Source or Collection Instrument (Identify the specific data source/data collection instrument e.g. name of database, clinical registry, collection instrument, etc.)

IF a PRO-PM, identify the specific PROM(s); and standard methods, modes, and languages of administration.

Not applicable.

S.25. 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.26. Level of Analysis (Check ONLY the levels of analysis for which the measure is SPECIFIED AND TESTED)

Clinician : Group/Practice, Clinician : Individual

S.27. Care Setting (Check ONLY the settings for which the measure is SPECIFIED AND TESTED)

Inpatient/Hospital, Outpatient Services

If other:

S.28. 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. Not a composite measure.

2a. Reliability – See attached Measure Testing Submission Form

2b. Validity – See attached Measure Testing Submission Form
[0268_Testing_Attachment-635306610021067931.pdf](#)

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*)

[ALL data elements are in defined fields in electronic claims](#)

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.

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.

[No feasibility assessment](#) Attachment:

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. Describe what you have learned/modified 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 a PRO-PM, consider implications for both individuals providing PROM 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*).

[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, NCQA, 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.](#)

[CPT® contained in the Measures specifications is copyright 2014 American Medical Association](#)

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.

Planned	Current Use (for current use provide URL)
Public Reporting	<p>Payment Program CMS: Physician Quality Reporting System http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/pqrs/index.html</p> <p>Quality Improvement (Internal to the specific organization) ACS: Surgeon Specific Registry http://www.facs.org/members/pbls.html</p>

4a.1. For each CURRENT use, checked above, provide:

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

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.

- CMS 2010 Physician Quality Reporting Initiative:

Eligible Professionals: 69,130 eligible professionals
Professionals Reporting: >=1 valid QDC: 6175 professionals
% Professionals Reporting who reported >=1 valid QDC: 8.9%
Professionals Satisfactorily Reporting: 3415
% Professionals Satisfactorily Reporting: 55.3%

CMS 2008 Physician Quality Reporting Initiative:

170,155 patients were reported on for the 2008 program.
Eligible Professionals: 73,193
Professionals Reporting >=1 Valid QDC: 5929
% Professionals Reporting >=1 Valid QDC: 8.10%
Professionals Satisfactorily Reporting: 2955
% Professionals Satisfactorily Reporting: 49.84%

Surgeon Specific Registry (SSR)-Sponsored by the American College of Surgeons (ACS)

-Purpose: The SSR has been refined to better address many of the regulatory requirements for individual surgeons, including the CMS Physician Quality Reporting System, Maintenance of Certification by some of the boards of surgery, and other regulatory measures. The ACS Surgeon Specific Registry (case log system) allows surgeons to track their cases and outcomes in a convenient, easy-to-use manner. This system allows surgeons to compare their outcomes to others in a confidential manner. The system supports Part IV of Maintenance of Certification (MOC) and provides for electronic transmittal of cases to the American Board of Surgery for recertification. Participation in the SSR is open to all ACS surgeons.

4a.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

4a.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

4b. 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.

4b.1. Progress on Improvement. (Not required for initial endorsement unless available.)

Performance results on this measure (current and over time) should be provided in 1b.2 and 1b.4. Discuss:

- Progress (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

Confidential CMS PQRI 2010 Performance Information by Measure. Jan-Sept TAP file.

CMS Physician Quality Reporting Initiative:

Data Source: This measure was used in the 2010 CMS Physician Quality Reporting Initiative/System. There is a gap in care as shown by this data; 94.60% is the aggregate performance rate in the total patient population and 93.53% is the mean performance rate of TIN/NPI's. A total of 69,130 NPI's submitted PQRS information for this measure.

10th percentile: 85.29%

25th percentile: 100%

50th percentile: 100%

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Exception Rate: 4.96%

Maximum Performance Score: 100%

Interquartile Range: 0%

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Data Source: This measure was used in the 2008 CMS Physician Quality Reporting Initiative/System. There is a gap in care as shown by this data; 62.66% is the aggregate performance rate in the total patient population. A total of 90,563 NPI's submitted PQRS information for this measure. 2

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25th percentile: 33.33%
50th percentile: 68.69%
75th percentile: 91.67%
90th percentile: 100%

Exception Rate: 3.16%

Maximum Performance Score: 100%
Interquartile Range: 58.34%

It is important to note that PQRS is currently a voluntary reporting program, with about 29% of eligible professionals participating using any reporting option in 2011, and performance rates may not be nationally representative.

4b.2. 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.

4c. 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).

4c.1. Were any unintended negative consequences to individuals or populations identified during testing; OR has evidence of unintended negative consequences to individuals or populations been reported since implementation? If so, identify the negative unintended consequences and describe how benefits outweigh them or actions taken to mitigate them.

We are not aware of any unintended consequences at this time, but we take unintended consequences very seriously and, therefore, continuously monitor for them

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)

0126 : Selection of Antibiotic Prophylaxis for Cardiac Surgery Patients
0528 : Prophylactic Antibiotic Selection for Surgical Patients

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

Not applicable

5a. Harmonization

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 completely harmonized?

No

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

Measure 0528 is a facility-level measure that focuses on a selected range of procedures, our measure is an individual-physician level measure that focuses on use of cephalosporins for a broader range of codes. The measures have been harmonized to the extent possible. Measure 0126 focuses on cardiac procedures, while our measure includes a broad range of procedures.

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.)

While the general focus of the measures is similar, the scope and target populations of the measures are different. Our measure is specified at the clinician level, but measure results can be aggregated at a higher level of measurement.

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.

Attachment Attachment: [Measure_0268_Appendix_A1_Antibiotic_Selection_Guideline_Table.pdf](#)

Contact Information

Co.1 Measure Steward (Intellectual Property Owner): American Society of Plastic Surgeons

Co.2 Point of Contact: Carol, Sieck, quality@plasticsurgery.org

Co.3 Measure Developer if different from Measure Steward: American Medical Association - Physician Consortium for Performance Improvement

Co.4 Point of Contact: Toni, Kaye, toni.kaye@ama-assn.org, 312-464-4901-

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.

Perioperative Care Work Group

Ronald A. Gabel, MD (Co-Chair)

American Society of Anesthesiologists

Frank G. Opelka, MD, FACS (Co-Chair)

American College of Surgeons

Priscilla Arnold, MD: American Society of Cataract and Refractive Surgery
Raj Behal, MD, MPH: Internal Medicine
Dale W. Bratzler, DO, MPH: Oklahoma Foundation for Medical Quality
Quentin Clemens, MD: American Urological Association
Charles Drueck, MD FACC: American Society of General Surgeons
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Tom Read, MD: American Society of Colon and Rectal Surgeons
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William Wooden, MD: American Society of Plastic Surgeons

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.

Measure Developer/Steward Updates and Ongoing Maintenance

Ad.2 Year the measure was first released: 2006

Ad.3 Month and Year of most recent revision: 10, 2012

Ad.4 What is your frequency for review/update of this measure? Coding/specifications updates occur annually. For more information, see Ad.8.

Ad.5 When is the next scheduled review/update for this measure? 12, 2014

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