

## Measure Information Form

### **Project Title:**

Inpatient Psychiatric Facility (IPF) Outcome and Process Measure Development and Maintenance

### **Project Overview:**

The Centers for Medicare & Medicaid Services (CMS) has contracted with HSAG to develop, maintain, reevaluate, and support the implementation of quality outcome and process measures for the CMS Inpatient Psychiatric Facility Quality Reporting (IPFQR) Program. The contract name is Inpatient Psychiatric Facility Outcome and Process Measure Development and Maintenance. The contract number is HHSM-500-2013-13007I; HHSM-500-T0004.

### **Date:**

Information included is current as of December 10, 2014.

### **Descriptive Information**

#### **Measure Name (Measure Title De.2.)**

NQF 1879: Adherence to Antipsychotic Medications for Individuals with Schizophrenia

#### **Measure Type De.1.**

Process

#### **Brief Description of Measure De.3.**

Percentage of individuals at least 18 years of age as of the beginning of the measurement period with schizophrenia or schizoaffective disorder who had at least two prescription drug claims for antipsychotic medications and had a Proportion of Days Covered (PDC) of at least 0.8 for antipsychotic medications during the measurement period (12 consecutive months).

#### **If Paired or Grouped De.4.**

Not applicable

#### **Subject/Topic Areas De.5.**

Mental Health: Mental Health  
Mental Health: Serious Mental Illness  
Disparities

## **Measure Specifications**

### **Measure-Specific Web Page S.1.**

Not applicable

### **If This is an eMeasure S.2a.**

Not applicable

### **Data Dictionary Code Table S.2b.**

ICD-9 to ICD-10 Crosswalk and National Drug Code (NDC) Table are available in the attached file.

### **For Endorsement Maintenance S.3.**

Date Endorsed: November 2, 2012

#### Release Notes

Statement of intent for the selection of ICD-10 codes: The goal was to convert this measure to a new code set, fully consistent with the intent of the original measure.

#### **2011 Updates**

- Updated NDCs as of October 28, 2011.
- Added new 2011 CPT visit type codes, 99224-99226.
- Added new 2011 CPT J-codes for depot injections, paliperidone (J2426), and updated olanzapine (J2358).
- Updated ICD-9-CM and ICD-10-CM diagnosis codes with 2011 changes for dementia to be excluded. Added missing fifth digits to 290.1, 290.2, 290.4, and 294.1. Added new code V40.31.

#### **2012 Updates**

- Updated NDCs as of October 31, 2012.
- Harmonized measure with NCQA 1936 for NQF submission and endorsement.
- Modified age requirement to at least 18 at the beginning of the measurement period.
- Modified codes used to identify encounter type to align with NCQA 1936.
- Removed the exclusion of depot injections following considerations for harmonization. Included antipsychotic depot drugs as part of the NDC list.

#### **2013 Updates**

- Updated NDCs as of November 6, 2013.
- Added aripiprazole long-acting injection to Atypical Antipsychotic Medications.
- Updated the physician group attribution methodology and removed reference to UPIN, since UPIN is no longer used for the attribution.

#### **2014 Updates**

- Updated NDCs as of December 10, 2014.
- Removed CPT visit type codes 90801, 90802, 90804-90819, 90821-90824, 90826-90829, 90857, and 90862, and added the replacement codes 90791, 90792, 90832, 90834, and 90837.
- Added CPT code 90839 for psychotherapy for crisis.
- Added CPT add-on codes for psychotherapy 90833, 90836, 90838, 90863, and 90840.
- Updated ICD-9-CM and ICD-10-CM diagnosis codes with 2014 changes for dementia to be excluded. Added new codes 294.20 and 294.21 for dementia and added code 292.82 for drug-induced persisting dementia. Removed V40.31.

### **Numerator Statement S.4.**

Individuals with schizophrenia or schizoaffective disorder who had at least two prescription drug claims for antipsychotic medications and have a PDC of at least 0.8 for antipsychotic medications.

## *Adherence to Antipsychotic Medications for Individuals with Schizophrenia*

### **Time Period for Data S.5.**

The time period of data is defined as any time during the measurement period (12 consecutive months).

### **Numerator Details S.6.**

The numerator is defined as individuals with a PDC of 0.8 or greater.

The PDC is calculated as follows:

#### **PDC NUMERATOR**

The PDC numerator is the sum of the days covered by the days' supply of all prescription drug claims for all antipsychotic medications. The period covered by the PDC starts on the day the first prescription is filled (index date) and lasts through the end of the measurement period, or death, whichever comes first. For prescription drug claims with a days' supply that extends beyond the end of the measurement period, count only the days for which the drug was available to the individual during the measurement period. If there are claims for the same drug (generic name) on the same date of service, keep the claim with the largest days' supply. If claims for the same drug (generic name) overlap, then adjust the prescription start date to be the day after the previous fill has ended.

#### **PDC DENOMINATOR**

The PDC denominator is the number of days from the first prescription drug claim date through the end of the measurement period, or death date, whichever comes first.

### **Denominator Statement S.7.**

Individuals at least 18 years of age as of the beginning of the measurement period with schizophrenia or schizoaffective disorder and at least two prescription drug claims for antipsychotic medications during the measurement period (12 consecutive months).

### **Target Population Category S.8.**

Adult/Elderly Care

### **Denominator Details S.9.**

Target population meets the following conditions:

1. Continuously enrolled in Part D with no more than a one-month gap in enrollment during the measurement period;
2. Continuously enrolled in Part A and Part B with no more than a one-month gap in Part A enrollment and no more than a one-month gap in Part B enrollment during the measurement period; and,
3. No more than one month of HMO (Health Maintenance Organization) enrollment during the measurement period.

#### **IDENTIFICATION OF SCHIZOPHRENIA**

Individuals with schizophrenia or schizoaffective disorder are identified by having a diagnosis of schizophrenia within the inpatient or outpatient claims data. Individuals must have:

At least two encounters with a diagnosis of schizophrenia or schizoaffective disorder with different dates of service in an outpatient setting, emergency department setting, or non-acute inpatient setting during the measurement period;

OR

At least one encounter with a diagnosis of schizophrenia or schizoaffective disorder in an acute inpatient setting during the measurement period.

#### **Table 1: Codes Used to Identify Schizophrenia or Schizoaffective Disorder Diagnosis**

ICD-9-CM: 295.xx

ICD-10-CM: F20.0, F20.1, F20.2, F20.3, F20.5, F20.81, F20.89, F20.9, F25.0, F25.1, F25.8, F25.9

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### CODES USED TO IDENTIFY ENCOUNTER TYPE:

#### Table 2.1: Outpatient Setting

Current Procedural Terminology (CPT): 98960-98962, 99078, 99201-99205, 99211-99215, 99217-99220, 99241-99245, 99341-99345, 99347-99350, 99385-99387, 99395-99397, 99401-99404, 99411, 99412, 99429, 99510

HCPCS: G0155, G0176, G0177, G0409-G0411, G0463, H0002, H0004, H0031, H0034-H0037, H0039, H0040, H2000, H2001, H2010-H2020, M0064, S0201, S9480, S9484, S9485, T1015

UB-92 revenue: 0510, 0511, 0513, 0516-0517, 0519-0523, 0526-0529, 0770, 0771, 0779, 0900-0905, 0907, 0911-0917, 0919, 0982, 0983

OR

CPT: 90791, 90792, 90832-90834, 90836-90840, 90845, 90847, 90849, 90853, 90863, 90867-90870, 90875, 90876, 90880, 99221-99223, 99231-99233, 99238, 99239, 99251-99255, 99291

WITH

Place of Service (POS): 03, 05, 07, 09, 11, 12, 13, 14, 15, 20, 22, 24, 33, 49, 50, 52, 53, 71, 72

#### Table 2.2: Emergency Department Setting

CPT: 99281-99285

UB-92 revenue: 0450, 0451, 0452, 0456, 0459, 0981

OR

CPT: 90791, 90792, 90832-90834, 90836-90840, 90845, 90847, 90849, 90853, 90863, 90867-90870, 90875, 90876, 99291

WITH

POS: 23

#### Table 2.3: Non-Acute Inpatient Setting

CPT: 99304-99310, 99315, 99316, 99318, 99324-99328, 99334-99337

HCPCS: H0017-H0019, T2048

UB-92 revenue: 0118, 0128, 0138, 0148, 0158, 0190-0194, 0199, 0524, 0525, 0550-0552, 0559, 0660-0663, 0669, 1000, 1001, 1003-1005

OR

CPT: 90791, 90792, 90832-90834, 90836-90840, 90845, 90847, 90849, 90853, 90863, 90867-90870, 90875, 90876, 99291

WITH

POS: 31, 32, 56

#### Table 2.4: Acute Inpatient Setting

UB-92 revenue: 0100, 0101, 0110-0114, 0119-0124, 0129-0134, 0139-0144, 0149-0154, 0159, 0160, 0164, 0167, 0169, 0200-0204, 0206-0209, 0210-0214, 0219, 0720-0724, 0729, 0987

OR

CPT: 90791, 90792, 90832-90834, 90836-90840, 90845, 90847, 90849, 90853, 90863, 90867-90870, 90875, 90876, 99221-99223, 99231-99233, 99238, 99239, 99251-99255, 99291

## *Adherence to Antipsychotic Medications for Individuals with Schizophrenia*

WITH

POS: 21, 51

The following are the oral antipsychotic medications by class for the denominator. The route of administration includes all oral formulations of the medications listed below.

Table 3: Oral Antipsychotic Medications

**Typical Antipsychotic Medications:**

chlorpromazine  
fluphenazine  
haloperidol  
loxapine  
molindone  
perphenazine  
pimozide  
prochlorperazine  
thioridazine  
thiothixene  
trifluoperazine

**Atypical Antipsychotic Medications:**

aripiprazole  
asenapine  
clozapine  
iloperidone  
lurasidone  
olanzapine  
paliperidone  
quetiapine  
risperidone  
ziprasidone

**Antipsychotic Combinations:**

olanzapine-fluoxetine  
perphenazine-amitriptyline

The following are the long-acting (depot) injectable antipsychotic medications by class for the denominator. The route of administration includes all injectable and intramuscular formulations of the medications listed below.

Table 4: Long-Acting Injectable Antipsychotic Medications

**Typical Antipsychotic Medications:**

fluphenazine decanoate (J2680)  
haloperidol decanoate (J1631)

**Atypical Antipsychotic Medications:**

aripiprazole (J0401)  
olanzapine pamoate (J2358)  
paliperidone palmitate (J2426)  
risperidone microspheres (J2794)

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Note: Since the days' supply variable is not reliable for long-acting injections in administrative data, the days' supply is imputed as listed below for the long-acting (depot) injectable antipsychotic medications billed under Part D and Part B:

fluphenazine decanoate (J2680) – 28 days' supply  
haloperidol decanoate (J1631) – 28 days' supply  
aripiprazole (J0401) – 28 days' supply  
olanzapine pamoate (J2358) – 28 days' supply  
paliperidone palmitate (J2426) – 28 days' supply  
risperidone microspheres (J2794) – 14 days' supply

### **Denominator Exclusions (NQF Includes “Exceptions” in the “Exclusion” Field) S.10.**

Individuals with any diagnosis of dementia during the measurement period.

### **Denominator Exclusion Details (NQF Includes “Exceptions” in the “Exclusion” Field) S.11.**

Individuals with any diagnosis of dementia are identified with the diagnosis codes listed below.

#### Table 5: Codes Used to Identify Dementia

ICD-9-CM: 290.0, 290.10, 290.11, 290.12, 290.13, 290.20, 290.21, 290.3, 290.40, 290.41, 290.42, 290.43, 290.8, 290.9, 291.2, 292.82, 294.10, 294.11, 294.20, 294.21, 330.1, 331.0, 331.19, 331.82

ICD-10-CM: E75.00, E75.01, E75.02, E75.09, E75.10, E75.11, E75.19, E75.4, F01.50, F01.51, F02.80, F02.81, F03.90, F03.91, F05, F10.27, F11.122, F13.27, F13.97, F18.17, F18.27, F18.97, F19.17, F19.27, F19.97, G30.0, G30.1, G30.8, G30.9, G31.09, G31.83

### **Stratification Details/Variables S.12.**

Depending on the operational use of the measure, measure results will be stratified by:

- State
- Physician Group\*
- Age – Divided into six categories: 18-24, 25-44, 45-64, 65-74, 75-84, and 85+ years
- Race/Ethnicity
- Dual Eligibility

\*See **Calculation Algorithm/Measure Logic S.18** below for physician group attribution methodology used for this measure.

### **Risk Adjustment Type S.13.**

No risk adjustment or risk stratification

### **Statistical Risk Model and Variables S.14.**

Not applicable

### **Detailed Risk Model Specifications S.15.**

Not applicable

### **Type of Score S.16.**

Rate/proportion

### **Interpretation of Score S.17.**

Better quality = higher score

### **Calculation Algorithm/Measure Logic S.18.**

**Target Population:** Individuals at least 18 years of age as of the beginning of the measurement period who have met the enrollment criteria for Parts A, B, and D.

## *Adherence to Antipsychotic Medications for Individuals with Schizophrenia*

**Denominator:** Individuals at least 18 years of age as of the beginning of the measurement period with schizophrenia or schizoaffective disorder and at least two prescription drug claims for antipsychotic medications during the measurement period (12 consecutive months).

### **Create Denominator:**

1. Pull individuals who are 18 years of age or older as of the beginning of the measurement period.
2. Include individuals who were continuously enrolled in Part D coverage during the measurement period, with no more than a one-month gap in enrollment during the measurement period, or up until their death date if they died during the measurement period.
3. Include individuals who had no more than a one-month gap in Part A enrollment, no more than a one-month gap in Part B enrollment, and no more than one month of HMO (Health Maintenance Organization) enrollment during the current measurement period (fee-for-service [FFS] individuals only).
4. Of those individuals identified in Step 3, keep individuals who had:  
At least two encounters with a diagnosis of schizophrenia or schizoaffective disorder with different dates of service in an outpatient setting, emergency department setting, or non-acute inpatient setting during the measurement period;  
OR  
Individuals who had at least one encounter with a diagnosis of schizophrenia or schizoaffective disorder in an acute inpatient setting during the measurement period.
5. For the individuals identified in Step 4, extract Part D claims for any antipsychotic medication during the measurement period. Attach the generic name and the drug ID to the dataset.
6. Of the individuals identified in Step 5, exclude those who did not have at least two prescription drug claims for any antipsychotic medication on different dates of service (identified by having at least two Part D claims with the specific codes) during the measurement period.
7. Exclude those individuals with a diagnosis of dementia during the measurement period.

**Numerator:** Individuals with schizophrenia or schizoaffective disorder who had at least two prescription drug claims for antipsychotic medications and have a PDC of at least 0.8 for antipsychotic medications.

### **Create Numerator:**

For the individuals in the denominator, calculate the PDC for each individual according to the following methods:

1. Determine the individual's medication therapy period, defined as the number of days from the index prescription date through the end of the measurement period, or death, whichever comes first. The index date is the service date (fill date) of the first prescription drug claim for an antipsychotic medication in the measurement period.
2. Within the medication therapy period, count the days the individual was covered by at least one drug in the antipsychotic medication class based on the prescription drug claim service date and days of supply.
  - a. Sort and de-duplicate Part D antipsychotic medication claims by beneficiary ID, service date, generic name, and descending days' supply. If prescriptions for the same drug (generic name) are dispensed on the same date of service for an individual, keep the dispensing with the largest days' supply.
  - b. Calculate the number of days covered by antipsychotic drug therapy per individual.
    - i. For prescription drug claims with a days' supply that extends beyond the end of the measurement period, count only the days for which the drug was available to the individual during the measurement period.
    - ii. If claims for the same drug (generic name) overlap, then adjust the prescription start date to be the day after the previous fill has ended.
    - iii. If claims for different drugs (different generic names) overlap, do not adjust the prescription start date.
3. Calculate the PDC for each individual. Divide the number of covered days found in Step 2 by the number of days in the individual's medication therapy period found in Step 1.

An example of SAS code for Steps 1-3 was adapted from Pharmacy Quality Alliance (PQA) and is available at the URL: <http://www2.sas.com/proceedings/forum2007/043-2007.pdf>.

## *Adherence to Antipsychotic Medications for Individuals with Schizophrenia*

4. Of the individuals identified in Step 3, count the number of individuals with a calculated PDC of at least 0.8 for the antipsychotic medications. This is the numerator.

### **Physician Group Attribution:**

Physician group attribution was adapted from Generating Medicare Physician Quality Performance Measurement Results (GEM) Project: Physician and Other Provider Grouping and Patient Attribution Methodologies

(<http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/GEM/downloads/GEMMethodologies.pdf>). The following is intended as guidance and reflects only one of many methodologies for assigning individuals to a medical group. Please note that the physician group attribution methodology excludes patients who died, even though the overall measure does not.

### **I. Identify Physician and Medical Groups**

1. Identify all Tax Identification Numbers (TINs)/National Provider Identification (NPIs) combinations from all Part B claims in the measurement year and the prior year. Keep records with valid NPI. Valid NPIs have 10 numeric characters (no alpha characters).
2. For valid NPIs, pull credentials and specialty code(s) from the CMS provider tables.
3. Create one record per NPI with all credentials and all specialties. A provider may have more than one specialty.
4. Attach TIN to NPI, keeping only those records with credentials indicating a physician (MD or DO), physician assistant (PA), or nurse practitioner (NP).
5. Identify medical group TINs: Medical group TINs are defined as TINs that had physician, physician assistant, or nurse practitioner provider specialty codes on at least 50% of Part B carrier claim line items billed by the TIN during the measurement year or prior year. (The provider specialty codes are listed after Patient Attribution.)
  - a. Pull Part B records billed by TINs identified in Step 4 during the measurement year and prior year.
  - b. Identify claims that had the performing NPI (npi\_prfrmng) in the list of eligible physicians/TINs, keeping those that match by TIN, performing NPI, and provider state code.
  - c. Calculate the percentage of Part B claims that match by TIN, npi\_prfrmng, and provider state code for each TIN, keeping those TINs with percentages greater than or equal to 50%.
  - d. Delete invalid TINs. Examples of invalid TINs are defined as having the same value for all nine digits or values of 012345678, 012345678, 123456789, 987654321, or 87654321.
6. Identify TINs that are not solo practices.
  - a. Pull Part B records billed by physicians identified in Step 4 for the measurement year and/or prior year.
  - b. Count unique NPIs per TIN.
  - c. Keep only those TINs having two or more providers.
  - d. Delete invalid TINs. Examples of invalid TINs are defined as having the same value for all nine digits or values of 012345678, 012345678, 123456789, 987654321, or 87654321.
7. Create final group of TINs from Step 5 and Step 6 (TINs that are medical groups and are not solo practices).
8. Create file of TINs and NPIs associated with those TINs. These are now referred to as the medical group TINs.
9. Determine the specialty of the medical group (TIN) to be used in determining the specialty of nurse practitioners and physician assistants. The plurality of physician providers in the medical group determines the specialty of care for nurse practitioners and physician assistants.
  - a. From the TIN/NPI list created in Step 8, count the NPIs per TIN/specialty.
  - b. The specialty with the maximum count is assigned to the medical group.

### **II. Identify Individual Sample and Claims**

10. Create individual sample.
  - a. Pull individuals with 11+ months of Parts A, B, & D during the measurement year.
  - b. Verify the individual did not have any months with Medicare as secondary payer. Remove individuals with BENE\_PRMRY\_PYR\_CD not equal to one of the following:
    - A = working-age individual/spouse with an employer group health plan (EGHP)
    - B = End Stage Renal Disease (ESRD) in the 18-month coordination period with an EGHP
    - G = working disabled for any month of the year
  - c. Verify the individual resides in the U.S., Puerto Rico, Virgin Islands, or Washington D.C.
  - d. Exclude individuals who enter the Medicare hospice at any point during the measurement year.
  - e. Exclude individuals who died during the measurement year.



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11. For individuals identified in Step 10, pull office visit claims that occurred during the measurement year and in the six months prior to the measurement year.
  - a. Office visit claims have CPT codes of 99201-99205, 99211-99215, and 99241-99245.
  - b. Exclude claims with no np\_i\_prfrmng.
12. Attach medical group TIN to claims by NPI.

### **III. Patient Attribution**

13. Pull all Part B office claims from Step 12 with specialties indicating primary care or psychiatry (see list of provider specialties and specialty codes below). Attribute each individual to at most one medical group TIN for each measure.
  - a. Evaluate specialty on claim (HSE\_B\_HCFA\_PRVDR\_SPCLTY\_CD) first. If specialty on claim does not match any of the measure-specific specialties, then check additional specialty fields.
  - b. If the provider specialty indicates nurse practitioners or physician assistants (code 50 or code 97), then assign the medical group specialty determined in Step 9.
14. For each individual, count claims per medical group TIN. Keep only individuals with two or more E&M claims.
15. Attribute individual to the medical group TIN with the most claims. If a tie occurs between medical group TINs, attribute the TIN with the most recent claim.
16. Attach the medical group TIN to the denominator and numerator files by individual.

### **Provider Specialties and Specialty Codes**

Provider specialties and specialty codes include only physicians, physician assistants, and nurse practitioners for physician grouping, TIN selection, and patient attribution. The provider specialty codes and the associated provider specialty are shown below:

01—General practice\*  
02—General surgery  
03—Allergy/immunology  
04—Otolaryngology  
05—Anesthesiology  
06—Cardiology  
07—Dermatology  
08—Family practice\*  
09—Interventional pain management  
10—Gastroenterology  
11—Internal medicine\*  
12—Osteopathic manipulative therapy  
13—Neurology  
14—Neurosurgery  
16—Obstetrics/gynecology\*  
18—Ophthalmology  
20—Orthopedic surgery  
22—Pathology  
24—Plastic and reconstructive surgery  
25—Physical medicine and rehabilitation  
26—Psychiatry\*  
28—Colorectal surgery  
29—Pulmonary disease  
30—Diagnostic radiology  
33—Thoracic surgery  
34—Urology  
37—Nuclear medicine  
38—Geriatric medicine\*  
39—Nephrology  
39—Pediatric medicine

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40—Hand surgery  
44—Infectious disease  
46—Endocrinology  
50—Nurse practitioner\*  
66—Rheumatology  
70—Multi-specialty clinic or group practice\*  
72—Pain management  
76—Peripheral vascular disease  
77—Vascular surgery  
78—Cardiac surgery  
79—Addiction medicine  
81—Critical care (intensivists)  
82—Hematology  
83—Hematology/oncology  
84—Preventive medicine\*  
85—Maxillofacial surgery  
86—Neuropsychiatry\*  
90—Medical oncology  
91—Surgical oncology  
92—Radiation oncology  
93—Emergency medicine  
94—Interventional radiology  
97—Physician assistant\*  
98—Gynecologist/oncologist  
99—Unknown physician specialty  
Other—NA

\*Provider specialty codes specific to this measure

### **Calculation Algorithm/Measure Logic Diagram URL or Attachment S.19.**

Not applicable

### **Sampling S.20.**

Not applicable; this measure does not use a sample or survey.

### **Survey/Patient-Reported Data S.21.**

Not applicable; this measure does not use a sample or survey.

### **Missing Data S.22.**

To reduce the potential for measure result bias, patients who have prescription drug claims with missing days' supply are excluded from the analysis.

### **Data Source S.23.**

Administrative Claims

Electronic Clinical Data: Pharmacy

Other: Please see the next section for further details.

### **Data Source or Collection Instrument S.24.**

For measure calculation, the following Medicare files are required:

- Denominator tables
- Prescription drug benefit (Part D) coverage tables
- Beneficiary file
- Institutional claims (Part A)
- Non-institutional claims (Part B)—physician carrier/non-DME
- Prescription drug benefit (Part D) claims

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For physician group attribution, the following are required:

- Non-institutional claims (Part B)—physician carrier/non-DME
- Denominator tables to determine individual enrollment
- Beneficiary file or coverage table to determine hospice benefit and Medicare as secondary payer status
- CMS physician and physician specialty tables

Payer Source:

- Medicare FFS
- Prescription Drug Plans (PDPs)

### **Data Source or Collection Instrument (Reference) S.25.**

Not applicable

### **Level of Analysis S.26.**

Health Plan

Clinician: Group/Practice

Population: State

### **Care Setting S.27.**

Ambulatory Care: Clinician Office

Behavioral Health/Psychiatric: Outpatient

### **Composite Performance Measure S.28.**

Not applicable

### **Version Number and Effective Date**

Version 4.0

January 1, 2014 – December 31, 2014

### **Measure Steward**

Centers for Medicare & Medicaid Services (CMS)

Point of Contact: CMS Measures Management System, [MMSSupport@Battelle.org](mailto:MMSSupport@Battelle.org)

Measure Developer: Health Services Advisory Group, Inc., 3000 Bayport Dr., Suite 300, Tampa, Florida, 33607

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This performance measure does not establish a standard of medical care and has not been tested for all potential applications.