



Measure Information

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

Brief Measure Information

NQF #: 0052

Corresponding Measures:

De.2. Measure Title: Use of Imaging Studies for Low Back Pain

Co.1.1. Measure Steward: National Committee for Quality Assurance

De.3. Brief Description of Measure: The percentage of patients with a primary diagnosis of low back pain who did not have an imaging study (plain X-ray, MRI, CT scan) within 28 days of diagnosis.

1b.1. Developer Rationale: This measure assesses the overuse of imaging studies (plain x-ray, MRI, and CT scans) in adults with acute, uncomplicated low back pain. The intent of this measure is to reduce inappropriate imaging for low back pain – that is, imaging in the absence of “red flags” (indications that back pain is caused by a serious, underlying pathology that would warrant imaging). Inappropriate imaging is problematic because it is not associated with improved outcomes and exposes patients to unnecessary harms such as radiation exposure and further unnecessary treatment (Chou, Fu, Carrino and Deyo, 2009).

Chou R, Fu R, Carrino JA, Deyo RA. 2009. “Imaging strategies for low-back pain: systematic review and meta-analysis.” Lancet 373:463-72.

S.4. Numerator Statement: Patients who received an imaging study (x-ray, CT, MRI) within the 28 days following a diagnosis of low back pain.

S.7. Denominator Statement: All patients 18 years as of January 1 of the measurement year to 50 years as of December 31 of the measurement year with a claim/encounter for an outpatient, observation, emergency department, physical therapy, or telehealth visit, or osteopathic or chiropractic manipulative treatment, with a principal diagnosis of low back pain during the Intake Period (January 1 – December 3 of the measurement year).

S.10. Denominator Exclusions: Because the intent of the measure is to assess imaging for patients with a new episode of low back pain, exclude patients with a recent diagnosis of low back pain.

Also, exclude any patient who had a diagnosis for which imaging is clinically appropriate. Any of the following meet criteria:

- (1) Cancer
- (2) Trauma
- (3) Recent IV drug abuse
- (4) Neurologic impairment
- (5) HIV
- (6) Spinal infection
- (7) Major organ transplant
- (8) Prolonged use of corticosteroids

De.1. Measure Type: Process

S.23. Data Source: Claims

S.26. Level of Analysis: Health Plan, Integrated Delivery System

IF Endorsement Maintenance – Original Endorsement Date: Aug 10, 2009 **Most Recent Endorsement Date:** Aug 10, 2009

IF this measure is included in a composite, NQF Composite#/title:

IF this measure is paired/grouped, NQF#/title:

De.4. IF PAIRED/GROUPED, what is the reason this measure must be reported with other measures to appropriately interpret results? N/A

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

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

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

[FINAL_2016_Evidence_Form_0052_LBP.docx](#)

1b. Performance Gap

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

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

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

This measure assesses the overuse of imaging studies (plain x-ray, MRI, and CT scans) in adults with acute, uncomplicated low back pain. The intent of this measure is to reduce inappropriate imaging for low back pain –

that is, imaging in the absence of “red flags” (indications that back pain is caused by a serious, underlying pathology that would warrant imaging). Inappropriate imaging is problematic because it is not associated with improved outcomes and exposes patients to unnecessary harms such as radiation exposure and further unnecessary treatment (Chou, Fu, Carrino and Deyo, 2009).

Chou R, Fu R, Carrino JA, Deyo RA. 2009. “Imaging strategies for low-back pain: systematic review and meta-analysis.” *Lancet* 373:463-72.

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

UPDATED INFORMATION FOR AD-HOC REVIEW (2016)

The following data are from HEDIS data collection reflecting the most recent years of measurement prior to this measure reevaluation. Performance data is summarized at the health plan level and summarized by mean, standard deviation, minimum health plan performance, maximum health plan performance and performance at the 10th, 25th, 50th, 75th, 90th percentile and interquartile range (IQR). Data is stratified by year, geographic region, and product line (i.e. commercial HMO and PPO combined, Medicaid HMO and PPO combined).

The following data demonstrate the variation in the rate of appropriate imaging for patients with low back pain across health plans. In 2014, there was a 15-point difference between plans in the 10th percentile and plans in the 90th percentile for commercial plans and 15 points for Medicaid plans. These gaps in performance underscore the opportunity for improvement.

Commercial Rate (HMO and PPO Combined)

YEAR	MEAN	ST DEV	Min	10TH	25TH	50TH	75TH	90TH	IQR
2014	75%	6%	54%	68%	71%	75%	80%	83%	9
2013	75%	6%	26%	67%	70%	75%	79%	83%	9
2012	75%	6%	56%	67%	70%	75%	79%	82%	9

Medicaid Rate (HMO and PPO Combined)

YEAR	MEAN	ST DEV	Min	10TH	25TH	50TH	75TH	90TH	IQR
2014	75%	6%	55%	68%	71%	75%	78%	83%	7
2013	76%	5%	58%	68%	72%	75%	78%	84%	6
2012	76%	6%	58%	68%	72%	75%	79%	82%	8

These data come from HEDIS data collection reflecting the most recent years of measurement for this measure. In 2014, HEDIS measures covered more than 171 million health plan members. Below is a description of the denominator for this measure. It includes the number of health plans included in HEDIS data collection and the median eligible population for the measure across health plans.

Commercial (HMO and PPO Combined)

YEAR | N Plans | Average Denominator Size

2014 | 404 | 3593

2013 | 408 | 3677

2012 | 409 | 3964

Medicaid HMO

YEAR | N Plans | Average Denominator Size

2014 | 200 | 1264

2013 | 193 | 1054

2012 | 180 | 1123

The tables below highlight geographic variation in 2014 performance rates for both commercial and Medicaid plans. The average performance rates in top performing regions are six and five percentage points above the national average for commercial and Medicaid plans, respectively. Additionally, the performance rates in the top performing regions are 13 and 11 percentage points above the lowest performing regions for Commercial and Medicaid plans, respectively. This underscores opportunities for improvement among lower performing regions of the country.

2014 Commercial Rate (HMO and PPO Combined) by HHS Region

Region | N Plans | MEAN | ST DEV | 10TH | 25TH | 50TH | 75TH | 90TH | IQR

Atlanta | 62 | 68% | 5% | 61% | 65% | 68% | 68% | 73% | 4

Boston | 44 | 78% | 6% | 71% | 74% | 79% | 83% | 85% | 9

Chicago | 80 | 76% | 5% | 71% | 72% | 75% | 79% | 83% | 7

Dallas | 40 | 71% | 6% | 64% | 68% | 70% | 75% | 78% | 7

Denver | 23 | 78% | 6% | 73% | 75% | 79% | 82% | 86% | 7

Kansas City | 36 | 77% | 5% | 74% | 75% | 77% | 79% | 81% | 4

New York | 34 | 76% | 5% | 71% | 73% | 75% | 79% | 81% | 6

Philadelphia | 54 | 74% | 5% | 69% | 71% | 74% | 77% | 79% | 6

San Francisco | 45 | 78% | 6% | 72% | 75% | 79% | 81% | 84% | 6

Seattle | 30 | 81% | 6% | 76% | 78% | 81% | 85% | 86% | 7

2014 Medicaid Rate (HMO and PPO Combined) by HHS Region

Region | N Plans | MEAN | ST DEV | 10TH | 25TH | 50TH | 75TH | 90TH | IQR

Atlanta | 29 | 69% | 6% | 60% | 67% | 70% | 73% | 75% | 6

Boston | 13 | 75% | 3% | 71% | 73% | 75% | 77% | 78% | 4

Chicago | 42 | 76% | 5% | 69% | 72% | 76% | 79% | 82% | 7

Dallas | 17 | 74% | 2% | 71% | 73% | 74% | 75% | 77% | 2

Denver | 5 | 79% | 4% | 72% | 80% | 80% | 81% | 83% | 1

Kansas City | 9 | 74% | 4% | 69% | 70% | 74% | 77% | 77% | 7

New York | 11 | 75% | 3% | 72% | 73% | 75% | 77% | 78% | 4

Philadelphia | 27 | 74% | 6% | 70% | 73% | 77% | 83% | 92% | 10

San Francisco | 42 | 80% | 6% | 74% | 77% | 79% | 84% | 87% | 7

Seattle | 5 | 76% | 3% | 71% | 75% | 78% | 79% | 79% | 4

INFORMATION FROM PREVIOUS SUBMISSION (2014)

The following data are from HEDIS data collection reflecting the most recent years of measurement for this measure. Performance data is summarized at the health plan level and summarized by mean, standard deviation, minimum health plan performance, maximum health plan performance and performance at the 10th, 25th, 50th, 75th, 90th percentile and interquartile range (IQR).

Data is stratified by year and product line (i.e. commercial HMO and PPO combined, Medicaid HMO).

The following data demonstrate the variation in the rate of appropriate imaging for patients with low back pain across health plans. In 2012, there was a 15.5 point difference between plans in the 10th percentile and plans in the 90th percentile for commercial plans and 13.9 points for Medicaid plans. These gaps in performance underscore the opportunity for improvement.

Commercial Rate (HMO and PPO Combined)

YEAR | MEAN | ST DEV | Min | 10TH | 25TH | 50TH | 75TH | 90TH | IQR

2012 | 75% | 6% | 56% | 67% | 70% | 75% | 79% | 82% | 9

2011 | 74% | 6% | 45% | 66% | 69% | 74% | 79% | 82% | 9

2010 | 74% | 6% | 53% | 66% | 70% | 74% | 78% | 81% | 8

Medicaid Rate (HMO)

YEAR | MEAN | ST DEV | Min | 10TH | 25TH | 50TH | 75TH | 90TH | IQR

2012 | 76% | 6% | 58% | 68% | 72% | 75% | 79% | 82% | 8

2011 | 76% | 5% | 62% | 70% | 72% | 76% | 79% | 82% | 7

2010 | 75% | 6% | 58% | 67% | 72% | 76% | 80% | 82% | 8

These data come from HEDIS data collection reflecting the most recent years of measurement for this measure. In 2012, HEDIS measures covered 107.3 million commercial health plan members and 21.7 million Medicaid HMO members. Below is a description of the denominator for this measure. It includes the number of health plans included in HEDIS data collection and the median eligible population for the measure across health plans.

Commercial HMO

YEAR | N Plans | Median Denominator Size per plan

2012 | 210 | 835

2011 | 210 | 932

2010 | 232 | 1178

Commercial PPO

YEAR | N Plans | Median Denominator Size per plan

2012 | 199 | 2547

2011 | 189 | 2350

2010 | 171 | 2434

Medicaid HMO

YEAR | N Plans | Median Denominator Size per plan

2012 | 180 | 698

2011 | 162 | 749

2010 | 151 | 744

1b.3. If no or limited performance data on the measure as specified is reported in 1b2, then provide a summary of data from the literature that indicates opportunity for improvement or overall less than optimal performance on the specific focus of measurement.

N/A

1b.4. Provide disparities data from the measure as specified (current and over time) by population group, e.g., by race/ethnicity, gender, age, insurance status, socioeconomic status, and/or disability. (This is required for endorsement maintenance. Describe the data source including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities include.) This information also will be used to address the subcriterion on improvement (4b.1) under Usability and Use.

HEDIS data is stratified by type of insurance (e.g. Commercial, Medicaid, Medicare). NCQA does not currently collect performance data stratified by race, ethnicity, or language. Escare et al. have described in detail the difficulty of collecting valid data on race, ethnicity and language at the health plan level (Escare, 2011). While not specified in the measure, this measure can also be stratified by demographic variables, such as race/ethnicity or socioeconomic status, in order to assess the presence of health care disparities. The HEDIS Health Plan Measure Set contains two measures that can assist with stratification to assess health care disparities. The

Race/Ethnicity Diversity of Membership and the Language Diversity of Membership measures were designed to promote standardized methods for collecting these data. These measures follow Office of Management and Budget and Institute of Medicine guidelines for collecting and categorizing race/ethnicity and language data. In addition, NCQA's Multicultural Health Care Distinction Program outlines standards for collecting, storing and using race/ethnicity and language data to assess health care disparities. Based on extensive work by NCQA to understand how to promote culturally and linguistically appropriate services among plans and providers, we have many examples of how health plans have used HEDIS measures to design quality improvement programs to decrease disparities in care.

Escare J.J., Carreon R., Vesolovskiy G., and Lawson E.H. 2011. Collection Of Race And Ethnicity Data By Health Plans Has Grown Substantially, But Opportunities Remain To Expand Efforts. *Health Affairs* 20(10): 1984-1991.

1b.5. If no or limited data on disparities from the measure as specified is reported in 1b4, then provide a summary of data from the literature that addresses disparities in care on the specific focus of measurement. Include citations.

We found limited data about disparities in the overuse of imaging for low back pain. One study from the Department of Veterans Affairs, using data from 110,661 outpatient MRIs of the lumbar spine, reported significantly higher rates of MRIs in younger adults (those under 35 years) compared to other ages (35-44 years, 45-54 years, 55-64 years, and older than 65; $p < .0001$). The study also reported significantly lower rates of MRIs in black adults compared to white adults ($OR = 0.82$, $p < 0.001$) (Gidwani R et al, 2016).

Gidwani R, Sinnott P, Avoundijian T, Lo J, Asch SM, Barnett PG. 2016. "Inappropriate ordering of lumbar spine magnetic resonance imaging: are providers Choosing Wisely?" *Am J Manag Care* 22(2): e68-76.

1c. High Priority (previously referred to as High Impact)

The measure addresses:

- a specific national health goal/priority identified by DHHS or the National Priorities Partnership convened by NQF; OR
- a demonstrated high-priority (high-impact) aspect of healthcare (e.g., affects large numbers of patients and/or has a substantial impact for a smaller population; leading cause of morbidity/mortality; high resource use (current and/or future); severity of illness; and severity of patient/societal consequences of poor quality).

1c.1. Demonstrated high priority aspect of healthcare

Affects large numbers, Frequently performed procedure, High resource use

1c.2. If Other:

1c.3. Provide epidemiologic or resource use data that demonstrates the measure addresses a high priority aspect of healthcare.

List citations in 1c.4.

Low back pain is a pervasive problem that affects three-quarters of adults at some time in their lives (Chou, 2012). Each year in the United States low back pain is experienced by 25 to 50 percent of adults, making it one of the most common reasons for seeking health care services (Haldeman, 2008). According to the U.S. Preventive Services Task Force, it is second only to upper respiratory problems as a symptom-related reason for visits to a physician (USPSTF, 2004), and accounts for over 4.7 million missed work days per year (Dagenis, 2008).

Low back pain also results in high indirect costs from disability, lost time from work, and decreased productivity while at work, and is the number one cause for activity limitations in younger adults (Chou, 2012). Given the high prevalence of back pain, it is not surprising that its economic consequences are severe. The costs associated with health care services for spine pain (primarily low back pain) in the U.S. increased from \$45.9 billion in 1997 to \$102.6 billion in 2004 (Martin, 2008). Research suggests that the reasons for the increase in cost and use of diagnostic imaging can be attributed to multiple factors including changing demographics, increased care seeking and patient expectations about low back pain, increased physician ownership of imaging facilities, and fee-for-service payment models (Pham, 2009). The supply of imaging equipment may also play a role, as the number of MRI scanners in the U.S. increased from 7.6 per 1 million people to 26.6 per 1 million people between 2000 and 2005 (Baras, 2009).

The three imaging modalities included in this measure are: x-ray, CT scan, and MRI, all of which have varying individual costs. Generally, the reimbursement rates and charges for lumbar spine CT run 5 to 10 times higher and MRI 10 to 15 times higher than low back radiography. Although radiography is relatively lower in cost, it represents a financial burden as it is much more frequently used than the two other imaging mechanisms. In 2004, an estimated 66 million lumbar radiographs were performed in the United States (Chou, 2012). These imaging practices directly affect the patient, and also result in downstream costs associated with invasive

and expensive operations and procedures.

1c.4. Citations for data demonstrating high priority provided in 1a.3

Baras JD, Baker LC. Magnetic resonance imaging and low back pain care for Medicare patients. *Health Aff* 2009; 28:w1133–40.
 Chou R, et al. Radiologic Clinics of North America. Appropriate Use of Lumbar Imaging for Evaluation of Low Back Pain. 2012 Jul, Vol. 50, No. 4: 569-85.
 Dagenais S, et al. A systematic review of low back pain cost of illness studied in the United States and internationally. *Spine Journal* 2008; 8-1: 8-20
 Dagenais S, et al, A systematic review of diagnostic imaging use for low back pain in the United States. *Spine J* 2013, doi: 10.1016/j.spinee.2013.10.031.
 Haldeman S, Dagenais S. A supermarket approach to the evidence informed management of chronic low back pain. *Spine J* 2008;8: 1–7.
 Martin BI, Deyo RA, Mirza SK, et al. Expenditures and health status among adults with back and neck problems. *JAMA* 2008;299: 656–64.
 Pham HH, Landon BE, Reschovsky JD, et al. Rapidity and modality of imaging for acute low back pain in elderly patients. *Arch Intern Med* 2009; 169:972–81.
 US Preventive Services Task Force. Primary Care Interventions to Prevent Low Back Pain: Brief Evidence Update (Feb 2004). Source: <http://www.uspreventiveservicestaskforce.org/3rduspstf/lowback/lowbackup.htm>.

1c.5. If a PRO-PM (e.g. HRQoL/functional status, symptom/burden, experience with care, health-related behaviors), provide evidence that the target population values the measured PRO and finds it meaningful. (Describe how and from whom their input was obtained.)

N/A

2. Reliability and Validity—Scientific Acceptability of Measure Properties

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

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

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

Musculoskeletal, Musculoskeletal : Low Back Pain

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

Safety : Overuse

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

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

This is not an eMeasure Attachment:

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

Attachment Attachment: 2016_0052_LBP_Value_Sets.xlsx

S.3. For endorsement maintenance, please briefly describe any changes to the measure specifications since last endorsement date and explain the reasons.

In 2015, NCQA initiated a reevaluation of the Use of Imaging Studies for Low Back Pain measure used in the Healthcare Effectiveness Data and Information Set (HEDIS®). Changes to the measure were recommended based upon a review of evidence and guidelines, and feedback from numerous stakeholder groups and measurement advisory panels. The revisions were vetted through a 30-day public comment process and approved by NCQA's Committee on Performance Measurement (CPM). The intent of these changes was to better align the measure with the evidence and to improve the face validity of the measure. Both the changes and their rationale are detailed below.

(1) Include physical therapy and telehealth visits with a primary diagnosis of low back pain in the denominator.

Rationale: Harmonization with an existing measure. Under some health plans, individuals can self-refer to physical therapy, bypassing a physician visit. Including these visits could provide a more accurate index episode start date for a member's low back pain symptoms.

(2) Shorten the look-back period for the "recent trauma" exclusion from 12 months to 3 months.

Rationale: The longer 12-month look-back period may include past trauma that is unrelated to current low back pain complaints and inadvertently remove patients who should be assessed for inappropriate imaging by the measure.

(3) Exclude members with at least 90 consecutive days of corticosteroid use anytime in the past 12 months.

Rationale: Existing evidence indicates prolonged use of corticosteroids is significantly associated with fracture in individuals with low back pain; imaging may be appropriate in this scenario.

(4) Exclude members with HIV anytime in their history.

Rationale: Harmonization with an existing measure. Individuals with HIV are at increased risk for infection; imaging may be appropriate in this scenario.

(5) Exclude members with a major organ transplant anytime in their history.

Rationale: Individuals who have undergone a major organ transplant are at increased risk for infection due to continual treatment with immunosuppressive therapy; imaging may be appropriate in this scenario.

(6) Exclude members with current or recent (past 12 months) spinal infection (e.g., intraspinal abscess, osteomyelitis, discitis).

Rationale: Spinal infections are most often diagnosed through imaging. While most people with low back pain do not have a spinal infection, spinal infections often present with low back pain as a symptom.

S.4. Numerator Statement (Brief, narrative description of the measure focus or what is being measured about the target population, i.e., cases from the target population with the target process, condition, event, or outcome)

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

Patients who received an imaging study (x-ray, CT, MRI) within the 28 days following a diagnosis of low back pain.

S.5. Time Period for Data (What is the time period in which data will be aggregated for the measure, e.g., 12 mo, 3 years, look back to August for flu vaccination? Note if there are different time periods for the numerator and denominator.)

12 months

S.6. Numerator Details (All information required to identify and calculate the cases from the target population with the target process, condition, event, or outcome such as definitions, specific data collection items/responses, code/value sets – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format at S.2b)

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

Patients who received an imaging study (see Imaging Study Value Set) with a diagnosis of low back pain (see Uncomplicated Low Back Pain Value Set) on the Index Episode Start Date (IESD) or in the 28 days following the IESD.

The Index Episode Start Date is the earliest date of service for an outpatient, observation, emergency department, physical therapy, or telehealth visit, or osteopathic or chiropractic manipulative treatment, during the Intake Period (January 1-December 3 of the measurement year) with a principal diagnosis of low back pain.

The measure is reported as an inverted rate (i.e. $1 - \text{numerator/denominator}$). A higher score indicates appropriate treatment of low back pain (i.e. the proportion for whom imaging studies did not occur).

S.7. Denominator Statement *(Brief, narrative description of the target population being measured)*

All patients 18 years as of January 1 of the measurement year to 50 years as of December 31 of the measurement year with a claim/encounter for an outpatient, observation, emergency department, physical therapy, or telehealth visit, or osteopathic or chiropractic manipulative treatment, with a principal diagnosis of low back pain during the Intake Period (January 1 – December 3 of the measurement year).

S.8. Target Population Category *(Check all the populations for which the measure is specified and tested if any):*

Adults

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

All patients 18 years as of January 1 of the measurement year to 50 years as of December 31 of the measurement year who had any of the following during the intake period (January 1 to December 3 of the measurement year):

(1) Outpatient visit (Outpatient Value Set), with a principal diagnosis of uncomplicated low back pain (Uncomplicated Low Back Pain Value Set).

(2) Observation visit (Observation Value Set), with a principal diagnosis of uncomplicated low back pain (Uncomplicated Low Back Pain Value Set). Do not include observation visits that result in an inpatient stay (Inpatient Stay Value Set). An observation visit results in an inpatient stay when the ED/observation date of service and the admission date for the inpatient stay are one calendar day apart or less.

(3) ED visit (ED Value Set), with a principal diagnosis of uncomplicated low back pain (Uncomplicated Low Back Pain Value Set). Do not include ED visits that result in an inpatient stay (Inpatient Stay Value Set). An ED visit results in an inpatient stay when the ED date of service and the admission date for the inpatient stay are one calendar day apart or less.

(4) Osteopathic or chiropractic manipulative treatment (Osteopathic and Chiropractic Manipulative Treatment Value Set), with a principal diagnosis of uncomplicated low back pain (Uncomplicated Low Back Pain Value Set).

(5) Physical Therapy visit (Physical Therapy Value Set), with a principal diagnosis of uncomplicated low back pain (Uncomplicated Low Back Pain Value Set).

(6) Telehealth visit (Telehealth Value Set), with a principal diagnosis of uncomplicated low back pain (Uncomplicated Low Back Pain Value Set).

S.10. Denominator Exclusions *(Brief narrative description of exclusions from the target population)*

Because the intent of the measure is to assess imaging for patients with a new episode of low back pain, exclude patients with a recent diagnosis of low back pain.

Also, exclude any patient who had a diagnosis for which imaging is clinically appropriate. Any of the following meet criteria:

- (1) Cancer
- (2) Trauma
- (3) Recent IV drug abuse
- (4) Neurologic impairment

- (5) HIV
- (6) Spinal infection
- (7) Major organ transplant
- (8) Prolonged use of corticosteroids

S.11. Denominator Exclusion Details (All information required to identify and calculate exclusions from the denominator such as definitions, specific data collection items/responses, code/value sets – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format at S.2b)

Because the intent of the measure is to assess imaging for patients with a new episode of low back pain, exclude patients with a diagnosis of uncomplicated low back pain (Uncomplicated Low Back Pain Value Set) during the 180 days (6 months) prior to the IESD.

Also, exclude any patient who had a diagnosis for which imaging is clinically appropriate. Any of the following meet criteria:

- (1) Cancer (Malignant Neoplasms Value Set, Other Neoplasms Value Set, History of Malignant Neoplasms Value Set) any time during the patient's history through 28 days after the IESD.
- (2) Trauma (Trauma Value Set) any time during the 3 months (90 days) prior to the IESD through 28 days after the IESD.
- (3) IV drug abuse (IV Drug Abuse Value Set) any time during the 12 months (1 year) prior to the IESD through 28 days after the IESD.
- (4) Neurologic impairment (Neurologic Impairment Value Set) any time during the 12 months (1 year) prior to the IESD through 28 days after the IESD.
- (5) HIV (HIV Value Set) any time during the patient's history through 28 days after the IESD.
- (6) Spinal Infection (Spinal Infection Value Set) any time during the 12 months (1 year) prior to the IESD through 28 days after the IESD.
- (7) Major organ transplant (Organ Transplant Other Than Kidney Value Set; Kidney Transplant Value Set) any time in the patient's history through 28 days after the IESD.
- (8) Prolonged use of corticosteroids. 90 consecutive days of corticosteroid treatment any time during the 12 months (1 year) prior to and including the IESD.

To identify consecutive treatment days, identify calendar days covered by at least one dispensed corticosteroid (Table LBP-A). For overlapping prescriptions assume the patient started taking the second prescription after exhausting the first prescription. For example, if a patient had a 30-day prescription dispensed on June 1 and a 30-day prescription dispensed on June 26, there are 60 covered calendar days (June 1 – July 30).

Count only medications dispensed during the 12 months (1 year) prior to and including the IESD. When identifying consecutive treatment days, do not count days supply that extend beyond the IESD. For example, if a patient had a 90-day prescription dispensed on the IESD, there is one covered calendar day (the IESD).

No gaps are allowed.

Table LBP-A: Prescriptions to Identify Corticosteroids
Hydrocortisone; Cortisone; Prednisone; Prednisolone;
Methylprednisolone; Triamcinolone; Dexamethasone;
Betamethasone

S.12. Stratification Details/Variables (All information required to stratify the measure results including the stratification variables, definitions, specific data collection items/responses, code/value sets – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format with at S.2b)

N/A

S.13. Risk Adjustment Type (Select type. Provide specifications for risk stratification in S.12 and for statistical model in S.14-15)

No risk adjustment or risk stratification

If other:

S.14. Identify the statistical risk model method and variables (Name the statistical method - e.g., logistic regression and list all the risk factor variables. Note - risk model development and testing should be addressed with measure testing under Scientific Acceptability)

N/A

S.15. Detailed risk model specifications (must be in attached data dictionary/code list Excel or csv file. Also indicate if available at measure-specific URL identified in S.1.)

Note: Risk model details (including coefficients, equations, codes with descriptors, definitions), should be provided on a separate worksheet in the suggested format in the Excel or csv file with data dictionary/code lists at S.2b.

S.15a. Detailed risk model specifications (if not provided in excel or csv file at S.2b)

N/A

S.16. Type of score:

Rate/proportion

If other:

S.17. Interpretation of Score (Classifies interpretation of score according to whether better quality is associated with a higher score, a lower score, a score falling within a defined interval, or a passing score)

Better quality = Higher score

S.18. Calculation Algorithm/Measure Logic (Describe the calculation of the measure score as an ordered sequence of steps including identifying the target population; exclusions; cases meeting the target process, condition, event, or outcome; aggregating data; risk adjustment; etc.)

Step 1: Identify all patients 18 years as of January 1 of the measurement year to 50 years as of December 31 of the measurement year who had any of the following visits during the Intake Period (i.e. January 1 – December 3):

- Outpatient visit (Outpatient Value Set), with a principal diagnosis of uncomplicated low back pain (Uncomplicated Low Back Pain Value Set).
- Observation visit (Observation Value Set), with a principal diagnosis of uncomplicated low back pain (Uncomplicated Low Back Pain Value Set). Do not include observation visits that result in an inpatient stay (Inpatient Stay Value Set). An observation visit results in an inpatient stay when the ED/observation date of service and the admission date for the inpatient stay are one calendar day apart or less.
- ED visit (ED Value Set), with a principal diagnosis of uncomplicated low back pain (Uncomplicated Low Back Pain Value Set). Do not include ED visits that result in an inpatient stay (Inpatient Stay Value Set). An ED visit results in an inpatient stay when the ED date of service and the admission date for the inpatient stay are one calendar day apart or less.
- Osteopathic or chiropractic manipulative treatment (Osteopathic and Chiropractic Manipulative Treatment Value Set), with a principal diagnosis of uncomplicated low back pain (Uncomplicated Low Back Pain Value Set).
- Physical Therapy visit (Physical Therapy Value Set), with a principal diagnosis of uncomplicated low back pain (Uncomplicated Low Back Pain Value Set).
- Telehealth visit (Telehealth Value Set), with a principal diagnosis of uncomplicated low back pain (Uncomplicated Low Back Pain Value Set).

Step 2: Determine the Index Episode Start Date (IESD). The IESD is the earliest date of service for an outpatient, observation, emergency department, physical therapy, or telehealth visit, or osteopathic or chiropractic manipulative treatment, during the Intake Period (January 1-December 3 of the measurement year) with a principal diagnosis of low back pain. For each patient identified in step 1, determine the earliest episode of low back pain. If the member had more than one encounter, include only the first encounter.

Step 3: Exclude patients with a diagnosis of uncomplicated low back pain (Uncomplicated Low Back Pain Value Set) during the 180

days (6 months) prior to the IESD (i.e., test for Negative Diagnosis History).

Step 4: Exclude any patient who had a diagnosis for which imaging is clinically appropriate. Any of the following meet criteria:

- Cancer. Cancer any time during the patient's history through 28 days after the IESD. Any of the following meet criteria:
 - Malignant Neoplasms Value Set.
 - Other Neoplasms Value Set.
 - History of Malignant Neoplasm Value Set.
- Recent trauma. Trauma (Trauma Value Set) any time during the 3 months (90 days) prior to the IESD through 28 days after the IESD.
- Intravenous drug abuse. IV drug abuse (IV Drug Abuse Value Set) any time during the 12 months (1 year) prior to the IESD through 28 days after the IESD.
- Neurologic impairment. Neurologic impairment (Neurologic Impairment Value Set) any time during the 12 months (1 year) prior to the IESD through 28 days after the IESD.
- HIV. HIV (HIV Value Set) any time during the patient's history through 28 days after the IESD.
- Spinal infection. Spinal Infection (Spinal Infection Value Set) any time during the 12 months (1 year) prior to the IESD through 28 days after the IESD.
- Major organ transplant. Major organ transplant (Organ Transplant Other Than Kidney Value Set; Kidney Transplant Value Set) any time in the patients's history through 28 days after the IESD.
- Prolonged use of corticosteroids. 90 consecutive days of corticosteroid treatment any time during the 12 months (1 year) prior to and including the IESD.

To identify consecutive treatment days, identify calendar days covered by at least one dispensed corticosteroid (Table LBP-A). For overlapping prescriptions assume the patient started taking the second prescription after exhausting the first prescription. For example, if a patient had a 30-day prescription dispensed on June 1 and a 30-day prescription dispensed on June 26, there are 60 covered calendar days (June 1 – July 30).

Count only medications dispensed during the 12 months (1 year) prior to and including the IESD. When identifying consecutive treatment days, do not count days supply that extend beyond the IESD. For example, if a patient had a 90-day prescription dispensed on the IESD, there is one covered calendar day (the IESD).

No gaps are allowed.

Table LBP-A: Prescriptions to Identify Corticosteroids

Hydrocortisone; Cortisone; Prednisone; Prednisolone;
Methylprednisolone; Triamcinolone; Dexamethasone;
Betamethasone

Step 5: Calculate a rate (number of patients receiving an imaging study (i.e. plain x-ray, MRI, CT scan).

Step 6: Subtract the rate calculated in Step 6 from one to invert the measure result to represent appropriate treatment of low back pain (i.e. the proportion for whom imaging studies did not occur). The measure is reported as an inverted rate (i.e. 1-numerator/denominator) to reflect the number of people who did not receive an imaging study.

S.19. Calculation Algorithm/Measure Logic Diagram URL or Attachment (You also may provide a diagram of the Calculation Algorithm/Measure Logic described above at measure-specific Web page URL identified in S.1 OR in attached appendix at A.1)
No diagram provided

S.20. Sampling (If measure is based on a sample, provide instructions for obtaining the sample and guidance on minimum sample size.)

IF a PRO-PM, identify whether (and how) proxy responses are allowed.

N/A

S.21. Survey/Patient-reported data (If measure is based on a survey, provide instructions for conducting the survey and guidance on minimum response rate.)

IF a PRO-PM, specify calculation of response rates to be reported with performance measure results.

N/A

S.22. Missing data (specify how missing data are handled, e.g., imputation, delete case.)Required for Composites and PRO-PMs.

N/A

S.23. Data Source (Check *ONLY* the sources for which the measure is SPECIFIED AND TESTED).*If other, please describe in S.24.*

Claims

S.24. Data Source or Collection Instrument (Identify the specific data source/data collection instrument e.g. name of database, clinical registry, collection instrument, etc.)If a PRO-PM, identify the specific PROM(s); and standard methods, modes, and languages of administration.

This measure is based on administrative claims collected in the course of providing care to health plan members. NCQA collects the Healthcare Effectiveness Data and Information Set (HEDIS) data for this measure directly from Health Management Organizations and Preferred Provider Organizations via NCQA's online data submission system.

S.25. Data Source or Collection Instrument (available at measure-specific Web page URL identified in S.1 OR in attached appendix at A.1)

No data collection instrument provided

S.26. Level of Analysis (Check *ONLY* the levels of analysis for which the measure is SPECIFIED AND TESTED)

Health Plan, Integrated Delivery System

S.27. Care Setting (Check *ONLY* the settings for which the measure is SPECIFIED AND TESTED)

Emergency Department and Services, Outpatient Services

If other:

S.28. COMPOSITE Performance Measure - Additional Specifications (Use this section as needed for aggregation and weighting rules, or calculation of individual performance measures if not individually endorsed.)

N/A

2a. Reliability – See attached Measure Testing Submission Form**2b. Validity** – See attached Measure Testing Submission Form

FINAL_2016_Testing_Form_0052_LBP.docx

3. Feasibility

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

3a. Byproduct of Care Processes

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

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

Generated or collected by and used by healthcare personnel during the provision of care (e.g., blood pressure, lab value, diagnosis, depression score), Coded by someone other than person obtaining original information (e.g., DRG, ICD-9 codes on claims)

If other:

3b. Electronic Sources

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

3b.1. To what extent are the specified data elements available electronically in defined fields? (i.e., data elements that are needed to compute the performance measure score are in defined, computer-readable fields)

ALL data elements are in defined fields in electronic claims

3b.2. If ALL the data elements needed to compute the performance measure score are not from electronic sources, specify a credible, near-term path to electronic capture, OR provide a rationale for using other than electronic sources.

3b.3. If this is an eMeasure, provide a summary of the feasibility assessment in an attached file or make available at a measure-specific URL.

Attachment:

3c. Data Collection Strategy

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

3c.1. Describe what you have learned/modified as a result of testing and/or operational use of the measure regarding data collection, availability of data, missing data, timing and frequency of data collection, sampling, patient confidentiality, time and cost of data collection, other feasibility/implementation issues.

IF a PRO-PM, consider implications for both individuals providing PROM data (patients, service recipients, respondents) and those whose performance is being measured.

NCQA recognizes that, despite the clear specifications defined for HEDIS measures, data collection and calculation methods may vary, and other errors may taint the results, diminishing the usefulness of HEDIS data for managed care organization (MCO) comparison. In order for HEDIS to reach its full potential, NCQA conducts an independent audit of all HEDIS collection and reporting processes, as well as an audit of the data which are manipulated by those processes, in order to verify that HEDIS specifications are met. NCQA has developed a precise, standardized methodology for verifying the integrity of HEDIS collection and calculation processes through a two-part program consisting of an overall information systems capabilities assessment followed by an evaluation of the MCO's ability to comply with HEDIS specifications. NCQA-certified auditors using standard audit methodologies will help enable purchasers to make more reliable "apples-to-apples" comparisons between health plans.

The HEDIS Compliance Audit addresses the following functions:

- 1) information practices and control procedures
- 2) sampling methods and procedures
- 3) data integrity
- 4) compliance with HEDIS specifications
- 5) analytic file production
- 6) reporting and documentation

In addition to the HEDIS Audit, NCQA provides a system to allow "real-time" feedback from measure users. Our Policy Clarification Support System receives thousands of inquiries each year on over 100 measures. Through this system NCQA responds immediately to questions and identifies possible errors or inconsistencies in the implementation of the measure. This system is vital to the regular re-evaluation of NCQA measures.

Input from NCQA auditing and the Policy Clarification Support System informs the annual updating of all HEDIS measures including updating value sets and clarifying the specifications. Measures are re-evaluated on a periodic basis and when there is a significant change in evidence. During re-evaluation information from NCQA auditing and Policy Clarification Support System is used to inform evaluation of the scientific soundness and feasibility of the measure.

3c.2. Describe any fees, licensing, or other requirements to use any aspect of the measure as specified (e.g., value/code set, risk model, programming code, algorithm).

Broad public use and dissemination of these measures is encouraged and NCQA has agreed with NQF that noncommercial uses do not require the consent of the measure developer. Use by health care physicians in connection with their own practices is not commercial use. Commercial use of a measure requires the prior written consent of NCQA. As used herein, "commercial use" refers to any sale, license or distribution of a measure for commercial gain, or incorporation of a measure into any product or service that is sold, licensed or distributed for commercial gain, even if there is no actual charge for inclusion of the measure.

4. Usability and Use

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

4a. Accountability and Transparency

Performance results are used in at least one accountability application within three years after initial endorsement and are publicly reported within six years after initial endorsement (or the data on performance results are available). If not in use at the time of initial endorsement, then a credible plan for implementation within the specified timeframes is provided.

4.1. Current and Planned Use

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

Planned	Current Use (for current use provide URL)
	Public Reporting Health Plan Ranking http://reportcard.ncqa.org/plan/external/plansearch.aspx Annual State of Health Care Quality: http://www.ncqa.org/tabid/836/Default.aspx Physician Quality Reporting System (PQRS) https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/ Quality Rating System (Marketplace) https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/Health-Insurance-Marketplace-Quality-Initiatives.html Consensus Core Quality Measures Set: ACO and PCMH/Primary Care Measures https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityMeasures/Core-Measures.html Health Plan Ranking http://reportcard.ncqa.org/plan/external/plansearch.aspx Annual State of Health Care Quality: http://www.ncqa.org/tabid/836/Default.aspx Physician Quality Reporting System (PQRS) https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/ Quality Rating System (Marketplace) https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/Health-Insurance-Marketplace-Quality-Initiatives.html Consensus Core Quality Measures Set: ACO and PCMH/Primary Care Measures https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityMeasures/Core-Measures.html Payment Program California's Value Based Pay for Performance Program http://www.iha.org/our-work/accountability/value-based-p4p CMS Eligible Professional EHR Incentive Program (Meaningful Use) https://www.healthit.gov/providers-professionals/meaningful-use-definition-objectives Regulatory and Accreditation Programs HEDIS Health Plan Accreditation http://www.ncqa.org/programs/accreditation/health-plan-hp

	HEDIS Accountable Care Organization (ACO) Core Performance Measures: http://www.ncqa.org/Programs/Accreditation/AccountableCareOrganizationACO.aspx HEDIS Health Plan Accreditation http://www.ncqa.org/programs/accreditation/health-plan-hp HEDIS Accountable Care Organization (ACO) Core Performance Measures: http://www.ncqa.org/Programs/Accreditation/AccountableCareOrganizationACO.aspx Quality Improvement (external benchmarking to organizations) Annual State of Health Care Quality http://www.ncqa.org/tabid/836/Default.aspx Quality Compass http://www.ncqa.org/tabid/177/Default.aspx California's Value Based Pay for Performance Program http://www.iha.org/our-work/accountability/value-based-p4p Consensus Core Quality Measures Set: ACO and PCMH/Primary Care Measures https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityMeasures/Core-Measures.html
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4a.1. For each CURRENT use, checked above, provide:

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

ANNUAL STATE OF HEALTH CARE QUALITY REPORT: This measure is publicly reported nationally and by geographic regions in the NCQA State of Health Care annual report. This annual report published by NCQA summarizes findings on quality of care. In 2015 the report included data from 814 HMOs and 353 PPOs, representing more than 171 million patients.

CALIFORNIA'S VALUE BASED PAY FOR PERFORMANCE PROGRAM: This measure is used in the California P4P program, which is the largest non-governmental physician incentive program in the United States. Founded in 2001, it is managed by the Integrated Healthcare Association (IHA) on behalf of eight commercial HMO health plans representing 9 million insured persons. IHA reports results on approximately 35,000 physicians in 200 physician organizations.

CONSENSUS CORE QUALITY MEASURES SET: This measure is included in the ACO and PCMH / Primary Care Measure set within the Consensus Core Quality Measures Set. The Centers for Medicare & Medicaid Services (CMS), commercial plans, Medicare and Medicaid managed care plans, purchasers, physician and other care provider organizations, and consumers worked together through the Core Quality Measures Collaborative to identify core sets of quality measures that payers have committed to using for reporting as soon as feasible.

CMS ELIGIBLE PROFESSIONAL EHR INCENTIVE PROGRAM (MEANINGFUL USE): The Medicare and Medicaid Electronic Health Care Record (EHR) Incentive Programs provide incentive payments to eligible professionals as they adopt, implement, upgrade or demonstrate meaningful use of certified EHR technology.

HEALTH PLAN ACCREDITATION: This measure is used in scoring for accreditation of commercial and Medicaid Health Plans. In 2012, a total of 77 Medicaid health plans were accredited using this measure covering 9.1 million members and 336 commercial health plans covering 87 million lives. Health plans are scored based on performance compared to benchmarks.

HEALTH PLAN RATINGS/REPORT CARDS: This measure is used to calculate health plan ratings which are reported in Consumer Reports and on the NCQA website. These ratings are based on performance on HEDIS measures among other factors. The 2015-2016 health plan ratings reviewed nearly 1,500 health plans and rated more than 1,000 private, Medicare and Medicaid health insurance plans.

HEDIS ACCOUNTABLE CARE ORGANIZATION ACCREDITATION: This measure is used in NCQA's ACO Accreditation program, that helps health care organizations demonstrate their ability to improve quality, reduce costs and coordinate patient care. ACO standards and guidelines incorporate whole-person care coordination throughout the health care system.

PHYSICIAN QUALITY REPORTING SYSTEM: This measure is used in the Physician Quality Reporting System (PQRS) which is a reporting program that uses a combination of incentive payments and payment adjustments to promote reporting of quality information by eligible professionals (EPs). Eligible professionals who satisfactorily report data on quality measures for covered Physician Fee Schedule services furnished to Medicare Part B beneficiaries (including Railroad Retirement Board and Medicare Secondary Payer) receive these payment incentives and adjustments.

QUALITY COMPASS: This measure is used in Quality Compass which is an indispensable tool used for selecting a health plan, conducting competitor analysis, examining quality improvement and benchmarking plan performance. Provided in this tool is the ability to generate custom reports by selecting plans, measures, and benchmarks (averages and percentiles) for up to three trended years. Results in table and graph formats offer simple comparison of plans' performance against competitors or benchmarks.

QUALITY RATING SYSTEM: Quality Rating System (QRS) clinical measure data is submitted for Qualified Health Plans (QHP) as a condition of certification and participation in the Marketplaces. QRS data is used to create quality rating information in every Marketplace.

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

N/A

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

N/A

4b. Improvement

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

4b.1. Progress on Improvement. (Not required for initial endorsement unless available.)

Performance results on this measure (current and over time) should be provided in 1b.2 and 1b.4. Discuss:

- Progress (trends in performance results, number and percentage of people receiving high-quality healthcare)
- Geographic area and number and percentage of accountable entities and patients included

From 2012 to 2014, the average performance rate of appropriate treatment of low back pain has remained around 75 percent for both commercial and Medicaid plans. Rates in the 10th and 90th percentile scores over the same years were approximately 67 percent and 83 percent for commercial plans and 68 percent and 84 percent for Medicaid plans, respectively. Data going back to 2005 reveals that the average performance scores have remained relatively unchanged, with averages ranging from 73-79 percent for both plan types from 2005-2014.

Although the performance rates have not improved, 2014 regional average performance rate data highlights a gap in performance rates across HHS regions for both commercial and Medicaid plans. The performance rates for the plans in the lowest and highest performing regions is 69 percent and 80 percent for Medicaid plans and 68 percent and 81 percent for commercial plans, respectively.

We revised the measure in 2016 to include additional visit types in the denominator (i.e., telehealth and physical therapy visits) and to exclude individuals with indications of serious, underlying pathologies for low back pain (i.e., exclusions for HIV, spinal infection, major organ transplant, and prolonged use of corticosteroids). We made these revisions to better align the measure with the clinical guidelines; the changes may impact plan performance on this measure.

4b.2. If no improvement was demonstrated, what are the reasons? If not in use for performance improvement at the time of initial endorsement, provide a credible rationale that describes how the performance results could be used to further the goal of

high-quality, efficient healthcare for individuals or populations.

The variation in scores between plans in the 10th percentile and 90th percentile, and the variation in regional average performance scores, indicate that plans with poorer performance can improve.

When considering changes to this measure, we sought feedback on adding additional exclusions that may affect the measure's performance. The addition of these exclusions could affect the measure's performance rate over time.

Increased public awareness of appropriate imaging for low back pain could also affect the measure's performance rate. Choosing Wisely, an initiative of the American Board of Internal Medicine Foundation in collaboration with more than 70 specialty society partners, promotes a, "national dialogue on avoiding wasteful or unnecessary medical tests, treatments and procedures" by publishing recommendations from the specialty societies to, "facilitate wise decisions about the most appropriate care based on a patient's individual situation." Since the release of the initial Choosing Wisely lists, six specialty societies have published recommendations regarding the use of imaging for patients with low back pain (Choosing Wisely, 2015), indicating the topic's importance to healthcare providers.

4c. Unintended Consequences

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

4c.1. Were any unintended negative consequences to individuals or populations identified during testing; OR has evidence of unintended negative consequences to individuals or populations been reported since implementation? If so, identify the negative unintended consequences and describe how benefits outweigh them or actions taken to mitigate them.

We will evaluate performance results in 2017, as well as feedback from stakeholders, to assess if the changes to the measure impacted performance.

5. Comparison to Related or Competing Measures

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

5. Relation to Other NQF-endorsed Measures

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

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

0514 : MRI Lumbar Spine for Low Back Pain

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

5a. Harmonization

The measure specifications are harmonized with related measures;

OR

The differences in specifications are justified

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

Are the measure specifications completely harmonized?

No

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

Concurrently with the most recent measure reevaluation, the NCQA and CMS measure teams compared the specifications for NQF

#0052 and NQF #0514, and identified several opportunities for harmonization. NCQA and CMS measure teams shared this memo with NQF staff that describes several areas of harmonization between the two measures.

5b. Competing Measures

The measure is superior to competing measures (e.g., is a more valid or efficient way to measure);

OR

Multiple measures are justified.

5b.1. If this measure conceptually addresses both the same measure focus and the same target population as NQF-endorsed measure(s):

Describe why this measure is superior to competing measures (e.g., a more valid or efficient way to measure quality); OR provide a rationale for the additive value of endorsing an additional measure. (Provide analyses when possible.)

The NCQA measure (NQF #0052) addresses a different target population than the CMS measure (NQF #0514), and as such the measures are not competing measures.

Appendix

A.1 Supplemental materials may be provided in an appendix. All supplemental materials (such as data collection instrument or methodology reports) should be organized in one file with a table of contents or bookmarks. If material pertains to a specific submission form number, that should be indicated. Requested information should be provided in the submission form and required attachments. There is no guarantee that supplemental materials will be reviewed.

No appendix Attachment:

Contact Information

Co.1 Measure Steward (Intellectual Property Owner): National Committee for Quality Assurance

Co.2 Point of Contact: Bob, Rehm, nqf@ncqa.org, 202-955-1728-

Co.3 Measure Developer if different from Measure Steward: National Committee for Quality Assurance

Co.4 Point of Contact: Kristen, Swift, swift@ncqa.org, 202-955-5174-

Additional Information

Ad.1 Workgroup/Expert Panel involved in measure development

Provide a list of sponsoring organizations and workgroup/panel members' names and organizations. Describe the members' role in measure development.

UPDATED INFORMATION FOR AD-HOC REVIEW (2016)

Bone and Joint Measurement Advisory Panel

Elizabeth Drye, MD, MS, Yale/Yale New Haven Hospital

Cissy Kraft, MD, MS, MHS, FAAFP, Anthem BCBS of Colorado/Nevada

Kathy Lester, Morpace Inc.

Carolyn Oddo, PT, MS, FACHE, American Physical Therapy Association, Board of Directors

Jeffrey Susman, MD, Northeast Ohio Medical University

The NCQA Bone and Joint Measurement Advisory Panel advised NCQA during measure reevaluation. They evaluated the measure specification, reviewed field test results, and assessed NCQA's overall desirable attributes of Relevance, Scientific Soundness and Feasibility. The advisory panel consisted of a balanced group of experts, including representation from primary care. In addition to this advisory panel, we vetted the measure with a host of other stakeholders (see below). Thus, our measures are the result of consensus from a broad and diverse group of stakeholders.

Committee on Performance Measurement

Bruce Bagley, MD, American Medical Association & American Association for Physician Leadership

Andrew Baskin, MD, Aetna

Patrick Conway, MD, MSC, Center for Medicare & Medicaid Services

Jonathan D. Darer, MD, MPH, Medicalis

Helen Darling, Interim – National Quality Forum

Rebekah Gee, MD, MPH, FACOG, LSU School of Medicine and Public Health

Foster Gesten, MD, NY State Department of Health
David Grossman, MD, MPH, Group Health Physician
Christine S. Hunter, MD (Co-Chair)
Jeffrey Kelman, MMSc, MD, Centers for Medicare & Medicaid Services
Nancy Lane, PhD, Vanderbilt University Medical Center
Bernadette Loftus, MD, The Permanente Medical Group
Amanda Parsons, MD, Montefiore Health System
J. Brent Pawlecki, MD, MMM, The Goodyear Tire & Rubber Company
Susan Reinhard, PhD, RN, AARP Public Policy Institute
Eric C Schneider, MD, MSc, FACP (Co-Chair), The Commonwealth Fund
Marcus Thygeson, MD, MPH, Blue Shield of California
JoAnn Volk, MA, Georgetown University Center on Health Insurance Reforms

HEDIS Expert Coding Panel

Glen Braden, MBA, CHCA, Attest Health Care Advisors, LLC
Denene Harper, RHIA, American Hospital Association
DeHandro Hayden, BS, American Medical Association
Patience Hoag, RHIT, CHCA, CHDA, CCS, CCS-P, CDIP, CHTS-CP, CPHQ, Aqurate Health Data Management, Inc.
Elonia Griffin, RN, BSN, CareSource
Nelly Leon-Chisen, RHIA, American Hospital Association
Tammy Marshall, LVN, Aetna
Alec McLure, MPH, RHIA, CCS-P, Verisk Health
Michele Mouradian, RN, BSN, McKesson Corporation
Craig Thacker, RN, Cigna
Mary Jane Toomey, RN, CPC, WellCare Health Plans, Inc.

HEDIS Expert Pharmacy Panel

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Gerry Hobson, RPh, Cerner Multum
Chronis H. Manolis, RPh, UPMC Health Plan
Cathrine Misquitta, PharmD, BCPS, FCSHP, Health Net Pharmaceutical Services
Kevin Park, MD, Molina Healthcare, Inc.

Technical Measurement Advisory Panel

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Kathryn Coltin, MPH, Independent Consultant
Lekisha Daniel-Robinson, MSPH, Centers for Medicare and Medicaid Services
Marissa M. Finn, MBA, Cigna HealthCare
Scott Fox, MS, Med, Independence Blue Cross
Carlos Hernandez, CenCal Health
Kelly Isom, RN, MA, Aetna
Harmon S. Jordan, ScD, RTI International
Ernest Moy, MD, MPH, Agency for Healthcare Research and Quality (AHRQ)
Patrick Roohan, New York State Department of Health (NYSDOH)
Lynne Rothney-Kozlak, MPH, Rothney-Kozlak Consulting, LLC
Natan Szapiro, Independence Blue Cross

INFORMATION FROM PREVIOUS SUBMISSION (2014)

Musculoskeletal Work Group
Teresa Brady, PhD, Centers for Disease Control and Prevention
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Measure Developer/Steward Updates and Ongoing Maintenance

Ad.2 Year the measure was first released: 2004

Ad.3 Month and Year of most recent revision: 07, 2016

Ad.4 What is your frequency for review/update of this measure? Approximately every 3 years, sooner if the clinical guidelines have changed significantly.

Ad.5 When is the next scheduled review/update for this measure?

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