



Measure Information

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

Brief Measure Information

NQF #: 0420

Corresponding Measures:

De.2. Measure Title: Pain Assessment and Follow-Up

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

De.3. Brief Description of Measure: Percentage of visits for patients aged 18 years and older with documentation of a pain assessment using a standardized tool(s) on each visit AND documentation of a follow-up plan when pain is present

1b.1. Developer Rationale: This measure addresses a gap in care. There are disparities in care across population groups as outlined in the following statements:

The American Pain Foundation (2009) identified medically underserved populations endure a disproportionate pain burden in all health care settings.

A growing body of research reveals even more extensive gaps in pain assessment and treatment among racial and ethnic populations, with minorities receiving less care for pain than non-Hispanic whites (Green, 2003; Green, 2007; Green et al., 2011; Todd et al., 2004; Todd et al., 2007). Differences in pain care occur across all types of pain (e.g., acute, chronic, cancer-related) and medical settings (e.g., emergency departments and primary care) (Green, 2003; Green, 2007; Todd et al., 2007). Even when income, insurance status and access to health care are accounted for, minorities are still less likely than whites to receive necessary pain treatments (Green, 2003; Green, 2007; Paulson et al., 2007). Black race is associated with neighborhood socio-economic status (SES) and race plays a role in pain outcomes beyond SES (Green, 2012).

Research also shows gender differences in the experience and treatment of pain. Most chronic pain conditions are more prevalent among women; however, women's pain complaints tend to be poorly assessed and undertreated (Green, 2003; Chronic Pain Research Alliance 2011, Weimer 2013). Although women may have higher baseline pain, differences in pain levels may not persist at one month (Peterson, 2012).

"When assessing and treating pain, practitioner sex, race, age, and duration of experience were all significantly associated with pain management decisions. These findings suggest that pain assessment and treatment decisions may be impacted by the health care providers' demographic characteristics, effects which may contribute to pain management disparities." (Bartley et al., 2015).

The aim of this quality measure is to assist eligible providers to identify patients experiencing pain and provide a follow-up plan which addresses the patients' pain in an effort to reduce or eliminate the pain. Ultimately, reducing or eliminating pain will improve a patients' quality of life, minimize the disparities that exist in the assessment and treatment of pain and reduce the cost and utilization of healthcare resources.

S.4. Numerator Statement: Patient visits with a documented pain assessment using a standardized tool(s) AND documentation of a follow-up plan when pain is present

S.6. Denominator Statement: All visits for patients aged 18 years and older

S.8. Denominator Exclusions: Pain Assessment not Documented Patient not Eligible

Denominator Exception: G8442: Pain assessment NOT documented as being performed, documentation the patient is not eligible for a pain assessment using a standardized tool

Not Eligible – A patient is not eligible if one or more of the following reason(s) is documented:

Severe mental and/or physical incapacity where the person is unable to express himself/herself in a manner understood by others. For example, cases where pain cannot be accurately assessed through use of nationally recognized standardized pain assessment tools
Patient is in an urgent or emergent situation where time is of the essence and to delay treatment would jeopardize the patient's health status

De.1. Measure Type: Process

S.17. Data Source: Claims, Paper Medical Records

S.20. Level of Analysis: Clinician : Group/Practice, Clinician : Individual

IF Endorsement Maintenance – Original Endorsement Date: Jul 31, 2008 **Most Recent Endorsement Date:** Oct 25, 2016

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

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

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

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

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

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

[NQF_0420_MeasSubm_Evidence_033016.docx](#)

1a.1 For Maintenance of Endorsement: Is there new evidence about the measure since the last update/submission?

Do not remove any existing information. If there have been any changes to evidence, the Committee will consider the new evidence. Please use the most current version of the evidence attachment (v7.1). Please use red font to indicate updated evidence.

1b. Performance Gap

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

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

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

If a COMPOSITE (e.g., combination of component measure scores, all-or-none, any-or-none), SKIP this question and answer the composite questions.

This measure addresses a gap in care. There are disparities in care across population groups as outlined in the following statements:

The American Pain Foundation (2009) identified medically underserved populations endure a disproportionate pain burden in all health care settings.

A growing body of research reveals even more extensive gaps in pain assessment and treatment among racial and ethnic populations, with minorities receiving less care for pain than non-Hispanic whites (Green, 2003; Green, 2007; Green et al., 2011; Todd et al., 2004; Todd et al., 2007). Differences in pain care occur across all types of pain (e.g., acute, chronic, cancer-related) and medical settings (e.g., emergency departments and primary care) (Green, 2003; Green, 2007; Todd et al., 2007). Even when income, insurance status and access to health care are accounted for, minorities are still less likely than whites to receive necessary pain treatments (Green, 2003; Green, 2007; Paulson et al., 2007). Black race is associated with neighborhood socio-economic status (SES) and race plays a role in pain outcomes beyond SES (Green, 2012).

Research also shows gender differences in the experience and treatment of pain. Most chronic pain conditions are more prevalent among women; however, women's pain complaints tend to be poorly assessed and undertreated (Green, 2003; Chronic Pain

Research Alliance 2011, Weimer 2013). Although women may have higher baseline pain, differences in pain levels may not persist at one month (Peterson, 2012).

“When assessing and treating pain, practitioner sex, race, age, and duration of experience were all significantly associated with pain management decisions. These findings suggest that pain assessment and treatment decisions may be impacted by the health care providers’ demographic characteristics, effects which may contribute to pain management disparities.”(Bartley et al., 2015).

The aim of this quality measure is to assist eligible providers to identify patients experiencing pain and provide a follow-up plan which addresses the patients’ pain in an effort to reduce or eliminate the pain. Ultimately, reducing or eliminating pain will improve a patients’ quality of life, minimize the disparities that exist in the assessment and treatment of pain and reduce the cost and utilization of healthcare resources.

1b.2. Provide performance scores on the measure as specified (current and over time) at the specified level of analysis. *(This is required for maintenance of endorsement. Include mean, std dev, min, max, interquartile range, scores by decile. Describe the data source including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities include.) This information also will be used to address the sub-criterion on improvement (4b1) under Usability and Use.*

This PQRS measure is designed to encourage and improve the documentation and reporting of standardized pain assessments. It is scored as a simple count of valid submissions on payment claims in the time frame where Part B Medicare claims were available for analysis.

The measure is constructed so that a performance score can be easily derived by dividing the number of claims with codes indicating that the recommended processes were followed (or that the patient was ineligible) by the total number of numerator G codes submitted.

2014 Performance Scores: Claims data consists of all Medicare Part B claims submitted from 1/1/2014 to 12/31/2014 with one of the numerator G codes for this measure. The numerator G code submissions are voluntary and providers who report may not be representative of all eligible professionals. Performance rates cannot be generalized to the population.

A. Quality Indicator Performance 1/1/2014 through 12/31/2014

1. Total Claims Submitted- 10,555,143
2. Valid Denominator Criteria - 9,515,468/ 90.2% of total
3. Performance Exclusion – 341,159/ 3.5% of valid
4. Measure Performance Rate- 7,627,424 / 9,174,309 83.1%

B. Performance Variation by Eligible Professional 1/1/2014 through 12/31/2014: Describes the variation of measure scores by discrete National Provider Identification (NPI).

- N (# of NPIs) – 59,722
- Mean Measure Score – 81.9%
- Standard Deviation - .35
- Min/Max – 0/100%
- 1st percentile – 0.0%
- 5th percentile – 0.0%
- 10th percentile – 0.0%
- 25th percentile – 90.6%
- 50th percentile – 100.0%

Performance scores for the majority of reporting providers skew high (90.6% at the 25th percentile) but drop off sharply for the below the 25th percentile (0% at the 10th percentile). As the eligible provider pool has expanded average performance rates decreased (97.4% in 2009, 88.5% in 2014).

Reporting for the measure is voluntary and providers who report may not be representative of all eligible professionals. In 2014 only 10.7% of eligible providers reported this measure. Reported performance rates from this group cannot be generalized to the total eligible population

Provider and Patients Statistics for program year 2014 (from “2014 Physician Quality Reporting System Program Monitoring and

Evaluation Report”):

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

2009 – 97.4%

2010 – 97.3%

2011 – 94.8%

2012 – 86.9%

2013 – 85.7%

2014 – 88.5%

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

n/a

1b.4. Provide disparities data from the measure as specified (current and over time) by population group, e.g., by race/ethnicity, gender, age, insurance status, socioeconomic status, and/or disability. (This is required for maintenance of endorsement. Describe the data source including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities included.) For measures that show high levels of performance, i.e., “topped out”, disparities data may demonstrate an opportunity for improvement/gap in care for certain sub-populations. This information also will be used to address the sub-criterion on improvement (4b1) under Usability and Use.

Disparities in performance based on race/ethnicity, urban/rural status, gender and age were identified. Analysis of claims from 1/1/2014 through 12/31/2014 reveal statistically significant differences in measure performance between genders and age groups with larger differences observed between urban/rural providers and patient race/ethnic group.

Performance rates by categories:

Rural 87.3%, Urban 81.8% ($X^2 = 34753.95$, $N = 9,159,741$ $p < .0001$)

Female 83.7%, Male 82.2 % ($X^2 = 3424.87$, $N = 9,174,309$ $p < .0001$)

White 84.2%, Non-white 70.6% ($X^2 = 85850.38$, $N = 9,002,090$ $p < .0001$)

Asian 76.2%, Black 68.2%, Hispanic 79.1%, Native 73.6%, White 84.2%, Other 79.6%, Unknown 86.1% ($X^2 = 95281.16$, $N = 9,174,309$ $p < .0001$)

Age Under 50 years 80.0%, 50-64 years 80.9%, 65-69 years 85.4%, 70-74 years 84.6%, ≥ 75 81.7% ($X^2 = 23394.64$, $N = 9,174,309$, $p < .0001$)

Refer to section IV. Analysis of Claims Data in attached “NQF Endorsement Measurement Submission Summary Materials” document

1b.5. If no or limited data on disparities from the measure as specified is reported in 1b.4, then provide a summary of data from the literature that addresses disparities in care on the specific focus of measurement. Include citations. Not necessary if performance data provided in 1b.4

n/a

2. Reliability and Validity—Scientific Acceptability of Measure Properties

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

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

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

Musculoskeletal, Musculoskeletal : Low Back Pain

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

Health and Functional Status : Change, Primary Prevention, Screening

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

Elderly

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

<https://www.cms.gov/apps/ama/license.asp?file=/Medicare/Quality-Payment-Program/Resource-Library/2018-Claims-Registry-Measures-401-467.zip>

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

[This is not an eMeasure](#) Attachment:

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

Attachment Attachment: [NQF_420_DataDic_1117.xlsx](#)

S.2c. Is this an instrument-based measure (i.e., data collected via instruments, surveys, tools, questionnaires, scales, etc.)? Attach copy of instrument if available.

[No, this is not an instrument-based measure](#) Attachment:

S.2d. Is this an instrument-based measure (i.e., data collected via instruments, surveys, tools, questionnaires, scales, etc.)? Attach copy of instrument if available.

[Not an instrument-based measure](#)

S.3.1. For maintenance of endorsement: Are there changes to the specifications since the last updates/submission. If yes, update the specifications for S1-2 and S4-22 and explain reasons for the changes in S3.2.

[Yes](#)

S.3.2. For maintenance of endorsement, please briefly describe any important changes to the measure specifications since last measure update and explain the reasons.

[For PY 2017, the following changes were made to the measure:](#)

[Addition of PROMIS tool to standardized tools, addition of "behavioral" for inclusion in follow-up plan, updated rationale per recommendation of technical expert panel](#)

[Deleted Denominator Coding, CPT 97001, 97002, 97003, 97004 as these codes were discontinued and replaced with](#)

[CPT 97161, 97162, 97163, 97164, 97165, 97166, 97167, 97168](#)

[Added denominator criteria \(Telehealth Modifier Exclusion\)](#)

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

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

[Patient visits with a documented pain assessment using a standardized tool\(s\) AND documentation of a follow-up plan when pain is present](#)

S.5. Numerator Details (All information required to identify and calculate the cases from the target population with the target process, condition, event, or outcome such as definitions, time period for data collection, specific data collection items/responses, code/value sets – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format at S.2b)

[IF an OUTCOME MEASURE, describe how the observed outcome is identified/counted. Calculation of the risk-adjusted outcome should be described in the calculation algorithm \(S.14\).](#)

Definitions:

Pain Assessment – Documentation of a clinical assessment for the presence or absence of pain using a standardized tool is required. A multi-dimensional clinical assessment of pain using a standardized tool may include characteristics of pain, such as: location, intensity, description, and onset/duration.

Standardized Tool – An assessment tool that has been appropriately normed and validated for the population in which it is used. Examples of tools for pain assessment, include, but are not limited to: Brief Pain Inventory (BPI), Faces Pain Scale (FPS), McGill Pain Questionnaire (MPQ), Multidimensional Pain Inventory (MPI), Neuropathic Pain Scale (NPS), Numeric Rating Scale (NRS), Oswestry Disability Index (ODI), Roland Morris Disability Questionnaire (RMDQ), Verbal Descriptor Scale (VDS), Verbal Numeric Rating Scale (VNRS), Visual Analog Scale (VAS)), and Patient-Reported Outcomes Measurement Information System (PROMIS).

Follow-Up Plan – A documented outline of care for a positive pain assessment is required. This must include a planned follow-up appointment or a referral, a notification to other care providers as applicable OR indicate the initial treatment plan is still in effect. These plans may include pharmacologic, behavioral, physical medicine and/or educational interventions.

Not Eligible (Denominator Exception)– A patient is not eligible if one or more of the following reason(s) is documented:

- Severe mental and/or physical incapacity where the person is unable to express himself/herself in a manner understood by others. For example, cases where pain cannot be accurately assessed through use of nationally recognized standardized pain assessment tools
- Patient is in an urgent or emergent situation where time is of the essence and to delay treatment would jeopardize the patient's health status

NUMERATOR NOTE: The standardized tool used to assess the patient's pain must be documented in the medical record (exception: A provider may use a fraction such as 5/10 for Numeric Rating Scale without documenting this actual tool name when assessing pain for intensity).

Numerator Quality-Data Coding Options:

Pain Assessment Documented as Positive AND Follow-Up Plan Documented

Performance Met: G8730: Pain assessment documented as positive using a standardized tool AND a follow-up plan is documented
OR

Pain Assessment Documented as Negative, No Follow-Up Plan Required

Performance Met: G8731: Pain assessment using a standardized tool is documented as negative, no follow-up plan required

OR

Pain Assessment not Documented, Reason not Given

Performance Not Met: G8732: No documentation of pain assessment, reason not given

OR

Pain Assessment Documented as Positive, Follow-Up Plan not Documented, Reason not Given

Performance Not Met: G8509: Pain assessment documented as positive using a standardized tool, follow-up plan not documented, reason not given

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

All visits for patients aged 18 years and older

S.7. Denominator Details (All information required to identify and calculate the target population/denominator such as definitions, time period for data collection, specific data collection items/responses, code/value sets – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format at S.2b.)

IF an OUTCOME MEASURE, describe how the target population is identified. Calculation of the risk-adjusted outcome should be described in the calculation algorithm (S.14).

Denominator Criteria (Eligible Cases): Patients aged greater than or equal to 18 years on date of encounter AND Patient encounter

during the reporting period (CPT or HCPCS): 90791, 90792, 92002, 92004, 92012, 92014, 92507, 92508, 92526, 96116, 96118, 96150, 96151, 97161, 97162, 97164, 97165, 97166, 97167, 97168, 97532, 98940, 98941, 98942, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, D7140, D7210, G0101, G0402, G0438, G0439 WITHOUT Telehealth Modifier: GQ, GT

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

Pain Assessment not Documented Patient not Eligible

Denominator Exception: G8442: Pain assessment NOT documented as being performed, documentation the patient is not eligible for a pain assessment using a standardized tool

Not Eligible – A patient is not eligible if one or more of the following reason(s) is documented:

Severe mental and/or physical incapacity where the person is unable to express himself/herself in a manner understood by others. For example, cases where pain cannot be accurately assessed through use of nationally recognized standardized pain assessment tools

Patient is in an urgent or emergent situation where time is of the essence and to delay treatment would jeopardize the patient's health status

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

Pain Assessment not Documented Patient not Eligible

Denominator Exception: G8442: Pain assessment NOT documented as being performed, documentation the patient is not eligible for a pain assessment using a standardized tool

OR

Pain Assessment Documented as Positive, Follow-Up Plan not Documented, Patient not Eligible

Denominator Exception: G8939: Pain assessment documented as positive, follow-up plan not documented, documentation the patient is not eligible

S.10. Stratification Information (Provide all information required to stratify the measure results, if necessary, including the stratification variables, definitions, specific data collection items/responses, code/value sets, and the risk-model covariates and coefficients for the clinically-adjusted version of the measure when appropriate – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format with at S.2b.)

N/A

S.11. Risk Adjustment Type (Select type. Provide specifications for risk stratification in measure testing attachment)

No risk adjustment or risk stratification

If other:

S.12. Type of score:

Rate/proportion

If other:

S.13. Interpretation of Score (Classifies interpretation of score according to whether better quality is associated with a higher score, a lower score, a score falling within a defined interval, or a passing score)

Better quality = Higher score

S.14. Calculation Algorithm/Measure Logic (Diagram or describe the calculation of the measure score as an ordered sequence of steps including identifying the target population; exclusions; cases meeting the target process, condition, event, or outcome; time period for data, aggregating data; risk adjustment; etc.)

Satisfactory reporting criteria are met by valid submission of one of six G codes on claims that meet denominator criteria.

A rate of quality performance is calculated by dividing the number of records with G codes indicating that the quality actions were performed or that the patient was not eligible by total number of valid G code submissions.

THIS SECTION PROVIDES DEFINITIONS & FORMULAS FOR THE NUMERATOR (A), TOTAL DENOMINATOR POPULATION (TDP), DENOMINATOR EXCEPTIONS (B) CALCULATION & PERFORMANCE DENOMINATOR (PD) CALCULATION.

NUMERATOR (A): HCPCS Clinical Quality Codes G8730, G8731

TOTAL DENOMINATOR POPULATION (TDP): Patient aged 18 years and older on the date of the encounter of the 12-month reporting period, with denominator defined encounter codes & Medicare Part B Claims reported HCPCS Clinical Quality Codes G8730, G8731, G8442, G8939, G8732, G8509

DENONINATOR Exception(B): HCPCS Clinical Quality Code G8442, G8939

DENOMINATOR Exception CALCULATION: Denominator Exception (B): # of patients with valid exceptions # G8442+G8939 / # TDP

PERFORMANCE DENOMINATOR CALCULATION: Performance Denominator (B): Patients meeting criteria for performance denominator calculation # A / (# TDP - # B)

S.15. Sampling (If measure is based on a sample, provide instructions for obtaining the sample and guidance on minimum sample size.)

IF an instrument-based performance measure (e.g., PRO-PM), identify whether (and how) proxy responses are allowed.

n/a

S.16. Survey/Patient-reported data (If measure is based on a survey or instrument, provide instructions for data collection and guidance on minimum response rate.)

Specify calculation of response rates to be reported with performance measure results.

n/a

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

If other, please describe in S.18.

Claims, Paper Medical Records

S.18. Data Source or Collection Instrument (Identify the specific data source/data collection instrument (e.g. name of database, clinical registry, collection instrument, etc., and describe how data are collected.)

IF instrument-based, identify the specific instrument(s) and standard methods, modes, and languages of administration.

The data source is the patient medical record. Medicare Part B claims data and registry data is provided for test purposes.

S.19. Data Source or Collection Instrument (available at measure-specific Web page URL identified in S.1 OR in attached appendix at A.1)

No data collection instrument provided

S.20. Level of Analysis (Check ONLY the levels of analysis for which the measure is SPECIFIED AND TESTED)

Clinician : Group/Practice, Clinician : Individual

S.21. Care Setting (Check ONLY the settings for which the measure is SPECIFIED AND TESTED)

Outpatient Services

If other:

S.22. COMPOSITE Performance Measure - Additional Specifications (Use this section as needed for aggregation and weighting rules, or calculation of individual performance measures if not individually endorsed.)

n/a

2. Validity – See attached Measure Testing Submission Form

NQF_0420_Testing_Attachment_033016.docx

2.1 For maintenance of endorsement

Reliability testing: If testing of reliability of the measure score was not presented in prior submission(s), has reliability testing of the measure score been conducted? If yes, please provide results in the Testing attachment. Please use the most current version of the testing attachment (v7.1). Include information on all testing conducted (prior testing as well as any new testing); use red font to indicate updated testing.

2.2 For maintenance of endorsement

Has additional empirical validity testing of the measure score been conducted? If yes, please provide results in the Testing attachment. Please use the most current version of the testing attachment (v7.1). Include information on all testing conducted (prior testing as well as any new testing); use red font to indicate updated testing.

2.3 For maintenance of endorsement

Risk adjustment: For outcome, resource use, cost, and some process measures, risk-adjustment that includes social risk factors is not prohibited at present. Please update sections 1.8, 2a2, 2b1,2b4.3 and 2b5 in the Testing attachment and S.140 and S.11 in the online submission form. NOTE: These sections must be updated even if social risk factors are not included in the risk-adjustment strategy. You MUST use the most current version of the Testing Attachment (v7.1) -- older versions of the form will not have all required questions.

3. Feasibility

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

3a. Byproduct of Care Processes

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

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

Generated 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), Abstracted from a record by someone other than person obtaining original information (e.g., chart abstraction for quality measure or registry)

If other:

3b. Electronic Sources

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

3b.1. To what extent are the specified data elements available electronically in defined fields (i.e., data elements that are needed to compute the performance measure score are in defined, computer-readable fields) Update this field for **maintenance of endorsement**.

No data elements are in defined fields in electronic sources

3b.2. If ALL the data elements needed to compute the performance measure score are not from electronic sources, specify a credible, near-term path to electronic capture, OR provide a rationale for using other than electronic sources. For **maintenance of endorsement**, if this measure is not an eMeasure (eCQM), please describe any efforts to develop an eMeasure (eCQM).

At the time of this submission, this measure is not currently being considered as eMeasure.

3b.3. If this is an eMeasure, provide a summary of the feasibility assessment in an attached file or make available at a measure-specific URL. Please also complete and attach the NQF Feasibility Score Card.

Attachment:

3c. Data Collection Strategy

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

3c.1. Required for maintenance of endorsement. Describe difficulties (as a result of testing and/or operational use of the measure) regarding data collection, availability of data, missing data, timing and frequency of data collection, sampling, patient confidentiality, time and cost of data collection, other feasibility/implementation issues.

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

In an effort to reduce future variability in measure specification interpretation, the following changes will be reviewed:

1. Simplifying Numerator Quality codes [G8442 or G8939] from two G codes to one G code to identify the "Not Eligible" population.
2. Identify locations in the measure specification to emphasize documentation of the standardized tool

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).

None

4. Usability and Use

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

4a. Accountability and Transparency

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

4.1. Current and Planned Use

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

Specific Plan for Use	Current Use (for current use provide URL)
	Public Reporting Physician Quality Reporting System http://www.cms.gov/PQRS Payment Program Physician Quality Reporting System http://www.cms.gov/PQRS

4a1.1 For each CURRENT use, checked above (update for maintenance of endorsement), provide:

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

Public Use

Name: Physician Quality Reporting System (PQRS)

Sponsor: Centers for Medicare and Medicaid Services

Purpose and Geographical Area: PQRS is a national reporting program that uses a combination of incentive payments and payment adjustments to promote reporting of quality information by eligible professionals (EPs). EPs satisfactorily report data on quality measures for covered Physician Fee Schedule (PFS) services furnished to Medicare Part B Fee-for-Service (FFS) beneficiaries. Refer to the following link for additional information: <http://www.cms.gov/PQRS>

In 2014, there were 573,233 (10.7%) Eligible Professionals who could report NQF# 0420. In 2013, NQF #0420 was the 6th most reported measure within PQRS with 664,929 (7.4%) eligible professionals participating in reporting this measure.

Provider and Patients Statistics for program year 2014 (from "2014 Physician Quality Reporting System Program Monitoring and Evaluation Report"):

Providers

Eligible EPs in 2013-664,929

Eligible EPs in 2014=573,233

% of Eligible EPs who report in 2013=7.4%

% of Eligible EPs who report in 2014=10.7%

Beneficiaries

- Eligible Beneficiaries – 26,978,892
- Beneficiaries reported – 2,212,704
- % of Beneficiaries reported – 8.2%

Many types of providers/specialists report this measure as part of the PQRS as defined by the CPT codes in the measure specification.

Refer to section IV. Analysis of Claims Data in attached “NQF Endorsement Measurement Submission Summary Materials” document

4a1.2. If not currently publicly reported OR used in at least one other accountability application (e.g., payment program, certification, licensing) what are the reasons? (e.g., Do policies or actions of the developer/steward or accountable entities restrict access to performance results or impede implementation?)

n/a

4a1.3. If not currently publicly reported OR used in at least one other accountability application, provide a credible plan for implementation within the expected timeframes -- any accountability application within 3 years and publicly reported within 6 years of initial endorsement. (Credible plan includes the specific program, purpose, intended audience, and timeline for implementing the measure within the specified timeframes. A plan for accountability applications addresses mechanisms for data aggregation and reporting.)

n/a

4a2.1.1. Describe how performance results, data, and assistance with interpretation have been provided to those being measured or other users during development or implementation.

How many and which types of measured entities and/or others were included? If only a sample of measured entities were included, describe the full population and how the sample was selected.

N/A

4a2.1.2. Describe the process(es) involved, including when/how often results were provided, what data were provided, what educational/explanatory efforts were made, etc.

N/A

4a2.2.1. Summarize the feedback on measure performance and implementation from the measured entities and others described in 4d.1.

Describe how feedback was obtained.

N/A

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

N/A

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

N/A

4a2.3. Describe how the feedback described in 4a2.2.1 has been considered when developing or revising the measure specifications or implementation, including whether the measure was modified and why or why not.

N/A

Improvement

Progress toward achieving the goal of high-quality, efficient healthcare for individuals or populations is demonstrated. If not in use

for performance improvement at the time of initial endorsement, then a credible rationale describes how the performance results could be used to further the goal of high-quality, efficient healthcare for individuals or populations.

4b1. Refer to data provided in 1b but do not repeat here. Discuss any progress on improvement (trends in performance results, number and percentage of people receiving high-quality healthcare; Geographic area and number and percentage of accountable entities and patients included.)

If no improvement was demonstrated, what are the reasons? If not in use for performance improvement at the time of initial endorsement, provide a credible rationale that describes how the performance results could be used to further the goal of high-quality, efficient healthcare for individuals or populations.

It is difficult to say with certainty the reason for the decrease after 2010. These performance rates are submitted voluntarily by providers and cannot be generalized to the total population of eligible providers. The smaller group of early adopters may have been biased towards better performers. As a larger percentage of providers opt to report the measure we would expect to see the aggregate performance rate more closely estimate the true rate for the population.

4b2. Unintended Consequences

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

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

There were no unintended consequences

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

5. Comparison to Related or Competing Measures

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

5. Relation to Other NQF-endorsed Measures

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

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

0383 : Oncology: Medical and Radiation - Plan of Care for Pain
0676 : Percent of Residents Who Self-Report Moderate to Severe Pain (Short Stay)
0677 : Percent of Residents Who Self-Report Moderate to Severe Pain (Long Stay)
1628 : Patients with Advanced Cancer Screened for Pain at Outpatient Visits
1634 : Hospice and Palliative Care -- Pain Screening
1637 : Hospice and Palliative Care -- Pain Assessment

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

0050 : Osteoarthritis: Function and Pain Assessment/ National Committee for Quality Assurance
0306 : Back Pain: Patient Reassessment/ National Committee for Quality Assurance
0322 : Back Pain: Initial Visit/ National Committee for Quality Assurance
0341 : PICU Pain Assessment on Admission/ National Association of Children's Hospitals and Related Institutions
0342 : PICU Periodic Pain Assessment/ National Association of Children's Hospitals and Related Institutions
0523 : Pain Assessment Conducted/ Centers for Medicare and Medicaid Services
0675 : The Percentage of Residents on a Scheduled Pain Medication Regimen on Admission Who Self-Report a Decrease in Pain Intensity or Frequency (Short-stay)/ Centers for Medicare and Medicaid

5a. Harmonization of Related Measures

The measure specifications are harmonized with related measures;

OR

The differences in specifications are justified

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

Are the measure specifications harmonized to the extent possible?

No

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

Six related measures were identified that are not harmonized with NQF# 0420. The differences between these related measures and the submitted measure NQF# 0420 are listed below: 0383 - Oncology: Plan of Care for Pain – Medical Oncology and Radiation Oncology (paired with 0384 which is unrelated to and non-competing with 0420) - target population is specific to patients with a diagnosis of cancer currently receiving chemotherapy or radiation therapy who report having pain; 0383 does not include the use of a standardized pain assessment tool. Both measures are process measures. Both measures have outpatient care setting.

0676 - Percent of Residents Who Self-Report Moderate to Severe Pain (Short-Stay) – target population is specific to short - stay residents whereas 0420 has a broader outpatient population; 0420 is NOT a self-report measure, it is an eligible provider report; 0676 does not include the use of a standardized pain assessment tool; 0676 does not include documentation of a follow-up plan if pain is present; 0676 is an outcome measure whereas 0420 is a process measure. Care setting for 0676 is long term care/skilled nursing facilities whereas 0420 care setting is outpatient clinician office or outpatient rehabilitation.

0677 - Percent of Residents Who Self-Report Moderate to Severe Pain (Long-Stay) – target population is specific to long - stay residents whereas 0420 has a broader outpatient population; 0420 is NOT a self-report measure, it is an eligible provider report; 0677 does not include the use of a standardized pain assessment tool; 0677 does not include documentation of a follow-up plan if pain is present; 0677 is an outcome measure whereas 0420 is a process measure. Care setting for 0677 is long term care/skilled nursing facilities whereas 0420 care setting is outpatient clinician office or outpatient rehabilitation.

1628 - Patients with Advanced Cancer Screened for Pain at Outpatient Visits - target population is specific to patients with a diagnosis of advanced cancer; 1628 does not include a follow-up plan if pain is present; Both 1628 and 0420 are process measures; Both measures have outpatient care setting.

1634 - Hospice and Palliative Care -- Pain Screening: target population has no age parameters whereas 0420 has an age range (> 18 yrs.); 1634 target population is specific to hospice and palliative care patients whereas 0420 is not diagnosis specific; 1634 does not include documentation of a follow-up plan if pain is present; Both 1634 and 0420 are process measures; Care setting for 1634 is restricted to Hospice/Hospital/Acute Care Facility, whereas 0420 care setting is outpatient clinician office or outpatient rehabilitation.

1637 – Hospice and Palliative Care—Pain Assessment- target population has no age parameters whereas 0420 has an age range (> 18 yrs.); 1637 target population is specific to hospice and palliative care patients whereas 0420 is not diagnosis specific; 1637 measure focus is clinical assessment within 24hrs of positive screening for pain; 0420 measure focus is performing a screening and a documented follow-up plan not just limited to a clinical assessment; Both are process measures; Care setting for 1637 is restricted to Hospice/Hospital/Acute Care Facility; whereas 0420 care setting is outpatient clinician office or outpatient rehabilitation.

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.)

There are no 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.

Attachment **Attachment:** [NQF_Endorsement_Measurement_Submission_Summary_Materials.docx](#)

Contact Information

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

Co.2 Point of Contact: Susan, Arday, Sophia.Arday@cms.hhs.gov, 410-786-3141-

Co.3 Measure Developer if different from Measure Steward: Centers for Medicare & Medicaid Services

Co.4 Point of Contact: Susan, Arday, Sophia.Arday@cms.hhs.gov, 410-786-3141-

Additional Information

Ad.1 Workgroup/Expert Panel involved in measure development

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

Through a collaborative process, the Technical Expert Panel (TEP) reviewed the current 2016 measure specifications (description, numerator, denominator, definitions, clinical recommendation, and environmental scan).

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Measure Developer/Steward Updates and Ongoing Maintenance

Ad.2 Year the measure was first released: 2008

Ad.3 Month and Year of most recent revision: 09, 2015

Ad.4 What is your frequency for review/update of this measure? Annually

Ad.5 When is the next scheduled review/update for this measure? 09, 2016

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

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Ad.7 Disclaimers: This measure and specifications are provided "as is" without warranty of any kind. This measure does not represent a practice guideline.

Ad.8 Additional Information/Comments:

