



## 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 #: 0421**

**Corresponding Measures:**

**De.2. Measure Title:** Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan

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

**De.3. Brief Description of Measure:** Percentage of patients aged 18 years and older with a BMI documented during the current encounter or during the previous twelve months AND with a BMI outside of normal parameters, a follow-up plan is documented during the encounter or during the previous twelve months of the current encounter

Normal Parameters: Age 18 years and older BMI  $\geq 18.5$  and  $< 25$  kg/m<sup>2</sup>

**1b.1. Developer Rationale:** This measure addresses the importance of BMI measurement and follow-up when the measurement is outside of normal parameters. Both obesity and underweight continue to have a negative impact on the health and well-being of adults. Literature shows a performance gap among clinicians with regard to recommending exercise and physical activity to adults with obesity.

#### BMI Above Normal Parameters

CDC has found, using 2009 data, that all states lagged behind the Healthy People 2010 obesity target of 15%. In the United States, the prevalence of self-reported obesity among adults in 2009 was 26.7%, which has increased 1.1 percentage points from 2007 (CDC, 2010). Data from 2012 show that over one-third (34.9%) of adults are obese as defined by BMI, with the highest rate (39.5%) among middle-aged adults ages 40–59. The prevalence of obesity is higher among black adult women (56.6%) compared with 37.1% of black adult men (Ogden, 2013).

Screening for BMI and follow-up therefore is critical to closing this gap and contributes to quality goals of population health and cost reduction. Despite the high prevalence of obesity and its related costs, less than 50% of obese adults in 2010 received advice to exercise or perform physical activity (Barnes & Schoenborn, 2012). However, due to concerns for other underlying conditions, such as bone health or nutrition related deficiencies, providers are cautioned to use clinical judgment when considering weight management programs for overweight patients, especially the elderly (NHLBI, 1998).

#### BMI Below Normal Parameters

On the other end of the body weight spectrum is underweight (BMI  $< 18.5$  kg/m<sup>2</sup>), which is equally detrimental to population health. Patients can become underweight due to poor nutrition or underlying health conditions (Fryar, 2012). When compared to normal-weight individuals (BMI 18.5–25 kg/m<sup>2</sup>), underweight individuals have been found to have significantly higher death rates with a hazard ratio of 2.27 (95% confidence interval = 1.78, 2.90) (Borrell, 2014). Results from the 2007–2010 National Health and Nutrition Examination Survey (NHANES), indicates that an estimated 1.7% of U.S. adults ages 20 and over are considered underweight, with women more likely to be underweight than men. Data from 2007–2008 estimates the prevalence of underweight among women ages 20 and over to be 2.4% and men 1.0% (Fryar, 2012). Although being underweight is less prevalent, losing weight involuntary can lead to muscle wasting, decreased immunity, depression, increased rate of disease complications, and ultimately death especially in elderly patients (Huffman, 2002). A history and physical examination, including BMI, is essential to determine underweight and the treatment to follow (Huffman, 2002). Treatment is centered on preventing any further weight loss with contributions of dietitians, speech therapists (for oropharyngeal and swallowing evaluations) and social services being an important aspect to strategize and implement nutritional support to prevent further weight loss (Huffman, 2002). In conclusion, patients should be equally screened for weight at both ends of the spectrum, and if they are found to be underweight, encouraged to follow up for nutritional support.

**S.4. Numerator Statement:** Patients with a documented BMI during the encounter or during the previous twelve months, AND when the BMI is outside of normal parameters, a follow-up plan is documented during the encounter or during the previous twelve months of the current encounter.

**S.6. Denominator Statement:** All patients aged 18 and older on the date of the encounter with at least one eligible encounter during the measurement period

**S.8. Denominator Exclusions:** Not Eligible for BMI Calculation or Follow-Up Plan (Denominator Exclusion) – A patient is not eligible if one or more of the following reasons are documented:

Patients receiving palliative care on the date of the current encounter or any time prior to the current encounter

Patients who are pregnant on the date of the current encounter or any time during the measurement period prior to the current encounter

Patients who refuse measurement of height and/or weight or refuse follow-up on the date of the current encounter or any time during the measurement period prior to the current encounter

Patients with a documented BMI outside normal limits and a documented reason for not completing BMI follow-up plan during the current encounter or within the previous 12 months of the current encounter (Denominator Exception):

Patients with a documented Medical Reason. The Medical Reason exception could include, but is not limited to, the following patients as deemed appropriate by the health care provider

Elderly Patients (65 or older) for who weight reduction/weight gain would complicate other underlying health conditions such as the following examples:

- Illness or physical disability
- Mental illness, dementia, confusion
- Nutritional deficiency, such as vitamin/mineral deficiency

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, 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:** Jan 17, 2017

**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

[NQF\\_0421\\_-2828\\_3039-\\_MeasSubm\\_Evidence\\_Form-636023611388550935.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.*

This measure addresses the importance of BMI measurement and follow-up when the measurement is outside of normal parameters. Both obesity and underweight continue to have a negative impact on the health and well-being of adults. Literature shows a performance gap among clinicians with regard to recommending exercise and physical activity to adults with obesity.

#### BMI Above Normal Parameters

CDC has found, using 2009 data, that all states lagged behind the Healthy People 2010 obesity target of 15%. In the United States, the prevalence of self-reported obesity among adults in 2009 was 26.7%, which has increased 1.1 percentage points from 2007 (CDC, 2010). Data from 2012 show that over one-third (34.9%) of adults are obese as defined by BMI, with the highest rate (39.5%) among middle-aged adults ages 40–59. The prevalence of obesity is higher among black adult women (56.6%) compared with 37.1% of black adult men (Ogden, 2013).

Screening for BMI and follow-up therefore is critical to closing this gap and contributes to quality goals of population health and cost reduction. Despite the high prevalence of obesity and its related costs, less than 50% of obese adults in 2010 received advice to exercise or perform physical activity (Barnes & Schoenborn, 2012). However, due to concerns for other underlying conditions, such as bone health or nutrition related deficiencies, providers are cautioned to use clinical judgment when considering weight management programs for overweight patients, especially the elderly (NHLBI, 1998).

#### BMI Below Normal Parameters

On the other end of the body weight spectrum is underweight (BMI < 18.5 kg/m<sup>2</sup>), which is equally detrimental to population health. Patients can become underweight due to poor nutrition or underlying health conditions (Fryar, 2012). When compared to normal-weight individuals (BMI 18.5–25 kg/m<sup>2</sup>), underweight individuals have been found to have significantly higher death rates with a hazard ratio of 2.27 (95% confidence interval = 1.78, 2.90) (Borrell, 2014). Results from the 2007–2010 National Health and Nutrition Examination Survey (NHANES), indicates that an estimated 1.7% of U.S. adults ages 20 and over are considered underweight, with women more likely to be underweight than men. Data from 2007–2008 estimates the prevalence of underweight among women ages 20 and over to be 2.4% and men 1.0% (Fryar, 2012). Although being underweight is less prevalent, losing weight involuntary can lead to muscle wasting, decreased immunity, depression, increased rate of disease complications, and ultimately death especially in elderly patients (Huffman, 2002). A history and physical examination, including BMI, is essential to determine underweight and the treatment to follow (Huffman, 2002). Treatment is centered on preventing any further weight loss with contributions of dietitians, speech therapists (for oropharyngeal and swallowing evaluations) and social services being an important aspect to strategize and implement nutritional support to prevent further weight loss (Huffman, 2002). In conclusion, patients should be equally screened for weight at both ends of the spectrum, and if they are found to be underweight, encouraged to follow up for nutritional support.

**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.

Provider-level performance scores suggest that there are still gaps in care and opportunities for improvement.

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

2011–59.9% (2.7% of eligible professionals reporting)

2012–57.5% (5.9% of eligible professionals reporting)

2013–57.8% (10.7% of eligible professionals reporting)

2014–60.7% (19.2% of eligible professionals reporting)

\*From the 2014 PQRS Reporting Experience Report and Appendix

Claims submitted 1/1/2014 through 12/31/2014

Number of Providers 67,715

Number of reported claims 11,643,511

Average Unweighted Score 70.0%

Average Weighted Score 68.1%

Standard deviation 32.8%

Minimum 0%

Interquartile range 56.6%  
10th percentile 24.8%  
20th percentile 39.1%  
30th percentile 47.8%  
40th percentile 60.0%  
Median 84.6%  
60th percentile 98.4%  
70th percentile 100.0%  
80th percentile 100.0%  
90th percentile 100.0%  
Maximum 100.0%

Registry submitted 1/1/2014 through 12/31/2014  
Number of Providers 19,087  
Number of reported patients 160,188  
Average Unweighted Score 66.3%  
Average Weighted Score 59.8%  
Standard deviation 31.1%  
Minimum 0.0%  
Interquartile range 56.5  
10th percentile 21.8%  
20th percentile 37.7%  
30th percentile 47.5%  
40th percentile 57.6%  
Median 70.9%  
60th percentile 83.6%  
70th percentile 95.6%  
80th percentile 100.0%  
90th percentile 100.0%  
Maximum 100.0%

**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.**

N/A

**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, age, rural/urban, underserved/non-underserved, and region. Examining aggregate performance rates may identify disparities in performance.

Aggregate performance rates by patient age, race, and sex using 11,495,018 Medicare claims from 1/1/2014 to 12/31/2014 are included below. Medicare claims do not provide data on patients’ insurance status, socioeconomic status, and/or disability status. These results represent only those providers who voluntarily reported this measure and may not be generalizable to the population of all eligible providers.

Age Groups  
18–64: 54.4%  
65–79: 69.6%  
80+: 73.2%

(X<sup>2</sup> = 201,509; df: 2; N: 11,495,018; p < 0.0001)

Race

Unknown: 68.3%

White: 68.7%

Black: 59.8%

Other: 72.7%

Asian: 78.3%

Hispanic: 70.7%

North American Native: 61.9%

(X<sup>2</sup> = 45,987; df: 6; N: 11,495,018; p < 0.0001)

Sex

Female: 66.7%

Male: 70.0%

(X<sup>2</sup>: 14,388.3; df: 1; N: 11,495,018; p < 0.0001)

**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**

N/A

## 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):

Health and Functional Status : Obesity, Primary Prevention, Screening

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

Elderly, Populations at Risk, Populations at Risk : Dual eligible beneficiaries, Populations at Risk : Individuals with multiple chronic conditions, Populations at Risk : Veterans

**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://qpp.cms.gov/mips/explore-measures/quality-measures?py=2019#measures>

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

This is not an eMeasure Attachment:

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

Attachment Attachment: NQF\_0421\_QI\_128\_AU2019\_Coding\_Table\_S2b.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.

During 2018 annual update for the 2019 performance year several changes were made to the measure specification in accordance with the 2016 American Association of Clinical Endocrinologists (AACE) and American College of Endocrinology (ACE) Comprehensive Clinical Practice Guidelines for Medical Care of Patients with Obesity Guidelines and expert panel input. The following updates were made: BMI measurements greater than or equal to 25kg/m<sup>2</sup> should be used to initiate further evaluation of overweight or obesity after taking into account age, gender, ethnicity, fluid status, and muscularity; therefore, clinical evaluation and judgment must be used when BMI is employed as the anthropometric indicator of excess adiposity, particularly in athletes and those with sarcopenia. Additionally, added overweight and underweight categories. Updated clinical recommendations to include when evaluating patients for adiposity related disease risk, waist circumference should be measured in all patients with BMI greater than 35 kg/m<sup>2</sup>. Added waist circumference cutoff points used in the United States to indicate increased risk are greater or equal to 102 cm (greater than 40 inches) for men and greater or equal to 88 cm (greater than 35 inches) for women. Lifestyle/Behavioral Therapy for Overweight and Obesity was updated and to include behavioral interventions that enhance adherence to prescriptions for a reduced-calorie meal plan and increased physical activity (behavioral interventions can include: self-monitoring of weight, food intake, and physical activity; clear and reasonable goal-setting; education pertaining to obesity, nutrition, and physical activity; face-to-face and group meetings; stimulus control; systematic approaches for problem solving; stress reduction; cognitive restructuring [i.e., cognitive behavioral therapy], motivational interviewing; behavioral contracting; psychological counseling; and mobilization of social support structures) and behavioral lifestyle intervention should be tailored to a patient's ethnic, cultural, socioeconomic, and educational background. In accordance with the 2016 AACE/ACE guidelines, the follow-up plan was updated to include lifestyle/behavioral therapy. The instructions were updated to include a reminder for providers to review the exclusions and exceptions criteria to determine those patients that BMI measurement may not be appropriate or necessary. Clarification was added to the denominator exclusion regarding patients who refuse measurement of height and or weight or refuse follow-up can occur any time during the measurement period prior to the current encounter. The rationale was updated to reflect current literature findings. The expert work group recommended adding the following denominator codes to accommodate nursing facility and other assistive living type encounters: 99236, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99315, 99316, 99318, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99339, 99340, 99401, 99402, G0473.

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

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

Patients with a documented BMI during the encounter or during the previous twelve months, AND when the BMI is outside of normal parameters, a follow-up plan is documented during the encounter or during the previous twelve months of the current encounter.

**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).*

Instructions include the following:

There is no diagnosis associated with this measure.

This measure is to be submitted a minimum of once per performance period for patients seen during the performance period.

This measure may be submitted by Merit-based Incentive Payment System (MIPS) eligible clinicians who perform the quality actions described in the measure based on the services provided at the time of the qualifying visit and the measure-specific denominator coding.

The BMI may be documented in the medical record of the provider or in outside medical records obtained by the provider. If the most recent documented BMI is outside of normal parameters, then a follow-up plan is documented during the encounter or during the previous twelve months of the current encounter.

The documented follow-up plan must be based on the most recent documented BMI outside of normal parameters, example: "Patient referred to nutrition counseling for BMI above or below normal parameters" (See Definitions for examples of follow-up plan treatments). If more than one BMI is submitted during the measurement period, the most recent BMI will be used to determine if the performance has been met.

Review the exclusions and exceptions criteria to determine those patients that BMI measurement may not be appropriate or necessary.

Definitions:

BMI – Body mass index (BMI), is a number calculated using the Quetelet index: weight divided by height squared (W/H<sup>2</sup>) and is commonly used to classify weight categories. BMI can be calculated using:

Metric Units: BMI = Weight (kg) / (Height (m) × Height (m))

OR

English Units: BMI = Weight (lbs) / (Height (in) × Height (in)) × 703

Follow-Up Plan – Proposed outline of treatment to be conducted as a result of a BMI out of normal parameters. A follow-up plan may include but is not limited to: documentation of education, a referral (e.g., a registered dietitian nutritionist, occupational therapist, physical therapist, primary care provider, exercise physiologist, mental health professional, or surgeon), pharmacological interventions, dietary supplements, exercise counseling, and/or nutrition counseling.

Numerator Quality-Data Coding Options:

BMI not Documented, Patient not Eligible

Denominator Exclusion: G8422: BMI not documented, documentation the patient is not eligible for BMI calculation

OR

BMI Documented Outside of Normal Limits, Follow-up Plan not Documented, Patient not Eligible

Denominator Exclusion: G8938: BMI is documented as being outside of normal limits, follow-up plan is not documented, documentation the patient is not eligible

OR

BMI Documented as Normal, No Follow-Up Plan Required

Performance Met: G8420: BMI is documented within normal parameters and no follow-up plan is required

OR

BMI Documented as Above Normal Parameters, AND Follow-Up Documented

Performance Met: G8417: BMI is documented above normal parameters and a follow-up plan is documented

OR

BMI Documented as Below Normal Parameters, AND Follow-Up Documented

Performance Met: G8418: BMI is documented below normal parameters and a follow-up plan is documented

OR

BMI Documented Outside of Normal Limits, Follow-Up Plan not Completed for Documented Reason

Denominator Exception: G9716: BMI is documented as being outside of normal limits, follow-up plan is not completed for documented reason

OR

BMI not Documented, Reason not Given

Performance Not Met: G8421: BMI not documented and no reason is given

OR

BMI Documented Outside of Normal Parameters, Follow-Up Plan not Documented, Reason not Given

Performance Not Met: G8419: BMI documented outside normal parameters, no follow-up plan documented, no reason given

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

All patients aged 18 and older on the date of the encounter with at least one eligible encounter during the measurement period



**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).

Denominator Criteria (Eligible Cases):

Patients aged ≥18 years on date of encounter

AND

Patient encounter during the performance period (CPT or HCPCS): 90791, 90792, 90832, 90834, 90837, 96150, 96151, 96152, 97161, 97162, 97163, 97165, 97166, 97167, 97802, 97803, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99236, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99315, 99316, 99318, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99339, 99340, 99385\*, 99386\*, 99387\*, 99395\*, 99396\*, 99397\*, 99401, 99402, D7140, D7210, G0101, G0108, G0270, G0271, G0402, G0438, G0439, G0447, G0473

WITHOUT

Telehealth Modifier: GQ, GT, 95, POS 02

\*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.

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

Not Eligible for BMI Calculation or Follow-Up Plan (Denominator Exclusion) – A patient is not eligible if one or more of the following reasons are documented:

Patients receiving palliative care on the date of the current encounter or any time prior to the current encounter

Patients who are pregnant on the date of the current encounter or any time during the measurement period prior to the current encounter

Patients who refuse measurement of height and/or weight or refuse follow-up on the date of the current encounter or any time during the measurement period prior to the current encounter

Patients with a documented BMI outside normal limits and a documented reason for not completing BMI follow-up plan during the current encounter or within the previous 12 months of the current encounter (Denominator Exception):

Patients with a documented Medical Reason. The Medical Reason exception could include, but is not limited to, the following patients as deemed appropriate by the health care provider

Elderly Patients (65 or older) for who weight reduction/weight gain would complicate other underlying health conditions such as the following examples:

Illness or physical disability

Mental illness, dementia, confusion

Nutritional deficiency, such as vitamin/mineral deficiency

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.)

Performance exclusion

BMI not Documented, Patient not Eligible

Denominator Exclusion: G8422: BMI not documented, documentation the patient is not eligible for BMI calculation

OR

BMI Documented Outside of Normal Limits, Follow-up Plan not Documented, Patient not Eligible

Denominator Exclusion: G8938: BMI is documented as being outside of normal limits, follow-up plan is not documented, documentation the patient is not eligible

**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.)

No stratification.



**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.)

PERFORMANCE CALCULATION

To calculate provider performance, complete a fraction with the following measure components: Numerator (A), Performance Denominator (PD), Denominator Exclusions (B) and Denominator Exceptions (C).

Definitions:

Numerator (A): Number of patients meeting numerator criteria

Performance Denominator (PD): Number of patients meeting criteria for denominator inclusion

Denominator Exclusions (B): Number of patients with valid exclusions

Denominator Exceptions (C): Number of patients with valid exceptions

1) Identify the patients who meet the eligibility criteria for the performance denominator (PD) 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 patients with valid denominator exclusions (B) and subtract from performance denominator (PD).

3) Identify which of those patients meet the numerator (A) criteria.

4) For those patients who do not meet the numerator criteria, determine whether appropriate denominator exception(s) apply (C) and subtract those patients from the performance denominator (PD).

5) Calculate performance with the following:

Numerator (A)/ [Performance Denominator (PD) – Denominator Exclusions (B) – 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.

No sampling

**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.

Measure is not based on a survey or patient-reported data

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

If other, please describe in S.18.

Claims, 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.

N/A

**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.)

No composite

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

[NQF3039\\_Measure\\_Testing\\_Form.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)

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 a combination of electronic sources

**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:**

**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.

Given our experiences with this measure's use in current CMS quality reporting programs, we have found that providers find the measure feasible to report, and that its reporting is facilitated by the availability of QDCs in claims and registry data. (Eligible professionals report QDCs on claims to identify encounters that meet or fail to meet performance, or are ineligible or excluded from performance.) Since we have found this measure to be feasible, we made no modifications to it as a result of recent testing.

**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)

**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

The Physician Quality Reporting System (PQRS) is sponsored by Centers for Medicare & 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 <http://www.cms.gov/PQRS>.

According to the 2014 PQRS Reporting Experience, in 2014, this measure was one of the top five reported measures within PQRS: 104,996 EPs (19.1% of all eligible entities) reported the measure.

**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.**

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. The 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 collection: Qualified Clinical Data Registries (QCDRs), MIPS Clinical Quality Measures (MIPS CQMs), eCQMs, CMS Web Interface measures, the Consumer Assessment of Healthcare Providers and Systems (CAHPS) for MIPS survey, and Part B Claims measures. In order to measure performance that is comparable across the spectrum of performance, benchmarks are established using historical data. Historical benchmarks are based on actual performance data from 2017 that was submitted to the Quality Payment Program (QPP) in 2017, except for the CAHPS surveys. For 2019 CAHPS for MIPS, we have not yet established benchmarks.

The 2019 benchmarks for this measure are available <https://qpp.cms.gov/mips/explore-measures/quality-measures?py=2019#measures>.

Assistance with interpretation is provided through the QPP Service Now help desk for eligible clinicians and providers to receive assistance and ask questions about claims and registry based measures.

**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.**

The QRUR feedback report for 2019 is available from the QPP website and will continue to be available 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 are currently published for program year 2019. 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.

**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.**

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>  
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.

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

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.

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

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.

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.

**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.**

Questions or feedback received from the QPP help desk are considered and discussed with a EWG on an annual basis and revisions to measure specifications are made accordingly. The following issues were received and discussed with the expert workgroup included patient refusal of BMI, denominator exclusion, and adding nursing facility and assisted living facility type codes to the measure.

**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.**

The average performance rate has not improved over the past four years (from 59.9% in 2011 to 60.7% in 2014); however, the frequency with which the measure is being reported has increased significantly (from 2.7% of EPs in 2011 to 19.2% in 2014). This makes it difficult to assess trends over time, as the EPs who recently began reporting the measure may have lower performance rates than those who have been reporting it for a longer period of time. Although the reporting has increased each year, there are still a substantial number of EPs who are not reporting the measure, and the average performance rate illustrates that there is still a gap in care. In addition, EPs submit this performance data voluntarily, and it may not be representative of all EPs.

**4b2. Unintended Consequences**

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

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

We have not identified any unintended consequences in our recent testing, or in the measure's implementation.

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

## 5. Comparison to Related or Competing Measures

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

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

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

Yes

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

0023 : Body Mass Index (BMI) in adults > 18 years of age

0024 : Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)

0024 : Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)

0689 : Percent of Residents Who Lose Too Much Weight (Long Stay)

1349 : Child Overweight or Obesity Status Based on Parental Report of Body-Mass-Index (BMI)

1349 : Child Overweight or Obesity Status Based on Parental Report of Body-Mass-Index (BMI)

2601 : Body Mass Index Screening and Follow-Up for People with Serious Mental Illness

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

- Body Mass Index (BMI) in adults > 18 years of age: City of New York Department of Health and Mental Hygiene Steward by City of New York Department of Health and Mental Hygiene (Previously NQF 0023, endorsement removed with last update in 2012)

- Healthy Physical Development by 18 Years of Age: National Committee for Quality Assurance Steward by National Committee for Quality Assurance (Previously NQF 1514, endorsement removed with last update in 2014)

### 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 0024 - Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC) has a similar, but not identical, measure focus. First, NQF0024 requires counseling for nutrition and physical activity based on the results of the weight assessment, while our measure allows for greater provider discretion when selecting the best type of follow-up. NQF0024 also has a different target population (children and adolescents aged 3-17, rather than adults 18 and older). Both are process measures focused on Ambulatory Care: Clinician Office/Clinic settings, but our measure is also appropriate for other settings of care (for instance, Outpatient Rehabilitation, Behavioral Health/Psychiatric: Outpatient, Home Health, and Other.) NQF1349 - Child Overweight or Obesity Status Based on Parental Report of Body Mass Index (BMI) has a similar measure focus, but differs in target population (is specific to children and adolescents aged 10-17, rather than adults 18 and older), the calculation of BMI (is based on parent-reported height and weight of the child rather than actual BMI value), the measure uses CDC BMI-for-age guidelines in attributing overweight and obesity status (85th–94th percentile up to 95th-and-above percentile rather than specific parameters to classify obesity from AHA/ACC/TOS and the National Heart, Lung and Blood Institute (NHLBI) clinical guidelines). Last, NQF1349 does not require documentation of a recommendation for follow-up for under or overweight findings whereas our measure requires that a follow up plan be documented for any BMI outside normal range. NQF1349 is an outcome measure, and the care setting is identified as other. Our measure is a process measure, but it is also appropriate for other settings of care (for instance, NQF3039 is also appropriate for Outpatient Rehabilitation, Behavioral Health/Psychiatric: Outpatient, Home Health, and Other.) NQF2601 - Body Mass Index Screening and Follow-up for People with Serious Mental Illness shares a similar measure focus (BMI and Screening and Follow-up) and target population (18 years and older.) However, NQF2601 is specific to patients with a serious mental illness,



whereas NQF3039 is not specific to a certain illness and incorporates the general population. Both are process measures, but our measure is more inclusive than NQF2601. Not only does our measure include all patients, not just those with severe mental illness, but it is also appropriate in other settings of care (for instance, NQF3039 is appropriate for Ambulatory Care: Clinician Office/Clinic, Ambulatory Care: Outpatient Rehabilitation, Behavioral Health/Psychiatric: Outpatient, Home Health, and Other while NQF2601 includes only Ambulatory Care: Clinician Office/Clinic, Behavioral Health/Psychiatric: Outpatient).

#### 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: NQF\\_3039\\_2828\\_NQF\\_Endorsement\\_\\_Summary\\_Materials-636023670540876979.pdf](#)

## Contact Information

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

**Co.2 Point of Contact:** Sophia, Autrey, [Sophia.Autrey@cms.hhs.gov](mailto:Sophia.Autrey@cms.hhs.gov), 410-786-2004-

**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.

Through a collaborative process, the expert workgroup annually reviewed the measure specifications (description, numerator, denominator, definitions, clinical recommendation, and environmental scan).

- Christina K. Biesemeier, MS, RD, LDN, FADA, Clinical Nutritionist, Vanderbilt University
- Mirean Coleman, MSW, LICSW, CT, Social Worker, Independent Practice
- Gregory M. Martino, PhD, Clinical Psychologist, Independent Practice
- Kathleen Niedert, PhD, MBA, RD, CSG, LD, FADA, NAHA, Executive Director, Western Home Communities
- Margaret Ayres, PhD, Physical Therapist, Associate Professor, Thomas Jefferson University's Jefferson School of Health Professions and the Department of Physical Therapy
- Scott Kahan, MD, MPH, Obesity Medicine and Clinical Preventive Medicine Practice, Director of the National Center for Weight and Wellness
- Donna Hargrove, DO, Obstetrics and Gynecology, Independent Practice

### 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, 2015

**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?** 09, 2016



**Ad.6 Copyright statement:** These measures were developed by Quality Insights of Pennsylvania as a special project under the Quality Insights' Medicare Quality Improvement Organization (QIO) contract HHSM-500-2005-PA001C with the Centers for Medicare & Medicaid Services. These measures are in the public domain.

Limited proprietary coding is contained in the measure specifications for convenience. Users of the proprietary code sets should obtain all necessary licenses from the owners of these code sets. Quality Insights of Pennsylvania disclaims all liability for use or accuracy of any Current Procedural Terminology (CPT [R]) or other coding contained in the specifications. CPT® contained in the Measures specifications is copyright 2004-2015 American Medical Association. All Rights Reserved. These performance measures are not clinical guidelines and do not establish a standard of medical care, and have not been tested for all potential applications.

**Ad.7 Disclaimers:** The measure and specification are provided "as is" without warranty of any kind.

**Ad.8 Additional Information/Comments:** N/A