Quality Measures with Substantive Changes for MIPS Year 4 (2020)

Quality# 001 – Diabetes: Hemoglobin A1c (HbA1v) Poor Control (>9%)
Substantive Change:
Updated denominator exclusions: For eCQM Specifications collection type: Added the following:
(1) Patients 66 years of age and older with advanced illness and frailty.
(2) Patients 66 years of age and older who are living in a long-term institutional setting, such as a nursing home, for more than 90 days during the measurement period.
For Medicare Part B Claims Measure Specifications, CMS Web Interface Measure Specifications, and MIPS CQMs Specifications collection type: Added the following:
(1) Patients 66 and older who are living long term in an institution for more than 90 days during the measurement period.
(2) Patients 66 years of age and older with at least one claim/encounter for frailty during the measurement period AND a dispensed medication for dementia during the measurement period or the year prior to the measurement period.
(3) Patients 66 years of age and older with at least one claim/encounter for frailty during the measurement period AND either one acute inpatient encounter with a diagnosis of advanced illness or two outpatient, observation, ED or nonacute inpatient encounters on different dates of service with an advanced illness diagnosis during the measurement period or the year prior to the measurement period. (4) Dementia Exclusion Medications: Cholinesterase inhibitors: Donepezil, Galantamine, Rivastigimine Miscellaneous central nervous system agents: Memantine

Quality# 005 – Heart Failure (HF): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) or Angiotensin Receptor-Neprilysin Inhibitor (ARNI) Therapy for Left Ventricular Systolic Dysfunction (LVSD)
Substantive Change:
The measure title is revised to read: Heart Failure (HF): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) or Angiotensin Receptor-Neprilysin Inhibitor (ARNI) Therapy for Left Ventricular Systolic Dysfunction (LVSD).
The measure description is revised to read: Percentage of patients aged 18 years and older with a diagnosis of heart failure (HF) with a current or prior left ventricular ejection fraction (LVEF) < 40% who were prescribed ACE inhibitor or ARB or ARNI therapy either within a 12- month period when seen in the outpatient setting OR at each hospital discharge.
Updated denominator: For the MIPS CQMs Specifications collection type for Submission Criteria 1 – "At least on additional patient encounter during performance period", telehealth encounters will be included as denominator eligible encounters.
Updated numerator: Added language for ARNI therapy.
Updated definition: Added language for ARNI therapy.

Quality# 007 - Coronary Artery Disease (CAD): Beta-Blocker Therapy – Prior Myocardial Infarction (MI) or Left Ventricular Systolic Dysfunction (LVEF < 40%)

Substantive Change:

Updated calculation method: For the MIPS CQMs Specifications collection type: To be submitted as a single performance rate.

Updated denominator: For the MIPS CQMs Specifications collection type, "At least one additional patient encounter during performance period", telehealth encounters will be included as denominator eligible encounters.

Quality# 008 - Heart Failure (HF): Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)

Substantive Change:

For the eCQM Specifications collection type: The timing for cardiac pacer in situ diagnosis logic has been changed to 'overlaps after'.

Updated denominator: For the MIPS CQMs Specifications collection type: For Submission Criteria 1, "At least one additional patient encounter during performance period", telehealth encounters will be included as denominator eligible encounters.

Quality# 009 – Anti-Depressant Medication Management

Substantive Change:

Updated guidance: Guidance statement updated to reflect the 105-day negative medication history.

Updated denominator: The required visit needs to be in the 60 days before or after the initial patient population antidepressant medication dispensing event. The initial patient population dispensing period will be from May 1st of the year prior to the measurement period to April 30th of the measurement period. Added nursing home encounters to list of qualifying encounters.

Updated denominator exclusion: Changed timing to 'overlaps' so that medications that are active in the 105 days prior may count.

Quality# 019 – Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care

Substantive Change:

Modified collection type: eCQM Specifications, MIPS CQMs Specifications

Quality# 066 – Appropriate Testing for Children with Pharyngitis

Substantive Change:

Updated numerator: For the eCQM Specifications collection type: Removed Ambulatory/ED grouping value set, instead using the individual value sets.

Updated denominator exclusions: Added exclusion for competing diagnosis at the same encounter as the pharyngitis diagnosis or in the 3 days after the pharyngitis diagnosis.

Quality# 076 – Prevention of Central Venous Catheter (CVC) – Related Bloodstream Infections

Substantive Change:

Updated numerator definition: Added definition for Hand Hygiene: Washing hands with conventional soap and water or with alcohol-based hand rubs (ABHR).

Quality# 102 - Prostate Cancer: Avoidance of Overuse of Bone Scan for staging Low Risk Prostate Cancer Patients

Substantive Change:

The measure description is revised to read: Percentage of patients, regardless of age, with a diagnosis of prostate cancer at low (or very low) risk of recurrence receiving interstitial prostate brachytherapy, OR external beam radiotherapy to the prostate, OR radical prostatectomy who did not have a bone scan performed at any time since diagnosis of prostate cancer.

Updated denominator: Removed cryotherapy from denominator statement/header.

Updated denominator definition: Removed "Note: Patients with multiple adverse factors may be shifted into the high/very high-risk category" from definition of Intermediate Risk.

For the eCQM Specifications collection type: removed SNOMED and CPT codes related to cryotherapy from the SNOMED CT extensional OID and CPT extensional OID "Prostate Cancer Treatment" value set.

Quality# 107 – Adult major Depressive Disorder (MDD): Suicide Risk Assessment

Substantive Change:

Updated denominator: Added telehealth data element to "Major Depressive Disorder Encounter" definition using "Telehealth Services" value set.

Updated guidance: Updated to reflect the inclusion of telehealth encounters.

Updated definition: The specific type and magnitude of the suicide risk assessment is intended to be at the discretion of the individual clinician and should be specific to the needs of the patient. At a minimum, suicide risk assessment should evaluate:

(1) Suicidal ideation

(2) Patient's intent of initiating a suicide attempt AND, if either is present,

(3) Patient plans for a suicide attempt

(4) Whether the patient has means for completing suicide

Low burden tools to track suicidal ideation and behavior such as the Columbia-Suicide Severity Rating Scale (C-SSRS) and the Suicide Assessment Five-Step Evaluation and Triage (SAFE-T) can also be used. Because no validated assessment tool or instrument fully meets the aforementioned requirements for the suicide risk assessment, individual tools or instruments have not been explicitly included in coding.

Quality# 112 – Breast Cancer Screening

Substantive Change:

The measure description is revised to read: Percentage of women 50 - 74 years of age who had a mammogram to screen for breast cancer in the 27 months prior to the end of the measurement period.

The numerator is revised to read: Women with one or more mammograms 27 months prior to the end of the measurement period.

Updated denominator exclusions: For eCQM Specifications collection type:

(1) Patients 66 years of age and older with advanced illness and frailty.

(2) Patients 66 years of age and older who are living in a long-term institutional setting, such as a nursing home, for more than 90 days during the measurement

For Medicare Part B Claims Measure Specifications, CMS Web Interface Measure Specifications, and MIPS CQMs Specifications collection type: Added the following:

(1) Patients 66 and older who are living long term in an institution for more than 90 days during the measurement period.

(2) Patients 66 years of age and older with at least one claim/encounter for frailty during the measurement period AND a dispensed medication for dementia during the measurement period or the year prior to the measurement period.

(3) Patients 66 years of age and older with at least one claim/encounter for frailty during the measurement period AND either one acute inpatient encounter with a diagnosis of advanced illness or two outpatient, observation, ED or nonacute inpatient encounters on different dates of service with an advanced illness diagnosis during the measurement period or the year prior to the measurement period. (4) Dementia Exclusion Medications: Cholinesterase inhibitors: Donepezil, Galantamine, Rivastigimine Miscellaneous central nervous system agents: Memantine

Updated numerator guidance: For the Medicare Part B Claims Measure Specifications, CMS Web Interface Measure Specifications, MIPS CQMs Specifications collection types: Added "This measure evaluates primary screening. Do not count biopsies, breast ultrasounds, or MRIs because they are not appropriate methods for primary breast cancer screening. Mammography screening is defined as a bilateral screening (both breasts) of

breast tissue. If only one breast is present, unilateral screening (one side) must be performed on the remaining breast."

Quality# 113 – Colorectal Cancer Screening

Substantive Change:

Updated denominator exclusions: For eCQM Specifications collection type: Added the following:
(1) Patients aged 66 years and older with advanced illness and frailty.
(2) Patients 66 years of age and older who are living in a long-term institutional setting, such as a nursing home, for more than 90 days in the measurement period.

For Medicare Part B Claims Measure Specifications, CMS Web Interface Measure Specifications, and MIPS CQMs Specifications collection type: Added the following:
(1) Patients 66 and older who are living long term in an institution for more than 90 days during the measurement period.
(2) Patients 66 years of age and older with at least one claim/encounter for frailty during the measurement period AND a dispensed medication for dementia during the measurement period or the year prior to the measurement period.
(3) Patients 66 years of age and older with at least one claim/encounter for frailty during the measurement period AND either one acute inpatient encounter with a diagnosis of advanced illness or two outpatient, observation, ED or nonacute inpatient encounters on different dates of service with an advanced illness diagnosis during the measurement period or the year prior to the measurement period. (4) Dementia Exclusion Medications: Cholinesterase inhibitors: Donepezil, Galantamine, Rivastigimine Miscellaneous central nervous system agents: Memantine

Updated numerator guidance: For Medicare Part B Claims Measure Specification and MIPS CQMs Specifications collection types: Do not count DRE, FOBT tests performed in an office setting or performed on a sample collected via DRE.

Quality# 117 – Diabetes: Eye Exam

Substantive Change:

The measure description is revised to read: Percentage of patients 18-75 years of age with diabetes and an active diagnosis of retinopathy overlapping the measurement period who had a retinal or dilated eye exam by an eye care professional during the measurement period or diabetics with no diagnosis of retinopathy overlapping the measurement period who had a retinal or dilated eye exam by an eye care professional during the measurement period or in the 12 months prior to the measurement period.

Updated denominator exclusions: For eCQM Specifications collection type: Added the following:
(1) Patients 66 years of age and older with advanced illness and frailty.
(2) Patients 66 years of age and older who are living in a long-term institutional setting, such as a nursing home, for more than 90 days in the measurement period.

For Medicare Part B Claims Measure Specifications and MIPS CQMs Specifications collection type: Added the following:
(1) Patients 66 and older who are living long term in an institution for more than 90 days during the measurement period.
(2) Patients 66 years of age and older with at least one claim/encounter for frailty during the measurement period AND a dispensed medication for dementia during the measurement period or the year prior to the measurement period.
(3) Patients 66 years of age and older with at least one claim/encounter for frailty during the measurement period AND either one acute inpatient encounter with a diagnosis of advanced illness or two outpatient, observation, ED or nonacute inpatient encounters on different dates of service with an advanced illness diagnosis during the measurement period or the year prior to the measurement period. (4) Dementia Exclusion Medications: Cholinesterase inhibitors: Donepezil, Galantamine, Rivastigimine Miscellaneous central nervous system agents: Memantine

Updated numerator: Allows use of a diagnosis of retinopathy as a proxy for a positive eye exam.
• If the patient has a diagnosis of retinopathy that overlaps the measurement period, the patient will be required to have an eye exam in the measurement period.
• If the patient does not have a diagnosis of retinopathy that overlaps the measurement period, the patient will be required to have an eye exam in the 24 months prior to the end of the measurement period.

Quality# 119 – Diabetes: Medical Attention for Nephropathy

Substantive Change:

Updated denominator exclusions: For eCQM Specifications collection type: Added the following: (1) Patients 66 years of age and older with advanced illness and frailty. (2) Patients 66 years of age and older who are living in a long-term institutional setting, such as a nursing home, for more than 90 days in the measurement period.

For CQMs Specifications collection type: Added the following:

(1) Patients 66 and older who are living long term in an institution for more than 90 days during the measurement period.

(2) Patients 66 years of age and older with at least one claim/encounter for frailty during the measurement period AND a dispensed medication for dementia during the measurement period or the year prior to the measurement period.

(3) Patients 66 years of age and older with at least one claim/encounter for frailty during the measurement period AND either one acute inpatient encounter with a diagnosis of advanced illness or two outpatient, observation, ED or nonacute inpatient encounters on different dates of service with an advanced illness diagnosis during the measurement period or the year prior to the measurement period. (4) Dementia Exclusion Medications: Cholinesterase inhibitors: Donepezil, Galantamine, Rivastigimine Miscellaneous central nervous system agents: Memantine

Quality# 128 – Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan

Substantive Change:

Updated denominator exclusions: Added patients in hospice care. Removed "or refuse follow-up" language from denominator exclusion.

For the eCQM Specifications collection type: Added a 'union' operator of 'Intervention, Performed' for each 'Intervention, Order' for Above and Below Normal Follow-Up Interventions, and a 'union' operator of 'Intervention, Not Performed' for each 'Intervention, Not Ordered' for Above and Below Normal Follow-up Interventions not done due to a medical reason.

Quality# 134

Substantive Change:

The measure description is revised to read: Percentage of patients aged 12 years and older screened for depression on the date of the encounter or up to 14 days prior to the date of the encounter using an age appropriate standardized depression screening tool AND if positive, a follow-up plan is documented on the date of the eligible encounter.

Updated denominator: Added speech language pathology MIPS eligible clinician type.

For the Medicare Part B Claims Measure Specifications, CMS Web Interface Measure Specifications, and MIPS CQMs Specifications: Added physical therapy MIPS eligible clinician type.

Updated denominator exception: Updated language to situations where the patient's cognitive capacity, functional capacity or motivation to improve may impact the accuracy of results of standardized depression assessment.

The numerator is revised to read: Patients screened for depression on the date of the encounter or up to 14 days prior to the date of the encounter using an age appropriate standardized tool AND if positive, a follow-up plan is documented on the date of the eligible encounter.

For the eCQM Specifications collection type: Updated the "Depression medications – adolescent" and the "Additional evaluation for depression – adolescent" value sets to include additional medications. Steward

Quality# 143 – Oncology: Medical and Radiation – Pain Intensity Quantified
Substantive Change:
Updated Guidance: For the eCQM Specifications collection type: This measure is an episode-of-care measure; the level of analysis for this measure is every visit for patients with a diagnosis of cancer who are also currently receiving chemotherapy or radiation therapy during the measurement period. For patients receiving radiation therapy, pain intensity should be quantified at each radiation treatment management encounter where the patient and physician have a face-to-face interaction. Due to the nature of some applicable coding related to the radiation therapy (e.g., delivered in multiple fractions), the billing date for certain codes may or may not be the same as the face-to-face encounter date. In this instance, for the reporting purposes of this measure, the billing date should be used to pull the appropriate patients into the initial population. It is expected, though, that the numerator criteria would be performed at the time of the actual face-to-face encounter during the series of treatments. For patients receiving chemotherapy, pain intensity should be quantified at each face-to-face encounter with the physician while the patient is currently receiving chemotherapy. For purposes of identifying eligible encounters, patients "currently receiving chemotherapy" refers to patients administered chemotherapy within 30 days prior to the encounter AND administered chemotherapy within 30 days after the date of the encounter.

Quality# 144 – Oncology: Medical and Radiation – Plan of Care for Pain
Substantive Change:
Updated the description to read: Percentage of visits for patients, regardless of age, with a diagnosis of cancer currently receiving chemotherapy or radiation therapy who report having pain with a documented plan of care to address pain.
Updated the denominator to read: All visits for patients, regardless of age, with a diagnosis of cancer currently receiving chemotherapy who report having pain
All visits for patients, regardless of age, with a diagnosis of cancer currently receiving radiation therapy who report having pain
Updated the numerator to read: Patient visits that included a documented plan of care to address pain

Quality# 176 – Rheumatoid Arthritis (RA): Tuberculosis Screening
Substantive Change:
Updated definition: Biologic DMARD Therapy- Includes Abatacept (Orencia), Adalimumab (Humira), Adalimumab-adbm (Cyltezo), Adalimumab-atto (Amjevita), Anakinra (Kineret), Baricitinib (Olumiant), Certolizumab pegol (Cimzia), Etanercept (Enbrel), Etanercept-szzs (Erelzi), Golimumab (Simponi), Infliximab (Remicade), Infliximab-abda (Renflexis), Infliximab-dyyb (Inflectra), Infliximab-qbtx (Ixifi), Sarilumab (Kevzara), Tocilizumab (Actemra), Tofacitinib (Xeljanz).

Quality# 177 – Rheumatoid Arthritis (RA): periodic Assessment of Disease Activity
Substantive Change:
Updated description: Percentage of patients aged 18 years and older with a diagnosis of rheumatoid arthritis (RA) who have an assessment of disease activity using an ACR-preferred RA disease activity assessment tool at ≥50% of encounters for RA for each patient during the measurement year.
Updated definition: Removed Patient Activity Scale (PAS) from definition of "Assessment of Disease Activity".

Quality# 180 – Rheumatoid Arthritis (RA): Glucocorticoid Management
Substantive Change:
The measure description is revised to read: Percentage of patients aged 18 years and older with a diagnosis of rheumatoid arthritis (RA) who have been assessed for glucocorticoid use and, for those on prolonged doses of prednisone >5 mg daily (or equivalent) with improvement or no change in disease activity, documentation of glucocorticoid management plan within 12 months.
The numerator is revised to read: Patients who have been assessed for glucocorticoid use and for those on prolonged doses of prednisone >5 mg daily (or equivalent) with improvement or no change in disease activity, documentation of a glucocorticoid management plan within 12 months.

Quality# 181 – Elder Maltreatment Screen and Follow-Up Plan
Substantive Change:
Updated denominator: Added physical and occupational therapy, ophthalmology, audiology and speech language pathology MIPS eligible clinician types.

Quality# 182 – Functional Outcome Assessment
Substantive Change:
Updated denominator: Added mental/behavioral health, audiology, and speech language pathology MIPS eligible clinicians.

Quality# 191 – Cataracts: 20/40 or Better Visual Acuity within 90 Days Following Cataract Surgery
Substantive Change:
The measure description is revised to read: Percentage of cataract surgeries for patients aged 18 and older with a diagnosis of uncomplicated cataract and no significant ocular conditions impacting the visual outcome of surgery and had best-corrected visual acuity of 20/40 or better (distance or near) achieved in the operative eye within 90 days following the cataract surgery.
The initial population is revised to read: For the eCQM Specifications collection type: All cataract surgeries for patients aged 18 years and older who did not meet any exclusion criteria.
The denominator is revised to read: For the MIPS CQMs Specifications collection type: All cataract surgeries for patients aged 18 years and older who did not meet any exclusion criteria.
The denominator exclusion is revised to read: Cataract surgeries in patients with significant ocular conditions impacting the visual outcome of surgery.
Update denominator exclusions: Removed the following data elements/value sets: 'Chorioretinal Scars,' 'Moderate or Severe Impairment, Better Eye, Profound Impairment, Lesser Eye,' 'Other Corneal Deformities,' 'Other Disorders of Sclera,' 'Other Retinal Disorders,' and 'Profound Impairment, Both Eyes'. Add the following data elements/value sets: 'Cataract, Congenital,' 'Cataract, Mature or Hypermature,' 'Cataract, Posterior Polar,' 'Hypotony of Eye,' 'Macular Scar of Posterior Polar' (new value set), 'Morgagnian Cataract,' 'Posterior Lenticonus,' 'Retrolental Fibroplasias,' 'Traumatic Cataract,' and 'Vascular Disorders of Iris and Ciliary Body'.
The numerator is revised to read: Cataract surgeries with best-corrected visual acuity of 20/40 or better (distance or near) achieved in the operative eye within 90 days following cataract surgery

Quality# 217 - Functional Status Change for Patients with Knee Impairments
Substantive Change:
Updated numerator: Changed to define Performance Met as meeting or exceeding the risk adjusted prediction of functional status change. Numerator option "Risk-Adjusted Functional Status Change Residual Score for the knee impairment successfully calculated and the score was less than zero (< 0)" will become Performance Not Met.
Updated definitions: Removed:
(1) Admission (Option 1 & 2)
(2) Admission (Option 3 & 4)
(3) Discharge (Option 1 & 2)
(4) Discharge (Option 3 &4)
Added:
(1) Initial Evaluation: An Initial Evaluation is the first encounter for a functional deficit involving the knee and includes an evaluation (CPT 97161, 97162, 97163, 97165, 97166, 97167, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 98940, 98941, 98942, or 98943), or an Initial Evaluation Status M-code. A patient presenting with a knee impairment, who has had an interruption of a Treatment Episode for the same functional knee deficit secondary to an appropriate reason like hospitalization or surgical intervention, is an Initial Evaluation.
(2) Discharge: Discharge is accompanied by a treatment finalization and evaluation completion M-Code (M1009) identifying the close of a Treatment Episode for the same knee deficit identified at the Initial Evaluation and documented by a Discharge report by the MIPS eligible clinician. An interruption in clinical care for an appropriate reason like hospitalization or surgical intervention requires a discharge from the current Treatment Episode.
Updated:
Treatment Episode: A Treatment Episode is defined as beginning with an Initial Evaluation for a functional knee deficit, progressing through treatment without interruption (for example a hospitalization or surgical intervention), and ending with Discharge signifying that the treatment has been completed. A patient currently under clinical

care for a knee deficit remains in a single Treatment Episode until the Discharge is conducted and documented by the MIPS eligible clinician.
Updated denominator: Consolidated all options into one denominator criteria.
The denominator is revised to read: All patients 14 years and older with knee impairments who have initiated a Treatment Episode.
Updated denominator exclusions: Added the following:
(1) Patients with diagnosis of a degenerative neurological condition such as ALS, MS, Parkinson's diagnosed at any time before or during the episode of care.
Updated denominator exceptions: Added the following:
(1) Ongoing care not indicated, patient self-discharged early and seen only 1-2 visits (e.g., financial or insurance reasons, transportation problems, or reason unknown).
(2) Ongoing care not indicated, patient discharged after only 1-2 visits due to specific medical events, documented in the medical record that make the treatment episode impossible such as the patient becomes hospitalized or scheduled for surgery.
(3) Ongoing care not indicated, patient seen only 1-2 visits (e.g., home program only, referred to another provider or facility, consultation only).

Moved from denominator exclusion to denominator exception (1) Patient refused to participate.

The numerator is revised to read: Patients who were presented with the Knee FS PROM at Initial Evaluation (Intake) and at or near Discharge (Status) for the purpose of calculating the patient's Risk-Adjusted Functional Status Change Residual Score. Steward

Quality# 218 – Functional Status Change for Patients with Hip Impairments
Substantive Change:
Updated numerator: Changed to define Performance Met as meeting or exceeding the risk adjusted prediction of functional status change. Numerator option "Risk-Adjusted Functional Status Change Residual Score for the hip impairment successfully calculated and the score was less than zero (< 0)" will become Performance Not Met.
Updated definitions: Removed:
(1) Admission (Option 1 & 2)
(2) Admission (Option 3 & 4)
(3) Discharge (Option 1 & 2)
(4) Discharge (Option 3 &4)
Added:
(1) Initial Evaluation: An Initial Evaluation is the first encounter for a functional deficit involving the hip and includes an evaluation (CPT 97161, 97162, 97163, 97165, 97166, 97167, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 98940, 98941, 98942, or 98943), or an Initial Evaluation Status M-code. A patient presenting with a hip impairment, who has had an interruption of a Treatment Episode for the same functional hip deficit secondary to an appropriate reason like hospitalization or surgical intervention, is an Initial Evaluation.
(2) Discharge: Discharge is accompanied by a treatment finalization and evaluation completion M-Code (M1010) identifying the close of a Treatment Episode for the same hip deficit identified at Initial Evaluation and documented by a discharge report by the MIPS eligible clinician. An interruption in clinical care for an appropriate reason like hospitalization or surgical intervention requires a discharge from the current Treatment Episode.
Updated:
Treatment Episode: A Treatment Episode is defined as beginning with an Initial Evaluation for a functional hip deficit, progressing through treatment without interruption (for example, a hospitalization or surgical intervention), and ending with Discharge signifying that the treatment has been completed. A patient currently under clinical care for a hip deficit remains in a single Treatment Episode until the Discharge is conducted and documented by the MIPS eligible clinician.
Updated denominator: Consolidated all options into one denominator criteria.
The denominator is revised to read: All patients 14 years and older with hip impairments who have initiated a Treatment Episode.
Updated denominator exclusions: Added the following:
(1) Patients with diagnosis of a degenerative neurological condition such as ALS, MS, Parkinson's diagnosed at any time before or during the episode of care.
Updated denominator exceptions: Added the following:

(1) Ongoing care no indicated, patient self-discharged early and seen only 1-2 visits (e.g., financial or insurance reasons, transportation problems, or reason unknown).
(2) Ongoing care not indicated, patient discharged after only 1-2 visits due to specific medical events documented in the medical record that make the treatment episode impossible such as the patient becomes hospitalized or scheduled for surgery.
(3) Ongoing care not indicated, patient seen only 1-2 visits (e.g., home program only, referred to another provider or facility, consultation only).
Moved from denominator exclusion to denominator exception
(1) Patient refused to participate.
The numerator is revised to read: Patients who were presented with the Hip FS PROM at Initial Evaluation (Intake) and at or near Discharge (Status) for the purpose of calculating the patient's Risk-Adjusted Functional Status Change Residual Score.

Quality# 219 – Functional Status Change for Patients with Lower leg, Foot or Ankle Impairments
Substantive Change:
Updated numerator: Changed to define Performance Met as meeting or exceeding the risk adjusted prediction of functional status change. Numerator option "Risk-Adjusted Functional Status Change Residual Score for the lower leg, foot, or ankle impairment successfully calculated and the score was less than zero (< 0)" will become Performance Not Met.
Updated definitions: Removed:
(1) Admission (Option 1 & 2)
(2) Admission (Option 3 & 4)
(3) Discharge (Option 1 & 2)
(4) Discharge (Option 3 &4)
Added:
(1)Initial Evaluation: An Initial Evaluation is the first encounter for a functional deficit involving the lower leg, foot or ankle and includes an evaluation (CPT 97161, 97162, 97163, 97165, 97166, 97167, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 98940, 98941, 98942, or 98943), or an Initial Evaluation Status M-code. A patient presenting with a lower leg, foot or ankle impairment, who has had an interruption of a Treatment Episode for the same functional lower leg, foot or ankle deficit secondary to an appropriate reason like hospitalization or surgical intervention, is an Initial Evaluation.
(2) Discharge: Discharge is accompanied by a treatment finalization and evaluation completion M-Code (M1011) identifying the close of a Treatment Episode for the same lower leg, foot or ankle deficit identified at the Initial Evaluation and documented by a discharge report by the MIPS eligible clinician. An interruption in clinical care for an appropriate reason like hospitalization or surgical intervention requires a discharge from the current Treatment Episode.
Updated:
Treatment Episode: A Treatment Episode is defined as beginning with an Initial Evaluation for a functional lower leg, foot or ankle deficit, progressing through treatment, without interruption (for example, a hospitalization or surgical intervention), and ending with Discharge signifying that the treatment has been completed. A patient currently under clinical care for a foot, ankle or lower leg deficit remains in a single Treatment Episode until the Discharge is conducted and documented by the MIPS eligible clinician.
Updated denominator: Consolidated all options into one denominator criteria.
The denominator is revised to read: All patients 14 years and older with foot, ankle or lower leg impairments who have initiated a Treatment Episode.
Updated denominator exclusions: Added the following:
(1) Patients with diagnosis of a degenerative neurological condition such as ALS, MS, Parkinson's diagnosed at any time before or during the episode of care.
Updated denominator exceptions: Added the following:
(1) Ongoing care not indicated, patient self-discharged early and seen only 1-2 visits (e.g., financial or insurance reasons, transportation problems, or reason unknown).
(2) Ongoing care no indicated, patient discharged after only 1-2 visits due to specific medical events, documented in the medical record that make the treatment episode impossible such as the patient becomes hospitalized or scheduled for surgery.
(3) Ongoing care not indicated, patient seen only 1-2 visits (e.g., home program only, referred to another provider or facility, consultation only).
Moved from denominator exclusion to denominator exception
(1) Patient refused to participate.

The numerator is revised to read: Patients who were presented with the Foot/Ankle FS PROM at Initial Evaluation (Intake) and at or near Discharge (Status) for the purpose of calculating the patient's Risk-Adjusted Functional Status Change Residual Score.

Quality# 220 – Functional Status Change for Patients with Low Back Impairments

Substantive Change:

Updated numerator: Changed to define Performance Met as meeting or exceeding the risk adjusted prediction of functional status change. Numerator option "Risk-Adjusted Functional Status Change Residual Score for the low back impairment successfully calculated and the score was less than zero (< 0)" will become Performance Not Met.

Updated definitions: Removed:

(1) Admission (Option 1 & 2)
(2) Admission (Option 3 & 4)
(3) Discharge (Option 1 & 2)
(4) Discharge (Option 3 &4)

Added:

(1) Initial Evaluation: An Initial Evaluation is the first encounter for a functional deficit involving the low back and includes an evaluation (CPT 97161, 97162, 97163, 97165, 97166, 97167, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 98940, 98941, 98942, or 98943), or an Initial Evaluation Status M-code. A patient presenting with a low back impairment, who has had an interruption of a Treatment Episode for the same functional low back deficit secondary to an appropriate reason like hospitalization or surgical intervention, is an Initial Evaluation.

(2) Discharge: Discharge is accompanied by a treatment finalization and evaluation completion M-Code (M1012) identifying the close of a Treatment Episode for the same low back deficit identified at Initial Evaluation and documented by a Discharge report by the MIPS eligible clinician. An interruption in clinical care for an appropriate reason like hospitalization or surgical intervention requires a Discharge from the current Treatment Episode.

Updated:

Treatment Episode: A Treatment Episode is defined as beginning with an Initial Evaluation for a functional low back deficit, progressing through treatment without interruption (for example, a hospitalization or surgical intervention), and ending with Discharge, signifying that the treatment has been completed. A patient currently under clinical care for a low back functional deficit remains in a single Treatment Episode until the Discharge is conducted and documented by the MIPS eligible clinician.

Updated denominator: Consolidated all options into one denominator criteria.

The denominator is revised to read: All patients 14 years and older with a low back impairment who have initiated a Treatment Episode.

Updated denominator exclusions: Added the following:

(1) Patients with diagnosis of a degenerative neurological condition such as ALS, MS, Parkinson's diagnosed at any time before or during the episode of care.

Updated denominator exceptions: Added the following:

(1) Ongoing care not indicated, patient self-discharged early and seen only 1-2 visits (e.g., financial or insurance reasons, transportation problems, or reason unknown).

(2) Ongoing care not indicated, patient discharged after only 1-2 visits due to specific medical events, documented in the medical record that make the treatment episode impossible such as the patient becomes hospitalized or scheduled for surgery. (3) Ongoing care not indicated, patient seen only 1-2 visits (e.g., home program only, referred to another provider or facility, consultation only).

Moved from denominator exclusion to denominator exception

(1) Patient refused to participate.

The numerator is revised to read: Patients who were presented with the Low Back FS PROM at Initial Evaluation (Intake) and at or near Discharge (Status) for the purpose of calculating the patient's Risk-Adjusted Functional Status Change Residual Score.

Quality# 221 – Functional Status Change for Patients with Shoulder Impairments

Substantive Change:

Updated numerator: Changed to define Performance Met as meeting or exceeding the risk adjusted prediction of functional status change. Numerator option "Risk-Adjusted Functional Status Change Residual Score for the shoulder impairment successfully calculated and the score was less than zero (< 0)" will become Performance Not Met.

Updated definitions: Removed:

(1) Admission (Option 1 & 2)
(2) Admission (Option 3 & 4)
(3) Discharge (Option 1 & 2)
(4) Discharge (Option 3 &4)
Added:
(1) Initial Evaluation: An Initial Evaluation is the first encounter for a functional deficit involving the shoulder and includes an evaluation (CPT 97161, 97162, 97163, 97165, 97166, 97167, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 98940, 98941, 98942, or 98943), or an Initial Evaluation Status M-code. A patient presenting with a shoulder impairment, who has had an interruption of a Treatment Episode for the same functional shoulder deficit secondary to an appropriate reason like hospitalization or surgical intervention, is an Initial Evaluation.
(2) Discharge: Discharge is accompanied by a treatment finalization and evaluation completion M-Code (M1013) identifying the close of a Treatment Episode for the same shoulder deficit identified at the Initial Evaluation and documented by a discharge report by the MIPS eligible clinician. An interruption in clinical care for an appropriate reason like hospitalization or surgical intervention requires a discharge from the current Treatment Episode.
Updated:
Treatment Episode: A Treatment Episode is defined as beginning with an Initial Evaluation for a functional shoulder deficit, progressing through treatment, without interruption (for example, a hospitalization or surgical intervention), and ending with Discharge, signifying that the treatment has been completed. A patient currently under clinical care for a shoulder functional deficit remains in a single Treatment Episode until the Discharge is conducted and documented by the MIPS eligible clinician.
Updated denominator: Consolidated all options into one denominator criteria.
The denominator is revised to read: All patients 14 years and older with shoulder impairments who have initiated a Treatment Episode.
Updated denominator exclusions: Added the following:
(1) Patients with diagnosis of a degenerative neurological condition such as ALS, MS, Parkinson's diagnosed at any time before or during the episode of care.
Updated denominator exceptions: Added the following:
(1) Ongoing care not indicated, patient self-discharged early and seen only 1-2 visits (e.g., financial or insurance reasons, transportation problems, or reason unknown).
(2) Ongoing care not indicated, patient discharged after only 1-2 visits due to specific medical events, documented in the medical record that make the treatment episode impossible such as the patient becomes hospitalized or scheduled for surgery.
(3) Ongoing care not indicated, patient seen only 1-2 visits (e.g., home program only, referred to another provider or facility, consultation only).
Moved from denominator exclusion to denominator exception
(1) Patient refused to participate.
The numerator is revised to read: Patients who were presented with the Shoulder FS PROM at Initial Evaluation (Intake) and at or near Discharge (Status) for the purpose of calculating the patient's Risk-Adjusted Functional Status Change Residual Score.

Quality# 222 – Functional Status Change for Patients with Elbow, Wrist or hand Impairments
Substantive Change:
Updated numerator: Changed to define Performance Met as meeting or exceeding the risk adjusted prediction of functional status change. Numerator option "Risk-Adjusted Functional Status Change Residual Score for the elbow, wrist, or hand impairment successfully calculated and the score was less than zero (< 0)" will become Performance Not Met.
Updated definitions: Removed:
(1) Admission (Option 1 & 2)
(2) Admission (Option 3 & 4)
(3) Discharge (Option 1 & 2)
(4) Discharge (Option 3 &4)
Added:
(1) Initial Evaluation: An Initial Evaluation is the first encounter for a functional deficit involving the elbow, wrist, or hand and includes an evaluation (CPT 97161, 97162, 97163, 97165, 97166, 97167, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 98940, 98941, 98942, or 98943), or an Initial Evaluation Status M-code. A patient presenting with an elbow, wrist, or hand impairment, who has had an interruption of a Treatment

Episode for the same functional knee deficit secondary to an appropriate reason like hospitalization or surgical intervention, is an Initial Evaluation.
(2) Discharge: Discharge is accompanied by a treatment finalization and evaluation completion M-Code (M1014) for identifying the close of a Treatment Episode for the same elbow, wrist or hand deficit identified at the Initial Evaluation and documented by a Discharge report by the MIPS eligible clinician. An interruption in clinical care for an appropriate reason like hospitalization or surgical intervention requires a discharge from the current Treatment Episode.
Updated:
Treatment Episode: A Treatment Episode is defined as beginning with an Initial Evaluation for a functional elbow, wrist or hand deficit, progressing through treatment without interruption (for example, a hospitalization or surgical intervention), and ending with Discharge, signifying that the treatment has been completed. A patient currently under clinical care for an elbow, wrist or hand deficit remains in a single Treatment Episode until the Discharge is conducted and documented by the MIPS eligible clinician.
Updated denominator: Consolidated all options into one denominator criteria.
The denominator is revised to read: All patients 14 years and older with elbow, wrist or hand impairments who have initiated a Treatment Episode.
Updated denominator exclusions: Added the following:
(1) Patients with diagnosis of a degenerative neurological condition such as ALS, MS, Parkinson's diagnosed at any time before or during the episode of care.
Updated denominator exceptions: Added the following:
(1) Ongoing care not indicated, patient self-discharged early and seen only 1-2 visits (e.g., financial or insurance reasons, transportation problems, or reason unknown).
(2) Ongoing care not indicated, patient discharged after only 1-2 visits due to specific medical events, documented in the medical record that make the treatment episode impossible such as the patient becomes hospitalized or scheduled for surgery.
(3) Ongoing care not indicated, patient seen only 1-2 visits (e.g., home program only, referred to another provider or facility, consultation only).
Moved from denominator exclusion to denominator exception
(1) Patient refused to participate.
The numerator is revised to read: Patients who were presented with the Elbow/Wrist/Hand FS PROM at Initial Evaluation (Intake) and at or near Discharge (Status) for the purpose of calculating the patient's Risk-Adjusted Functional Status Change Residual Score.

Quality# 226 – Preventive Care and Screening: Tobacco use: Screening and Cessation Intervention
Substantive Change:
The measure description is revised to read: Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months **AND** who received tobacco cessation intervention if identified as a tobacco user
a. Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months.
b. Percentage of patients aged 18 years and older who were identified as a tobacco user who received tobacco cessation intervention.
c. Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received tobacco cessation intervention if identified as a tobacco user.
Updated denominator: For the Medicare Part B Claims Measure Specifications and MIPS CQMs Specifications collection types: Added physical therapy MIPS eligible clinician type.
Updated Guidance: For the Medicare Part B Claims Measure Specifications, eCQM Specifications, CMS Web Interface Measure Specifications, and MIPS CQMs Specifications collection types: Added:
(1) The denominator of population criteria 2 is a subset of the resulting numerator for population criteria 1, as population criteria 2 is limited to assessing if patients identified as tobacco users received an appropriate tobacco cessation intervention. For all patients, population criteria 1 and 3 are applicable, but population criteria 2 will only be applicable for those patients who are identified as tobacco users. Therefore, data for every patient that meets the initial population criteria will only be submitted for population 1 and 3, whereas data submitted for population 2 will be for a subset of patients who meet the initial population criteria, as the denominator has been further limited to those who were identified as tobacco users.
(2) To satisfy the intent of this measure, a patient must have at least one tobacco use screening during the 24-month period. If a patient has multiple tobacco use screenings during the 24-month period, only the most recent

screening, which has a documented status of tobacco user or tobacco non-user, will be used to satisfy the measure requirements.

Updated instructions: For the MIPS CQM Specifications collection types: This measure is to be submitted a minimum of once per performance period for patients seen during the performance period. This measure is intended to reflect the quality of services provided for preventive screening for tobacco use. This measure may be submitted by Merit-based Incentive Payment System (MIPS) eligible clinicians who provided the measure-specific denominator coding. For this implementation of the measure, the 24 month look back period includes the program year and the year prior. For Quality Payment Program (QPP) 2020, the 24 month period would be from 1/1/2019-12/31/2020.

Updated guidance: For the CMS Web Interface Measure Specifications collection types:

• If there is more than 1 patient query regarding tobacco use, use the most recent query during the 24-month period to determine tobacco status.
• "Within 24 months" is defined as the 24-month look-back from the measurement period end date (1/1/2019 - 12/31/2020).
• Screening for tobacco use may be completed during a telehealth encounter.
• Tobacco cessation intervention can be performed by another healthcare provider; therefore, the tobacco use screening and tobacco cessation intervention do not need to be performed by the same provider or clinician.
• Screening for tobacco use and cessation intervention do not have to occur on the same encounter, but both must occur during the 24-month look-back period.
• Screening for tobacco use and cessation intervention may be completed during a telehealth encounter.
• Tobacco cessation intervention may be completed during a telehealth encounter.

Quality# 236 – Controlling High Blood Pressure

Substantive Change:

The measure description is revised to read: Percentage of patients 18-85 years of age who had a diagnosis of hypertension overlapping the measurement period and whose most recent blood pressure was adequately controlled (<140/90mmHg) during the measurement period.

Updated denominator: For the eCQM Specifications collection type: Removed Blood Pressure Visit grouping value set and added in the individual value sets.

Updated denominator exclusions: For eCQM Specifications collection type: Added the following:

(1) Patients 66 years of age and older who are living in a long-term institutional setting, such as a nursing home, for more than 90 days in the measurement period.
(2) Patients 66 year of age and older with advanced illness and frailty.

For Medicare Part B Claims Measure Specifications, CMS Web Interface Measure Specifications, and MIPS CQMs Specifications collection type: Updated:

(1)Patients 66 and older who are living long term in an institution for more than 90 days during the measurement period.

Added:

(1) Patients 66 years of age and older with at least one claim/encounter for frailty during the measurement period AND a dispensed medication for dementia during the measurement period or the year prior to the measurement period.
(2) Patients 66 years of age and older with at least one claim/encounter for frailty during the measurement period AND either one acute inpatient encounter with a diagnosis of advanced illness or two outpatient, observation, ED or nonacute inpatient encounters on different dates of service with an advanced illness diagnosis during the measurement period or the year prior to the measurement period. (3) Dementia Exclusion Medications: Cholinesterase inhibitors: Donepezil, Galantamine, Rivastigimine Miscellaneous central nervous system agents: Memantine

Updated numerator/guidance:

Updated to allow blood pressures taken by a clinician from remote monitoring devices in a medical setting or in an offsite setting (that is, patient's domicile) to count towards the measure with additional clarification regarding usable blood pressure readings:

-Not requiring the numerator blood pressure reading to be during a visit or overlap with a diagnosis of hypertension. (Applicable to eCQM only).
-If the day of the last blood pressure reading there are multiple blood pressure readings on that day, use the lowest systolic and diastolic on that day.
-The blood pressure reading that is being used should not come from an ED or inpatient visit.
-Do not include blood pressure readings reported by or taken by the patient.

Quality# 238 – Use of High-Risk Medications in the Elderly
Substantive Change:
Updated numerator statement for submission criteria 2: Percentage of patients who were ordered at least two of the same high-risk medications on different days.
Updated guidance: Added 'on different days' to align with update to numerator submission criteria 2.

Quality# 240 – Childhood Immunization Status
Substantive Change:
The measure description is revised to read: Percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV), one measles, mumps and rubella (MMR); three or four H influenza type B (HiB); three hepatitis B (Hep B); one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (Hep A); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday.
Updated numerator: Added value set for Hepatitis B carriers to allow Hepatitis B carriers to meet this part of the numerator.
Updated definition: Removed 'Three HiB Vaccinations' and added new definition statements 'HiB 3 Dose Immunizations or Procedures,' 'HiB 4 Dose Immunizations or Procedures,' 'HiB 3 or 4 Dose Immunizations,' 'All HiB Vaccinations,' and 'Has Appropriate Number of HiB Immunizations.' Revised logic to include the correct number of HiB doses depending on the manufacturer of the vaccine given to align with current guidelines.
Updated the logic for the HiB vaccine to require the correct amount of doses depending on the manufacturer of the vaccine given. Create a 3 dose and a 4 dose HiB vaccine.

Quality# 243 – Cardiac Rehabilitation Patient Referral from an Outpatient Setting
Substantive Change:
Updated denominator exceptions: Added
(1) Documentation of patient reason(s) for not referring to an outpatient CR program (for example, no traditional CR program available to the patient, within 60 min [travel time] from the patient's home, patient does not have access to an alternative model of CR delivery that meets all criteria for a CR program, patient refused or other patient reasons)

Quality# 268 – Epilepsy: Counseling for Women of Childbearing potential with Epilepsy
Substantive Change:
The measure description is revised to read: Percentage of all patients of childbearing potential (12 years and older) diagnosed with epilepsy who were counseled at least once a year about how epilepsy and its treatment may affect contraception and pregnancy.
Updated denominator: All females aged 12 years and older with a diagnosis of epilepsy.
Updated numerator: Female patients or caregivers counseled at least once a year about how epilepsy and its treatment may affect contraception and pregnancy
Updated denominator exceptions: Removed
(1) Documentation of medical reason(s) why counseling was not performed for women of childbearing potential with epilepsy (4340F with 1P)

Updated definition of "Counseling" - Counseling must include a discussion of at least two of the following three counseling topics:
• Need for folic acid supplementation,
• Drug to drug interactions with contraception medication,
• Potential anti-seizure medications effect(s) on fetal/child development and/or pregnancy.

Quality# 283 – Dementia Associated Behavioral and Ssychiatric Symptoms Screening and Management
Substantive Change:
Update denominator: Added physical therapy MIPS eligible clinician type.

Quality# 286 - Dementia: Safety Concern Screening and Follow-Up for Patients with Dementia
Substantive Change:
Updated denominator: Added physical therapy MIPS eligible clinician type.

Quality# 290 -Parkinson's Disease: Psychiatric Symptoms Assessment for Patients with Parkinson's Disease
Substantive Change:
Updated numerator options: Performance Met: Psychosis, depression, anxiety, apathy, AND impulse control disorder assessed Performance Not Met: Psychosis, depression, anxiety, apathy, AND impulse control disorder not assessed

Quality# 305 - Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
Substantive Change:
The measure description is revised to read: Percentage of patients 13 years of age and older with a new episode of alcohol or other drug abuse or (AOD) dependence who received the following. Two rates are reported.
a. Percentage of patients who initiated treatment including either an intervention or medication for the treatment of AOD abuse or dependence within 14 days of the diagnosis.
b. Percentage of patients who engaged in ongoing treatment including two additional interventions or a medication for the treatment of AOD abuse or dependence within 34 days of the initiation visit. For patients who initiated treatment with a medication, at least one of the two engagement events must be a treatment intervention.
Updated initial population: Changed intake period for the initial population to January 1 to November 14. Added telehealth services to initial population encounter value sets.
Updated numerator: Added telehealth services to the numerator encounter value sets. Added Opiate Antagonists for numerator compliance
Numerator 1 is revised to read: Initiation of treatment includes either an intervention or medication for the treatment of AOD abuse or dependence within 14 days of the diagnosis.
Numerator 2 is revised to read: Engagement in ongoing treatment includes two additional interventions or a medication for the treatment of AOD abuse or dependence within 34 days of the initiation visit. For patients who initiated treatment with a medication, at least one of the two engagement events must be a treatment intervention (that is, engagement for these members cannot be satisfied with medication treatment alone).

Quality# 317 – Preventive Care and Screening: Screening for high Blood Pressure and Follow-Up Documented
Substantive Change:
Updated numerator: For the eCQM Specifications collection type: Updated logic to allow for the documentation of a reason (finding of elevated blood pressure or hypertension) for scheduling a follow up visit and added value set "Finding of Elevated Blood Pressure or Hypertension". Added Potassium and Sodium codes to the Dietary Recommendation value set.
Updated numerator definition: Added potassium and sodium for dietary/lifestyle recommendations.

Quality# 326 – Atrial Fibrillation and Atrial Flutter: Chronic Anticoagulation Therapy
Substantive Change:
Updated denominator: Removed emergency medicine setting.

Quality# 332 - Adult Sinusitis: Appropriate Choice of Antibiotic: Amoxicillin With or Without Clavulanate Prescribed for Patients with Acute Bacterial Sinusitis (Appropriate Use)
Substantive Change:
Updated denominator: Changed requirements for denominator eligibility
Patients aged ≥ 18 years on date of encounter **AND**
Diagnosis for bacterial and infectious agent **OR**
Sinusitis caused by, or presumed to be caused by, bacterial infection **AND**
Patient encounter WITHOUT Telehealth Modifier AND Antibiotic regiment prescribed

Quality# 335 – Maternity Care: Elective Delivery or Early Induction Without Medical Indication at <39 Weeks (Overuse)

Substantive Change:

The measure title is revised from Elective Delivery or Early Induction Without Medical Indication ≥ 37 and < 39 Weeks (Overuse) to read: Maternity Care: Elective Delivery or Early Induction Without Medical Indication at < 39 Weeks (Overuse).

The measure description is revised to read: Percentage of patients, regardless of age, who gave birth during a 12month period who delivered a live singleton at < 39 weeks of gestation completed who had elective deliveries or early inductions without medical indication.

Updated denominator: Changed to include all deliveries at < 39 weeks of gestation.

Updated numerator: Numerator options will be updated to reflect the measure now including all deliveries at < 39 weeks gestation.

Quality# 336 – Maternity Care: Postpartum Follow-up and Care Coordination

Substantive Change:

Updated description to read: Percentage of patients, regardless of age, who gave birth during a 12-month period who were seen for postpartum care within 8 weeks of giving birth and who received a breast-feeding evaluation and education, postpartum depression screening, postpartum glucose screening for gestational diabetes patients, family and contraceptive planning counseling, tobacco use screening and cessation education, healthy lifestyle behavioral advice, and an immunization review and update.

Updated numerator: Added clinical actions necessary for numerator compliance

(1) Tobacco use screening and cessation education

(2) Healthy lifestyle behavioral advice to bring the BMI within healthy limits

(3) Immunization review and education

Quality# 337 - Psoriasis: Tuberculosis (TB) Prevention for Patients with Psoriasis, Psoriatic Arthritis and Rheumatoid Arthritis on a Biological Immune Response Modifier

Substantive Change:

The description is revised to read: Percentage of patients, regardless of age, with psoriasis, psoriatic arthritis and/or rheumatoid arthritis on a biological immune response modifier whose providers are ensuring active tuberculosis prevention either through negative standard tuberculosis screening tests or are reviewing the patient's history to determine if they have had appropriate management for a recent or prior positive test.

The numerator is revised to read: Patients who have a documented negative TB screening or have documentation of the management of a positive TB screening test with no evidence of active tuberculosis, confirmed through use of radiographic imaging (that is, chest x-ray, CT) prior to treatment with a biologic immune response modifier.

Quality# 342 – Pain Brought Under Control Within 48 Hours

Substantive Change:

Updated denominator: Added the outpatient setting.

Quality# 348 - Implantable Cardioverter-Defibrillator (ICD) Complications Rate

Substantive Change:

The measure title is revised from HRS-3: Implantable Cardioverter-Defibrillator (ICD) Complications Rate to read: Implantable Cardioverter-Defibrillator (ICD) Complications Rate.

Quality# 370 – Depression Remission at Twelve Months

Substantive Change:

Updated denominator: Allow PHQ-9/PHQ9M to be administered during the index encounter or up to 7 days prior to encounter

Quality# 377 – Functional Status Assessments for Congestive Heart Failure
Substantive Change:
Updated numerator: Added the Minnesota Living with Heart Failure Questionnaire (MLHQF) tool and the Kansas City Cardiomyopathy Questionnaire (KCCQ-12) tool to the list of acceptable FSAs.

Quality# 378 – Children Who Have Dental Decay or Cavities
Substantive Change:
The numerator is revised to read: Children who had cavities or decayed teeth overlapping the measurement period.

Quality# 379 – Primary Caries Prevention as Offered by Primary Care Providers, including Dentists
Substantive Change:
The numerator is revised to read: Children who receive a fluoride varnish application during the measurement period.

Quality# 382 – Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment
Substantive Change:
Updated numerator: Added telehealth data element to "Major Depressive Disorder Encounter" definition using "Telehealth Services" value set (OID: 2.16.840.1.113883.3.464.1003.101.12.1031).

Updated guidance: A suicide risk assessment should be performed at every visit for major depressive disorder during the measurement period. This measure is an episode-of-care measure; the level of analysis for this measure is every visit for major depressive disorder during the measurement period. For example, at every visit for MDD, the patient should have a suicide risk assessment. Use of a standardized tool(s) or instrument(s) to assess suicide risk will meet numerator performance, so long as the minimum criteria noted above is evaluated. Standardized tools can be mapped to the concept "Intervention, Performed": "Suicide risk assessment (procedure)" included in the numerator logic below, as no individual suicide risk assessment tool or instrument would satisfy the requirements alone.
Updated numerator definition: The specific type and magnitude of the suicide risk assessment is intended to be at the discretion of the individual clinician and should be specific to the needs of the patient. At a minimum, suicide risk assessment should evaluate:
(1) Risk (for example, age, sex, stressors, comorbid conditions, hopelessness, impulsivity) and protective factors (for example, religious belief, concern not to hurt family) that may influence the desire to attempt suicide.
(2) Current severity of suicidality.
(3) Most severe point of suicidality in episode and lifetime.
Low burden tools to track suicidal ideation and behavior such as the Columbia-Suicidal Severity Rating Scale can also be used. Because no validated assessment tool or instrument fully meets the aforementioned requirements for the suicide risk assessment, individual tools or instruments have not been explicitly included in coding.

Quality# 385 – Adult Primary Rhegmatogenous Retinal Detachment Surgery: Visual Acuity Improvement Within 90 Days of Surgery
Substantive Changes:
Updated denominator exclusion: Added an exclusion to remove patients with a pre-operative visual acuity of better than 20/40.

Quality# 391 – Follow-up After Hospitalization for Mental Illness (FUH)
Substantive Changes:
Updated denominator: Added self-harm as a denominator eligible diagnosis.
The measure description is revised to read: The percentage of discharges for patients 6 years of age and older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit with a mental health practitioner. Two rates are submitted:
• The percentage of discharges for which the patient received follow-up within 30 days after discharge. • The percentage of discharges for which the patient received follow-up within 7 days after discharge.

Quality# 392 – Cardiac Tamponade and/or Pericardiocentesis Following Atrial Fibrillation Ablation
Substantive Changes:
The measure title is revised from HRS-12: Cardiac Tamponade and/or Pericardiocentesis Following Atrial Fibrillation to read: Cardiac Tamponade and/or Pericardiocentesis Following Atrial Fibrillation Ablation.

Quality# 393 – Infection within 180 Days of Cardiac Implantable Electronic Device (CIED) Implantation, Replacement, or Revision
Substantive Changes:
The measure title is revised from HRS-9: Infection within 180 Days of Cardiac Implantable Electronic Device (CIED) Implantation, Replacement, or Revision to read: Infection within 180 Days of Cardiac Implantable Electronic Device (CIED) Implantation, Replacement, or Revision.
Quality# 394 – Immunizations for Adolescents
Substantive Changes:
Updated denominator exclusions: Added exclusion for encephalopathy due to Tdap vaccine.
Updated numerator to specify compliant serogroups: Serogroups A, C, W, Y

Quality# 405 – Appropriate Follow-up Imaging for Incidental Abdominal Lesions
Substantive Changes:
Updated measure assessment: The measure analytic is being updated and will no longer be inverse.
The measure description is revised to read: Percentage of final reports for abdominal imaging studies for patients aged 18 years and older with one or more of the following noted incidentally with a specific recommendation for no follow- up imaging recommended based on radiological findings:
• Cystic renal lesion that is simple appearing* (Bosniak I or II)
• Adrenal lesion ≤ 1.0 cm
• Adrenal lesion >1.0 cm but ≤ 4.0 cm classified as likely benign by unenhanced CT or washout protocol CT, or MRI with in- and opposed-phase sequences or other equivalent institutional imaging protocols
The denominator is revised to read: All final reports for imaging studies for patients aged 18 years and older with one or more of the following incidentally noted:
• Cystic renal lesion that is simple appearing* (Bosniak I or II)
• Adrenal lesion ≤ 1.0 cm
• Adrenal lesion >1.0 cm but ≤ 4.0 cm classified as likely benign by unenhanced CT or washout protocol CT, or MRI with in- and opposed-phase sequences or other equivalent institutional imaging protocols
Updated denominator note: For the MIPS CQMs Specifications collection type: Updated to include changes in the denominator and to include: *Other "simple-appearing criteria":
• Incidental renal mass on non-contrast enhanced abdominal CT that does not contain fat, is homogenous in appearance, -10-20 HU or ≥70 HU. (ACR, 2017)
• Incidental renal mass on contrast-enhanced abdominal CT that does not contain fat, is homogenous in appearance, 10-20 HU. (ACR, 2017)
Radiologists may choose not to include in the radiology report benign-appearing renal cysts (Bosniak I or II or equivalent*) or cystic lesions that are too small to characterize (TSTC) but likely benign (a lesion is too small to characterize (TSTC) when the lesion size is less than twice reconstructed slice thickness (ACR, 2017).
Updated denominator: For the MIPS CQMs Specifications collection type: Updated criteria: Incidental finding: Cystic renal lesion that is simple appearing* (Bosniak I or II), or Adrenal lesion ≤ 1.0 cm or Adrenal lesion >1.0 cm but ≤ 4.0 cm classified as likely benign by unenhanced CT or washout protocol CT, or MRI with in- and opposed-phase sequences or other equivalent institutional imaging protocols
Updated numerator note: For the Medicare Part B Claims Measure Specifications collection type: Updated to include changes in the denominator and to include: *Other "simple-appearing criteria":
• Incidental renal mass on non-contrast enhanced abdominal CT that does not contain fat, is homogenous in appearance, -10-20 HU or ≥70 HU. (ACR, 2017)
• Incidental renal mass on contrast-enhanced abdominal CT that does not contain fat, is homogenous in appearance, 10-20 HU. (ACR, 2017)
Radiologists may choose not to include in the radiology report benign-appearing renal cysts (Bosniak I or II or equivalent*) or cystic lesions that are too small to characterize (TSTC) but likely benign (a lesion is too small to characterize (TSTC) when the lesion size is less than twice reconstructed slice thickness (ACR, 2017).

Updated numerator instructions: Removed inverse measure instructions.
Added:

A short note can be made in the final report, such as:
"No follow-up imaging is recommended as incidental lesions are likely benign " or
"No follow-up imaging is recommended per consensus recommendations based on imaging criteria. Further lab evaluation could be pursued based on clinical findings"
Updated denominator exclusion: For the Medicare Part B Claims Measure Specifications collection type: Updated to reflect the changes to what is considered an incidental lesion.
The numerator is revised to read: Final reports for imaging studies that include a description of incidental cystic renal lesion or adrenal lesion stating follow-up imaging is not recommended.
Updated numerator options: Updated to reflect changes to the analytics of the measure and what is considered an incidental lesion.
Updated denominator exception: Updated to read: Documentation of medical reason(s) that follow-up imaging is indicated (e.g., patient has lymphadenopathy, signs of metastasis or an active diagnosis or history of cancer, and other medical reason(s).

Quality# 415 – Emergency Medicine: Emergency Department Utilization of CT for Minor Blunt head Trauma for patients Aged 18 Years and Older
Substantive Changes:
Modified collection type: MIPS CQMs Specifications
Update description: Percentage of emergency department visits for patients aged 18 years and older who presented with a minor blunt head trauma who had a head CT for trauma ordered by an emergency care provider who have an indication for a head CT.
Update denominator exclusions: Removed pregnancy and revised list of antiplatelets applicable to the exclusion.

Quality# 416 - Emergency Medicine: Emergency Department Utilization of CT for Minor Blunt Head Trauma for Patients Aged 2 through 17 Years
Substantive Changes:
Updated denominator exclusions: Removed thrombocytopenia.

Quality# 418 – osteoporosis Management in Women Who Had a Fracture
Substantive Changes:
Updated denominator exclusions: Updated:
(1). Patients 66 and older who are living long term in an institution for more than 90 days during the measurement period.
Added:
(1) Patients 66 years of age and older with at least one claim/encounter for frailty during the measurement period AND a dispensed medication for dementia during the measurement period or the year prior to the measurement period.
(2) Patients 66 years of age and older with at least one claim/encounter for frailty during the measurement period AND either one acute inpatient encounter with a diagnosis of advanced illness or two outpatient, observation, ED or nonacute inpatient encounters on different dates of service with an advanced illness diagnosis during the measurement period or the year prior to the measurement period. (3) Dementia Exclusion Medications: Cholinesterase inhibitors: Donepezil, Galantamine, Rivastigimine Miscellaneous central nervous system agents: Memantine

Quality# 438 – Statin Therapy for the Prevention and Treatment of Cardiovascular Disease
Substantive Changes:
Updated denominator exception: Added hospice care.

Quality# 439 – Age Appropriate Screening Colonoscopy
Substantive Changes:
Updated denominator: Removed exclusion for modifiers 52, 53, 73, and 74.

Quality# 440 – Skin Cancer: Biopsy Reporting Time – Pathologist to Clinician
Substantive Changes:
The measure title is revised from Basal Cell Carcinoma (BCC)/Squamous Cell Carcinoma (SCC): Biopsy Reporting Time – Pathologist to Clinician to read: Skin Cancer: Biopsy Reporting Time – Pathologist to Clinician.
The measure description is revised to read: Percentage of biopsies with a diagnosis of cutaneous Basal Cell Carcinoma (BCC), Squamous Cell Carcinoma (SCC) (including in situ disease), or melanoma in which the pathologist communicates results to the clinician within 7 days from the time when the tissue specimen was received by the pathologist.
Updated denominator: Added melanoma diagnosis codes.
Updated numerator: Included language to reflect the addition of melanoma to the denominator.

Quality# 441 – Ischemic Vascular Disease (IVD) All or None Outcome Measure (Optimal Control)
Substantive Changes:
Updated denominator exceptions: Added Procedure-Related BP's not taken during an outpatient visit. Examples of Procedure-related BP Locations: Same Day Surgery, Ambulatory Service Center, G.I. Lab, Dialysis, Infusion Center, Chemotherapy.

Quality# 448 – Appropriate Workup Prior to Endometrial Ablation
Substantive Changes:
The measure description is revised to read: Percentage of patients, aged 18 years and older, who undergo endometrial sampling or hysteroscopy with biopsy and results are documented before undergoing an endometrial ablation.
Updated denominator: Replace the word "women" with "patients".
Updated numerator: Replace the word "women" with "patients".

Quality# 450 - Trastuzumab Received By Patients With AJCC Stage I (T1c) – III And HER2 Positive Breast Cancer Receiving Adjuvant Chemotherapy
Substantive Changes:
Updated denominator definition:
Use the 2018 ASCO/CAP guideline definitions to determine HER2 status-
HER2 Positive:
• If result is IHC 3+ based on circumferential membrane staining that is complete, intense and in >10% of the invasive tumor cells
• If result is ISH positive based on:
• Single-probe average HER2 copy number ≥= 6. 0 signals/cell
• Dual-probe HER2/CEP17 ratio ≥= 2. 0 with an average HER2 copy number ≥= 4. 0 signals/cell
• Dual-probe HER2/CEP17 ratio < 2. 0 with an average HER2 copy number = 6. 0 signals/cell
HER2 Equivocal:
• If result is IHC 2+ based on circumferential membrane staining that is incomplete and/or weak/moderate and within > 10% of the invasive tumor cells
• If result is ISH equivocal based on:
• Single-probe ISH average HER2 copy number ≥= 4. 0 and < 6. 0 signals/cell
• Dual-probe HER2/CEP17 ratio < 2. 0 with an average HER2 copy number ≥= 4. 0 and < 6. 0 signals/cell HER2 Negative:
• If result is IHC 1+ based on incomplete membrane staining that is faint/barely perceptible and within > 10% of the invasive tumor cells
• If result is IHC 0 based on no staining observed or membrane staining that is incomplete and is faint/barely perceptible and ≤= 10% of the invasive tumor cells
• ISH negative based on:
• Single-probe average HER2 copy number < 4. 0 signals/cell
• Dual-probe HER2/CEP17 ratio < 2. 0 with an average HER2 copy number < 4. 0 signals/cell
HER2 Indeterminate:
Report HER2 test result as indeterminate if technical issues prevent one or both tests (IHC and ISH) from being reported as positive, negative, or equivocal.
Conditions may include:

• Inadequate specimen handling
• Artifacts (crush or edge artifacts) that make interpretation difficult
• Analytic testing failure.

Quality# 459 – Back pain After Lumbar Discectomy/Laminectomy

Substantive Changes:

The measure title is revised from Average Change in Back Pain Following Lumbar Discectomy / Laminotomy to read: Back Pain After Lumbar Discectomy/Laminectomy.

The measure description is revised to read: For patients 18 years of age or older who had a lumbar discectomy/laminectomy procedure, back pain is rated by the patients as less than or equal to 3.0 OR an improvement of 5.0 points or greater on the Visual Analog Scale (VAS) Pain scale at three months (6 to 20 weeks) postoperatively.

Updated measure assessment: Changed measure assessment from continuous variable to a proportional measure.

Updated denominator: Added discectomy/ laminectomy CPT procedure codes: 63005, 63012, 63017, 63030, 63042 and 63047. Removed diagnosis of disc herniation.

Updated denominator exclusions: Added spine related cancer, acute fracture or infection, neuromuscular, idiopathic or congenital scoliosis.

Updated numerator: For numerator compliance patients need either a post-op pain assessment (to meet the target portion) or if post-op pain assessment is greater than 3.0, need a pre and post-op assessment to hit the change target of 5.0 points. Patients who are missing an assessment will be considered numerator non-compliant. The measure will now be target-based with performance met being back pain is less than or equal to 3.0 OR a change of 5.0 points or greater on the VAS Pain scale at 3 months postoperatively (6 to 20 weeks).

Updated definitions: Added:

(1) Back Pain Target #1 - A patient who is assessed postoperatively at three months (6 to 20 weeks) after the procedure who rates their back pain as less than or equal to 3.0.

(2) Back Pain Target #2 - A patient who does not meet Back Pain Target #1 is assessed both preoperatively within 3 months prior to the procedure AND postoperatively at three months (6 to 20 weeks) after the procedure AND the change is greater than or equal to 5.0 points.

Updated numerator note: It is recommended that both a preoperative and postoperative be administered to the patient increasing the chances that one of the numerator targets will be met. The following situations are those in which the numerator target cannot be reached and Performance Not Met G9943 is submitted.

• VAS Pain Scale is not administered postoperatively at three months (6 to 20 weeks)
• Back pain is measured using a different patient reported tool or via telephone screening
• Postoperative VAS Pain Scale is administered less than six weeks or more than 20 weeks (3 month window)
• Postoperative VAS value is greater than 3.0 and no valid preoperative to measure change
• Preoperative VAS Pain Scale (to measure change) is administered beyond the three month timeframe prior to and including the date of procedure (e.g. 6 months before procedure)

Quality# 460 – Back Pain After Lumbar Fusion

Substantive Changes:

The measure title is revised from Average Change in Back Pain Following Lumbar Fusion to read: Back Pain After Lumbar Fusion.

The measure description is revised to read: For patients 18 years of age or older who had a lumbar fusion procedure, back pain is rated by the patient as less than or equal to 3.0 OR an improvement of 5.0 points or greater on the Visual Analog Scale (VAS) Pain* scale at one year (9 to 15 months) postoperatively. * hereafter referred to as VAS Pain

Updated measure assessment: Changed measure assessment from continuous variable to a proportional measure.

Updated numerator: For numerator compliance patients need either a post-op pain assessment (to meet the target portion) or if post-op greater than 3.0, need a pre and post-op assessment to hit the change target of 5.0 points. Patients who are missing an assessment will be considered numerator non-compliant. The measure will now be target-based with performance met being back pain is less than or equal to 3.0 OR a change of 5.0 points or greater on the VAS Pain scale at one year postoperatively (9 to 15 months).

Updated definitions: Added:

(1) Back Pain Target #1 – A patient who is assessed postoperatively at one year (9 to 15 months) after the procedure rates their back pain as less than or equal to 3.0.

(2) Back Pain Target #2 – A patient who does not meet Back Pain Target #1 is assessed both preoperatively within 3 months prior to the procedure AND postoperatively at one year (9 to 15 months) after the procedure AND the change is greater than or equal to 5.0 points.

Updated numerator note;

It is recommended that both a preoperative and postoperative be administered to the patient increasing the chances that one of the numerator targets will be met. The following situations are those in which the numerator target cannot be reached and Performance Not Met G9946 is submitted.

- VAS Pain Scale is not administered postoperatively at one year (9 to 15 months)
- Back pain is measured using a different patient reported tool or via telephone screening
- Postop VAS Pain Scale is administered less than nine months or more than 15 months (1 year window) • Postoperative VAS value is greater than 3.0 and no valid preop to measure change
- Preoperative VAS Pain Scale (to measure change) is administered beyond the three month timeframe prior to and including the date of procedure (e.g. 6 months before procedure)

Quality# 461 – Leg Pain After Lumbar Discectomy/Laminectomy

Substantive Changes:

The measure title is revised from Average Change in Leg Pain Following Lumbar Discectomy and/or Laminotomy to read: Leg Pain After Lumbar Discectomy/Laminectomy.

The measure description is revised to read: For patients 18 years of age or older who had a lumbar discectomy/laminectomy procedure, leg pain is rated by the patient as less than or equal to 3.0 OR an improvement of 5.0 points or greater on the VAS Pain scale at three months (6 to 20 weeks) postoperatively.

Updated measure assessment: Changed measure assessment from continuous variable to a proportional measure.

Updated denominator: Added the following discectomy/ laminectomy CPT procedure codes: 63005, 63012, 63017, 63030, 63042 and 63047. Removed diagnosis of disc herniation.

Updated denominator exclusions: Added spine related cancer, acute fracture or infection, neuromuscular, idiopathic or congenital scoliosis.

Updated numerator: For numerator compliance patients need either a post-op pain assessment (to meet the target portion) or if post-op greater than 3.0, need a pre and post-op assessment to hit the change target of 5.0 points. Patients who are missing an assessment will be considered numerator non-compliant. The measure will now be target-based with performance met being leg pain is less than or equal to 3.0 OR a change of 5.0 points or greater on the VAS Pain scale at 3 months postoperatively (6 to 20 weeks).

Updated definitions: Added:

(1) Leg Pain Target #1 - A patient who is assessed postoperatively at three months (6 to 20 weeks) after the procedure who rates their leg pain as less than or equal to 3.0.

(2) Leg Pain Target #2 - A patient who does not meet Leg Pain Target #1 is assessed both preoperatively within 3 months prior to the procedure AND postoperatively at three months (6 to 20 weeks) after the procedure AND the change is greater than or equal to 5.0 points.

Updated numerator note:

It is recommended that both a preoperative and postoperative be administered to the patient increasing the chances that one of the numerator targets will be met. The following situations are those in which the numerator target cannot be reached and Performance Not Met G9949 is submitted.

- VAS Pain Scale is not administered postoperatively at three months (6 to 20 weeks)
- Leg pain is measured using a different patient reported tool or via telephone screening
- Postoperative VAS Pain Scale is administered less than six weeks or more than 20 weeks (3-month window)
- Postoperative VAS value is greater than 3.0 and no valid preop to measure change
- Preoperative VAS Pain Scale (to measure change) is administered beyond the three-month timeframe prior to and including the date of procedure (e.g. 6 months before procedure)

Quality# 462 – Bone Density Evaluation for Patients with prostate Cancer and Receiving Androgen Deprivation Therapy

Substantive Changes:

The measure description is revised to read: Patients determined as having prostate cancer who are currently starting or undergoing androgen deprivation therapy (ADT), for an anticipated period of 12 months or greater and who receive an initial bone density evaluation. The bone density evaluation must be prior to the start of ADT or within 3 months of the start of ADT.

Quality# 469 – Functional Status After Lumbar Fusion

Substantive Changes:

The measure title is revised from Average Change in Functional Status Following Lumbar Fusion Surgery to read: Functional Status After Lumbar Fusion.

The measure description is revised to read: For patients 18 years of age and older who had a lumbar fusion procedure, functional status is rated by the patient as less than or equal to 22 OR a change of 30 points or greater on the Oswestry Disability Index (ODI version 2.1a)* at one year (9 to 15 months) postoperatively.

Updated measure assessment: Changed measure assessment from continuous variable to a proportional measure.

Updated numerator: For numerator compliance patients need either a post-op pain assessment (to meet the target portion) or if post-op greater than 22, need a pre and post-op assessment to hit the change target of 30 points. Patients who are missing an assessment will be considered numerator non-compliant. The measure will now be target-based with performance met being functional status is less than or equal to 22 OR a change of 30 points or greater on the Oswestry Disability Index (ODI) at one year postoperatively (9 to 15 months).

Added numerator definition: Functional Status Target #1 - A patient who is assessed postoperatively at one year (9 to 15 months) after the procedure rates their functional status as less than or equal to 22. Functional Status Target #2 - A patient who does not meet Functional Status Target #1 is assessed both preoperatively within 3 months prior to the procedure AND postoperatively at one year (9 to 15 months) after the procedure AND the change is greater than or equal to 30 points.

Updated numerator note: It is recommended that both a preoperative and postoperative tool be administered to the patient to increase the chance that one of the numerator targets will be met. The following situations are those in which the numerator target cannot be reached and Performance Not Met M1043 is submitted.

- ODI is not administered postoperatively at one year (9 to 15 months)
- Functional status is measured using a different patient reported functional status tool or ODI version
- Postoperative ODI is administered less than 9 months or greater than 15 months (1 year window)
- Postoperative ODI is greater than 22 and no valid preoperative ODI to measure change
- Preoperative ODI (to measure change) is administered beyond the three month timeframe prior to and including the date of procedure (e.g. 6 months before procedure.)

NQF endorsement removed until the measure can be evaluated with the new analytics.

Quality# 470 – Functional Status After Primary Total Knee Replacement

Substantive Changes:

The measure title is revised to read: Functional Status After Primary Total Knee Replacement.

The measure description is revised: For patients age 18 and older who had a primary total knee replacement procedure, functional status is rated by the patient as greater than or equal to 37 on the Oxford Knee Score (OKS) at one year (9 to 15 months) postoperatively.

Updated measure assessment: Changed measure assessment from continuous variable to a proportional measure.

Updated numerator: For numerator compliance patients need a post-op OKS assessment. The measure will now be target-based with performance met being functional status is greater than or equal to 37 on the Oxford Knee Score (OKS) at one year postoperatively (9 to 15 months). Patients who are missing an assessment will be considered numerator non-compliant.

Added numerator definition: OKS Target - A patient who is assessed postoperatively at one year (9 to 15 months) after the procedure rates their functional status score as greater than or equal to 37.

Updated numerator note:

The following situations are those in which the numerator targets cannot be reached and Performance Not Met (M1046) is submitted:

- Oxford Knee Score (OKS) is not administered postoperatively at one year (9 to 15 Months)
- Functional status is measured using a different patient-reported functional status tool or Oxford Knee Score (OKS) version
- Postoperative Oxford Knee Score (OKS) is administered less than 9 Months or greater than 15 Months • Postoperative Oxford Knee Score (OKS) score is less than 37

NQF endorsement removed until the measure can be evaluated with the new analytics

Quality# 471 – Functional Status After Lumbar Discectomy/Laminectomy

Substantive Changes:

The measure title is revised from Average Change in Functional Status Following Lumbar Discectomy/Laminotomy Surgery to read: Functional Status After Lumbar Discectomy/Laminectomy.

The measure description is revised to read: For patients age 18 and older who had lumbar discectomy/laminectomy procedure, functional status is rated by the patient as less than or equal to 22 OR a change of 30 points or greater on the Oswestry Disability Index (ODI version 2.1a) * at three months (6 to 20 weeks) postoperatively.

Updated measure assessment: Changed measure assessment from continuous variable to a proportional measure.

Updated denominator: Added the following discectomy/ laminectomy CPT procedure codes: 63005, 63012, 63017, 63030, 63042 and 63047.

Update denominator exclusions: Added spine related cancer, acute fracture or infection, neuromuscular, idiopathic or congenital scoliosis.

Removed diagnosis of disc herniation.

Updated numerator: For numerator compliance patients need either a post-op functional assessment (to meet the target portion) or if post-op greater than 22, need a pre and post-op assessment to hit the change target of 30 points. Patients who are missing an assessment will be considered numerator non-compliant. The measure will now be target-based with performance met being functional status is less than or equal to 22 OR a change of 30 points or greater on the Oswestry Disability Index (ODI) at 3 months postoperatively (6 to 20 weeks).

Added numerator definition: Functional Status Target #1 - A patient who is assessed postoperatively at three months (6 to 20 weeks) after the procedure rates their functional status as less than or equal to 22. Functional Status Target #2 - A patient who does not meet Functional Status Target #1 is assessed both preoperatively within 3 months prior to the procedure AND postoperatively at three months (6 to 20 weeks) after the procedure AND the change is greater than or equal to 30 points.

Updated numerator note: It is recommended that both a preoperative and postoperative be administered to the patient increasing chances that one of the numerator targets will be met. The following situations are those in which the numerator target cannot be reached and Performance Not Met M1049 is submitted.

- ODI is not administered postoperatively at three months (6 to 20 weeks)
- Functional status is measured using a different patient reported functional status tool or ODI version
- Postoperative ODI is administered less than 6 weeks or greater than 20 weeks (3-month window)
- Postoperative ODI is greater than 22 and no valid preoperative ODI to measure change

Preoperative ODI (to measure change) is administered beyond the three-month timeframe prior to and including the date of procedure (e.g. 6 months before procedure)

Quality# 472 - Appropriate Use of DXA Scans in Women Under 65 Years Who Do Not Meet the Risk Factor Profile for Osteoporotic Fracture

Substantive Changes:

Updated guidance:

There are two ways that a patient can be excluded from the measure:

1. The patient has a specific number of "combination" risk factors (the number of risk factors varies by age).
2. The patient has one or more of the "independent" risk factors, including a 10-year probability of major osteoporotic fracture of 8.4 percent or higher as determined by the FRAX.

Denominator exclusions statement:

Exclude patients with a combination of risk factors (as determined by age) or one of the independent risk factors

Ages: 50-54 (>=4 combination risk factors) or 1 independent risk factor

Ages: 55-59 (>=3 combination risk factors) or 1 independent risk factor

Ages: 60-64 (>=2 combination risk factors) or 1 independent risk factor

COMBINATION RISK FACTORS [The following risk factors are all combination risk factors; they are grouped by when they occur in relation to the measurement period]:

The following risk factors may occur any time in the patient's history but must be active during the measurement period:

White (race)

BMI <= 20 kg/m2 (must be the first BMI of the measurement period)

Smoker (current during the measurement period)

Alcohol consumption (> two units per day (one unit is 12 oz. of beer, 4 oz. of wine, or 1 oz. of liquor)) The following risk factor may occur any time in the patient's history and must not start during the measurement period:

Osteopenia
The following risk factors may occur at any time in the patient's history or during the measurement period:
Rheumatoid arthritis
Hyperthyroidism
Malabsorption Syndromes: celiac disease, inflammatory bowel disease, ulcerative colitis, Crohn's disease, cystic fibrosis, malabsorption
Chronic liver disease
Chronic malnutrition
The following risk factors may occur any time in the patient's history and do not need to be active at the start of the measurement period:
Documentation of history of hip fracture in parent
Osteoporotic fracture
Glucocorticoids (>= 5 mg/per day) [cumulative medication duration >= 90 days]
INDEPENDENT RISK FACTORS (The following risk factors are all independent risk factors; they are grouped by when they occur in relation to the measurement period):
The following risk factors may occur at any time in the patient's history and must not start during the measurement period:
Osteoporosis
The following risk factors may occur at any time in the patient's history prior to the start of the measurement period, but do not need to be active during the measurement period:
Gastric bypass
FRAX[R] ten-year probability of all major osteoporosis related fracture >= 8.4 percent
Aromatase inhibitors
The following risk factors may occur at any time in the patient's history or during the measurement period:
Type I Diabetes
End stage renal disease
Osteogenesis imperfecta
Ankylosing spondylitis
Psoriatic arthritis
Ehlers-Danlos syndrome
Cushing's syndrome
Hyperparathyroidism
Marfan syndrome
Lupus
Updated denominator exclusions: Changed FRAX[R] ten-year probability of all major osteoporosis related fracture result from 9.3% to 8.4%.

Quality# 473 – Leg Pain After lumbar Fusion
Substantive Changes:
The measure title is revised from Average Change in Leg Pain Following Lumbar Fusion Surgery to read: Leg Pain After Lumbar Fusion.
The measure description is revised to read: For patients 18 years of age or older who had a lumbar fusion procedure, leg pain is rated by the patient as less than or equal to 3.0 OR an improvement of 5.0 points or greater on the Visual Analog Scale (VAS) Pain* scale at one year (9 to 15 months) postoperatively.
Updated measure assessment: Changed measure assessment from continuous variable to a proportional measure.
Updated numerator: For numerator compliance Patients need either a post-op pain assessment (to meet the target portion) or if post-op greater than 3.0, need a pre and post-op assessment to hit the change target of 5.0 points. Patients who are missing an assessment will be considered numerator non-compliant. The measure will now be target-based with performance met being leg pain is less than or equal to 3.0 OR an improvement of 5.0 points or greater on the VAS Pain scale at one year postoperatively (9 to 15 months).

Quality# 475 – HIV Screening
Substantive Changes:
The measure description is revised to read: Percentage of patients aged 15-65 at the start of the measurement period who were between 15-65 years old when tested for HIV.
The numerator is revised to read: Patients with documentation of an HIV test performed on or after their 15th birthday and before their 66th birthday.

Quality# 282 – Dementia: Functional Status Assessment
Substantive Changes:
Updated denominator: Added physical therapy MIPS eligible clinician type.

Quality# 288 – Dementia: Education and Support of Caregivers for patients with Dementia
Substantive Changes:
Updated denominator: Added physical therapy MIPS eligible clinician type.

Quality# 110 – Preventive Care and Screening: Influenza Immunization
Substantive Changes:
Updated numerator instructions:
Due to the changing nature of the CDC/ACIP recommendations regarding the live attenuated influenza vaccine (LAIV) for a particular flu season, this measure will not include the administration of this specific formulation of the flu vaccination. Given the variance of the timeframes for the annual update cycles, program implementation, and publication of revised recommendations from the CDC/ACIP, it has been determined that the coding for this measure will specifically exclude this formulation, so as not to inappropriately include this form of the vaccine for flu seasons when CDC/ACIP explicitly advise against it. However, it is recommended that all eligible professionals or eligible clinicians review the guidelines for each flu season to determine appropriateness of the LAIV and other formulations of the flu vaccine. If the LAIV is recommended for administration for a particular flu season, an eligible professional or clinician may consider one of the following options: 1) satisfy the numerator by reporting previous receipt, 2) report a denominator exception, either as a patient reason (e.g., for patient preference) or a system reason (e.g., the institution only carries LAIV).

Quality# 111 – Pneumococcal Vaccination Status for Older Adults
Substantive Changes:
Updated denominator: Added the skilled nursing facility and domiciliary settings.

Quality# 178 – Rheumatoid Arthritis (RA): Functional Status Assessment
Substantive Changes:
Numerator statement revised to read: Patients for whom a standardized functional status assessment using an ACR preferred, patient-reported functional status assessment tool was performed at least once within 12 months.
Updated definition:
Functional Status Assessment: This measure assesses if physicians are using a standardized descriptive or numeric scale, standardized questionnaire, or notation of tool to assessment of the impact of RA on patient activities of daily living. Examples of tools used to assess functional status include but are not limited to: Health Assessment Questionnaire (HAQ), Modified HAQ, HAQ-2, and American College of Rheumatology's Classification of Functional Status in Rheumatoid Arthritis. Functional status should be assessed using a measurement tool assigned preferred status by the ACR. The instruments listed are the ACR-preferred tools that fulfill the measure requirements: PROMIS Physical Function 10-item (PROMIS PF10a), Health Assessment Questionnaire-II (HAQ-II), and Multi-Dimensional Health Assessment Questionnaire (MD-HAQ).