2016 Web Interface Clinical Quality Measure

Quick Reference Guide for CARE-2: Falls: Screening for Future Fall Risk

Intended for informational purposes only. Please refer to the narrative specifications, data guidance, and/or supporting documents for more detailed information on this measure, available at: ***http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/GPRO_Web_Interface.html***

September 2016

Measure Description:

Percentage of patients 65 years of age and older who were screened for future fall risk during the measurement period.

Denominator Exclusions:[1] None
Denominator Exceptions:[2] Medical reasons

WHAT is the Quality Action?

Completion of a fall risk screening. The screening may be done with a formal screening tool as long as it fulfills the fall history documentation requirements.

WHO may perform the Quality Action?

Any healthcare professional reporting this measure may document measure information received from the patient, authorized representative(s), caregiver(s) or other available healthcare resources.

WHEN must the Quality Action be performed?

The screening must take place within the measurement period.

What are the DOCUMENTATION REQUIREMENTS relative to the Quality Action?

The patient's medical record must contain:

- Documentation of whether the patient has been assessed for a history of falls or any fall with injury. Documentation of no falls is sufficient;

or

- Documentation of the reason why the Quality Action is not performed due to an exception (see Data Guidance for specific medical reason exceptions).

NOTE: Although not required, screening may be done with any formal screening tool as long as it fulfills the fall history documentation requirements.

The Centers for Medicare & Medicaid Services established a Shared Savings Program where Accountable Care Organizations (ACOs) coordinate to improve the quality of care for Medicare Fee-For-Service beneficiaries and reduce unnecessary costs. This series of Quick Reference Guides highlights different aspects of ACO quality data reporting and collection, an essential part of the Shared Savings Program.

Measure Logic (see the CARE-2 flow charts for additional information)

Confirm Patient Qualified Options

- Yes (*patient included in the denominator – continue to Screening for Future Fall Risk*)
- No - Other CMS Approved Reason [*requested through help desk ticket – **if CMS approval received**, stop abstraction – patient removed from CARE-2 sample (skipped) and replaced with another patient]*

Screening for Future Fall Risk Options

- No (*patient does not meet numerator criteria)*
- Yes *(patient meets numerator criteria)*
- No - Denominator Exception - Medical Reasons *(patient removed from denominator)*

[1] When “Exclusions” are documented in the medical record, the abstraction stops for that patient for that measure and the patient is skipped and replaced by the next consecutive patient in the Web Interface.

[2] When “Exceptions” are documented in the medical record, the abstraction stops for that patient for that measure and the patient is removed from the denominator without replacement by another patient.

2016 Web Interface
Clinical Quality Measure

Quick Reference Guide for CARE-3: Documentation of Current Medications in the Medical Record

Intended for informational purposes only. Please refer to the narrative specifications, data guidance, and/or supporting documents for more detailed information on this measure, available at: ***http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/GPRO_Web_Interface.html***

September 2016

Measure Description:

Percentage of visits for patients aged 18 years and older for which the eligible professional 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.

Denominator Exclusions:[1] None
Denominator Exceptions:[2] Medical reasons

WHAT is the Quality Action?

Documenting, updating or reviewing the patient's current medications using all immediate resources available on the date of the encounter. This documentation must include each medication's name, dosage, frequency, and route of administration.[3]

Current medication(s) are defined as all medications the patient is presently taking including:

- All prescription medications,
- Over-the-counter (OTC) medications,
- Herbal medications,
- Vitamin, mineral, or dietary (nutritional) supplements

If the patient is not currently taking any medications, that should be documented in the medical record.

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WHO may perform the Quality Action?

Eligible professionals reporting this measure may document measure information received from the patient, authorized representative(s), caregiver(s) or other available healthcare resources.

WHEN must the Quality Action be performed?

This measure is to be reported for every pre-filled (in the Web Interface) encounter during the measurement period.

What are the DOCUMENTATION REQUIREMENTS relative to the Quality Action?

The patient's medical record must contain the following for each visit:

- A dated list of all of the patient's current medications, including each medication's name, dosage, frequency, and route of administration;

or

- Indication that the patient is not currently taking any medications;

or

- Documentation of the reason why the Quality Action is not performed due to an exception (see Data Guidance for specific medical reason exceptions).

Measure Logic (see the CARE-3 flow charts for additional information)

Confirm Patient Qualified Options

- Yes (*continue to Patient Seen in Office/Clinic Visit Date*)
- No - Other CMS Approved Reason *[requested through help desk ticket – **if CMS approval received**, stop abstraction – patient removed from CARE-3 sample (skipped) and replaced with another patient]*

Patient Seen in Office/Clinic Visit Date Options (repeat for each pre-filled visit)

- No *(stop abstraction for this visit – visit not included in denominator – continue to next visit date for this patient, if applicable)*
- Yes (*visit included in denominator – continue to Current Medications Documented for this visit*)

Current Medications Documented Options

- No *(stop abstraction – visit does not meet numerator criteria*
- Yes *(visit meets numerator criteria)*
- No - Denominator Exception - Medical Reasons *(visit removed from denominator)*

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[1] When "Exclusions" are documented in the medical record, the abstraction stops for that patient for that measure and the patient is skipped and replaced by the next consecutive patient in the Web Interface.

[2] When "Exceptions" are documented in the medical record, the abstraction stops for that patient for that measure and the patient is removed from the denominator without replacement by another patient.

[3] Route is defined as the way the medication enters the body (some examples include, but are not limited to: oral, sublingual, subcutaneous injections, and/or topical).

2016 Web Interface Clinical Quality Measure

Quick Reference Guide for CAD-7: Coronary Artery Disease: Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy - Diabetes or Left Ventricular Systolic Dysfunction (LVEF < 40%)

Intended for informational purposes only. Please refer to the narrative specifications, data guidance, and/or supporting documents for more detailed information on this measure, available at: ***http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/GPRO_Web_Interface.html***

September 2016

Measure Description:

Percentage of patients aged 18 years and older with a diagnosis of coronary artery disease seen within a 12 month period who also have diabetes OR a current or prior Left Ventricular Ejection Fraction (LVEF) < 40% who were prescribed ACE inhibitor or ARB therapy.

Denominator Exclusions:[1] None
Denominator Exceptions:[2] Medical reasons, patient reasons, or system reasons

WHAT is the Quality Action?

Prescription of either ACE inhibitor or ARB therapy.

WHO may perform the Quality Action?

Any eligible professional with prescribing authority may prescribe ACE inhibitor or ARB therapy.

WHEN must the Quality Action be performed?

The prescription of either ACE inhibitor or ARB therapy must be documented as either initiated or continued during the measurement period.

The Centers for Medicare & Medicaid Services established a Shared Savings Program where Accountable Care Organizations (ACOs) coordinate to improve the quality of care for Medicare Fee-For-Service beneficiaries and reduce unnecessary costs. This series of Quick Reference Guides highlights different aspects of ACO quality data reporting and collection, an essential part of the Shared Savings Program.

What are the DOCUMENTATION REQUIREMENTS relative to the Quality Action?

The patient's medical record must contain:

- An active diagnosis of coronary artery disease or history of cardiac surgery;

and

- An active diagnosis of diabetes and/or LVEF *less than* 40% (or documentation of moderate or severe LVSD) at any time in their history, up through the last day of the measurement period;

and

- An active prescription for ACE inhibitor or ARB therapy at any time during the measurement period;

or

- Documentation of the reason why the Quality Action is not performed due to an exception (see Data Guidance for specific medical, patient or system reason exceptions).

<u>Measure Logic (see the CAD-7 flow charts for additional information)</u>

Confirm Active Diagnosis of Coronary Artery Disease/History of Cardiac Surgery Options

- Yes *(continue to Diabetes or LVSD)*
- Not Confirmed-Diagnosis *[stop abstraction – patient removed from CAD sample (skipped) and replaced with another patient]*
- No-Other CMS Approved Reason *[requested through help desk ticket – **if CMS approval received**, stop abstraction – patient removed from CAD sample (skipped) and replaced with another patient]*

Diabetes or LVSD Options

- No *[stop abstraction – patient removed from denominator (skipped) and replaced with another patient]*
- Yes *(patient is included in the denominator – continue to ACE/ARB Therapy)*

ACE/ARB Therapy Options

- No *(patient does not meet numerator criteria)*
- Yes *(patient meets numerator criteria)*
- No - Denominator Exception - Medical Reasons *(patient removed from denominator)*
- No - Denominator Exception - Patient Reasons *(patient removed from denominator)*
- No - Denominator Exception - System Reasons *(patient removed from denominator)*

[1] When "Exclusions" are documented in the medical record, the abstraction stops for that patient for that measure and the patient is skipped and replaced by the next consecutive patient in the Web Interface.

[2] When "Exceptions" are documented in the medical record, the abstraction stops for that patient for that measure and the patient is removed from the denominator without replacement by another patient.

2016 Web Interface Clinical Quality Measure

Quick Reference Guide for DM-2: Diabetes: Hemoglobin A1c Poor Control

Intended for informational purposes only. Please refer to the narrative specifications, data guidance, and/or supporting documents for more detailed information on this measure, available at: ***http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/GPRO_Web_Interface.html***

DM-7 is one of two component measures comprising the DM Composite (All or Nothing Scoring)

September 2016

Measure Description:

Percentage of patients 18 – 75 years of age with diabetes who had hemoglobin A1c > 9.0% during the measurement period.

Denominator Exclusions:[1] None
Denominator Exceptions:[2] None

WHAT is the Quality Action?

Performance of an HbA1c test and documentation of its result. The patient meets the numerator criteria if the most recent HbA1c level is *greater than* 9.0% OR the test result is missing OR the HbA1c test was not done.

Note*:* This is an inverse measure where a lower score indicates better quality.

WHO may perform the Quality Action?

Any qualified healthcare professional may obtain the HbA1c test and record its result.

WHEN must the Quality Action be performed?

The HbA1c test must be performed, and its results documented, within the measurement period. If there is more than one HbA1c test performed, use the most recent.

What are the DOCUMENTATION REQUIREMENTS relative to the Quality Action?

The patient's medical record must contain:

- A diagnosis of diabetes;

and

- The date and value of the HbA1c test.

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Measure Logic (see the DM flow charts for additional information)

Confirm History or Active Diagnosis of Diabetes Options

- Yes *(patient included in the denominator – continue to HbA1c Test)*
- Not Confirmed-Diagnosis [*stop abstraction – patient removed from DM sample (skipped) and replaced with another patient]*
- No - Other CMS Approved Reason *[requested through help desk ticket – **if CMS approval received**, stop abstraction – patient removed from DM sample (skipped) and replaced with another patient]*

HbA1c Test Options

- No *(patient meets numerator criteria)*
- Yes
    - *enter most recent HbA1c date*
    - *enter most recent HbA1c value*

NOTE: Patient with value greater than 9 OR no test performed OR missing value meets numerator criteria. Patient with value equal to or less than 9 does not meet numerator criteria.

[1] When “Exclusions” are documented in the medical record, the abstraction stops for that patient for that measure and the patient is skipped and replaced by the next consecutive patient in the Web Interface.

[2] When “Exceptions” are documented in the medical record, the abstraction stops for that patient for that measure and the patient is removed from the denominator without replacement by another patient.

2016 Web Interface Clinical Quality Measure

Quick Reference Guide for DM-7: Diabetes: Eye Exam

Intended for informational purposes only. Please refer to the narrative specifications, data guidance, and/or supporting documents for more detailed information on this measure, available at: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/GPRO_Web_Interface.html

DM-7 is one of two component measures comprising the DM Composite (All or Nothing Scoring)

September 2016

Measure Description:

Percentage of patients 18 – 75 years of age with diabetes who had retinal or dilated eye exam by an eye care professional during the measurement period or a negative retinal exam (no evidence of retinopathy) in the 12 months prior to the measurement period.

Denominator Exclusions:[1] None
Denominator Exceptions:[2] None

WHAT is the Quality Action?

Performance of a retinal or dilated eye exam. Retinal imaging is also acceptable if reviewed by an appropriate professional, as described below.

WHO may perform the Quality Action?

The eye exam must be performed or results reviewed by an optometrist or ophthalmologist.

NOTE: The measure permits the use of retinal imaging provided it includes the date the fundus photography was performed and evidence that an eye care professional (optometrist or ophthalmologist) reviewed the results. Alternatively, results may be read by a qualified reading center that operates under the direction of a medical director who is a retinal specialist.

For example, if an endocrinologist or PCP performs the appropriate imaging in their office and the results are reviewed by an eye care professional (optometrist or ophthalmologist) during the measurement period or the year prior to the measurement period (if negative for retinopathy) then it is eligible for use in reporting.

WHEN must the Quality Action be performed?

The retinal or dilated eye exam can occur during the measurement period (2016) OR a negative retinal exam (no evidence of retinopathy) can occur in the year prior to the measurement period (2015).

What are the DOCUMENTATION REQUIREMENTS relative to the Quality Action?

The patient's medical record must contain:

- A diagnosis of diabetes;

and

- Evidence a retinal or dilated eye exam was performed by an eye care processional and the date it was performed during the measurement period. If a retinal or dilated eye exam was not performed during the measurement period but was performed the year prior to the measurement period and the results were negative, the date and result of that eye exam;

or

- If retinal imaging was performed, the date imaging was performed and evidence that it was reviewed by an eye care professional.

<u>Measure Logic (see the DM flow charts for additional information)</u>

Confirm History or Active Diagnosis of Diabetes Options

- Yes *(patient included in the denominator – continue to Eye Exam)*
- Not Confirmed-Diagnosis *[stop abstraction – patient removed from DM sample (skipped) and replaced with another patient]*
- No - Other CMS Approved Reason *[requested through help desk ticket – **if CMS approval received**, stop abstraction – patient removed from DM sample (skipped) and replaced with another patient]*

Eye Exam *Options*

- No *(patient does not meet numerator criteria)*
- Yes *(patient meets numerator criteria)*

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[2] When "Exceptions" are documented in the medical record, the abstraction stops for that patient for that measure and the patient is removed from the denominator without replacement by another patient.

2016 Web Interface Clinical Quality Measure

Quick Reference Guide for HF-6: Heart Failure: Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)

Intended for informational purposes only. Please refer to the narrative specifications, data guidance, and/or supporting documents for more detailed information on this measure, available at: ***http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/GPRO_Web_Interface.html***

September 2016

Measure Description:

Percentage of patients aged 18 years and older with a diagnosis of heart failure (HF) with a current or prior left ventricular ejection fraction (LVEF) < 40% who were prescribed beta-blocker therapy either within a 12 month period when seen in the outpatient setting OR at each hospital discharge.

Denominator Exclusions:[1] None
Denominator Exceptions:[2] Medical reasons, patient reasons, or system reasons

WHAT is the Quality Action?

Prescription of beta-blocker therapy. Beta-blocker therapy is limited to the prescription of bisoprolol, carvedilol, sustained release metoprolol succinate, or their brand name equivalents.

NOTE: Within the RxNorm terminology, "metoprolol succinate extended release" is identified as "metoprolol tartrate extended release." You will note that metoprolol tartrate alone, meaning not the extended release form, is not included in the medication list.

WHO may perform the Quality Action?

Any eligible professional with prescribing authority may prescribe the beta-blocker therapy.

WHEN must the Quality Action be performed?

The prescription for beta-blocker therapy must be either initiated or continued during the measurement period.

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What are the DOCUMENTATION REQUIREMENTS relative to the Quality Action?

The patient's medical record must contain:

- An active diagnosis of heart failure;

and

- LVEF of *less than* 40% (or documentation of moderate or severe LVSD) at any time in the patient's history, up through the last day of the measurement period;

and

- An active prescription for beta-blocker therapy at any time during the measurement period;

or

- Documentation of the reason why the Quality Action is not performed due to an exception (see Data Guidance for specific medical, patient or system reason exceptions).

<u>Measure Logic (see the HF-6 flow charts for additional information)</u>

Confirm Active Diagnosis of Heart Failure Options

- Yes *(continue to LVSD)*
- Not Confirmed-Diagnosis *[stop abstraction – patient removed from HF sample (skipped) and replaced with another patient]*
- No - Other CMS Approved Reason *[requested through help desk ticket – **if CMS approval received**, stop abstraction – patient removed from HF sample (skipped) and replaced with another patient]*

LVSD Options

- No *[stop abstraction – patient removed from HF sample (skipped) and replaced with another patient]*
- Yes *(patient included in the denominator – continue to Beta-Blocker Therapy)*

Beta-Blocker Therapy Options

- No *(patient does not meet numerator criteria)*
- Yes *(patient meets numerator criteria)*
- No - Denominator Exception - Medical Reasons *(patient removed from denominator)*
- No - Denominator Exception - Patient Reasons *(patient removed from denominator)*
- No - Denominator Exception - System Reasons *(patient removed from denominator)*

[1] When "Exclusions" are documented in the medical record, the abstraction stops for that patient for that measure and the patient is skipped and replaced by the next consecutive patient in the Web Interface.

[2] When "Exceptions" are documented in the medical record, the abstraction stops for that patient for that measure and the patient is removed from the denominator without replacement by another patient.

2016 Web Interface
Clinical Quality Measure

Quick Reference Guide for HTN-2: Hypertension: Controlling High Blood Pressure

Intended for informational purposes only. Please refer to the narrative specifications, data guidance, and/or supporting documents for more detailed information on this measure, available at: ***http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/GPRO_Web_Interface.html***

September 2016

Measure Description:

Percentage of patients 18 – 85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90 mmHg) during the measurement period.

Denominator Exclusions:[1] Dialysis or renal transplant before or during the measurement period; ESRD, chronic kidney disease stage 5, or pregnancy during the measurement period
Denominator Exceptions:[2] None

WHAT is the Quality Action?

Performance of a blood pressure reading and documentation of its result. A result of *less than* 140 mmHg and *less than* 90 mmHg is required for numerator inclusion (in control).

WHO may perform the Quality Action?

Any qualified healthcare professional may take the patient's blood pressure. Patient reported blood pressure readings, including readings directly from home monitoring devices, are not acceptable.

WHEN must the Quality Action be performed?

The blood pressure must be taken and the value recorded during the measurement period. If there is more than one blood pressure reading, use the most recent.

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What are the DOCUMENTATION REQUIREMENTS relative to the Quality Action?

The patient's medical record must contain:

- A diagnosis of essential hypertension within the first six months of the measurement period or at any time prior to the measurement period but does not end before the start of the measurement period;

and

- The date and value of the most recent systolic and diastolic blood pressure readings. If there are multiple blood pressure readings on the same date of service, use the lowest systolic and lowest diastolic pressures on that date;

or

- Documentation of exclusion criteria.

<u>Measure Logic (see the HTN-2 flow charts for additional information)</u>

Confirm Diagnosis of Essential Hypertension Options

- Yes *(patient included in the denominator – continue to Blood Pressure Measurement)*
- Not Confirmed - Diagnosis *[stop abstraction – patient removed from HTN sample (skipped) and replaced with another patient]*
- Denominator Exclusion *[stop abstraction – patient removed from HTN sample (skipped) and replaced with another patient]*
- No - Other CMS Approved Reason *[requested through help desk ticket – **if CMS approval received**, stop abstraction – patient removed from HTN sample (skipped) and replaced with another patient]*

Blood Pressure Documented Options

- No *(patient does not meet numerator criteria)*
- Yes
    - *enter most recent systolic and diastolic blood pressure date*
    - *enter most recent systolic and diastolic blood pressure values*

NOTE: Patient with values less than 140 and less than 90 meets numerator criteria. Patient with values greater than or equal to 140 or greater than or equal to 90 does not meet numerator criteria.

[1] When "Exclusions" are documented in the medical record, the abstraction stops for that patient for that measure and the patient is skipped and replaced by the next consecutive patient in the Web Interface.

[2] When "Exceptions" are documented in the medical record, the abstraction stops for that patient for that measure and the patient is removed from the denominator without replacement by another patient.

2016 Web Interface Clinical Quality Measure

Quick Reference Guide for IVD-2: Ischemic Vascular Disease: Use of Aspirin or Another Antithrombotic

Intended for informational purposes only. Please refer to the narrative specifications, data guidance, and/or supporting documents for more detailed information on this measure, available at: ***http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/GPRO_Web_Interface.html***

September 2016

Measure Description:

Percentage of patients 18 years of age and older who were discharged alive for acute myocardial infarction (AMI), coronary artery bypass graft (CABG) or percutaneous coronary interventions (PCI) in the 12 months prior to the measurement period, or who had an active diagnosis of ischemic vascular disease (IVD) during the measurement period, and who had documentation of use of aspirin or another antithrombotic during the measurement period.

Denominator Exclusions:[1] None
Denominator Exceptions:[2] None

WHAT is the Quality Action?

Prescription of aspirin or another antithrombotic.

WHO may perform the Quality Action?

Any eligible professional with prescribing authority may prescribe the use of aspirin or another antithrombotic. In addition to aspirin, antithrombotic medications may include: clopidogrel, a combination of aspirin and extended release dipyridamole, Prasugrel, Ticagrelor, and Ticlopidine.

WHEN must the Quality Action be performed?

The prescription for aspirin or another antithrombotic must be either initiated or continued during the measurement period.

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What are the DOCUMENTATION REQUIREMENTS relative to the Quality Action?

The patient's medical record must contain:

- An active diagnosis of ischemic vascular disease during the measurement period or discharged alive for AMI, CABG or PCI during the 12 months prior to the measurement period;

and

- An active prescription for aspirin or another antithrombotic at anytime during the measurement period.

<u>Measure Logic (see the IVD-2 flow charts for additional information)</u>

Confirm Active Diagnosis of Ischemic Vascular Disease or Patient Discharged Alive for AMI, CABG or PCI Options

- Yes *(patient included in the denominator – continue to Aspirin/Antithrombotic Therapy)*
- Not Confirmed-Diagnosis *[stop abstraction – patient removed from IVD sample (skipped) and replaced with another patient]*
- No - Other CMS Approved Reason *[requested through help desk ticket – **if CMS approval received**, stop abstraction – patient removed from IVD sample (skipped) and replaced with another patient]*

Aspirin/Antithrombotic Therapy Options

- No *(patient does not meet numerator criteria)*
- Yes *(patient meets numerator criteria)*

[1] When "Exclusions" are documented in the medical record, the abstraction stops for that patient for that measure and the patient is skipped and replaced by the next consecutive patient in the Web Interface.

[2] When "Exceptions" are documented in the medical record, the abstraction stops for that patient for that measure and the patient is removed from the denominator without replacement by another patient.

2016 Web Interface Clinical Quality Measure

Quick Reference Guide for MH-1: Depression Remission at Twelve Months

Intended for informational purposes only. Please refer to the narrative specifications, data guidance, and/or supporting documents for more detailed information on this measure, available at: ***http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/GPRO_Web_Interface.html***

September 2016

Measure Description:

Adult patients age 18 and older with major depression or dysthymia and an initial PHQ-9 score > 9 who demonstrate remission at twelve months defined as PHQ-9 score less than 5. This measure applies to both patients with newly diagnosed and existing depression whose current PHQ-9 score indicates a need for treatment.

Denominator Exclusions:[1] Permanent nursing home residents or active diagnosis of bipolar or personality disorder
Denominator Exceptions:[2] None

WHAT is the Quality Action?

Remission attained at 12 months (+/- 30 days) from the index date. Remission is defined as a PHQ-9 score *less than* 5. The index date is defined as the date of the first PHQ-9 score *greater than* 9 that occurs between 12/1/2014 and 11/30/2015.

A follow-up PHQ-9 score *less than* 5 is considered numerator compliant. If more than one PHQ-9 score was obtained between the 11 and 13 month window, select the most recent PHQ-9 date and score within that window.

WHO may perform the Quality Action?

Any designee of the beneficiary's provider may administer the screening tool.

WHEN must the Quality Action be performed?

An initial PHQ-9 score *greater than* 9 between 12/1/2014 and 11/30/2015. A follow-up PHQ-9 score *less than* 5 at 12 months (+/- 30 days) from the index date.

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What are the DOCUMENTATION REQUIREMENTS relative to the Quality Action?

The patient's medical record must contain:

- A diagnosis of major depression or dysthymia;

and

- A PHQ-9 score *greater than* 9 between 12/1/2014 and 11/30/2015;

and

- A follow-up PHQ-9 score *less than* 5 at 12 months (+/- 30 days) after the initial PHQ-9 score *greater than* 9. If there is more than one PHQ-9 score obtained between the 11 and 13 month window, select the most recent PHQ-9 date and score within that window;

or

- Documentation of exclusion criteria.

Measure Logic (see the MH-1 flow charts for additional information)

Confirm Active Diagnosis of Major Depression or Dysthymia Options

- Yes *(continue to Index PHQ-9 administered)*
- Not Confirmed - Diagnosis *[stop abstraction – patient removed from MH-1 sample (skipped) and replaced with another patient]*
- Denominator Exclusion *[stop abstraction – patient removed from MH-1 sample (skipped) and replaced with another patient]*
- No - Other CMS Approved Reason *[requested through help desk ticket – **if CMS approval received**, stop abstraction – patient removed from MH-1 sample (skipped) and replaced with another patient]*

Index PHQ-9 Administered Options

- No *[stop abstraction – patient removed from MH-1 sample (skipped) and replaced with another patient]*
- Yes *(continue to PHQ-9 Score >9)*

Index PHQ-9 Score >9 Options

- No *[stop abstraction – patient removed from MH-1 sample (skipped) and replaced with another patient]*
- Yes *(patient included in the denominator – continue to Assessment PHQ-9 administered)*
    - *enter the date of the first PHQ-9 score greater than 9*
    - *enter the score of the first PHQ-9*

Assessment PHQ-9 Administered Options

- *No (patient does not meet numerator criteria)*
- *Yes (continue to Assessment PHQ-9 <5)*

Assessment PHQ-9 <5 Options

- *No (patient does not meet numerator criteria)*
- *Yes (patient meets numerator criteria)*
    - *enter the date of the most recent PHQ-9 score less than 5*
    - *enter the score of the most recent PHQ-9*

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[1] When "Exclusions" are documented in the medical record, the abstraction stops for that patient for that measure and the patient is skipped and replaced by the next consecutive patient in the Web Interface.

[2] When "Exceptions" are documented in the medical record, the abstraction stops for that patient for that measure and the patient is removed from the denominator without replacement by another patient.

2016 Web Interface Clinical Quality Measure

Quick Reference Guide for PREV-5: Breast Cancer Screening

Intended for informational purposes only. Please refer to the narrative specifications, data guidance, and/or supporting documents for more detailed information on this measure, available at: ***http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/GPRO_Web_Interface.html***

November 2016

Measure Description:

Percentage of women 50 through 74 years of age who had a mammogram to screen for breast cancer within 27 months.

Denominator Exclusions:[1] A bilateral mastectomy or evidence of two unilateral mastectomies
Denominator Exceptions:[2] None

WHAT is the Quality Action?

A mammogram to screen for breast cancer.

NOTE**:** 3D mammography, MRI, and ultrasound are not considered acceptable breast cancer screening for this measure's numerator. However, if the patient received a 3D mammography you may request CMS approval to select "Other CMS Approved Reason". This will remove the patient from the measure (i.e., the patient will be "skipped" and replaced with another patient from the sample). Note that such a request must be submitted in a helpdesk ticket which will be reviewed by CMS. CMS will respond to your inquiry to confirm whether or not they have approved your request, and this response will include a HelpDesk ticket resolution number. This resolution number must be entered into the Web Interface.

WHO may perform the Quality Action?

Any qualified healthcare professional may perform the mammogram.

WHEN must the Quality Action be performed?

The mammogram must be performed during the measurement period, or 27 months prior to the end of the measurement period (October 1, 2014 – December 31, 2016); however, it may not precede the patient's 50th birthday.

The Centers for Medicare & Medicaid Services established a Shared Savings Program where Accountable Care Organizations (ACOs) coordinate to improve the quality of care for Medicare Fee-For-Service beneficiaries and reduce unnecessary costs. This series of Quick Reference Guides highlights different aspects of ACO quality data reporting and collection, an essential part of the Shared Savings Program.

What are the DOCUMENTATION REQUIREMENTS relative to the Quality Action?

The patient's medical record must contain:

- Date the mammogram was performed and results;

or

- Documentation of exclusion criteria.

NOTE**:** NCQA, the measure developer, has stated the 27 month look-back period does not apply to patients aged 50. For patients that are 51 years of age during the measurement period, look back only to age 50. Please see supporting documents for further guidance which are available on the GPRO Web Interface webpage.

The measure steward has clarified that documentation of "abnormal" or "normal" results is considered sufficient documentation of mammography results.

Measure Logic (see the PREV-5 flow charts for additional information)

Confirm Patient Qualified Options

- Yes *(patient included in the denominator – continue to Breast Cancer Screening)*
- Denominator Exclusion *[stop abstraction – patient removed from PREV-5 sample (skipped) and replaced with another patient]*
- No - Other CMS Approved Reason *[requested through help desk ticket – **if CMS approval received**, stop abstraction – patient removed from PREV-5 sample (skipped) and replaced with another patient]*

Breast Cancer Screening Options

- No *(patient does not meet numerator criteria)*
- Yes *(patient meets numerator criteria)*

[1] When "Exclusions" are documented in the medical record, the abstraction stops for that patient for that measure and the patient is skipped and replaced by the next consecutive patient in the Web Interface.

[2] When "Exceptions" are documented in the medical record, the abstraction stops for that patient for that measure and the patient is removed from the denominator without replacement by another patient.

2016 Web Interface Clinical Quality Measure

Quick Reference Guide for PREV-6: Colorectal Cancer Screening

Intended for informational purposes only. Please refer to the narrative specifications, data guidance, and/or supporting documents for more detailed information on this measure, available at: ***http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/GPRO_Web_Interface.html***

September 2016

Measure Description:

Percentage of adults 50 – 75 years of age who had appropriate screening for colorectal cancer.

Denominator Exclusions:[1] A diagnosis or past history of total colectomy or colorectal cancer
Denominator Exceptions:[2] None

WHAT is the Quality Action?

An appropriate colorectal cancer screening defined by any one of the following criteria:

- Fecal occult blood test (FOBT) during the measurement period
- Flexible sigmoidoscopy during the measurement period or the four years prior to the measurement period
- Colonoscopy during the measurement period or the nine years prior to the measurement period.

NOTE: Based on the updated USPSTF guidelines (June 2016), the 2016 PREV-6: Colorectal Cancer Screening measure will allow for FIT-DNA screening such as ColoGuard to be considered numerator compliant when reporting via the 2016 GPRO Web Interface. Documented performance of Fecal Immunochemical DNA Testing during the measurement period or two years prior to the measurement period will be numerator compliant.

Also, based on the 2016 guidelines, CT Colonography screening will be considered numerator compliant when reporting via this mechanism.

WHO may perform the Quality Action?

Any qualified healthcare professional may perform the cancer screening.

WHEN must the Quality Action be performed?

The colorectal cancer screening must be current, which is defined by the type of screening administered. Please refer to the "What is the Quality Action" section above for additional details regarding screening intervals that equate to colorectal screening that is current.

The Centers for Medicare & Medicaid Services established a Shared Savings Program where Accountable Care Organizations (ACOs) coordinate to improve the quality of care for Medicare Fee-For-Service beneficiaries and reduce unnecessary costs. This series of Quick Reference Guides highlights different aspects of ACO quality data reporting and collection, an essential part of the Shared Savings Program.

What are the DOCUMENTATION REQUIREMENTS relative to the Quality Action?

The patient's medical record must contain:

- Indication of a current colorectal cancer screening as evidenced by the completion of one of the previously mentioned tests or procedures within its corresponding timeframe and must indicate the date the screening was performed and the result;

or

- Documentation of exclusion criteria.

The measure steward has clarified that documentation of "abnormal" or "normal" results is considered sufficient documentation of colorectal cancer screening results.

Measure Logic (see the PREV-6 flow charts for additional information)

Confirm Patient Qualified Options

- Yes *(patient included in the denominator – continue to Colorectal Cancer Screening)*
- Denominator Exclusion *[stop abstraction – patient removed from PREV-6 sample (skipped) and replaced with another patient]*
- No - Other CMS Approved Reason *[requested through help desk ticket – **if CMS approval received**, stop abstraction – patient removed from PREV-6 sample (skipped) and replaced with another patient]*

Colorectal Cancer Screening Options

- No *(patient does not meet numerator criteria)*
- Yes *(patient meets numerator criteria)*

[1] When "Exclusions" are documented in the medical record, the abstraction stops for that patient for that measure and the patient is skipped and replaced by the next consecutive patient in the Web Interface.

[2] When "Exceptions" are documented in the medical record, the abstraction stops for that patient for that measure and the patient is removed from the denominator without replacement by another patient.

2016 Web Interface Clinical Quality Measure

Quick Reference Guide for PREV-7: Influenza Immunization

Intended for informational purposes only. Please refer to the narrative specifications, data guidance, and/or supporting documents for more detailed information on this measure, available at: ***http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/GPRO_Web_Interface.html***

September 2016

Measure Description:

Percentage of patients aged 6 months and older seen for a visit between October 1 and March 31 who received an influenza immunization OR who reported previous receipt of an influenza immunization.

Denominator Exclusions:[1] None
Denominator Exceptions:[2] Medical reasons, patient reasons, or system reasons

WHAT is the Quality Action?

Receipt of an influenza immunization between August 1, 2015 and March 31, 2016.

WHO may perform the Quality Action?

Any healthcare professional may provide the influenza immunization.

WHEN must the Quality Action be performed?

The influenza immunization must be given between August 1, 2015 and March 31, 2016.

What are the DOCUMENTATION REQUIREMENTS relative to the Quality Action?

The patient's medical record must contain:

- Indication the patient received an influenza immunization between August 1, 2015 and March 31, 2016 (not required if prefilled with "Yes" in the Web Interface);

or

- Documentation of the reason why the Quality Action is not performed due to an exception (See Data Guidance for specific medical, patient or system reason exceptions).

The Centers for Medicare & Medicaid Services established a Shared Savings Program where Accountable Care Organizations (ACOs) coordinate to improve the quality of care for Medicare Fee-For-Service beneficiaries and reduce unnecessary costs. This series of Quick Reference Guides highlights different aspects of ACO quality data reporting and collection, an essential part of the Shared Savings Program.

Measure Logic (see the PREV-7 flow charts for additional information)

Confirm Patient Qualified Options

- Yes *(patient included in the denominator – continue to Influenza Immunization)*
- No - Other CMS Approved Reason [*requested through help desk ticket – **if CMS approval received**, stop abstraction – patient removed from PREV-7 sample (skipped) and replaced with another patient]*

Influenza Immunization Options

- No *(patient does not meet numerator criteria)*
- Yes *(patient meets numerator criteria)*
- No - Denominator Exception - Medical Reasons *(patient removed from denominator)*
- No - Denominator Exception - Patient Reasons *(patient removed from denominator)*
- No - Denominator Exception - System Reasons *(patient removed from denominator)*

[1] When “Exclusions” are documented in the medical record, the abstraction stops for that patient for that measure and the patient is skipped and replaced by the next consecutive patient in the Web Interface.

[2] When “Exceptions” are documented in the medical record, the abstraction stops for that patient for that measure and the patient is removed from the denominator without replacement by another patient.

2016 Web Interface Clinical Quality Measure

Quick Reference Guide for PREV-8: Pneumonia Vaccination Status for Older Adults

Intended for informational purposes only. Please refer to the narrative specifications, data guidance, and/or supporting documents for more detailed information on this measure, available at: ***http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/GPRO_Web_Interface.html***

September 2016

Measure Description:

Percentage of patients 65 years of age and older who have ever received a pneumococcal vaccine.

Denominator Exclusions:[1] None
Denominator Exceptions:[2] None

WHAT is the Quality Action?

Receipt of a pneumococcal vaccine.

WHO may perform the Quality Action?

Any healthcare professional may provide the pneumococcal vaccine.

WHEN must the Quality Action be performed?

The pneumococcal vaccination may occur at any time in the patient's history, but must be prior to the end of the measurement period.

What are the DOCUMENTATION REQUIREMENTS relative to the Quality Action?

The patient's medical record must contain:

- Documentation of receipt of a pneumococcal vaccine.
  - The medical record should state the year (up through the last day of the measurement period) and type of pneumococcal vaccine provided
  - If patient reported prior to 2015, documentation indicating receipt of a pneumococcal vaccine is sufficient
  - If patient reported in 2015 or 2016, documentation indicating the year of the vaccination and confirmation of the type as PPSV23 or PCV13 is required

The Centers for Medicare & Medicaid Services established a Shared Savings Program where Accountable Care Organizations (ACOs) coordinate to improve the quality of care for Medicare Fee-For-Service beneficiaries and reduce unnecessary costs. This series of Quick Reference Guides highlights different aspects of ACO quality data reporting and collection, an essential part of the Shared Savings Program.

NOTE**:** While the measure provides credit for adults 65 years of age and older who have ever received either the PCV13 or PPSV23 vaccine (or both) to adults 65 years of age and older, according to ACIP recommendations, patients should receive both vaccines. The order and timing of the vaccinations depends on certain patient characteristics, and are described in more detail in the ACIP recommendations.

Measure Logic (see the PREV-8 flow charts for additional information)

Confirm Patient Qualified Options

- Yes *(patient included in the denominator – continue to Pneumococcal Vaccination)*
- No - Other CMS Approved Reason *[requested through help desk ticket – **if CMS approval received**, stop abstraction – patient removed from PREV-8 sample (skipped) and replaced with another patient]*

Pneumococcal Vaccination Options

- No *(patient does not meet numerator criteria)*
- Yes *(patient meets numerator criteria)*

[1] When “Exclusions” are documented in the medical record, the abstraction stops for that patient for that measure and the patient is skipped and replaced by the next consecutive patient in the Web Interface.

[2] When “Exceptions” are documented in the medical record, the abstraction stops for that patient for that measure and the patient is removed from the denominator without replacement by another patient.

2016 Web Interface Clinical Quality Measure

Quick Reference Guide for PREV-9: Body Mass Index (BMI) Assessment and Follow-Up Plan

Intended for informational purposes only. Please refer to the narrative specifications, data guidance, and/or supporting documents for more detailed information on this measure, available at: ***http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/GPRO_Web_Interface.html***

September 2016

Measure Description:

Percentage of patients aged 18 years and older with a BMI documented during the current encounter or during the previous six months AND with a BMI outside of normal parameters, a follow-up plan is documented during the encounter or during the previous six months of the current encounter.

Denominator Exclusions:[1] Pregnancy, medical reasons or patient reasons
Denominator Exceptions:[2] None

WHAT is the Quality Action?

Completion of a BMI screening that is calculated using a patient's height and weight. If the screening is outside of normal parameters, documentation of a follow-up plan is also required.

Normal Parameters are as follows:

- Aged 18 – 64 years: BMI *greater than or equal to* 18.5 and *less than* 25 kg/m2
- Aged 65 years or older: BMI *greater than or equal to* 23 and *less than* 30 kg/m2

Examples of a follow-up plan may include but are not limited to:

- Providing an educational document (e.g., exercise, nutrition, healthy living)
- Referring the patient to another healthcare professional (e.g., dietician, nutritionist, occupational therapist, physical therapist, primary care provider, exercise physiologist, mental health professional, surgeon, etc.)
- Prescribing weight loss medication or dietary supplements
- Providing exercise or nutrition counseling

WHO may perform the Quality Action?

Any healthcare professional may perform a BMI screening and recommend an appropriate follow-up plan. Patient reported values of height, weight, or BMI are not acceptable.

The Centers for Medicare & Medicaid Services established a Shared Savings Program where Accountable Care Organizations (ACOs) coordinate to improve the quality of care for Medicare Fee-For-Service beneficiaries and reduce unnecessary costs. This series of Quick Reference Guides highlights different aspects of ACO quality data reporting and collection, an essential part of the Shared Savings Program.

WHEN must the Quality Action be performed?

The BMI screening must take place during the most recent visit within the measurement period or within the 6 months prior to that visit.

A follow-up plan must be documented during the current visit or within 6 months prior to that visit if the BMI is outside normal parameters.

What are the DOCUMENTATION REQUIREMENTS relative to the Quality Action?

The patient's medical record must contain:

- BMI screening date and results;
- If a follow-up plan is required, documentation of discussion of the plan. The follow-up plan must be specified as an intervention that pertains to the BMI outside of normal parameters;

or

- Documentation of exclusion criteria.

Measure Logic (see the PREV-9 flow charts for additional information)

Confirm Patient Qualified Options

- Yes *(patient included in the denominator – continue to BMI Documented)*
- Denominator Exclusion *[stop abstraction – patient removed from PREV-9 sample (skipped) and replaced with another patient]*
- No - Other CMS Approved Reason [*requested through help desk ticket – **if CMS approval received**, stop abstraction – patient removed from PREV-9 sample (skipped) and replaced with another patient]*

BMI Documented Options

- No *(patient does not meet numerator criteria)*
- Yes (*continue to BMI Within Normal Parameters)*

BMI Within Normal Parameters Options

- No *(continue to Follow-Up Plan)*
- Yes *(patient meets numerator criteria)*

Follow-Up Plan Options

- No *(patient does not meet numerator criteria)*
- Yes *(patient meets numerator criteria)*

[1] When "Exclusions" are documented in the medical record, the abstraction stops for that patient for that measure and the patient is skipped and replaced by the next consecutive patient in the Web Interface.

[2] When "Exceptions" are documented in the medical record, the abstraction stops for that patient for that measure and the patient is removed from the denominator without replacement by another patient.

2016 Web Interface Clinical Quality Measure

Quick Reference Guide for PREV-10: Tobacco Use: Screening and Cessation Intervention

Intended for informational purposes only. Please refer to the narrative specifications, data guidance, and/or supporting documents for more detailed information on this measure, available at: ***http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/GPRO_Web_Interface.html***

September 2016

Measure Description:

Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation counseling intervention if identified as a tobacco user.

Denominator Exclusions:[1] None
Denominator Exceptions:[2] Medical reasons

WHAT is the Quality Action?

Screening for tobacco use at least once within 24 months. For any patient identified as a tobacco user, tobacco cessation intervention must also be provided. Tobacco use includes any type of tobacco.

WHO may perform the Quality Action?

Any healthcare professional may screen for tobacco use.

WHEN must the Quality Action be performed?

The screening for tobacco use must occur within the 24 months prior to the end of the measurement period (1/1/2015 – 12/31/2016). The same time frame also applies for cessation intervention for those patients identified as tobacco users. If there is more than one tobacco screening, use the most recent screening.

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What are the DOCUMENTATION REQUIREMENTS relative to the Quality Action?

The patient's medical record must contain:

- The date and results of a query of the patient's use of tobacco;
- If identified as a tobacco user, documentation of cessation intervention;

or

- Documentation of the reason why the Quality Action is not performed due to an exception (see Data Guidance for specific medical reason exceptions).

NOTE: The USPSTF does not currently classify ENDS (electronic nicotine delivery systems) as tobacco use or as cessation aid.

Measure Logic (see the PREV-10 flow charts for additional information)

Confirm Patient Qualified Options

- Yes *(patient included in the denominator – continue to Tobacco Use Screening)*
- No - Other CMS Approved Reason *[requested through help desk ticket – **if CMS approval received**, stop abstraction – patient removed from PREV-10 sample (skipped) and replaced with another patient]*

Tobacco Use Screening Options

- No *(patient meets numerator criteria)*
- Yes *(continue to Tobacco Cessation Intervention)*
- Not Screened/Unknown *(patient does not meet numerator criteria)*
- No - Denominator Exception - Medical Reasons *(patient removed from denominator)*

Tobacco Cessation Intervention Options

- No *(patient does not meet numerator criteria)*
- Yes *(patient meets numerator criteria)*

[1] When "Exclusions" are documented in the medical record, the abstraction stops for that patient for that measure and the patient is skipped and replaced by the next consecutive patient in the Web Interface.

[2] When "Exceptions" are documented in the medical record, the abstraction stops for that patient for that measure and the patient is removed from the denominator without replacement by another patient.

2016 Web Interface Clinical Quality Measure

Quick Reference Guide for PREV-11: Screening for High Blood Pressure and Follow-up Documented

Intended for informational purposes only. Please refer to the narrative specifications, data guidance, and/or supporting documents for more detailed information on this measure, available at: ***http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/GPRO_Web_Interface.html***

September 2016

Measure Description:

Percentage of patients aged 18 years and older seen during the reporting period who were screened for high blood pressure AND a recommended follow-up plan is documented based on the current blood pressure (BP) reading as indicated.

Denominator Exclusions:[1] Active diagnosis of hypertension
Denominator Exceptions:[2] Medical reasons (BP measurement) or patient reasons (either BP measurement or follow-up)

WHAT is the Quality Action?

Completion of high blood pressure screening, which consists of a systolic and diastolic blood pressure reading. If the screening indicates pre-hypertension or hypertension, a follow-up plan is also required. Blood pressure classifications and the recommended follow-up plans are specified in the Data Guidance.

WHO may perform the Quality Action?

Any healthcare professional may perform a high blood pressure screening. Patient reported blood pressure readings, including readings directly from home monitoring devices, are not acceptable.

WHEN must the Quality Action be performed?

The blood pressure screening must take place during the measurement period. If more than one blood pressure screening is performed, use the most recent. If follow-up is necessary based on the result of the blood pressure screening, the recommended follow-up must be documented during the visit where the screening took place.

NOTE**:** If the blood pressure is pre-hypertensive (SBP *greater than* 120 and *less than* 139 OR DBP *greater than* 80 and *less than* 89) at a PCP encounter no additional follow-up would be needed, this would meet the intent of the measure (select "Yes" to follow-up plan).

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What are the DOCUMENTATION REQUIREMENTS relative to the Quality Action?

The patient's medical record must contain:

- Date and values of the most recent systolic and diastolic blood pressure measurements. If there are multiple blood pressure measurements on the same date of service, use the most recent as the representative blood pressure;
- If a follow-up plan is required, documentation of the plan is also required. The follow-up plan must be specified as an intervention that pertains to the blood pressure measurement;

or

- Documentation of the reason why the Quality Action is not performed due to an exception (see Data Guidance for specific medical or patient reason exceptions);

or

- Documentation of exclusion criteria.

Measure Logic (see the PREV-11 flow charts for additional information):

Confirm Patient Qualified Options

- Yes *(patient included in the denominator – continue to Blood Pressure Screening)*
- Denominator Exclusion [*stop abstraction – patient removed from PREV-11 sample (skipped) and replaced with another patient*]
- No - Other CMS Approved Reason *[requested through help desk ticket – **if CMS approval received**, stop abstraction – patient removed from PREV-11 sample (skipped) and replaced with another patient*]

Blood Pressure Screening Options

- No *(patient does not meet numerator criteria)*
- Yes *(continue to Blood Pressure Within Normal Parameters)*
- No - Denominator Exception - Medical Reasons *(patient removed from denominator)*
- No - Denominator Exception - Patient Reasons *(patient removed from denominator)*

Blood Pressure Within Normal Parameters Options

- No *(continue to Follow-Up Plan)*
- Yes (*patient meets numerator criteria*)

Follow-Up Plan Options

- No *(patient does not meet numerator criteria)*
- Yes *(patient meets numerator criteria)*
- No - Denominator Exception - Patient Reasons *(patient removed from denominator)*

[1] When "Exclusions" are documented in the medical record, the abstraction stops for that patient for that measure and the patient is skipped and replaced by the next consecutive patient in the Web Interface.

[2] When "Exceptions" are documented in the medical record, the abstraction stops for that patient for that measure and the patient is removed from the denominator without replacement by another patient.

2016 Web Interface Clinical Quality Measure

Quick Reference Guide for PREV-12: Screening for Clinical Depression and Follow-up Plan

Intended for informational purposes only. Please refer to the narrative specifications, data guidance, and/or supporting documents for more detailed information on this measure, available at: ***http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/GPRO_Web_Interface.html***

September 2016

Measure Description:

Percentage of patients aged 12 years and older screened for clinical depression on the date of the encounter using an age appropriate standardized depression screening tool AND if positive, a follow-up plan is documented on the date of the positive screen.

Denominator Exclusions:[1] Active diagnosis of depression or bipolar disorder
Denominator Exceptions:[2] Medical reasons or patient reasons

WHAT is the Quality Action?

Completion of a depression screening using an age appropriate standardized (normalized and validated) depression screening tool. If the screening is positive, a follow-up plan is also required.

The following are examples of appropriate depression screening tools:

- Adolescent Screening Tools (12-17 years): Patient Health Questionnaire for Adolescents (PHQ-A), Beck Depression Inventory-Primary Care Version (BDI-PC), Mood Feeling Questionnaire (MFQ), Center for Epidemiologic Studies Depression Scale (CES-D), PHQ-2 and PRIME MD-PHQ-2
- Adult Screening Tools (18 years and older): Patient Health Questionnaire (PHQ-9), Beck Depression Inventory (BDI or BDI-II), Center for Epidemiologic Studies Depression Scale (CES-D), Depression Scale (DEPS), Duke Anxiety-Depression Scale (DADS), Geriatric Depression Scale (GDS), Cornell Scale Screening, PHQ-2 and PRIME MD-PHQ-2

A follow-up plan for a positive screen must contain one or more of the following:

- Additional evaluation for depression
- Suicide risk assessment
- Referral to a practitioner who is qualified to diagnose and treat depression
- Pharmacological interventions
- Other interventions or follow-up for the diagnosis or treatment of depression

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WHO may perform the Quality Action?

A qualified healthcare professional must administer the screening tool.

WHEN must the Quality Action be performed?

The depression screening must be performed during the measurement period. If a follow-up plan is required, it must be documented on the date of the positive screen.

What are the DOCUMENTATION REQUIREMENTS relative to the Quality Action?

The patient's medical record must contain:

- The date and results of a named age appropriate standardized depression screening tool;
- If a follow-up plan is required, documentation of discussion of the plan. The follow-up plan must be specified as an intervention that pertains to depression;

or

- Documentation of the reason why the Quality Action is not performed due to an exception (see Data Guidance for specific medical or patient reason exceptions);

or

- Documentation of exclusion criteria.

NOTE: The results must be reviewed/verified and documented by the eligible professional in the medical record on the date of the encounter to meet the screening portion of this measure.

Measure Logic (see the PREV-12 flow charts for additional information)

Confirm Patient Qualified Options

- Yes *(patient included in the denominator – continue to Clinical Depression Screening)*
- Denominator Exclusion *[stop abstraction – patient removed from PREV-12 sample (skipped) and replaced with another patient]*
- No - Other CMS Approved Reason *[requested through help desk ticket – **if CMS approval received**, stop abstraction – patient removed from PREV-12 sample (skipped) and replaced with another patient]*

Clinical Depression Screening Options

- No *(patient does not meet numerator criteria)*
- Yes *(continue to Positive Depression Screen)*
- No - Denominator Exception - Medical Reasons *(patient removed from denominator)*
- No - Denominator Exception - Patient Reasons *(patient removed from denominator)*

Positive Depression Screen Options

- No *(patient meets numerator criteria)*
- Yes (*continue to Follow-Up Plan*)

Follow-Up Plan Options

- No *(patient does not meet numerator criteria)*
- Yes *(patient meets numerator criteria)*

[1] When “Exclusions” are documented in the medical record, the abstraction stops for that patient for that measure and the patient is skipped and replaced by the next consecutive patient in the Web Interface.

[2] When “Exceptions” are documented in the medical record, the abstraction stops for that patient for that measure and the patient is removed from the denominator without replacement by another patient.

2016 Web Interface Clinical Quality Measure

Quick Reference Guide for PREV-13: Statin Therapy for the Prevention and Treatment of Cardiovascular Disease

Intended for informational purposes only. Please refer to the narrative specifications, data guidance, and/or supporting documents for more detailed information on this measure, available at: ***http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/GPRO_Web_Interface.html***

September 2016

Measure Description:

Percentage of the following patients—all considered at high risk of cardiovascular events—who were prescribed or were on statin therapy during the measurement period:

- Adults aged >= 21 years who were previously diagnosed with or currently have an active diagnosis of clinical atherosclerotic cardiovascular disease (ASCVD); OR
- Adults aged >=21 years with a fasting or direct low-density lipoprotein cholesterol (LDL-C) level >= 190 mg/dL; OR
- Adults aged 40-75 years with a diagnosis of diabetes with a fasting or direct LDL-C level of 70-189 mg/dL.

Denominator Exclusions:[1] None
Denominator Exceptions:[2] Medical reasons

WHAT is the Quality Action?

Prescription for statin therapy.

WHO may perform the Quality Action?

Any eligible professional with prescribing authority may prescribe statin therapy.

WHEN must the Quality Action be performed?

The prescription of statin therapy must be documented as either initiated or continued during the measurement period.

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What are the DOCUMENTATION REQUIREMENTS relative to the Quality Action?

The patient's medical record must contain:

- An active diagnosis of clinical atherosclerotic cardiovascular disease (ASCVD);

or

- A fasting or direct low-density lipoprotein cholesterol (LDL-C) level *greater than or equal to* 190 mg/dL (any time in the patient's history – but prior to the end of the measurement period)

or

- Adults aged 40-75 years with a diagnosis of diabetes with a fasting or direct LDL-C level of 70-189 mg/dL (during the measurement period or two years prior to the beginning of the measurement period);

and

- An active prescription for statin therapy anytime during the measurement period;

or

- Documentation of the reason why the Quality Action is not performed due to an exception (see Data Guidance for specific medical reason exceptions).

<u>Measure Logic (see the PREV-13 flow charts for additional information):</u>

Confirm Diagnosis of ASCVD Options (Risk Category 1)

- Yes *(patient included in the denominator – continue to Statin Therapy)*
- No - Diagnosis *(continue to Risk Category 2)*

LDL-C ≥ 190 mg/dL Options (Risk Category 2)

- Yes *(patient included in the denominator – continue to Statin Therapy)*
- No *(continue to Risk Category 3)*

Patient aged 40-75 with a Diagnosis of Type 1 or 2 Diabetes Options (Risk Category 3)

- Yes *(continue to LDL-C level)*
- No *[stop abstraction – patient removed from PREV-13 sample (skipped) and replaced with another patient]*

LDL-C ≥ 70-89 mg/dL Options (Risk Category 3 continued)

- Yes *(patient included in the denominator – continue to Statin Therapy)*
- No *[stop abstraction – patient removed from PREV-13 sample (skipped) and replaced with another patient]*
- No - Other CMS Approved Reason* *[requested through help desk ticket – **if CMS approval received**, stop abstraction – patient removed from PREV-13 sample (skipped) and replaced with another patient]*

Statin Therapy Options

- No *(patient does not meet numerator criteria)*
- Yes *(patient meets numerator criteria)*
- No - Denominator Exception - Medical Reasons *(patient removed from denominator)*

*Applicable to all risk categories.

[1] When "Exclusions" are documented in the medical record, the abstraction stops for that patient for that measure and the patient is skipped and replaced by the next consecutive patient in the Web Interface.

[2] When "Exceptions" are documented in the medical record, the abstraction stops for that patient for that measure and the patient is removed from the denominator without replacement by another patient.