DETAILED METHODOLOGY FOR THE 2017 VALUE MODIFIER AND THE 2015 QUALITY AND RESOURCE USE REPORT

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ABOUT THE DETAILED METHODOLOGY

The Detailed Methodology for the 2017 Value-Based Payment Modifier (Value Modifier) describes the process and methodology used to compute the Value Modifier that will be used to adjust Medicare Physician Fee Schedule (PFS) payments to physicians in groups with two or more eligible professionals and physician solo practitioners (as identified by their Medicare Taxpayer Identification Number [TIN]) in 2017.

Section I provides an overview of the 2017 Value Modifier, including the relationship between the 2017 Value Modifier and the 2015 Quality and Resource Use Reports (QRURs) that the Centers for Medicare and Medicaid Services (CMS) made available to groups and solo practitioners. Section II describes the methodology for computing the 2017 Value Modifier, and Section III explains the methodology for producing additional statistics included in the 2015 Mid-Year and 2015 Annual QRURs to help physicians and other eligible professionals better understand the measures included in the 2017 Value Modifier and support practice improvement.

I. OVERVIEW OF THE 2017 VALUE MODIFIER, 2015 MID-YEAR, AND 2015 ANNUAL QUALITY AND RESOURCE USE REPORTS

A. Statutory Authority and Phased Approach to Implementation

As established by section 3007 of the Affordable Care Act (ACA), the Value-Based Payment Modifier (Value Modifier) provides for differential payment to groups of physicians and physician solo practitioners under the Medicare Physician Fee Schedule (PFS) based on the quality of care furnished compared to the cost of care during a performance period. The Centers for Medicare and Medicaid Services (CMS) computes the Value Modifier at the Medicare Taxpayer Identification Number (TIN) level, which means that all physicians who are subject to the Value Modifier and billing under a given TIN receive the Value Modifier computed for that TIN.

The ACA requires application of the Value Modifier to specific physicians and groups of physicians starting January 1, 2015, and to all physicians by January 1, 2017. CMS has followed a phased approach to implementing the Value Modifier. As described in greater detail below, in 2017, physicians in TINs with two or more eligible professionals and physician solo practitioners will be subject to the Value Modifier based on their TINs' performance in 2015.

B. The 2017 Value Modifier

CMS will apply the 2017 Value Modifier to physicians in groups with two or more eligible professionals and physician solo practitioners (as identified by their TIN), provided that at least one physician submitted a Medicare claim in 2015 under that TIN. CMS will also apply the 2017 Value Modifier to physicians in TINs that participated in a Medicare Shared Savings Program (subsequently Shared Savings Program) Accountable Care Organization (ACO) in 2015, based on the quality performance of the Shared Savings Program ACO in which the TIN participated.[1] The 2017 Value Modifier will be waived for groups and solo practitioners, as identified by their TIN, if at least one eligible professional who billed for Medicare PFS items and services under the TIN in 2015 participated in the Pioneer ACO Model or the Comprehensive Primary Care (CPC) initiative in 2015, **and** none of the TIN's eligible professionals participated in a Shared Savings Program ACO in 2015.

In 2015, eligible professionals in groups with two or more eligible professionals and physician solo practitioners were required to participate in the Physician Quality Reporting System (PQRS) and satisfy PQRS requirements as a group or as individuals. Groups could avoid the automatic downward Value Modifier payment adjustment in 2017 by participating in one of three reporting mechanisms under the 2015 PQRS Group Practice Reporting Option (GPRO): (1) Web Interface (for TINs with 25 or more eligible professionals), (2) qualified PQRS registry, or (3) electronic health record (EHR)[2] and meeting the criteria to avoid the 2017 PQRS payment

[1] For additional information, please see the document entitled, "Medicare Shared Savings Program Interaction with the 2017 Value Modifier Frequently Asked Questions," available at the following URL: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Downloads/2017-VM-MSSP-FAQs.pdf.

[2] EHR data submitted via direct EHR using certified EHR technology (CEHRT) or CEHRT data submission vendor.

adjustment. Alternatively, groups could avoid the automatic downward adjustment in 2017 if at least 50 percent of the eligible professionals in the TIN met the criteria to avoid the 2017 PQRS payment adjustment as individuals.

For purposes of calculating the 2017 Value Modifier, CMS will consider quality data reported by a TIN through PQRS reporting mechanisms other than the one initially selected. If a TIN registered to report via GPRO, but failed as a group to meet the criteria to avoid the 2017 PQRS payment adjustment, CMS will use quality data reported by the individual eligible professionals in the TIN for purposes of applying the 2017 Value Modifier, if at least 50 percent of the eligible professionals in the TIN met the criteria to avoid the 2017 PQRS payment adjustment as individuals. Similarly, for purposes of applying the 2017 Value Modifier, CMS will use GPRO data reported through another mechanism if the TIN registered but failed to meet the criteria to avoid the 2017 PQRS payment adjustment through the registered mechanism, provided the TIN met the criteria to avoid the PQRS payment adjustment via the alternative reporting mechanism. In addition, if a TIN did not register to report as a GPRO, and less than 50 percent of the TIN's eligible professionals satisfactorily reported as individuals, then CMS will use any GPRO data the TIN reported that met the criteria to avoid the 2017 PQRS payment adjustment for the 2017 Value Modifier computations. Additional information on avoiding the 2017 PQRS payment adjustment is available at: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Payment-Adjustment-Information.html.

CMS uses the term Category 1 to refer to TINs with two or more eligible professionals subject to the 2017 Value Modifier that (1) met the criteria to avoid the 2017 PQRS payment adjustment as a group, or (2) had at least 50 percent of the eligible professionals in the TIN met the criteria to avoid the 2017 PQRS payment adjustment as individuals. Category 1 TINs also include physician solo practitioners subject to the 2017 Value Modifier that met the criteria to avoid the 2017 PQRS payment adjustment as individuals. TINs that participated in a Shared Savings Program ACO in 2015 are classified as Category 1 if their ACO satisfactorily reported quality data via the GPRO Web Interface in 2015 to avoid the 2017 PQRS payment adjustment. TINs subject to the 2017 Value Modifier that do not meet the criteria for inclusion in Category 1 are classified as Category 2 TINs. Physician solo practitioners and physicians in groups with between 2 to 9 eligible professionals that are classified as Category 2 TINs will be subject to an automatic negative two percent (-2.0%) adjustment, and physicians in groups with 10 or more eligible professionals will be subject to an automatic negative four percent (-4.0%) adjustment in 2017.

Quality-tiering is mandatory for all Category 1 TINs. As described in Section II, quality-tiering determines the direction (upward, neutral, or downward) and size of the 2017 Value Modifier payment adjustment for each TIN based on the number of eligible professionals in the TIN and the TIN's performance on quality and cost measures in 2015. For TINs that participated in a Shared Savings Program ACO in 2015, their 2017 Value Modifier payment adjustment is based on the number of eligible professionals in the TIN and the ACO's performance on quality in 2015. As a result, (1) physicians in TINs with 10 or more eligible professionals could receive an upward, neutral, or downward Value Modifier payment adjustment to their Medicare PFS payments in 2017; and (2) physicians in TINs with between one and nine eligible professionals could receive an upward or neutral Value Modifier payment

adjustment to their Medicare PFS payments in 2017, and are held harmless from any downward adjustment under the quality-tiering methodology.

PQRS Special Secondary Reporting Period for ACO Participant TINs: CMS has removed the prohibition on eligible professionals who bill under the TIN of an ACO participant in a Shared Savings Program ACO from reporting outside the ACO. This prohibition was removed for purposes of PQRS quality reporting and avoiding the PQRS payment adjustment and the automatic downward adjustment under the Value Modifier. CMS created a one-time PQRS special secondary reporting period for eligible professionals who participated in an ACO that did not successfully report quality data via the GPRO Web Interface for 2015, on behalf of its ACO participant TINs.

Affected eligible professionals may separately report outside the ACO either as individual eligible professionals (using registry, qualified clinical data registry (QCDR), or EHR reporting option) or using one of the group reporting options (registry, QCDR, or EHR) during this PQRS special secondary reporting period if they were participating in an ACO that did not report quality data via the GPRO Web Interface for 2015 on their behalf. Those utilizing a group reporting option do not need to register for it, but must mark the data as group data in their submission. The GPRO Web Interface, CAHPS, and claims reporting are not available options for the PQRS special secondary reporting period. The PQRS special secondary reporting period for the 2017 PQRS payment adjustment will coincide with the 2016 reporting period for the 2018 PQRS payment adjustment and will use the same 2016 data reported by EPs outside the ACO (that is, the January 1, 2016 through December 31, 2016 performance period).

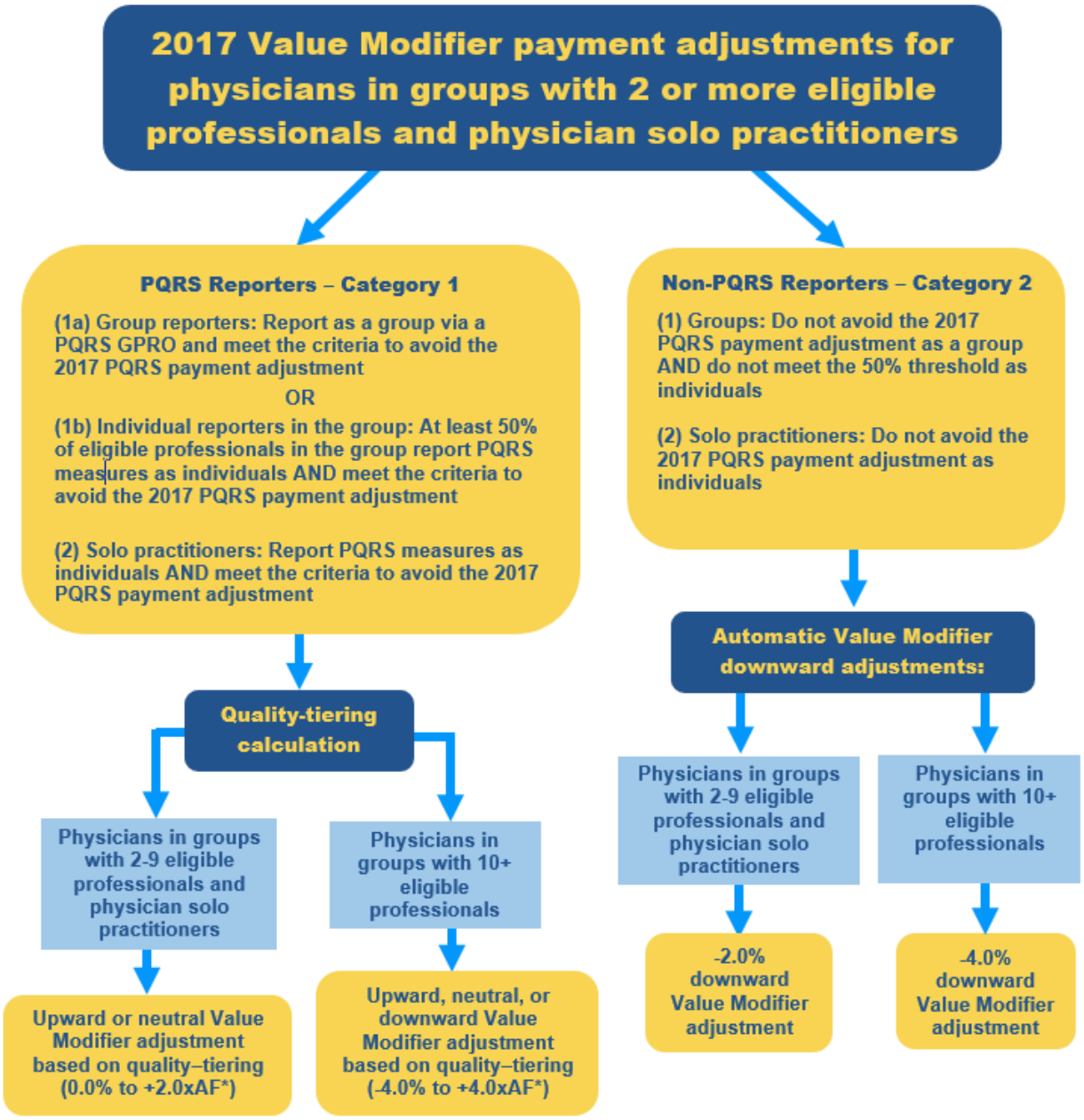
For the 2017 Value Modifier payment adjustment, CMS will assess the individual or group's 2016 data submitted outside the ACO during the PQRS special secondary reporting period against the reporting requirements for the 2018 PQRS payment adjustment to determine if the individual or group practice satisfies PQRS reporting requirements. CMS will use the data reported to the PQRS by the affected eligible professionals under the ACO participant TIN outside of the ACO during the PQRS special secondary reporting period to determine whether the TIN will fall in Category 1 or Category 2 under the 2017 Value Modifier. Groups that meet the criteria to avoid the 2018 PQRS payment adjustment as a group practice participating in the PQRS GPRO (using one of the group registry, QCDR, or EHR reporting options) or have at least 50 percent of the group's EPs meet the criteria to avoid the 2018 PQRS payment adjustment as individuals (using the registry, QCDR, or EHR reporting option), based on data submitted outside the ACO during the PQRS special secondary reporting period, will be included in Category 1 for the 2017 Value Modifier. Solo practitioners who meet the criteria to avoid the 2018 PQRS payment adjustment as individuals using the registry, QCDR, or EHR reporting option, based on data submitted outside the ACO during the PQRS special secondary reporting period, will also be included in Category 1 for the 2017 Value Modifier. Category 2 will include those groups and solo practitioners subject to the 2017 Value Modifier that participated in a Shared Savings Program ACO in 2015 and do not fall within Category 1. Category 2 group and solo practitioner TINs will be subject to the automatic downward payment adjustment under the 2017 Value Modifier.

If eligible professionals who are part of a TIN that participated in a Shared Savings Program ACO that did not satisfactorily report quality data via the GPRO Web Interface on their behalf in 2015 decide to use the PQRS special secondary reporting period, it is important to note that such

TINs should expect to be initially classified as Category 2 and receive an automatic downward adjustment under the 2017 Value Modifier for items and services furnished in 2017 until CMS is able to determine whether the TIN has met the criteria to avoid the 2018 PQRS payment adjustment as described above via the PQRS special secondary reporting period. CMS will process the data submitted for 2016, determine whether the group or solo practitioner will be classified as Category 1 or Category 2 for the 2017 Value Modifier, and notify the TIN if there is a change in the TIN's 2017 Value Modifier status. If CMS determines that the group or solo practitioner will be classified as Category 1, then the TIN will receive an Average Quality / Average Cost designation. CMS will then update the TIN's status so that physicians billing under the TIN will stop receiving an automatic downward adjustment under the Value Modifier for items and services furnished in 2017 and reprocess all claims that were previously paid. Since TINs taking advantage of this PQRS special secondary reporting period will have missed the deadline for submitting an informal review request for the 2017 Value Modifier, the informal review submission periods for these TINs will occur during the 60 days following the release of the QRURs for the 2018 Value Modifier.

Exhibit I.1 summarizes how the Value Modifier will be applied in 2017.

Exhibit I.1. Overview of the Application of the 2017 Value Modifier



*Higher-performing TINs treating high-risk beneficiaries (based on mean CMS-Hierarchical Condition Category [CMS-HCC] risk scores) are eligible for an additional adjustment of +1.0 x the adjustment factor (AF).

C. Relationship between the 2017 Value Modifier and the 2015 Quality and Resource Use Reports (QRURs)

In 2016, CMS made available two confidential feedback reports to every TIN nationwide, including those not subject to the 2017 Value Modifier:

- **2015 Mid-Year QRURs** provide interim information to TINs about their performance on the three claims-based quality outcome measures and six cost measures that CMS calculates from Medicare FFS claims. These measures are a subset of the measures that are used to calculate the 2017 Value Modifier. The data included for these measures in the Mid-Year QRURs are based on care provided from July 1, 2014 through June 30, 2015. The 2015 Mid-Year QRURs do not contain information about the 2017 Value Modifier payment adjustment, Quality and Cost Composite Scores, or quality measures data reported under the PQRS. The information contained in the Mid-Year QRURs does not affect TINs' payments under the Medicare PFS. The Mid-Year QRUR is intended to provide timely feedback so that providers may better understand and improve the care they provide and their performance on the claims-based quality outcome and cost measures that will be included in the 2017 Value Modifier. The 2015 Mid-Year QRURs were made available in April 2016.
- **2015 Annual QRURs** provide information on TINs' performance on all available quality and cost measures used to calculate the 2017 Value Modifier. For physicians in TINs that are subject to the Value Modifier in 2017, the 2015 Annual QRURs provide information on how the TINs' quality and cost performance will affect their physicians' Medicare PFS payments in 2017.

For detailed information about the 2017 Value Modifier and 2015 QRURs, see: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/2015-QRUR.html.

II. COMPUTATION OF THE 2017 VALUE MODIFIER

A. Overview

To calculate the Value Modifier for TINs that are subject to the Value Modifier in 2017, CMS computes a Quality Composite Score that summarizes a TIN's performance on quality measures, and a Cost Composite Score that summarizes a TIN's performance on cost measures for its attributed beneficiaries. For each measure for which a TIN has at least the minimum number of required eligible cases, CMS uses benchmark data to standardize measure-level performance to permit valid cross-measure comparisons. Standardized quality measures are categorized into one of six domains. Standardized cost measures are categorized into one of two domains. From the standardized measures, CMS computes performance scores for each domain, which are then averaged and standardized to yield the Quality Composite Score and the Cost Composite Score.

Using the Quality Composite and Cost Composite Scores, quality-tiering analysis determines the direction of a TIN's Value Modifier payment adjustment (upward, neutral, or downward) and the magnitude of the adjustment. Each Quality and Cost Composite Score indicates how many standard deviations a TIN's overall quality or cost performance is from the peer group mean. Only composite scores that are statistically significantly different and at least one standard deviation from the peer group mean are assigned to the High or Low Quality or Cost Tier. Composite scores that are not statistically significantly different or not at least one standard deviation from the peer group mean are deemed Average Quality or Cost for the purpose of quality-tiering. Exhibit II.1 summarizes the methodology for calculating the 2017 Value Modifier.

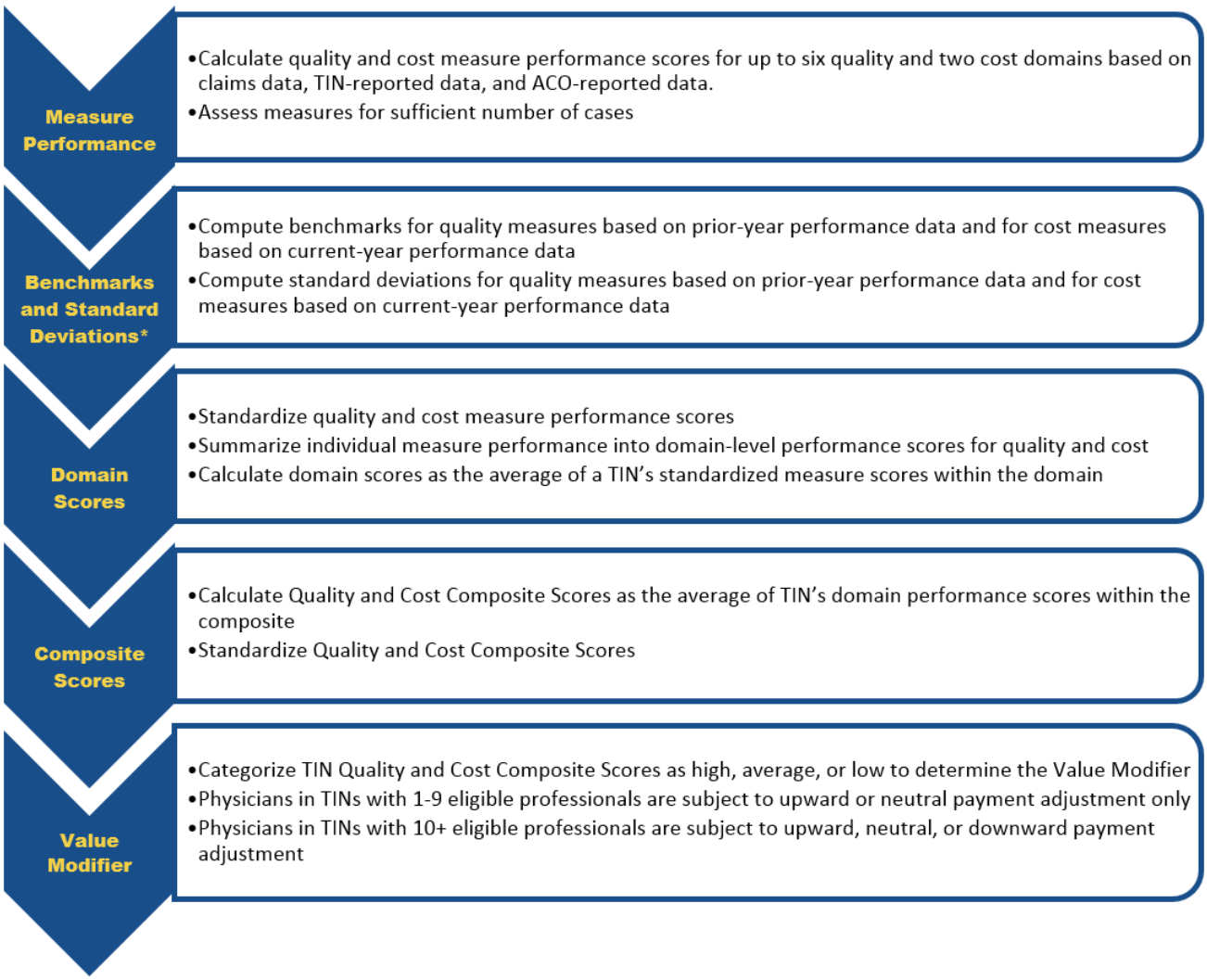
B. TINs Subject to the Value Modifier

CMS will apply the 2017 Value Modifier to physicians in TINs with one or more eligible professionals, provided that at least one physician submitted a Medicare claim in 2015 under that TIN. To determine the size of a TIN for purposes of applying the 2017 Value Modifier, CMS first counts the number of eligible professionals identified in the Provider Enrollment, Chain and Ownership System (PECOS) as of July 10, 2015. Specifically, CMS first identifies the actively enrolled medical professionals, as identified by their National Provider Identifier (NPI), who have reassigned their billing rights to the TIN. CMS then examines each NPI's specialty under that TIN to determine whether the individual is an eligible professional. Exhibit E.1 in Appendix E provides a list of eligible professional specialties. CMS then identifies the number of eligible professionals who submitted claims to Medicare under the TIN for services furnished during 2015 through March 31, 2016 (to account for lags in claims submissions). The size of the TIN (10 or more eligible professionals, or one to nine eligible professionals) for the purpose of applying the Value Modifier is the lower of the TIN's number of eligible professionals identified in PECOS and the number of eligible professionals who submitted claims to Medicare under the

TIN during 2015.[3] Both full-time and part-time eligible professionals are included in the calculation.

CMS will also apply the 2017 Value Modifier to physicians in TINs that participated in a Shared Savings Program ACO in 2015. CMS uses 2015 participation lists from the Shared Savings Program to identify these TINs.

Exhibit II.1. Methodology for Determining the 2017 Value Modifier for Category 1 TINs



*The performance rates of TINs with fewer than the minimum number of required eligible cases for a given cost or quality measure are excluded from the calculation of the benchmark for the measure.

[3] If a TIN-NPI is associated with both an individual practice and a group practice in PECOS, CMS will apply the group size associated with the TIN-NPIs that billed Medicare FFS during 2015. If a TIN-NPI that is listed as a solo practice in PECOS is associated with more than one eligible professional, CMS will drop the TIN-NPIs that have no billings.

C. Quality Measures Included in the Quality Composite Score

In calculating the Quality Composite Score for the 2017 Value Modifier, CMS includes (1) PQRS measures reported by the TIN as a group or by individual eligible professionals within the TIN who reported PQRS measures as individuals and (2) up to three claims-based quality outcome measures calculated from Medicare FFS claims submitted for Medicare beneficiaries attributed to the TIN. Measures from the Consumer Assessment of Healthcare Providers and Systems (CAHPS) for PQRS survey are also included if the TIN was eligible to report them through the PQRS and elected to include these survey results in the calculation of the TIN's 2017 Value Modifier.

1. CMS-Calculated Claims-Based Quality Outcome Measures

Hospital Admissions for Ambulatory Care-Sensitive Conditions (ACSCs): Acute Conditions Composite. This is the risk-adjusted rate of hospital admissions among Medicare beneficiaries for three acute ACSCs—bacterial pneumonia, urinary tract infection, and dehydration—that are potentially avoidable with appropriate primary and preventive care. This measure is computed at the TIN level and only for TINs that did not participate in a Shared Savings Program ACO in 2015.

For detailed information, please see the document entitled, "2015 Measure Information about the Hospital Admissions for Acute and Chronic Ambulatory Care–Sensitive Condition (ACSC) Composite Measures, Calculated For the 2017 Value-Based Payment Modifier Program," available at the following URL: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Downloads/2015-ACSC-MIF.pdf.

Hospital Admissions for ACSCs: Chronic Conditions Composite. This is the risk-adjusted rate of hospital admissions among Medicare beneficiaries for three chronic ACSCs—diabetes, chronic obstructive pulmonary disease (COPD), and heart failure—that are potentially avoidable with appropriate primary and preventive care. This measure is computed at the TIN level and only for TINs that did not participate in a Shared Savings Program ACO in 2015.

For detailed information, please see the document entitled, "2015 Measure Information about the Hospital Admissions for Acute and Chronic Ambulatory Care–Sensitive Condition (ACSC) Composite Measures, Calculated For the 2017 Value-Based Payment Modifier Program," available at the following URL: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Downloads/2015-ACSC-MIF.pdf.

30-Day All-Cause Hospital Readmission Measure. This is the risk-adjusted rate of unplanned hospital readmissions for any cause within 30 days after discharge from an acute care or critical access hospital. For TINs that did not participate in a Shared Savings Program ACO in 2015, this measure is computed at the TIN level and is not included in the domain score for TINs with fewer than 10 eligible professionals. For TINs that participated in a Shared Savings Program ACO in 2015, this measure is computed at the ACO level and is based on the ACO's performance.

For detailed information, please see the document entitled, "2015 Measure Information about the 30-Day All-Cause Hospital Readmission Measure, Calculated for the Value-Based

Payment Modifier Program," available at the following URL: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Downloads/2015-ACR-MIF.pdf

For additional information about the two-step process used to attribute beneficiaries to TINs for the claims-based quality outcome measures, please refer to the document entitled, "Two-Step Attribution for Claims-Based Quality Outcome Measures and Per Capita Cost Measures Included in the Value Modifier," available at the following URL: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Downloads/2016-03-25-Attribution-Fact-Sheet.pdf.

2. PQRS Quality Measures

For TINs that registered to report quality data to PQRS as a group through the PQRS GPRO in 2015 and met the criteria to avoid the 2017 PQRS payment adjustment as a group, the TIN-level PQRS quality measures used to calculate the Quality Composite Score for the 2017 Value Modifier reflect data reported through the reporting mechanism the TIN selected—GPRO Web Interface, qualified PQRS registry, or EHR.[4] CMS considered quality data reported by a TIN through PQRS reporting mechanisms other than the one initially selected, as well as quality data reported by the individual eligible professionals within the TIN as described below.

In 2015, TINs with 100 or more eligible professionals were required to participate in the CAHPS for PQRS survey, while it was optional for TINs with 2 to 99 eligible professionals that register for GPRO to choose to participate in the CAHPS for PQRS survey. All TINs that participate in the CAHPS for PQRS survey were able to elect to include their CAHPS for PQRS summary survey measures in the calculation of their 2017 Value Modifier. The CAHPS for PQRS survey assesses beneficiaries' experience of care in a group practice. For more information about CAHPS for PQRS survey reporting mechanisms, please see the document entitled, "2015 Physician Quality Reporting System (PQRS): CMS-Certified Survey Vendor Reporting Consumer Assessment of Healthcare Providers and Systems (CAHPS) for PQRS Made Simple," available at the following URL: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/downloads/2015PQRS_CMS_CertifSurveyVendorMadeSimple.pdf.

For information on reporting requirements under the different GPRO reporting mechanisms, please refer to: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/2015_Physician_Quality_Reporting_System.html.

For TINs that did not register to report via GPRO, CMS evaluated their quality performance based on PQRS measures reported by individual eligible professionals in their TIN, provided that at least 50 percent of the eligible professionals in the TIN met the criteria to avoid the 2017 PQRS payment adjustment as individuals. In addition, if a TIN did not register to report as a GPRO but reported GPRO data only (and reported it satisfactorily), then CMS used the GPRO

[4] For TINs that participated in a Shared Savings Program ACO, the Quality Composite Score will be calculated based on the quality data submitted by the ACO via the GPRO Web Interface and the ACO's performance on the All-cause Hospital Readmission measure.

data in Value Modifier computations (see Appendix F for the hierarchy of PQRS data used in the calculation of the 2017 Value Modifier).

CMS calculated the percent of eligible professionals in a TIN that met the criteria as individuals to avoid the 2017 PQRS payment adjustment as the total number of eligible professionals in the TIN who met the criteria to avoid the 2017 PQRS payment adjustment as individuals, divided by the total number of eligible professionals in the TIN, multiplied by 100. Both full-time and part-time eligible professionals are included in the calculations. Specifically:

• The numerator is the number of eligible professionals in the TIN who avoided the 2017 PQRS payment adjustment and either (a) billed under the TIN for services furnished during 2015, or (b) were associated with the TIN in PECOS as of July 10, 2015 and reported PQRS data in 2015.

• The denominator is based on the lower of the number of eligible professionals indicated by a query of PECOS on July 10, 2015 as having reassigned their billing rights to the TIN and the number of eligible professionals who submitted claims to Medicare under the TIN for services furnished in 2015.

For physician solo practitioners, CMS evaluated quality performance based on the PQRS quality measures they reported as individuals, provided they met the criteria to avoid the 2017 PQRS payment adjustment.

Only the individually reported PQRS measures that were reported by eligible professionals in the TIN who met the criteria to avoid the 2017 PQRS payment adjustment as individuals are computed at the TIN-NPI level. To convert these to TIN-level measures, performance numerators are summed across all of the eligible professionals reporting that measure under the TIN who avoided the 2017 PQRS payment adjustment, then performance denominators are summed and the TIN-level performance rates are computed as the ratio of the aggregated performance numerator to the aggregated performance denominator, multiplied by 100.

Detailed specifications and additional information about the 2015 PQRS quality measures can be found at: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/2015_Physician_Quality_Reporting_System.html.

Each PQRS measure is assigned to one of the following six quality domains: (1) Effective Clinical Care, (2) Person and Caregiver-Centered Experience and Outcomes, (3) Community/Population Health, (4) Patient Safety, (5) Communication and Care Coordination, and (6) Efficiency and Cost Reduction. The three CMS-calculated claims-based quality outcome measures are assigned to the Communication and Care Coordination Domain, and the CAHPS for PQRS survey measures are assigned to the Person and Caregiver-Centered Experience and Outcomes Domain. See Appendix B for a list of PQRS measures included in each quality domain. For PQRS measures with multiple performance rates, CMS determines an overall rate for inclusion in the 2017 Value Modifier by calculating a mean of the component parts or by selecting one component part that represents overall performance, depending on the particular measure. See Appendix C for details on PQRS and non-PQRS Qualified Clinical Data Registry (QCDR) measures with multiple performance rates, and measures that CMS has excluded from calculations of the 2017 Value Modifier for technical reasons.

D. Cost Measures Included in the Cost Composite Score

For all TINs, CMS calculates six cost measures based on Medicare FFS claims submitted for Medicare beneficiaries (or episodes, for the Medicare Spending per Beneficiary (MSPB) measure) attributed to the TIN. These measures are categorized into one of two cost domains. The Costs for All Attributed Beneficiaries Domain includes two distinct measures—Per Capita Costs for All Attributed Beneficiaries and MSPB. The Costs for Beneficiaries with Specific Conditions Domain includes four condition-specific per capita cost measures for beneficiaries with the following conditions: diabetes, coronary artery disease (CAD), COPD, and heart failure.

Per Capita Costs for All Attributed Beneficiaries. This measure represents the mean of all Medicare Parts A and B allowed charges for a TIN's attributed beneficiaries during 2015. Part D outpatient drug costs are not included.

For detailed information, please see the document entitled, "2015 Measure Information about the Per Capita Costs for All Attributed Beneficiaries Measure, Calculated for the 2017 Value-Based Payment Modifier Program," available at the following URL: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Downloads/2015-TPCC-MIF.pdf

Per Capita Costs for Beneficiaries with Specific Conditions. These four measures are computed analogously to the Per Capita Cost for All Attributed Beneficiaries measure, but are only computed for attributed beneficiaries with diabetes, CAD, COPD, or heart failure.

For detailed information, please see the document entitled, "2015 Measure Information about the Four Per Capita Costs for Beneficiaries with Specific Conditions Measures, Calculated for the 2017 Value-Based Payment Modifier Program," available at the following URL: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Downloads/2015-CSTPCC-MIF.pdf

Medicare Spending per Beneficiary (MSPB). This measure captures all Medicare Part A and Part B payments for services for episodes spanning from three days before an inpatient hospital admission through 30 days after discharge.

For detailed information, please see the document entitled, "Measure Information about the Medicare Spending Per Beneficiary, Calculated for the 2017 Value Modifier and 2015 Annual QRURs," available at the following URL: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Downloads/2017-MSPBM-MIF.pdf

Although the methodologies for calculating the per capita cost and MSPB measures differ in key respects, all cost measures are adjusted to account for variations in Medicare payment rates unrelated to resource use (such as differences due to geographic location or add-on payments for special programs), a process known as payment standardization. They are also adjusted to account for differences in beneficiary characteristics, including prior health conditions that can

affect their medical costs or utilization (risk adjustment) and differences in the mix of specialties across TINs (specialty adjustment).[5, 6]

Additional details relating to the payment standardization algorithm are available at: http://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier4&cid=1228772057350.[7]

E. Determining Which Measures Have the Required Number of Eligible Cases to be Included in the 2017 Value Modifier Calculations

The minimum number of eligible cases for all quality and cost measures is 20, with two exceptions. The MSPB measure requires at least 125 eligible episodes to be included in the Cost Composite Score. The 30-day All-Cause Hospital Readmission measure requires at least 200 eligible cases for non-Shared Savings Program ACO TINs to be included in the Quality Composite and applies only to TINs with 10 or more eligible professionals; however, the ACO-level All-Cause Hospital Readmission measure calculated for Shared Savings Program ACO TINs is included in the Quality Composite Score regardless of case size.

For PQRS measures reported by individual eligible professionals, the total number of eligible cases across all eligible professionals submitting the measure under the TIN and avoiding the 2017 PQRS payment adjustment is used to determine if the minimum case threshold was reached. For multi-part measures rolled up to a single performance rate based on an equally-weighted mean, the number of eligible cases is the number of eligible cases for any one of the component parts. For multi-part measures that are rolled up to a single performance rate based on a *non*-equally-weighted mean of the component parts, the number of eligible cases for the rolled-up measure is the sum of the number of eligible cases for each component part. For more information about calculating the performance rates for these measures, please refer to Appendix C.

F. Computing Measure Benchmarks and Standard Deviations

With the exception of the 30-day All-Cause Hospital Readmission measure, benchmark for each quality measure in the 2017 Value Modifier calculations, the is the case-weighted national mean performance rate during 2014 (the year prior to the 2015 performance period) among all TINs in the measure's peer group. For each quality measure, the peer group is defined as all TINs nationwide that had at least 20 eligible cases for the measure.

Benchmarks are calculated for quality measures where at least 20 TINs have at least the minimum number of required eligible cases during 2014. Quality measures where no prior-year

[5] Additional information can be found in the document entitled, "Risk Adjustment," available at the following URL: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Downloads/2015-RiskAdj-FactSheet.pdf.

[6] Additional information can be found in the document entitled, "Specialty Adjustment," available at the following URL: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Downloads/2015-SpecAdj-FactSheet.pdf.

[7] The CMS document available on QualityNet refers to this process as "price standardization" rather than "payment standardization," however the two terms are equivalent.

benchmark is available (for example, measures new to PQRS in 2015) are not included in the calculation of the Quality Composite Score, but performance on these measures is reported in the 2015 Annual QRUR for informational purposes only.

The benchmark for the 30-day All-Cause Hospital Readmission measure is the case-weighted national mean performance rate during 2014 among all TINs and ACOs in the measure's peer group. The peer group for the 30-day All-Cause Hospital Readmission is defined as all TINs nationwide with 10 or more eligible professionals that had at least 200 eligible cases and all ACOs in the Shared Savings Program with at least one eligible case.

Additional information on the quality benchmarks used in the calculation of the 2017 Value Modifier can be found in "Benchmarks for Measures Included in the Performance Year 2015 Quality and Resource Use Reports," available at the following URL: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Downloads/PY2015-Prior-Year-Benchmarks.pdf.

The benchmark for each cost measure is the case-weighted national mean cost during 2015 among all TINs in the measure's peer group. For each of the five total per capita cost measures, the peer group is defined as all TINs nationwide that had at least 20 eligible cases for the measure. For the MSPB measure, the peer group is defined as all TINs nationwide that had at least 125 eligible episodes.

Benchmarks are calculated for each cost measure where at least 20 TINs have at least the minimum number of required eligible cases (or episodes in the case of the MSPB measure) during 2015.

In addition to computing benchmarks, CMS also computes each quality and cost measure's standard deviation. Peer group standard deviations for quality and cost measures are case weighted, with the measure performance rate for each TIN in the peer group receiving a weight equal to the number of eligible cases that the TIN had for the specific measure. As with the benchmarks, the standard deviations for quality measures are based on data from 2014 (the year prior to the 2015 performance period) and the standard deviations for cost measures are based on data from 2015.

G. Standardizing Scores and Computing Domain Scores

Standardizing measure performance transforms measures with disparate scales to a common scale, which enables different measures to be compared and combined with one another into a composite. Measure-level performance is standardized by subtracting the benchmark for the measure from the TIN's per capita or per episode cost or quality performance rate and dividing by the case-weighted peer group standard deviation of the measure. A standardized score for a measure reflects the number of standard deviations that a TIN's overall performance differs from the benchmark.

Quality and cost domain scores are calculated as the simple (equally-weighted) mean of the TIN's standardized measure scores within the domain, if the TIN has a score for at least one measure included in the quality or cost domain. Only measures with at least the minimum number of required eligible cases and where benchmarks are available are included in quality

and cost domain scores for the 2017 Value Modifier. A domain score is not computed for any domain in which the TIN does not have at least one measure with at least the minimum number of required eligible cases.

H. Computing Mean Domain Scores and Standardized Composite Scores

For each TIN with at least the minimum number of eligible cases required to compute at least one quality measure with a benchmark for at least one quality domain score, CMS computes the simple (equally-weighted) mean of the TIN's quality domain scores. CMS standardizes this score to generate a distribution of mean quality domain scores centered at a mean of zero with a standard deviation of one. This involves subtracting the peer group mean from each TIN's average domain score and dividing the difference by the peer group standard deviation. For TINs subject to the 2017 Value Modifier, the peer group for the Quality Composite includes all TINs subject to the 2017 Value Modifier for which a Quality Composite Score could be calculated. For all other TINs, the peer group for the Quality Composite includes all TINs for which a Quality Composite Score could be calculated, with the exception of TINs that participated in the Pioneer ACO Model, or the CPC initiative in 2015. The standardized score created through this process is the Quality Composite Score. If a TIN's Quality Composite Score cannot be calculated because the TIN does not have at least the minimum number of required eligible cases for at least one quality measure with a benchmark, then the TIN's quality performance will be designated as average for the 2017 Value Modifier.

The Cost Composite Score is computed analogously to the Quality Composite Score. For each TIN with at least the required minimum number of eligible cases for at least one cost measure with a benchmark for at least one cost domain score, CMS computes the simple (equally-weighted) mean of the TIN's cost domain scores. CMS standardizes this score to generate a distribution of mean cost domain scores centered at a mean of zero with a standard deviation of one This involves subtracting the peer group mean from each TIN's average domain score and dividing the difference by the peer group standard deviation. For TINs subject to the 2017 Value Modifier, the peer group for the Cost Composite includes all TINs subject to the 2017 Value Modifier for which a Cost Composite Score could be calculated, with the exception of TINs that participated in the Shared Savings Program in 2015. For all other TINs, the peer group for the Cost Composite includes all TINs for which a Cost Composite Score could be calculated, with the exception of TINs that participated in the Shared Savings Program, the Pioneer ACO Model, or the CPC initiative in 2015. The standardized score created through this process is the Cost Composite Score. A Cost Composite Score is not calculated for TINs that do not have at least the minimum number of required eligible cases for at least one cost measure with a benchmark. If a TIN's Cost Composite Score cannot be calculated because the TIN does not have at least the minimum number of required eligible cases for at least one cost measure with a benchmark, then the TIN's cost performance will be designated as average for the 2017 Value Modifier.

I. Categorizing TINs on Quality and Cost Performance Based on Composite Scores and Statistical Significance (Quality-Tiering)

TINs subject to the 2017 Value Modifier that meet the criteria to avoid the 2017 PQRS payment adjustment (Category 1) will have their Value Modifier calculated using a quality-tiering approach based on their 2015 quality and cost performance.

To be considered either a high or low performer relative to its peers on the Quality Composite Score, a TIN's score must be at least one standard deviation above or below the peer group mean Quality Composite Score and statistically significantly different from the peer group mean. (The peer groups are defined above.) This ensures that payment adjustments under the Value Modifier are only made to those TINs whose performance reflects a meaningful difference from the mean. A TIN is classified as Average Quality for purposes of calculating the Value Modifier if (1) the TIN's score is at least one standard deviation above or below the peer group mean Quality Composite Score, but the difference between the TIN's score and the mean is not statistically significant, or (2) the TIN does not have at least the minimum number of required eligible cases for at least one quality measure with a benchmark. If the TIN's score is within one standard deviation of the peer group mean, regardless of its statistical significance, its performance is designated as average. Statistical significance is assessed using a two-tailed test.

High, average, and low performance is determined similarly for the Cost Composite Score as for the Quality Composite Score; however, lower Cost Composite Scores indicate better performance. To be considered either a high or low performer relative to its peers on the Cost Composite Score, a TIN's score must be at least one standard deviation above or below the peer group mean Cost Composite Score and statistically significantly different from the peer group mean. A TIN is classified as Average Cost for purposes of calculating the Value Modifier if (1) the TIN's score is at least one standard deviation above or below the peer group mean Cost Composite Score, but the difference between the TIN's score and the mean is not statistically significant, or (2) the TIN does not have at least the minimum number of required eligible cases for at least one cost measure with a benchmark. If the TIN's score is within one standard deviation of the peer group mean, regardless of its statistical significance, its performance is designated as average.

For TINs that participated in a Shared Savings Program ACO in 2015 that satisfactorily reported quality data via the GPRO Web Interface to avoid the 2017 PQRS payment adjustment, the Quality Composite Score is calculated based on the quality data submitted by the ACO via the GPRO Web Interface and the ACO's performance on the claims-based 30-day All-Cause Hospital Readmission measure calculated by Medicare for 2015. The Cost Composite for these TINs will be designated as average.

For TINs that participated in a Shared Savings Program ACO in 2015 that did not satisfactorily report quality data via the GPRO Web Interface to avoid the 2017 PQRS payment adjustment and are in Category 1 as a result of reporting quality data to the PQRS outside of the ACO using the PQRS special secondary reporting period (described in more detail on page 5 of this document), their Quality Composite will be classified as Average Quality and their Cost Composite will be classified as Average Cost under the 2017 Value Modifier.

Exhibit II.2 below displays the basic structure of the 2017 Value Modifier under the quality-tiering approach. Because the Value Modifier must be budget-neutral, the size of the upward payment adjustments will be based on an Adjustment Factor (AF) calculated to redistribute downward adjustments from low-performing TINs and Category 2 TINs to the high-performing TINs. The AF is derived from actuarial estimates of projected billings and is calculated after the conclusion of the 2015 performance period. It is reflected in the exhibit as the variable AF.

Because it is based on the number and relative performance of TINs subject to quality-tiering, it will vary from year to year with differences in actuarial estimates.

Exhibit II.2. 2017 Value Modifier Payment Adjustments Based on Quality-Tiering

	Low Quality	Average Quality	High Quality
Physicians in TINs with between 1 and 9 eligible professionals			
Low cost	0.0%	+1.0 x AF*	+2.0 x AF*
Average cost	0.0%	0.0%	+1.0 x AF*
High cost	0.0%	0.0%	0.0%
Physicians in TINs with 10 or more eligible professionals			
Low cost	0.0%	+2.0 x AF*	+4.0 x AF*
Average cost	-2.0%	0.0%	+2.0 x AF*
High cost	-4.0%	-2.0%	0.0%

*Higher-performing TINs treating high-risk beneficiaries (based on mean CMS-Hierarchical Condition Category [CMS-HCC] risk scores) are eligible for an additional adjustment of +1.0 x AF.

The 2017 Value Modifier will be applied on a claim-by-claim basis to claims for services paid under the Medicare PFS and for which the Medicare provider has accepted assignment. A claim adjustment reason code (CARC) and a remittance advice remark code (RARC) are code sets used to report payment adjustments on an eligible professional's or group practice's Remittance Advice. The Value Modifier program currently uses CARC 237 – Legislated/Regulatory Penalty, to designate the application of a negative or downward payment adjustment. At least one remark code must be provided (may be comprised of either the National Council for Prescription Drug Programs' Reject Reason Code, or RARC that is not an alert) in combination with Value Modifier RARC "VBM – N701 - Payment adjusted based on the Value-based Payment Modifier."[8]

J. Assessing Whether the TIN Treats a Disproportionate Share of Beneficiaries with High Risk Scores

TINs receiving an upward payment adjustment are eligible for an additional +1.0 x AF upward adjustment if the mean CMS-HCC risk score of the TIN's attributed beneficiaries is at or above the 75th percentile of all beneficiary risk scores nationwide. The 2014 CMS-HCC risk scores are calculated by CMS and are used to measure the mean risk of each TIN's attributed beneficiaries. For TINs not participating in a Shared Savings Program ACO in 2015, this includes the beneficiaries attributed to the TIN for the claims-based quality outcome and cost measures. TINs participating in a Shared Savings Program ACO in 2015 that are receiving an upward adjustment are eligible for an additional +1.0 x AF upward adjustment if the beneficiary population assigned to the ACO under the Shared Savings Program has an average beneficiary

[8] Further information can be found in the document entitled, "Understanding 2017 Medicare Quality Program Payment Adjustments," available at the following URL: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Downloads/Understanding2017MedicarePayAdjs.pdf.

CMS-HCC risk score at or above the 75th percentile of all beneficiary CMS-HCC risk scores nationwide.

The risk score assigned to each Medicare beneficiary predicts the beneficiary's medical costs in 2015 relative to mean costs among all Medicare FFS beneficiaries nationwide based on the presence of factors known to affect costs and utilization. A score of 1.0 represents average risk, with higher scores corresponding to higher risk. The 2014 CMS-HCC risk score distribution, spanning the lowest beneficiary risk score to the highest beneficiary risk score, and percentile thresholds were determined for all Medicare FFS beneficiaries nationally. Mean risk scores for beneficiaries attributed to TINs subject to the Value Modifier were compared with these national thresholds to determine whether the beneficiaries attributed to a TIN had a mean risk score that was at or above the 75th percentile.

K. Computation of Budget-neutral Adjustment Factor

For the CMS Office of the Actuary (OACT) to compute the budget-neutral AF for the 2017 Value Modifier, OACT must estimate the total value of both upward and downward payment adjustments under the Value Modifier in 2017. OACT's calculations are based on a file of claim line amounts paid to physicians in 2015 under the Medicare PFS, aggregated to the TIN level. Prior to performing these calculations, CMS removes any payment adjustments resulting from incentive payment programs such as the Value Modifier, Medicare EHR Incentive Program, and PQRS adjustments. This file includes information about which TINs will be subject to an upward, neutral, or downward payment adjustment under the 2017 Value Modifier. Line items are considered to have been paid under the Medicare PFS if the Healthcare Common Procedure Coding System (HCPCS) code and modifiers on the claim line are associated with any of the following status codes: Active, Carriers Price the Code, Anesthesia Services, Restricted Coverage, or Injections. Certain pathology codes[9] are paid under the Medicare PFS only if the line item includes a modifier value of 26 (professional component); otherwise, they are paid under the Clinical Laboratory Fee Schedule and thus are not included in the billings sum. The status codes associated with HCPCS and HCPC/modifier combinations are found in the Medicare Physician Fee Schedule Relative Value File.[10]

L. Value Modifier Informal Review Policies

For TINs that are subject to the 2017 Value Modifier, CMS has established an informal review period for TINs to request a correction of a perceived error in their Value Modifier calculation after the release of the QRURs. CMS has established policies under four scenarios to determine how the Quality and Cost Composites under the Value Modifier would be affected as a result of informal review decisions or if unanticipated issues were to arise (e.g., errors made by a third-party such as a vendor or errors in CMS' calculation of the Quality and/or Cost Composites are identified). Exhibit II.3 below summarizes the four scenarios.

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[9] These include services with any of the following HCPCS codes: 83020, 84165, 84166, 84181, 84182, 85390, 85576, 86153, 86255, 86256, 86320, 86325, 86327, 86334, 86335, 87164, 87207, 88371, 88372, and 89060.

[10] Status code versions (by year and updates during the year) are found at: http://cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files.html.

Exhibit II.3. Quality and Cost Composite Status for TINs Due to Informal Review Decisions and Widespread Quality and Cost Data Issues

	Scenario 1: TINs Moving from Category 2 to Category 1 as a Result of PQRS or Value Modifier Informal Review Process		Scenario 2: Non-GPRO Category 1 TINs with Additional Eligible Professionals Avoiding PQRS Payment Adjustment as a Result of PQRS Informal Review Process		Scenario 3: Category 1 TINs with Widespread Quality Data Issues		Scenario 4: Category 1 TINs with Widespread Claims Data Issues	
	Initial Composite	Revised Composite	Initial Composite	Revised Composite	Initial Composite	Revised Composite	Recalculated Composite	Revised Composite
Quality	N/A	Average	Low	Average	N/A	Average	Low	Average
	N/A	Average	Average	Average	N/A	Average	Average	Average
	N/A	Average	High	High	N/A	Average	High	High
Cost	Low	Low	Low	Low	Low	Low	Low	Low
	Average	Average	Average	Average	Average	Average	Average	Average
	High	Average	High	High	High	Average	High	Average

Scenario 1: TINs Moving from Category 2 to Category 1 as a result of PQRS or Value Modifier Informal Review Process

For the 2017 Value Modifier, if a TIN is initially classified as Category 2, and subsequently, through the PQRS or Value Modifier informal review process, it is reclassified as Category 1, then the TIN's Quality Composite will be classified as Average Quality. The TIN's Cost Composite will be calculated using the quality-tiering methodology. If the TIN is classified as High Cost based on its performance on the cost measures, then the TIN's Cost Composite will be reclassified as Average Cost. If the TIN is classified as Average Cost or Low Cost, then the TIN will retain the calculated cost tier designation.

Scenario 2: Non-GPRO Category 1 TINs with Additional Eligible Professionals Avoiding PQRS Payment Adjustment as a result of PQRS Informal Review Process

If a TIN is classified as Category 1 for the 2017 Value Modifier by having at least 50 percent of the group's eligible professionals meet the criteria to avoid the 2017 PQRS payment adjustment as individuals, and subsequently, through the PQRS informal review process, it is determined that additional eligible professionals that are in the TIN also meet the criteria to avoid the 2017 PQRS payment adjustment as individuals, then the following policies will be used to determine the TIN's Quality and Cost Composites:

- If the TIN's Quality Composite is initially classified as Low Quality, then the TIN's Quality Composite will be reclassified as Average Quality.
- If the TIN's Quality Composite is initially classified as Average Quality or High Quality, then the TIN will retain that quality tier designation.
- The TIN's Cost Composite that was initially calculated will be maintained.

Scenario 3: Category 1 TINs with Widespread Quality Data Issues

In cases where there is a systematic issue with any of a Category 1 TIN's quality data that renders it unusable for calculating a TIN's Quality Composite, the TIN's Quality Composite will be classified as Average Quality. CMS considers widespread quality data issues as issues that impact multiple TINs and for which CMS is unable to determine the accuracy of the data submitted via these TINs. The TIN's Cost Composite will be calculated using the quality-tiering methodology. If the TIN is classified as High Cost based on its performance on the cost measures, then the TIN's Cost Composite will be reclassified as Average Cost. If the TIN is classified as Average Cost or Low Cost, then the TIN will retain the calculated cost tier designation.

Scenario 4: Category 1 TINs with Widespread Claims Data Issues

If CMS determines after the release of the QRURs that there is a widespread claims data issue that impacts the calculation of the quality and/or Cost Composites for Category 1 TINs, then the Quality and Cost Composites for affected TINs will be recalculated. CMS considers widespread claims data issues as issues that impact multiple TINs and require the recalculation of the Quality and/or Cost Composites.

After recalculating the composites, if the TIN's Quality Composite is classified as Low Quality, then the Quality Composite will be reclassified as Average Quality. If the TIN's Cost Composite is classified as High Cost, then the Cost Composite will be reclassified as Average Cost. If the TIN is classified as Average Quality, High Quality, Average Cost, or Low Cost, then the TIN will retain the calculated quality or cost tier designation.

Additional Upward Adjustment for the Treatment of Complex Beneficiaries

Under Scenarios 1 and 3, for TINs classified as Average Quality/Low Cost as a result of informal review, an additional +1.0 x AF upward payment adjustment will be applied to TINs if the mean CMS-HCC risk score of the TIN's attributed beneficiaries is at or above the 75th percentile of all beneficiary risk scores nationwide. Under Scenarios 2 and 4, for TINs classified as High Quality/Low Cost, High Quality/Average Cost, or Average Quality/Low Cost as a result of informal review, an additional +1.0 x AF upward payment adjustment will be applied to TINs if the mean CMS-HCC risk score of the TIN's attributed beneficiaries is at or above the 75th percentile of all beneficiary risk scores nationwide.

An issue with the 2015 Measure-Applicability Validation (MAV) process impacted CMS' ability to determine, for purposes of the 2017 Value Modifier, what PQRS data were satisfactorily reported for certain TINs and eligible professionals reporting PQRS via registry and claims. Accordingly, CMS applied the aforementioned Scenario 3 informal review policy to TINs affected by this MAV issue in order to calculate their 2017 Value Modifier.

III. COMPUTATION OF ADDITIONAL STATISTICS

The 2015 Mid-Year and 2015 Annual QRURs include tables to help report recipients better understand their TINs' quality and cost performance. These include data on hospital admissions for any cause, costs disaggregated by type of service, and medical professionals' specialties. This section describes the computational details behind these statistics.

A. Hospital Admissions for Any Cause

Because hospital costs are a large portion of per capita costs, Table 2B accompanying the 2015 Annual QRUR and Exhibit 6 in the Mid-Year QRUR identify hospitals that accounted for at least five percent of a TIN's attributed beneficiary hospital stays during 2015 to help TINs understand their per capita costs. CMS identifies beneficiary hospital stays by looking at admissions for beneficiaries attributed to each TIN via the two-step attribution process for per capita cost measures and claims-based quality outcome measures.[11] CMS identifies the names, CMS Certification Numbers (CCNs), and locations of these hospitals by combining information from the Provider of Service (POS) files and PECOS.

Table 2C accompanying the 2015 Annual QRUR[12] and Table 3 accompanying the Mid-Year QRUR further identifies each beneficiary-level hospital admission (excluding beneficiary MSPB episodes). Individual attributed beneficiaries are identified by an index variable, based on healthcare insurance claim (HIC) number, sex, and date of birth, which allows users to link beneficiary-level information across tables without using personally identifiable information. Each hospital stay listed also indicates the date of discharge and discharge disposition based on the two-digit patient discharge status code on the last claim in a hospital stay (Exhibit III.1).

CMS provides similar information to help TINs understand hospital admissions reflected in the MSPB measure based on beneficiary MSPB episodes attributed to a TIN. However, admissions are reported for beneficiary MSPB episodes attributed to a TIN via the MSPB attribution rule instead of the two-step attribution process. Table 5A accompanying the 2015 Annual QRUR and Exhibit 7 in the Mid-Year QRUR identify hospitals that accounted for at least five percent of beneficiary MSPB episodes attributed to the TIN through the MSPB attribution rule during 2015. Table 5B accompanying the 2015 Annual QRUR provides information on the beneficiaries attributed to the TIN for the MSPB measure. For the Mid-Year QRUR, Exhibit 4 and accompanying Table 4 provide information on the beneficiaries attributed to the TIN for the MSPB measure.

Hospital admissions with a principal diagnosis for conditions associated with alcohol and substance abuse are excluded from all patient-level data on hospital admissions for purposes of

[11] For additional information about the two-step attribution process, refer to the document entitled, "Two-Step Attribution for Claims-Based Quality Outcome Measures and Per Capita Cost Measures Included in the Value Modifier," available at the following URL: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Downloads/2016-03-25-Attribution-Fact-Sheet.pdf.

[12] For TINs participating in Shared Savings Program ACOs, the information is provided in Table 6A accompanying the 2015 Annual QRUR. Shared Savings Program ACO data is not provided in the 2015 Mid-Year QRUR.

confidentiality but are included in total counts of hospital admissions in the Annual QRUR Table 2B and Mid-Year QRUR Exhibit 6.

Exhibit III.1. Medicare Hospital Claim Patient Discharge Status Codes

Discharge status code	Discharge status
01	Discharged to home
02	Transferred to another short-term general hospital
03	Discharged to SNF with Medicare certification
04	Discharged to intermediate care facility
05	Discharged to other hospital
06	Discharged to home health
07	Left against medical advice (AMA)
08	(Discontinued)
09	Admitted to same hospital
20	Expired
21	Discharged to court
30	Still patient
40	Expired at home – hospice
41	Expired at facility – hospice
42	Expired at unknown location – hospice
43	Discharged to federal hospital
50	Discharged to hospice – home
51	Discharged to hospice – facility
61	Transferred to Medicare-approved swing bed
62	Discharged to rehabilitation facility
63	Discharged to long-term care hospital
64	Discharged to SNF with Medicaid certification
65	Discharged to psychiatric hospital
66	Discharged to critical access hospital
69	Discharged to designated disaster alternate care
70	Discharged to other facility
71	(Discontinued)
72	(Discontinued)
81	Discharged to home – planned readmission
82	Transferred to short-term general hospital – planned readmission
83	Discharged to SNF with Medicare certification – planned readmission
84	Discharged to custodial or support care – planned readmission
85	Discharged to other hospital – planned readmission
86	Discharged to home health – planned readmission
87	Discharged to court – planned readmission
88	Discharged to federal hospital – planned readmission
89	Transferred to Medicare-approved swing bed – planned readmission
90	Discharged to rehabilitation facility – planned readmission
91	Discharged to long-term care hospital – planned readmission
92	Discharged to SNF with Medicaid certification – planned readmission
93	Discharged to psychiatric hospital – planned readmission
94	Discharged to critical access hospital – planned readmission
95	Discharged to other facility – planned readmission

Source: Research Data Assistance Center (ResDAC) 2013, http://www.resdac.org/cms-data/variables/patient-discharge-status-code.

B. Categorical Breakdown of Costs by Type of Service

Several tables accompanying the 2015 Annual QRUR—one for each of the six cost measures—provide a breakdown of the TIN's per capita or per episode costs in comparison to peers by type of service. Types of service include inpatient services and evaluation and management (E&M), among others. Each type of service category includes the costs of *all* services in that category that were furnished to the TIN's attributed beneficiaries and included in the cost measure (not only those services provided by the TIN). Taken together, these category of service amounts add up to the per capita or per episode cost measure value, to allow TINs to identify more readily which categories were particular drivers of their measure-level costs. The specific tables are Table 3A: Per Capita Costs, by Categories of Service, for the Per Capita Costs for the All Attributed Beneficiaries Measure; Tables 4A – 4D: Per Capita Costs, by Categories of Service, for Beneficiaries with Specific Conditions; and Table 5C: Costs per Episode, by Category of Service, for the Medicare Spending per Beneficiary (MSPB) Measure. Comparable information in the Mid-Year QRUR is provided in Exhibits 9 and 10 and Tables 5 – 10. These data are reported for informational purposes to help TINs better understand what is driving their beneficiaries' costs; they are not used individually in calculations of the Cost Composite Score.

In addition to separating costs by service category, services are further broken down based on whether the service was provided by eligible professionals in the TIN or by eligible professionals in another TIN for two categories—E&M services and procedures in non-emergency settings. For each of these two categories, service costs are further divided by the broad specialty category of the eligible professionals rendering them: primary care physicians (PCPs), medical specialists, surgeons, and other professionals (including physician assistants, nurse practitioners, clinical nurse specialists, certified nurse anesthetists, clinical social workers, clinical psychologists, dieticians, audiologists, physical and occupational therapists, and speech-language therapists). The method for determining an eligible professional's specialty is described in the next section.

To ensure that the costs displayed across all categories of service for a given TIN sum to the actual per capita or per episode cost measure amount for that TIN, costs for each category of service are scaled by a multiplier equal to the ratio of the TIN's standardized, risk-adjusted, and specialty-adjusted cost measure to the TIN's standardized but not risk-adjusted and not specialty-adjusted costs. For example, suppose for Per Capita Costs for Beneficiaries with Diabetes, a TIN's payment-standardized but not risk-adjusted costs for its attributed beneficiaries with diabetes are $10,000: $2,000 of which is due to E&M and $8,000 of which is due to inpatient services. Suppose further that the TIN's risk- and specialty-adjusted costs for this measure are $15,000. These costs are 1.5 times higher than the TIN's corresponding unadjusted costs of $10,000. Rescaling the costs for the E&M and inpatient services categories by that factor of 1.5—to $3,000 and $12,000, respectively—results in a distribution of costs across categories for the TIN that adds up to the measure-level cost while preserving the share of those costs due to E&M and inpatient services, respectively, that is reflected in the unadjusted costs.

Appendix D provides more detail on how Medicare claims are categorized into the mutually exclusive service categories for the per capita cost measures displayed in Exhibit D.1. Exhibit D.2. displays how cost categories are defined for the MSPB measure.

Exhibits III.2 and III.3 list the categories of services displayed in the 2015 QRURs and tables. The disaggregated statistics relate to the measure scores as follows:

Exhibit III.2. Service Categories Displayed for Per Capita Costs Measures in the 2015 QRURs

Major category	Subcategories
Outpatient E&M services, procedures, and therapy (excluding emergency department)	E&M services billed by EPs – Your TIN E&M services billed by EPs – Other TINs Major procedures billed by EPs – Your TIN Major procedures billed by EPs – Other TINs Ambulatory/minor procedures billed by EPs – Your TIN Ambulatory/minor procedures billed by EPs –Other TINs Outpatient physical, occupational, or speech and language pathology therapy
Ancillary services	Laboratory, pathology, and other tests Imaging services Durable medical equipment and supplies
Hospital inpatient services	Inpatient hospital facility services EP services during hospitalization—Your TIN EP services during hospitalization—Other TINs
Post-acute care services	Home health SNF Inpatient rehabilitation or long-term care hospital
Hospice	No subcategories
All other services	Ambulance services Anesthesia services Chemotherapy and other Part B–covered drugs Dialysis Other facility-billed E&M expenses Other facility-billed expenses for major procedures Other facility-billed expenses for ambulatory/minor procedures All other services not otherwise classified

Note: EP = eligible professional

Exhibit III.3. Service Categories Displayed for the MSPB Measure in the 2015 QRURs

Major category	Subcategories
Acute inpatient services	Acute inpatient hospital: index admission Acute inpatient hospital: readmission Eligible professional services billed by your TIN during index hospitalization Eligible professional services billed by other TINs during index hospitalization Other physician or supplier Part B services billed during any hospitalization
Post-acute care services	Home health Skilled nursing facility Inpatient rehabilitation or long-term care hospital
Emergency services not included in a hospital admission	Emergency E&M services Procedures Laboratory, pathology, and other tests Imaging services
Outpatient E&M services, procedures, and therapy (excluding emergency department)	Physical, occupational, or speech and language pathology therapy Dialysis E&M services Major procedures and anesthesia Ambulatory/minor procedures
Ancillary services	Laboratory, pathology, and other tests Imaging services Durable medical equipment and supplies
Hospice	No subcategories
All other services	Ambulance services Chemotherapy and other Part B-covered drugs All other services not otherwise classified

C. Physicians and Non-physician Eligible Professionals Billing Under the TIN

In order to attribute beneficiaries to TINs for five of the six cost measures and for the three claims-based quality outcome measures, CMS takes into account the level of primary care services received (as measured by Medicare-allowed charges during 2015) and the provider specialties that performed these services such (e.g., physicians, nurse practitioners, physician assistants, and clinical nurse specialists). Information on treating physicians' medical specialties is also used in category-of-service breakdowns, as described above. CMS uses the following broad specialty categories for the category-of-service breakdowns: PCP, medical specialist, surgeon, and other eligible professional. CMS uses the two-digit CMS specialty codes that appear on Medicare carrier claims files to define specialties. The Medicare Claims Processing Manual delineates which specialties are physician specialties and which are not. Assignment of medical professionals to broad specialty categories, referred to here as professional stratification categories, comprises two steps. First, each provider is assigned a medical specialty. Second, each specialty is assigned a professional stratification categories.

The CMS specialty codes that appear on Medicare carrier claims files reflect self-reported specialties recorded in PECOS. To account for changes in specialties or multiple PECOS enrollments during a performance year, CMS determines the specialty from CMS carrier claims files based on the CMS specialty code associated with the plurality of total allowed charges on line items for services rendered by the professional during 2015. In the case of a tie, the specialty listed on the most recent claim is selected. Appendix E provides a mapping from CMS specialty codes to physician, eligible professional, and professional stratification categories.

APPENDIX A

DESCRIPTION OF DATA SOURCES

CMS uses multiple data sources, described briefly below, to calculate the quality and cost measures included in the 2017 Value Modifier. A more detailed discussion of how these sources are used in specific quality and cost measures is available in the Measure Information Forms available at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/2015-QRUR.html.

A. PQRS Quality Measure Data

PQRS reporting and performance data included in the 2017 Value Modifier and displayed in the 2015 Annual QRURs are obtained from PQRS in a Universal Data Set (UDS). PQRS data from calendar year 2015 are used for the 2015 Annual QRUR and 2017 Value Modifier. The data include information on measures submitted by TINs (via GPRO) and individual eligible professionals, by TIN, including which measures were submitted, number of cases submitted, number of exclusions, number of cases that successfully met the relevant measure criteria, and performance rates. The UDS contains similar data for non-PQRS QCDR measures. The UDS data also include information on which TINs and individual eligible professionals avoided the 2017 PQRS payment adjustment and the reporting mechanism(s) by which the measures were submitted: Medicare Part B claims, qualified PQRS registry, direct CEHRT, CEHRT via data submission vendor, QCDR, or GPRO Web Interface.

For groups that report CAHPS for PQRS survey measures and elect to have them included in the calculation of their Value Modifier, CMS uses CAHPS for PQRS survey data collected by CMS-certified CAHPS survey vendors in the performance year. Like the other PQRS data, the CAHPS data include information on number of responses and performance rate. They also include additional information needed to incorporate CAHPS measures into the 2017 Value Modifier for TINs electing that option, such as CAHPS-specific standard errors.

B. Medicare Enrollment Data

CMS uses Medicare Part A and Part B enrollment data to attribute beneficiaries to TINs for the three claims-based quality outcome measures and six cost measures included in the 2017 Value Modifier. Medicare enrollment data from calendar year 2015 are used for the 2015 Annual QRUR and 2017 Value Modifier. Medicare enrollment data from July 1, 2014 through June 30, 2015 are used for the 2015 Mid-Year QRURs. These data contain demographic and enrollment information about each beneficiary enrolled in Medicare during a calendar year. The data include the beneficiary's unique Medicare identifier, state and county residence codes, zip code, date of birth, date of death, sex, race/ethnicity, age, monthly Medicare entitlement indicators, reasons for entitlement, whether the beneficiary's state of residence paid for the beneficiary's Medicare Part A or Part B monthly premiums ("state buy-in"), and monthly Medicare managed care enrollment indicators. These variables help determine whether a given beneficiary should be attributed to a TIN. For example, beneficiaries enrolled in Medicare managed care or living outside the U.S., its territories, and its possessions are excluded from the claims-based measures included in the Value Modifier. The enrollment data are accessed via CMS's Integrated Data Repository (IDR). The denominator table, updated quarterly, is accessed via the Medicare Enrollment Database (EDB). The beneficiary table, updated daily, is accessed via the Common Medicare Environment (CME).

C. Medicare Claims Data

For the 2015 Mid-Year and Annual QRURs, computations for the three claims-based quality outcome measures and six cost measures use all final-action Medicare claims for services provided during the performance period. Specifically, CMS analyzes inpatient hospital; outpatient hospital; skilled nursing facility (SNF); home health; hospice; carrier (physician/supplier); and durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) claims, as appropriate for the relevant measure. These claims are identified from CMS's IDR based on at least a 90-day runout period. The date on which the claims are identified is the Wednesday of the first full week in the month (for this purpose, a week starts on Saturday), following 90 days after the end of the performance period. This ensures that there is enough time for claims from the last few days of the month to have been uploaded to the IDR during the weekly updates.[13]

Under Medicare procedures, when an error is discovered on a claim, a duplicate claim is submitted indicating that the prior claim was in error; a subsequent claim containing the corrected information can then be submitted. The National Claims History database is the source of Medicare FFS claims in the IDR. The IDR contains only the final action claims developed from the Medicare National Claims History database—that is, non-rejected claims for which a payment has been made after all disputes and adjustments have been resolved and details clarified—and these are the claims used to populate the Annual QRUR and calculate the Value Modifier. The scope of claims in the IDR is national. Medicare Administrative Contractors (MACs) submit data continually to CMS, which updates the IDR weekly as noted above. TINs submit claims to their MAC for processing and payment. For the purpose of computing the Value Modifier, the end date of the claim determines the performance period with which the claim is associated.

D. Other Data

CMS-HCC risk scores. Derived from Medicare enrollment and claims data, CMS-HCC risk scores are used to (1) risk adjust the Per Capita Costs for All Attributed Beneficiaries and Per Capita Costs for Beneficiaries with Specific Conditions measures[14] and (2) determine which high-performing TINs are eligible for an additional upward payment adjustment if their average beneficiary CMS-HCC risk score is at or above the 75th percentile of all beneficiary risk scores nationwide. Final risk scores for the 2017 Value Modifier are obtained directly from the contractor that produces these scores for CMS. CMS-HCC risk scores from calendar year 2014 (the 2015 Final Model scores using Version 22) are used for the 2015 Annual QRUR and 2017 Value Modifier. CMS-HCC risk scores from calendar year 2013 are used for the 2015 Mid-Year QRURs.

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[13] Specifically, CMS calculates the date that is 90 days after the close of the performance period. If the dates falls on a weekday, all claims through at least that date will be captured the following Tuesday and claims are locked the following Wednesday. If the date falls on a weekend, the data will be captured a week later (two Wednesdays after the 90-day runout).

[14] For additional details about the risk-adjustment methodology for the per capita cost measures, see the Measure Information Forms for Overall and Condition-Specific Total Per Capita Cost Measures available at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/2015-QRUR.html.

Standardized payments. Standardized payments data are used to standardize Medicare allowed charges for the cost measures included in the 2017 Value Modifier. These data associate a standardized amount with each actual allowed amount for each service billed by Medicare providers. These data are obtained directly from the contractor responsible for producing CMS's agency-wide standardized payments. Standardized payments data from calendar year 2015 are used for the 2015 Annual QRUR and 2017 Value Modifier. Standardized payments data from July 1, 2014 through June 30, 2015 are used for the 2015 Mid-Year QRURs.

PECOS. PECOS data are used to develop an initial list of TINs that could be subject to the 2017 Value Modifier, based on the number of eligible professionals associated with the TIN in PECOS as of July 10, 2015. The PECOS database includes information on enrolled eligible professionals, including their NPIs, any TINs to which they have reassigned their billing rights, and their primary and secondary specialties (if applicable). PECOS data are accessed by querying the PECOS reporting database 10 calendar days after the 2015 PQRS GPRO registration period ended.

Pioneer ACO Model and CPC initiative participation lists. To assess which TINs will be exempt from the 2017 Value Modifier because eligible professionals billing under the TIN participated in the Pioneer ACO Model or the CPC initiative during 2015, TIN-level and TIN-NPI-level participation lists are obtained directly from the contractors supporting these programs and initiatives.

APPENDIX B

QUALITY MEASURES, BY DOMAIN

The exhibits in this appendix display, by quality domain, the PQRS measures considered for inclusion in the 2017 Value Modifier, and included in the 2015 Annual QRURs. The six domains are Effective Clinical Care, Person and Caregiver-Centered Experience and Outcomes, Community/Population Health, Patient Safety, Communication and Care Coordination, and Efficiency and Cost Reduction. The three CMS-calculated quality outcome measures, as shown in Exhibit B.6, are included in the 2015 Mid-Year QRURs and 2015 Annual QRURs.

Exhibit B.1. Effective Clinical Care Domain Quality Indicators

PQRS or QCDR Number (GPRO/eCQM Number)	Measure Name	Quality Domain
1* (GPRO DM-2, CMS122v3)	Diabetes: Hemoglobin A1c Poor Control	Effective Clinical Care
2 (CMS163v3)	Diabetes: Low Density Lipoprotein (LDL-C) Control (< 100 mg/dL)	Effective Clinical Care
5 (CMS135v3)	Heart Failure (HF): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD)	Effective Clinical Care
6	Coronary Artery Disease (CAD): Antiplatelet Therapy	Effective Clinical Care
7 (CMS145v3)	Coronary Artery Disease (CAD): Beta-Blocker Therapy – Prior Myocardial Infarction (MI) or Left Ventricular Systolic Dysfunction (LVEF < 40%)	Effective Clinical Care
8 (GPRO HF-6, CMS144v3)	Heart Failure (HF): Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)	Effective Clinical Care
9 (CMS128v3)	Anti-Depressant Medication Management	Effective Clinical Care
12 (CMS143v3)	Primary Open-Angle Glaucoma (POAG): Optic Nerve Evaluation	Effective Clinical Care
14	Age-Related Macular Degeneration (AMD): Dilated Macular Examination	Effective Clinical Care
18 (CMS167v3)	Diabetic Retinopathy: Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy	Effective Clinical Care
19 (CMS142v3)	Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care	Effective Clinical Care
32	Stroke and Stroke Rehabilitation: Discharged on Antithrombotic Therapy	Effective Clinical Care
33	Stroke and Stroke Rehabilitation: Anticoagulant Therapy Prescribed for Atrial Fibrillation (AF) at Discharge	Effective Clinical Care
39	Screening or Therapy for Osteoporosis for Women Aged 65 Years and Older	Effective Clinical Care
40	Osteoporosis: Management Following Fracture of Hip, Spine or Distal Radius for Men and Women Aged 50 Years and Older	Effective Clinical Care
41	Osteoporosis: Pharmacologic Therapy for Men and Women Aged 50 Years and Older	Effective Clinical Care

PQRS or QCDR Number (GPRO/eCQM Number)	Measure Name	Quality Domain
43	Coronary Artery Bypass Graft (CABG): Use of Internal Mammary Artery (IMA) in Patients with Isolated CABG Surgery	Effective Clinical Care
44	Coronary Artery Bypass Graft (CABG): Preoperative Beta-Blocker in Patients with Isolated CABG Surgery	Effective Clinical Care
48	Urinary Incontinence: Assessment of Presence or Absence of Urinary Incontinence in Women Aged 65 Years and Older	Effective Clinical Care
51	Chronic Obstructive Pulmonary Disease (COPD): Spirometry Evaluation	Effective Clinical Care
52	Chronic Obstructive Pulmonary Disease (COPD): Inhaled Bronchodilator Therapy	Effective Clinical Care
53	Asthma: Pharmacologic Therapy for Persistent Asthma - Ambulatory Care Setting	Effective Clinical Care
54	Emergency Medicine: 12-Lead Electrocardiogram (ECG) Performed for Non-Traumatic Chest Pain	Effective Clinical Care
67	Hematology: Myelodysplastic Syndrome (MDS) and Acute Leukemias: Baseline Cytogenetic Testing Performed on Bone Marrow	Effective Clinical Care
68	Hematology: Myelodysplastic Syndrome (MDS): Documentation of Iron Stores in Patients Receiving Erythropoietin Therapy	Effective Clinical Care
69	Hematology: Multiple Myeloma: Treatment with Bisphosphonates	Effective Clinical Care
70	Hematology: Chronic Lymphocytic Leukemia (CLL): Baseline Flow Cytometry	Effective Clinical Care
71 (CMS140v3)	Breast Cancer: Hormonal Therapy for Stage IC -IIIC Estrogen Receptor/Progesterone Receptor (ER/PR) Positive Breast Cancer	Effective Clinical Care
72 (CMS141v3)	Colon Cancer: Chemotherapy for AJCC Stage III Colon Cancer Patients	Effective Clinical Care
82	Adult Kidney Disease: Peritoneal Dialysis Adequacy: Solute	Effective Clinical Care
84	Hepatitis C: Ribonucleic Acid (RNA) Testing Before Initiating Treatment	Effective Clinical Care
85	Hepatitis C: Hepatitis C Virus (HCV) Genotype Testing Prior to Treatment	Effective Clinical Care
87	Hepatitis C: Hepatitis C Virus (HCV) Ribonucleic Acid (RNA) Testing Between 4-12 Weeks After Initiation of Treatment	Effective Clinical Care
91	Acute Otitis Externa (AOE): Topical Therapy	Effective Clinical Care
99	Breast Cancer Resection Pathology Reporting: pT Category (Primary Tumor) and pN Category (Regional Lymph Nodes) with Histologic Grade	Effective Clinical Care

PQRS or QCDR Number (GPRO/eCQM Number)	Measure Name	Quality Domain
100	Colorectal Cancer Resection Pathology Reporting: pT Category (Primary Tumor) and pN Category (Regional Lymph Nodes) with Histologic Grade	Effective Clinical Care
104	Prostate Cancer: Adjuvant Hormonal Therapy for High Risk Prostate Cancer Patients	Effective Clinical Care
107 (CMS161v3)	Adult Major Depressive Disorder (MDD): Suicide Risk Assessment	Effective Clinical Care
108	Rheumatoid Arthritis (RA): Disease Modifying Anti-Rheumatic Drug (DMARD) Therapy	Effective Clinical Care
112 (GPRO Prev-5, CMS125v3)	Breast Cancer Screening	Effective Clinical Care
113 (GPRO Prev-6, CMS130v3)	Colorectal Cancer Screening	Effective Clinical Care
117 (GPRO DM-7, CMS131v3)	Diabetes: Eye Exam	Effective Clinical Care
118 (GPRO CAD-7)	Coronary Artery Disease (CAD): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy -- Diabetes or Left Ventricular Systolic Dysfunction (LVEF < 40%)	Effective Clinical Care
119 (CMS134v3)	Diabetes: Medical Attention for Nephropathy	Effective Clinical Care
121	Adult Kidney Disease: Laboratory Testing (Lipid Profile)	Effective Clinical Care
122	Adult Kidney Disease: Blood Pressure Management	Effective Clinical Care
126	Diabetes Mellitus: Diabetic Foot and Ankle Care, Peripheral Neuropathy – Neurological Evaluation	Effective Clinical Care
127	Diabetes Mellitus: Diabetic Foot and Ankle Care, Ulcer Prevention – Evaluation of Footwear	Effective Clinical Care
140	Age-Related Macular Degeneration (AMD): Counseling on Antioxidant Supplement	Effective Clinical Care
160 (CMS52v3)	HIV/AIDS: Pneumocystis Jiroveci Pneumonia (PCP) Prophylaxis	Effective Clinical Care
163 (CMS123v3)	Diabetes: Foot Exam	Effective Clinical Care
164*	Coronary Artery Bypass Graft (CABG): Prolonged Intubation	Effective Clinical Care
165*	Coronary Artery Bypass Graft (CABG): Deep Sternal Wound Infection Rate	Effective Clinical Care
166*	Coronary Artery Bypass Graft (CABG): Stroke	Effective Clinical Care
167*	Coronary Artery Bypass Graft (CABG): Postoperative Renal Failure	Effective Clinical Care
168*	Coronary Artery Bypass Graft (CABG): Surgical Re-Exploration	Effective Clinical Care
172	Hemodialysis Vascular Access Decision-Making by Surgeon to Maximize Placement of Autogenous Arterial Venous (AV) Fistula	Effective Clinical Care

PQRS or QCDR Number (GPRO/eCQM Number)	Measure Name	Quality Domain
176	Rheumatoid Arthritis (RA): Tuberculosis Screening	Effective Clinical Care
177	Rheumatoid Arthritis (RA): Periodic Assessment of Disease Activity	Effective Clinical Care
178	Rheumatoid Arthritis (RA): Functional Status Assessment	Effective Clinical Care
179	Rheumatoid Arthritis (RA): Assessment and Classification of Disease Prognosis	Effective Clinical Care
180	Rheumatoid Arthritis (RA): Glucocorticoid Management	Effective Clinical Care
187	Stroke and Stroke Rehabilitation: Thrombolytic Therapy	Effective Clinical Care
191 (CMS133v3)	Cataracts: 20/40 or Better Visual Acuity Within 90 Days Following Cataract Surgery	Effective Clinical Care
194	Oncology: Cancer Stage Documented	Effective Clinical Care
195	Radiology: Stenosis Measurement in Carotid Imaging Reports	Effective Clinical Care
204 (GPRO IVD-2, CMS164v3)	Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic	Effective Clinical Care
205	HIV/AIDS: Sexually Transmitted Disease Screening for Chlamydia, Gonorrhea, and Syphilis	Effective Clinical Care
236 (GPRO HTN-2, CMS165v3)	Controlling High Blood Pressure	Effective Clinical Care
241 (CMS182v4)	Ischemic Vascular Disease (IVD): Complete Lipid Profile and LDL-C Control (< 100 mg/dL)	Effective Clinical Care
242	Coronary Artery Disease (CAD): Symptom Management	Effective Clinical Care
243	Cardiac Rehabilitation Patient Referral from an Outpatient Setting	Effective Clinical Care
249	Barrett's Esophagus	Effective Clinical Care
250	Radical Prostatectomy Pathology Reporting	Effective Clinical Care
251	Quantitative Immunohistochemical (IHC) Evaluation of Human Epidermal Growth Factor Receptor 2 Testing (HER2) for Breast Cancer Patients	Effective Clinical Care
254	Ultrasound Determination of Pregnancy Location for Pregnant Patients with Abdominal Pain	Effective Clinical Care
255	Rh Immunoglobulin (Rhogam) for Rh-Negative Pregnant Women at Risk of Fetal Blood Exposure	Effective Clinical Care
257	Statin Therapy at Discharge After Lower Extremity Bypass (LEB)	Effective Clinical Care
263	Preoperative Diagnosis of Breast Cancer	Effective Clinical Care
264	Sentinel Lymph Node Biopsy for Invasive Breast Cancer	Effective Clinical Care

PQRS or QCDR Number (GPRO/eCQM Number)	Measure Name	Quality Domain
268	Epilepsy: Counseling for Women of Childbearing Potential with Epilepsy	Effective Clinical Care
270	Inflammatory Bowel Disease (IBD): Preventive Care: Corticosteroid Sparing Therapy	Effective Clinical Care
271	Inflammatory Bowel Disease (IBD): Preventive Care: Corticosteroid Related Iatrogenic Injury – Bone Loss Assessment	Effective Clinical Care
274	Inflammatory Bowel Disease (IBD): Testing for Latent Tuberculosis (TB) Before Initiating Anti-TNF (Tumor Necrosis Factor) Therapy	Effective Clinical Care
275	Inflammatory Bowel Disease (IBD): Assessment of Hepatitis B Virus (HBV) Status Before Initiating Anti-TNF (Tumor Necrosis Factor) Therapy	Effective Clinical Care
276	Sleep Apnea: Assessment of Sleep Symptoms	Effective Clinical Care
277	Sleep Apnea: Severity Assessment at Initial Diagnosis	Effective Clinical Care
278	Sleep Apnea: Positive Airway Pressure Therapy Prescribed	Effective Clinical Care
279	Sleep Apnea: Assessment of Adherence to Positive Airway Pressure Therapy	Effective Clinical Care
280	Dementia: Staging of Dementia	Effective Clinical Care
281 (CMS149v3)	Dementia: Cognitive Assessment	Effective Clinical Care
282	Dementia: Functional Status Assessment	Effective Clinical Care
283	Dementia: Neuropsychiatric Symptom Assessment	Effective Clinical Care
284	Dementia: Management of Neuropsychiatric Symptoms	Effective Clinical Care
285	Dementia: Screening for Depressive Symptoms	Effective Clinical Care
287	Dementia: Counseling Regarding Risks of Driving	Effective Clinical Care
289	Parkinson's Disease: Annual Parkinson's Disease Diagnosis Review	Effective Clinical Care
290	Parkinson's Disease: Psychiatric Disorders or Disturbances Assessment	Effective Clinical Care
291	Parkinson's Disease: Cognitive Impairment or Dysfunction Assessment	Effective Clinical Care
292	Parkinson's Disease: Querying About Sleep Disturbances	Effective Clinical Care
305 (CMS137v3)	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	Effective Clinical Care
309 (CMS124v3)	Cervical Cancer Screening	Effective Clinical Care
311 (CMS126v3)	Use of Appropriate Medications for Asthma	Effective Clinical Care

PQRS or QCDR Number (GPRO/eCQM Number)	Measure Name	Quality Domain
316a (CMS61v4)	Preventive Care and Screening: Cholesterol - Fasting Low Density Lipoprotein (LDL-C) Test Performed	Effective Clinical Care
316b (CMS64v4)	Preventive Care and Screening: Risk-Stratified Cholesterol – Fasting Low Density Lipoprotein (LDL-C)	Effective Clinical Care
326	Atrial Fibrillation and Atrial Flutter: Chronic Anticoagulation Therapy	Effective Clinical Care
327	Pediatric Kidney Disease: Adequacy of Volume Management	Effective Clinical Care
328*	Pediatric Kidney Disease: ESRD Patients Receiving Dialysis: Hemoglobin Level < 10 g/Dl	Effective Clinical Care
329*	Adult Kidney Disease: Catheter Use at Initiation of Hemodialysis	Effective Clinical Care
330*	Adult Kidney Disease: Catheter Use for Greater Than or Equal to 90 Days	Effective Clinical Care
337	Tuberculosis Prevention for Psoriasis, Psoriatic Arthritis and Rheumatoid Arthritis Patients on a Biological Immune Response Modifier	Effective Clinical Care
338	HIV Viral Load Suppression	Effective Clinical Care
339	Prescription of HIV Antiretroviral Therapy	Effective Clinical Care
343	Screening Colonoscopy Adenoma Detection Rate Measure	Effective Clinical Care
344	Rate of Carotid Artery Stenting (CAS) for Asymptomatic Patients, Without Major Complications (Discharged to Home by Postoperative Day #2)	Effective Clinical Care
345*	Rate of Postoperative Stroke or Death in Asymptomatic Patients Undergoing Carotid Artery Stenting (CAS)	Effective Clinical Care
346*	Rate of Postoperative Stroke or Death in Asymptomatic Patients Undergoing Carotid Endarterectomy (CEA)	Effective Clinical Care
349	Optimal Vascular Composite	Effective Clinical Care
356*	Unplanned Hospital Readmission Within 30 Days of Principal Procedure	Effective Clinical Care
357*	Surgical Site Infection (SSI)	Effective Clinical Care
365 (CMS148v3)	Hemoglobin A1c Test for Pediatric Patients	Effective Clinical Care
366 (CMS136v4)	ADHD: Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication	Effective Clinical Care

PQRS or QCDR Number (GPRO/eCQM Number)	Measure Name	Quality Domain
367 (CMS169v3)	Bipolar Disorder and Major Depression: Appraisal for Alcohol or Chemical Substance Use	Effective Clinical Care
368 (CMS62v3)	HIV/AIDS: Medical Visit	Effective Clinical Care
369 (CMS158v3)	Pregnant Women that Had HBsAg Testing	Effective Clinical Care
370 (GPRO MH-1, CMS159v3)	Depression Remission at Twelve Months	Effective Clinical Care
371 (CMS160v3)	Depression Utilization of the PHQ-9 Tool	Effective Clinical Care
373 (CMS65v4)	Hypertension: Improvement in Blood Pressure	Effective Clinical Care
378* (CMS75v3)	Children Who Have Dental Decay or Cavities	Effective Clinical Care
379 (CMS74v4)	Primary Caries Prevention Intervention as Offered by Primary Care Providers, Including Dentists	Effective Clinical Care
381 (CMS77v3)	HIV/AIDS: RNA Control for Patients with HIV	Effective Clinical Care
384	Adult Primary Rhegmatogenous Retinal Detachment Repair Success Rate	Effective Clinical Care
385	Adult Primary Rhegmatogenous Retinal Detachment Surgery Success Rate	Effective Clinical Care
387	Annual Hepatitis C Virus (HCV) Screening for Patients Who Are Active Injection Drug Users	Effective Clinical Care
389	Cataract Surgery: Difference Between Planned and Final Refraction	Effective Clinical Care
398	Optimal Asthma Control	Effective Clinical Care
399	Post-Procedural Optimal Medical Therapy Composite (Percutaneous Coronary Intervention)	Effective Clinical Care
400	Hepatitis C: One-Time Screening for Hepatitis C Virus (HCV) for Patients at Risk	Effective Clinical Care
401	Screening for Hepatocellular Carcinoma (HCC) in Patients with Hepatitis C Cirrhosis	Effective Clinical Care
-	Diabetes Mellitus (DM): Composite (All or Nothing Scoring)	Effective Clinical Care
AAAAI 2	Asthma: Assessment of Asthma Control - Ambulatory Care Setting	Effective Clinical Care
AAAAI 8	Achievement of Projected Effective Dose of Standardized Allergens for Patient Treated with Allergen Immunotherapy for at Least One Year	Effective Clinical Care
AAAAI 11	Asthma Assessment and Classification	Effective Clinical Care
AAAAI 12	Lung Function/Spirometry Evaluation	Effective Clinical Care
ABG 1	Anesthesia Safety in the Perioperative Period	Effective Clinical Care

PQRS or QCDR Number (GPRO/eCQM Number)	Measure Name	Quality Domain
ABG 6*	Rate of Unplanned Use of Difficult Airway Equipment and/or Failed Airway	Effective Clinical Care
ACCCath 5	STEMI Patients Receiving Immediate PCI Within 90 Minutes	Effective Clinical Care
ACCCath 6	ACE-I or ARB Prescribed at Discharge for Patients with an Ejection Fraction < 40% Who Had a PCI During the Episode of Care	Effective Clinical Care
ACCCath 7	Beta-Blockers Prescribed at Discharge for AMI Patients Who Had a PCI During Admission	Effective Clinical Care
ACCCath 8	Percutaneous Coronary Intervention (PCI): Post-Procedural Optimal Medical Therapy	Effective Clinical Care
ACCFocus 9*	Ratio: Initial Evaluations to Post Procedure/Follow-Up Evaluations with Cardiac Stress Imaging	Effective Clinical Care
ACCFocus 10*	Ratio: Initial Evaluations with Cardiac Stress Imaging for Symptomatic Patients to Initial Evaluations for Asymptomatic Patients	Effective Clinical Care
ACCPin 1	Hypertension (HTN): Blood Pressure (BP) Management	Effective Clinical Care
ACCPin 2	Coronary Artery Disease (CAD): Blood Pressure Control	Effective Clinical Care
ACEP 14	tPA Considered	Effective Clinical Care
ACR 1	Disease Activity Measurement for Patients with Rheumatoid Arthritis (RA)	Effective Clinical Care
ACR 2	Functional Status Assessment for Patients with Rheumatoid Arthritis (RA)	Effective Clinical Care
ACR 3	Disease-Modifying Anti-Rheumatic Drug (DMARD) Therapy for Active Rheumatoid Arthritis (RA)	Effective Clinical Care
ACR 5	Glucocorticosteroids and Other Secondary Causes	Effective Clinical Care
ACR 6	Serum Urate Monitoring	Effective Clinical Care
ACR 7	Gout: Serum Urate Target	Effective Clinical Care
ACR 8	Gout: ULT Therapy	Effective Clinical Care
ACRad 1	CT Colonography True Positive Rate	Effective Clinical Care
ACRad 3	Screening Mammography Cancer Detection Rate (CDR)	Effective Clinical Care
ACRad 4	Screening Mammography Invasive Cancer Detection Rate (ICDR)	Effective Clinical Care
ACRad 6	Screening Mammography Positive Predictive Value 2 (PPV2 – Biopsy Recommended)	Effective Clinical Care
ACRad 7	Screening Mammography Node Negativity Rate	Effective Clinical Care
ACRad 8	Screening Mammography Minimal Cancer Rate	Effective Clinical Care
ACRad 21	Lung Cancer Screening Cancer Detection Rate (CDR)	Effective Clinical Care

PQRS or QCDR Number (GPRO/eCQM Number)	Measure Name	Quality Domain
ACRad 22	Lung Cancer Screening Positive Predictive Value (PPV)	Effective Clinical Care
ACS 7*	Risk Standardized Mortality Rate Within 30 Days Following Trauma Operation	Effective Clinical Care
ACS 8*	Risk Standardized Pneumonia Rate Within 30 Days Following Operation	Effective Clinical Care
ACS 9*	Risk Standardized Urinary Tract Infection Rate Within 30 Days Following Operation	Effective Clinical Care
ACS 10*	Risk Standardized Decubitus Ulcer Rate Within 30 Days Following Operation	Effective Clinical Care
AGACCSSR 2	Colonoscopy Assessment (Cecum Reached) - Cecal Intubation / Depth of Intubation	Effective Clinical Care
AQI 5	Composite Anesthesia Safety	Effective Clinical Care
AQI 18	Coronary Artery Bypass Graft (CABG): Prolonged Intubation	Effective Clinical Care
AQI 19	Coronary Artery Bypass Graft (CABG): Stroke	Effective Clinical Care
AQI 20	Coronary Artery Bypass Graft (CABG): Postoperative Renal Failure	Effective Clinical Care
AQI 21	Rate of Postoperative Stroke or Death in Asymptomatic Patients Undergoing Carotid Artery Stenting (CAS)	Effective Clinical Care
AQI 22	Rate of Postoperative Stroke or Death in Asymptomatic Patients Undergoing Carotid Artery Endarterectomy (CAE)	Effective Clinical Care
AQI 23	Rate of Endovascular Aneurysm Repair (EVAR) of Small or Moderate Non-Ruptured Abdominal Aortic Aneurysms (AAA) Who Die While in Hospital	Effective Clinical Care
AQI 26	Unplanned Hospital Readmission Within 30 Days of Principal Procedure	Effective Clinical Care
AQI 27	Surgical Site Infection	Effective Clinical Care
ASBS 1	Surgeon Assessment for Hereditary Cause of Breast Cancer	Effective Clinical Care
ASNC 11	Overall Study Quality	Effective Clinical Care
ASPIRE 2	Train of Four Monitor Documented After Last Dose of Nondepolarizing Neuromuscular Blocker	Effective Clinical Care
ASPIRE 3	Administration of Neostigmine Before Extubation for Cases with Nondepolarizing Neuromuscular Blockade	Effective Clinical Care
ASPIRE 4	Administration of Insulin or Glucose Recheck for Patients with Hyperglycemia	Effective Clinical Care
ASPIRE 7	Active Warming for All Patients at Risk of Intraoperative Hypothermia	Effective Clinical Care
ASPIRE 8	Core Temperature Measurement for All General Anesthetics	Effective Clinical Care
ASPIRE 12	Hemoglobin or Hematrocrit Measurement for Patients Receiving Discretionary Intraoperative Red Blood Cell Transfusions	Effective Clinical Care
ASPIRE 17	Avoiding Gaps in Systolic or Mean Arterial Pressure Measurement	Effective Clinical Care

PQRS or QCDR Number (GPRO/eCQM Number)	Measure Name	Quality Domain
ASPIRE 18*	Avoiding Myocardial Injury	Effective Clinical Care
ASPIRE 19*	Avoiding Acute Kidney Injury	Effective Clinical Care
ASPIRE 21*	All Cause 30-Day Mortality	Effective Clinical Care
AUGSPFDR 2	Performing Vaginal Apical Suspension at the Time of Hysterectomy to Address Pelvic Organ Prolapse	Effective Clinical Care
AUGSPFDR 9	Preoperative Evaluation for Stress Urinary Incontinence Prior to Hysterectomy for Pelvic Organ Prolapse	Effective Clinical Care
AUGSPFDR 12	Preoperative Assessment of Sexual Function Prior to Any Pelvic Organ Prolapse Repair	Effective Clinical Care
ECPR 24	Initiation of the Initial Sepsis Bundle	Effective Clinical Care
FORCE 4	Improvement in Function After Knee Replacement	Effective Clinical Care
FORCE 5	Improvement in Pain After Knee Replacement	Effective Clinical Care
FORCE 9	Improvement in Function After Hip Replacement	Effective Clinical Care
FORCE 10	Improvement in Pain After Hip Replacement Measure	Effective Clinical Care
GIQIC 1	Adenoma Detection Rate	Effective Clinical Care
GIQIC 2	Adequacy of Bowel Preparation	Effective Clinical Care
GIQIC 3	Photodocumentation of the Cecum (also known as Cecal Intubation Rate) - All Colonoscopies	Effective Clinical Care
GIQIC 4	Photodocumentation of the Cecum (also known as Cecal Intubation Rate) - Screening Colonoscopies	Effective Clinical Care
GIQIC 9	Documentation of History and Physical Rate - Colonoscopy	Effective Clinical Care
GIQIC 12	Appropriate Indication for Colonoscopy	Effective Clinical Care
HCPR 14	Stroke Patients Discharged on Statin Medication	Effective Clinical Care
ICLOPS 12*	Cholecystectomy Outcomes After 90 Days	Effective Clinical Care
ICLOPS 13*	Unexpected Outcomes After Breast Cancer Surgery	Effective Clinical Care
ICLOPS 14*	Postoperative Sepsis Rate	Effective Clinical Care
IRIS 1	Corneal Graft: 20/40 or Better Visual Acuity Within 90 Days Following Corneal Graft Surgery	Effective Clinical Care
IRIS 2	Open-Angle Glaucoma: Intraocular Pressure Reduction	Effective Clinical Care
IRIS 3*	Open-Angle Glaucoma: Visual Field Progression	Effective Clinical Care

PQRS or QCDR Number (GPRO/eCQM Number)	Measure Name	Quality Domain
IRIS 4	Open-Angle Glaucoma: Intraocular Pressure Reduction Following Laser Trabeculoplasty	Effective Clinical Care
IRIS 5	Acquired Involutional Ptosis: Improvement of Marginal Reflex Distance Within 90 Days Following Surgery for Acquired Involutional Ptosis	Effective Clinical Care
IRIS 6	Acquired Involutional Entropion: Normalization of Eyelid Position Within 90 Days Following Surgery for Acquired Involutional Entropion	Effective Clinical Care
IRIS 7	Amblyopia: Improvement of Corrected Interocular Visual Acuity Difference to 2 or Fewer Lines	Effective Clinical Care
IRIS 8	Surgical Esotropia: Patients with Postoperative Alignment of 15 PD or Less	Effective Clinical Care
IRIS 9	Diabetic Retinopathy: Dilated Eye Exam	Effective Clinical Care
IRIS 10	Exudative Age-Related Macular Degeneration: Loss of Visual Acuity	Effective Clinical Care
IRIS 11	Nonexudative Age-Related Macular Degeneration: Loss of Visual Acuity	Effective Clinical Care
IRIS 12*	Age-Related Macular Degeneration: Disease Progression	Effective Clinical Care
IRIS 13	Diabetic Macular Edema: Loss of Visual Acuity	Effective Clinical Care
IRIS 14	Rhegmatogenous Retinal Detachment Surgery: Visual Acuity Improvement Within 90 Days of Surgery	Effective Clinical Care
IRIS 15*	Rhegmatogenous Retinal Detachment Surgery: Return to the Operating Room Within 90 Days of Surgery	Effective Clinical Care
IRIS 16	Acute Anterior Uveitis: Post-Treatment Visual Acuity	Effective Clinical Care
IRIS 17	Acute Anterior Uveitis: Post-Treatment Grade 0 Anterior Chamber Cells	Effective Clinical Care
IRIS 18	Chronic Anterior Uveitis: Post-Treatment Visual Acuity	Effective Clinical Care
IRIS 19	Chronic Anterior Uveitis: Post-Treatment Grade 0 Anterior Chamber Cells	Effective Clinical Care
M2S 1	Procedures with Statin and Antiplatelet Agents Prescribed at Discharge	Effective Clinical Care
M2S 7	Ipsilateral Stroke-Free Survival at One-Year Following Isolated Carotid Artery Stenting for Asymptomatic Procedures	Effective Clinical Care
M2S 8	Ipsilateral Stroke-Free Survival at One-Year Following Isolated CEA for Asymptomatic Procedures	Effective Clinical Care
M2S 10	One-Year Survival After Elective Repair of Small Thoracic Aortic Aneurysms	Effective Clinical Care
M2S 12	One-Year Survival After Elective Repair of Small Abdominal Aortic Aneurysms	Effective Clinical Care
M2S 13	One-Year Survival After Elective Open Repair of Small Abdominal Aortic Aneurysms	Effective Clinical Care
M2S 15	Appropriate Management of Retrievable IVC Filters	Effective Clinical Care
MBS 4	MBSC Venous Thromboembolism Prophylaxis Adherence Rates for Perioperative Care	Effective Clinical Care

PQRS or QCDR Number (GPRO/eCQM Number)	Measure Name	Quality Domain
MBS 5	MBSC Venous Thromboembolism Prophylaxis Adherence Rates for Postoperative Care	Effective Clinical Care
MBS 6	MBSC Venous Thromboembolism Prophylaxis Adherence Rates for Post-discharge Care	Effective Clinical Care
MBSAQIP 1*	Risk Standardized Rate of Patients Who Experienced a Postoperative Complication Within 30 Days Following a Laparoscopic Roux-en-Y Gastric Bypass or Laparoscopic Sleeve Gastrectomy Operation, Performed as a Primary (Not Revisional) Procedure	Effective Clinical Care
MBSAQIP 4*	Risk Standardized Rate of Patients Who Experienced an Anastomotic/Staple Line Leak Within 30 Days Following a Laparoscopic Roux-en-Y Gastric Bypass or Laparoscopic Sleeve Gastrectomy Operation, Performed as a Primary (Not Revisional) Procedure	Effective Clinical Care
MBSAQIP 5*	Risk Standardized Rate of Patients Who Experienced a Bleeding/Hemorrhage Event Requiring Transfusion, Intervention/Operation, or Readmission Within 30 Days Following a Laparoscopic Roux-en-Y Gastric Bypass or Laparoscopic Sleeve Gastrectomy Operation, Performed as a Primary (Not Revisional) Procedure	Effective Clinical Care
MBSAQIP 6*	Risk Standardized Rate of Patients Who Experienced a Postoperative Surgical Site Infection (SSI) (Superficial Incisional, Deep Incisional, or Organ/Space SSI) Within 30 Days Following a Laparoscopic Roux-en-Y Gastric Bypass or Laparoscopic Sleeve Gastrectomy Operation, Performed as a Primary (Not Revisional) Procedure	Effective Clinical Care
MBSAQIP 7*	Risk Standardized Rate of Patients Who Experienced Postoperative Nausea, Vomiting or Fluid/Electrolyte/Nutritional Depletion Within 30 Days Following a Laparoscopic Roux-en-Y Gastric Bypass or Laparoscopic Sleeve Gastrectomy Operation, Performed as a Primary (Not Revisional) Procedure	Effective Clinical Care
MUSIC 2*	Unplanned Hospital Admission Within 30 Days of TRUS Biopsy	Effective Clinical Care
MUSIC 4	Prostate Cancer: Proportion of Patients with Low-Risk Prostate Cancer Receiving Active Surveillance	Effective Clinical Care
MUSIC 5*	Prostate Cancer: Percentage of Prostate Cancer Cases with a Length of Stay > 2 Days	Effective Clinical Care
MUSIC 7	Prostate Biopsy: Proportion of Patients Undergoing Initial Prostate Biopsy in the Registry Found to Have Prostate Cancer	Effective Clinical Care
MUSIC 9	Prostate Biopsy: Proportion of Patients Undergoing a Repeat Prostate Biopsy Within 12 Months of Their Initial Biopsy in the Registry as a Result of a Finding of Atypical Small Acinar Proliferation (ASAP) as per the NCCN Guidelines	Effective Clinical Care
NHCR 1	Adequacy of Bowel Preparation	Effective Clinical Care
NHCR 2	Successful Cecal Intubation	Effective Clinical Care
NHCR 5	Repeat Colonoscopy Recommended Due to Piecemeal Resection	Effective Clinical Care
NHCR 7	Documentation of Family History	Effective Clinical Care
NHCR 8	Documentation of Indication for Exam	Effective Clinical Care

PQRS or QCDR Number (GPRO/eCQM Number)	Measure Name	Quality Domain
NOF 1	Laboratory Investigation for Secondary Causes of Fracture	Effective Clinical Care
NOF 4	Osteoporosis Management in Women Who Had a Fracture	Effective Clinical Care
NOF 5	Osteoporosis Testing in Older Women	Effective Clinical Care
NOF 6*	Hip Fracture Mortality Rate (IQI 19)	Effective Clinical Care
NOF 7	Osteoporosis: Percentage of Patients, Any Age, with a Diagnosis of Osteoporosis Who Are Either Receiving Both Calcium & Vitamin D Intake, & Exercise at Least Once Within 12 Months	Effective Clinical Care
NOF 8	Osteoporosis: Percentage of Patients Aged 50 Years and Older with a Diagnosis of Osteoporosis Who Were Prescribed Pharmacologic Therapy Within 12 Months	Effective Clinical Care
NOF 9	Communication with the Physician or Other Clinician Managing On-Going Care Post Fracture for Men and Women Aged 50 Years and Older	Effective Clinical Care
NOF 11	Care for Older Adults (COA) - Medication Review	Effective Clinical Care
NOF 12*	Median Time to Pain Management for Long Bone Fracture	Effective Clinical Care
NOF 13	Osteoporosis: Management Following Fracture of Hip, Spine or Distal Radius for Men and Women Aged 50 Years and Older	Effective Clinical Care
NOF 15	Screening for Osteoporosis for Women 65-85 Years of Age	Effective Clinical Care
NOF 16	Glucocorticosteroids and Other Secondary Causes ("ACR5")	Effective Clinical Care
NPA 6*	Spine-Related Procedure Site Infection	Effective Clinical Care
NPA 7*	Complication Following Spine-Related Procedure	Effective Clinical Care
NPA 8*	Hospital Mortality Following Spine Procedure	Effective Clinical Care
NPA 9	Referral for Post-Acute Care Rehabilitation	Effective Clinical Care
OBERD 10	Quality of Life (VR-12 or Promis Global 10) Monitoring	Effective Clinical Care
OBERD 11	Quality of Life (VR-12 or Promis Global 10) Outcomes	Effective Clinical Care
OBERD 13*	Orthopedic Functional and Pain Level Outcomes	Effective Clinical Care
OBERD 14	Orthopedic 3-Month Surgery Follow-Up	Effective Clinical Care
OBERD 15	Orthopedic 3-Month Surgery Outcome	Effective Clinical Care
OBERD 16	Orthopedic 3-Month Surgery Success Rate	Effective Clinical Care
OBERD 18	Orthopedic 3-Month Surgery Outcome with Promis	Effective Clinical Care

PQRS or QCDR Number (GPRO/eCQM Number)	Measure Name	Quality Domain
ONSQIR 1	Symptom Assessment	Effective Clinical Care
ONSQIR 2	Intervention for Psychosocial Distress	Effective Clinical Care
ONSQIR 3	Intervention for Fatigue	Effective Clinical Care
ONSQIR 4	Intervention for Sleep -Wake Disturbance	Effective Clinical Care
ONSQIR 5	Assessment for Chemotherapy Induced Nausea and Vomiting	Effective Clinical Care
ONSQIR 6	Education on Neutropenia Precautions	Effective Clinical Care
ONSQIR 7	Post-Treatment Symptom Assessment	Effective Clinical Care
ONSQIR 8	Post-Treatment Symptom Intervention	Effective Clinical Care
OQIC 10*	PET Utilization in Breast Cancer Surveillance	Effective Clinical Care
OQIC 11*	CEA and Breast Cancer	Effective Clinical Care
OQIC 12*	GCSF Utilization in Metastatic Colon Cancer	Effective Clinical Care
OQIC 13	Appropriate Antiemetic Usage	Effective Clinical Care
OQIC 14	Appropriate Trastuzumab Use in Women with HER2/neu Gene Over Expression	Effective Clinical Care
OQIC 15	Appropriate Use of Antibody Therapy in Colon Cancer	Effective Clinical Care
OQIC 16	Appropriate Use of Late Line Chemotherapy in Metastatic Lung Cancer	Effective Clinical Care
OQIC 17	Intensity-Modulated Radiation Therapy (IMRT)	Effective Clinical Care
OQIC 24	Cancer Care: Electronic Documentation of IOM Care Management Plan	Effective Clinical Care
OQIC 26	Cancer Care: Guideline-Compliant Treatment	Effective Clinical Care
PInc 38	Adolescent Well Care Visit	Effective Clinical Care
PInc 39	Well-Child Visits in the 1st 15 Months of Life	Effective Clinical Care
PInc 40	Developmental Screening in 1st 3 Years of Life	Effective Clinical Care
PInc 41	Well Child Visits in the 3rd, 4th, 5th, and 6th Years of Life	Effective Clinical Care
PPRNET 1	Diabetes Mellitus (DM): Hemoglobin A1c Control (< 8%)	Effective Clinical Care
PPRNET 2	Diabetes Mellitus (DM): Nephropathy Assessment	Effective Clinical Care

PQRS or QCDR Number (GPRO/eCQM Number)	Measure Name	Quality Domain
PPRNET 3	Diabetes Mellitus (DM): Dilated Eye Exam	Effective Clinical Care
PPRNET 4	Hypertension (HTN): Appropriate Diagnosis	Effective Clinical Care
PPRNET 5	Hypertension (HTN): Controlling Blood Pressure	Effective Clinical Care
PPRNET 6	Concordance with ACC/AHA Cholesterol Guidelines for ASCVD Risk Reduction	Effective Clinical Care
PPRNET 8	Antiplatelet Medication for High Risk Patients	Effective Clinical Care
PPRNET 9	Antithrombotic Medication for Patients with Atrial Fibrillation	Effective Clinical Care
PPRNET 10	Heart Failure (HF): ACEI or ARB Therapy	Effective Clinical Care
PPRNET 11	Heart Failure (HF): Beta-Blocker Therapy	Effective Clinical Care
PPRNET 13	Chronic Kidney Disease (CKD): eGFR Monitoring	Effective Clinical Care
PPRNET 14	Chronic Kidney Disease (CKD): Hemoglobin Monitoring	Effective Clinical Care
QOPI 1	Staging Documented Within One Month of First Office Visit	Effective Clinical Care
QOPI 7	Antiemetic Therapy Prescribed for Highly Emetogenic Chemotherapy	Effective Clinical Care
QOPI 8	Antiemetic Therapy Prescribed for Moderately Emetogenic Chemotherapy	Effective Clinical Care
QOPI 11	Combination Chemotherapy Received Within 4 Months of Diagnosis by Women Under 70 with AJCC Stage I (T1c) to III ER/PR Negative Breast Cancer	Effective Clinical Care
QOPI 12	Test for Her2/neu Overexpression or Gene Amplification	Effective Clinical Care
QOPI 13	Trastuzumab Received by Patients with AJCC Stage I (T1c) to III Her2/neu Positive Breast Cancer	Effective Clinical Care
QOPI 14	Tamoxifen or AI Received Within 1 Year of Diagnosis by Patients with AJCC Stage I (T1c) to III ER or PR Positive Breast Cancer	Effective Clinical Care
QOPI 16	Adjuvant Chemotherapy Received Within 4 Months of Diagnosis by Patients with AJCC Stage III Colon Cancer	Effective Clinical Care
QOPI 17	Location of Death Documented (*Paired Measure)	Effective Clinical Care
QUANTUM 19*	Unplanned Hospital Admission	Effective Clinical Care
QUANTUM 20*	Unplanned ICU Admission	Effective Clinical Care
QUANTUM 21*	Blood Pressure Support Requiring Vasoactive Medication Infusion	Effective Clinical Care
RPAQIR 1	Angiotensin Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy (PCPI Measure #: AKID-2)	Effective Clinical Care
RPAQIR 2	Adequacy of Volume Management (PCPI Measure #: AKID-4)	Effective Clinical Care

PQRS or QCDR Number (GPRO/eCQM Number)	Measure Name	Quality Domain
RPAQIR 3*	ESRD Patients Receiving Dialysis: Hemoglobin Level < 19g/dL (PCPI Measure #: AKID-6)	Effective Clinical Care
RPAQIR 4	Arteriovenous Fistula Rate (PCPI Measure #: AKID-8)	Effective Clinical Care
THPSO 2*	Post-Dural Puncture Headache Rate	Effective Clinical Care
THPSO 3*	Perioperative Peripheral Nerve Injury Rate	Effective Clinical Care
THPSO 5	Ultrasound Guidance for Central Line Placement	Effective Clinical Care
THPSO 19	Composite Anesthesia Safety	Effective Clinical Care
CDR 1	Adequate Off-Loading of Diabetic Foot Ulcers at Each Visit	Effective Clinical Care
CDR 3	Plan of Care Creation for Diabetic Foot Ulcer (DFU) Patients Not Achieving 30% Closure at 4 Weeks	Effective Clinical Care
CDR 4	Diabetic Foot & Ankle Care: Comprehensive Diabetic Foot Examination	Effective Clinical Care
CDR 5	Adequate Compression at Each Visit for Patients with Venous Leg Ulcers (VLU)	Effective Clinical Care
CDR 7	Plan of Care for Venous Leg Ulcer Patients Not Achieving 30% Closure at 4 Weeks	Effective Clinical Care
CDR 9	Appropriate Use of Cellular or Tissue Based Products (CTP) for Patients Aged 18 Years or Older with a Diabetic Foot Ulcer (DFU) or Venous Leg Ulcer (VLU)	Effective Clinical Care
CDR 10	Vascular Assessment of Patients with Chronic Leg Ulcers	Effective Clinical Care
CDR 11	Wound Bed Preparation Through Debridement of Necrotic or Non-Viable Tissue	Effective Clinical Care
USWR 15	Healing or Closure of Wagner Grade 3, 4 or 5 Diabetic Foot Ulcers (DFUs) Treated with HBOT	Effective Clinical Care
USWR 16	Major Amputation in Wagner Grade 3, 4 or 5 Diabetic Foot Ulcers (DFUs) Treated with HBOT	Effective Clinical Care
USWR 17	Preservation of Function with a Minor Amputation Among Patients with Wagner Grade 3, 4, or 5 Diabetic Foot Ulcers (DFUs) Treated with HBOT	Effective Clinical Care
WCHQ 1	Diabetes Care A1C Blood Sugar Testing (Chronic Care)	Effective Clinical Care
WCHQ 2	Diabetes Care A1C Blood Sugar Control (Chronic Care)	Effective Clinical Care
WCHQ 5	Diabetes Care Kidney Function Monitored (Chronic Care)	Effective Clinical Care
WCHQ 6	Diabetes Care Blood Pressure Control (Chronic Care)	Effective Clinical Care
WCHQ 7	Diabetes Care Tobacco Free (Chronic Care)	Effective Clinical Care
WCHQ 8	Diabetes Care Daily Aspirin or Other Antiplatelet unless Contraindicated (Chronic Care)	Effective Clinical Care
WCHQ 9	Diabetes Care All or None Process Measure: Optimal Testing (Chronic Care)	Effective Clinical Care

PQRS or QCDR Number (GPRO/eCQM Number)	Measure Name	Quality Domain
WCHQ 10	Diabetes Care All or None Outcome Measure: Optimal Control (Chronic Care)	Effective Clinical Care
WCHQ 11	Controlling High Blood Pressure Blood Pressure Control (Chronic Care)	Effective Clinical Care
WCHQ 12	Ischemic Vascular Disease Care Daily Aspirin or Antiplatelet Medication Usage unless Contraindicated (Chronic Care)	Effective Clinical Care
WCHQ 13	Ischemic Vascular Disease Care Blood Pressure Control (Chronic Care)	Effective Clinical Care
WCHQ 14	Adults with Pneumococcal Vaccinations (Preventive Care)	Effective Clinical Care
WCHQ 15	Screening for Osteoporosis (Preventive Care)	Effective Clinical Care
WCHQ 16	Adult Tobacco Use Screening for Tobacco Use (Preventive Care)	Effective Clinical Care
WCHQ 17	Adult Tobacco Use Tobacco User Receiving Cessation Advice (Preventive Care)	Effective Clinical Care
WCHQ 18	Breast Cancer Screening (Preventive Care)	Effective Clinical Care
WCHQ 19	Cervical Cancer Screening (Preventive Care)	Effective Clinical Care
WCHQ 20	Colorectal Cancer Screening (Preventive Care)	Effective Clinical Care
WCHQ 21	Diabetes Care - Statin Use for Patients Ages 40 Through 75 or Patients with IVD of Any Age (Chronic Care)	Effective Clinical Care
WCHQ 22	Ischemic Vascular Disease Care - Statin Use (Chronic Care)	Effective Clinical Care
WCHQ 23	Ischemic Vascular Disease Care - Tobacco Free (Chronic Care)	Effective Clinical Care
WCHQ 24	Ischemic Vascular Disease Care - All or None Outcome Measure: Optimal Control (Chronic Care)	Effective Clinical Care
WCHQ 25	Screening for CKD (Preventive Care)	Effective Clinical Care
WCHQ 26	CKD Care in Stages I, II, and III. Annual eGFR (Estimated Glomerular Filtration Rate) Test (Chronic Care)	Effective Clinical Care
WCHQ 27	CKD Care in Stages I, II, and III. LDL Cholesterol Testing (Chronic Care)	Effective Clinical Care
WCHQ 28	CKD Care in Stages I, II, and III. LDL Cholesterol Control (Chronic Care)	Effective Clinical Care
WCHQ 29	CKD Care in Stages I, II, and III. Blood Pressure Control (Chronic Care)	Effective Clinical Care
WCQIC 9	Chronic Wound Care: Misdiagnosis and Differential Diagnosis	Effective Clinical Care
WCQIC 11	Hyperbaric Oxygen Therapy: Following UHMS Protocols	Effective Clinical Care
WCQIC 12	Chronic Wound Care: Documentation of Assessment of Wound Healing Progress	Effective Clinical Care
WELL 8	Depression Remission at 12 Months	Effective Clinical Care

PQRS or QCDR Number (GPRO/eCQM Number)	Measure Name	Quality Domain
WELL 10	HIV/AIDS: Pneumocystis Jiroveci Pneumonia (PCP) Prophylaxis	Effective Clinical Care
WELL 11	Primary Caries Prevention Intervention as Offered by Primary Care Providers, Including Dentists	Effective Clinical Care
WELL 12	Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication	Effective Clinical Care
WELL 13	Hemoglobin A1c Test for Pediatric Patients	Effective Clinical Care
WELL 14	Chlamydia Screening for Women	Effective Clinical Care
WELL 16	Low Density Lipoprotein (LDL) Management	Effective Clinical Care
WELL 18	Ischemic Vascular Disease (IVD): Complete Lipid Panel and LDL Control	Effective Clinical Care
WELL 21	Disease-Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis	Effective Clinical Care
WELL 25	Osteoporosis Management in Women Who Had a Fracture	Effective Clinical Care
WELL 26	Prenatal and Postpartum Care	Effective Clinical Care

*Lower performance rates on these measures indicate better performance. However, when standardizing measures for inclusion in the domain score, CMS transforms these measures to ensure that for all standardized scores entering the domain score, positive (+) scores indicate better performance and negative (-) scores indicate worse performance.

Exhibit B.2. Person and Caregiver-Centered Experience and Outcomes Domain Quality Indicators

PQRS or QCDR Number (GPRO/eCQM Number)	Measure Name	Quality Domain
50	Urinary Incontinence: Plan of Care for Urinary Incontinence in Women Aged 65 Years and Older	Person and Caregiver-Centered Experience and Outcomes
109	Osteoarthritis (OA): Function and Pain Assessment	Person and Caregiver-Centered Experience and Outcomes
143 (CMS157v3)	Oncology: Medical and Radiation – Pain Intensity Quantified	Person and Caregiver-Centered Experience and Outcomes
144	Oncology: Medical and Radiation – Plan of Care for Pain	Person and Caregiver-Centered Experience and Outcomes
303	Cataracts: Improvement in Patient's Visual Function Within 90 Days Following Cataract Surgery	Person and Caregiver-Centered Experience and Outcomes
304	Cataracts: Patient Satisfaction Within 90 Days Following Cataract Surgery	Person and Caregiver-Centered Experience and Outcomes
342	Pain Brought Under Control Within 48 Hours	Person and Caregiver-Centered Experience and Outcomes
358	Patient-Centered Surgical Risk Assessment and Communication	Person and Caregiver-Centered Experience and Outcomes
375 (CMS66v3)	Functional Status Assessment for Knee Replacement	Person and Caregiver-Centered Experience and Outcomes
376 (CMS56v3)	Functional Status Assessment for Hip Replacement	Person and Caregiver-Centered Experience and Outcomes
377 (CMS90v4)	Functional Status Assessment for Complex Chronic Conditions	Person and Caregiver-Centered Experience and Outcomes
386	Amyotrophic Lateral Sclerosis (ALS) Patient Care Preferences	Person and Caregiver-Centered Experience and Outcomes
390	Discussion and Shared Decision Making Surrounding Treatment Options	Person and Caregiver-Centered Experience and Outcomes
AAAAI 10	Documentation of the Consent Process for Subcutaneous Allergen Immunotherapy in the Medical Record	Person and Caregiver-Centered Experience and Outcomes
AAAAI 14	Patient Self-Management and Action Plan	Person and Caregiver-Centered Experience and Outcomes
AAAAI 16	Optimal Asthma Control	Person and Caregiver-Centered Experience and Outcomes
AAAAI 17	Asthma Control: Minimal Important Difference Improvement	Person and Caregiver-Centered Experience and Outcomes

PQRS or QCDR Number (GPRO/eCQM Number)	Measure Name	Quality Domain
ABG 7	Immediate Adult Postoperative Pain Management	Person and Caregiver-Centered Experience and Outcomes
ABG 12	Anesthesia: Patient Experience Survey	Person and Caregiver-Centered Experience and Outcomes
ACEP 5*	ED LOS for Discharged Patients - Overall Rate	Person and Caregiver-Centered Experience and Outcomes
ACEP 6*	ED LOS for Discharged Patients - General Rate	Person and Caregiver-Centered Experience and Outcomes
ACEP 7*	ED LOS for Discharged Patients - Psych/Mental Health	Person and Caregiver-Centered Experience and Outcomes
ACEP 8*	ED LOS for Discharged Patients - Transfers	Person and Caregiver-Centered Experience and Outcomes
AQI 2	Prevention of Postoperative Nausea and Vomiting (PONV) - Combination Therapy (Adults)	Person and Caregiver-Centered Experience and Outcomes
AQI 3	Prevention of Postoperative Vomiting (POV) - Combination Therapy (Pediatrics)	Person and Caregiver-Centered Experience and Outcomes
AQI 9	Short-Term Pain Management	Person and Caregiver-Centered Experience and Outcomes
AQI 11	Composite Patient Experience Measure	Person and Caregiver-Centered Experience and Outcomes
ASBS 2*	Surgical Site Infection and Cellulitis After Breast and/or Axillary Surgery	Person and Caregiver-Centered Experience and Outcomes
ASPIRE 9	At-Risk Adults Undergoing General Anesthesia Given 2 or More Classes of Antiemetics	Person and Caregiver-Centered Experience and Outcomes
ASPIRE 10	At-Risk Pediatric Patients Undergoing General Anesthesia Given 2 or More Classes of Antiemetics	Person and Caregiver-Centered Experience and Outcomes
ASPIRE 20	Preventing Uncontrolled Postoperative Pain	Person and Caregiver-Centered Experience and Outcomes
BIVARUS 11	The Doctor Provided Follow-Up Care Instructions in a Way I Could Understand	Person and Caregiver-Centered Experience and Outcomes
BIVARUS 12	I Was Involved in Developing My Care or Follow-Up Plan	Person and Caregiver-Centered Experience and Outcomes
BIVARUS 13	My Pain Was Treated Effectively	Person and Caregiver-Centered Experience and Outcomes
BIVARUS 14	My Doctor Involved Me in Decisions About My Tests	Person and Caregiver-Centered Experience and Outcomes

PQRS or QCDR Number (GPRO/eCQM Number)	Measure Name	Quality Domain
BIVARUS 15	My Doctor Involved Me in Decisions About My Treatment or Referrals	Person and Caregiver-Centered Experience and Outcomes
BIVARUS 16	My Doctor Listened to Me	Person and Caregiver-Centered Experience and Outcomes
BIVARUS 17	My Doctor Made Me Feel Comfortable About Asking Questions	Person and Caregiver-Centered Experience and Outcomes
BIVARUS 18	My Doctor Included My Family in Decisions About My Care	Person and Caregiver-Centered Experience and Outcomes
CUHSM 3	CAHPS Clinician/Group Surveys - (Adult Primary Care, Pediatric Care, and Specialist Care Surveys)	Person and Caregiver-Centered Experience and Outcomes
CUHSM 4	CAHPS Health Plan Survey v 4.0 - Adult Questionnaire	Person and Caregiver-Centered Experience and Outcomes
CUHSM 5	Care for Older Adults (COA) - Medication Review	Person and Caregiver-Centered Experience and Outcomes
ECPR 4*	Mean Time from Emergency Department (ED) Arrival to ED Departure for All Discharged ED Patients	Person and Caregiver-Centered Experience and Outcomes
ECPR 5*	Mean Time from Emergency Department (ED) Arrival to ED Departure for Discharged Lower Acuity ED Patients	Person and Caregiver-Centered Experience and Outcomes
ECPR 6*	Mean Time from Emergency Department (ED) Arrival to ED Departure for Discharged Higher Acuity ED Patients	Person and Caregiver-Centered Experience and Outcomes
ECPR 7*	Mean Time from Emergency Department (ED) Arrival to ED Departure for Discharged Psychiatric/Mental Health Patients	Person and Caregiver-Centered Experience and Outcomes
ECPR 8*	Mean Time from Emergency Department (ED) Arrival to ED Departure for All ED Patients Placed into Inpatient or Observation Status	Person and Caregiver-Centered Experience and Outcomes
ECPR 9*	Mean Time from Emergency Department (ED) Arrival to ED Departure for Adult ED Patients Placed into Inpatient or Observation Status	Person and Caregiver-Centered Experience and Outcomes
ECPR 10*	Mean Time from Emergency Department (ED) Arrival to ED Departure for Pediatric ED Patients Placed into Inpatient or Observation Status	Person and Caregiver-Centered Experience and Outcomes
ECPR 25	Pain Management for Long Bone Fracture	Person and Caregiver-Centered Experience and Outcomes
FORCE 1	Functional Status Assessment for Knee Replacement	Person and Caregiver-Centered Experience and Outcomes
FORCE 2	Pain Status Assessment for Knee Replacement	Person and Caregiver-Centered Experience and Outcomes
FORCE 6	Functional Status Assessment for Hip Replacement	Person and Caregiver-Centered Experience and Outcomes

PQRS or QCDR Number (GPRO/eCQM Number)	Measure Name	Quality Domain
FORCE 7	Pain Status Assessment for Hip Replacement	Person and Caregiver-Centered Experience and Outcomes
FORCE 11	Functional Status Assessment for Patients with Knee OA	Person and Caregiver-Centered Experience and Outcomes
FORCE 12	Pain Status Assessment for Patients with Knee OA	Person and Caregiver-Centered Experience and Outcomes
FORCE 14	Functional Status Assessment for Patients with Hip OA	Person and Caregiver-Centered Experience and Outcomes
FORCE 15	Pain Status Assessment for Patients with Hip OA	Person and Caregiver-Centered Experience and Outcomes
HCPR 1*	Mean Time from Emergency Department (ED) Arrival to ED Departure for All ED Patients Placed into Inpatient or Observation Status	Person and Caregiver-Centered Experience and Outcomes
HCPR 10*	In-Hospital Mortality Rate for Inpatients with Pneumonia	Person and Caregiver-Centered Experience and Outcomes
HCPR 11*	In-Hospital Mortality Rate for Inpatients with CHF	Person and Caregiver-Centered Experience and Outcomes
HCPR 12*	In-Hospital Mortality Rate for Inpatients with COPD	Person and Caregiver-Centered Experience and Outcomes
ICLOPS 4	Patients Admitted to the ICU Who Have Care Preferences Documented	Person and Caregiver-Centered Experience and Outcomes
ICLOPS 10	Hospice and Palliative Care: Treatment Preferences	Person and Caregiver-Centered Experience and Outcomes
ICLOPS 11	Percentage of Hospice Patients with Documentation in the Clinical Record of a Discussion of Spiritual/Religious Concerns or Documentation that the Patient/Caregiver Did Not Want to Discuss	Person and Caregiver-Centered Experience and Outcomes
ICLOPS 26	Proactive Treatment for Patients with Diabetes	Person and Caregiver-Centered Experience and Outcomes
ICLOPS 27	Proactive Treatment for Patients with Heart Failure	Person and Caregiver-Centered Experience and Outcomes
ICLOPS 28	Proactive Treatment for Patients with Chronic Obstructive Pulmonary Disease (COPD)	Person and Caregiver-Centered Experience and Outcomes
ICLOPS 29	Proactive Treatment for Patients with Coronary Artery Disease (CAD)	Person and Caregiver-Centered Experience and Outcomes
INVIVO 2	Patient Education Documentation	Person and Caregiver-Centered Experience and Outcomes

PQRS or QCDR Number (GPRO/eCQM Number)	Measure Name	Quality Domain
INVIVO 3	Orthopedic and Spine Surgery: Depression & Anxiety Assessment	Person and Caregiver-Centered Experience and Outcomes
M2S 14	Disease Specific Patient-Reported Outcome Surveys for Varicose Vein Procedures	Person and Caregiver-Centered Experience and Outcomes
NOF 10	Advance Care Plan	Person and Caregiver-Centered Experience and Outcomes
NPA 1	Spine Pain Assessment	Person and Caregiver-Centered Experience and Outcomes
NPA 2	Extremity (Radicular) Pain Assessment	Person and Caregiver-Centered Experience and Outcomes
NPA 3	Functional Outcome Assessment for Spine Intervention	Person and Caregiver-Centered Experience and Outcomes
NPA 4	Quality of Life Assessment for Spine Intervention	Person and Caregiver-Centered Experience and Outcomes
NPA 5	Patient Satisfaction with Spine Care	Person and Caregiver-Centered Experience and Outcomes
OBERD 3	Back Pain: Shared Decision Making	Person and Caregiver-Centered Experience and Outcomes
OBERD 8	Orthopedic Pain: Shared Decision Making	Person and Caregiver-Centered Experience and Outcomes
OBERD 12	CG-CAHPS Adult Visit Composite Tracking	Person and Caregiver-Centered Experience and Outcomes
OBERD 17	CG-CAHPS Patient Rating	Person and Caregiver-Centered Experience and Outcomes
ONSQIR 10	Post-Treatment Goal Setting	Person and Caregiver-Centered Experience and Outcomes
ONSQIR 11	Post-Treatment Goal Attainment	Person and Caregiver-Centered Experience and Outcomes
ONSQIR 13*	Fatigue Improvement	Person and Caregiver-Centered Experience and Outcomes
ONSQIR 14	Psychosocial Distress Improvement	Person and Caregiver-Centered Experience and Outcomes
OQIC 1*	Hospital Emergency Room Chemotherapy Related Visits	Person and Caregiver-Centered Experience and Outcomes
OQIC 2*	Hospital Admissions Related to Complications of Chemotherapy	Person and Caregiver-Centered Experience and Outcomes

PQRS or QCDR Number (GPRO/eCQM Number)	Measure Name	Quality Domain
OQIC 4	Advance Care Planning in Stage 4 Disease	Person and Caregiver-Centered Experience and Outcomes
OQIC 5*	Chemotherapy in the Last Two Weeks of Life	Person and Caregiver-Centered Experience and Outcomes
OQIC 6*	In Hospital Deaths	Person and Caregiver-Centered Experience and Outcomes
OQIC 7*	In ICU Deaths	Person and Caregiver-Centered Experience and Outcomes
OQIC 9*	Hospice Admission Rate for Patients Dying with a Cancer Diagnosis	Person and Caregiver-Centered Experience and Outcomes
OQIC 23	Cancer Care: Assessment Using a Patient-Reported Outcomes Tool	Person and Caregiver-Centered Experience and Outcomes
PInc 27	VTE Warfarin Therapy Discharge Instructions	Person and Caregiver-Centered Experience and Outcomes
PInc 29*	Median Time from ED Arrival to ED Departure for Admitted ED Patients	Person and Caregiver-Centered Experience and Outcomes
PInc 30*	Admit Decision Time to ED Departure Time for Admitted Patients	Person and Caregiver-Centered Experience and Outcomes
QOPI 2	Pain Intensity Quantified by Second Office Visit	Person and Caregiver-Centered Experience and Outcomes
QOPI 3	Chemotherapy Intent Documented Before or Within Two Weeks After Administration	Person and Caregiver-Centered Experience and Outcomes
QOPI 9	Pain Intensity Quantified on Either of the Last Two Visits Before Death	Person and Caregiver-Centered Experience and Outcomes
QOPI 10	Hospice Enrollment and Enrolled More than 3 Days Before Death	Person and Caregiver-Centered Experience and Outcomes
QOPI 18	Death from Cancer in Intensive Care Unit (*Paired Measure)	Person and Caregiver-Centered Experience and Outcomes
QOPI 19*	Chemotherapy Administered Within Last 2 Weeks of Life (Lower Score Is Better)	Person and Caregiver-Centered Experience and Outcomes
QOPI 20	Documentation of Patients Advance Directives by the Third Office Visit	Person and Caregiver-Centered Experience and Outcomes
QUANTUM 27	Use of a Postoperative and Vomiting Risk Protocol Aged 3 to 18 Years of Age	Person and Caregiver-Centered Experience and Outcomes
QUANTUM 28	Use of a Postoperative Nausea and Vomiting Risk Protocol Aged 18 Years or Older	Person and Caregiver-Centered Experience and Outcomes

PQRS or QCDR Number (GPRO/eCQM Number)	Measure Name	Quality Domain
QUANTUM 29	Prevention of Post Operative Vomiting with an Appropriate Medical Regimen Guided by Risk Assessment in Patients Aged 3 to 18 Years of Age	Person and Caregiver-Centered Experience and Outcomes
QUANTUM 30	Prevention of Post Operative Nausea and Vomiting with an Appropriate Medical Regimen Guided by Risk Assessment in Patients Aged 18 Years or Older	Person and Caregiver-Centered Experience and Outcomes
RPAQIR 6	Advance Care Planning (PCPI Measure #: AKID-14a)	Person and Caregiver-Centered Experience and Outcomes
RPAQIR 7	Advance Directives Completed (PCPI Measure #: AKID-14b)	Person and Caregiver-Centered Experience and Outcomes
RPAQIR 9	Advance Care Planning (Pediatric Kidney Disease) (PCPI Measure #: PKID-4)	Person and Caregiver-Centered Experience and Outcomes
STS 7	Patient Centered Surgical Risk Assessment and Communication Using the STS Risk Calculator	Person and Caregiver-Centered Experience and Outcomes
THPSO 9*	Postoperative Nausea and Vomiting Rate - Adults	Person and Caregiver-Centered Experience and Outcomes
THPSO 10*	Postoperative Nausea and Vomiting Rate - Pediatrics	Person and Caregiver-Centered Experience and Outcomes
THPSO 14	Patient Experience: Post Anesthesia Follow Up	Person and Caregiver-Centered Experience and Outcomes
THPSO 16	Prevention of Postoperative Nausea and Vomiting (PONV) - Combination Therapy (Adults)	Person and Caregiver-Centered Experience and Outcomes
THPSO 17	Prevention of Postoperative Vomiting (POV) - Combination Therapy (Pediatrics)	Person and Caregiver-Centered Experience and Outcomes
THPSO 23*	Short-Term Pain Management	Person and Caregiver-Centered Experience and Outcomes
CDR 2	Diabetic Foot Ulcer (DFU) Healing or Closure	Person and Caregiver-Centered Experience and Outcomes
CDR 6	Venous Leg Ulcer Outcome Measure: Healing or Closure	Person and Caregiver-Centered Experience and Outcomes
CDR 12	Wound Related Quality of Life	Person and Caregiver-Centered Experience and Outcomes
USWR 20	Nutritional Screening and Intervention Plan in Patients with Chronic Wounds and Ulcers	Person and Caregiver-Centered Experience and Outcomes
CAHPS	Getting Timely Care	Person and Caregiver-Centered Experience and Outcomes
CAHPS	Provider Communication	Person and Caregiver-Centered Experience and Outcomes

PQRS or QCDR Number (GPRO/eCQM Number)	Measure Name	Quality Domain
CAHPS	Rating of Provider	Person and Caregiver-Centered Experience and Outcomes
CAHPS	Access to Specialists	Person and Caregiver-Centered Experience and Outcomes
CAHPS	Health Promotion and Education	Person and Caregiver-Centered Experience and Outcomes
CAHPS	Shared Decision-Making	Person and Caregiver-Centered Experience and Outcomes
CAHPS	Health Status/Functional Status	Person and Caregiver-Centered Experience and Outcomes
CAHPS	Courteous/Helpful Office Staff	Person and Caregiver-Centered Experience and Outcomes
CAHPS	Care Coordination	Person and Caregiver-Centered Experience and Outcomes
CAHPS	Between Visit Communication	Person and Caregiver-Centered Experience and Outcomes
CAHPS	Education About Medication Adherence	Person and Caregiver-Centered Experience and Outcomes
CAHPS	Stewardship of Patient Resources	Person and Caregiver-Centered Experience and Outcomes

*Lower performance rates on these measures indicate better performance. However, when standardizing measures for inclusion in the domain score, CMS transforms these measures to ensure that for all standardized scores entering the domain score, positive (+) scores indicate better performance and negative (-) scores indicate worse performance.

Note: CAHPS for PQRS survey measures are scored on a 0 to 100 point scale. Data on the "Health Status/Functional Status" measure, a descriptive measure of beneficiary characteristics, is being provided to TINs for their information only. Since this measure will not be used in the calculation of the 2017 Value Modifier, no benchmark is calculated.

Exhibit B.3. Community/Population Health Domain Quality Indicators

PQRS or QCDR Number (GPRO/eCQM Number)	Measure Name	Quality Domain
110 (GPRO Prev-7, CMS147v4)	Preventive Care and Screening: Influenza Immunization	Community/Population Health
111 (GPRO Prev-8, 127v3)	Pneumonia Vaccination Status for Older Adults	Community/Population Health
128 (GPRO Prev-9, CMS69v3)	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan	Community/Population Health
131	Pain Assessment and Follow-Up	Community/Population Health
134 (GPRO Prev-12, CMS2v4)	Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan	Community/Population Health
173	Preventive Care and Screening: Unhealthy Alcohol Use – Screening	Community/Population Health
183	Hepatitis C: Hepatitis A Vaccination	Community/Population Health
226 (GPRO Prev-10, CMS138v3)	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	Community/Population Health
239 (CMS155v3)	Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents	Community/Population Health
240 (CMS117v3)	Childhood Immunization Status	Community/Population Health
310 (CMS153v3)	Chlamydia Screening for Women	Community/Population Health
317 (GPRO Prev-11, CMS22v3)	Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented	Community/Population Health
372 (CMS82v2)	Maternal Depression Screening	Community/Population Health
394	Immunizations for Adolescents	Community/Population Health
402	Tobacco Use and Help with Quitting Among Adolescents	Community/Population Health
AAAAI 13	Influenza Immunization	Community/Population Health
AAAAI 15	Body Mass Index	Community/Population Health
ACCFocus 7*	Disparities in Appropriate Patient Selection for Cardiac Imaging Between Men and Women	Community/Population Health
ACCFocus 8*	Cardiac Stress Imaging Not Meeting Appropriate Use Criteria in Patients Less than 50 Years Old	Community/Population Health
ACEP 15	Tobacco Screening and Cessation Intervention for ED Patients with Asthma and COPD	Community/Population Health
AQI 16	Smoking Abstinence Measure	Community/Population Health
ASNC 7*	Nuclear Cardiac Stress Imaging Not Meeting Appropriate Use Criteria	Community/Population Health

PQRS or QCDR Number (GPRO/eCQM Number)	Measure Name	Quality Domain
FORCE 3	Mental Health Assessment for Knee Replacement	Community/Population Health
FORCE 8	Mental Health Assessment for Hip Replacement	Community/Population Health
FORCE 13	Mental Health Assessment for Patients with Knee OA	Community/Population Health
FORCE 16	Mental Health Assessment for Patients with Hip OA	Community/Population Health
MUSIC 8*	Prostate Biopsy: Proportion of Patients Undergoing a Prostate Biopsy with a PSA < 4	Community/Population Health
NPA 18	Smoking Assessment and Cessation Coincident with Spine Related Therapies	Community/Population Health
NPA 19	Body Mass Assessment and Follow-up Coincident with Spine Related Therapies	Community/Population Health
NPA 20	Unhealthy Alcohol Use Assessment Coincident with Spine Care	Community/Population Health
NPA 21	Participation in a Systematic National Database for Spine Care Interventions	Community/Population Health
OBERD 19	Surgery 3-Month QoL Changes (VR-6D)	Community/Population Health
OBERD 20	Orthopedic Surgery 3-Month QoL Changes (EQ-5D)	Community/Population Health
PInc 28	Tobacco Use Treatment Provided or Offered	Community/Population Health
PInc 36	Timeliness of Prenatal Care	Community/Population Health
PInc 37	Human Papillomavirus Screening (HPV) Vaccine	Community/Population Health
PInc 42	Access to Primary Care Practitioners – Children	Community/Population Health
PPRNET 7	Screening for Lipid Disorders in Adults	Community/Population Health
PPRNET 12	Screening for Abdominal Aortic Aneurysm	Community/Population Health
PPRNET 15	Osteoporosis Screening for Women	Community/Population Health
PPRNET 16	Cervical Cancer Screening	Community/Population Health
PPRNET 17	Breast Cancer Screening	Community/Population Health
PPRNET 18	Colorectal Cancer Screening	Community/Population Health
PPRNET 19	Pneumococcal Vaccination in Elderly	Community/Population Health
PPRNET 20	Zoster (Shingles) Vaccination	Community/Population Health
PPRNET 21	Depression Screening	Community/Population Health
PPRNET 22	Alcohol Misuse Screening	Community/Population Health
PPRNET 23	Tobacco Use: Screening and Cessation Intervention	Community/Population Health
QOPI 6	Smoking Status/Tobacco Use Documented in Past Year	Community/Population Health

PQRS or QCDR Number (GPRO/eCQM Number)	Measure Name	Quality Domain
WCHQ 30	Adolescent Immunization (Preventive Care)	Community/Population Health
WCHQ 31	Childhood Immunization (Preventive Care)	Community/Population Health
WELL 15	Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents	Community/Population Health
WELL 22	Children and Adolescents Access to Primary Care Practitioners	Community/Population Health

*Lower performance rates on these measures indicate better performance. However, when standardizing measures for inclusion in the domain score, CMS transforms these measures to ensure that for all standardized scores entering the domain score, positive (+) scores indicate better performance and negative (-) scores indicate worse performance.

Exhibit B.4. Patient Safety Domain Quality Indicators

PQRS or QCDR Number (GPRO/eCQM Number)	Measure Name	Quality Domain
21	Perioperative Care: Selection of Prophylactic Antibiotic – First OR Second Generation Cephalosporin	Patient Safety
22	Perioperative Care: Discontinuation of Prophylactic Parenteral Antibiotics (Non-Cardiac Procedures)	Patient Safety
23	Perioperative Care: Venous Thromboembolism (VTE) Prophylaxis (When Indicated in ALL Patients)	Patient Safety
76	Prevention of Central Venous Catheter (CVC)-Related Bloodstream Infections	Patient Safety
130 (GPRO Care-3, CMS68v4)	Documentation of Current Medications in the Medical Record	Patient Safety
145	Radiology: Exposure Time Reported for Procedures Using Fluoroscopy	Patient Safety
154	Falls: Risk Assessment	Patient Safety
156	Oncology: Radiation Dose Limits to Normal Tissues	Patient Safety
181	Elder Maltreatment Screen and Follow-Up Plan	Patient Safety
192* (CMS132v3)	Cataracts: Complications Within 30 Days Following Cataract Surgery Requiring Additional Surgical Procedures	Patient Safety
193	Perioperative Temperature Management	Patient Safety
238* (CMS156v3)	Use of High-Risk Medications in the Elderly	Patient Safety
258	Rate of Open Repair of Small or Moderate Non-Ruptured Abdominal Aortic Aneurysms (AAA) Without Major Complications (Discharged to Home by Postoperative Day #7)	Patient Safety
259	Rate of Endovascular Aneurysm Repair (EVAR) of Small or Moderate Non-Ruptured Abdominal Aortic Aneurysms (AAA) Without Major Complications (Discharged to Home by Postoperative Day #2)	Patient Safety
260	Rate of Carotid Endarterectomy (CEA) for Asymptomatic Patients, Without Major Complications (Discharged to Home by Postoperative Day #2)	Patient Safety
262	Image Confirmation of Successful Excision of Image–Localized Breast Lesion	Patient Safety
286	Dementia: Counseling Regarding Safety Concerns	Patient Safety
318 (GPRO Care-2, CMS139v3)	Falls: Screening for Fall Risk	Patient Safety
335	Maternity Care: Elective Delivery or Early Induction Without Medical Indication at ≥ 37 and < 39 Weeks	Patient Safety
347*	Rate of Endovascular Aneurysm Repair (EVAR) of Small or Moderate Non-Ruptured Abdominal Aortic Aneurysms (AAA) Who Die While in Hospital	Patient Safety
348*	HRS-3: Implantable Cardioverter-Defibrillator (ICD) Complications Rate	Patient Safety

PQRS or QCDR Number (GPRO/eCQM Number)	Measure Name	Quality Domain
351	Total Knee Replacement: Venous Thromboembolic and Cardiovascular Risk Evaluation	Patient Safety
352	Total Knee Replacement: Preoperative Antibiotic Infusion with Proximal Tourniquet	Patient Safety
353	Total Knee Replacement: Identification of Implanted Prosthesis in Operative Report	Patient Safety
354*	Anastomotic Leak Intervention	Patient Safety
355*	Unplanned Reoperation Within the 30 Day Postoperative Period	Patient Safety
360	Optimizing Patient Exposure to Ionizing Radiation: Count of Potential High Dose Radiation Imaging Studies: Computed Tomography (CT) and Cardiac Nuclear Medicine Studies	Patient Safety
361	Optimizing Patient Exposure to Ionizing Radiation: Reporting to a Radiation Dose Index Registry	Patient Safety
380 (CMS179v3)	ADE Prevention and Monitoring: Warfarin Time in Therapeutic Range	Patient Safety
382 (CMS177v3)	Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment	Patient Safety
383	Adherence to Antipsychotic Medications for Individuals with Schizophrenia	Patient Safety
388*	Cataract Surgery with Intra-Operative Complications (Unplanned Rupture of Posterior Capsule Requiring Unplanned Vitrectomy)	Patient Safety
392*	HRS-12: Cardiac Tamponade and/or Pericardiocentesis Following Atrial Fibrillation Ablation	Patient Safety
393*	HRS-9: Infection Within 180 Days of Cardiac Implantable Electronic Device (CIED) Implantation, Replacement, or Revision	Patient Safety
AAAAI 5	Allergen Immunotherapy Treatment: Allergen Specific Immunoglobulin E (IgE) Sensitivity Assessed and Documented Prior to Treatment	Patient Safety
AAAAI 9	Assessment of Asthma Symptoms Prior to Administration of Allergen Immunotherapy Injection(s)	Patient Safety
ABG 2*	Total Perioperative Cardiac Arrest Rate	Patient Safety
ABG 3*	Total Perioperative Mortality Rate	Patient Safety
ABG 4*	PACU Intubation Rate	Patient Safety
ABG 5*	Composite Procedural Safety for All Vascular Access Procedures	Patient Safety
ABG 9*	OR Fire	Patient Safety
ABG 11*	Anaphylaxis During Anesthesia Care	Patient Safety
ABG 13*	Malignant Hyperthermia	Patient Safety
ABG 14*	Corneal Abrasion	Patient Safety
ABG 15*	Dental Injury	Patient Safety

PQRS or QCDR Number (GPRO/eCQM Number)	Measure Name	Quality Domain
ACCCath 1*	Stroke Intra or Post PCI Procedure in Patients Without CABG or Other Major Surgeries During Admission	Patient Safety
ACCCath 2*	New Requirement for Dialysis Post PCI in Patients Without CABG or Other Major Surgeries During Admission	Patient Safety
ACCCath 3*	Vascular Access Site Injury Requiring Treatment or Major Bleeding Post PCI in Patients Without CABG or Other Major Surgeries During Admission	Patient Safety
ACCCath 4*	Cardiac Tamponade Post PCI in Patients Without CABG or Other Major Surgery During Admission	Patient Safety
ACCCath 14	Contrast Dose Monitored and Recorded During the Procedure	Patient Safety
ACEP 9*	Door to Diagnostic Evaluation by a Qualified Medical Personnel	Patient Safety
ACEP 10	Anti-Coagulation for Acute Pulmonary Embolism Patients	Patient Safety
ACEP 11	Pregnancy Test for Female Abdominal Pain Patients	Patient Safety
ACR 4	Tuberculosis Test Prior to First Course Biologic Therapy	Patient Safety
ACRad 9*	Median Dose Length Product for CT Head/Brain Without Contrast (Single Phase Scan)	Patient Safety
ACRad 10*	Median Size Specific Dose Estimate for CT Chest Without Contrast (Single Phase Scan)	Patient Safety
ACRad 11*	Median Dose Length Product for CT Chest Without Contrast (Single Phase Scan)	Patient Safety
ACRad 12*	Median Size Specific Dose Estimate for CT Abdomen-Pelvis with Contrast (Single Phase Scan)	Patient Safety
ACRad 13*	Median Dose Length Product for CT Abdomen-Pelvis with Contrast (Single Phase Scan)	Patient Safety
ACRad 14	Participation in a National Dose Index Registry	Patient Safety
ACRad 20*	CT IV Contrast Extravasation Rate (Low Osmolar Contrast Media)	Patient Safety
ACRad 24	Timing of Antibiotics-Ordering Physician	Patient Safety
ACS 1	Prophylactic Antibiotics in Abdominal Trauma	Patient Safety
ACS 2	Discontinuation of Prophylactic Antibiotics in Abdominal Trauma	Patient Safety
ACS 3	Venous Thromboembolism (VTE) Prophylaxis in Trauma Patients	Patient Safety
ACS 4	Prevention of Central Venous Catheter (CVC) - Related Bloodstream Infections in Elective CVC Insertions Following Trauma	Patient Safety
ACS 5	Documentation of Anticoagulation Use in the Medical Record	Patient Safety
AGACCSSR 1	Colonoscopy Assessment (Procedure Adequacy) - Assessment of Bowel Preparation	Patient Safety
AGACCSSR 3*	Hospital Visit Rate After Outpatient Colonoscopy	Patient Safety
AQI 6	Immediate Perioperative Cardiac Arrest Rate	Patient Safety

PQRS or QCDR Number (GPRO/eCQM Number)	Measure Name	Quality Domain
AQI 7	Immediate Perioperative Mortality Rate	Patient Safety
AQI 8	PACU Reintubation Rate	Patient Safety
AQI 10	Composite Procedural Safety for Central Line Placement	Patient Safety
AQI 12	Perioperative Care: Timely Administration of Prophylactic Parenteral Antibiotics	Patient Safety
AQI 13	Perioperative Temperature Management	Patient Safety
AQI 14	Preoperative Use of Aspirin for Patients with Drug-Eluting Coronary Stents	Patient Safety
AQI 15	Surgical Safety Checklist - Applicable Safety Checks Completed Before Induction of Anesthesia	Patient Safety
AQI 17	Corneal Injury Diagnosed in the Post-Anesthesia Care Unit/Recovery Area After Anesthesia Care	Patient Safety
AQI 24	Total Knee Replacement: Venous Thromboembolic and Cardiovascular Risk Evaluation	Patient Safety
AQI 25	Total Knee Replacement: Preoperative Antibiotic Infusion with Proximal Tourniquet	Patient Safety
ASBS 5	Perioperative Care: Selection of Prophylactic Antibiotic - First OR Second Generation Cephalosporin	Patient Safety
ASBS 6	Perioperative Care: Discontinuation of Prophylactic Parenteral Antibiotics (Non-Cardiac Procedures)	Patient Safety
ASBS 7	Unplanned 30 Day Reoperation After Mastectomy	Patient Safety
ASNC 8	Laboratory Accreditation for Nuclear Cardiology Imaging Studies	Patient Safety
ASNC 9	Physician Reader Is CBNC Certified in Nuclear Cardiology	Patient Safety
ASPIRE 1	Prophylactic Antibiotic Received Within One Hour Prior to Surgical Incision	Patient Safety
ASPIRE 5	Administration of Dextrose Containing Solution or Glucose Recheck for Patients with Perioperative Glucose < 60	Patient Safety
ASPIRE 6	Avoiding Excessively High Tidal Volumes During Positive Pressure Ventilation	Patient Safety
ASPIRE 16	Avoiding Intraoperative Hypotension	Patient Safety
ASPIRE 22*	Avoiding Medication Overdose	Patient Safety
AUGSPFDR 1	Performing Cystoscopy at the Time of Hysterectomy for Pelvic Organ Prolapse to Detect Lower Urinary Tract Injury	Patient Safety
AUGSPFDR 6*	Proportion of Patients Sustaining a Bladder Injury at the Time of Any Pelvic Organ Prolapse Repair	Patient Safety
AUGSPFDR 7*	Proportion of Patients Sustaining a Ureter Injury at the Time of Any Pelvic organ Prolapse Repair	Patient Safety
AUGSPFDR 8*	Proportion of Patients Sustaining a Major Viscus Injury at the Time of Any Pelvic Organ Prolapse Repair	Patient Safety
AUGSPFDR 10	Preoperative Exclusion of Uterine Malignancy Prior to Any Pelvic Organ Prolapse Repair	Patient Safety

PQRS or QCDR Number (GPRO/eCQM Number)	Measure Name	Quality Domain
AUGSPFDR 11	Performing an Intraoperative Rectal Examination at the Time of Prolapse Repair	Patient Safety
BIVARUS 1	Hand Sanitation Performed by My Provider	Patient Safety
BIVARUS 2	Medication Reconciliation Performed at My Visit	Patient Safety
BIVARUS 3	Practice Asked Me About Allergies	Patient Safety
BIVARUS 4	Practice Verified My Name Before Giving Medications	Patient Safety
BIVARUS 5	Practice Explained Medications Before Giving Them	Patient Safety
BIVARUS 6	Practice Verified Name Before Performing Tests	Patient Safety
BIVARUS 7	Coordination of Care Among Physicians and Nurses	Patient Safety
BIVARUS 8	Explained Medications Told to Take at Home	Patient Safety
BIVARUS 9	I Was Told How to Arrange an Appointment for Follow-Up Care	Patient Safety
BIVARUS 10	Overall Assessment of Safety	Patient Safety
CUHSM 6	Adherence to Mood Stabilizers for Individuals with Bipolar I Disorder	Patient Safety
CUHSM 7	Diabetes Monitoring for People with Diabetes and Schizophrenia (SMD)	Patient Safety
CUHSM 8	Cardiovascular Health Screening for People with Schizophrenia or Bipolar Disorder Who Are Prescribed Antipsychotic Medications	Patient Safety
ECPR 1*	Door to Diagnostic Evaluation by a Provider - All Emergency Department (ED) Patients	Patient Safety
ECPR 2*	Door to Diagnostic Evaluation by a Provider - Adult Emergency Department (ED) Patients	Patient Safety
ECPR 3*	Door to Diagnostic Evaluation by a Provider - Pediatric Emergency Department (ED) Patients	Patient Safety
ECPR 26	Pregnancy Test for Female Abdominal Pain Patients	Patient Safety
ECPR 27	Rh Status Evaluation of Pregnant Women at Risk of Fetal Blood Exposure	Patient Safety
GIQIC 5*	Incidence of Perforation	Patient Safety
HCPR 13	Stroke Venous Thromboembolism (VTE) Prophylaxis	Patient Safety
HCPR 15	Venous Thromboembolism (VTE) Prophylaxis	Patient Safety
HCPR 16	Venous Thromboembolism (VTE) Patients with Anticoagulation Overlap Therapy	Patient Safety
ICLOPS 3	Hospitalized Patients Who Die an Expected Death with an ICD that Has Been Deactivated	Patient Safety
M2S 2	Amputation-Free Survival at One-Year Following Infra-Inguinal Bypass for Intermittent Claudication	Patient Safety

PQRS or QCDR Number (GPRO/eCQM Number)	Measure Name	Quality Domain
M2S 4	Amputation-Free Survival at One-Year Following Supra-Inguinal Bypass for Claudication	Patient Safety
M2S 5	Amputation-Free Survival at One-Year Following Peripheral Vascular Intervention for Intermittent Claudication	Patient Safety
MBS 1*	Medical Complications	Patient Safety
MBS 2*	Surgical Site Complications	Patient Safety
MBS 3*	Serious Complications	Patient Safety
MBSAQIP 8*	Risk Standardized Rate of Patients Who Experienced Extended Length of Stay (> 7 Days) Following a Laparoscopic Roux-en-Y Gastric Bypass or Laparoscopic Sleeve Gastrectomy Operation, Performed as a Primary (Not Revisional) Procedure	Patient Safety
MUSIC 1	Prostate Biopsy: Compliance with AUA Best Practices for Antibiotic Prophylaxis for Transrectal Ultrasound-Guided (TRUS) Biopsy	Patient Safety
NHCR 3*	Incidence of Perforation	Patient Safety
NPA 10*	Unplanned Reoperation Following Spine Procedure Within the 30 Day Postoperative Period	Patient Safety
NPA 11*	Unplanned Readmission Following Spine Procedure Within the 30 Day Postoperative Period	Patient Safety
NPA 12	Selection of Prophylactic Antibiotic-First or Second Generation Cephalosporin Prior to Spine Procedure	Patient Safety
NPA 13	Discontinuation of Prophylactic Parenteral Antibiotics Following Spine Procedure	Patient Safety
ONSQIR 9	Post-Treatment Education	Patient Safety
OQIC 25	Cancer Care: Patient Access to Appropriate Clinician	Patient Safety
PInc 4*	30 Day Mortality for Acute Myocardial Infarction	Patient Safety
PInc 5*	30 Day Mortality for Heart Failure	Patient Safety
PInc 6*	30 Day Mortality for Pneumonia	Patient Safety
PInc 7	Venous Thromboembolism (VTE) Prophylaxis	Patient Safety
PInc 24	Venous Thromboembolism (VTE) Prophylaxis	Patient Safety
PInc 25	ICU VTE Prophylaxis	Patient Safety
PInc 26	VTE Patients with Anticoagulation Overlap Therapy	Patient Safety
PPRNET 26	Use of High-Risk Medications in the Elderly	Patient Safety
PPRNET 27	Use of Benzodiazepines in the Elderly	Patient Safety
PPRNET 28	NSAID or Cox 2 Inhibitor Use in Patients with Heart Failure (HF) or Chronic Kidney Disease (CKD)	Patient Safety
PPRNET 29	Monitoring Serum Potassium	Patient Safety

PQRS or QCDR Number (GPRO/eCQM Number)	Measure Name	Quality Domain
PPRNET 30	Treatment of Hypokalemia	Patient Safety
QUANTUM 1	Perioperative Care: Timely Administration of Prophylactic Parenteral Antibiotics	Patient Safety
QUANTUM 2	Central Venous Line: Ultrasound Used for Placement	Patient Safety
QUANTUM 3*	Procedural Safety for Central Line Placement	Patient Safety
QUANTUM 4*	Difficult Intubation Due to Unrecognized Difficult Airway	Patient Safety
QUANTUM 5*	Failed Airway (Requiring Surgical Tracheostomy or Wakeup)	Patient Safety
QUANTUM 6*	PACU Intubation Rate	Patient Safety
QUANTUM 7*	Laryngospasm	Patient Safety
QUANTUM 8*	Dental Damage/Loss	Patient Safety
QUANTUM 9*	Inadvertent Dural Puncture During Epidural	Patient Safety
QUANTUM 10*	High Spinal Requiring Intubation and/or Assisted Ventilation	Patient Safety
QUANTUM 11*	Major Systemic Local Anesthetic Toxicity	Patient Safety
QUANTUM 12*	Failed Regional Requiring General Anesthesia	Patient Safety
QUANTUM 13*	Medication Error by Anesthesia Care Team	Patient Safety
QUANTUM 14*	Anaphylaxis	Patient Safety
QUANTUM 15*	Aspiration of Gastric Contents	Patient Safety
QUANTUM 16*	Surgical Fire	Patient Safety
QUANTUM 17*	Immediate Perioperative Cardiac Arrest	Patient Safety
QUANTUM 18*	Immediate Perioperative Mortality	Patient Safety
RPAQIR 10*	NHSN Bloodstream Infection in Hemodialysis Outpatients	Patient Safety
THPSO 1*	Perioperative Aspiration Pneumonia Rate	Patient Safety
THPSO 4*	Pneumothorax Rate as a Complication of Central Line Placement	Patient Safety
THPSO 6*	Perioperative Myocardial Infarction Rate in Low Risk Patients	Patient Safety
THPSO 7*	Perioperative Myocardial Infarction Rate in High Risk Patients	Patient Safety
THPSO 8*	New Perioperative Central Neurologic Deficit	Patient Safety
THPSO 11*	Post-Obstructive Pulmonary Edema Rate Following Endo-Tracheal Intubation	Patient Safety
THPSO 12*	Respiratory Arrest in PACU Rate	Patient Safety

PQRS or QCDR Number (GPRO/eCQM Number)	Measure Name	Quality Domain
THPSO 13*	Dental Injury Rate Following Airway Management	Patient Safety
THPSO 20*	Immediate Perioperative Cardiac Arrest Rate	Patient Safety
THPSO 21*	Immediate Perioperative Mortality Rate	Patient Safety
THPSO 22*	PACU Reintubation Rate	Patient Safety
USWR 13	Patient Vital Sign Assessment Prior to HBOT	Patient Safety
USWR 14	Blood Glucose Check Prior to Hyperbaric Oxygen Therapy (HBOT) Treatment	Patient Safety
USWR 18	Complications or Side Effects Among Patients Undergoing Treatment with HBOT	Patient Safety
USWR 19	Completion of a Risk Assessment at the Time of HBOT Consultation	Patient Safety
WCQIC 10	Chronic Wound Care: Arterial Testing in Venous Leg Ulcer Prior to Compression Therapy	Patient Safety
WCQIC 13*	Chronic Wound Care: Hospital Readmission in Patients After Wide Surgical Debridement for Pressure Ulcer Discharged Home with Air vs. Circulating Sand Bed	Patient Safety
WELL 24	Annual Monitoring for Patients on Persistent Medications	Patient Safety

*Lower performance rates on these measures indicate better performance. However, when standardizing measures for inclusion in the domain score, CMS transforms these measures to ensure that for all standardized scores entering the domain score, positive (+) scores indicate better performance and negative (-) scores indicate worse performance.

Exhibit B.5. Communication and Care Coordination Domain Quality Indicators

PQRS or QCDR Number (GPRO/eCQM Number)	Measure Name	Quality Domain
24	Osteoporosis: Communication with the Physician Managing On-Going Care Post-Fracture of Hip, Spine, or Distal Radius for Men and Women Aged 50 Years and Older	Communication and Care Coordination
46	Medication Reconciliation	Communication and Care Coordination
47	Care Plan	Communication and Care Coordination
81	Adult Kidney Disease: Hemodialysis Adequacy: Solute	Communication and Care Coordination
137	Melanoma: Continuity of Care – Recall System	Communication and Care Coordination
138	Melanoma: Coordination of Care	Communication and Care Coordination
141	Primary Open-Angle Glaucoma (POAG): Reduction of Intraocular Pressure (IOP) by 15% OR Documentation of a Plan of Care	Communication and Care Coordination
147	Nuclear Medicine: Correlation with Existing Imaging Studies for All Patients Undergoing Bone Scintigraphy	Communication and Care Coordination
155	Falls: Plan of Care	Communication and Care Coordination
182	Functional Outcome Assessment	Communication and Care Coordination
185	Colonoscopy Interval for Patients with a History of Adenomatous Polyps – Avoidance of Inappropriate Use	Communication and Care Coordination
217	Functional Deficit: Change in Risk-Adjusted Functional Status for Patients with Knee Impairments	Communication and Care Coordination
218	Functional Deficit: Change in Risk-Adjusted Functional Status for Patients with Hip Impairments	Communication and Care Coordination
219	Functional Deficit: Change in Risk-Adjusted Functional Status for Patients with Lower Leg, Foot, or Ankle Impairments	Communication and Care Coordination
220	Functional Deficit: Change in Risk-Adjusted Functional Status for Patients with Lumbar Spine Impairments	Communication and Care Coordination
221	Functional Deficit: Change in Risk-Adjusted Functional Status for Patients with Shoulder Impairments	Communication and Care Coordination
222	Functional Deficit: Change in Risk-Adjusted Functional Status for Patients with Elbow, Wrist, or Hand Impairments	Communication and Care Coordination

PQRS or QCDR Number (GPRO/eCQM Number)	Measure Name	Quality Domain
223	Functional Deficit: Change in Risk-Adjusted Functional Status for Patients with Neck, Cranium, Mandible, Thoracic Spine, Ribs, or Other General Orthopedic Impairments	Communication and Care Coordination
225	Radiology: Reminder System for Screening Mammograms	Communication and Care Coordination
261	Referral for Otologic Evaluation for Patients with Acute or Chronic Dizziness	Communication and Care Coordination
265	Biopsy Follow-Up	Communication and Care Coordination
288	Dementia: Caregiver Education and Support	Communication and Care Coordination
293	Parkinson's Disease: Rehabilitative Therapy Options	Communication and Care Coordination
294	Parkinson's Disease: Parkinson's Disease Medical and Surgical Treatment Options Reviewed	Communication and Care Coordination
320	Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients	Communication and Care Coordination
325	Adult Major Depressive Disorder (MDD): Coordination of Care of Patients with Specific Comorbid Conditions	Communication and Care Coordination
336	Maternity Care: Post-Partum Follow-Up and Care Coordination	Communication and Care Coordination
350	Total Knee Replacement: Shared Decision-Making: Trial of Conservative (Non-surgical) Therapy	Communication and Care Coordination
359	Optimizing Patient Exposure to Ionizing Radiation: Utilization of a Standardized Nomenclature for Computed Tomography (CT) Imaging Description	Communication and Care Coordination
362	Optimizing Patient Exposure to Ionizing Radiation: Computed Tomography (CT) Images Available for Patient Follow-Up and Comparison Purposes	Communication and Care Coordination
363	Optimizing Patient Exposure to Ionizing Radiation: Search for Prior Computed Tomography (CT) Studies Through a Secure, Authorized, Media-Free, Shared Archive	Communication and Care Coordination
364	Optimizing Patient Exposure to Ionizing Radiation: Appropriateness: Follow-Up CT Imaging for Incidentally Detected Pulmonary Nodules According to Recommended Guidelines	Communication and Care Coordination
374 (CMS50v3)	Closing the Referral Loop: Receipt of Specialist Report	Communication and Care Coordination
391	Follow-Up After Hospitalization for Mental Illness (FUH)	Communication and Care Coordination

PQRS or QCDR Number (GPRO/eCQM Number)	Measure Name	Quality Domain
395	Lung Cancer Reporting (Biopsy/Cytology Specimens)	Communication and Care Coordination
396	Lung Cancer Reporting (Resection Specimens)	Communication and Care Coordination
397	Melanoma Reporting	Communication and Care Coordination
AAAAI 6	Documentation of Clinical Response to Allergen Immunotherapy Within One Year	Communication and Care Coordination
AAAAI 18	Penicillin Allergy: Appropriate Removal or Confirmation	Communication and Care Coordination
ABG 8	Use of Checklist for Transfer of Care from Anesthesia Provider	Communication and Care Coordination
ACCCath 12*	Stress Testing with Spect MPI Performed and the Results Were Not Available in the Medical Record	Communication and Care Coordination
ACCCath 13	Cardiac Rehabilitation Patient Referral from an Inpatient Setting	Communication and Care Coordination
ACEP 12*	Three Day Return Rate ED	Communication and Care Coordination
ACEP 13*	Three Day Return Rate UC	Communication and Care Coordination
ACRad 15*	Report Turnaround Time: Radiography	Communication and Care Coordination
ACRad 16*	Report Turnaround Time: Ultrasound (Excluding Breast US)	Communication and Care Coordination
ACRad 17*	Report Turnaround Time: MRI	Communication and Care Coordination
ACRad 18*	Report Turnaround Time: CT	Communication and Care Coordination
ACRad 19*	Report Turnaround Time: PET	Communication and Care Coordination
ACS 6	Documentation of Glasgow Coma Score at Time of Initial Evaluation	Communication and Care Coordination
AQI 1	Post-Anesthetic Transfer of Care: Use of Checklist or Protocol for Direct Transfer of Care from Procedure Room to Intensive Care Unit (ICU)	Communication and Care Coordination

PQRS or QCDR Number (GPRO/eCQM Number)	Measure Name	Quality Domain
AQI 4	Anesthesiology: Post-Anesthetic Transfer of Care Measure: Procedure Room to a Post Anesthesia Care Unit	Communication and Care Coordination
ASBS 3	Specimen Orientation for Partial Mastectomy or Excisional Breast Biopsy	Communication and Care Coordination
ASNC 4	Utilization of Standardized Nomenclature and Reporting for Nuclear Cardiology Imaging Studies	Communication and Care Coordination
ASNC 5	Single-Photon Emission Computed Tomography (SPECT) Myocardial Perfusion Imaging (MPI) Study Report Turnaround Time < 24 Hours	Communication and Care Coordination
ASNC 6	Positron Emission Tomography (PET) Imaging Study Report Turnaround Time < 24 Hours	Communication and Care Coordination
ASPIRE 14	Appropriate Intraoperative Handoff Performed	Communication and Care Coordination
ASPIRE 15	Appropriate Postoperative Transition of Care Handoff Performed	Communication and Care Coordination
AUGSPFDR 3	Complete Assessment and Evaluation of Patients Pelvic Organ Prolapse Prior to Surgical Repair	Communication and Care Coordination
AUGSPFDR 4	Preoperative Pessary for Pelvic Organ Prolapse Offered	Communication and Care Coordination
AUGSPFDR 5	Preoperative Pessary for Pelvic Organ Prolapse Attempted	Communication and Care Coordination
BIVARUS 19	My Doctor Explained My Final Diagnosis	Communication and Care Coordination
BIVARUS 20	I Understood what the Physician Told Me	Communication and Care Coordination
BIVARUS 21	My Doctor Explained what Tests He/She Was Ordering	Communication and Care Coordination
BIVARUS 22	My Doctor Informed Me of My Treatment Options	Communication and Care Coordination
BIVARUS 23	My Doctor Told Me how Long Things Would Take	Communication and Care Coordination
BIVARUS 24	My Doctor Did Not Seem Rushed While with Me	Communication and Care Coordination
BIVARUS 25	While In My Room, My Doctor Was Focused on Me/My Issues	Communication and Care Coordination

PQRS or QCDR Number (GPRO/eCQM Number)	Measure Name	Quality Domain
BIVARUS 26	How Likely Are You to Recommend this Physician to Your Family and Friends	Communication and Care Coordination
CUHSM 1	Adherence to Statins	Communication and Care Coordination
CUHSM 2	Proportion of Days Covered (PDC): 5 Rates by Therapeutic Category	Communication and Care Coordination
ECPR 11*	Three Day All Cause Return ED Visit Rate - All Patients	Communication and Care Coordination
ECPR 12*	Three Day All Cause Return ED Visit Rate - Adults	Communication and Care Coordination
ECPR 13*	Three Day All Cause Return ED Visit Rate - Pediatrics	Communication and Care Coordination
ECPR 14*	Three Day All Cause Return ED Visit Rate - Community Acquired Pneumonia (CAP)	Communication and Care Coordination
ECPR 15*	Three Day All Cause Return ED Visit Rate - Congestive Heart Failure (CHF)	Communication and Care Coordination
ECPR 16*	Three Day All Cause Return ED Visit Rate - Chronic Obstructive Pulmonary Disease (COPD)	Communication and Care Coordination
ECPR 17*	Three Day All Cause Return ED Visit Rate with Placement into Inpatient or Observation Status on Re-Visit	Communication and Care Coordination
GIQIC 6	Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients	Communication and Care Coordination
GIQIC 10	Appropriate Management of Anticoagulation in the Peri-Procedural Period Rate - EGD	Communication and Care Coordination
GIQIC 11	Helicobacter Pylori (H. pylori) status Rate	Communication and Care Coordination
GIQIC 15	Appropriate Follow-Up Interval of 3 Years Recommended Based on Pathology Findings from Screening Colonoscopy in Average-Risk Patients	Communication and Care Coordination
HCPR 6*	30 Day All Cause Re-Admission Rate for All Discharged Inpatients	Communication and Care Coordination
HCPR 7*	30 Day All Cause Re-Admission Rate Following Pneumonia Hospitalization	Communication and Care Coordination
HCPR 8*	30 Day All Cause Re-Admission Rate Following CHF Hospitalization	Communication and Care Coordination

PQRS or QCDR Number (GPRO/eCQM Number)	Measure Name	Quality Domain
HCPR 9*	30 Day All Cause Re-Admission Rate Following COPD Hospitalization	Communication and Care Coordination
ICLOPS 1	Comfortable Dying: Pain Brought to a Comfortable Level Within 48 Hours of Initial Assessment	Communication and Care Coordination
ICLOPS 2	Patients Treated with an Opioid Who Are Given a Bowel Regimen	Communication and Care Coordination
ICLOPS 5	Patients with Advanced Cancer Screened for Pain at Outpatient Visits	Communication and Care Coordination
ICLOPS 6	Hospice and Palliative Care: Pain Screening	Communication and Care Coordination
ICLOPS 7	Hospice and Palliative Care: Pain Assessment	Communication and Care Coordination
ICLOPS 8	Hospice and Palliative Care: Dyspnea Treatment	Communication and Care Coordination
ICLOPS 9	Hospice and Palliative Care: Dyspnea Screening	Communication and Care Coordination
ICLOPS 17	Rate of Follow Up Visits Within 7 Days of Discharge (Including Physician Response)	Communication and Care Coordination
INVIVO 1	Back Pain: Patient Reassessment	Communication and Care Coordination
INVIVO 4	Orthopedic Pain & Function: Patient Reassessment Over Time	Communication and Care Coordination
INVIVO 5	Back Pain & Function: Patient Reassessment Over Time	Communication and Care Coordination
M2S 3	Infrainguinal Bypass for Claudication Patency Assessed at Least 9 Months Following Surgery	Communication and Care Coordination
M2S 6	Peripheral Vascular Intervention Patency Assessed at One-Year Following Infrainguinal PVI for Claudication	Communication and Care Coordination
M2S 9	Imaging-Based Maximum Aortic Diameter Assessed at One-Year Following Thoracic and Complex EVAR Procedures	Communication and Care Coordination
M2S 11	Imaging-Based Maximum Aortic Diameter Assessed at One-Year Following Endovascular AAA Repair Procedures	Communication and Care Coordination
MBSAQIP 9	Percentage of Patients Who Dad Complete 30 Day Follow-Up Following Any Metabolic and Bariatric Procedure	Communication and Care Coordination

PQRS or QCDR Number (GPRO/eCQM Number)	Measure Name	Quality Domain
MUSIC 6*	Unplanned Hospital Readmission Within 30 Days of Radical Prostatectomy	Communication and Care Coordination
NOF 2	Risk Assessment/Treatment After Fracture	Communication and Care Coordination
NOF 3	Discharge Instructions: Emergency Department	Communication and Care Coordination
NPA 14	Medicine Reconciliation Following Spine Related Procedure	Communication and Care Coordination
NPA 15	Risk-Assessment for Elective Spine Procedure	Communication and Care Coordination
NPA 16	Depression and Anxiety Assessment Prior to Spine-Related Therapies	Communication and Care Coordination
NPA 17	Narcotic Pain Medicine Management Following Elective Spine Procedure	Communication and Care Coordination
OBERD 1	Back Pain: Mental Health Assessment	Communication and Care Coordination
OBERD 2	Back Pain: Patient Reassessment	Communication and Care Coordination
OBERD 4	Pain Assessment and Follow-Up	Communication and Care Coordination
OBERD 6	Orthopedic Pain: Mental Health Assessment	Communication and Care Coordination
OBERD 7	Orthopedic Pain: Patient Reassessment	Communication and Care Coordination
OBERD 9	Orthopedic Pain: Assessment and Follow-Up	Communication and Care Coordination
ONSQIR 12	Post-Treatment Follow Up Care	Communication and Care Coordination
OQIC 18	Combination Chemotherapy Is Considered or Administered Within 4 Months (120 Days) of Diagnosis for Women Under 70 with AJCC T1cN0M0, or Stage IB - III Hormone Receptor Negative Breast Cancer	Communication and Care Coordination
OQIC 19	Adjuvant Chemotherapy Is Considered or Administered Within 4 Months (120 Days) of Diagnosis to Patients Under the Age of 80 with AJCC III (Lymph Node Positive) Colon Cancer	Communication and Care Coordination
OQIC 20	Recording of Performance Status Prior to Lung or Esophageal Cancer Resection	Communication and Care Coordination

PQRS or QCDR Number (GPRO/eCQM Number)	Measure Name	Quality Domain
OQIC 21	Palliative Care Consultation	Communication and Care Coordination
OQIC 22	Psychosocial Screening and Intervention	Communication and Care Coordination
OQIC 27	Cancer Care: Patient Navigation	Communication and Care Coordination
PInc 1*	30 Day Readmission for Acute Myocardial Infarction	Communication and Care Coordination
PInc 2*	30 Day Readmission for Heart Failure	Communication and Care Coordination
PInc 3*	30 Day Readmission for Pneumonia	Communication and Care Coordination
PInc 21	Thrombolytic Therapy	Communication and Care Coordination
PInc 22	Discharged on Statin Medication	Communication and Care Coordination
PInc 23	Stroke Education	Communication and Care Coordination
PInc 31*	Median Time from ED Arrival to ED Departure for Discharged ED Patients	Communication and Care Coordination
PInc 32*	Door to Diagnostic Evaluation by a Qualified Medical Professional	Communication and Care Coordination
PInc 43	Follow-Up Office Visit Within 7 Days or 14 Days After Hospitalization	Communication and Care Coordination
QUANTUM 22	Anesthesiology: Post Anesthetic Transfer of Care Measure: Use of Checklist or Protocol for Direct Transfer of Care from OR or Procedure Room to the Post Anesthesia Care Unit (PACU)	Communication and Care Coordination
QUANTUM 23	Anesthesiology: Post Anesthetic Transfer of Care Measure: Use of Checklist or Protocol for Direct Transfer of Care from OR or Procedure Room to Intensive Care Unit (ICU)	Communication and Care Coordination
QUANTUM 24*	Surgical Case Cancellation	Communication and Care Coordination
QUANTUM 25	Functional Outcome Assessment; Overall Pain Control During Episode of Care: General, Regional Anesthesia, or Labor and Delivery	Communication and Care Coordination
QUANTUM 26	Overall Assessment of Anesthetic Care Quality by Patient	Communication and Care Coordination

PQRS or QCDR Number (GPRO/eCQM Number)	Measure Name	Quality Domain
RPAQIR 5	Transplant Referral (PCPI Measure #: AKID-13)	Communication and Care Coordination
RPAQIR 8	Referral to Hospice (PCPI Measure #: AKID-15)	Communication and Care Coordination
THPSO 15	Post-Anesthetic Transfer of Care: Use of Checklist or Protocol for Direct Transfer of Care from Procedure Room to Intensive Care Unit (ICU)	Communication and Care Coordination
THPSO 18	Anesthesiology: Post-Anesthetic Transfer of Care Measure: Procedure Room to a Post Anesthesia Care Unit	Communication and Care Coordination
WCQIC 8*	Hyperbaric Oxygen Therapy: Timeliness of Starting HBOT	Communication and Care Coordination
WCQIC 14	Chronic Wound Care: Timeliness of Referral of Pressure Ulcer Patients to Plastic/Reconstructive Surgeon	Communication and Care Coordination
WELL 1*	Risk Standardized All Condition Readmission	Communication and Care Coordination
WELL 2*	Ambulatory Sensitive Conditions Admissions: Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults	Communication and Care Coordination
WELL 3*	Ambulatory Sensitive Conditions Admissions: Heart Failure	Communication and Care Coordination
WELL 9	Closing the Referral Loop: Receipt of Specialist Report	Communication and Care Coordination
WELL 19	Adults Access to Preventive/Ambulatory Health Services	Communication and Care Coordination
WELL 20	Antidepressant Medication Management	Communication and Care Coordination
WELL 23	Follow-Up After Hospitalization for Mental Illness	Communication and Care Coordination

*Lower performance rates on these measures indicate better performance. However, when standardizing measures for inclusion in the domain score, CMS transforms these measures to ensure that for all standardized scores entering the domain score, positive (+) scores indicate better performance and negative (-) scores indicate worse performance.

Exhibit B.6. Communication and Care Coordination Domain Quality Indicators (CMS-Calculated Quality Outcome Measures)

PQRS Number (GPRO/eCQM Number)	Measure Name	Quality Domain
CMS-1	**Acute Conditions Composite**	Communication and Care Coordination
-	Bacterial Pneumonia	Communication and Care Coordination
-	Urinary Tract Infection	Communication and Care Coordination
-	Dehydration	Communication and Care Coordination
CMS-2	**Chronic Conditions Composite**	Communication and Care Coordination
-	Diabetes (Composite of 4 Indicators)	Communication and Care Coordination
-	Chronic Obstructive Pulmonary Disease (COPD) or Asthma	Communication and Care Coordination
-	Heart Failure	Communication and Care Coordination
CMS-3	**All-Cause Hospital Readmission**	Communication and Care Coordination

Note: Lower performance rates on these measures indicates better performance. However, when standardizing measures for inclusion in the domain score, CMS transforms these measures to ensure that for all standardized scores entering the domain score, positive (+) scores indicate better performance and negative (-) scores indicate worse performance. CMS-1, CMS-2, and CMS-3 are calculated by CMS using claims data.

Exhibit B.7. Efficiency and Cost Reduction Domain Quality Indicators

PQRS or QCDR Number (GPRO/eCQM Number)	Measure Name	Quality Domain
65 (CMS154v3)	Appropriate Treatment for Children with Upper Respiratory Infection (URI)	Efficiency and Cost Reduction
66 (CMS146v3)	Appropriate Testing for Children with Pharyngitis	Efficiency and Cost Reduction
93	Acute Otitis Externa (AOE): Systemic Antimicrobial Therapy – Avoidance of Inappropriate Use	Efficiency and Cost Reduction
102 (CMS129v3)	Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low Risk Prostate Cancer Patients	Efficiency and Cost Reduction
116	Antibiotic Treatment for Adults with Acute Bronchitis: Avoidance of Inappropriate Use	Efficiency and Cost Reduction
146*	Radiology: Inappropriate Use of "Probably Benign" Assessment Category in Mammography Screening	Efficiency and Cost Reduction
224	Melanoma: Overutilization of Imaging Studies in Melanoma	Efficiency and Cost Reduction
312 (CMS166v4)	Use of Imaging Studies for Low Back Pain	Efficiency and Cost Reduction
322*	Cardiac Stress Imaging Not Meeting Appropriate Use Criteria: Preoperative Evaluation in Low-Risk Surgery Patients	Efficiency and Cost Reduction
323*	Cardiac Stress Imaging Not Meeting Appropriate Use Criteria: Routine Testing After Percutaneous Coronary Intervention (PCI)	Efficiency and Cost Reduction
324*	Cardiac Stress Imaging Not Meeting Appropriate Use Criteria: Testing in Asymptomatic, Low-Risk Patients	Efficiency and Cost Reduction
331*	Adult Sinusitis: Antibiotic Prescribed for Acute Sinusitis (Appropriate Use)	Efficiency and Cost Reduction
332	Adult Sinusitis: Appropriate Choice of Antibiotic: Amoxicillin Prescribed for Patients with Acute Bacterial Sinusitis (Appropriate Use)	Efficiency and Cost Reduction
333*	Adult Sinusitis: Computerized Tomography for Acute Sinusitis (Overuse)	Efficiency and Cost Reduction
334*	Adult Sinusitis: More than One Computerized Tomography (CT) Scan Within 90 Days for Chronic Sinusitis (Overuse)	Efficiency and Cost Reduction
340	HIV Medical Visit Frequency	Efficiency and Cost Reduction
AAAAI 7	Documented Rationale to Support Long-Term Aeroallergen Immunotherapy Beyond Five Years, as Indicated	Efficiency and Cost Reduction
ABG 10*	Day of Surgery Case Cancellation Rate	Efficiency and Cost Reduction
ACCCath 9	PCI Procedures that Were Inappropriate for Patients with Acute Coronary Syndrome (ACS)	Efficiency and Cost Reduction
ACCCath 10*	Median Length of Stay Post PCI Procedure for Patients with STEMI and Without CABG or Without Other Major Surgery During Admission	Efficiency and Cost Reduction
ACCCath 11*	Median Length of Stay Post PCI Procedure for Patients with a PCI Indication that Is Not STEMI and Without CABG or Without Other Major Surgery During Admission	Efficiency and Cost Reduction
ACCFocus 1*	Cardiac Stress Imaging Not Meeting Appropriate Use Criteria: Asymptomatic, low Risk Patients	Efficiency and Cost Reduction

PQRS or QCDR Number (GPRO/eCQM Number)	Measure Name	Quality Domain
ACCFocus 2*	Cardiac Stress Imaging Not Meeting Appropriate Use Criteria: Symptomatic, Low Pre-Test Probability Patients Who Can Exercise and Have an Interpretable ECG	Efficiency and Cost Reduction
ACCFocus 3*	Cardiac Stress Imaging Not Meeting Appropriate Use Criteria: Low Risk Surgery Preoperative Testing	Efficiency and Cost Reduction
ACCFocus 4*	Cardiac Stress Imaging Not Meeting Appropriate Use Criteria: Routine Testing After Percutaneous Coronary Intervention (PCI)	Efficiency and Cost Reduction
ACCFocus 5*	Cardiac Stress Imaging Not Meeting Appropriate Use Criteria: Routine Surveillance Testing After an Interpretable Prior SPECT MPI or Stress Echo in Asymptomatic Patients	Efficiency and Cost Reduction
ACCFocus 6*	Ratio: Rarely Appropriate Tests Ordered per Physician Compared to the National Average	Efficiency and Cost Reduction
ACEP 1	Emergency Department Utilization of CT for Minor Blunt Head Trauma for Patients Aged 18 Years and Older	Efficiency and Cost Reduction
ACEP 2*	Emergency Department Utilization of CT for Minor Blunt Head Trauma for Patients Aged 2 Through 17 Years	Efficiency and Cost Reduction
ACEP 3*	Coagulation Studies in Patients Presenting with Chest Pain with No Coagulopathy or Bleeding	Efficiency and Cost Reduction
ACEP 4	Appropriate Emergency Department Utilization of CT for Pulmonary Embolism	Efficiency and Cost Reduction
ACEP 16*	Antibiotic Prescribed for Adult Acute Sinusitis	Efficiency and Cost Reduction
ACEP 17	Adult Sinusitis: Appropriate Choice of Antibiotic	Efficiency and Cost Reduction
ACEP 18	Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis	Efficiency and Cost Reduction
ACRad 2	CT Colonography Clinically Significant Extracolonic Findings	Efficiency and Cost Reduction
ACRad 5*	Screening Mammography Abnormal Interpretation Rate (Recall Rate)	Efficiency and Cost Reduction
ACRad 23*	Lung Cancer Screening Abnormal Interpretation Rate	Efficiency and Cost Reduction
AGACCSSR 4	Performance of Upper Endoscopic Examination with Colonoscopy	Efficiency and Cost Reduction
AGACCSSR 5*	Unnecessary Screening Colonoscopy in Older Adults	Efficiency and Cost Reduction
ASNC 1*	Cardiac Stress Nuclear Imaging Not Meeting Appropriate Use Criteria: Preoperative Evaluation in Low Risk Surgery Patients	Efficiency and Cost Reduction
ASNC 2*	Cardiac Stress Nuclear Imaging Not Meeting Appropriate Use Criteria: Routine Testing After Percutaneous Coronary Intervention (PCI)	Efficiency and Cost Reduction
ASNC 3*	Cardiac Stress Nuclear Imaging Not Meeting Appropriate Use Criteria: Testing in Asymptomatic, Low-Risk Patients	Efficiency and Cost Reduction
ASNC 10*	Nuclear Cardiology Imaging Studies Terminated Due to Technical Problems	Efficiency and Cost Reduction
ASPIRE 11	Colloid Use Limited in Cases with No Indication	Efficiency and Cost Reduction
ASPIRE 13	Transfusion Goal of Hematocrit Less than 30	Efficiency and Cost Reduction

PQRS or QCDR Number (GPRO/eCQM Number)	Measure Name	Quality Domain
CDR 8	Appropriate Use of Hyperbaric Oxygen Therapy for Patients with Diabetic Foot Ulcers	Efficiency and Cost Reduction
ECPR 18	Avoid Head CT in Patients with Uncomplicated Syncope	Efficiency and Cost Reduction
ECPR 19	Emergency Department Utilization of CT for Minor Blunt Head Trauma for Patients Aged 18 Years and Older	Efficiency and Cost Reduction
ECPR 20	Emergency Department Utilization of CT for Minor Blunt Head Trauma for Patients Aged 2 to 17 Years	Efficiency and Cost Reduction
ECPR 21	Avoid Imaging with X-Rays in Non-traumatic Low Back Pain	Efficiency and Cost Reduction
ECPR 22	Computerized Tomography (CT) for Acute Sinusitis (Overuse)	Efficiency and Cost Reduction
ECPR 23	Appropriate Treatment for Children with Upper Respiratory Infection (URI) - Were Not Dispensed an Antibiotic Prescription	Efficiency and Cost Reduction
ECPR 28	Coagulation Studies in Patients Presenting with Chest Pain with No Coagulopathy or Bleeding	Efficiency and Cost Reduction
GIQIC 8*	Age Appropriate Screening Colonoscopy	Efficiency and Cost Reduction
GIQIC 14	Repeat Screening Colonoscopy Recommended Within One Year Due to Inadequate Bowel Preparation	Efficiency and Cost Reduction
HCPR 2*	Mean Length of Stay for Inpatients - All Patients	Efficiency and Cost Reduction
HCPR 3*	Mean Length of Stay for Inpatients - Pneumonia	Efficiency and Cost Reduction
HCPR 4*	Mean Length of Stay for Inpatients - CHF	Efficiency and Cost Reduction
HCPR 5*	Mean Length of Stay for Inpatients - COPD	Efficiency and Cost Reduction
ICLOPS 15	Excess Days Rate and Degree of Excess (Including Physician Response)	Efficiency and Cost Reduction
ICLOPS 16	Re-Admission Rate Within 30 Days (Including Physician Response)	Efficiency and Cost Reduction
ICLOPS 19	Medical Visit Frequency: Diabetes	Efficiency and Cost Reduction
ICLOPS 20	Medical Visit Frequency: Heart Failure	Efficiency and Cost Reduction
ICLOPS 21	Medical Visit Frequency: Chronic Obstructive Pulmonary Disease (COPD)	Efficiency and Cost Reduction
ICLOPS 22	Medical Visit Frequency: Coronary Artery Disease (CAD)	Efficiency and Cost Reduction
ICLOPS 23	Physician Response to ACSC Admissions: Diabetes Composite	Efficiency and Cost Reduction
ICLOPS 24	Physician Response to ACSC Admissions: Cardiopulmonary Composite	Efficiency and Cost Reduction
ICLOPS 25	Physician Response to ACSC Admissions: Acute Conditions Composite	Efficiency and Cost Reduction
ICLOPS 30	Physician Response for Reoperation or Complication Following a Procedure	Efficiency and Cost Reduction

PQRS or QCDR Number (GPRO/eCQM Number)	Measure Name	Quality Domain
ICLOPS 31	Physician Response to Emergency Department Care: Chronic Conditions Composite	Efficiency and Cost Reduction
MBS 7*	Extended Length of Stay (LOS)	Efficiency and Cost Reduction
MBS 8*	Unplanned Emergency Room (ER) Visits	Efficiency and Cost Reduction
MBS 9*	Unplanned Hospital Readmission Within 30 Days of Principal Procedure	Efficiency and Cost Reduction
MBSAQIP 2*	Risk Standardized Rate of Patients Who Experienced an Unplanned Readmission (Likely Related to the Initial Operation) to Any Hospital Within 30 Days Following a Laparoscopic Roux-en-Y Gastric Bypass or Laparoscopic Sleeve Gastrectomy Operation, Performed as a Primary (Not Revisional) Procedure	Efficiency and Cost Reduction
MBSAQIP 3*	Risk Standardized Rate of Patients Who Experienced a Reoperation (Likely Related to the Initial Operation) Within 30 Days Following a Laparoscopic Roux-en-Y Gastric Bypass or Laparoscopic Sleeve Gastrectomy Operation, Performed as a Primary (Not Revisional) Procedure	Efficiency and Cost Reduction
MUSIC 3	Prostate Cancer: Avoidance of Overuse of CT Scan for Staging Low Risk Prostate Cancer Patients	Efficiency and Cost Reduction
NHCR 4	Repeat Colonoscopy Recommended Due to Poor Bowel Preparation	Efficiency and Cost Reduction
NHCR 6*	Age Inappropriate Screening Colonoscopy	Efficiency and Cost Reduction
NOF 14	Payment-Standardized Medicare Spending per Beneficiary (MSPB) (Resource Use Measure)	Efficiency and Cost Reduction
OBERD 5*	Back Pain: Surgical Timing	Efficiency and Cost Reduction
OQIC 3*	Hospital Days	Efficiency and Cost Reduction
PInc 33*	Risk-Adjusted Average Length of Inpatient Hospital Stay for Acute Myocardial Infarction (AMI)	Efficiency and Cost Reduction
PInc 34*	Risk-Adjusted Average Length of Inpatient Hospital Stay for Heart Failure (HF)	Efficiency and Cost Reduction
PInc 35*	Risk-Adjusted Average Length of Inpatient Hospital Stay for Pneumonia (PN)	Efficiency and Cost Reduction
PPRNET 24	Appropriate Treatment for Adults with Upper Respiratory Infection	Efficiency and Cost Reduction
PPRNET 25	Appropriate Antibiotic Use	Efficiency and Cost Reduction
QOPI 4	Performance Status Documented Prior to Initiating Chemotherapy	Efficiency and Cost Reduction
QOPI 5*	Chemotherapy Administered to Patients with Metastatic Solid Tumors and Performance Status of 3, 4, or Undocumented (Lower Score - Better)	Efficiency and Cost Reduction
QOPI 15*	GCSF Administered to Patients Who Received Chemotherapy for Metastatic Cancer (Lower Score - Better)	Efficiency and Cost Reduction
STS 1*	CABG - Prolonged Postoperative Length of Stay (PLOS)	Efficiency and Cost Reduction
STS 2	CABG - Short Postoperative LOS (SLOS)	Efficiency and Cost Reduction

PQRS or QCDR Number (GPRO/eCQM Number)	Measure Name	Quality Domain
STS 3*	CABG + Valve - Prolonged Postoperative Length of Stay (PLOS)	Efficiency and Cost Reduction
STS 4	CABG + Valve - Short Postoperative Length of Stay (SLOS)	Efficiency and Cost Reduction
STS 5*	Isolated Valve - Prolonged Postoperative Length of Stay (PLOS)	Efficiency and Cost Reduction
STS 6	Isolated Valve - Short Postoperative LOS (SLOS)	Efficiency and Cost Reduction
WELL 4*	Skilled Nursing Facility 30-Day All-Cause Readmission	Efficiency and Cost Reduction
WELL 5*	All-Cause Unplanned Admissions for Patients with Diabetes	Efficiency and Cost Reduction
WELL 6*	All-Cause Unplanned Admissions for Patients with Heart Failure	Efficiency and Cost Reduction
WELL 7*	All-Cause Unplanned Admissions for Patients with Multiple Chronic Conditions	Efficiency and Cost Reduction
WELL 17	Use of Imaging Studies for Low Back Pain	Efficiency and Cost Reduction

*Lower performance rates on these measures indicate better performance. However, the domain score for this domain has been calculated such that positive (+) scores indicate better performance and negative (-) scores indicate worse performance.

APPENDIX C

APPROACH TO PQRS AND NON-PQRS QCDR MEASURES WITH MULTIPLE PERFORMANCE RATES OR TECHNICAL ISSUES

In 2015, several PQRS and non-PQRS QCDR measures included in the Annual QRUR have multiple sub-measures, where one sub-measure may or may not represent a single overall performance rate. Exhibit C.1 displays (1) measures for which a single sub-measure represents the overall rate, and (2) measures for which no sub-measure represents the overall performance rate. This exhibit also describes CMS's approach to measures with technical issues.

Exhibit C.1. Approach to PQRS and non-PQRS QCDR Measures with Multiple Performance Rates and Measures with Technical Issues

PQRS Number (GPRO/eCQM Number) or Non-PQRS QCDR Measure Number	Measure Name	Reporting Method(s) Affected	Approach
Measures with Multiple Performance Rates			
7 (CMS145v3)	Coronary Artery Disease (CAD): Beta-Blocker Therapy—Prior Myocardial Infarction (MI) or Left Ventricular Systolic Dysfunction (LVSD) (LVEF < 40%)	EHR, Registry, QCDR (using EHR or Registry measure specifications)	Overall rate is computed as the case-weighted average of each sub-measure if reported via EHR, Registry or via QCDR using EHR or Registry specifications.
9 (CMS128v3)	Anti-Depressant Medication Management	EHR, QCDR (using EHR measure specifications)	Overall rate is computed as the simple average of each sub-measure if reported via EHR or via QCDR using EHR specifications.
46	Medication Reconciliation	Claims, Registry, QCDR (using Claims and Registry measure specifications)	Overall rate is computed as the case-weighted average of each sub-measure if reported via Claims or Registry or via QCDR using Claims or Registry specifications.
53	Asthma: Pharmacologic Therapy for Persistent Asthma - Ambulatory Care Setting	Registry, QCDR (using Registry measure specifications)	The third sub-measure, which measure specifications define as the overall rate, is used as the overall rate if reported via Registry or via QCDR using Registry specifications.
122	Adult Kidney Disease: Blood Pressure Management	Registry, QCDR (using Registry measure specifications)	The third sub-measure, which measure specifications define as the overall rate, is used as the overall rate if reported via Registry or via QCDR using Registry specifications.
128 (CMS69v3)	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan	EHR, QCDR (using EHR measure specifications)	Overall rate is computed as the case-weighted average of each sub-measure if reported via EHR or via QCDR using EHR specifications.
160 (CMS52v3)	HIV/AIDS: Pneumocystis Jiroveci Pneumonia (PCP) Prophylaxis	EHR, QCDR (using EHR measure specifications)	Overall rate is computed as the case-weighted average of each sub-measure if reported via EHR or via QCDR using EHR specifications.

PQRS Number (GPRO/eCQM Number) or Non-PQRS QCDR Measure Number	Measure Name	Reporting Method(s) Affected	Approach
238 (CMS156v3)	Use of High-Risk Medications in the Elderly	EHR, Registry, QCDR (using EHR or Registry measure specifications)	The first sub-measure, which measure specifications define as the overall rate, is used as the overall rate if reported via EHR or Registry or via QCDR using EHR or Registry specifications.
239 (CMS155v3)	Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents	EHR, QCDR (using EHR measure specifications)	Overall rate is computed as the simple average of each sub-measure if reported via EHR or via QCDR using EHR specifications.
241 (CMS182v4)	Ischemic Vascular Disease (IVD): Complete Lipid Profile and LDL-C Control (< 100 mg/dL)	EHR, QCDR (using EHR measure specifications)	The first sub-measure, which measure specifications define as the overall rate, is used as the overall rate if reported via EHR, or via QCDR using EHR specifications.
242	Coronary Artery Disease (CAD): Symptom Management	Registry, QCDR (using Registry measure specifications)	The third sub-measure, which measure specifications define as the overall rate, is used as the overall rate if reported via Registry or via QCDR using Registry specifications.
305 (CMS137v3)	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	EHR, QCDR (using EHR measure specifications)	Overall rate is computed as the simple average of each sub-measure if reported via EHR or via QCDR using EHR specifications.
316a (CMS61v4)	Preventive Care and Screening: Cholesterol - Fasting Low Density Lipoprotein (LDL-C) Test Performed	EHR, QCDR (using EHR measure specifications)	Overall rate is computed as the case-weighted average of each sub-measure if reported via EHR or via QCDR using EHR specifications.
316b (CMS64v4)	Preventive Care and Screening: Risk-Stratified Cholesterol – Fasting Low Density Lipoprotein (LDL-C)	EHR, QCDR (using EHR measure specifications)	Overall rate is computed as the case-weighted average of each sub-measure if reported via EHR or via QCDR using EHR specifications.
349	Optimal Vascular Composite	Registry, QCDR (using Registry measure specifications)	The first sub-measure, which measure specifications define as the overall rate, is used as the overall rate if reported via Registry or via QCDR using Registry specifications.
366 (CMS136v4)	ADHD: Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication	EHR, QCDR (using EHR measure specifications)	Overall rate is computed as the simple average of each sub-measure if reported via EHR or via QCDR using EHR specifications.
371 (CMS160v3)	Depression Utilization of the PHQ-9 Tool	EHR, QCDR (using EHR measure specifications)	Overall rate is computed as the case-weighted average of each sub-measure if reported via EHR or via QCDR using EHR specifications.

PQRS Number (GPRO/eCQM Number) or Non-PQRS QCDR Measure Number	Measure Name	Reporting Method(s) Affected	Approach
391	Follow-up After Hospitalization for Mental Illness (FUH)	Registry, QCDR (using Registry measure specifications)	The second sub-measure, which measure specifications define as the overall rate, is used as the overall rate if reported via Registry or via QCDR using Registry specifications.
392	HRS-12: Cardiac Tamponade and/or Pericardiocentesis Following Atrial Fibrillation Ablation	Registry, QCDR (using Registry measure specifications)	The fifth sub-measure, which measure specifications define as the overall rate, is used as the overall rate if reported via Registry or via QCDR using Registry specifications.
394	Immunizations for Adolescents	Registry, QCDR (using Registry measure specifications)	The third sub-measure, which measure specifications define as the overall rate, is used as the overall rate if reported via Registry or via QCDR using Registry specifications.
399	Post-Procedural Optimal Medical Therapy Composite (Percutaneous Coronary Intervention)	Registry, QCDR (using Registry measure specifications)	The first sub-measure, which measure specifications define as the overall rate is used as the overall rate if reported via Registry or via QCDR using Registry specifications.
ACCCath 3	Vascular access site injury requiring treatment or major bleeding post PCI in patients without CABG or other major surgeries during admission.	QCDR	The first sub-measure, which measure specifications define as the overall rate, is used as the overall rate if reported via QCDR.
ACCCath 6	ACE-I or ARB prescribed at discharge for patients with an ejection fraction < 40% who had a PCI during the episode of care.	QCDR	The first sub-measure, which measure specifications define as the overall rate, is used as the overall rate if reported via QCDR.
ACCCath 8	Percutaneous Coronary Intervention (PCI): Post-procedural Optimal Medical Therapy	QCDR	The first sub-measure, which measure specifications define as the overall rate, is used as the overall rate if reported via QCDR.
ACEP 1	Emergency Department Utilization of CT for Minor Blunt Head Trauma for Patients Aged 18 Years and Older	QCDR	The first sub-measure, which measure specifications define as the overall rate, is used as the overall rate if reported via QCDR.
ACEP 2	Emergency Department Utilization of CT for Minor Blunt Head Trauma for Patients Aged 2 Through 17 Years	QCDR	The first sub-measure, which measure specifications define as the overall rate, is used as the overall rate if reported via QCDR.
ACEP 4	Appropriate Emergency Department Utilization of CT for Pulmonary Embolism	QCDR	The first sub-measure, which measure specifications define as the overall rate, is used as the overall rate if reported via QCDR.

PQRS Number (GPRO/eCQM Number) or Non-PQRS QCDR Measure Number	Measure Name	Reporting Method(s) Affected	Approach
ACEP 5	ED LOS for discharged patients-Overall Rate	QCDR	The first sub-measure, which measure specifications define as the overall rate, is used as the overall rate if reported via QCDR.
ACEP 6	ED LOS for discharged patients – General Rate	QCDR	The first sub-measure, which measure specifications define as the overall rate, is used as the overall rate if reported via QCDR.
ACEP 7	ED LOS for discharged patients – Psych/Mental Health	QCDR	The first sub-measure, which measure specifications define as the overall rate, is used as the overall rate if reported via QCDR.
ACEP 8	ED LOS for discharged patients – Transfers	QCDR	The first sub-measure, which measure specifications define as the overall rate, is used as the overall rate if reported via QCDR.
ACEP 9	Door to Diagnostic Evaluation by a Qualified Medical Personnel	QCDR	The first sub-measure, which measure specifications define as the overall rate, is used as the overall rate if reported via QCDR.
ACEP 14	tPA Considered	QCDR	The first sub-measure, which measure specifications define as the overall rate, is used as the overall rate if reported via QCDR.
ACEP 15	Tobacco Screening and Cessation Intervention for ED patients with asthma and COPD:	QCDR	The first sub-measure, which measure specifications define as the overall rate, is used as the overall rate if reported via QCDR.
ACEP 16	Antibiotic Prescribed for Adult Acute Sinusitis	QCDR	The first sub-measure, which measure specifications define as the overall rate, is used as the overall rate if reported via QCDR.
ACEP 18	Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	QCDR	The first sub-measure, which measure specifications define as the overall rate, is used as the overall rate if reported via QCDR.
CUHSM 2	Proportion of Days Covered (PDC): 5 Rates by Therapeutic Category	QCDR	Overall rate is computed as the simple average of each sub-measure if reported via QCDR.
ICLOPS 15	Excess Days Rate and Degree of Excess (Including Physician Response)	QCDR	The first sub-measure, which measure specifications define as the overall rate, is used as the overall rate if reported via QCDR.
ICLOPS 16	Re-Admission Rate Within 30 Days (Including Physician Response)	QCDR	The first sub-measure, which measure specifications define as the overall rate, is used as the overall rate if reported via QCDR.
ICLOPS 17	Rate of Follow Up Visits Within 7 Days of Discharge (Including Physician Response)	QCDR	The first sub-measure, which measure specifications define as the overall rate, is used as the overall rate if reported via QCDR.

PQRS Number (GPRO/eCQM Number) or Non-PQRS QCDR Measure Number	Measure Name	Reporting Method(s) Affected	Approach
INVIVO 1	Back Pain: Patient Reassessment	QCDR	Overall rate is computed as the simple average of each sub-measure if reported via QCDR.
INVIVO 2	Patient Education Documentation	QCDR	Overall rate is computed as the simple average of each sub-measure if reported via QCDR.
INVIVO 3	Orthopedic and Spine Surgery: Depression & Anxiety Assessment	QCDR	Overall rate is computed as the case-weighted average of each sub-measure if reported via QCDR.
INVIVO 4	Orthopedic Pain & Function: Patient Reassessment Over Time	QCDR	Overall rate is computed as the simple average of each sub-measure if reported via QCDR.
INVIVO 5	Back Pain & Function: Patient Reassessment Over Time	QCDR	Overall rate is computed as the simple average of each sub-measure if reported via QCDR.
MBS 1	Medical Complications	QCDR	Overall rate is computed as the simple average of each sub-measure if reported via QCDR.
MBS 2	Surgical Site Complications	QCDR	Overall rate is computed as the simple average of each sub-measure if reported via QCDR.
MBS 3	Serious Complications	QCDR	The twenty-third sub-measure, which measure specifications define as the overall rate, is used as the overall rate if reported via QCDR.
NPA 1	Spine Pain Assessment	QCDR	The first sub-measure, which measure specifications define as the overall rate, is used as the overall rate if reported via QCDR.
NPA 2	Extremity (Radicular) Pain Assessment	QCDR	The first sub-measure, which measure specifications define as the overall rate, is used as the overall rate if reported via QCDR.
NPA 3	Functional Outcome Assessment for Spine Intervention	QCDR	The first sub-measure, which measure specifications define as the overall rate, is used as the overall rate if reported via QCDR.
NPA 4	Quality of Life Assessment for Spine Intervention	QCDR	The first sub-measure, which measure specifications define as the overall rate, is used as the overall rate if reported via QCDR.
NPA 5	Patient Satisfaction with Spine Care	QCDR	The first sub-measure, which measure specifications define as the overall rate, is used as the overall rate if reported via QCDR.
NPA 6	Spine-related procedure site infection	QCDR	The first sub-measure, which measure specifications define as the overall rate, is used as the overall rate if reported via QCDR.

PQRS Number (GPRO/eCQM Number) or Non-PQRS QCDR Measure Number	Measure Name	Reporting Method(s) Affected	Approach
NPA 7	Complication Following Spine-Related Procedure	QCDR	The first sub-measure, which measure specifications define as the overall rate, is used as the overall rate if reported via QCDR.
NPA 8	Hospital Mortality following Spine Procedure	QCDR	The first sub-measure, which measure specifications define as the overall rate, is used as the overall rate if reported via QCDR.
NPA 9	Referral for post-acute care rehabilitation	QCDR	The first sub-measure, which measure specifications define as the overall rate, is used as the overall rate if reported via QCDR.
NPA 10	Unplanned Reoperation Following Spine Procedure Within the 30 Day Post-Operative Period	QCDR	The first sub-measure, which measure specifications define as the overall rate, is used as the overall rate if reported via QCDR.
NPA 11	Unplanned Readmission Following Spine Procedure Within the 30 Day Post-Operative Period	QCDR	The first sub-measure, which measure specifications define as the overall rate, is used as the overall rate if reported via QCDR.
NPA 12	Selection of Prophylactic Antibiotic-First or Second Generation Cephalosporin Prior to Spine Procedure	QCDR	The first sub-measure, which measure specifications define as the overall rate, is used as the overall rate if reported via QCDR.
NPA 13	Discontinuation of Prophylactic Parenteral Antibiotics Following Spine Procedure	QCDR	The first sub-measure, which measure specifications define as the overall rate, is used as the overall rate if reported via QCDR.
NPA 14	Medicine Reconciliation Following Spine Related Procedure	QCDR	The first sub-measure, which measure specifications define as the overall rate, is used as the overall rate if reported via QCDR.
NPA 15	Risk –assessment for elective spine procedure	QCDR	The first sub-measure, which measure specifications define as the overall rate, is used as the overall rate if reported via QCDR.
NPA 16	Depression and Anxiety Assessment Prior to Spine-Related Therapies	QCDR	The first sub-measure, which measure specifications define as the overall rate, is used as the overall rate if reported via QCDR.
NPA 17	Narcotic Pain Medicine Management Following Elective Spine Procedure	QCDR	The first sub-measure, which measure specifications define as the overall rate, is used as the overall rate if reported via QCDR.
NPA 18	Smoking Assessment and Cessation Coincident with Spine Related Therapies	QCDR	The first sub-measure, which measure specifications define as the overall rate, is used as the overall rate if reported via QCDR.

PQRS Number (GPRO/eCQM Number) or Non-PQRS QCDR Measure Number	Measure Name	Reporting Method(s) Affected	Approach
NPA 19	Body Mass Assessment and Follow-up Coincident with Spine Related Therapies	QCDR	The first sub-measure, which measure specifications define as the overall rate, is used as the overall rate if reported via QCDR.
NPA 20	Unhealthy Alcohol Use Assessment Coincident With Spine Care	QCDR	The first sub-measure, which measure specifications define as the overall rate, is used as the overall rate if reported via QCDR.
NPA 21	Participation in a Systematic National Database for Spine Care Interventions	QCDR	The first sub-measure, which measure specifications define as the overall rate, is used as the overall rate if reported via QCDR.
OBERD 2	Back Pain: Patient Reassessment	QCDR	Overall rate is computed as the simple average of each sub-measure if reported via QCDR.
OBERD 7	Orthopedic Pain: Patient Reassessment	QCDR	Overall rate is computed as the simple average of each sub-measure if reported via QCDR.
OBERD 13	Orthopedic Functional and Pain Level Outcomes	QCDR	Overall rate for OBERD-13 is calculated by finding (value for sub-measure)*(sub-measure #)/100 and summing over all 5 strata if reported via QCDR.
OBERD 16	Orthopedic 3-Month Surgery Success Rate	QCDR	The second sub-measure, which measure specifications define as the overall rate, is used as the overall rate if reported via QCDR.
OBERD 17	CG-CAHPS Patient Rating	QCDR	Overall rate is computed as the simple average of each sub-measure if reported via QCDR.
PInc 39	Well-Child Visits in the 1st 15 Months of life	QCDR	Overall rate is computed as the case-weighted average of each sub-measure if reported via QCDR.
PInc 40	Developmental Screening in 1st 3 years of life	QCDR	Overall rate is computed as the case-weighted average of each sub-measure if reported via QCDR.
PInc 42	Access to Primary Care Practitioners - Children	QCDR	Overall rate is computed as the case-weighted average of each sub-measure if reported via QCDR.
PInc 43	Follow-up office visit within 7 days or 14 days after hospitalization	QCDR	Overall rate is computed as the case-weighted average of each sub-measure if reported via QCDR.
STS 2	CABG- Short postoperative LOS (SLOS)	QCDR	The first sub-measure, which measure specifications define as the overall rate, is used as the overall rate if reported via QCDR.
STS 4	CABG + Valve- Short postoperative length of stay (SLOS)	QCDR	The first sub-measure, which measure specifications define as the overall rate, is used as the overall rate if reported via QCDR.

PQRS Number (GPRO/eCQM Number) or Non-PQRS QCDR Measure Number	Measure Name	Reporting Method(s) Affected	Approach
STS 6	Isolated Valve- Short postoperative LOS (SLOS)	QCDR	The first sub-measure, which measure specifications define as the overall rate, is used as the overall rate if reported via QCDR.
STS 7	Patient Centered Surgical Risk Assessment and Communication	QCDR	The first sub-measure, which measure specifications define as the overall rate, is used as the overall rate if reported via QCDR.
WCQIC 12	Chronic Wound Care: Documentation of Assessment of Wound Healing Progress	QCDR	Overall rate is computed as the simple average of each sub-measure if reported via QCDR.
WCQIC 13	Chronic Wound Care: Hospital Readmission in Patients After Wide Surgical Debridement For Pressure Ulcer Discharged Home With Air vs. Circulating Sand Bed	QCDR	The second sub-measure, which measure specifications define as the overall rate, is used as the overall rate if reported via QCDR.
WELL 10	HIV/AIDS: Pneumocystis Jiroveci Pneumonia (PCP) Prophylaxis	QCDR	The fourth sub-measure, which measure specifications define as the overall rate, is used as the overall rate if reported via QCDR.
WELL 12	Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication	QCDR	The first sub-measure, which measure specifications define as the overall rate, is used as the overall rate if reported via QCDR.
WELL 15	Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents	QCDR	The first sub-measure, which measure specifications define as the overall rate, is used as the overall rate if reported via QCDR.
WELL 18	Ischemic Vascular Disease (IVD): Complete Lipid Panel and LDL Control	QCDR	The second sub-measure, which measure specifications define as the overall rate, is used as the overall rate if reported via QCDR.
WELL 19	Adults' Access to Preventive/Ambulatory Health Services	QCDR	The fourth sub-measure, which measure specifications define as the overall rate, is used as the overall rate if reported via QCDR.
WELL 20	Antidepressant Medication Management	QCDR	The first sub-measure, which measure specifications define as the overall rate, is used as the overall rate if reported via QCDR.
WELL 22	Children and Adolescents' Access to Primary Care Practitioners	QCDR	Overall rate is computed as the case-weighted average of each sub-measure if reported via QCDR.

PQRS Number (GPRO/eCQM Number) or Non-PQRS QCDR Measure Number	Measure Name	Reporting Method(s) Affected	Approach
WELL 23	Follow-Up After Hospitalization for Mental Illness	QCDR	The first sub-measure, which measure specifications define as the overall rate, is used as the overall rate if reported via QCDR.
WELL 24	Annual Monitoring for Patients on Persistent Medications	QCDR	The fourth sub-measure, which measure specifications define as the overall rate, is used as the overall rate if reported via QCDR.
WELL 26	Prenatal and Postpartum Care	QCDR	The second sub-measure, which measure specifications define as the overall rate, is used as the overall rate if reported via QCDR.
Measures with Technical Issues			
1 (CMS122v3)	Diabetes: Hemoglobin A1c Poor Control	EHR, QCDR (using EHR measure specifications)	Submissions made via EHR or via QCDR using EHR specifications are excluded from the QRUR and Value Modifier due to an error in the measure specifications.
112 (CMS125v3)	Breast Cancer Screening	EHR, QCDR (using EHR measure specifications)	Submissions made via EHR or via QCDR using EHR specifications are excluded from the QRUR and Value Modifier because measure specifications are not comparable to prior year benchmark.
134 (CMS2v4)	Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan	EHR, QCDR (using EHR measure specifications)	Submissions made via EHR or via QCDR using EHR specifications are excluded from the QRUR and Value Modifier due to an error in the measure specifications.
Diabetes Composite	Diabetes Composite	GPRO Web Interface	Measure is excluded from the Value Modifier because measure specifications are not comparable to prior year benchmark.
354 (General Surgery Measures Group (American College of Surgeons)	Anastomotic Leak Intervention	Registry Measures Group, QCDR (using Registry Measures Group specifications)	Measure is excluded from the Value Modifier due to inconsistencies in the use of risk adjustment across different vendors reporting the measure.
355 (General Surgery Measures Group (American College of Surgeons)	Unplanned Reoperation within the 30 Day Postoperative Period	Registry Measures Group, QCDR (using Registry Measures Group specifications)	Measure is excluded from the Value Modifier due to inconsistencies in the use of risk adjustment across different vendors reporting the measure.

PQRS Number (GPRO/eCQM Number) or Non-PQRS QCDR Measure Number	Measure Name	Reporting Method(s) Affected	Approach
356 (General Surgery Measures Group (American College of Surgeons)	Unplanned Hospital Readmission within 30 Days of Principal Procedure	Registry Measures Group, QCDR (using Registry Measures Group specifications)	Measure is excluded from the Value Modifier due to inconsistencies in the use of risk adjustment across different vendors reporting the measure.
357 (General Surgery Measures Group (American College of Surgeons)	Surgical Site Infection (SSI)	Registry Measures Group and QCDR (using Registry Measures Group specifications)	Measure is excluded from the Value Modifier due to inconsistencies in the use of risk adjustment across different vendors reporting the measure.

APPENDIX D

METHOD FOR DEFINING SERVICE CATEGORIES

For the purposes of reporting cost breakdowns by category of service (shown in Tables 3A, 3B, 4A, 4B, 4C, and 4D of the Annual QRUR and Tables 2B, 5, 7, 8, 9, and 10 of the Mid-Year QRUR), each Medicare claim for an attributed beneficiary is categorized into one of the service categories displayed in Exhibit D.1. Claim costs are included in a given service category based on the claim type, Berenson-Eggers Type of Service (BETOS) code, place of service, type of bill, type of service, HCPCS modifier, and/or provider type.

For the purposes of reporting cost breakdowns by category of service (shown in Tables 5C and 5D of the Annual QRUR and Tables 4 and 6 of the Mid-Year QRUR), each claim associated with an MSPB episode is categorized into one of the service categories displayed in Exhibit D.2. Episode costs are included in a given service category based on the claim type, BETOS code, claim criteria, and provider type. CMS assigns a BETOS code to each HCPCS code that might appear on a carrier or outpatient hospital claim. For example, BETOS code M1A (office visits—new) consists of the following E&M HCPCS codes: 99201, 99202, 99203, 99204, 99205, 99381, 99382, 99383, 99384, 99385, 99386, 99387, 0500F, G0101, G0245, G0248, and G0402. CMS developed the BETOS coding system primarily for analyzing the growth in Medicare expenditures. The coding system covers all HCPCS codes, assigns an HCPCS code to one, and only one, BETOS code, consists of readily understood clinical categories (as opposed to statistical or financial categories), consists of categories that permit objective assignment, is stable over time, and is relatively immune to minor changes in technology or practice patterns. Exhibit D.3 lists BETOS code descriptions.

Exhibit D.1. Categorization Codes for Type of Service Categories for Per Capita Cost Measures

		Criteria for Including Claim (Line Item) in Category		
Category	Claim Type(s)	Claim Criterion	Place of Service Criterion	Specialty Criterion
Outpatient E&M Services, Procedures, and Therapy (Excluding Emergency Department)	Sum of 1a, 1b, 2a, 2b, 2c, 2d, 2e			
1a. E&M Services Billed by EPs – Your TIN	Carrier claim line items	All Carrier line items with BETOS in {M1-M6}, HCPCS modifier* not equal to GN, GO, or GP (outpatient therapy), and Type of Service not equal to F (Ambulatory Surgical Center)	Place of Service not equal to 23 (emergency department), 21 (inpatient hospital), or 51 (inpatient psychiatric facility)	CMS specialty code NOT in {31, 45, 47, 49, 51–61, 63, 69, 73–75, 87–88, 95–96, A0–A8, B1–B5, C1, C2, or C4} AND limited to Carrier line items provided by a performing NPI associated with the TIN (“Your Group”)

Category	Claim Type(s)	Criteria for Including Claim (Line Item) in Category		
		Claim Criterion	Place of Service Criterion	Specialty Criterion
1b. E&M Services Billed by EPs – Other TINs	Carrier claim line items	All Carrier line items with BETOS in {M1-M6}, HCPCS modifier* not equal to GN, GO, or GP (outpatient therapy), and Type of Service not equal to F (Ambulatory Surgical Center)	Place of Service not equal to 23 (emergency room), 21 (inpatient hospital), or 51 (inpatient psychiatric facility)	CMS specialty code NOT in {31, 45, 47, 49, 51–61, 63, 69, 73–75, 87–88, 95–96, A0–A8, B1–B5, C1, C2, or C4} AND limited to Carrier line items provided by a performing NPI NOT associated with the TIN (“Other Groups”)
2a. Major Procedures Billed by EPs – Your TIN	Carrier claim line items	All Carrier line items with BETOS in {P1-P3, P7}, HCPCS modifier* not in GN, GO, or GP (outpatient therapy), and Type of Service not equal to F (Ambulatory Surgical Center)	Place of Service not equal to 23 (emergency department), 21 (inpatient hospital), or 51 (inpatient psychiatric facility)	CMS specialty code NOT in {31, 45, 47, 49, 51–61, 63, 69, 73–75, 87–88, 95–96, A0–A8, B1–B5, C1, C2, or C4} AND limited to Carrier line items provided by a performing NPI associated with the TIN (“Your Group”)
2b. Major Procedures Billed by EPs – Other TINs	Carrier claim line items	All Carrier line items with BETOS in {P1-P3, P7}, HCPCS modifier* not in GN, GO, or GP (outpatient therapy), and Type of Service not equal to F (Ambulatory Surgical Center)	Place of Service not equal to 23 (emergency department), 21 (inpatient hospital), or 51 (inpatient psychiatric facility)	CMS specialty code NOT in {31, 45, 47, 49, 51–61, 63, 69, 73–75, 87–88, 95–96, A0–A8, B1–B5, C1, C2, or C4} AND limited to carrier line items provided by a performing NPI NOT associated with the TIN (“Other Groups”)
2c. Ambulatory/ Minor Procedures Billed by EPs – Your TIN	Carrier claim line items	All carrier line items with BETOS in {P4-P6, P8}, HCPCS modifier* not equal to GN, GO, or GP (outpatient therapy), and Type of Service not equal to F (Ambulatory Surgical Center)	Place of Service not equal to 23 (emergency department), 21 (inpatient hospital), or 51 (inpatient psychiatric facility)	CMS specialty code NOT in {31, 45, 47, 49, 51–61, 63, 69, 73–75, 87–88, 95–96, A0–A8, B1–B5, C1, C2, or C4} AND limited to carrier line items provided by a performing NPI associated with the TIN (“Your Group”)
2d. Ambulatory/ Minor Procedures Billed by EPs –Other TINs	Carrier claim line items	All carrier line items with BETOS in {P4-P6, P8}, HCPCS modifier* not equal to GN, GO, or GP (outpatient therapy), and Type of Service not equal to F (Ambulatory Surgical Center)	Place of Service not equal to 23 (emergency department), 21 (inpatient hospital), or 51 (inpatient psychiatric facility)	CMS specialty code NOT in {31, 45, 47, 49, 51–61, 63, 69, 73–75, 87–88, 95–96, A0–A8, B1–B5, C1, C2, or C4} AND limited to carrier line items provided by a performing NPI NOT associated with the TIN (“Other Groups”)

Category	Claim Type(s)	Criteria for Including Claim (Line Item) in Category		
		Claim Criterion	Place of Service Criterion	Specialty Criterion
2e. Outpatient Physical, Occupational, or Speech and Language Pathology Therapy	Outpatient claim line items plus carrier claim line items	All claims/line items with HCPCS modifier* equal to GN, GO, or GP, BETOS code not in {P0, P9, O1A, O1D, O1E, or D1G}, and, for outpatient claims, Type of Bill not equal to 22x or 23x (SNF), 33x or 34x (Home Health), or 72x (dialysis)	For carrier claim line items, Place of Service not equal to 23 (emergency department), 21 (inpatient hospital), or 51 (inpatient psychiatric facility); For outpatient claims, Revenue Center line code is NOT in {0450-0459, 0981} (emergency department)	Not applicable
3. Ancillary Services	Sum of 3a, 3b, 3c	All BETOS codes in {T1, T2}; HCPCS modifier* not equal to GN, GO, or GP; and for outpatient Claims, Type of Bill not equal to 22x or 23x (SNF), 33x or 34x (Home Health), or 72x (dialysis)	For carrier claim line items, Place of Service not equal to 23 (emergency department), 21 (inpatient hospital), or 51 (inpatient psychiatric facility); For outpatient claims, Revenue Center line code is NOT in {0450-0459, 0981}	Not applicable
3a. Ancillary services: Laboratory, Pathology, and Other Tests	Outpatient claim line items plus carrier claim line items	All BETOS codes in {T1, T2}; HCPCS modifier* not equal to GN, GO, or GP; and for outpatient Claims, Type of Bill not equal to 22x or 23x (SNF), 33x or 34x (Home Health), or 72x (dialysis)	For carrier claim line items, Place of Service not equal to 23 (emergency department), 21 (inpatient hospital), or 51 (inpatient psychiatric facility); For outpatient claims, Revenue Center line code is NOT in {0450-0459, 0981}	Not applicable
3b. Ancillary services: Imaging Services	Outpatient claim line items plus carrier claim line items	All BETOS codes in {I1-I4}; HCPCS modifier* not equal to GN, GO, or GP; and for outpatient Claims, Type of Bill not equal to 22x or 23x (SNF), 33x or 34x (Home Health), or 72x (dialysis)	For carrier claim line items, Place of Service not equal to 23 (emergency department), 21 (inpatient hospital), or 51 (inpatient psychiatric facility); For outpatient claims, Revenue Center line code is NOT in {0450-0459, 0981}	Not applicable
3c. Ancillary services: Durable Medical Equipment and Supplies	Durable medical equipment claims	All DME claims with BETOS code not in {O1D, O1E, D1G}	Not applicable	Not applicable

Category	Claim Type(s)	Criteria for Including Claim (Line Item) in Category		
		Claim Criterion	Place of Service Criterion	Specialty Criterion
4. Hospital Inpatient Services	Sum of 4a, 4b, 4c			
4a. Hospital Inpatient Services: Inpatient Hospital Facility Services	Inpatient claims	Inpatient short-stay and psychiatric inpatient claims	Provider (CCN) number ends in {0001-0899}, {1300-1399}, {4000–4499} or its third position is in {M, S}	Not applicable
4b. Hospital Inpatient Services: Eligible Professional Services during Hospitalization—Your TIN	Carrier claim line items	All carrier line items with BETOS not in {P0, P9, O1A, O1D, O1E, or D1G}	Place of Service equal to 21 (inpatient hospital) or 51 (inpatient psychiatric facility)	CMS specialty code NOT in {31, 45, 47, 49, 51–61, 63, 69, 73–75, 87–88, 95–96, A0–A8, B1–B5, C1, C2, or C4} AND limited to carrier line items provided by a performing NPI associated with the TIN ("Your Group")
4c. Hospital Inpatient Services: Eligible Professional Services during Hospitalization—Other TINs	Carrier claim line items	All carrier line items with BETOS not in {P0, P9, O1A, O1D, O1E, or D1G}	Place of Service equal to 21 (inpatient hospital) or 51 (inpatient psychiatric facility)	CMS specialty code NOT in {31, 45, 47, 49, 51–61, 63, 69, 73–75, 87–88, 95–96, A0–A8, B1–B5, C1, C2, or C4} AND limited to carrier line items provided by a performing NPI NOT associated with the TIN ("Other Groups")
5. Emergency Services That Did Not Result in a Hospital Admission	Sum of 5a, 5b, 5c, 5d			
5a. Emergency Services: Emergency E&M Services	Outpatient claim line items plus carrier claim line items	All BETOS codes in {M1-M6} and, for outpatient claims, Type of Bill not equal to 72x (dialysis)	For carrier claim line items, Place of Service = 23; For outpatient claims, Revenue Center line code in {0450-0459, 0981}	None for outpatient claims;** for carrier claims: CMS specialty code NOT in {31, 45, 47, 49, 51–61, 63, 69, 73–75, 87–88, 95–96, A0–A8, B1–B5, C1, C2, or C4}
5b. Emergency Services: Procedures	Outpatient claim line items plus carrier claim line items	All BETOS codes in {P1-P8} and, for outpatient claims, Type of Bill not equal to 72x (dialysis)	For carrier claim line items, Place of Service = 23; For outpatient claims, Revenue Center line code in {0450-0459, 0981}	None for outpatient claims;** for carrier claims: CMS specialty code NOT in {31, 45, 47, 49, 51–61, 63, 69, 73–75, 87–88, 95–96, A0–A8, B1–B5, C1, C2, or C4}

Category	Claim Type(s)	Criteria for Including Claim (Line Item) in Category		
		Claim Criterion	Place of Service Criterion	Specialty Criterion
5c. Emergency Services: Laboratory, Pathology, and Other Tests	Outpatient claim line items plus carrier claim line items	All BETOS codes in {T1, T2} and, for outpatient claims, Type of Bill not equal to 72x (dialysis)	For carrier claim line items, Place of Service = 23; For outpatient claims, Revenue Center line code in {0450-0459, 0981}	Not applicable
5d. Emergency Services: Imaging Services	Outpatient claim line items plus carrier claim line items	All BETOS codes in {I1- I4} and, for outpatient claims, type of bill not equal to 72x (dialysis)	For carrier claim line items, Place of Service = 23; For outpatient claims, Revenue Center line code in {0450-0459, 0981}	Not applicable
6. Post-Acute Services	Sum of 6a, 6b, 6c			
6a. Post-Acute Services: Home Health	Home health claims and outpatient claim line items	All home health claims and all outpatient claims with Type of Bill = 33x or 34x and BETOS code not in {P0, P9, O1A, O1D, O1E, DIG}	None for Home Health claims; For outpatient claims, Revenue Center line code is NOT in {0450-0459, 0981} (emergency department)	Not applicable
6b. Post-Acute Services: Skilled Nursing Facilities	Skilled nursing facility claims and outpatient claim line items	All SNF claims and all outpatient claims with Type of Bill = 22x or 23x and BETOS code not in {P0, P9, O1A, O1D, O1E, DIG}	None for SNF claims; For outpatient claims, Revenue Center line code is NOT in {0450-0459, 0981} (emergency department)	Not applicable
6c. Post-Acute services: Inpatient Rehabilitation or Long-Term Care Hospital	Inpatient claims	Not applicable	Provider (CCN) number ends in {2000-2299, 3025–3099} or its third position is in {R, T}	Not applicable
7. Hospice	Hospice	Not applicable	Not applicable	Not applicable
8. All Other Services	Sum of 8a, 8b, 8c, 8d, 8e, 8f, 8g, 8h			
8a. Ambulance Services	Outpatient hospital claims plus carrier claim line items	All claims with BETOS code = O1A, and, for outpatient claims, Type of Bill not equal to 72x (dialysis)	Not applicable	Not applicable

Category	Claim Type(s)	Criteria for Including Claim (Line Item) in Category		
		Claim Criterion	Place of Service Criterion	Specialty Criterion
8b. Chemotherapy and Other Part B–Covered Drugs	Outpatient hospital claims plus carrier claim line items plus durable medical equipment claims	All claims with BETOS code in {O1D, O1E, D1G}, and, for outpatient claims, Type of Bill not equal to 72x (dialysis)	Not applicable	Not applicable
8c. Dialysis	Outpatient claim line items plus carrier claim line items	All Carrier claim line items or outpatient claims with BETOS code = P9 or outpatient claims with Type of Bill = 72x	Not applicable	Not applicable
8d. Anesthesia Services	Outpatient claim line items plus carrier claim line items	All claims with BETOS code = P0, and, for outpatient claims, Type of Bill not equal to 72x (dialysis)	Not applicable	Not applicable
8e. Other Facility-Billed E&M Expenses	Outpatient claim line items plus carrier claim line items	All claims/line items with BETOS in {M1-M6}; HCPCS modifier* not equal to GN, GO, or GP; for outpatient claims, Type of Bill not equal to 22x or 23x (SNF), 33x or 34x (Home Health), or 72x (dialysis); and, for carrier claims, CMS specialty code = 49 or Type of Service = F (Ambulatory Surgical Center)	For outpatient claims, Revenue Center line code is NOT in {0450-0459, 0981} (emergency department); For carrier claims, Place of Service not equal to 23 (emergency room), 21 (inpatient hospital), or 51 (inpatient psychiatric facility)	
8f. Other Facility-Billed Expenses for Major Procedures	Outpatient claim line items plus carrier claim line items	All claims/line items with BETOS in {P1-P3, P7}; HCPCS modifier* not equal to GN, GO, or GP; for outpatient claims, Type of Bill not equal to 22x or 23x (SNF), 33x or 34x (Home Health), or 72x (dialysis); and, for carrier claims, CMS specialty code = 49 or Type of Service = F (Ambulatory Surgical Center)	For outpatient claims, Revenue Center line code is NOT in {0450-0459, 0981} (emergency department); For carrier claims, Place of Service not equal to 23 (emergency room), 21 (inpatient hospital), or 51 (inpatient psychiatric facility)	Not applicable

Category	Claim Type(s)	Criteria for Including Claim (Line Item) in Category		
		Claim Criterion	Place of Service Criterion	Specialty Criterion
8g. Other Facility-Billed Expenses for Ambulatory/Minor Procedures	Outpatient claim line items plus carrier claim line items	All claims/line items with BETOS in {P4-P6, P8}; HCPCS modifier* not equal to GN, GO, or GP (outpatient therapy); for outpatient claims, Type of Bill not equal to 22x or 23x (SNF), 33x or 34x (Home Health), or 72x (dialysis); and, for carrier claims, CMS specialty code = 49 or Type of Service = F (Ambulatory Surgical Center)	For outpatient claims, Revenue Center line code is NOT in {0450-0459, 0981} (emergency department); For carrier claims, Place of Service not equal to 23 (emergency room), 21 (inpatient hospital), or 51 (inpatient psychiatric facility)	Not applicable
8h. All Other Services Not Otherwise Classified	Remainder of total costs from claims files (excluding Part D)	Total costs associated with all claims and/or line items not identified in rows above	Not applicable	Not applicable

* Only the first four HCPCS modifiers are considered due to data constraints.

** Under the “Emergency Services” category, in the “Lab Tests,” and “Imaging” subcategories, CMS includes services from non-eligible professionals (which is consistent with the definition of the “Ancillary Services” subcategories “Lab Tests,” and “Imaging”). In the “Visits,” and “Procedures” subcategories, CMS limits carrier claims to those provided by an eligible professional (which is consistent with the definition of the “E&M Services,” and “Procedures” type-of-service categories (1a, 1b, 2a, 2b, 2c, 2d)). However, given that outpatient claims do not include a specialty code, this exclusion is not made on outpatient claims.

Exhibit D.2. Definitions for Service Categories for the MSPB Measure

Category	Claim Type(s)	Criteria for Including Claim (Line Item) in Category			
		BETOS	Claim Criterion	Provider Number Criterion	Additional Criterion
Acute Inpatient Services					
Inpatient Hospital: Index Admission	Inpatient			MSPB-eligible hospitals	Acute inpatient hospitalization that triggered the MSPB episode
Inpatient Hospital: Readmission	Inpatient			Provider number with '0' in third digit (Acute Hospital) or with third and fourth digit = '13' (Critical Access Hospital CAH) or a Psychiatric hospital as identified by provider number ending in {4000-4499} or its third position is in {M, S}.	Any acute inpatient hospitalization other than the one that triggered the episode
Physician Services During Hospitalization	Carrier		Carrier claims line items between from_dt and thru_dt (exclusive) of trigger or readmission inpatient claim with no place of service restriction. For Acute and CAH inpatient stays, carrier claims line items on the from_dt must have Place of Service 21, 22, or 23 while carrier claims on the thru_dt must have Place of Service 21. For Psychiatric inpatient stays, carrier claims line items on the from_dt or thru_dt must have Place of Service 51.		
Post-Acute Care Services					
Home Health	Home Health, Outpatient		All Home Health claims. Outpatient claims with Type of Bill 34x		
Skilled Nursing Facility	Skilled Nursing Facility, Outpatient		All Skilled Nursing Facility claims. Outpatient claims with Type of Bill 22x or 23x		

Category	Claim Type(s)	Criteria for Including Claim (Line Item) in Category			
		BETOS	Claim Criterion	Provider Number Criterion	Additional Criterion
Inpatient Rehabilitation or Long-Term Care Hospital	Inpatient			Provider number ending in {2000-2299, 3025-3099} or with third position in {R, T}	
Emergency Room Outpatient Hospital Services					
ER E&M Services	Outpatient, Carrier	All M Codes	Outpatient revenue center line code in {0450-0459, 0981}, or carrier claim line items occurring during such an Outpatient claim and Place of Service 23.		Must not be counted in any categories above
ER Procedures	Outpatient, Carrier	P0, P1, P2, P3, P4, P5, P6, P7, P8	Outpatient revenue center line code in {0450-0459, 0981}, or carrier claim occurring during such an Outpatient claim and Place of Service 23		Must not be counted in any categories above
ER Laboratory, Pathology and Other Tests	Outpatient, Carrier	All T codes	Outpatient revenue center line code in {0450-0459, 0981}, or carrier claim occurring during such an Outpatient claim and Place of Service 23		Must not be counted in any categories above
ER Imaging Services	Outpatient, Carrier	All I codes	Outpatient revenue center line code in {0450-0459, 0981}, or carrier claim occurring during such an Outpatient claim and Place of Service 23		Must not be counted in any categories above
Outpatient (Non-ER) Hospital and Physician Office Services					
Outpatient Physical, Occupational, or Speech and Language Pathology Therapy	Outpatient, Carrier				Any modifier GN, GO, or GP
Dialysis	Outpatient, Carrier		Outpatient claims Type of Bill 72x. Carrier claim line items with BETOS code P9		Must not be counted in any categories above
Outpatient Non-ER E&M Services	Outpatient, Carrier	All M Codes			Must not be counted in any categories above

Category	Claim Type(s)	Criteria for Including Claim (Line Item) in Category			
		BETOS	Claim Criterion	Provider Number Criterion	Additional Criterion
Major Procedures and Anesthesia	Outpatient, Carrier	P0, P1, P2, P3, P7			Must not be counted in any categories above
Ambulatory/Minor procedures	Outpatient, Carrier	P4, P5, P6,P8			Must not be counted in any categories above
Ancillary Services in All Non-Inpatient Settings					
Ancillary Laboratory, Pathology, and Other Tests	Outpatient, Carrier	All T codes			Must not be counted in any categories above
Ancillary Imaging Services	Outpatient, Carrier	All I codes			Must not be counted in any categories above
Durable Medical Equipment and Supplies	Durable Medical Equipment	All codes except O1D (chemotherapy), O1E and D1G (drugs)			Must not be counted in any categories above
Hospice					
Hospice	Hospice				
Other Services					
Ambulance Services	Outpatient, Carrier	O1A			
Chemotherapy And Other Part B-Covered Drugs	Outpatient, Carrier, Durable Medical Equipment	O1D, O1E, D1G			
All Other Services Not Otherwise Classified	All remaining costs from all Parts A and B claim types				

Exhibit D.3. 2015 BETOS Codes and Descriptions

Code	Description
	Evaluation and management
M1A	Office visits—new
M1B	Office visits—established
M2A	Hospital visit—initial
M2B	Hospital visit—subsequent
M2C	Hospital visit—critical care
M3	Emergency room visit
M4A	Home visit
M4B	Nursing home visit
M5A	Specialist—pathology
M5B	Specialist—psychiatry
M5C	Specialist—ophthalmology
M5D	Specialist—other
M6	Consultations
	Procedures
P0	Anesthesia
P1A	Major procedure—breast
P1B	Major procedure—colectomy
P1C	Major procedure—cholecystectomy
P1D	Major procedure—transurethral resection of the prostate
P1E	Major procedure—hysterectomy
P1F	Major procedure—explor/decompr/excisdisc
P1G	Major procedure—other
P2A	Major procedure, cardiovascular— coronary artery bypass grafting
P2B	Major procedure, cardiovascular—aneurysm repair
P2C	Major procedure, cardiovascular—thromboendarterectomy
P2D	Major procedure, cardiovascular— percutaneous transluminal coronary angioplasty
P2E	Major procedure, cardiovascular—pacemaker insertion
P2F	Major procedure, cardiovascular—other
P3A	Major procedure, orthopedic—hip fracture repair
P3B	Major procedure, orthopedic—hip replacement
P3C	Major procedure, orthopedic—knee replacement
P3D	Major procedure, orthopedic—other
P4A	Eye procedure—corneal transplant
P4B	Eye procedure—cataract removal/lens insertion
P4C	Eye procedure—retinal detachment
P4D	Eye procedure—treatment of retinal lesions
P4E	Eye procedure—other
P5A	Ambulatory procedures—skin
P5B	Ambulatory procedures—musculoskeletal
P5C	Ambulatory procedures—groin hernia repair
P5D	Ambulatory procedures—lithotripsy

Code	Description
P5E	Ambulatory procedures—other
P6A	Minor procedures—skin
P6B	Minor procedures—musculoskeletal
P6C	Minor procedures—other (Medicare fee schedule)
P6D	Minor procedures—other (non-Medicare fee schedule)
P7A	Oncology—radiation therapy
P7B	Oncology—other
P8A	Endoscopy—arthroscopy
P8B	Endoscopy—upper gastrointestinal
P8C	Endoscopy—sigmoidoscopy
P8D	Endoscopy—colonoscopy
P8E	Endoscopy—cystoscopy
P8F	Endoscopy—bronchoscopy
P8G	Endoscopy—laparoscopic cholecystectomy
P8H	Endoscopy—laryngoscopy
P8I	Endoscopy—other
P9A	Dialysis services (Medicare fee schedule)
P9B	Dialysis services (non-Medicare fee schedule)
	Imaging
I1A	Standard imaging—chest
I1B	Standard imaging—musculoskeletal
I1C	Standard imaging—breast
I1D	Standard imaging—contrast gastrointestinal
I1E	Standard imaging—nuclear medicine
I1F	Standard imaging—other
I2A	Advanced imaging—CAT/CT/CTA: brain/head/neck
I2B	Advanced imaging—CAT/CT/CTA: other
I2C	Advanced imaging—MRI/MRA: brain/head/neck
I2D	Advanced imaging—MRI/MRA: other
I3A	Echography/ultrasonography—eye
I3B	Echography/ultrasonography—abdomen/pelvis
I3C	Echography/ultrasonography—heart
I3D	Echography/ultrasonography—carotid arteries
I3E	Echography/ultrasonography—prostate, transrectal
I3F	Echography/ultrasonography—other
I4A	Imaging/procedure—heart including cardiac catheter
I4B	Imaging/procedure—other
	Tests
T1A	Lab tests—routine venipuncture (non-Medicare fee schedule)
T1B	Lab tests—automated general profiles
T1C	Lab tests—urinalysis
T1D	Lab tests—blood counts
T1E	Lab tests—glucose

Code	Description
T1F	Lab tests—bacterial cultures
T1G	Lab tests—other (Medicare fee schedule)
T1H	Lab tests—other (non-Medicare fee schedule)
T2A	Other tests—electrocardiograms
T2B	Other tests—cardiovascular stress tests
T2C	Other tests—electrocardiogram monitoring
T2D	Other tests—other
	Durable medical equipment
D1A	Medical/surgical supplies
D1B	Hospital beds
D1C	Oxygen and supplies
D1D	Wheelchairs
D1E	Other DME
D1F	Prosthetic/orthotic devices
D1G	Drugs administered through DME
	Other
O1A	Ambulance
O1B	Chiropractic
O1C	Enteral and parenteral
O1D	Chemotherapy
O1E	Other drugs
O1F	Hearing and speech services
O1G	Immunizations/vaccinations
	Exceptions/unclassified
Y1	Other—Medicare fee schedule
Y2	Other—non-Medicare fee schedule
Z1	Local codes
Z2	Undefined codes

Source: Centers for Medicare & Medicaid Services Health Care Common Procedure Coding System, 2015.

Note: CAT = computerized axial tomography; CT = computerized tomography; CTA = computed tomography angiography; MRI = magnetic resonance imaging; MRA = magnetic resonance angiogram.

APPENDIX E

PROVIDER SPECIALTIES AND PROFESSIONAL STRATIFICATION CATEGORIES

Exhibit E.1 identifies which specialties are physician specialties, and the broad professional stratification categories to which each specialty is assigned. Specialty codes for which the provider stratification category is not applicable generally indicate nonmedical professionals, such as facilities or medical supply companies.

Exhibit E.1. Provider Specialties and Professional Stratification Categories

Provider or supplier specialty description	CMS specialty code	Eligible professional	Physician	Provider stratification category
Primary care specialties				
Family practice	08	Yes	Yes	PCPs
General practice	01	Yes	Yes	PCPs
Geriatric medicine	38	Yes	Yes	PCPs
Internal medicine	11	Yes	Yes	PCPs
All other specialties				
Addiction medicine	79	Yes	Yes	Medical specialists
All other suppliers (for example, drug stores)	87	No	No	Not applicable
Allergy/immunology	03	Yes	Yes	Medical specialists
Ambulance service supplier (for example, private ambulance companies, funeral homes)	59	No	No	Not applicable
Ambulatory surgical center	49	No	No	Not applicable
Anesthesiologist assistant	32	Yes	No	Other eligible professionals
Anesthesiology	05	Yes	Yes	Other eligible professionals
Audiologist (billing independently)	64	Yes	No	Other eligible professionals
Cardiac electrophysiology	21	Yes	Yes	Medical specialists
Cardiac surgery	78	Yes	Yes	Surgeons
Cardiology	06	Yes	Yes	Medical specialists
Centralized flu	C1	No	No	Not applicable
Clinical nurse specialist	89	Yes	No	Other eligible professionals
Certified nurse midwife	42	Yes	No	Other eligible professionals
Certified registered nurse anesthetist	43	Yes	No	Other eligible professionals
Chiropractor, licensed	35	Yes	Yes	Other eligible professionals

Provider or supplier specialty description	CMS specialty code	Eligible professional	Physician	Provider stratification category
Clinical laboratory (billing independently)	69	No	No	Not applicable
Clinical psychologist	68	Yes	No	Other eligible professionals
Clinical psychologist (billing independently)	62	Yes	No	Other eligible professionals
Colorectal surgery (formerly proctology)	28	Yes	Yes	Surgeons
Critical care (intensivists)	81	Yes	Yes	Medical specialists
Department store	A7	No	No	Not applicable
Dermatology	07	Yes	Yes	Medical specialists
Diagnostic radiology	30	Yes	Yes	Other eligible professionals
Emergency medicine	93	Yes	Yes	Other eligible professionals
Endocrinology	46	Yes	Yes	Medical specialists
Gastroenterology	10	Yes	Yes	Medical specialists
General surgery	02	Yes	Yes	Surgeons
Geriatric psychiatry	27	Yes	Yes	Medical specialists
Grocery store	A8	No	No	Not applicable
Gynecologist/oncologist	98	Yes	Yes	Surgeons
Hand surgery	40	Yes	Yes	Surgeons
Hematology	82	Yes	Yes	Medical specialists
Hematology/oncology	83	Yes	Yes	Medical specialists
Home health agency	A4	No	No	Not applicable
Hospice and palliative care	17	Yes	Yes	Medical specialists
Hospital	A0	No	No	Not applicable
Independent diagnostic testing facility	47	No	No	Not applicable
Indirect payment procedure	C2	No	No	Not applicable
Individual certified orthotist	55	No	No	Not applicable

Provider or supplier specialty description	CMS specialty code	Eligible professional	Physician	Provider stratification category
Individual certified prosthetist	56	No	No	Not applicable
Individual certified prosthetist-orthotist	57	No	No	Not applicable
Infectious disease	44	Yes	Yes	Medical specialists
Intensive cardiac rehabilitation	31	No	No	Not applicable
Intermediate care nursing facility	A2	No	No	Not applicable
Interventional Cardiology	C3	Yes	Yes	Medical specialists
Interventional pain management	09	Yes	Yes	Medical specialists
Interventional radiology	94	Yes	Yes	Other eligible professionals
Licensed clinical social worker	80	Yes	No	Other eligible professionals
Mammography screening center	45	No	No	Not applicable
Mass immunization roster biller	73	No	No	Not applicable
Maxillofacial surgery	85	Yes	Yes	Surgeons
Medical oncology	90	Yes	Yes	Medical specialists
Medical supply company not included in 51, 52, or 53	54	No	No	Not applicable
Medical supply company with certified orthotist	51	No	No	Not applicable
Medical supply company with certified prosthetist	52	No	No	Not applicable
Medical supply company with certified prosthetist-orthotist	53	No	No	Not applicable
Medical supply company with pedorthic personnel	B3	No	No	Not applicable
Medical supply company with registered pharmacist	58	No	No	Not applicable
Medical supply company with respiratory therapist	A6	No	No	Not applicable
Nephrology	39	Yes	Yes	Medical specialists
Neurology	13	Yes	Yes	Medical specialists
Neuropsychiatry	86	Yes	Yes	Medical specialists

Provider or supplier specialty description	CMS specialty code	Eligible professional	Physician	Provider stratification category
Neurosurgery	14	Yes	Yes	Surgeons
Nuclear medicine	36	Yes	Yes	Other eligible professionals
Nurse practitioner	50	Yes	No	Other eligible professionals
Nursing facility, other	A3	No	No	Not applicable
Obstetrics/gynecology	16	Yes	Yes	Surgeons
Occupational therapist (independently practicing)	67	Yes	No	Other eligible professionals
Ocularist	B5	No	No	Not applicable
Ophthalmology	18	Yes	Yes	Surgeons
Optician	96	No	No	Not applicable
Optometrist	41	Yes	Yes	Other eligible professionals
Oral surgery (dentists only)	19	Yes	Yes	Surgeons
Orthopedic surgery	20	Yes	Yes	Surgeons
Osteopathic manipulative therapy	12	Yes	Yes	Medical specialists
Otolaryngology	04	Yes	Yes	Surgeons
Oxygen/Oxygen Related Equipment	B1	No	No	Not applicable
Pain management	72	Yes	Yes	Other eligible professionals
Pathology	22	Yes	Yes	Other eligible professionals
Pediatric medicine	37	Yes	Yes	Other eligible professionals
Pedorthic personnel	B2	No	No	Not applicable
Peripheral vascular disease	76	Yes	Yes	Surgeons
Pharmacy	A5	No	No	Not applicable
Physical medicine and rehabilitation	25	Yes	Yes	Medical specialists
Physical therapist (independently practicing)	65	Yes	No	Other eligible professionals
Physician assistant	97	Yes	No	Other eligible professionals
Plastic and reconstructive surgery	24	Yes	Yes	Surgeons

Provider or supplier specialty description	CMS specialty code	Eligible professional	Physician	Provider stratification category
Podiatry	48	Yes	Yes	Other eligible professionals
Portable x-ray supplier	63	No	No	Not applicable
Preventive medicine	84	Yes	Yes	Medical specialists
Psychiatry	26	Yes	Yes	Medical specialists
Public health or welfare agencies (federal, state, and local)	60	No	No	Not applicable
Pulmonary disease	29	Yes	Yes	Medical specialists
Radiation oncology	92	Yes	Yes	Other eligible professionals
Radiation therapy centers	74	No	No	Not applicable
Registered dietician/nutrition professional	71	Yes	No	Other eligible professionals
Rehabilitation agency	B4	No	No	Not applicable
Restrictive use	C4	No	No	Not applicable
Rheumatology	66	Yes	Yes	Medical specialists
Single or multispecialty clinic or group practice	70	Yes	Yes	Other eligible professionals
SNF	A1	No	No	Not applicable
Sleep medicine	C0	Yes	Yes	Medical specialists
Slide preparation facilities	75	No	No	Not applicable
Speech language therapists	15	Yes	No	Other eligible professionals
Sports medicine	23	Yes	Yes	Other eligible professionals
Surgical oncology	91	Yes	Yes	Surgeons
Thoracic surgery	33	Yes	Yes	Surgeons
Unknown supplier	95	No	No	Not applicable
Unknown physician	99	Yes	Yes	Other eligible professionals
Unknown provider	88	No	No	Not applicable
Urology	34	Yes	Yes	Surgeons

Provider or supplier specialty description	CMS specialty code	Eligible professional	Physician	Provider stratification category
Vascular surgery	77	Yes	Yes	Surgeons
Voluntary health or charitable agencies (for example, National Cancer Society, National Heart Association, Catholic Charities)	61	No	No	Not applicable

Note: Physician specialties are those identified as such in the "Medicare Claims Processing Manual, Chapter 26—Completing and Processing Form CMS-1500 Data Set," available at the following URL: http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c26.pdf. Non-physician eligible professional specialties are those identified in the "2014 Physician Quality Reporting System (PQRS) List of Eligible Professionals," available at the following URL: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Downloads/PQRS_List-of-EligibleProfessionals_022813.pdf.

APPENDIX F

HIERARCHY OF PQRS DATA USED IN THE 2017 VALUE MODIFIER

Exhibit F.1 Hierarchy of PQRS Data Used in the 2017 Value Modifier

Did TIN register for GPRO?	Did TIN satisfactorily report under elected GPRO mechanism?	Did TIN satisfactorily report via another GPRO mechanism?	Did TIN report IEP PQRS data?	Data used in the Value Modifier
Yes	Yes	N/A	N/A	GPRO data of the elected mechanism
Yes	No	Yes	N/A	GPRO data that is reported satisfactorily (not GPRO mechanism elected by TIN)
Yes	No	No	Yes	IEP data (if Category 1)
Yes	No	No	No	N/A
No	N/A	N/A	Yes	IEP data (if Category 1)
No	N/A	Yes	No	GPRO data that is reported satisfactorily
No	N/A	No	No	N/A

APPENDIX G

LIST OF ACRONYMS

Exhibit G.1 List of Acronyms in the Detailed Methodology

Acronym	Description
ACA	Patient Protection and Affordable Care Act
ACO	Accountable Care Organization
ACR	All-cause Hospital Readmission
ACSC	Ambulatory Care-Sensitive Conditions
AF	Adjustment Factor
AHRQ	Agency for Healthcare Research and Quality
BETOS	Berenson-Eggers Type of Service
CAD	Coronary Artery Disease
CAH	Critical Access Hospital
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CCN	CMS Certification Number
CEHRT	Certified Electronic Health Record Technology
CME	Common Medicare Environment
CMS	Centers for Medicare & Medicaid Services
CMS-HCC	Centers for Medicare & Medicaid Services Hierarchical Condition Category
COPD	Chronic Obstructive Pulmonary Disease
CPC	Comprehensive Primary Care (initiative)
DME	Durable Medical Equipment
DMEPOS	Durable Medical Equipment, Prosthetics, Orthotics, and Supplies
EDB	Medicare Enrollment Database
E&M	Evaluation and Management
EHR	Electronic Health Record
ESRD	End-Stage Renal Disease
FFS	Fee-for-Service
GPRO	Group Practice Reporting Option
HCC	Hierarchical Condition Category
HCPCS	Healthcare Common Procedure Coding System
HIC	Health Insurance Claim (Number)
IDR	Integrated Data Repository
MAC	Medicare Administrative Contractor
PFS	Physician Fee Schedule
MSPB	Medicare Spending per Beneficiary
NPI	National Provider Identifier
OACT	CMS Office of the Actuary
PCP	Primary Care Physician

Acronym	Description
PECOS	Provider Enrollment, Chain, and Ownership System
PQRS	Physician Quality Reporting System
QCDR	Qualified Clinical Data Registry
QRUR	Quality and Resource Use Report
SNF	Skilled Nursing Facility
TIN	Taxpayer Identification Number
UDS	Universal Data Set