



## Measure Information

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

### Brief Measure Information

**NQF #: 0419e**

**Corresponding Measures:**

**De.2. Measure Title:** Documentation of Current Medications in the Medical Record

**Co.1.1. Measure Steward:** Centers for Medicare & Medicaid Services

**De.3. Brief Description of Measure:** For both the 2018 claims and registry specifications AND the 2019 performance period eMeasure (v8) the measure description is as follows:

Percentage of visits for patients aged 18 years and older for which the eligible professional or eligible clinician attests to documenting a list of current medications using all immediate resources available on the date of the encounter. This list must include ALL known prescriptions, over-the-counters, herbals, and vitamin/mineral/dietary (nutritional) supplements AND must contain the medications' name, dosage, frequency and route of administration.

**1b.1. Developer Rationale:** Evidence suggests that frequently identifying, documenting, and maintaining a list of patient's medications reflects high quality care, and (consequently) that not reviewing and documenting a patient's current medication list results in poor quality of care. Obtaining a current list of medications the patient is receiving and taking, and sources of medications, is essential to the delivery of safe medical care by reduction of medication discrepancies and prevention of adverse drug events (ADEs).

Two-thirds of physician visits result in writing at least one prescription (Stock, et al., 2009). Consequently, patients who see more than one provider are at risk for adverse drug events (AHRQ, 2013).

Most medication errors (87%) occur in those 18 years of age and older (AHRQ, 2013). Evidence suggests that inaccurate medication lists in an ambulatory clinic cause a larger number of fatal adverse drug effects (1 of 131 outpatient deaths) than in a hospital setting (1 of 854 inpatient deaths) (Nassaralla et al., 2007). One study (Sarkar et al. 2011) used nationally-representative data to examine annual rates of ADEs in the ambulatory care setting and estimated that there were about 4.5 million ambulatory ADE visits and 400,000 ADE-related hospitalizations each year. The study also found that ADE rates increase with age; adults 25-44 years old had a rate of 1.3 per 10,000 people per year, those 45-64 had a rate of 2.2 per 10,000 per year, and those 65 years and older had the highest rate, at 3.8 ADEs per 10,000 persons per year. According to the Institute of Medicine (IOM), as many as 98,000 deaths per year in the U.S. are attributable to preventable adverse events that occur in the hospitals setting, with annual costs of between \$17 billion and \$29 billion (Sarkar et al., 2011). Additionally, a 2010 report by The Commonwealth Fund determined that 11% to 28% of the 4.3 million visit related ADEs (VADEs) in 2001 might have been prevented with improved systems of care and better patient education, which could have yielded an estimated \$946 million to \$2.4 billion in cost savings.

"In the ambulatory care setting, adverse drug events (ADEs) have been reported to occur at a rate of 25%. Approximately 39% of these ADEs were preventable. Since many ADEs are associated with medication errors, and thus potentially preventable, understanding the nature of medication errors in ambulatory care settings can direct attention toward improvement of medication safety in ambulatory care." (Tache et al., 2011).

Unfortunately, and despite current health technology, managing complex medication lists remains one of the biggest challenges in healthcare today." (Sarzynski et al., 2014)

Agency for Healthcare Research and Quality (2013). National Healthcare Disparities Report 2013. Accessed February 25, 2015, <http://www.ahrq.gov/research/findings/nhqdr/nhdr13/2013nhdr.pdf>

Daly, M., & Lee, B. (2013). Examining medication reconciliation from a perspective of safety. *Formulary*, 48(8), 266-270.

Nassaralla, c. L., Naessens, J. M., et al. (2007). Implementation of a medication reconciliation process in an ambulatory internal medicine clinic. *Quality and Safety in Health Care*, 16:90-94.

Nassaralla, C. L., Naessens, J. M., Hunt, V.L., et al. (2009.) Medication reconciliation in ambulatory care: Attempts at improvement. *Quality and Safety in Health Care*, 18:402-407.

Sarkar, U., López, A., Maselli, J.H., Gonzalez, R. (2011). Adverse Drug Events in U.S. Adult Ambulatory Medical Care. *Health Services Research*, 46(5), 1517-1533.

Sarzynski, E., M., Luz, C., C., Rios-Bedoya, C., & Zhou, S. (2014). Considerations for using the 'brown bag' strategy to reconcile medications during routine outpatient office visits. *Quality in Primary Care*, 22(4), 177-187.

Stock, R., Scott, J., & Gurtel, S. (2009). Using an electronic prescribing system to ensure accurate medication lists in a large multidisciplinary medical group. *Joint Commission Journal on Quality Patient Safety*, 35:271-277.

Tache, S.V., Sonnichsen, A., & Ashcroft, D.M. (2011). Prevalence of Adverse Drug Events in Ambulatory Care: A Systematic Review. *The Annals of Pharmacotherapy*, 45(7-8), 977-989. doi: 10.1345/aph.1P627.

The Commonwealth Fund. Accessed June 1, 2010, <http://www.commonwealthfund.org/Content/Performance-Snapshots/Medication-Mistakes-and-Adverse-Drug-Events/Adverse-Drug-Events--Ambulatory-Care-Visits-for-Treatment.aspx>

**S.4. Numerator Statement:** Numerator statements for both the 2018 claims and registry specifications and the 2019 performance period eMeasure (v8) is as follows:

Eligible professional or eligible clinician attests to documenting, updating, or reviewing the patient's current medications using all immediate resources available on the date of the encounter. This list must include ALL prescriptions, over-the counters, herbals, vitamin/mineral/dietary (nutritional) supplements AND must contain the medications' name, dosages, frequency, and route of administration.

**S.6. Denominator Statement:** Denominator statement for the 2018 claims and registry specifications is as follows: "All visits for patients aged 18 years and older."

Denominator statement for the 2019 performance period eMeasure (v8) is "Equals Initial Population". Initial Population is defined as: "All visits occurring during the 12 month measurement period for patients aged 18 years and older."

**S.8. Denominator Exclusions:** Denominator exception for the 2018 claims and registry specifications is as follows:

A patient is not eligible if the following reason is documented: Patient is in an urgent or emergent medical situation where time is of the essence and to delay treatment would jeopardize the patient's health status on the date of the encounter

Denominator exception for the 2019 performance period eMeasure (v8) is as follows:

Medical Reason: Patient is in an urgent or emergent medical situation where time is of the essence and to delay treatment would jeopardize the patient's health status

**De.1. Measure Type:** Process

**S.17. Data Source:** Claims, Electronic Health Records, Registry Data

**S.20. Level of Analysis:** Clinician : Group/Practice, Clinician : Individual

**IF Endorsement Maintenance – Original Endorsement Date:** Jul 31, 2008 **Most Recent Endorsement Date:** Dec 10, 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?** N/A

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

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

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

[PQRS\\_130\\_\\_CMS\\_68\\_MeasSubm\\_Evidence\\_2015-635641743643624974.docx](#)

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

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

**1b. Performance Gap**

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

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

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

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

Evidence suggests that frequently identifying, documenting, and maintaining a list of patient's medications reflects high quality care, and (consequently) that not reviewing and documenting a patient's current medication list results in poor quality of care. Obtaining a current list of medications the patient is receiving and taking, and sources of medications, is essential to the delivery of safe medical care by reduction of medication discrepancies and prevention of adverse drug events (ADEs).

Two-thirds of physician visits result in writing at least one prescription (Stock, et al., 2009). Consequently, patients who see more than one provider are at risk for adverse drug events (AHRQ, 2013).

Most medication errors (87%) occur in those 18 years of age and older (AHRQ, 2013). Evidence suggests that inaccurate medication lists in an ambulatory clinic cause a larger number of fatal adverse drug effects (1 of 131 outpatient deaths) than in a hospital setting (1 of 854 inpatient deaths) (Nassaralla et al., 2007). One study (Sarkar et al. 2011) used nationally-representative data to examine annual rates of ADEs in the ambulatory care setting and estimated that there were about 4.5 million ambulatory ADE visits and 400,000 ADE-related hospitalizations each year. The study also found that ADE rates increase with age; adults 25-44 years old had a rate of 1.3 per 10,000 people per year, those 45-64 had a rate of 2.2 per 10,000 per year, and those 65 years and older had the highest rate, at 3.8 ADEs per 10,000 persons per year. According to the Institute of Medicine (IOM), as many as 98,000 deaths per year in the U.S. are attributable to preventable adverse events that occur in the hospitals setting, with annual costs of between \$17 billion and \$29 billion (Sarkar et al., 2011). Additionally, a 2010 report by The Commonwealth Fund determined that 11% to 28% of the 4.3 million visit related ADEs (VADEs) in 2001 might have been prevented with improved systems of care and better patient education, which could have yielded an estimated \$946 million to \$2.4 billion in cost savings.

"In the ambulatory care setting, adverse drug events (ADEs) have been reported to occur at a rate of 25%. Approximately 39% of these ADEs were preventable. Since many ADEs are associated with medication errors, and thus potentially preventable, understanding the nature of medication errors in ambulatory care settings can direct attention toward improvement of medication safety in ambulatory care." (Tache et al., 2011).

Unfortunately, and despite current health technology, managing complex medication lists remains one of the biggest challenges in healthcare today." (Sarzynski et al., 2014)

Agency for Healthcare Research and Quality (2013). National Healthcare Disparities Report 2013. Accessed February 25, 2015, <http://www.ahrq.gov/research/findings/nhqdr/nhdr13/2013nhdr.pdf>

Daly, M., & Lee, B. (2013). Examining medication reconciliation from a perspective of safety. *Formulary*, 48(8), 266-270.

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Nassaralla, C. L., Naessens, J. M., Hunt, V.L., et al. (2009.) Medication reconciliation in ambulatory care: Attempts at improvement. *Quality and Safety in Health Care*, 18:402-407.

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Tache, S.V., Sonnichsen, A., & Ashcroft, D.M. (2011). Prevalence of Adverse Drug Events in Ambulatory Care: A Systematic Review. *The Annals of Pharmacotherapy*, 45(7-8), 977-989. doi: 10.1345/aph.1P627.

The Commonwealth Fund. Accessed June 1, 2010, <http://www.commonwealthfund.org/Content/Performance-Snapshots/Medication-Mistakes-and-Adverse-Drug-Events/Adverse-Drug-Events--Ambulatory-Care-Visits-for-Treatment.aspx>

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

Performance scores from Physician Quality Reporting System program data:

Registry data, submitted 1/1/2013 through 12/31/2013:

Distribution of provider scores (by NPI): N=19,176 providers; Mean=82.3%; Median=97.4%; SD=0.284; Range=100; Min=0.0%; Max=100.0%;

10th percentile: 32.2%; 20th percentile: 66.7%; 30th percentile: 85.5%; 40th percentile: 93.8%; 50th percentile: 97.4%; 60th percentile: 99.3%; 70th percentile: 100.0%; 80th percentile 100.0%; 90th percentile: 100.0%

Interquartile range: 21.8%

Claims data, submitted 7/1/2013 through 12/31/2013:

Distribution of provider scores (by NPI): N=92,991 providers; Mean=94.3%; Median=100.0%; SD=0.154; Range: 100; Min=0.0%; Max=100.0%;

10th percentile: 81.3%; 20th percentile: 95.4%; 30th percentile: 99.7%; 40th percentile: 100.0%; 50th percentile: 100.0%; 60th percentile: 100.0%; 70th percentile: 100.0%; 80th percentile 100.0%; 90th percentile: 100.0%

Interquartile range: 1.7%

Average Performance Rates by Year (PQRS – all reporting methods):

2010 – 74.7%

2011 – 85.7%

2012 – 85.6%

2013 – 88.0%

Performance scores from EHR data from a convenience sample of three practices (collected to support recent scientific acceptability testing):

EHR data, reported for 1/1/2014 through 12/31/2014 (for two of the three physician practices) and between 10/1/2014 and 12/31/2014 (for the third physician practice). (Data for previous years was not collected as part of testing.):

Distribution of provider scores (by provider: N=40 providers; Mean=69.9%, Median=80.7%, SD=0.267; Range=93.3; Min=6.7%; Max=100.0%

10th percentile: 34.1%; 20th percentile: 45.2%; 30th percentile: 49.4%; 40th percentile: 64.0%; 50th percentile: 80.7%; 60th percentile: 87.7%; 70th percentile: 92.3%; 80th percentile: 95.9%; 90th percentile: 98.5%  
Interquartile range: 46.6%

**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.**

See 1b.2 for description of data

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

Data analysis can produce provider level performance rates as well as aggregate rates based on any classification and demographic data that can be linked to the provider or patient related to: Race, Gender, and Age. Disparities in performance may be identified by examining these aggregate performance rates.

The aggregate performance rates for the following population groups were calculated using Physician Quality Reporting System claims reported from 7/1/2013 to 12/31/2013. We used this data source as opposed to the other two available (registry and EHR) due to its size—the sample consists of 11,585,674 claims with valid denominator criteria and no performance exclusion. The performance rates below represent only those providers who voluntarily reported this measure and cannot be generalized to the population of eligible providers.

The differences in the following performance rates by population groups are statistically significant, owing to the large sample size. However, the magnitude of these differences is small, and therefore any observed disparities may not be clinically significant.

The following data on disparities is displayed as follows:

Disparities category

Subcategory: Performance Rate (sample size, in number of claims)

Patient Age

18-29 years: 92.1% (n=52,179); 30-39 years: 92.4% (n=159,475); 40-49 years: 92.7% (n=366,501); 50-59 years: 93.1% (n=765,625); 60-69 years: 94.0% (n=2,920,368); 70+: 94.1% (n=7,321,526)

X<sup>2</sup> = 3,044.3; df: 5; N: 11,585,674; p < 0.0001

Patient Race

Unknown: 93.3% (n=85,354); White: 94.0% (n=9,962,743); Black: 93.5% (n=1,004,608); Other: 93.9% (n=181,743); Asian: 94.2% (n=151,185); Hispanic: 93.7% (n=170,966); North American Native: 93.3% (n=29,075)

X<sup>2</sup> = 387.5; df: 6; N: 11,585,674; p < 0.0001

Patient Sex

Female: 93.8% (n=6,732,579) Male – 94.0% (n=4,853,095)

X<sup>2</sup>: 184.4; df: 1; N: 11,585,674; p < 0.0001

See Appendix A1\_NQF 0419\_2015 Re-endorsement for additional information.

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

See 1b.4

## 2. Reliability and Validity—Scientific Acceptability of Measure Properties

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

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

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

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

Primary Prevention, Safety : Medication

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

Elderly

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

<https://www.cms.gov/apps/ama/license.asp?file=/Medicare/Quality-Payment-Program/Resource-Library/2018-Claims-Registry-Measures-101-150.zip>; <https://ecqi.healthit.gov/ecqm/measures/cms68v8>

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

This is an eMeasure Attachment: CMS68v8.zip

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

Attachment Attachment: CMS68\_QI130\_NQF0419\_NQF\_AU\_2018\_S\_2b\_\_Code\_Table\_121218.xlsx

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

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

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

Not an instrument-based measure

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

Yes

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

The 2018 claims and registry specifications had updates to the following:

Description, numerator statement, definitions, numerator note, rationale and copyright.

Denominator CPT coding was added: 59400, 59510, 59610, 59618, 97127, 99024, 99281, 99282, 99283, 99284, 99285, 99385, 99386, 99387, 99395, 99396, and 99397.

Denominator CPT code 97532 was deleted. On 07/20/18, the 2018 claims and registry version was updated to version 2.1, and the denominator CPT code 99024 was deleted.

A denominator note was added: \*Signifies that this CPT Category I code is a non-covered service under the PFS (Physician Fee Schedule). These non-covered services will not be counted in the denominator population for claims-based measures.

The denominator exception (G8430) was updated.

Updates to these measure specifications have been made based on literature reviews, requests from various stakeholders, subject matter expert feedback, and code system updates.

The 2019 performance period eMeasure (v8) had updates to the following:

Version number, copyright, disclaimer, rationale, references, and logic.

Per expert consensus, language was added to the rationale from Qato et al., 2008 based on the literature review. This reference was added to the specification.

Value set Medications Encounter Code Set (2.16.840.1.113883.3.600.1.1834): Added 1 HCPCS code (G0515), added 14 CPT codes (97127, 99236, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99315, 99316, 99318, 99339, 99340), and deleted 2 CPT codes (97532, 99024).

Updates to these measure specifications have been made based on literature reviews, requests from various stakeholders, subject matter expert feedback, and code system updates.

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

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

Numerator statements for both the 2018 claims and registry specifications and the 2019 performance period eMeasure (v8) is as follows:

Eligible professional or eligible clinician attests to documenting, updating, or reviewing the patient's current medications using all immediate resources available on the date of the encounter. This list must include ALL prescriptions, over-the counters, herbals, vitamin/mineral/dietary (nutritional) supplements AND must contain the medications' name, dosages, frequency, and route of administration.

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

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

2018 claims and registry specifications: The numerator Quality-Data Coding Options for Reporting Satisfactorily:

Current Medications Documented

Performance Met: G8427: Eligible clinician attests to documenting in the medical record they obtained, updated, or reviewed the patient's current medications.

OR

Current Medications not Documented, Patient not Eligible

Denominator Exception: G8430: Eligible clinician attests to documenting in the medical record the patient is not eligible for a current list of medications being obtained, updated, or reviewed by the eligible clinician

OR

Current Medications with Name, Dosage, Frequency, or Route not Documented, Reason not Given.

Performance Not Met: G8428: Current list of medications not documented as obtained, updated, or reviewed by the eligible professional, reason not given.

Definitions include:

Current Medications – Medications the patient is presently taking including all prescriptions, over-the-counters, herbals and vitamin/mineral/dietary (nutritional) supplements with each medication's name, dosage, frequency and administered route.

Route – Documentation of the way the medication enters the body (some examples include but are not limited to: oral, sublingual, subcutaneous injections, and/or topical).

Within the 2019 performance period eMeasure (v8), the numerator is defined as:

"Medications Documented During Qualifying Encounter":

"Qualifying Encounters During Measurement Period" QualifyingEncounterDuringMeasurementPeriod

with ["Procedure, Performed": "Documentation of current medications (procedure)"] MedicationsDocumented such that

MedicationsDocumented.relevantPeriod during QualifyingEncounterDuringMeasurementPeriod.relevantPeriod

SNOMED-CT code (428191000124101) is used to capture the numerator.



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

Denominator statement for the 2018 claims and registry specifications is as follows: "All visits for patients aged 18 years and older."

Denominator statement for the 2019 performance period eMeasure (v8) is "Equals Initial Population". Initial Population is defined as: "All visits occurring during the 12 month measurement period for patients aged 18 years and older."

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

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

For the purposes of defining the denominator in both the claims and registry and eMeasure versions, the denominator is defined by the patient's age (based on patient's date of birth), encounter date, denominator CPT or HCPCS codes.

2018 claims and registry specifications:

Denominator Criteria (Eligible Cases): Patients aged  $\geq 18$  years on date of encounter

AND

Patient encounter during the reporting period (CPT or HCPCS): 59400, 59510, 59610, 59618, 90791, 90792, 90832, 90834, 90837, 90839, 92002, 92004, 92012, 92014, 92507, 92508, 92526, 92537, 92538, 92540, 92541, 92542, 92544, 92545, 92547, 92548, 92550, 92557, 92567, 92568, 92570, 92585, 92588, 92626, 96116, 96150, 96151, 96152, 97127\*, 97161, 97162, 97163, 97164, 97165, 97166, 97167, 97168, 97802, 97803, 97804, 98960, 98961, 98962, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99221, 99222, 99223, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, 99495, 99496, 99281, 99282, 99283, 99284, 99285, 99385\*, 99386\*, 99387\*, 99395\*, 99396\*, 99397\*, G0101, G0108, G0270, G0402, G0438, G0439 [\*Signifies that this CPT Category I code is a non-covered service under the PFS (Physician Fee Schedule). These non-covered services will not be counted in the denominator population for claims-based measures.]

Within the 2019 performance period eMeasure (v8), the denominator is defined as the initial population where:

"Qualifying Encounters During Measurement Period" QualifyingEncounter where "Patient Age 18 or Older at Start of Measurement Period"

The eMeasure denominator includes the above CPT and HCPCS codes as well as SNOMED-CT codes in the Medications Encounter Code Set Grouping Value set OID: 2.16.840.1.113883.3.600.1.1834.

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

Denominator exception for the 2018 claims and registry specifications is as follows:

A patient is not eligible if the following reason is documented: Patient is in an urgent or emergent medical situation where time is of the essence and to delay treatment would jeopardize the patient's health status on the date of the encounter

Denominator exception for the 2019 performance period eMeasure (v8) is as follows:

Medical Reason: Patient is in an urgent or emergent medical situation where time is of the essence and to delay treatment would jeopardize the patient's health status

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

2018 claims and registry specifications:

Current Medications not Documented, Patient not Eligible

Denominator Exception G8430: Eligible clinician attests to documenting in the medical record the patient is not eligible for a current list of medications being obtained, updated, or reviewed by the eligible clinician.

Within the 2019 performance period eMeasure (v8), the denominator exception is defined as:

"Qualifying Encounters During Measurement Period" EncounterDuringMeasurementPeriod  
with "Medications Not Documented for Medical Reason" MedicationsNotDocumented

such that MedicationsNotDocumented.authorDatetime during  
EncounterDuringMeasurementPeriod.relevantPeriod



The eMeasure denominator exception includes codes in the value set Medical or Other reason not done SNOMED-CT Value Set OID 2.16.840.1.113883.3.600.1.1502 to capture the denominator exception.

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

This measure is not stratified.

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

No risk adjustment or risk stratification

If other:

**S.12. Type of score:**

Rate/proportion

If other:

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

Better quality = Higher score

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

For both the 2018 claims and registry specifications and the 2019 performance period eMeasure (v8), the performance calculation is as follows:

**PERFORMANCE CALCULATION**

To calculate provider performance, complete a fraction with the following measure components:

Numerator (A), Denominator (D), and Denominator Exceptions (C)

Numerator (A): Number of visits meeting numerator criteria

Denominator (D): Number of visits meeting criteria for denominator inclusion

Denominator Exceptions (C): Number of visits not meeting numerator criteria with valid exceptions

The method of performance calculation is determined by the following:

1) identify the visits that meet the eligibility criteria for the denominator (D) which includes patients who are 18 years and older with appropriate encounters as defined by encounter codes or encounter value set during the reporting period.

2) identify which visits meet the numerator criteria (A)

3) for those visits who do not meet the numerator criteria, determine whether an appropriate exception applies (C) and subtract those visits from the denominator with the following calculation:

$$\text{Numerator (A)} / [\text{Denominator (D)} - \text{Denominator Exceptions (C)}]$$

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

IF an instrument-based performance measure (e.g., PRO-PM), identify whether (and how) proxy responses are allowed.

N/A

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

Specify calculation of response rates to be reported with performance measure results.

N/A

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

If other, please describe in S.18.

Claims, Electronic Health Records, Registry Data

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

If instrument-based, identify the specific instrument(s) and standard methods, modes, and languages of administration.

The data source is the medical record, which provides patient information for the encounter; Medicare Part B Claims and Registry data, and EHR reports.

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

No data collection instrument provided

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

Clinician : Group/Practice, Clinician : Individual

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

Outpatient Services

If other:

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

N/A

## 2. Validity – See attached Measure Testing Submission Form

NQF\_0419\_PQRS\_130\_CMS\_68\_MeasSubm\_MeasTesting\_2015-635641768986136974.docx

### 2.1 For maintenance of endorsement

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

### 2.2 For maintenance of endorsement

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

### 2.3 For maintenance of endorsement

Risk adjustment: For outcome, resource use, cost, and some process measures, risk-adjustment that includes social risk factors is not prohibited at present. Please update sections 1.8, 2a2, 2b1, 2b4.3 and 2b5 in the Testing attachment and S.140 and S.11 in the online submission form. NOTE: These sections must be updated even if social risk factors are not included in the risk-adjustment strategy. You MUST use the most current version of the Testing Attachment (v7.1) -- older versions of the form will not have all required questions.

## 3. Feasibility

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

### 3a. Byproduct of Care Processes

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

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

generated by and used by healthcare personnel during the provision of care, e.g., blood pressure, lab value, medical condition, Coded by someone other than person obtaining original information (e.g., DRG, ICD-9 codes on claims), Abstracted from a record by someone other than person obtaining original information (e.g., chart abstraction for quality measure or registry)

If other:

### 3b. Electronic Sources

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

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

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

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

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

Attachment: [Quality\\_Insights\\_eMeasure\\_Alpha\\_and\\_Beta\\_Testing\\_Summary\\_071812.pdf](#)

### 3c. Data Collection Strategy

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

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

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

The measure is in current operational use. Our 2012 initial assessment of the measure's feasibility (results available in the attached file, Appendix A1) indicated that this measure had moderate measure feasibility overall for reporting using data from claims or registries as part of the Physician Quality Reporting System (PQRS). (The rating of moderate feasibility indicated that the measure requires moderate work to implement, as the EHR captures all but (up to) 3 data elements and at least 1 data element cannot meet measure criteria.) Despite these limitations, the measure has been successfully implemented and reported by tens of thousands of providers who participate in PQRS.

For EHR-based reporting, the required data elements are currently available in EHR, and providers report that they are regularly documenting medications practices in their EHR systems. These providers—including the three physician practices who recently participated in scientific acceptability testing using this data source—do not anticipate that implementing this measure will add significantly to their documentation and reporting burden.

**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*).

N/A

## 4. Usability and Use

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

### 4a. Accountability and Transparency

Performance results are used in at least one accountability application within three years after initial endorsement and are publicly reported within six years after initial endorsement (or the data on performance results are available). If not in use at

the time of initial endorsement, then a credible plan for implementation within the specified timeframes is provided.

#### 4.1. Current and Planned Use

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

Specific Plan for Use	Current Use (for current use provide URL)
	<a href="#">Public Reporting</a> <a href="#">Physician Quality Reporting System</a> <a href="http://www.cms.gov/PQRS">http://www.cms.gov/PQRS</a>
	<a href="#">Payment Program</a> <a href="#">EHR Incentive Program/Meaningful Use</a> <a href="http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Meaningful_Use.html">http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Meaningful_Use.html</a> <a href="#">Physician Quality Reporting System</a> <a href="http://www.cms.gov/PQRS">http://www.cms.gov/PQRS</a>

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

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

Physician Quality Reporting System (PQRS) is sponsored by Centers for Medicare and Medicaid Services. 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). EPs must satisfactorily report data on quality measures for covered Physician Fee Schedule (PFS) services furnished to Medicare Part B Fee-for-Service (FFS) beneficiaries in order to be eligible for an incentive payment. More information about PQRS is available at the following link: <http://www.cms.gov/PQRS>. In 2013, NQF#0419 was the top reported measure within PQRS, with 17,216,626 valid instances covering 42.4% of denominator applicable cases, 23.4% of eligible Medicare beneficiaries, and 16.8% of eligible Tax Identification Numbers (TINs)/ National Provider Identifications (NPIs). Invalid reporting (denominator mismatches due to incorrect HCPCS or CPT codes) accounted for 5.2% of total submissions.

The Medicare and Medicaid EHR Incentive Programs (commonly referred to, collectively, as the Meaningful Use program) are also sponsored by Centers for Medicare and Medicaid Services. The Medicare and Medicaid EHR Incentive Programs provide financial incentives for the meaningful use of certified EHR technology to improve patient care. EPs, eligible hospitals, and critical access hospitals are required to report clinical quality measures (CQMs) during each year of participation in order to receive an incentive payment. More information about the Meaningful Use program is available at the following link: [http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Meaningful\\_Use.html](http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Meaningful_Use.html). The rate of EPs who report this measure as part of the Meaningful Use program has increased from 3.4% of participating EPs in 2010 to 16.8% of participating EPs in 2013.

Many types of providers/specialists report this measure as part of the PQRS, including Agencies/Hospitals/Nursing and Treatment Facilities, Allergy/Immunology, Anesthesiology, Audiologist, Cardiology, Certified Nurse Midwives, Chiropractor, Clinical Nurse Specialists, Colon/Rectal Surgery, Counselor/Psychologist, Critical Care, Dentist, Dermatology, Dietitian/Nutritionist, Emergency Medicine, Endocrinology, Family Practice, Gastroenterology, General Practice, General Surgery, Geriatrics, Hand Surgery, Infectious Disease, Internal Medicine, Interventional Radiologist, Nephrology, Neurology, Neurosurgery, Nuclear Medicine, Nurse Anesthetist, Nurse Practitioner, Obstetrics/Gynecology, Oncology/Hematology, Ophthalmology, Optometry, Oral/Maxillofacial Surgery, Orthopaedic Surgery, Other Eligible Professionals, Other MD/DO, Otolaryngology, Pathology, Pediatrics, Physical Medicine, Physical/Occupational Therapy, Physician Assistant, Plastic Surgery, Podiatrist, Psychiatry, Pulmonary Disease, Radiation Oncology, Radiologist, Registered Nurse, Rheumatology, Social Worker, Thoracic/Cardiac Surgery, Urology, and Vascular Surgery.

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

N/A

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

N/A

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

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

For both claims and registry specifications and eMeasure specifications:

Performance results to those being measured during implementation of this measure have occurred in two ways: (1) Quality and Resource Use Reports (QRURs) feedback reports and (2) Merit-based Incentive Payment System (MIPS) quality benchmarks. QRUR feedback reports are confidential feedback reports provided by the Centers for Medicare & Medicaid Services (CMS) to every group practice and solo practitioner nationwide. These reports show how physician, physician assistants (PAs), nurse practitioners (NPs), clinical nurse specialists (CNSs), and certified registered nurse anesthetists (CRNAs) in groups and solo practitioners performed on quality and cost measures relative to national benchmarks and indicate if physicians, PAs, NPs, CNSs, and CRNAs will receive an upward, neutral or downward Value Modifier adjustment to their payments for items and services rendered.

Performance measure feedback reports also contain important information about care delivered to Medicare beneficiaries that can be used to better understand quality and cost performance and that can be used to improve quality and better coordinate care, including information about the hospital and other providers that see your patients.

When a clinician or group submits measures for the Merit-based Incentive Payment System (MIPS) quality performance category, each measure is assessed against its benchmark to determine how many points the measure earns. Benchmarks are specific to the type of submission mechanism: Qualified Clinical Data Registries (QCDRs), Qualified Registries, Electronic Health Records (EHRs), CMS Web Interface, CMS-approved survey vendor (for the Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys), and Claims. In order to measure performance that is comparable across the spectrum of performance, benchmarks are established using historical data. Benchmarks (either historical or performance period benchmarks) are based on actual performance data from 2016 that was submitted to the Physician Quality Reporting System (PQRS) in 2017. The 2018 benchmarks for this measure are available <https://qpp.cms.gov/mips/explore-measures/quality-measures?py=2018#measures>.

For claims and registry based measures, assistance with interpretation is provided through the Quality Payment Program (QPP) Service Now help desk for eligible clinicians and providers to receive assistance and ask questions about claims and registry based measures.

For eMeasure specifications, the QPP supports a measure issues tracking system known as the ONC Project Tracking System or JIRA. The system is hosted by the Health and Human Services Office of National Coordinator for Health Information Technology (ONC) and provides internal and external users a common place to discuss measure related issues. Specifically, the eCQM Issue Tracker allows eligible clinicians, providers, vendors, or others implementing eCQMs to ask questions about the measure and receive assistance with interpretation of eCQMs.

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

For both claims and registry specifications and eMeasure specifications:

The QRUR feedback report was last made available on September 18, 2017, for 2016 performance. Reports for subsequent reporting years will be available from the QPP website on an annual basis. Authorized representatives of groups and solo practitioners can access the annual QRURs and QPP feedback reports and file an informal review on the CMS Enterprise Portal using an Enterprise Identify Data Management (EIDM) account with the correct role. The MIPS quality performance benchmarks are published annually and were last published for program year 2018. Benchmark information is publicly available.

For claims and registry based measures, providers or eligible clinicians can communicate questions with the QPP help desk via phone, fax, or email and receive responses and guidance regarding quality measures.

For eMeasure specifications, providers or eligible clinicians can communicate questions with the ONC Project Tracking System or JIRA using this web based program by logging in and submitting a ticket or email [onc-jira-questions@healthit.gov](mailto:onc-jira-questions@healthit.gov). JIRA also provides contact information for the QPP Information Center via phone, or email so that guidance or assistance can be provided to those implementing eCQMs.

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

**Describe how feedback was obtained.**

For both claims and registry specifications and eMeasure specifications:

Individual eligible professionals (EPs) and group practices have received feedback reports on whether they satisfactorily reported this measure. More information about the feedback reports that providers received can be found at the following link:

<https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/2016-QRUR.html>

For claims and registry based measures, feedback obtained from measure implementers via QPP help desk consists of information pertaining to measure coding additions and deletions as well as guidance to interpreting the measure intent. Additionally, the QPP help desk shares questions that may involve measure changes with the measure developer as they are received.

For eMeasure specifications, through various measure related issue tracker projects on JIRA, issue tickets can be created and submitted to be discussed with subject matter experts. Feedback, questions, or requests received through JIRA tickets are tracked for review during the next eCQM annual update cycle. More information about the ONC Project Tracking System, JIRA can be found at the following link: <https://oncprojecttracking.healthit.gov/>. Feedback obtained from measure implementers via JIRA consists of information pertaining to value set coding additions and deletions, measure logic, and guidance to interpreting the measure intent. Additionally, JIRA shares questions that may involve measure changes with the measure developer as they are received.

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

For claims and registry based measures, through the QPP help desk, those that report these measures have provided feedback related to measure coding, measure guidance, and measure interpretation that has been reviewed and given consideration to for potential measure changes. Feedback obtained through the help desk is taken under consideration during annual measure updates.

For eMeasure specifications, those that report these measures have provided feedback related to measure logic, coding within the measures value sets, measure guidance, and measure interpretation that has been reviewed and given consideration to for potential measure changes. Feedback obtained through JIRA is taken under consideration during annual measure updates. For example, from the review of the JIRA/QPP tickets, provider attestation emerged as the dominant topic related to provider burden. The team received multiple questions from providers requesting clarification on defining and documenting medication attestation.

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

For both claims and registry specifications and eMeasure specifications:

The Expert Work Group (EWG) reviews the measure specification, related evidence, and any related measure issues or feedback on an annual basis, offering general guidance and making determinations regarding any updates to the measure specification. Experts continue to support this measure and provide feedback as needed.

For claims and registry based measures, through the QPP help desk, those that report these measures have provided feedback related to measure coding, measure guidance, and measure interpretation that has been reviewed and given consideration to for potential measure changes.

For eMeasure specifications, those that report these measures have provided feedback related to measure logic, coding within the measures value sets, measure guidance, and measure interpretation that has been reviewed and given consideration to for potential measure changes. Feedback obtained through JIRA is taken under consideration during annual measure updates.

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

For claims and registry based measures, questions or feedback received from the QPP help desk are considered and discussed with an Expert Work Group (EWG) or Technical Expert Panel (TEP) on an annual basis and revisions to measure specifications are made accordingly.

For eMeasure specifications, questions or feedback received from JIRA are considered and discussed with an Expert Work Group (EWG) or Technical Expert Panel (TEP) on an annual basis and revisions to measure specifications are made accordingly.

**Improvement**

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

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



If no improvement was demonstrated, what are the reasons? If not in use for performance improvement at the time of initial endorsement, provide a credible rationale that describes how the performance results could be used to further the goal of high-quality, efficient healthcare for individuals or populations.

N/A

#### **4b2. Unintended Consequences**

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

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

No unintended consequences have been identified in the measure's testing or implementation as part of PQRS and the Medicare and Medicaid EHR Incentive program.

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

### **5. Comparison to Related or Competing Measures**

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

#### **5. Relation to Other NQF-endorsed Measures**

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

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

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

N/A

#### **5a. Harmonization of Related Measures**

The measure specifications are harmonized with related measures;

**OR**

The differences in specifications are justified

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

**Are the measure specifications harmonized to the extent possible?**

No

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

NQF 0553 is the most similar conceptually to NQF 0419. NQF 0553 is a process measure that focuses solely on the elderly population (namely, those 66 years and older) and requires evidence of at least one medication review during the entire measurement year. Our measure (NQF 0419) encompasses a larger population (all adults 18 years of age and older) and requires a medication review at every encounter. Unlike NQF 0419, there is no e Measure available for NQF 0553. Although completing and documenting a medication review at every visit is more burdensome on physician practices, NQF 0419 provides more rigorous assessment of quality of care, as more frequent medication reviews allows for more rapid identification of medication discrepancies and is more likely to prevent adverse drug events. NQF 0554 is a process measure focused on the elderly population (namely, those 66 years and older) that requires medication reconciliation within 30 days for patients discharged from the hospital. NQF 0419 is different from this measure in the following ways: (1) the population focus for NQF 0419 is inclusive of all patients 18 years and

older, not just those 66 years and older discharged from an inpatient setting; (2) the medication list to be reviewed and documented at each visit for NQF 0419, not just a single visit within 30 days after a patient's discharge; and (3) NQF 0419 focuses on updating the patients medication list from any source and is not limited to the specific process of medication reconciliation. In addition, NQF 0554 does not include an e Measure version. Although completing and documenting a medication review at every visit is more burdensome on physician practices, NQF 0419 provides more rigorous assessment of quality of care, as more frequent medication reviews allows for more rapid identification of medication discrepancies and is more likely to prevent adverse drug events. NQF 0097 is a process measure that reflects follow-up care following discharge from an inpatient setting for patients aged 18 years and older (performance is stratified into two age groups: patients 18-65 and patients 65 and older) who are discharged from any inpatient facility. This measure requires that medication reconciliation be conducted if the patient is seen within 30 days of discharge following an inpatient hospitalization. NQF 0097 is only reported if a patient receives follow-up care within 30 days following discharge from any inpatient setting. NQF 0419 is different from this measure in the following ways: (1) the population of focus for NQF 0419 is inclusive of all patients 18 years and older, not just those discharged from an inpatient setting; (2) the medication list to be reviewed and documented at each visit for NQF 0419, not just a single visit within 30 days after a patient's discharge; and (3) NQF 0419 focuses on updating the patients medication list from any source and is not limited to the specific process of medication reconciliation. In addition, NQF 0419 is appropriate for reporting by any EP and must be reported for every eligible encounter. Lastly, NQF 0097 does not include an e Measure version. Although completing and documenting a medication review at every visit is more burdensome on physician practices, NQF 0419 provides more rigorous assessment of quality of care, as more frequent medication reviews allows for more rapid identification of medication discrepancies and is more likely to prevent adverse drug events.

#### 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.)**

N/A

## 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:** [Appendix\\_A1\\_NQF\\_0419\\_2015\\_Re-endorsement-635640905942577736.pdf](#)

## Contact Information

**Co.1 Measure Steward (Intellectual Property Owner):** Centers for Medicare & Medicaid Services

**Co.2 Point of Contact:** Helen, Dollar-Maples, [Helen.Dollar-Maples@cms.hhs.gov](mailto:Helen.Dollar-Maples@cms.hhs.gov), 410-786-7214-

**Co.3 Measure Developer if different from Measure Steward:** Quality Insights of Pennsylvania

**Co.4 Point of Contact:** Anita, Somplasky, [asomplasky@wvmi.org](mailto:asomplasky@wvmi.org), 877-346-6180-7852

## 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.**

**Current Expert Panel Members:** Documentation of Current Medications in the Medical Record:

Mirean Coleman, MSW, LCSW, CT

Social Work National Association for Social Workers

Senior Practice Associate

Washington, DC

Mona Counts, PhD, CRNP, FNAP, FAANP, TEP Chair Nursing  
The Pennsylvania State University  
Elouise Ross Eberly Professor of Nursing  
University Park, PA

Denise Dougherty, MA, CCC-SLP, MFT  
Speech-Language Pathology  
The Arijah Children's Foundation, Consultant  
Indiana, PA

Anne Marie Feretti, Adv. MS, OTR/L, CH Occupational Therapy  
ProActive Physical and Hand Therapy  
President, Partner, Hand Therapy Supervisor  
Bronx, NY

Tracy Murphy, AuD Audiology  
Clinical Audiologist, North Shore Audio-Vestibular Lab  
Buffalo Grove, IL

Katherine C. Nordal, PhD Psychology  
American Psychological Association, Executive Director for Professional Practice Washington, DC

Heather Smith, PT, MPH Physical Therapy  
Program Director of Quality American Physical Therapy Association  
Alexandria, VA

Through a collaborative process, the TEP reviews measure specifications annually (description, numerator, denominator, definitions, and clinical recommendation statement). Recently, TEP members were given the opportunity to review recent testing results, environmental scan, and both measure specifications as discussed in this form. Any recommendations and feedback received is strongly considered.

#### **Measure Developer/Steward Updates and Ongoing Maintenance**

**Ad.2 Year the measure was first released:** 2008

**Ad.3 Month and Year of most recent revision:** 09, 2014

**Ad.4 What is your frequency for review/update of this measure?** Annually

**Ad.5 When is the next scheduled review/update for this measure?** 05, 2015

#### **Ad.6 Copyright statement:** Claims and Registry Copyright Statement:

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