

NATIONAL QUALITY FORUM

Measure Evaluation 4.1 December 2009

This form contains the measure information submitted by stewards. Blank fields indicate no information was provided. Attachments also may have been submitted and are provided to reviewers. The subcriteria and most of the footnotes from the [evaluation criteria](#) are provided in Word comments within the form and will appear if your cursor is over the highlighted area. Hyperlinks to the evaluation criteria and ratings are provided in each section.

TAP/Workgroup (if utilized): Complete all **yellow highlighted** areas of the form. Evaluate the extent to which each subcriterion is met. Based on your evaluation, summarize the strengths and weaknesses in each section.

Note: If there is no TAP or workgroup, the SC also evaluates the subcriteria (**yellow highlighted areas**).

Steering Committee: Complete all **pink** highlighted areas of the form. Review the workgroup/TAP assessment of the subcriteria, noting any areas of disagreement; then evaluate the extent to which each major criterion is met; and finally, indicate your recommendation for the endorsement. Provide the rationale for your ratings.

Evaluation ratings of the extent to which the criteria are met

C = Completely (unquestionably demonstrated to meet the criterion)

P = Partially (demonstrated to partially meet the criterion)

M = Minimally (addressed BUT demonstrated to only minimally meet the criterion)

N = Not at all (NOT addressed; OR incorrectly addressed; OR demonstrated to NOT meet the criterion)

NA = Not applicable (only an option for a few subcriteria as indicated)

(for NQF staff use) NQF Review #: 0364	NQF Project: Surgery Endorsement Maintenance 2010
MEASURE DESCRIPTIVE INFORMATION	
De.1 Measure Title: Incidental Appendectomy in the Elderly Rate (IQI 24)	
De.2 Brief description of measure: Percent of elderly cases with intra-abdominal procedure with an incidental appendectomy. Number of incidental appendectomies per 100 abdominal surgeries.	
1.1-2 Type of Measure: Process	
De.3 If included in a composite or paired with another measure, please identify composite or paired measure Not applicable	
De.4 National Priority Partners Priority Area: Population health, Safety, Overuse	
De.5 IOM Quality Domain: Effectiveness, Efficiency, Safety	
De.6 Consumer Care Need: Getting better	

CONDITIONS FOR CONSIDERATION BY NQF	
Four conditions must be met before proposed measures may be considered and evaluated for suitability as voluntary consensus standards:	NQF Staff
<p>A. The measure is in the public domain or an intellectual property (measure steward agreement) is signed. <i>Public domain only applies to governmental organizations. All non-government organizations must sign a measure steward agreement even if measures are made publicly and freely available.</i></p> <p>A.1 Do you attest that the measure steward holds intellectual property rights to the measure and the right to use aspects of the measure owned by another entity (e.g., risk model, code set)? Yes</p> <p>A.2 Indicate if Proprietary Measure (as defined in measure steward agreement):</p> <p>A.3 Measure Steward Agreement: Government entity and in the public domain - no agreement necessary</p> <p>A.4 Measure Steward Agreement attached:</p>	<p>A Y <input checked="" type="radio"/> NO <input checked="" type="radio"/></p>
B. The measure owner/steward verifies there is an identified responsible entity and process to maintain and	B

update the measure on a schedule that is commensurate with the rate of clinical innovation, but at least every 3 years. Yes, information provided in contact section	Y NO
C. The intended use of the measure includes both public reporting and quality improvement. ► Actual/Planned Use: Public Reporting, Quality Improvement (external benchmarking to organizations), Quality Improvement (Internal to the specific organization)	C Y NO
D. The requested measure submission information is complete. Generally, measures should be fully developed and tested so that all the evaluation criteria have been addressed and information needed to evaluate the measure is provided. Measures that have not been tested are only potentially eligible for a time-limited endorsement and in that case, measure owners must verify that testing will be completed within 12 months of endorsement. D.1 Testing: Yes, fully developed and tested D.2 Have NQF-endorsed measures been reviewed to identify if there are similar or related measures? Yes	D Y NO
(for NQF staff use) Have all conditions for consideration been met? Staff Notes to Steward (if submission returned):	Met Y NO
Staff Notes to Reviewers (issues or questions regarding any criteria):	
Staff Reviewer Name(s):	

Comment [KP]: 1a. The measure focus addresses:

- a specific national health goal/priority identified by NQF's National Priorities Partners; OR
- healthcare (e.g., affects large numbers, leading cause of morbidity/mortality, high resource use (current and/or future), severity of illness, and patient/societal consequences of poor quality).

TAP/Workgroup Reviewer Name:	
Steering Committee Reviewer Name:	
1. IMPORTANCE TO MEASURE AND REPORT	
Extent to which the specific measure focus is important to making significant gains in health care quality (safety, timeliness, effectiveness, efficiency, equity, patient-centeredness) and improving health outcomes for a specific high impact aspect of healthcare where there is variation in or overall poor performance. Measures must be judged to be important to measure and report in order to be evaluated against the remaining criteria. (evaluation criteria) (1a. High Impact)	Eval Rating
(for NQF staff use) Specific NPP goal:	
1a.1 Demonstrated High Impact Aspect of Healthcare: Patient/societal consequences of poor quality 1a.2 1a.3 Summary of Evidence of High Impact: Andrew and Roty showed that incidental appendectomy was associated with a higher risk of wound infection (5.9% versus 0.9%) among cholecystectomy patients who were at least 50 years of age, but not among younger patients.189 Based on this finding and the findings of Warren and colleagues, the risk of incidental appendectomy is believed to outweigh the benefits for elderly patients. [1] [2] [3] [4] [5] 1a.4 Citations for Evidence of High Impact: Updated citations will be presented in the May Steering Committee meeting [1] Warren JL, Penberthy LT, Addiss DG, et al. Appendectomy incidental to cholecystectomy among elderly Medicare beneficiaries. Surg Gynecol Obstet 1993;177(3):288-94. [2] Fisher KS, Ross DS. Guidelines for therapeutic decision in incidental appendectomy. Surg Gynecol Obstet 1990;171(1):95-8. [3] Synder TE, Selanders JR. Incidental appendectomy—yes or no? A retrospective case study and review of the literature. Infect Dis Obstet Gynecol 1998;6(1):30-7. [4] Wolff BG. Current status of incidental surgery. Dis Colon Rectum 1995;38(4):435-41. [5] Nockerts SR, Detmer DE, Fryback, DG. Incidental appendectomy in the elderly? No. Surgery	1a C P M NO

1980;88(2):301-6.

1b. Opportunity for Improvement

1b.1 Benefits (improvements in quality) envisioned by use of this measure: Removal of the appendix incidental to other abdominal surgery—such as urological, gynecological, or gastrointestinal surgeries—is intended to eliminate the risk of future appendicitis and to simplify any future differential diagnoses of abdominal pain. Incidental appendectomy among the elderly is contraindicated. As such, lower rates represent better quality.

1b.2 Summary of (data demonstrating performance gap) (variation or overall poor performance) across providers:

Adjusted per 1,000 rates by patient and hospital characteristics, 2007

Mean	Standard error	Location	P-value: Relative to Northeast
14.511	0.512	Northeast	1.000
21.482	0.474	Midwest	0.000
20.145	0.393	South	0.000
21.716	0.534	West	0.000

1b.3 Citations for data on performance gap:

See the following report for a complete treatment of the methodology: “Methods: Applying AHRQ Quality Indicators to Healthcare Cost and Utilization Project (HCUP) Data for the National Healthcare Quality Report” [URL: <http://hcupnet.ahrq.gov/QI%20Methods.pdf?JS=Y>]

1b.4 Summary of Data on disparities by population group:

Adjusted per 1,000 rates by patient/hospital characteristics, 2007

Estimate	Standard error	Age: for conditions affecting elderly
22.788	0.501	65-69
21.897	0.501	70-74
18.630	0.497	75-79
16.791	0.546	80-84
15.218	0.579	85 and over
Estimate	Standard error	Gender
23.991	0.454	Male
17.531	0.270	Female
Estimate	Standard error	Median income of patient's ZIP code
20.383	0.472	First quartile (lowest income)
20.801	0.460	Second quartile
19.020	0.471	Third quartile
18.142	0.468	Fourth quartile (highest income)
Estimate	Standard error	Location of patient residence (NCHS)
18.608	0.457	Large central metropolitan
17.801	0.476	Large fringe metropolitan
18.848	0.525	Medium metropolitan
23.178	0.734	Small metropolitan
20.819	0.678	Micropolitan
23.873	0.840	Not metropolitan or micropolitan
Estimate	Standard error	Expected payment source
20.582	0.721	Private insurance
19.384	0.250	Medicare

1b
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N

Comment [KP]: 1b. Demonstration of quality problems and opportunity for improvement, i.e., data demonstrating considerable variation, or overall poor performance, in the quality of care across providers and/or population groups (disparities in care).

Comment [k]: 1 Examples of data on opportunity for improvement include, but are not limited to: prior studies, epidemiologic data, measure data from pilot testing or implementation. If data are not available, the measure focus is systematically assessed (e.g., expert panel rating) and judged to be a quality problem.

26.535	2.421	Medicaid
21.177	2.811	Other insurance
20.580	3.200	Uninsured / self-pay / no charge
Estimate	Standard error	Hospital Ownership/control
18.867	0.268	Private, not-for-profit
22.948	0.684	Private, for-profit
20.994	0.682	Public
Estimate	Standard error	Teaching status
15.686	0.396	Teaching
21.699	0.290	Nonteaching
Estimate	Standard error	Location of hospital
19.750	0.402	Large central metropolitan
15.924	0.535	Large fringe metropolitan
18.790	0.500	Medium metropolitan
20.089	0.671	Small metropolitan
24.711	0.728	Micropolitan
28.949	1.467	Not metropolitan or micropolitan
Estimate	Standard error	Bed size of hospital
21.239	0.730	Less than 100
20.602	0.373	100 - 299
18.849	0.425	300 - 499
17.902	0.523	500 or more
1b.5 Citations for data on Disparities:		
See the following report for a complete treatment of the methodology: "Methods: Applying AHRQ Quality Indicators to Healthcare Cost and Utilization Project (HCUP) Data for the National Healthcare Quality Report" [URL: http://hcupnet.ahrq.gov/QI%20Methods.pdf?JS=Y]		
1c. Outcome or Evidence to Support Measure Focus		
1c.1 Relationship to Outcomes (For non-outcome measures, briefly describe the relationship to desired outcome. For outcomes, describe why it is relevant to the target population): Andrew and Roty showed that incidental appendectomy was associated with a higher risk of wound infection (5.9% versus 0.9%) among cholecystectomy patients who were at least 50 years of age, but not among younger patients. ¹⁸⁹ Based on this finding and the findings of Warren and colleagues, the risk of incidental appendectomy is believed to outweigh the benefits for elderly patients. [1] [2] [3] [4] [5]		
References: [1] Warren JL, Penberthy LT, Addiss DG, et al. Appendectomy incidental to cholecystectomy among elderly Medicare beneficiaries. Surg Gynecol Obstet 1993;177(3):288-94. [2] Fisher KS, Ross DS. Guidelines for therapeutic decision in incidental appendectomy. Surg Gynecol Obstet 1990;171(1):95-8. [3] Synder TE, Selanders JR. Incidental appendectomy—yes or no? A retrospective case study and review of the literature. Infect Dis Obstet Gynecol 1998;6(1):30-7. [4] Wolff BG. Current status of incidental surgery. Dis Colon Rectum 1995;38(4):435-41. [5] Nockerts SR, Detmer DE, Fryback, DG. Incidental appendectomy in the elderly? No. Surgery 1980;88(2):301-6.		
1c.2-3. Type of Evidence: Expert opinion, Systematic synthesis of research		

Comment [k]: 1c. The measure focus is:

- an outcome (e.g., morbidity, mortality, function, health-related quality of life) that is relevant to, or associated with, a national health goal/priority, the condition, population, and/or care being addressed;

OR

- if an intermediate outcome, process, structure, etc., there is evidence that supports the specific measure focus as follows:
 - Intermediate outcome** - evidence that the measured intermediate outcome (e.g., blood pressure, HbA1c) leads to improved health/avoidance of harm or cost/benefit.
 - Process** - evidence that the measured clinical or administrative process leads to improved health/avoidance of harm and if the measure focus is on one step in a multi-step care process, it measures the step that has the greatest effect on improving the specified desired outcome(s).
 - Structure** - evidence that the measured structure supports the consistent delivery of effective processes or access that lead to improved health/avoidance of harm or cost/benefit.

Comment [k]: 4 Clinical care processes typically include multiple steps: assess → identify problem/potential problem → choose/plan intervention (with patient input) → provide intervention → evaluate impact on health status. If the measure focus is one step in such a multi-step process, the step with the greatest effect on the desired outcome should be selected as the focus of measurement. For example, although assessment of immunization status and recommending immunization are necessary steps, they are not sufficient to achieve the desired impact on health status - patients must be vaccinated to achieve immunity. This does not preclude consideration of measures of preventive screening interventions where there is a strong link with desired outcomes (e.g., mammography) or measures for multiple care processes that affect a single outcome.

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NO

1c.4 Summary of Evidence (as described in the criteria; for outcomes, summarize any evidence that healthcare services/care processes influence the outcome):

Andrew and Roty showed that incidental appendectomy was associated with a higher risk of wound infection (5.9% versus 0.9%) among cholecystectomy patients who were at least 50 years of age, but not among younger patients.¹⁸⁹ Based on this finding and the findings of Warren and colleagues, the risk of incidental appendectomy is believed to outweigh the benefits for elderly patients. [1] [2] [3] [4] [5]

References:

- [1] Warren JL, Penberthy LT, Addiss DG, et al. Appendectomy incidental to cholecystectomy among elderly Medicare beneficiaries. *Surg Gynecol Obstet* 1993;177(3):288-94.
 [2] Fisher KS, Ross DS. Guidelines for therapeutic decision in incidental appendectomy. *Surg Gynecol Obstet* 1990;171(1):95-8.
 [3] Synder TE, Selanders JR. Incidental appendectomy—yes or no? A retrospective case study and review of the literature. *Infect Dis Obstet Gynecol* 1998;6(1):30-7.
 [4] Wolff BG. Current status of incidental surgery. *Dis Colon Rectum* 1995;38(4):435-41.
 [5] Nockerts SR, Detmer DE, Fryback, DG. Incidental appendectomy in the elderly? No. *Surgery* 1980;88(2):301-6.

1c.5 Rating of strength/quality of evidence (also provide narrative description of the rating and by whom):

13 Smoothing recommended Testing, rating, and review were conducted by the project team. A full report on the literature review and empirical evaluation can be found in Refinement of the HCUP Quality Indicators by the UCSF-Stanford EPC. Detailed coding information for each QI is provided in the document Prevention Quality Indicators Technical Specifications. Rating of performance on empirical evaluations, ranged from 0 to 26. The scores were intended as a guide for summarizing the performance of each indicator on four empirical tests of precision (signal variance, area-level share, signal ratio, and R-squared) and five tests of minimum bias (rank correlation, top and bottom decile movement, absolute change, and change over two deciles), as described in the previous section.

1c.6 Method for rating evidence: The project team conducted extensive empirical testing of all potential indicators using the 1995-97 HCUP State Inpatient Databases (SID) and Nationwide Inpatient Sample (NIS) to determine precision, bias, and construct validity. The 1997 SID contains uniform data on inpatient stays in community hospitals for 22 States covering approximately 60% of all U.S. hospital discharges. The NIS is designed to approximate a 20% of U.S. community hospitals and includes all stays in the sampled hospitals. Each year of the NIS contains between 6 million and 7 million records from about 1,000 hospitals. The NIS combines a subset of the SID data, hospital-level variables, and hospital and discharge weights for producing national estimates. The project team conducted tests to examine three things: precision, bias, and construct validity.

Precision. The first step in the analysis involved precision tests to determine the reliability of the indicator for distinguishing real differences in provider performance. For indicators that may be used for quality improvement, it is important to know with what precision, or surety, a measure can be attributed to an actual construct rather than random variation.

For each indicator, the variance can be broken down into three components: variation within a provider (actual differences in performance due to differing patient characteristics), variation among providers (actual differences in performance among providers), and random variation. An ideal indicator would have a substantial amount of the variance explained by between-provider variance, possibly resulting from differences in quality of care, and a minimum amount of random variation. The project team performed four tests of precision to estimate the magnitude of between-provider variance on each indicator:

- Signal standard deviation was used to measure the extent to which performance of the QI varies systematically across hospitals or areas.
- Provider/area variation share was used to calculate the percentage of signal (or true) variance relative to the total variance of the QI.
- Signal-to-noise ratio was used to measure the percentage of the apparent variation in QIs across providers that is truly related to systematic differences across providers and not random variations (noise) from year to year.
- In-sample R-squared was used to identify the incremental benefit of applying multivariate signal extraction methods for identifying additional signal on top of the signal-to-noise ratio.

Comment [k]: 3 The strength of the body of evidence for the specific measure focus should be systematically assessed and rated (e.g., USPSTF grading system <http://www.ahrq.gov/clinic/uspstf07/methods/benefit.htm>). If the USPSTF grading system was not used, the grading system is explained including how it relates to the USPSTF grades or why it does not. However, evidence is not limited to quantitative studies and the best type of evidence depends upon the question being studied (e.g., randomized controlled trials appropriate for studying drug efficacy are not well suited for complex system changes). When qualitative studies are used, appropriate qualitative research criteria are used to judge the strength of the evidence.

In general, random variation is most problematic when there are relatively few observations per provider, when adverse outcome rates are relatively low, and when providers have little control over patient outcomes or variation in important processes of care is minimal. If a large number of patient factors that are difficult to observe influence whether or not a patient has an adverse outcome, it may be difficult to separate the “quality signal” from the surrounding noise. Two signal extraction techniques were applied to improve the precision of an indicator:

- Univariate methods were used to estimate the “true” quality signal of an indicator based on information from the specific indicator and 1 year of data.
 - Multivariate signal extraction (MSX) methods were used to estimate the “true” quality signal based on information from a set of indicators and multiple years of data. In most cases, MSX methods extracted additional signal, which provided much more precise estimates of true hospital or area quality.
- Bias. To determine the sensitivity of potential QIs to bias from differences in patient severity, unadjusted performance measures for specific hospitals were compared with performance measures that had been adjusted for age and gender. All of the PQIs and some of the Inpatient Quality Indicators (IQIs) could only be risk-adjusted for age and sex. The 3M™ APR-DRG System Version 12 with Severity of Illness and Risk of Mortality subclasses was used for risk adjustment of the utilization indicators and the in-hospital mortality indicators, respectively. Five empirical tests were performed to investigate the degree of bias in an indicator:
- Rank correlation coefficient of the area or hospital with (and without) risk adjustment—gives the overall impact of risk adjustment on relative provider or area performance.
 - Average absolute value of change relative to mean—highlights the amount of absolute change in performance, without reference to other providers’ performance.
 - Percentage of highly ranked hospitals that remain in high decile—reports the percentage of hospitals or areas that are in the highest deciles without risk adjustment that remain there after risk adjustment is performed.
 - Percentage of lowly ranked hospitals that remain in low decile—reports the percentage of hospitals or areas that are in the lowest deciles without risk adjustment that remain there after risk adjustment is performed.
 - Percentage that change more than two deciles—identifies the percentage of hospitals whose relative rank changes by a substantial percentage (more than 20%) with and without risk adjustment.
- Construct validity. Construct validity analyses provided information regarding the relatedness or independence of the indicators. If quality indicators do indeed measure quality, then two measures of the same construct would be expected to yield similar results. The team used factor analysis to reveal underlying patterns among large numbers of variables—in this case, to measure the degree of relatedness between indicators. In addition, they analyzed correlation matrices for indicators.

1c.7 Summary of Controversy/Contradictory Evidence: See the following for a complete treatment of the topic:

http://www.qualityindicators.ahrq.gov/downloads/iqi/iqi_guide_v31.pdf

Note: The Literature Review Caveats column summarizes evidence specific to each potential concern on the link between the PQIs and quality of care, as described in step 3 above. A question mark (?) indicates that the concern is theoretical or suggested, but no specific evidence was found in the literature. A check mark indicates that the concern has been demonstrated in the literature.

1c.8 Citations for Evidence (other than guidelines): Updated citations will be presented in the May Steering Committee meeting

http://www.qualityindicators.ahrq.gov/downloads/iqi/iqi_guide_v31.pdf

1c.9 Quote the Specific guideline recommendation (including guideline number and/or page number): Not Applicable.

1c.10 Clinical Practice Guideline Citation: Not Applicable.

1c.11 National Guideline Clearinghouse or other URL: Not Applicable.

1c.12 Rating of strength of recommendation (also provide narrative description of the rating and by whom):

Comment [k]: USPSTF grading system <http://www.ahrq.gov/clinic/uspstf/grade.htm>: **A** - The USPSTF recommends the service. There is high certainty that the net benefit is substantial. **B** - The USPSTF recommends the service. There is high certainty that the net benefit is moderate or there is moderate certainty that the net benefit is moderate to substantial. **C** - The USPSTF recommends against routinely providing the service. There may be considerations that support providing the service in an individual patient. There is at least moderate certainty that the net benefit is small. Offer or provide this service only if other considerations support the offering or providing the service in an individual patient. **D** - The USPSTF recommends against the service. There is moderate or high certainty that the service has no net benefit or that the harms outweigh the benefits. **I** - The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of the service. Evidence is lacking, of poor quality, or conflicting, and the balance of benefits and harms cannot be determined.

Not Applicable.	
1c.13 Method for rating strength of recommendation (If different from USPSTF system , also describe rating and how it relates to USPSTF): Not Applicable.	
1c.14 Rationale for using this guideline over others: Not Applicable.	
TAP/Workgroup: What are the strengths and weaknesses in relation to the subcriteria for <i>Importance to Measure and Report</i> ?	1
Steering Committee: Was the threshold criterion, <i>Importance to Measure and Report</i> , met? Rationale:	1 Y O N
2. SCIENTIFIC ACCEPTABILITY OF MEASURE PROPERTIES	
Extent to which the measure, <u>as specified</u> , produces consistent (reliable) and credible (valid) results about the quality of care when implemented. (evaluation criteria)	Eval Rating
2a. MEASURE SPECIFICATIONS	
S.1 Do you have a web page where current detailed measure specifications can be obtained? S.2 If yes, provide web page URL:	2a- specs C O P M N
2a. Precisely Specified	
2a.1 Numerator Statement (Brief, text description of the numerator - what is being measured about the target population, e.g. target condition, event, or outcome): Number of incidental appendectomy procedures among cases meeting the inclusion and exclusion rules for the denominator.	
2a.2 Numerator Time Window (The time period in which cases are eligible for inclusion in the numerator): Time period is user defined. Users of the measure typically use a 12 month time period.	
2a.3 Numerator Details (All information required to collect/calculate the numerator, including all codes, logic, and definitions): Number of incidental appendectomy procedures among cases meeting the inclusion and exclusion rules for the denominator. ICD-9-CM incidental appendectomy procedure codes: 471 INCIDENTAL APPENDECTOMY OCT96- 4711 LAPAROSCOP INCID APPEND OCT96- 4719 OTH INCID APPEND OCT96-	
2a.4 Denominator Statement (Brief, text description of the denominator - target population being measured): All discharges, age 65 years and older, with ICD-9-CM codes for abdominal and pelvic surgery.	
2a.5 Target population gender: Female, Male 2a.6 Target population age range: 65 and older	
2a.7 Denominator Time Window (The time period in which cases are eligible for inclusion in the denominator): Time period is user defined. Users of the measure typically use a 12 month time period.	

Comment [KP]: 2a. The measure is well defined and precisely specified so that it can be implemented consistently within and across organizations and allow for comparability. The required data elements are of high quality as defined by NQF's Health Information Technology Expert Panel (HITEP).

2a.8 Denominator Details (All information required to collect/calculate the denominator - the target population being measured - including all codes, logic, and definitions):

1711
LAPAROSCOPIC REPAIR OF DIRECT INGUINAL HERNIA WITH GRAFT OR PROSTHESIS OCT08-
1712
LAPAROSCOPIC REPAIR OF INDIRECT INGUINAL HERNIA WITH GRAFT OR PROSTHESIS OCT08-
1713
LAPAROSCOPIC REPAIR OF INGUINAL HERNIA WITH GRAFT OR PROSTHESIS, NOS OCT08-
1721
LAPAROSCOPIC BILATERAL REPAIR OF DIRECT INGUINAL HERNIA WITH GRAFT OR PROSTHESIS OCT08-
1722
LAPAROSCOPIC BILATERAL REPAIR OF INDIRECT INGUINAL HERNIA WITH GRAFT OR PROSTHESIS OCT08-
1723
LAPAROSCOPIC BILATERAL REPAIR OF INGUINAL HERNIA, ONE DIRECT AND ONE INDIRECT, WITH GRAFT OR PROSTHESIS OCT08-
1724
LAPAROSCOPIC BILATERAL REPAIR OF INGUINAL HERNIA WITH GRAFT OR PROSTHESIS, NOS OCT08-
412
SPLENOTOMY
4133
OPEN BIOPSY OF SPLEEN
4141
MARSUPIALIZATION OF SPLENIC CYST
4142
EXCISION OF LESION OR TISSUE OF SPLEEN
4143
PARTIAL SPLENECTOMY
415
TOTAL SPLENECTOMY
4193
EXCISION OF ACCESSORY SPLEEN
4194
TRANSPLANTATION OF SPLEEN
4195
REPAIR AND PLASTIC OPERATIONS ON SPLEEN
4199
OTHER OPERATIONS ON SPLEEN
4240
ESOPHAGECTOMY, NOS
4241
PARTIAL ESOPHAGECTOMY (HAS 1 CASE_
4242
TOTAL ESOPHAGECTOMY (HASE 1 CASE)
4253
INTRATHORACIC ESOPHAGEAL ANASTOMOSIS W/ INTERPOSITION OF SMALL BOWEL
4254
OTHER INTRATHORACIC ESOPHAGOENTEROSTOMY
4255
INTRATHORACIC ESOPHAGEAL ANASTOMOSIS W/ INTERPOSITION OF COLON
4256
OTHER INTRATHORACIC ESOPHAGOCOLOSTOMY
4263
ANTESTERNAL ESOPHAGEAL ANASTOMOSIS W/ INTERPOSITION OF SMALL BOWEL
4264
OTHER ANTESTERNAL ESOPHAGOENTEROSTOMY
4265

ANTESTERNAL ESOPHAGEAL ANASTOMOSIS W/ INTERPOSITION OF COLON
 1711
 LAPAROSCOPIC REPAIR OF DIRECT INGUINAL HERNIA WITH GRAFT OR PROSTHESIS OCT08-
 1712
 LAPAROSCOPIC REPAIR OF INDIRECT INGUINAL HERNIA WITH GRAFT OR PROSTHESIS OCT08-
 1713
 LAPAROSCOPIC REPAIR OF INGUINAL HERNIA WITH GRAFT OR PROSTHESIS, NOS OCT08-
 1721
 LAPAROSCOPIC BILATERAL REPAIR OF DIRECT INGUINAL HERNIA WITH GRAFT OR PROSTHESIS OCT08-
 1722
 LAPAROSCOPIC BILATERAL REPAIR OF INDIRECT INGUINAL HERNIA WITH GRAFT OR PROSTHESIS OCT08-
 1723
 LAPAROSCOPIC BILATERAL REPAIR OF INGUINAL HERNIA, ONE DIRECT AND ONE INDIRECT, WITH GRAFT OR
 PROSTHESIS OCT08-
 1724
 LAPAROSCOPIC BILATERAL REPAIR OF INGUINAL HERNIA WITH GRAFT OR PROSTHESIS, NOS OCT08-
 412
 SPLENOTOMY
 4133
 OPEN BIOPSY OF SPLEEN
 4141
 MARSUPIALIZATION OF SPLENIC CYST
 4142
 EXCISION OF LESION OR TISSUE OF SPLEEN
 4143
 PARTIAL SPLENECTOMY
 415
 TOTAL SPLENECTOMY
 4193
 EXCISION OF ACCESSORY SPLEEN
 4194
 TRANSPLANTATION OF SPLEEN
 4195
 REPAIR AND PLASTIC OPERATIONS ON SPLEEN
 4199
 OTHER OPERATIONS ON SPLEEN
 4240
 ESOPHAGECTOMY, NOS
 4241
 PARTIAL ESOPHAGECTOMY (HAS 1 CASE_
 4242
 TOTAL ESOPHAGECTOMY (HASE 1 CASE)
 4253
 INTRATHORACIC ESOPHAGEAL ANASTOMOSIS W/ INTERPOSITION OF SMALL BOWEL
 4254
 OTHER INTRATHORACIC ESOPHAGOENTEROSTOMY
 4255
 INTRATHORACIC ESOPHAGEAL ANASTOMOSIS W/ INTERPOSITION OF COLON
 4256
 OTHER INTRATHORACIC ESOPHAGOCOLOSTOMY
 4263
 ANTESTERNAL ESOPHAGEAL ANASTOMOSIS W/ INTERPOSITION OF SMALL BOWEL
 4264
 OTHER ANTESTERNAL ESOPHAGOENTEROSTOMY
 4265
 ANTESTERNAL ESOPHAGEAL ANASTOMOSIS W/ INTERPOSITION OF COLON
 4266

OTHER ANTESTERNAL ESOPHAGOCOLOSTOMY
 4291
 LIGATION OF ESOPHAGEAL VARICES
 430
 GASTROTOMY
 433
 PYLOROMYOTOMY
 4342
 LOCAL EXCISION OF OTHER LESION OR TISSUE OF STOMACH (HAS 10 CASES)
 4349
 OTHER DESTRUCTION OF LESION OR TISSUE OF STOMACH (HAS 1 CASE)
 435
 PARTIAL GASTRECTOMY W/ ANASTOMOSIS TO ESOPHAGUS
 436
 PARTIAL GASTRECTOMY W/ ANASTOMOSIS TO DUODENUM
 437
 PARTIAL GASTRECTOMY W/ ANASTOMOSIS TO JEJUNUM
 4381
 PARTIAL GASTRECTOMY W/ JEJUNA TRANSPOSITION
 4389
 OTHER PARTIAL GASTRECTOMY
 4391
 TOTAL GASTRECTOMY W/ INTESTINAL INTERPOSITION
 4399
 OTHER TOTAL GASTRECTOMY
 4400
 VAGOTOMY, NOS
 4401
 TRUNCAL VAGOTOMY (HAS ONE CASE)
 4402
 HIGHLY SELECTIVE VAGOTOMY
 4403
 OTHER SELECTIVE VAGOTOMY
 4411
 TRANSABDOMINAL GASTROSCOPY
 4415
 OPEN BIOPSY OF STOMACH (HAS ONE CASE)
 4421
 DILATION OF PYLORUS BY INCISION
 4429
 OTHER PYLOROPLASTY HAS 6 CASES
 4431
 HIGH GASTRIC BYPASS HAS 1 CASE
 4438
 LAPAROSCOPIC GASTROENTEROSTOMY
 4439
 OTHER GASTROENTEROSTOMY
 4440
 SUTURE OF PEPTIC ULCER, NOS
 4441
 SUTURE OF GASTRIC ULCER SITE
 4442
 SUTURE OF DUODENAL ULCER SITE
 445
 REVISION OF GASTRIC ANASTOMOSIS
 4461
 SUTURE OF LACERATION OF STOMACH

4463
 CLOSURE OF OTHER GASTRIC FISTULA HAS 14 CASES
 4464
 GASTROPEXY
 4465
 ESOPHAGOGASTROPLASTY
 4466
 OTHER PROCEDURES FOR CREATION OF ESOPHAGOGASTRIC SPHINCTERIC COMPETENCE
 4467
 LAPAROSCOPIC PROCEDURES FOR CREATION OF ESOPHAGOGASTRIC SPHINCTERIC COMPETENCE
 4468
 LAPAROSCOPIC GASTROPLASTY
 4469
 OTHER REPAIR OF STOMACH
 4491
 LIGATION OF GASTRIC VARICES
 4492
 INTRAOPERATIVE MANIPULATION OF STOMACH
 4495
 LAPAROSCOPIC GASTRIC RESTRICTIVE PROCEDURE
 4496
 LAPAROSCOPIC REVISION OF GASTRIC RESTRICTIVE PROCEDURE
 4497
 LAPAROSCOPIC REVISION OF GASTRIC RESTRICTIVE DEVICES
 4499
 GASTRIC OPERATION NEC (OCT 04)
 4500
 INCISION OF INTESTINE, NOS
 4501
 INCISION OF DUODENUM
 4502
 OTHER INCISION OF SMALL INTESTINE
 4503
 INCISION OF LARGE INTESTINE
 4511
 TRANSABDOMINAL ENDOSCOPY
 4515
 OPEN BIOPSY OF SMALL INTESTINE
 4521
 TRANSABDOMINAL ENDOSCOPY OF LARGE INTESTINE
 4526
 OPEN BIOPSY OF LARGE INTESTINE
 4531
 OTHER LOCAL EXCISION OF LESION OF DUODENUM
 4532
 OTHER DESTRUCTION OF LESION OF DUODENUM
 4533
 LOCAL EXCISION OF LESION OR TISSUE OF SMALL INTESTINE, EXCEPT DUODENUM
 4534
 OTHER DESTRUCTION OF LESION OF SMALL INTESTINE, EXCEPT DUODENUM
 4541
 EXCISION OF LESION OR TISSUE OF LARGE INTESTINE
 4549
 OTHER DESTRUCTION OF LESION OF LARGE INTESTINE
 4550
 ISOLATION OF INTESTINAL SEGMENT, NOS
 4551

ISOLATION OF SEGMENT OF SMALL INTESTINE
4552
ISOLATION OF SEGMENT OF LARGE INTESTINE
4561
MULTIPLE SEGMENTAL RESECTION OF SMALL INTESTINE
4562
OTHER PARTIAL RESECTION OF SMALL INTESTINE
4563
TOTAL REMOVAL OF SMALL INTESTINE
458
TOTAL INTRA-ABDOMINAL COLECTOMY
4590
INTESTINAL ANASTOMOSIS, NOS
4591
SMALL-TO-SMALL INTESTINAL ANASTOMOSIS
4592
ANASTOMOSIS OF SMALL INTESTINE TO RECTAL STUMP
4593
OTHER SMALL-TO-LARGE INTESTINAL ANASTOMOSIS
4594
LARGE-TO-LARGE INTESTINAL ANASTOMOSIS
4595
ANASTOMOSIS TO ANUS
4601
EXTERIORIZATION OF SMALL INTESTINE
4603
EXTERIORIZATION OF LARGE INTESTINE
4610
COLOSTOMY, NOS
4611
TEMPORARY COLOSTOMY
4613
PERMANENT COLOSTOMY
4614
DELAYED OPENING OF COLOSTOMY
4620
ILEOSTOMY, NOS
4621
TEMPORARY ILESOSTOMY
4622
CONTINENT ILEOSTOMY
4623
OTHER PERMANENT ILEOSTOMY
4640
REVISION OF INTESTINA STOMA, NOS
4641
REVISION OF STOMA OF SMALL INTESTINE
4642
REPAIR OF PERICOLOSTOMY HERNIA
4643
OTHER REVISION OF STOMA OF LARGE INTESTINE
4650
CLOSURE OF INTESTINAL STOMA, NOT OTHERWISE SPECIFIED
4651
CLOSURE OF STOMA OF SMALL INTESTINE
4652
CLOSURE OF STOMA OF LARGE INTESTINE

4660
 FIXATION OF INTESTINE, NOS
 4661
 FIXATION OF SMALL INTESTINE TO ABDOMINAL WALL
 4662
 OTHER FIXATION OF SMALL INTESTINE
 4663
 FIXATION OF LARGE INTESTINE TO ABDOMINAL WALL
 4664
 OTHER FIXATION OF LARGE INTESTINE
 4672
 CLOSURE OF FISTULA OF DUODENUM
 4673
 SUTURE OF LACERATION OF SMALL INTESTINE, EXCEPT DUODENUM
 4674
 CLOSURE OF FISTULA OF SMALL INTESTINE, EXCEPT DUODENUM
 4675
 SUTURE OF LACERATION OF LARGE INTESTINE
 4676
 CLOSURE OF FISTULA OF LARGE INTESTINE
 4679
 OTHER REPAIR OF INTESTINE
 4680
 INTRA-ABDOMINAL MANIPULATION OF INTESTINE, NOS
 4681
 INTRA-ABDOMINAL MANIPULATION OF SMALL INTESTINE
 4682
 INTRA-ABDOMINAL MANIPULATION OF LARGE INTESTINE
 4691
 MYOTOMY OF SIGMOID COLON
 4692
 MYOTOMY OF OTHER PARTS OF COLON
 4693
 REVISION OF ANASTOMOSIS OF SMALL INTESTINE
 4694
 REVISION OF ANASTOMOSIS OF LARGE INTESTINE
 4697
 TRANSPLANT OF INTESTINE
 4699
 OTHER OPERATIONS ON INTESTINES
 4821
 TRANSABDOMINAL PROCTOSIGMOIDOSCOPY
 4825
 OPEN BIOPSY OF RECTUM
 4840
 PULL THROUGH RESECTION OF RECTUM, NOS OCT08-
 4841
 SUBMUCOSAL RESECTION OF RECTUM
 4842
 LAP PULL-THROUGH RESECTION OF RECTUM OCT08-
 4843
 OPEN PULL-THROUGH RESECTION OF RECTUM OCT08-
 4849
 OTHER PULL-THROUGH RESECTION OF RECTUM 485
 ABDOMINOPERINEAL RESECTION OF RECTUM
 4850
 ABDOMINOPERINEAL RESECTION OF RECTUM, NOS OCT08-

4851
 LAPAROSCOPIC ABDOMINOPERINEAL RESECTION OF RECTUM OCT08-
 4852
 OPEN ABDOMINOPERINEAL RESECTION OF RECTUM OCT08-
 4859
 OTHER ABDOMINOPERINEAL RESECTION OF RECTUM OCT08-
 4871
 SUTURE OF LACERATION OF RECTUM
 4874
 RECTORECTOSTOMY
 4875
 ABDOMINAL PROCTOPEXY
 500
 HEPATOTOMY
 5012
 OPEN BIOPSY OF LIVER
 5014
 LAPAROSCOPIC LIVER BIOPSY
 5019
 OTHER DIAGNOSTIC PROCEDURES ON LIVER
 5021
 MARSUPIALIZATION OF LESION OF LIVER
 5022
 PARTIAL HEPATECTOMY HAS 3 CASES
 5023
 OPN ABLTN LIVER LES/ TISS OCT06-
 5025
 LAPAROSCOPIC ABLATION OF LIVER LESION OR TISSUE
 5026
 ABLTN LIVER LES/ TISS NEC OCT06-
 5029
 OTHER DESTRUCTION OF LESION OF LIVER HAS 2 CASES
 503
 LOBECTOMY OF LIVER
 504
 TOTAL HEPATECTOMY
 5051
 AUXILIARY LIVER TRANSPLANT
 5059
 OTHER TRANSPLANT OF LIVER
 5061
 CLOSURE OF LACERATION OF LIVER
 5069
 OTHER REPAIR OF LIVER
 5102
 TROCAR CHOLECYSTOSTOMY
 5103
 OTHER CHOLECYSTOSTOMY
 5104
 OTHER CHOLECYSTOTOMY
 5113
 OPEN BIOPSY OF GALLBLADDER OR BILE DUCTS
 5119
 OTHER DIAGNOSTIC PROCEDURES ON BILIARY TRACT
 5121
 OTHER PARTIAL CHOLECYSTECTOMY
 5122

CHOLECYSTECTOMY
 5123
 LAPAROSCOPIC CHOLECYSTECTOMY SE 5122 WITH 116 CASES, THIS ONE HAS 7 CASES
 5124
 LAPAROSCOPIC PARTIAL CHOLECYSTECTOMY
 5131
 ANASTOMOSIS OF GALLBLADDER TO HEPATIC DUCTS
 5132
 ANASTOMOSIS OF GALLBLADDER TO INTESTINE
 5133
 ANASTOMOSIS OF GALLBLADDER TO PANCREAS
 5134
 ANASTOMOSIS OF GALLBLADDER TO STOMACH
 5135
 OTHER GALLBLADDER ANASTOMOSIS
 5136
 CHOLEDOCHOENTEROSTOMY
 5137
 ANASTOMOSIS OF HEPATIC DUCT TO GASTROINTESTINAL TRACT
 5139
 OTHER BILE DUCT ANASTOMOSIS
 5141
 COMMON DUCT EXPLORATION FOR REMOVAL OF CALCULUS
 5142
 COMMON DUCT EXPLORATION FOR RELIEF OF OTHER OBSTRUCTION
 5143
 INSERTION OF CHOLEDOCHOHEPATIC TUBE FOR DECOMPRESSION
 5149
 INCISION OF OTHER BILE DUCTS FOR RELIEF OF OBSTRUCTION
 5151
 EXPLORATION OF COMMON DUCT
 5159
 INCISION OF OTHER BILE DUCT
 5161
 EXCISION OF CYSTIC DUCT REMNANT
 5162
 EXCISION OF AMPULLA OF VATER (WITH REIMPLANTATION OF COMMON DUCT)
 5163
 OTHER EXCISION OF COMMON DUCT
 5169
 EXCISION OF OTHER BILE DUCT
 5171
 SIMPLE SUTURE OF COMMON BILE DUCT
 5172
 CHOLEDOCHOPLASTY
 5179
 REPAIR OF OTHER BILE DUCTS
 5181
 DILATION OF SPHINCTER OF ODDI
 5182
 PANCREATIC SPHINCTEROTOMY
 5183
 PANCREATIC SPHINCTEROPLASTY
 5189
 OTHER OPERATIONS ON SPHINCTER OF ODDI
 5191
 REPAIR OF LACERATION OF GALLBLADDER

5192
 CLOSURE OF CHOLECYSTOSTOMY
 5193
 CLOSURE OF OTHER BILIARY FISTULA
 5194
 REVISION OF ANASTOMOSIS OF BILIARY TRACT
 5195
 REMOVAL OF PROSTHETIC DEVICE FROM BILE DUCT
 5199
 OTHER OPERATIONS ON BILIARY TRACT
 5201
 DRAINAGE OF PANCREATIC CYST BY CATHETER
 5209
 OTHER PANCREATOTOMY
 5212
 OPEN BIOPSY OF PANCREAS
 5219
 OTHER DIAGNOSTIC PROCEDURES ON PANCREAS
 5222
 OTHER EXCISION OR DESTRUCT OF LESION OR TISSUE OF PANCREAS OR PANC DUCT
 523
 MARSUPIALIZATION OF PANCREATIC CYST
 524
 INTERNAL DRAINAGE OF PANCREATIC CYST
 5251
 PROXIMAL PANCREATECTOMY
 5252
 DISTAL PANCREATECTOMY
 5253
 RADICAL SUBTOTAL PANCREATECTOMY
 5259
 OTHER PARTIAL PANCREATECTOMY (HAS 1 CASE)
 526
 TOTAL PANCREATECTOMY
 527
 RADICAL PANCREATODUODENECTOMY
 5280
 PANCREATIC TRANSPLANT, NOS
 5281
 REIMPLANTATION
 5282
 HOMOTRANSPLANT OF PANCREAS
 5283
 HETEROTRANSPLANT OF PANCREAS
 5292
 CANNULATION OF PANCREATIC DUCT
 5295
 OTHER REPAIR OF PANCREAS
 5296
 ANASTOMOSIS OF PANCREAS (HAS 1 CASE)
 5299
 OTHER OPERATIONS ON PANCREAS
 5300
 UNILATERAL REPAIR OF INGUINAL HERNIA, NOS
 5301
 REPAIR OF DIRECT INGUINAL HERNIA HAS 2 CASES
 5302

REPAIR OF INDIRECT INGUINAL HERNIA HAS 2 CASES
 5303
 REPAIR OF DIRECT INGUINAL HERNIA W/ GRAFT OR PROSTHESIS HAS 1 CASE
 5304
 REPAIR OF INDIRECT INGUINAL HERNIA W/ GRAFT OR PROSTHESIS
 5305
 REPAIR OF INGUINAL HERNIA W/ GRAFT OR PROSTHESIS, NOS
 5310
 BILATERAL REPAIR OF INGUINAL HERNIA, NOS
 5311
 BILATERAL REPAIR OF DIRECT INGUINAL HERNIA HAS 1 CASE
 5312
 BILATERAL REPAIR OF INDIRECT INGUINAL HERNIA
 5313
 BILATERAL REPAIR OF INGUINAL HERNIA, ONE DIRECT AND ONE INDIRECT
 5314
 BILATERAL REPAIR OF DIRECT INGUINAL HERNIA W/ GRAFT OR PROSTHESIS
 5315
 BILATERAL REPAIR OF INDIRECT INGUINAL HERNIA W/ GRAFT OR PROSTHESIS
 5316
 BILATERAL REPAIR OF INGUIN HERNIA, 1 DIRECT 1 INDIRECT, W/ GRAFT OR PROS
 5317
 BILATERAL INGUINAL HERNIA REPAIR W/ GRAFT OR PROSTHESIS, NOS
 5321
 UNILATERAL REPAIR OF FEMORAL HERNIA
 5329
 OTHER UNILATERAL FEMORAL HERNIORRHAPHY HAS 1 CASE
 5331
 BILATERAL REPAIR OF FEMORAL HERNIA W/ GRAFT OR PROSTHESIS
 5339
 OTHER BILATERAL FEMORAL HERNIORRHAPHY
 5341
 REPAIR OF UMBILICAL HERNIA W/ PROSTHESIS
 5342
 LAPAROSCOPIC REPAIR OF UMBILICAL HERNIA WITH GRAFT OR PROSTHESIS OCT08-
 5343
 OTHER LAPAROSCOPIC UMBILICAL HERNIORRHAPHY OCT08-
 5349
 OTHER UMBILICAL HERNIORRHAPHY HAS 2 CASES
 5351
 INCISIONAL HERNIA REPAIR HAS 2 CASES
 5359
 REPAIR OF OTHER HERNIA OF ANTERIOR ABDOMINAL WALL (HAS 5 CASES)
 5361
 INCISIONAL HERNIA REPAIR W/ PROSTHESIS (HAS 6 CASES)
 5362
 LAPAROSCOPIC INCISIONAL HERNIA REPAIR WITH GRAFT OR PROSTHESIS OCT08-
 5363
 OTHER LAPAROSCOPIC REPAIR OF OTHER HERNIA OF ANTERIOR ABDOMINAL WALL WITH GRAFT OR
 PROSTHESIS OCT08-
 5369
 REPAIR OF OTHER HERNIA OF ANTERIOR ABDOMINAL WALL W/ PROSTHESIS HAS 1 CASE
 537
 REPAIR OF DIAPHRAGMATIC HERNIA, ABDOMINAL APPROACH
 5371
 LAP REPAIR OF DIAPHRAGMATIC HERNIA, ABDOMINAL APPROACH OCT08-
 5372

OTHER AND OPEN REPAIR OF DIAPHRAGMATIC HERNIA, ABDOMINAL APPROACH OCT08-
 5375
 REPAIR OF DIAPHRAGMATIC HERNIA, ABDOMINAL APPROACH, NOS OCT08-
 540
 INCISION OF ABDOMINAL WALL
 5411
 EXPLORATORY LAPAROTOMY
 5412
 REOPENING OF RECENT LAPAROTOMY SITE
 5419
 OTHER LAPAROTOMY
 5421
 LAPAROSCOPY
 5422
 BIOPSY OF ABDOMINAL WALL OR UMBILICUS
 5423
 BIOPSY OF ABDOMINAL WALL OR UMBILICUS (HAS 2 CASES)
 5429
 OTHER DIAGNOSTIC PROCEDURES ON ABDOMINAL REGION
 543
 EXCISION OR DESTRUCTION OF LESION OR TISSUE OF ABDOMINAL WALL OR UMBILICUS
 544
 EXCISION OR DESTRUCTION OF PERITONEAL TISSUE
 5451
 LAPAROSCOPIC LYSIS OF PERITONEAL ADHESIONS
 5459
 OTHER LYSIS OF PERITONEAL ADHESIONS HAS 463 CASES
 5461
 RECLOSURE OF POSTOPERATIVE DISRUPTION OF ABDOMINAL WALL
 6829
 OTHER EXCISION OR DESTRUCTION OF LESION OF UTERUS
 683
 SUBTOTAL ABDOMINAL HYSTERECTOMY
 6831
 LAPAROSCOPIC SUPRACERVICAL HYSTERECTOMY [LSH]
 6839
 OTHER SUBTOTAL ABDOMINAL HYSTERECTOMY
 684
 TOTAL ABDOMINAL HYSTERECTOMY
 6841
 LAP TOTAL ABDOMINAL HYST OCT06-
 6849
 TOTAL ABD HYST NEC/NOS OCT06-
 686
 RADICAL ABDOMINAL HYSTERECTOMY
 6861
 LAP RADICAL ABDOMNL HYST OCT06-
 6869
 RADICAL ABD HYST NEC/NOS OCT06-
 688
 PELVIC EVISCERATION
 689
 OTHER AND UNSPECIFIED HYSTERECTOMY
 6919
 OTHER EXCISION OR DESTRUCTION OF UTERUS AND SUPPORTING STRUCTURES
 6921
 INTERPOSITION OPERATION

6922
OTHER UTERINE SUSPENSION
6923
VAGINAL REPAIR OF CHRONIC INVERSION OF UTERUS
6929
OTHER REPAIR OF UTERUS AND SUPPORTING STRUCTURES
693
PARACERVICAL UTERINE DENERVATION
6941
SUTURE OF LACERATION OF UTERUS
6942
CLOSURE OF FISTULA OF UTERUS
6949
OTHER REPAIR OF UTERUS
6998
OTHER OPERATIONS ON SUPPORTING STRUCTURES OF UTERUS

2a.9 Denominator Exclusions (Brief text description of exclusions from the target population): **Exclude:**

- MDC 14 (pregnancy, childbirth, and puerperium)
- cases with a code for surgical removal of the colon (colectomy) or pelvic evisceration
- cases with any diagnosis of cancer involving or adjacent to the appendix

2a.10 Denominator Exclusion Details (All information required to collect exclusions to the denominator, including all codes, logic, and definitions):

ICD-9-CM surgical removal of the colon (colectomy) or pelvic evisceration procedure codes:

1731
LAPAROSCOPIC MULTIPLE SEGMENTAL RESECTION OF LARGE INTESTINE
1732
LAPAROSCOPIC CECECTOMY
1733
LAPAROSCOPIC RIGHT HEMICOLECTOMY
1734
LAPAROSCOPIC RESECTION OF TRANSVERSE COLON
1735
LAPAROSCOPIC LEFT HEMICOLECTOMY
1736
LAPAROSCOPIC SIGMOIDECTOMY
1739
OTHER LAPAROSCOPIC PARTIAL EXCISION OF LARGE INTESTINE
4571
OPN MUL SEG LG INTES NEC
4572
OPEN CECECTOMY NEC
4573
OPN RT HEMICOLECTOMY NEC
4574
OPN TRANSV COLON RES NEC
4575
OPN LFT HEMICOLECTMY NEC
4576
OPEN SIGMOIDECTOMY NEC
4579
PRT LG INTES EXC NEC/NOS
458
TOT ABD COLECTMY
4581
LAP TOT INTR-AB COLECTMY

Comment [k]: 11 Risk factors that influence outcomes should not be specified as exclusions.
12 Patient preference is not a clinical exception to eligibility and can be influenced by provider interventions.

4582
OP TOT INTR-ABD COLECTMY
4583
TOT ABD COLECTMY NEC/NOS
688
PELVIC EVISCERATION
ICD-9-CM Cancer Involving or Adjacent to the Appendix diagnosis codes
1534
MALIGNANT NEOPLASM OF COLON, CECUM
1535
MALIGNANT NEOPLASM OF COLON, APPENDIX
1536
MALIGNANT NEOPLASM OF COLON, ASCENDING COLON
1538
MALIGNANT NEOPLASM OF COLON, OTHER SPECIFIED SITES OF LARGE INTESTINE
1539
MALIGNANT NEOPLASM OF COLON, NOS
1588
MALIGNANT NEOPLASM OF RETROPERITONEUM AND PERITONEUM, SPECIFIED PARTS OF PERITONEUM
1589
MALIGNANT NEOPLASM OF RETROPERITONEUM AND PERITONEUM, PERITONEUM, UNSPECIFIED
1590
MALIGNANT NEOPLASM OF OTHER AND ILL-DEFINED SITES WITHIN THE DIGESTIVE ORGANS AND PERITONEUM, INTESTINAL TRACT, PART UNSPECIFIED
1598
MALIGNANT NEOPLASM OF OTHER AND ILL-DEFINED SITES WITHIN THE DIGESTIVE ORGANS AND PERITONEUM, OTHER SITES OF DIGESTIVE SYSTEM AND INTRA-ABDOMINAL ORGANS
1599
MALIGNANT NEOPLASM OF OTHER AND ILL-DEFINED SITES WITHIN THE DIGESTIVE ORGANS AND PERITONEUM, ILL-DEFINED
1952
MALIGNANT NEOPLASM OF OTHER AND ILL-DEFINED SITES, ABDOMEN
1975
SECONDARY MALIGNANT NEOPLASM OF RESPIRATORY AND DIGESTIVE SYSTEMS, LARGE INTESTINE AND RECTUM
1976
SECONDARY MALIGNANT NEOPLASM OF RESPIRATORY AND DIGESTIVE SYSTEMS, RETROPERITONEUM AND PERITONEUM
20974
SECONDARY NEUROENDOCRINE TUMOR OF PERITONEUM

2a.11 Stratification Details/Variables (All information required to stratify the measure including the stratification variables, all codes, logic, and definitions):

User has the option to stratify by gender, age (5-year age groups), race / ethnicity, primary payer, or use custom stratifiers.

2a.12-13 Risk Adjustment Type: No risk adjustment necessary

2a.14 Risk Adjustment Methodology/Variables (List risk adjustment variables and describe conceptual models, statistical models, or other aspects of model or method):

Not applicable

2a.15-17 Detailed risk model available Web page URL or attachment:

2a.18-19 Type of Score: Rate/proportion

2a.20 Interpretation of Score: Better quality = Lower score

2a.21 Calculation Algorithm (Describe the calculation of the measure as a flowchart or series of steps):

The indicator is expressed as a rate, is defined as outcome of interest / population at risk or numerator /

denominator. The AHRQ Quality Indicators (AHRQ QI) software performs five steps to produce the rates. 1) Discharge-level data is used to mark inpatient records containing the outcome of interest and 2) the population at risk. For provider indicators, the population at risk is also derived from hospital discharge records; for area indicators, the population at risk is derived from U.S. Census data. 3) Calculate observed rates. Using output from steps 1 and 2, rates are calculated for user-specified combinations of stratifiers. 4) Calculate expected rates. For indicators that are not risk-adjusted, use the reference population rate. 5) Calculate risk-adjusted rate. Use the indirect standardization to account for case-mix. For indicators that are not risk-adjusted, this is the same as the observed rate 6) Calculate smoothed rate. A Univariate shrinkage factor is applied to the risk-adjusted rates. The shrinkage estimate reflects a reliability adjustment unique to each indicator. Full information on calculation algorithms and specifications can be found at http://qualityindicators.ahrq.gov/IQI_download.htm	
2a.22 Describe the method for discriminating performance (e.g., significance testing): Significance testing is not prescribed by the software. Users may define their methods of discriminating performance according to their application. Although all cases are measured, the rate is considered a sample in time, given the variations in case mix over time. Confidence intervals can be calculated, but again are not prescribed.	
2a.23 Sampling (Survey) Methodology <i>If measure is based on a sample (or survey), provide instructions for obtaining the sample, conducting the survey and guidance on minimum sample size (response rate):</i> Not applicable	
2a.24 Data Source (Check the source(s) for which the measure is specified and tested) Claims	
2a.25 Data source/data collection instrument (Identify the specific data source/data collection instrument, e.g. name of database, clinical registry, collection instrument, etc.): The data source is hospital discharge data such as the HCUP State Inpatient Databases (SID) or equivalent using UB-04 coding standards. The data collection instrument is public-use AHRQ QI software available in SAS or Windows versions.	
2a.26-28 Data source/data collection instrument reference web page URL or attachment: URL None http://www.qualityindicators.ahrq.gov/software.htm	
2a.29-31 Data dictionary/code table web page URL or attachment: URL None http://www.qualityindicators.ahrq.gov/downloads/winqi/AHRQ_QI_Windows_Software_Documentation_V41a.pdf	
2a.32-35 Level of Measurement/Analysis (Check the level(s) for which the measure is specified and tested) Facility	
2a.36-37 Care Settings (Check the setting(s) for which the measure is specified and tested) Inpatient/Hospital	
2a.38-41 Clinical Services (Healthcare services being measured, check all that apply) Clinicians: Physicians (MD/DO)	
TESTING/ANALYSIS	
2b. Reliability testing	
2b.1 Data/sample (description of data/sample and size): AHRQ 2007 State Inpatient Databases (SID) with 4,000 hospitals and 30 million adult discharges	
2b.2 Analytic Method (type of reliability & rationale, method for testing): Literature summary, expert panels and empirical analysis	2b C● P● M● N●
2b.3 Testing Results (reliability statistics, assessment of adequacy in the context of norms for the test)	

Comment [KP]: 2b. Reliability testing demonstrates the measure results are repeatable, producing the same results a high proportion of the time when assessed in the same population in the same time period.

Comment [k]: 8 Examples of reliability testing include, but are not limited to: inter-rater/abstractor or intra-rater/abstractor studies; internal consistency for multi-item scales; test-retest for survey items. Reliability testing may address the data items or final measure score.

<p>conducted):</p> <p>Fewer than one-third of surgery departments routinely perform incidental appendectomies, and rates may be difficult to estimate with precision at the majority of hospitals where it is not a routine procedure.¹⁹⁵ Based on empirical evidence, this indicator is precise, with a raw provider level mean of 2.7% and a standard deviation of 3.5%.¹⁹⁶ Relative to other indicators, a higher percentage of the variation occurs at the discharge level than for some indicators. The signal ratio (i.e., the proportion of the total variation across providers that is truly related to systematic differences in provider performance rather than random variation) is moderate, at 55.4%, indicating that some of the observed differences in provider performance do not represent true differences.</p>	
<p>2c. Validity testing</p>	
<p>2c.1 Data/sample (description of data/sample and size): AHRQ 2007 State Inpatient Databases (SID) with 4,000 hospitals and 30 million adult discharges</p>	
<p>2c.2 Analytic Method (type of validity & rationale, method for testing): Literature summary, expert panels and empirical analysis</p>	
<p>2c.3 Testing Results (statistical results, assessment of adequacy in the context of norms for the test conducted):</p> <p>Most of the available evidence appears to contraindicate incidental appendectomy in the elderly, and performance of the procedure is subject to patient and surgeon preference. Therefore, incidental appendectomy rates may correlate poorly with other measures of hospital performance.</p>	<p>2c</p> <p>CO</p> <p>PO</p> <p>MO</p> <p>NO</p>
<p>2d. Exclusions Justified</p>	
<p>2d.1 Summary of Evidence supporting exclusion(s):</p> <p>Exclusions remove cases where the outcome of interest may be indicated</p>	
<p>2d.2 Citations for Evidence:</p> <p>Updated citations will be presented in the May Steering Committee meeting</p> <p>Refinement of the HCUP Quality Indicators (Technical Review), May 2001 http://qualityindicators.ahrq.gov/downloads/technical/qi_technical_review.zip</p>	
<p>2d.3 Data/sample (description of data/sample and size): AHRQ 2007 State Inpatient Databases (SID) with 4,000 hospitals and 30 million adult discharges</p>	
<p>2d.4 Analytic Method (type analysis & rationale): Expert panel and descriptive analyses stratified by exclusion categories</p>	<p>2d</p> <p>CO</p> <p>PO</p> <p>MO</p> <p>NO</p> <p>NA</p>
<p>2d.5 Testing Results (e.g., frequency, variability, sensitivity analyses): Refinement of the HCUP Quality Indicators (Technical Review), May 2001 http://qualityindicators.ahrq.gov/downloads/technical/qi_technical_review.zip</p>	<p>2d</p> <p>CO</p> <p>PO</p> <p>MO</p> <p>NO</p> <p>NA</p>
<p>2e. Risk Adjustment for Outcomes/ Resource Use Measures</p>	
<p>2e.1 Data/sample (description of data/sample and size): Not applicable</p>	
<p>2e.2 Analytic Method (type of risk adjustment, analysis, & rationale): Not applicable</p>	
<p>2e.3 Testing Results (risk model performance metrics): Not applicable</p>	<p>2e</p> <p>CO</p> <p>PO</p> <p>MO</p> <p>NO</p> <p>NA</p>
<p>2e.4 If outcome or resource use measure is not risk adjusted, provide rationale: Process measures; non-appropriate cases are excluded</p>	<p>2e</p> <p>CO</p> <p>PO</p> <p>MO</p> <p>NO</p> <p>NA</p>
<p>2f. Identification of Meaningful Differences in Performance</p>	<p>2f</p>

Comment [KP]: 2c. Validity testing demonstrates that the measure reflects the quality of care provided, adequately distinguishing good and poor quality. If face validity is the only validity addressed, it is systematically assessed.

Comment [k]: 9 Examples of validity testing include, but are not limited to: determining if measure scores adequately distinguish between providers known to have good or poor quality assessed by another valid method; correlation of measure scores with another valid indicator of quality for the specific topic; ability of measure scores to predict scores.

Comment [KP]: 2d. Clinically necessary measure exclusions are identified and must be:

- supported by evidence of sufficient frequency of occurrence so that results are distorted without the exclusion;

AND

- a clinically appropriate exception

Comment [k]: 10 Examples of evidence that an exclusion distorts measure results include, but are not limited to: frequency of occurrence, sensitivity analyses with and without the exclusion, and variability of exclusions across providers.

Comment [KP]: 2e. For outcome measures and other measures (e.g., resource use) when indicated:

- an evidence-based risk-adjustment strategy (e.g., risk models, risk stratification) is specified and is based on patient clinical factors that influence the measured outcome (but not disparities in care and treatment).

Comment [k]: 13 Risk models should not obscure disparities in care for populations by including factors that are associated with differences/inequalities in care such as race, socioeconomic status, gender (e.g., poorer treatment outcomes of African American men with prostate cancer, inequalities in treatment for CVD risk factors between men and women).

Comment [KP]: 2f. Data analysis demonstrates that methods for scoring and analysis of the specified measure allow for identification of statistically significant and practically/clinically meaningful differences in performance.

2f.1 Data/sample from Testing or Current Use (description of data/sample and size): AHRQ 2007 State Inpatient Databases (SID) with 4,000 hospitals and 30 million adult discharges	C P M N
2f.2 Methods to identify statistically significant and practically/meaningfully differences in performance (type of analysis & rationale): Posterior probability distribution parameterized using the Gamma distribution	
2f.3 Provide Measure Scores from Testing or Current Use (description of scores, e.g., distribution by quartile, mean, median, SD, etc.; identification of statistically significant and meaningfully differences in performance): 5th 25th Median 75th 95th 0.002606 0.007769 0.014193 0.023527 0.042807	
2g. Comparability of Multiple Data Sources/Methods	
2g.1 Data/sample (description of data/sample and size): Not applicable	2g C P M N NA
2g.2 Analytic Method (type of analysis & rationale): Not applicable	
2g.3 Testing Results (e.g., correlation statistics, comparison of rankings): Not applicable	
2h. Disparities in Care	
2h.1 If measure is stratified, provide stratified results (scores by stratified categories/cohorts): Median income of patient's ZIP code: 1) Estimate 2) Standard error 3) P-value: Relative to marked group-c 4) P-value: 2007 relative to 2006 First quartile (lowest income) 20.383 0.472 0.001 0.000 Second quartile 20.801 0.460 0.000 0.038 Third quartile 19.020 0.471 0.187 0.028 Fourth quartile (highest income)c 18.142 0.468 0.178	2h C P M N NA
2h.2 If disparities have been reported/identified, but measure is not specified to detect disparities, provide follow-up plans: Users may stratify based on gender and race/ethnicity	
TAP/Workgroup: What are the strengths and weaknesses in relation to the subcriteria for Scientific Acceptability of Measure Properties?	2
Steering Committee: Overall, to what extent was the criterion, Scientific Acceptability of Measure Properties, met? Rationale:	2 C P M N
3. USABILITY	
Extent to which intended audiences (e.g., consumers, purchasers, providers, policy makers) can understand the results of the measure and are likely to find them useful for decision making. (evaluation criteria)	Eval Rating
3a. Meaningful, Understandable, and Useful Information	
3a.1 Current Use: In use	3a C P M N
3a.2 Use in a public reporting initiative (disclosure of performance results to the public at large) (If used in a public reporting initiative, provide name of initiative(s), locations, Web page URL(s). If not publicly reported, state the plans to achieve public reporting within 3 years): Illinois (state)	

Comment [k]: 14 With large enough sample sizes, small differences that are statistically significant may or may not be practically or clinically meaningful. The substantive question may be, for example, whether a statistically significant difference of one percentage point in the percentage of patients who received smoking cessation counseling (e.g., 74% v. 75%) is clinically meaningful; or whether a statistically significant difference of \$25 in cost for an episode of care (e.g., \$5,000 v. \$5,025) is practically meaningful. Measures with overall poor performance may not demonstrate much variability across providers.

Comment [KP]: 2g. If multiple data sources/methods are allowed, there is demonstration they produce comparable results.

Comment [KP]: 2h. If disparities in care have been identified, measure specifications, scoring, and analysis allow for identification of disparities through stratification of results (e.g., by race, ethnicity, socioeconomic status, gender); OR rationale/data justifies why stratification is not necessary or not feasible.

Comment [KP]: 3a. Demonstration that information produced by the measure is meaningful, understandable, and useful to the intended audience(s) for both public reporting (e.g., focus group, cognitive testing) and informing quality improvement (e.g., quality improvement initiatives). An important outcome that may not have an identified improvement strategy still can be useful for informing quality improvement by identifying the need for and stimulating new approaches to improvement.

Illinois Hospital Report Card and Consumer Guide to Health Care
<http://www.healthcarereportcard.illinois.gov/>

Iowa (Iowa Healthcare Collaborative)
 Iowa Healthcare Collaborative
<http://www.ihconline.org/asp/publicreporting/iowareport.aspx>

Kentucky (Norton Healthcare, a hospital system)
 Norton Healthcare Quality Report
<http://www.nortonhealthcare.com/body.cfm?id=157>

Kentucky (state hospital association)
 Kentucky Hospital Association Quality Data
<http://info.kyha.com/QualityData/IQISite/>

Kentucky (state)
 Health Care Information Center
<http://chfs.ky.gov/ohp/healthdata>

Maine (state)
 Maine Health Data Organization
<http://gateway.maine.gov/mhdo2008Monahrq/home.html>

New Jersey (state)
 Find and Compare Quality Care in NJ Hospitals
<http://www.nj.gov/health/healthcarequality/>

New York (health care coalition)
 New York State Hospital Report Card
<http://www.myhealthfinder.com/>

Texas (state)
 Reports on Hospital Performance
<http://www.dshs.state.tx.us/thcic/>

Washington (health care coalition)
 Washington State Hospital Report Card
<http://www.myhealthfinder.com/wa09/index.php>

The measure is also reported on HCUPnet:
http://hcupnet.ahrq.gov/HCUPnet.jsp?Id=EB57801381F71C41&Form=MAINSEL&JS=Y&Action=%3E%3ENext%3E%3E&_MAINSEL=AHQ%20Quality%20Indicators

This measure is used in the MONAHRQ system that is provided for public reporting and quality improvement throughout the United States: <http://monahrq.ahrq.gov/>

3a.3 If used in other programs/initiatives (If used in quality improvement or other programs/initiatives, name of initiative(s), locations, Web page URL(s). If not used for QI, state the plans to achieve use for QI within 3 years):

University Healthcare Consortium - An alliance of 103 academic medical centers and 219 of their affiliated hospitals. Reporting the AHRQ QIs to their member hospitals. (see www.uhc.edu. Note: measure results reported to hospitals; not reported on site).

Dallas Fort Worth Hospital Council - Reporting on measure results to over 70 hospitals in Texas (see www.dfwhc.org. Note: measure results reported to hospitals; not reported on site).

Norton Healthcare - a multi-hospital system in Kentucky (see

http://www.nortonhealthcare.com/about/Our_Performance/index.aspx Ministry Health Care - a multi-hospital system in Wisconsin (see http://ministryhealth.org/display/router.aspx . Note: measure results reported to hospitals; not reported on site). Minnesota Hospital Association http://www.mnhospitals.org/ Note: measure used in quality improvement. Not reported publicly by the association) This measure is used in the MONAHRQ system that is provided for public reporting and quality improvement throughout the United States: http://monahrq.ahrq.gov/ Testing of Interpretability (Testing that demonstrates the results are understood by the potential users for public reporting and quality improvement) 3a.4 Data/sample (description of data/sample and size): AHRQ 2007 State Inpatient Databases (SID) with 4,000 hospitals and 30 million adult discharges 3a.5 Methods (e.g., focus group, survey, QI project): A research team from the School of Public Affairs, Baruch College, under contracts with the Department of Public Health, Weill Medical College and Battelle, Inc., has developed a pair of Hospital Quality Model Reports at the request of the Agency for Healthcare Research & Quality (AHRQ). These reports are designed specifically to report comparative information on hospital performance based on the AHRQ Quality Indicators (QIs). The work was done in close collaboration with AHRQ staff and the AHRQ Quality Indicators team. The Model Reports (discussed immediately above) are based on: <ul style="list-style-type: none"> • Extensive search and analysis of the literature on hospital quality measurement and reporting, as well as public reporting on health care quality more broadly; • Interviews with quality measurement and reporting experts, purchasers, staff of purchasing coalitions, and executives of integrated health care delivery systems who are responsible for quality in their facilities; • Two focus groups with chief medical officers of hospitals and/or systems and two focus groups with quality managers from a broad mix of hospitals; • Four focus groups with members of the public who had recently experienced a hospital admission; and • Four rounds of cognitive interviews (a total of 62 interviews) to test draft versions of the two Model Reports with members of the public with recent hospital experience, basic computer literacy but widely varying levels of education. 3a.6 Results (qualitative and/or quantitative results and conclusions): Given the above review of the literature and original research that was conducted, a Model report was the result that could help sponsors use the best evidence on public reports so they are most likely to have the desired effects on quality.		
3b/3c. Relation to other NQF-endorsed measures		
3b.1 NQF # and Title of similar or related measures:		
(for NQF staff use) Notes on similar/related <u>endorsed</u> or submitted measures:		
3b. Harmonization If this measure is related to measure(s) already <u>endorsed by NQF</u> (e.g., same topic, but different target population/setting/data source or different topic but same target population): 3b.2 Are the measure specifications <u>harmonized</u>? If not, why?	3b C P M N NA	
3c. Distinctive or Additive Value 3c.1 Describe the distinctive, improved, or additive value this measure provides to existing NQF-endorsed measures:	3c C P M	

Comment [KP]: 3b. The measure specifications are harmonized with other measures, and are applicable to multiple levels and settings.

Comment [k]: 16 Measure harmonization refers to the standardization of specifications for similar measures on the same topic (e.g., *influenza immunization* of patients in hospitals or nursing homes), or related measures for the same target population (e.g., eye exam and HbA1c for *patients with diabetes*), or definitions applicable to many measures (e.g., age designation for children) so that they are uniform or compatible, unless differences are dictated by the evidence. The dimensions of harmonization can include numerator, denominator, exclusions, and data source and collection instructions. The extent of harmonization depends on the relationship of the measures, the evidence for the specific measure focus, and differences in data sources.

Comment [KP]: 3c. Review of existing endorsed measures and measure sets demonstrates that the measure provides a distinctive or additive value to existing NQF-endorsed measures (e.g., provides a more complete picture of quality for a particular condition or aspect of healthcare, is a more valid or efficient way to measure).

5.1 If this measure is similar to measure(s) already endorsed by NQF (i.e., on the same topic and the same target population), Describe why it is a more valid or efficient way to measure quality: No competing measures found.	NO NA
TAP/Workgroup: What are the strengths and weaknesses in relation to the subcriteria for <i>Usability</i> ?	3
Steering Committee: Overall, to what extent was the criterion, <i>Usability</i> , met? Rationale:	3 CO PO MO NO
4. FEASIBILITY	
Extent to which the required data are readily available, retrievable without undue burden, and can be implemented for performance measurement. (evaluation criteria)	Eval Rating
4a. Data Generated as a Byproduct of Care Processes	4a
4a.1-2 How are the data elements that are needed to compute measure scores generated? Coding/abstraction performed by someone other than person obtaining original information (E.g., DRG, ICD-9 codes on claims, chart abstraction for quality measure or registry)	CO PO MO NO
4b. Electronic Sources	
4b.1 Are all the data elements available electronically? (<i>elements that are needed to compute measure scores are in defined, computer-readable fields, e.g., electronic health record, electronic claims</i>) Yes	4b CO PO MO NO
4b.2 If not, specify the near-term path to achieve electronic capture by most providers.	
4c. Exclusions	
4c.1 Do the specified exclusions require additional data sources beyond what is required for the numerator and denominator specifications? No	4c CO PO MO NO NA
4c.2 If yes, provide justification.	
4d. Susceptibility to Inaccuracies, Errors, or Unintended Consequences	
4d.1 Identify susceptibility to inaccuracies, errors, or unintended consequences of the measure and describe how these potential problems could be audited. If audited, provide results. Coding professionals follow detail guidelines, are subject to training and credentialing requirements, peer review and audit. Incidental appendectomy does not generally affect hospital payment; therefore, widespread use of this indicator may lead to less frequent coding of the procedure when it is performed. A reduction in the rate of incidental appendectomy may lead to a subsequent increase in the incidence of acute appendicitis, although this risk is expected to be small for the elderly population.	4d CO PO MO NO
4e. Data Collection Strategy/Implementation	
4e.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/frequency of data collection, patient confidentiality, time/cost of data collection, other feasibility/ implementation issues: None	4e CO PO MO NO

Comment [KP]: 4a. For clinical measures, required data elements are routinely generated concurrent with and as a byproduct of care processes during care delivery. (e.g., BP recorded in the electronic record, not abstracted from the record later by other personnel; patient self-assessment tools, e.g., depression scale; lab values, meds, etc.)

Comment [KP]: 4b. The required data elements are available in electronic sources. If the required data are not in existing electronic sources, a credible, near-term path to electronic collection by most providers is specified and clinical data elements are specified for transition to the electronic health record.

Comment [KP]: 4c. Exclusions should not require additional data sources beyond what is required for scoring the measure (e.g., numerator and denominator) unless justified as supporting measure validity.

Comment [KP]: 4d. Susceptibility to inaccuracies, errors, or unintended consequences and the ability to audit the data items to detect such problems are identified.

Comment [KP]: 4e. Demonstration that the data collection strategy (e.g., source, timing, frequency, sampling, patient confidentiality, etc.) can be implemented (e.g., already in operational use, or testing demonstrates that it is ready to put into operational use).

<p>4e.2 Costs to implement the measure (<i>costs of data collection, fees associated with proprietary measures</i>): All data necessary to calculate this measure are routinely collected for hospital administrative purposes. The software for calculating the measure is available for free at: http://www.qualityindicators.ahrq.gov/software.htm</p> <p>4e.3 Evidence for costs: All data necessary to calculate this measure are routinely collected for hospital administrative purposes. The software for calculating the measure is available for free at: http://www.qualityindicators.ahrq.gov/software.htm</p> <p>4e.4 Business case documentation: All data necessary to calculate this measure are routinely collected for hospital administrative purposes. The software for calculating the measure is available for free at: http://www.qualityindicators.ahrq.gov/software.htm</p>	
TAP/Workgroup: What are the strengths and weaknesses in relation to the subcriteria for <i>Feasibility</i>?	4
Steering Committee: Overall, to what extent was the criterion, <i>Feasibility</i>, met? Rationale:	4 C● P● M● N●
RECOMMENDATION	
(for NQF staff use) Check if measure is untested and only eligible for time-limited endorsement.	Time-limited ●
Steering Committee: Do you recommend for endorsement? Comments:	Y● N● A●
CONTACT INFORMATION	
Co.1 Measure Steward (Intellectual Property Owner) Co.1 <u>Organization</u> Agency for Healthcare Research and Quality, 540 Gaither Road, Rockville, Maryland, 20850 Co.2 <u>Point of Contact</u> John, Bott, Contractor, AHRQ Quality Indicators Measure Expert Center for Delivery, Organization and Markets, John.Bott@ahrq.hhs.gov, 301-427-1317-	
Measure Developer If different from Measure Steward Co.3 <u>Organization</u> Agency for Healthcare Research and Quality, 540 Gaither Road, Rockville, Maryland, 20850 Co.4 <u>Point of Contact</u> John, Bott, MSSW, MBA, John.Bott@AHRQ.hhs.gov, 301-427-1317-	
Co.5 Submitter If different from Measure Steward POC John, Bott, MSSW, MBA, John.Bott@AHRQ.hhs.gov, 301-427-1317-, Agency for Healthcare Research and Quality	
Co.6 Additional organizations that sponsored/participated in measure development UC Davis, Stanford University, Battelle Memorial Institute	
ADDITIONAL INFORMATION	
Workgroup/Expert Panel involved in measure development	

Ad.1 Provide a list of sponsoring organizations and workgroup/panel members' names and organizations. Describe the members' role in measure development. None
Ad.2 If adapted, provide name of original measure: None Ad.3-5 If adapted, provide original specifications URL or attachment
Measure Developer/Steward Updates and Ongoing Maintenance Ad.6 Year the measure was first released: 2001 Ad.7 Month and Year of most recent revision: 10, 2010 Ad.8 What is your frequency for review/update of this measure? Annual Ad.9 When is the next scheduled review/update for this measure? 05, 2011
Ad.10 Copyright statement: The AHRQ QI software is publicly available; no copyright disclaimers.
Ad.11 Disclaimers:
Ad.12 -14 Additional Information web page URL or attachment:
Date of Submission (MM/DD/YY): 02/01/2011