

## 3.Track and Report



Tracking and reporting antibiotic prescribing can guide changes in practice and be used to assess progress in improving antibiotic prescribing. Primary care providers can track and report antibiotic prescribing practices by doing the following:

- Complete the enclosed survey.**
  - Self-assess prescribing behavior by completing this survey:  
<http://tinyurl.com/pdsbsurvey>
- Participate in continuing medical education and quality improvement activities to track and improve prescribing practices.**
  - Attend the annual Illinois Summit on Antimicrobial Stewardship
- Implement at least one antibiotic prescribing tracking and reporting system.**
  - Review the Outpatient Antibiotic Stewardship Clinical Quality Measure Guidebook  
<https://tinyurl.com/otptmeasureguide>

# Track and Report Antibiotic Prescribing

Below are two suggestions on how you can track antibiotic use in your facility.

## 1. Monitor performance on HEDIS measures.

The Healthcare Effectiveness Data and Information Set (HEDIS) is a performance measurement tool used by most health plans in the United States. HEDIS includes the following clinical quality measures related to antibiotic use that are also part of the Centers for Medicare and Medicaid Services (CMS) Meaningful Use Stage 2 Electronic Health Record Incentive Program:

- *Appropriate testing for children with pharyngitis (NQF 0002, CMS146v3, PQRS 66)*  
Percent of children ages 2 to 18 years who were diagnosed with pharyngitis, prescribed antibiotics and received group A streptococcus (strep) test for the episode. Find more info here: <http://tinyurl.com/hedisphar>
- *Appropriate treatment for children with upper respiratory infection, URI (NQF 0069, CMS154v3, PQRS 65)*  
Percent of children ages 3 months to 18 years who were diagnosed with URI and were not dispensed an antibiotic prescription on or within three days after the episode date. Find more info here: <http://tinyurl.com/hedisuri>
- *Avoidance of antibiotic treatment in adults with acute bronchitis (NQF 0058, PQRS 116)*  
Percent of adults ages 18-64 years diagnosed with acute bronchitis who were not dispensed an antibiotic prescription. Find more info here: <http://tinyurl.com/hedisbronch>

## 2. Use template to collect summary data.

Link to template: <http://tinyurl.com/pdsbtemplate>

Facilities are encouraged to monitor their antibiotic prescribing as part of quality improvement efforts. To facilitate this activity, a simplified data reporting template was created. The template asks for facility-level summary information on antibiotic prescribing for:

- a. Acute respiratory tract infections (ARI) of multiple sites and sites not otherwise specified (ICD-9-CM 465.8 and 465.9; ICD-10-CM J06.9)
- b. Acute bronchitis and bronchitis not otherwise specified as acute or bronchitis (ICD-9-CM 466.x and 490.x; ICD-10-CM J20.9 and J40)

## 3. Give providers and staff feedback about the data

## **CHAPTER 3: SUPPLEMENTAL MATERIAL**

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These materials were compiled by CDPH to supplement the Track and Report Section of the IDPH Antibiotic Stewardship Toolkit.

### **Included:**

**1. Article: HEDIS Is the Hassle That Became a Habit**

Testimonials on Healthcare Effectiveness Data and Information Set (HEDIS) as a quality improvement tool; collecting information on the performance of facilities' physicians and bringing about value-based care.

**2. Outpatient Antibiotic Stewardship: Clinical Quality Measures Specification Guidebook**

Information related to quality measures that can be used to track and report antibiotic prescribing within facilities. ICD-10 codes included.



# HEDIS Is the Hassle That Became a Habit

After 25 years, the Healthcare Effectiveness Data and Information Set (HEDIS) is still criticized for focusing on process and taking up doctors' time. But it has been incorporated into physicians' workflow and may yet be instrumental in bringing about value-based care.

**By Joseph Burns**  
*Contributing Editor*

In 1991, the average premium for a family with employer-sponsored health care was less than \$1,300, and two thirds of all workers were in traditional fee-for-service insurance plans. One year later, a relatively unknown governor of Arkansas was elected president, and two years after that he introduced his ill-fated health care reform plan.

At the time, managed care plans were going like gangbusters—their 5% share of all workers in 1984 had risen to 26% in 1989 and 50% in 1993. Concerned that capitated payment might lead to poor care for American workers and their families, employers and consultants called for a system to evaluate the quality of care health plans delivered. The result was the HMO Employer Data and Information Set, since rechristened the Healthcare Effectiveness Data and Information Set,



**"We have a lot of work to do to clean up the way that measurement intersects with practitioners at the delivery system level,"** says NCQA President Peggy O'Kane.



a health plan performance measurement tool. American health care has never met an acronym it didn't like, so that long name gets shortened to HEDIS, which is pronounced HEE-dis. To some ears that sounds more

like an infectious disease than a quality improvement tool.

Two and half decades later, HEDIS plays as large a role as it ever has in the evaluation of health plans. More than 90% of managed care plans use HEDIS to collect information on the performance of their physicians in 81 areas of care delivery and service. In 2016, NCQA collected HEDIS data on health plans covering 81% of all insured lives.

Because of HEDIS, health plans collect data on everything from how many times a physician has eligible patients screened for colorectal cancer to what percentage of patients have their hypertension managed to how well patients adhere to immunization schedules.

Assessing care delivery in these 81 areas is important. But what do these assessments tell us? Are patients more or less likely to die as a result of being enrolled in one of the nation's best health plans? When doctors can check all the appropriate boxes on the HEDIS survey, are their patients healthier than those of a doctor who has no idea if HEDIS data are being collected on his or her patients?

And now there is another important question to ask. Because of MACRA, CMS is introducing new quality measurement requirements this year. Are doctors, already drowning in paperwork, being asked to fill out too many forms when they could be using that time caring for and listening to patients? The fact is that much of the data collection and reporting goes on behind the scenes. Many physicians aren't even aware that somewhere in their office, someone or

some system is busy scooping up data and plugging in 81 HEDIS measures. But those 81 represent less than 10% of the 900 or so quality measures in use today. It may happen in the background, but all this effort to measure quality is getting burdensome and adds to the cost of American health care.

Even though some physicians consider HEDIS data collection to be a burden, many others have developed sophisticated data systems to collect the numbers they need for quality reporting in the background. What's more, physicians who embrace HEDIS have come to view it for what it has become, a way to measure their ability to improve patient care and a key to collecting financial rewards for meeting health plans' quality goals.

### 'HEDIS schmedis'

While some physicians today see value in their HEDIS scores, others still echo the complaints heard about HEDIS from its earliest days, when critics noted that most of the measures were limited to the processes of care. Payers—chiefly employers—had no way to know if people were actually healthier than before they enrolled in an HMO—and part of the promise of the HMO was that preventive care would keep people healthier and their health care less expensive. That inability to evaluate patient outcomes is a flaw in HEDIS that remains today. But instead of addressing that flaw, quality measurement organizations have added many more quality measurement data collection requirements and are planning still more. So while HEDIS may be the most important and longest-tenured quality measurement system, many physicians and other providers tend to view it as, at best, a bother.

Here's a telling comment from a physician interviewed for *MANAGED CARE* in 2012, the year NCQA added the HPV vaccine as a HEDIS measure. Chuck McKinzie, MD, an ob-gyn in rural Minnesota, said HEDIS was not widely known among physicians in remote parts of the state. "Making it a HEDIS measure will help," he said of the HPV vaccine. "But out here HEDIS is hardly on anyone's radar. The doctors in these small rural towns think, 'HEDIS schmedis!'"

While McKinzie represents a sample of one, his comment is telling, says NCQA President Peggy O'Kane: "I don't blame doctors for thinking that way. To them, quality measures probably seem like an unnecessary nuisance defined by someone somewhere on behalf of employers or CMS or somebody else." Meeting such standards may seem removed from what physicians were trained to do.

"It's understandable that doctors are feeling frustrated," O'Kane says. They are asked to spend a good

part of every day collecting and reporting data on their own performance, pay for sophisticated systems to collect and report the data, or hire someone to do it for them. It doesn't end with HEDIS. Now there are new requirements from MACRA that will affect any physician with Medicare patients as well as the data-collection rules that most health plans impose in addition to HEDIS, which physicians can't blow off because they are often used to determine sizable bonus payments.

Certainly some of the data required to comply with MACRA will overlap with what's in HEDIS, and some



**"I am sympathetic** to doctors' complaints because each health plan seems to be doing something different from the standpoint of collecting data on quality," says Humana's chief medical officer, Roy Beveridge, MD.

health plans are just beginning to align the goals of disparate data-collection programs.

"That's a problem that we're collectively responsible for," O'Kane adds. "We have a lot of work to do to clean up the way that measurement intersects with practitioners at the delivery system level." Even something as straightforward as a blood-pressure check can get needlessly complicated because of the proliferation of quality measurements and the differences among them.

Humana's chief medical officer, Roy Beveridge, MD, agrees that quality measurement takes up an extraordinary amount of physicians' time. "Having practiced for 20 years, I am sympathetic to doctors' complaints because each health plan seems to be doing something different from the standpoint of collecting data on quality," he says. "We're taking time from providers that they should be spending with their patients."

### Measurement overload

Early last year, Humana, other insurers, AHIP (the health insurance trade association), and 18 specialty societies began grappling with how to reduce the overload. AHIP and CMS released seven sets of clinical quality measures that support what CMS calls "multi-payer alignment." The core measure sets are designed to align quality measures for physicians and group practices serving patients in ACOs and patient-centered medical homes. The measures apply to physicians in primary care, cardiology, gastroenterology, oncology, ob-gyn, and orthopedics, among other specialties.

Still, HEDIS isn't going away. "HEDIS scores work

well, particularly for primary care,” says Beveridge. “They’re universally accepted in the United States.” Physicians may not like quality measures in general, says Beveridge, but by now most have gotten used to HEDIS and are comfortable with meeting its requirements. But reaching that comfort level has been expensive. Doctors and medical groups have invested considerable time and money to develop systems that collect and report the required data. Some use their electronic health record (EHR) systems to collect the data, others hire assistants to comb through claims, and many use a combination of the EHR and human handwork.

In October, the Government Accountability Office (GAO) reported that the wide variety of quality measurement systems in use today and the lack of alignment among them can have adverse effects on physicians and other providers and on efforts to improve quality of care. “Misalignment occurs when health care payers require providers to report on measures that focus on different quality issues or define the measures using different specifications,” said the report. Bruce Muma, MD, the chief medical officer of Henry Ford Health System ACO in Detroit, says that different organizations use the 900 quality measures differently.

“Every insurer has its own subset of those 900 measures,” he says. “Then, it builds its own pay-for-



**Health plans** should eliminate all but about 30 to 50 of the best quality measures, suggests Bruce Muma, MD, the chief medical officer of Henry Ford Health System ACO in Detroit.

performance contracts and value-based payments around those measures. Then it imposes those measures on the doctors in multiple ways by sending us reports, requiring us to submit data, sending people out to our practices to extract data from our charts, and forcing us to have educational programs about their particular metrics that they think are important.”

Health plans should eliminate all but about 30 to 50 of the best quality measures, he suggests. “If all of the payers agreed on 30 metrics that would define value and quality and all doctors were measured on those 30 metrics, we would not have the problems we have today with such an abundance of measures,” Muma says. “Of course, all the EMRs would need to be programmed to collect and report data on those 30 measures, and then automation would handle everything behind the scenes.”

Oak Street Health is a group practice that uses

several electronic tools to collect HEDIS data, says Griffin Myers, MD, co-founder and chief medical officer. Its 75 physicians serve 25,000 low-income Medicaid and Medicare Advantage patients in some of Chicago’s underserved neighborhoods. “Collecting HEDIS data is not all done at the point of care,” says Myers. The data also come from claims, reviews of lab reports, and a variety of other sources.

The data systems at Oak Street Health are sophisticated enough so that Myers and his staff often recognize problems with their HEDIS data before their health plans do, he says. The group contracts with Blue Cross Blue Shield of Illinois, Cigna, Community Care Alliance of Illinois, HealthSpring, Humana, and WellCare, among other plans. “The reason we know

## **B**ecause of HEDIS, plans collect data on everything from how many times a patient is screened for colon cancer to which patients have their hypertension managed.

about gaps in HEDIS before they do is that we keep all those data in our enterprise data warehouse so that we can submit them directly to the plans,” he says. “That way, they don’t have to audit our charts as they did in the past.”

Myers is not among those who view HEDIS as so heinous. Quality metrics, including HEDIS, are a way to measure the group’s progress toward improving the health of all patients, he says. While he concedes that HEDIS does not capture outcomes, adhering to processes can be an adequate proxy.

“My personal commentary on quality measurement systems, including HEDIS, is that they do not reflect whether we deliver good care or not,” says Myers. Instead, HEDIS reflects whether a physician or group practice is meeting certain minimum standards of care. “Doing these things on the HEDIS scorecard is better than not doing them, and so in that way HEDIS demonstrates our commitment to value-based care and to quality reporting,” he explains. “And to do all these things well, including reporting our HEDIS scores, we need to have a sound infrastructure, which we have.”

### **Subset of many different things**

“In a fee-for-service environment, your price is whatever is listed on the fee schedule,” Myers says. In a value-based model, price is based on how sick somebody is today and how well I can make him or her tomorrow, he adds. “So we’ve invested in the systems needed to demonstrate clearly what our HEDIS results are, and

HEDIS is a subset of the many different things that we report on because there are many different things that we think are important to care.”

Collecting the number of flu shots dispensed is not a HEDIS metric, Myers says. But Oak Street tracks and reports those data because that is meaningful in terms of the health of the group’s patients. The data



**When physicians begin** collecting data to comply with MACRA, 60% or more of the data they collect will be based on HEDIS scores, says Anas Daghestani, MD, CEO of the Austin Regional Clinic.

collection system even collects data when patients get a flu shot at another facility, such as a Walgreens pharmacy, when a patient is on vacation. “Otherwise, we would never know that and so that would be a gap that we would need to address,” he says.

The data warehouse contains all the patient data that Oak Street Health collects and data on any in-network care. “Because we’re value-based, we’re paying all those claims for all of the care that patients get, whether it’s in our building or not. So we need that data on every patient encounter,” he says.

Data-collection systems like the one Oak Street Health uses are necessary because most physicians are to this day unaware that HEDIS scores need to be collected on every patient encounter, says Anas Daghestani, MD, CEO of the Austin Regional Clinic, one of the largest group practices in Texas.

“As a physician seeing patients, you don’t think in HEDIS terms,” he says. “You are just doing whatever you think is the right thing and hoping that will translate into a better HEDIS score.”

Like Oak Street Health, Austin Regional has a data warehouse system that collects HEDIS data from the group’s electronic health record system and other sources. Daghestani notes that HEDIS is the source of many—if not most—of the quality measurement systems in use today. The 33 metrics CMS uses in its ACO program are based on HEDIS. Even when physicians begin collecting data to comply with MACRA, 60% or more of the data they collect will be based on HEDIS scores, he says.

To ensure that it collects all the HEDIS numbers needed from every patient encounter, Austin Regional has a group of programmers who build data collection programs into the group’s electronic record system. “That way, the system can alert them to any gaps in care and they can address that gap right then and there,” Daghestani says. All of this HEDIS-related work

doesn’t come cheaply, however. Austin Regional spent about \$1 million to build the necessary infrastructure, and the annual operating budget is about \$2 million.

“We’re also looking at what data we can get the system to collect so that we can avoid pushing all of that data collection work onto our physicians,” Daghestani says. “If it’s something that can be done behind the scenes, we’ll do that. If it’s something that our nursing staff can do, we’ll do that.”

Two months ago, Humana released the results of a study that compared 1.2 million members under value-based Medicare Advantage (MA) contracts to 170,000 members under standard MA contracts. The HEDIS scores for the providers associated with the value-based contracts were 19% higher than those associated with the standard contracts. Members served by value-based MA providers had 6% fewer ER visits than members in standard MA arrangements and also had higher breast cancer screening rates (6% higher), colon cancer screening rates (8% higher), and management of osteoporosis (13% higher).

Cost is not part of HEDIS, but, of course, it is an issue that insurers are concerned about. Humana reported that costs for the valued-based MA members were 20% lower than for the standard-issue MA members.

“If you want to drive cost out of the system, you start by making sure that all of your patients get colon cancer screening at the right time, because screening for colon cancer is a lot cheaper than treating someone who develops metastatic colon cancer,” Beveridge says. “Same thing with mammograms, and screenings for prostate cancer and flu shots.”

He waves off the old objection that prevention doesn’t pay because some other insurers may reap the benefit of people staying healthy long after they leave the health plan that paid for the preventive efforts. Humana members stay with the company an average of seven years, according to Beveridge, which may not be long enough to get all of the return on the investment in prevention but it’s enough to get some. Besides, sometimes the return can show up quickly. Flu shots for a plan’s members are a good deal compared with a hospital stay for a complicated case of flu, which could cost up to \$80,000, Beveridge explains. And many patients with diabetes will avoid hospitalizations and emergency room visits if their HbA1c levels are kept under control. **MC**





**Outpatient  
Antibiotic  
Stewardship**

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**OUTPATIENT ANTIBIOTIC  
STEWARDSHIP  
CLINICAL QUALITY  
MEASURE SPECIFICATION  
GUIDEBOOK**





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# INTRODUCTION

Outpatient antibiotic stewardship is the coordination of efforts to promote appropriate prescribing of antibiotics for non-hospitalized patients in clinics, offices and emergency rooms. The goal is to promote adherence to clinical practice guidelines, thus providing the best standard of care and minimizing the spread of antibiotic-resistant bacteria.

The [Core Elements of Outpatient Antibiotic Stewardship](#) provide a framework for outpatient clinicians and facilities that routinely provide antibiotic treatment. One of the Core Elements of Outpatient Antibiotic Stewardship is tracking and reporting.

Tracking and reporting antibiotic prescribing, also referred to as audit and feedback, can guide changes in practice and assess progress toward improved antibiotic prescribing. When setting up tracking and reporting systems, decisions are needed about:

- The level of detail to be collected (for example, clinician- or facility-level data)
- The outcomes to be tracked and reported
- Tracking and reporting data collection

The *Outpatient Antibiotic Stewardship Clinical Quality Measures Guidebook* offers outpatient antibiotic stewardship initiative participants information related to quality measures that can be used to track and report antibiotic prescribing within their facilities. It's designed to help organizations – including individuals or groups of eligible practitioners (EPs) – that are tracking and reporting quality measures specific to the Quality Payment Program (QPP).

[Quality measures](#) created by the Centers for Medicare & Medicaid Services (CMS) can help you:

- Measure or quantify healthcare processes
- Assess outcomes
- Evaluate patient perceptions
- Review organizational structures and systems associated with the ability to provide high-quality healthcare and relate to one or more quality goals for healthcare

Measure specifications and flowcharts in this guidebook can be used to support new measure builds or to optimize existing measures within an electronic medical record (EHR). These measures align directly with the CMS QPP and can be used to meet the quality requirements related to antibiotics.



## MEASURE SPECIFICATIONS

**Measure title:** Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis

**Measure description:** The percentage of adults 18 to 64 years of age with a diagnosis of acute bronchitis who were not dispersed an antibiotic prescription

**Quality ID:** 116

**NQF number:** 0058

**National Quality Strategy domain:** Efficiency and Cost Reduction

**Denominator:** All patients 18 through 64 years of age who've had an outpatient or emergency department (ED) visit and a diagnosis of acute bronchitis during the measurement period

- **Denominator note:** To determine eligibility, check the antibiotic drugs table below in the 30 days prior to the visit associated with the acute bronchitis diagnosis. If there are no prescriptions for the listed antibiotics during this time period, the patient is eligible for denominator inclusion.

- **Denominator criteria (eligible cases):** Patients 18 through 64 years of age on date of encounter

**AND**

**Diagnosis for acute bronchitis (ICD-10-CM):** J20.3, J20.4, J20.5, J20.6, J20.7, J20.8, J20.9

**AND**

**Patient encounter during the reporting period (CPT® or HCPCS):** 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99217, 99218, 99219, 99220, 99281, 99282, 99283, 99284, 99285, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, G0402, G0438, G0439

## ANTIBIOTIC DRUGS:

- amikacin
- kanamycin
- tobramycin
- gentamicin
- streptomycin
- amoxicillin
- ampicillin
- piperacillin
- erythromycin
- amoxicillin-clavulanate
- ampicillin-sulbactam
- ticarcillin-clavulanate
- piperacillin-tazobactam
- cefadroxil
- cefazolin
- cephalixin
- cefepime
- erythromycin-ethylsuccinate
- telithromycin
- clindamycin
- lincosycin
- azithromycin
- clarithromycin
- erythromycin-lactobionate
- erythromycin stearate
- aztreonam
- daptomycin
- metronidazole
- chloramphenicol
- erythromycin-sulfisoxazole
- vancomycin
- dalfo pristin-quinupristin
- linezolid
- penicillin G benzathine-procaine
- penicillin G potassium
- penicillin G procaine
- penicillin G sodium
- penicillin G benzathine
- penicillin V potassium
- dicloxacillin
- nafcillin
- oxacillin
- ciprofloxacin
- levofloxacin
- norfloxacin
- gemifloxacin
- moxifloxacin
- ofloxacin
- rifampin
- cefaclor
- cefoxitin
- cefuroxime
- cefotetan
- cefprozil
- sulfadiazine
- sulfamethoxazole-trimethoprim
- doxycycline
- minocycline
- tetracycline
- cefdinir
- cefotaxime
- ceftiofen
- ceftazidime
- ceftiofen
- cefepime
- cefixime
- cefazidime
- fosfomycin
- nitrofurantoin macrocrystals - monohydrate
- nitrofurantoin
- nitrofurantoin-macrocrystals
- trimethoprim

## ADULT ACUTE BRONCHITIS CONTINUED

**Numerator:** Patients who were neither prescribed nor dispensed antibiotics on or within three days of the initial date of service

- Numerator instructions:** For performance, the measure will be calculated as the number of patient encounters where antibiotics were neither prescribed nor dispensed on or within three days of the episode for acute bronchitis over the total number of encounters in the denominator. For this measure, patients are 18 through 64 years of age with an outpatient or emergency department visit for acute bronchitis. A higher score indicates appropriate treatment for patients with acute bronchitis, the proportion for whom antibiotics were not prescribed or dispensed on or within three days of the encounter

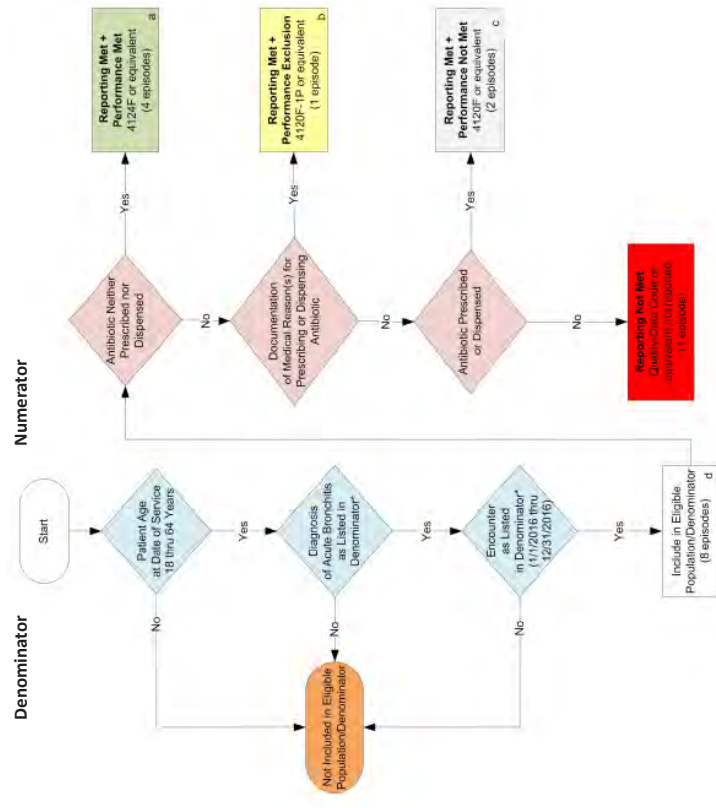
- Numerator options:**
  - Performance met:** Antibiotic neither prescribed nor dispensed (**4124F**)
  - OR**
  - Medical performance exclusion:** Documentation of medical reason(s) for prescribing or dispensing antibiotic; for example:
    - intestinal infection, pertussis, bacterial infection, Lyme disease, otitis media, acute sinusitis, acute pharyngitis, acute tonsillitis, chronic sinusitis; infection of the pharynx/larynx/tonsils;/adenoids, prostatitis, cellulitis/mastoiditis/bone infections, acute lymphadenitis, impetigo, skin staph infections, pneumonia, gonococcal infections/venereal disease (syphilis, chlamydia, inflammatory diseases [female reproductive organs]), infections of the kidney, cystitis/UTI, acne, HIV disease/asymptomatic HIV, cystic fibrosis, disorders of the immune system, malignancy neoplasms, chronic bronchitis, emphysema, bronchiectasis, extrinsic allergic alveolitis, chronic airway obstruction, chronic obstructive asthma, pneumoconiosis and other lung disease due to external agents, other diseases of the respiratory system and tuberculosis) (**4120F with 1P**)

**OR**

- Performance not met:** Antibiotic prescribed or dispensed (**4120F**)

## ADULT ACUTE BRONCHITIS CONTINUED

### MEASURE FLOWCHART: ESTABLISHING A NUMERATOR AND DENOMINATOR ADULT ACUTE BRONCHITIS



#### SAMPLE CALCULATIONS:

**Reporting Rate=**  

$$\frac{\text{Performance Met (a=4 episodes)} + \text{Performance Exclusion (b=1 episode)} + \text{Performance Not Met (c=2 episodes)}}{\text{Eligible Population / Denominator (d=8 episodes)}} = 87.50\%$$

**Performance Rate=**  

$$\frac{\text{Performance Met (a=4 episodes)}}{\text{Reporting Numerator (7 episodes)} - \text{Performance Exclusion (b=1 episode)}} = 66.66\%$$



## INDIVIDUAL MEASURE FLOW FOR ADULT ACUTE BRONCHITIS

1. **Start with denominator**
2. **Check patient age:**
  - a. If patient is NOT 18 through 64 years of age on date of service during the measurement period, do NOT include in eligible patient population and stop processing
  - b. If patient IS 18 through 64 years of age on date of service during the measurement period, proceed to check patient diagnosis
3. **Check patient diagnosis:**
  - a. If diagnosis of acute bronchitis listed in the denominator is NO, do not include in eligible patient population and stop processing
  - b. If diagnosis of acute bronchitis listed in the denominator is YES, proceed to check encounter performed
4. **Check encounter performed:**
  - a. If encounter listed in the denominator is NO, do not include in eligible patient population and stop processing
  - b. If encounter listed in the denominator is YES, include in the eligible population
5. **Denominator population:**
  - a. Denominator population is all eligible patients in the denominator
6. **Start numerator**
7. **Check antibiotic neither prescribed nor dispensed:**
  - a. If antibiotic neither prescribed nor dispensed is YES, include in reporting met and performance met
  - b. If antibiotic neither prescribed nor dispensed is NO, proceed to documentation of medical reason(s) for prescribing or dispensing antibiotic
8. **Check documentation of medical reason(s) for prescribing or dispensing antibiotic:**
  - a. If documentation of medical reason(s) for prescribing or dispensing antibiotic is YES, include in reporting met and performance exclusion
  - b. If documentation of medical reason(s) for prescribing or dispensing antibiotic is NO, proceed to antibiotic prescribed or dispensed
9. **Check antibiotic prescribed or dispensed:**
  - a. If antibiotic prescribed or dispensed is YES, include in the reporting met and performance not met
  - b. If antibiotic prescribed or dispensed is NO, proceed to reporting not met
10. **Check reporting not met:**
  - a. If reporting not met is NO, quality data code or equivalent is not reported



## ADULT SINUSITIS (OVERUSE)

## MEASURE SPECIFICATIONS

**Measure title:** Adult Sinusitis: Antibiotic Prescribed for Acute Sinusitis (Overuse)

**Measure description:** Percentage of patients, 18 years of age and older, with a diagnosis of acute sinusitis who were prescribed an antibiotic within 10 days after onset of symptoms

**Quality ID:** 331

**NQF number:** N/A

**National Quality Strategy domain:** Efficiency and Cost Reduction

**Denominator:** All patients 18 years of age and older with a diagnosis of acute sinusitis

- **Definition:**
  - **Acute sinusitis/rhinosinusitis-** Up to four weeks of purulent nasal drainage - anterior, posterior or both - accompanied by nasal obstruction, facial pain/pressure/fullness or both:
    - Purulent nasal discharge is cloudy or colored, in contrast to the clear secretions that typically accompany viral upper respiratory infection, and may be reported by the patient or observed on physical examination
    - Nasal obstruction may be reported by the patient as nasal obstruction, congestion, blockage or stiffness, or may be diagnosed by physical examination
    - Facial pain/pressure/fullness may involve the anterior face, periorbital region or manifest with headache that is localized or diffuse
- **Denominator criteria (eligible cases): Patients ≥ 18 years of age on date of encounter**

**AND**

**Diagnosis for acute sinusitis (ICD-10-CM):** J01.00, J01.01, J01.10, J01.11, J01.20, J01.21, J01.30, J01.31, J01.40, J01.41, J01.80, J01.90

**AND**

**Patient encounter during performance period (CPT®):** 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99281, 99282, 99283, 99284, 99285, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350

**WITHOUT**

**Telehealth Modifier:** GO, GT

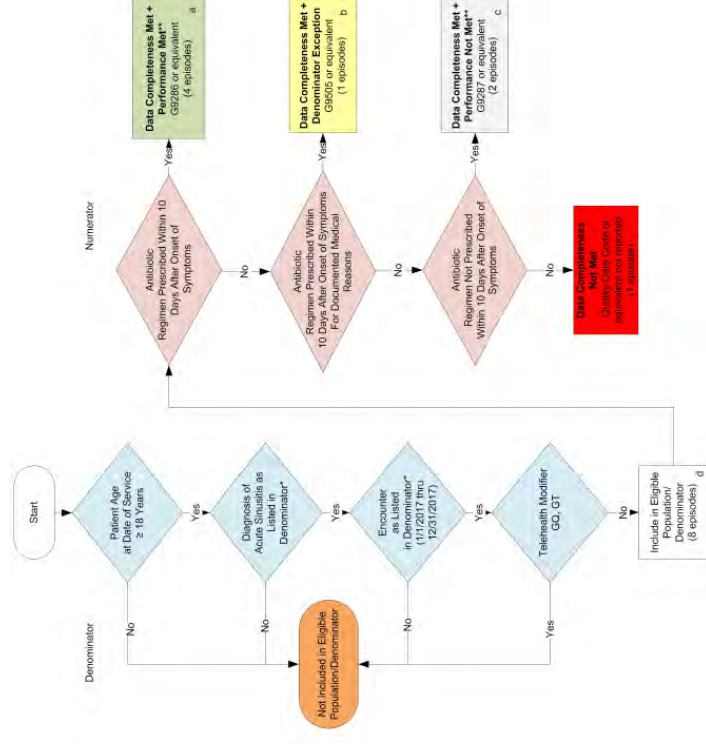


**Numerator:** Patients prescribed any antibiotic within 10 days after onset of symptoms

- Numerator instructions: INVERSE MEASURE** - A lower calculated performance rate for this measure indicates better clinical care or control. The performance not met numerator option for this measure represents better clinical quality or control. Reporting that numerator option will produce a performance rate that trends closer to zero percent as quality increases. Inverse measures of 100 percent mean all denominator-eligible patients did not receive the appropriate care, or were not in proper control.

- Numerator options:**
  - Performance met:** Antibiotic regimen prescribed within 10 days after onset of symptoms (G9286)
  - OR**
  - Denominator exception:** Antibiotic regimen prescribed within 10 days after onset of symptoms for documented medical reason (G9505)
  - OR**
  - Performance not met:** Antibiotic regimen not prescribed within 10 days after onset of symptoms (G9287)

## MEASURE FLOWCHART: ESTABLISHING A NUMERATOR AND DENOMINATOR ADULT SINUSITIS (OVERUSE)



### SAMPLE CALCULATIONS:

**Data Completeness**  
 Performance Met (a=4 episodes) + Denominator Exception (b=1 episode) + Performance Not Met (c=2 episodes) = 7 episodes = **87.50%**  
 Eligible Population / Denominator (d=8 episodes) = 8 episodes

**Performance Rate\*\*=**  
 Performance Met (a=4 episodes) = **66.66%**  
 Data Completeness Numerator (7 episodes) - Denominator Exception (b=1 episode) = 6 episodes



**INDIVIDUAL MEASURE FLOW FOR ADULT SINUSITIS (OVERUSE)**

1. **Start with denominator**
2. **Check patient age:**
  - a. If patient is NOT 18 years of age or older on date of service during the measurement period, do not include in eligible patient population, and stop processing
  - b. If patient IS 18 years of age or older on date of service during the measurement period, proceed to check patient diagnosis
3. **Check patient diagnosis:**
  - a. If diagnosis of acute sinusitis listed in the denominator is NO, do not include in eligible patient population, and stop processing
  - b. If diagnosis of acute sinusitis in the denominator is YES, proceed to check encounter performed
4. **Check encounter performed:**
  - a. If encounter listed in the denominator is NO, do not include in eligible patient population, and stop processing
  - b. If encounter listed in the denominator is YES, proceed to check telehealth modifier
5. **Check telehealth modifier:**
  - a. If telehealth modifier is YES, do not include in eligible patient population, and stop processing
  - b. If telehealth modifier is NO, include in the eligible population
6. **Denominator population**
  - a. Denominator population is all eligible patients in the denominator
7. **Start numerator**
8. **Check antibiotic regimen prescribed within 10 Days after onset of symptoms:**
  - a. If antibiotic regime prescribed within 10 Days after onset of symptoms is YES, include in data completeness met and performance met
  - b. If antibiotic regimen prescribed within 10 Days after onset of symptoms is NO, proceed to antibiotic regimen within 10 days after onset of symptoms for documented medical reason

9. **Check antibiotic regimen within 10 days after onset of symptoms for documented medical reason:**
  - a. If antibiotic regimen within 10 Days after onset of symptoms for documented medical reason is YES, include in the data completeness met and denominator exception
  - b. If antibiotic regimen within 10 Days after onset of symptoms for documented medical reason is NO, proceed to antibiotic regimen not prescribed within 10 days after onset of symptoms
10. **Check antibiotic regimen not prescribed within 10 days after onset of symptoms:**
  - a. If antibiotic regimen not prescribed within 10 Days after onset of symptoms is YES, include in the data completeness met and performance not met
  - b. If antibiotic regimen not prescribed within 10 Days after onset of symptoms is NO, proceed to data completeness not met
11. **Check data completeness not met:**
  - a. If data completeness not met is NO, and quality data code or equivalent is NOT reported
    - i. Note: One episode has been subtracted from the data completeness numerator in the sample calculation





## ADULT SINUSITIS (APPROPRIATE USE)

### MEASURE SPECIFICATION

**Measure title:** Adult Sinusitis: Appropriate Choice of Antibiotic: Amoxicillin with or Without Clavulanate Prescribed for Patients with Acute Bacterial Sinusitis (Appropriate Use)

**Measure description:** Percentage of patients 18 years of age and older, with a diagnosis of acute bacterial sinusitis that were prescribed amoxicillin, with or without clavulanate, as a first-line antibiotic at the time of diagnosis

**Quality ID:** 332

**NQF number:** N/A

**National Quality Strategy domain:** Efficiency and Cost Reduction

**Denominator:** All patients 18 years of age and older with a diagnosis of acute bacterial sinusitis who are prescribed an antibiotic

- **Definition:**
  - **Acute bacterial rhinosinusitis (ABRS):** Acute rhinosinusitis caused by, or is presumed to be caused by, a bacterial infection. A clinician should diagnose ABRS when:
    - Symptoms or signs of acute rhinosinusitis are present 10 days or more beyond the onset of upper respiratory symptoms
  - OR**
  - Symptoms or signs of acute rhinosinusitis worsen within 10 days after an initial improvement (double worsening)

- **Denominator criteria (eligible cases):** Patients  $\geq$  18 years of age on date of encounter

**AND**

**Diagnosis for acute sinusitis (ICD-10-CM):** J01.00, J01.01, J01.10, J01.11, J01.20, J01.21, J01.30, J01.31, J01.40, J01.41, J01.80, J01.90

**AND**

**Patient encounter during reporting period (CPT®):** 99201, 99202, 99203, 99204, 99205, 99212, 99214, 99215, 99281, 99282, 99283, 99284, 99285, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350

**AND**

**Sinusitis caused by, or presumed to be caused by, bacterial infection:** G9364

**AND**

**Antibiotic regimen prescribed:** G9498



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## ADULT SINUSITIS (APPROPRIATE USE) CONTINUED

**Numerator:** Patients who were prescribed amoxicillin, with or without clavulanate, as a first-line antibiotic at the time of diagnosis

- **Numerator options:**

- **Performance met:** Amoxicillin, with or without clavulanate, prescribed as a first-line antibiotic at the time of diagnosis (G9315)

**OR**

- **Other performance exclusion:** Amoxicillin, with or without Clavulanate, was NOT prescribed as a first-line antibiotic at the time of diagnosis for a documented reason; for example:
  - cystic fibrosis, immotile cilia disorders, ciliary dyskinesia, immune deficiency, prior history of sinus surgery within the past 12 months, anatomic abnormalities, such as deviated nasal septum, resistant organisms, allergy to medication, recurrent sinusitis, chronic sinusitis or other reasons (**G9313**)

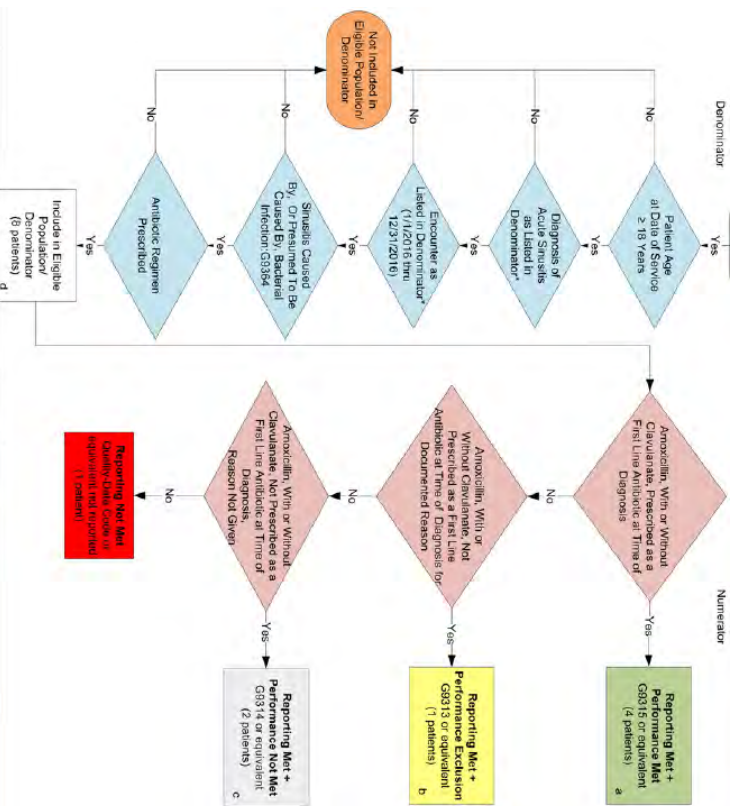
**OR**

- **Performance not met:** Amoxicillin, with or without clavulanate, not prescribed as first-line antibiotic at the time of diagnosis, reason not given (**G9314**)



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MEASURE FLOWCHART: ESTABLISHING A NUMERATOR AND DENOMINATOR ADULT SINUSITIS (APPROPRIATE USE)



**Reporting Rate=**  
 Performance Met (a=4 patients) + Performance Exclusion (b=1 patients) + Performance Not Met (c=2 patients) = 7 patients = 87.50%  
 Eligible Population / Denominator (d=8 patients)

**Performance Rate=**  
 Performance Met (a=4 patients) = 4 patients = 66.67%  
 Reporting Numerator (7 patients) - Performance Exclusion (b=1 patients) = 6 patients

**SAMPLE CALCULATIONS:**



INDIVIDUAL MEASURE FLOW FOR ADULT SINUSITIS (APPROPRIATE USE)

1. Start with denominator
2. Check patient age:
  - a. If patient is NOT 18 years of age or older on date of service during the measurement period, do not include in eligible patient population, and stop processing
  - b. If patient IS 18 years of age or older on date of service during the measurement period, proceed to check patient diagnosis
3. Check patient diagnosis:
  - a. If diagnosis of acute bacterial sinusitis listed in the denominator is NO, do not include in eligible patient population, and stop processing
  - b. If diagnosis of acute bacterial sinusitis listed in the denominator is YES, check encounter performed
4. Check encounter performed:
  - a. If encounter listed in the denominator is NO, do not include in eligible patient population, and stop processing
  - b. If encounter listed in the denominator is YES, proceed to check sinusitis caused by, or presumed to be caused by, bacterial infection: G9364.
5. Check sinusitis caused by, or presumed to be caused by, bacterial infection:
  - a. If sinusitis caused by, or presumed to be caused by, bacterial infection is NO, do not include in eligible patient population, and stop processing
  - b. If sinusitis caused by, or presumed to be caused by, bacterial infection is YES, proceed to antibiotic regimen prescribed:
6. Check antibiotic regimen prescribed:
  - a. If antibiotic regimen prescribed is NO, do not include in eligible patient population, and stop processing
  - b. If antibiotic regimen prescribed is YES, include in the eligible population
7. Denominator population:
  - a. Denominator population is all eligible patients in the denominator
8. Start numerator



9. Check amoxicillin with or without clavulanate, prescribed as a first-line antibiotic at time of diagnosis:

- a. If amoxicillin with or without clavulanate, prescribed as a first-line antibiotic at time of diagnosis is YES, include in reporting met and performance met
- b. If amoxicillin with or without clavulanate, prescribed as a first-line antibiotic at time of diagnosis is NO, proceed to amoxicillin with or without clavulanate, not prescribed as a first-line antibiotic at time of diagnosis for documented reason

10. Check amoxicillin with or without clavulanate, not prescribed as a first-line antibiotic at time of diagnosis for documented reason:

- a. If amoxicillin with or without clavulanate, not prescribed as a first-line antibiotic at time of diagnosis for documented reason is YES, include in reporting met and performance exclusion
- b. If amoxicillin with or without clavulanate, not prescribed as a first-line antibiotic at time of diagnosis for documented reason is NO, proceed to amoxicillin with or without clavulanate, not prescribed as a first-line antibiotic at time of diagnosis, reason not given

11. Check amoxicillin, with or without clavulanate, not prescribed as a first-line antibiotic at time of diagnosis, reason not given:

- a. If amoxicillin with or without clavulanate, not prescribed as a first-line antibiotic at time of diagnosis, reason not given is YES, include in the reporting met and performance not met
- b. If amoxicillin with or without clavulanate, not prescribed as a first-line antibiotic at time of diagnosis, reason not given is NO, proceed to reporting not met

12. Check reporting not met

- a. If reporting not met is NO, quality data code or equivalent is not reported
  - i. Note: One patient has been subtracted from the reporting numerator in the sample calculation



## MEASURE SPECIFICATIONS

**Measure title:** Acute Otitis Externa (AOE): Systemic Antimicrobial Therapy-Avoidance of Inappropriate Use

**Measure description:** Percentage of patients two years of age and older with a diagnosis of AOE who were not prescribed systemic antimicrobial therapy

**Quality ID:** 093

**NOF number:** 0654

**National Quality Strategy domain:** Efficiency and Cost Reduction

**Denominator:** All patients two years of age and older with a diagnosis of AOE

- **Definition:** Patients ≥ two years of age on date of encounter

**AND**

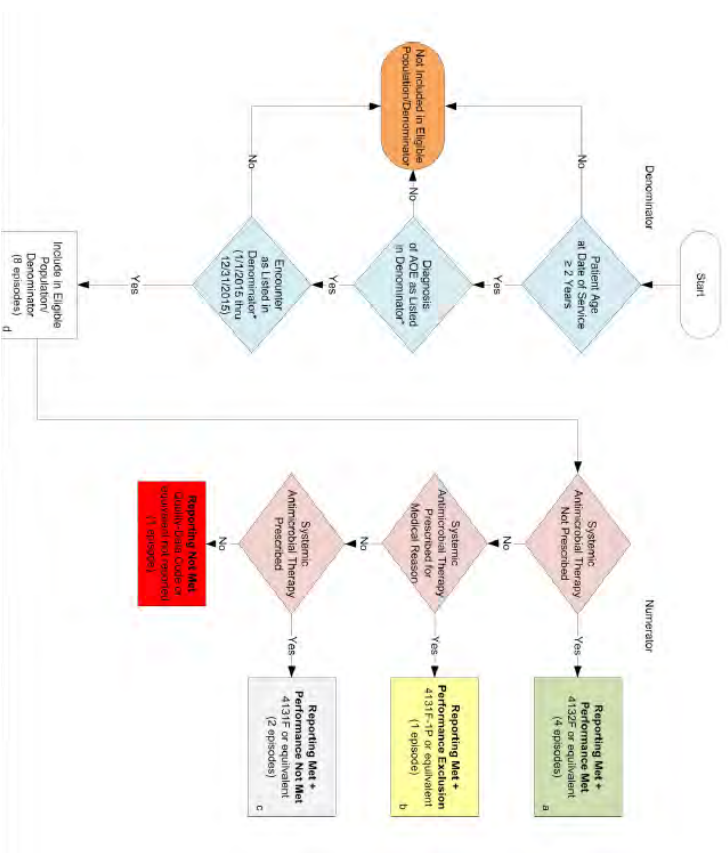
**Diagnosis for AOE (ICD-10-CM):** H60.00, H60.01, H60.02, H60.03, H60.10, H60.11, H60.12, H60.13, H60.312, H60.313, H60.319, H60.321, H60.322, H60.323, H60.329, H60.331, H60.332, H60.333, H60.339, H60.391, H60.392, H60.393, H60.399, H60.501, H60.502, H60.503, H60.509, H60.511, H60.512, H60.513, H60.519, H60.521, H60.522, H60.523, H60.529, H60.531, H60.532, H60.533, H60.539, H60.541, H60.542, H60.543, H60.549, H60.551, H60.552, H60.553, H60.559, H60.591, H60.592, H60.593, H60.599, H61.90, H61.91, H61.92, H61.93, H62.40, H62.41, H62.42, H62.43, H62.8x1, H62.8x2, H62.8x3, H62.8x9

**AND**

**Patient encounter during the reporting period (CPT®):** 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99281, 99282, 99283, 99284, 99285, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350



**MEASURE FLOWCHART: ESTABLISHING A NUMERATOR AND DENOMINATOR ACUTE OTITIS EXTERNA (AOE)**



**SAMPLE CALCULATIONS:**

**Reporting Rate**  
 Performance Met (a=4 episodes) + Performance Exclusion (b=1 episode) + Performance Not Met (c=2 episodes) = 7 episodes = 87.50%  
 Eligible Population / Denominator (d=8 episodes)

**Performance Rate**  
 Reporting Numerator (7 episodes) - Performance Exclusion (b=1 episode) = 6 episodes = 66.67%

**Numerator:** Patients who were not prescribed systemic antimicrobial therapy

- **Numerator Instructions:** For performance, the measure will be calculated as the number of patients for whom systemic antimicrobial therapy was not prescribed over the number of patients in the denominator. Patients in the denominator are two years of age and older with acute otitis externa. A higher score indicates appropriate treatment of patients with AOE where the proportion of systemic antimicrobials were not prescribed

• **Numerator Options:**

- **Performance met:** Systemic antimicrobial therapy NOT prescribed (4132F)
- OR**
- **Systemic antimicrobial therapy prescribed for medical reasons:** Documentation of medical reason(s) for prescribing systemic antimicrobial therapy such as coexisting diabetes and immune deficiency (4131F with 1P)
- OR**
- **Performance not met:** Systemic antimicrobial therapy prescribed (4131F)



## INDIVIDUAL MEASURE FLOW FOR ACUTE OTITIS EXTERNA (AOE)

1. **Start with denominator**
2. **Check patient age:**
  - a. If the patient is NOT two years of age or older on date of service during the measurement period, do not include in eligible patient population, and stop processing
  - b. If the patient IS two years of age or older on date of service during the measurement period, proceed to check patient diagnosis
3. **Check patient diagnosis:**
  - a. If diagnosis of AOE in the denominator is NO, do not include in eligible patient population, and stop processing
  - b. If diagnosis of AOE in the denominator is YES, proceed to check encounter performed
4. **Check encounter performed:**
  - a. If encounter in the denominator is NO, do not include in eligible patient population, and stop processing
  - b. If encounter in the denominator is YES, include in the eligible population
5. **Denominator population**
  - a. Denominator population is all eligible patients in the denominator
6. **Start numerator**
7. **Check systemic antimicrobial therapy not prescribed:**
  - a. If systemic antimicrobial therapy not prescribed is YES, include in reporting met and performance met
  - b. If systemic antimicrobial therapy not prescribed is NO, proceed to systemic antimicrobial therapy prescribed for medical reason
8. **Check systemic antimicrobial therapy prescribed for medical reason:**
  - a. If systemic antimicrobial therapy prescribed for medical reason is YES, include in reporting met and performance exclusion
  - b. If systemic antimicrobial therapy prescribed for medical reason is NO, proceed to systemic antimicrobial therapy prescribed
9. **Check systemic antimicrobial therapy prescribed:**
  - a. If systemic antimicrobial therapy prescribed is YES, include in the reporting met and performance not met
  - b. If systemic antimicrobial therapy prescribed is NO, proceed to reporting not met
10. **Check reporting not met:**
  - a. If reporting not met is NO, quality data code or equivalent is not reported



## MEASURE SPECIFICATIONS

**Measure title:** Acute Otitis Externa (AOE): Topical Therapy

**Measure description:** Percentage of patients two years of age and older with a diagnosis of AOE who were prescribed topical preparations

**Quality ID:** 091

**NQF number:** 0653

**National Quality Strategy domain:** Effective Clinical Care

**Denominator:** All patients two years of age and older with a diagnosis of AOE

- **Denominator criteria (eligible cases):** Patients  $\geq$  two years of age on date of encounter

**AND**

**Diagnosis for AOE (ICD-10-CM):** H60.00, H60.01, H60.02, H60.03, H60.10, H60.11, H60.12, H60.13, H60.311, H60.312, H60.313, H60.319, H60.321, H60.322, H60.323, H60.329, H60.331, H60.332, H60.333, H60.339, H60.391, H60.392, H60.393, H60.399, H60.501, H60.502, H60.503, H60.509, H60.511, H60.512, H60.513, H60.519, H60.521, H60.522, H60.523, H60.529, H60.531, H60.532, H60.533, H60.539, H60.541, H60.542, H60.543, H60.549, H60.551, H60.552, H60.553, H60.559, H60.591, H60.592, H60.593, H60.599, H61.90, H61.91, H61.92, H61.93, H62.40, H62.41, H62.42, H62.43, H62.8x1, H62.8x2, H62.8x3, H62.8x9

**AND**

**Patient encounter during the reporting period (CPT®):** 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99281, 99282, 99283, 99284, 99285, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350



**Numerator:** Patients who were prescribed topical preparations

• **Definition:** Prescribed – May include:

- Prescription given to the patient for topical preparations at one or more visits during the episode of AOE
- OR**
- Patient already receiving topical preparations as documented in the current medication list

• **Numerator options:**

- **Performance met:** Topical preparations, including over-the-counter (OTC), prescribed for acute otitis externa **(4130F)**

**OR**

- **Medical performance exclusion:** Documentation of medical reason(s) for not prescribing topical preparations, including OTC for acute otitis externa, for example, coexisting acute otitis media or tympanic membrane perforation **(4130F with 1P)**

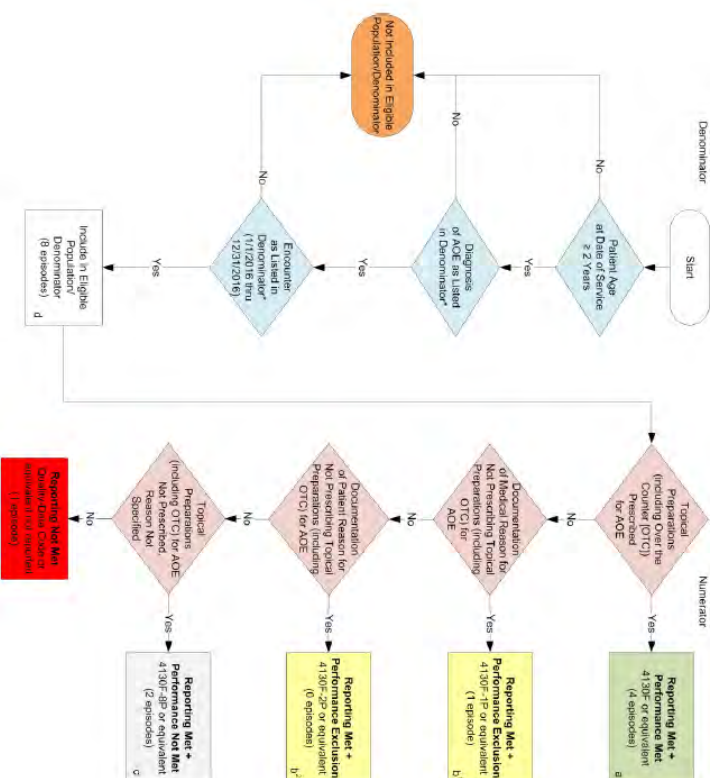
**OR**

- **Patient performance exclusion:** Documentation of patient reason(s) for not prescribing topical preparations, including OTC, for acute otitis externa **(4130F with 2P)**

**OR**

- **Performance not met:** Topical preparations, including OTC, for acute otitis externa not prescribed, reason not otherwise specified **(4130F with 8P)**

**MEASURE FLOWCHART: ESTABLISHING A NUMERATOR AND DENOMINATOR ACUTE OTITIS EXTERNA (AOE) TOPICAL THERAPY**



**SAMPLE CALCULATIONS:**

**Reporting Rate=**  
 Performance Met (a=4 episodes) + Performance Exclusion (b+c=1 episode) + Performance Not Met (e=2 episodes) = 7 episodes = **87.50%**  
 Eligible Population / Denominator (d=8 episodes)

**Performance Rate=**  
 Performance Met (a=4 episodes) + Performance Exclusion (b+c=1 episode) = 5 episodes = **66.67%**  
 Reporting Numerator (7 episodes) – Performance Exclusion (b+c=1 episode) = 6 episodes



### INDIVIDUAL MEASURE FLOW FOR ACUTE OTITIS EXTERNA (AOE) TOPICAL THERAPY

1. **Start with denominator**
2. **Check patient age:**
  - a. If the patient is NOT two years of age or older at date of service during the measurement period, do not include in eligible patient population, and stop processing
  - b. If the patient IS two years of age or older at date of service during the measurement period, proceed to check patient diagnosis
3. **Check patient diagnosis:**
  - a. If diagnosis for AOE listed in the denominator is NO, do not include in eligible patient population, and stop processing
  - b. If diagnosis for AOE listed in the denominator is YES, proceed to check encounter performed
4. **Check encounter performed:**
  - a. If encounter listed in denominator is NO, do not include in eligible patient population, and stop processing
  - b. If encounter in denominator is YES, include in the eligible population
5. **Denominator population:**
  - a. Denominator population is all eligible patients in the denominator
6. **Start numerator**
7. **Check topical preparations including over-the-counter (OTC) prescribed for AOE:**
  - a. If topical preparations including OTC prescribed for AOE is YES, include in reporting met and performance met
  - b. If topical preparations including OTC prescribed for AOE is NO, proceed to documentation of medical reason for not prescribing topical preparations including OTC for AOE
8. **Check documentation of medical reason for not prescribing topical preparations including OTC for AOE:**
  - a. If documentation of medical reason for not prescribing topical preparations for AOE is YES, include in the reporting met and performance exclusion
  - b. If documentation of medical reason for not prescribing topical preparations including OTC for AOE is NO, proceed to documentation of patient reason for not prescribing topical preparations including OTC for AOE



9. **Check documentation of patient reason for not prescribing topical preparations including OTC for AOE:**
  - a. If documentation of patient reason for not prescribing topical preparations including OTC for AOE is YES, include in the reporting met and performance exclusion
  - b. If documentation of patient reason for not prescribing topical preparations including OTC for AOE is NO, proceed to topical preparations for AOE not prescribed, reason not specified
10. **Check topical preparations including OTC for AOE not prescribed, reason not specified:**
  - a. If topical preparations including OTC for AOE not prescribed, reason not specified is YES, include in the reporting met and performance not met
  - b. If topical preparations including OTC for AOE not prescribed, reason not specified is NO, proceed to reporting not met
11. **Check reporting not met:**
  - a. If reporting not met, the quality data code or equivalent was not reported



## QUALITY PAYMENT PROGRAM (QPP) AND ANTIBIOTIC STEWARDSHIP ALIGNMENT

Your outpatient antibiotic stewardship program can help you meet Centers for Medicaid & Medicare Services (CMS) Quality Payment Program (QPP) requirements.

- You can select CMS clinical quality measures related to antibiotic prescribing. These measures meet both the quality performance category requirements of QPP as well as the tracking and reporting core element of the outpatient antibiotic stewardship initiative.
- Implementation of an antibiotic stewardship program qualifies as an improvement activity for QPP.

Quality ID	NQS Domain	Measure Type	High-Priority Measure	Data Submission Method	Specialty
<b>#116:</b> Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis	Efficiency and Cost Reduction	Process	Yes	Registry	Internal Medicine, Emergency Medicine, General Practice/Family
<b>#331:</b> Adult Sinusitis: Antibiotic Prescribed for Acute Sinusitis (Overuse)	Efficiency and Cost Reduction	Process	Yes	Registry	Allergy/Immunology, Internal Medicine, Otolaryngology, General Practice/Family Medicine
<b>#332:</b> Adult Sinusitis: Appropriate choice of Antibiotic: Amoxicillin, with or without Clavulanate Prescribed for Patients with Acute Bacterial Sinusitis (Appropriate Use)	Efficiency and Cost Reduction	Process	Yes	Registry	Allergy/Immunology, Internal Medicine, Otolaryngology, General Practice/Family Medicine
<b>#93:</b> Acute Otitis Externa (AOE): Systemic Antimicrobial Therapy-Avoidance of Inappropriate Use	Efficiency and Cost Reduction	Process	Yes	Claims, Registry	Emergency Medicine, Otolaryngology, General Practice/Family Medicine
<b>#91:</b> Acute Otitis Externa (AOE): Topical Therapy	Effective Clinical Care	Process	Yes	Claims, Registry	Emergency Medicine, Otolaryngology, Pediatrics



## QUALITY PAYMENT PROGRAM (QPP) AND ANTIBIOTIC STEWARDSHIP ALIGNMENT CONTINUED

### FOR MORE INFORMATION ON CMS QUALITY PAYMENT PROGRAM:

Contact the Quality Payment Program Service Center at **1-866-288-8292** or **TTY: 1-877-715-6222** or [QPP@cms.hhs.gov](mailto:QPP@cms.hhs.gov)

Visit the [Quality Payment Program](https://qpp.cms.gov/) website: <https://qpp.cms.gov/>

### RESOURCES:

**Adult Acute Bronchitis (Avoidance):** [https://mdinteractive.com/files/uploaded/file/CMS2017/2017\\_Measure\\_116\\_Registry.pdf](https://mdinteractive.com/files/uploaded/file/CMS2017/2017_Measure_116_Registry.pdf)

**Adult Sinusitis (Overuse):** [https://mdinteractive.com/files/uploaded/file/CMS2017/2017\\_Measure\\_331\\_Registry.pdf](https://mdinteractive.com/files/uploaded/file/CMS2017/2017_Measure_331_Registry.pdf)

**Adult Sinusitis (Appropriate Use):** [https://mdinteractive.com/files/uploaded/file/CMS2017/2017\\_Measure\\_332\\_Registry.pdf](https://mdinteractive.com/files/uploaded/file/CMS2017/2017_Measure_332_Registry.pdf)

**Acute Otitis Externa (AOE):** [http://www.mipsuccess.com/wp-content/uploads/2017/02/2017\\_Measure\\_093\\_Claims.pdf](http://www.mipsuccess.com/wp-content/uploads/2017/02/2017_Measure_093_Claims.pdf)

**Acute Otitis Externa (AOE): Topical Therapy:** [https://mdinteractive.com/files/uploaded/file/CMS2017/2017\\_Measure\\_091\\_Registry.pdf](https://mdinteractive.com/files/uploaded/file/CMS2017/2017_Measure_091_Registry.pdf)

**The Core Elements of Outpatient Antibiotic Stewardship booklet:** [https://www.cdc.gov/antibiotic-use/community/pdfs/16\\_268900-A-CoreElementsOutpatient\\_508.pdf](https://www.cdc.gov/antibiotic-use/community/pdfs/16_268900-A-CoreElementsOutpatient_508.pdf)

**The Core Elements of Outpatient Antibiotic Stewardship information:** <https://www.cdc.gov/getsmart/community/improving-prescribing/core-elements/core-outpatient-stewardship.html>

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