

2020 QCDR Measure Specifications

ANESTHESIA QUALITY INSTITUTE
NATIONAL ANESTHESIA CLINICAL OUTCOMES REGISTRY
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DISCLAIMER

Participation in the ASA® Quality Service does not guarantee satisfactory participation in CMS Merit-based Incentive Payment System (MIPS). Successful submission to CMS is contingent upon each individual eligible clinician (EC) and/or group meeting the MIPS program requirements and the timeliness, quality, and accuracy of the data they provide for reporting.

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The following applies to each Measure that contains the (†) symbol within its title:

† The efforts and contributions of Anesthesia Business Group, ePREOP and TeamHealth to harmonize this Measure with other similar anesthesia quality measures and to update this Measure on an ongoing basis is acknowledged.

Measures Removed from 2020 AQI NACOR QCDR Measure Set

Please note the following measures have been removed or retired from the AQI NACOR registry for QCDR reporting.

Measure ID	Measure Title	Reason for Removal
AQI59	Multimodal Pain Management	This measure has been included in the MIPS program as a MIPS CQM. Its new measure ID is MIPS 477
AQI63	Neuromuscular Blockade: Documented Assessment of Neuromuscular Function Prior to Extubation	Rejected by CMS due to high performance rate and lack of variability for improvement – Its new measure ID for reporting the AQI NACOR as a quality improvement measure is IIM 23
AQI64	Neuromuscular Blockade: Reversal Administered	Rejected by CMS due to high performance rate and lack of variability for improvement – Its new measure ID for reporting the AQI NACOR as a quality improvement measure is IIM 24
MIPS 131	Pain Assessment and Follow-Up	CMS removed this measure as a MIPS Clinical Quality Measure.

Modifications to 2019 QCDR Measures for 2020 AQI NACOR Measure Set

This table identifies changes that were made to AQI NACOR’s QCDR measure specifications in preparation for the 2019 performance year. This table only serves as a general reference in support of but not superseding the final measure specifications for each measure within the book. **Users must refer to the full measure specifications for complete code sets, measure criteria and instructions.**

Measure ID	Measure Title	Modifications
AQI48	Patient-Reported Experience with Anesthesia	<ul style="list-style-type: none"> The word “overall” was removed from the mandatory survey question described in the numerator. CPT codes removed from measure denominator: 01953, 01968, 01969, 62310, 62311, 62318, 62319, 64402, 64410, 64413, 64421, 64462, 64480, 64484, 64491, 64492, 64494, 64495, 64634, 64636 CPT codes added to measure denominator: 62320, 62321, 62322, 62323, 62324, 62325, 62327, 62328, 62329, 62326, 64451, 64454, 64624, 64625 Specifications re-formatted for clarity
AQI55	Team-Based Implementation of a Care-and-Communication Bundle for ICU Patients	<ul style="list-style-type: none"> CPT codes removed from measure denominator: +99292
AQI58	Infection Control Practices for Open Interventional Pain Procedures	<ul style="list-style-type: none"> CPT codes removed from measure denominator: + 22512, +22515
AQI61	Ambulatory Post-Discharge Patient Follow-Up	<ul style="list-style-type: none"> CPT codes removed from measure denominator: 01953, 01968, 01969, 62310, 62311, 62318, 62319, 64402, 64410, 64413, 64421, 64462, 64480, 64484, 64491, 64492, 94494, 64495, 64634, 64636 CPT codes added to measure denominator: 62320, 62321, 62322, 62323, 62324, 62325, 62326, 62327, 62328, 62329, 64451, 64454, 64624, 64625
AQI62	Obstructive Sleep Apnea: Patient Education	<ul style="list-style-type: none"> CPT codes removed from measure denominator: 01953, 01968, 01969

Measure ID	Measure Title	Modifications
AQI66 (2019); AQI68 (2020)	Obstructive Sleep Apnea: Mitigation Strategies	<ul style="list-style-type: none"> • Added a medical reason denominator exception to the measure: 11A38 • New QCDR Measure ID, due to new medical reason denominator: AQI68 • CPT codes removed from measure denominator: 01953, 01968, 01969
AQI67	Consultation for Frail Patients	<ul style="list-style-type: none"> • CPT codes removed from measure denominator: 01953, 62310, 62311, 62318, 62319, 64402, 64410, 64413, 64421, 64462, 64480, 64484, 64491, 64492, 64494, 64495, 64634, 64636 • CPT codes added to measure denominator: 62320, 62321, 62322, 62323, 62324, 62325, 62326, 62327, 62328, 62329, 64451, 64454, 64624, 64625
Quantum31	Central Line Ultrasound Guidance	<ul style="list-style-type: none"> • Denominator exclusion added: 11A39 • CPT code removed: +76937

2020 MIPS Measures Available for Reporting through AQI NACOR

Clinicians and groups reporting via Qualified Registry or Qualified Clinical Data Registry (QCDR) can report Merit-based Incentive Payment System (MIPS) measures to fulfill requirements for the MIPS Quality component. [Download full MIPS measure specifications from CMS.](#)

Measure ID	Measure Title	Measure Type
MIPS 44*	Coronary Artery Bypass Graft (CABG): Preoperative Beta-Blocker in Patients with Isolated CABG Surgery	Process
MIPS 47	Care Plan	Process – High Priority
MIPS 76*	Prevention of Central Venous Catheter (CVC) – Related Bloodstream Infections	Process – High Priority
MIPS 128	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan	Process
MIPS 130	Documentation of Current Medications in the Medical Record	Process – High Priority
MIPS 154	Falls: Risk Assessment	Process – High Priority
MIPS 155	Falls: Plan of Care	Process – High Priority
MIPS 182	Functional Outcome Assessment	Process – High Priority
MIPS 226	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	Process
MIPS 317	Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented	Process
MIPS 404*	Anesthesiology Smoking Abstinence	Intermediate Outcome – High Priority
MIPS 408	Opioid Therapy Follow-Up Evaluation	Process – High Priority
MIPS 412	Documentation of Signed Opioid Treatment Agreement	Process – High Priority
MIPS 414	Evaluation or Interview for Risk Opioid Misuse	Process – High Priority
MIPS 424*	Perioperative Temperature Management	Outcome – High Priority
MIPS 430*	Prevention of Post-Operative Nausea and Vomiting (PONV) – Combination Therapy	Process – High Priority
MIPS 463*	Prevention of Post-Operative Vomiting (POV) – Combination Therapy (Pediatrics)	Process – High Priority
MIPS 468	Continuity of Pharmacotherapy for Opioid Use Disorder (OUD)	Process – High Priority
MIPS 477*	Multimodal Pain Management	Outcome – High Priority

Measures with an asterisk () are included in the CMS-recommended Anesthesiology Measure Set. Eligible clinicians and groups are not required to report these measures towards the six measures required for the MIPS Quality Component but may find them applicable to their practice.

Measure Title

AQI18: Coronary Artery Bypass Graft (CABG): Prolonged Intubation – Inverse Measure

Measure Description

Percentage of patients aged 18 years and older undergoing isolated CABG surgery who require postoperative intubation > 24 hours.

NQS Domain / Meaningful Measures Area

Effective Clinical Care / Preventable Healthcare Harm

Measure Type

Outcome

High Priority Status

Yes

Inverse Measure

Yes

Instructions

This measure is to be reported each time an isolated CABG procedure is performed during the reporting period. It is anticipated that qualified anesthesia providers and eligible clinicians who provide services for isolated CABG will submit this measure. This measure is intended to reflect the quality of services provided for isolated CABG or isolated reoperation CABG patients.

Measure Reporting via the Qualified Clinical Data Registry

CPT codes and patient demographics are used to identify patients who are included in the measure's denominator. The measure must capture both the surgical and related anesthesia code. G-codes are used to report the numerator of the measure.

Denominator

All patients, aged 18 years and older, undergoing isolated CABG surgery

Definition: Isolated CABG refers to CABG using arterial and/or venous grafts only.

Denominator Criteria (Eligible Cases):

Patient aged 18 years and older on date of encounter

AND

Patient encounter during the reporting period (CPT): 33510, 33511, 33512, 33513, 33514, 33516, 33517, 33518, 33519, 33521, 33522, 33523, 33533, 33534, 33535, 33536

AND

00566, 00567

OR

Patient encounter during the reporting period (CPT): 33510, 33511, 33512, 33513, 33514, 33516, 33517, 33518, 33519, 33521, 33522, 33523, 33533, 33534, 33535, 33536

AND

Patient encounter during the reporting period (CPT): 33530

AND

00562

Denominator Exclusions

- Organ donors as designated by ASA Physical Status 6

Numerator

Patients who require intubation > 24 hours following exit from the operating room

Numerator Quality-Data Coding Options for Reporting Satisfactorily

Performance Met:

G8569 Prolonged postoperative intubation (> 24 hrs) required

OR

Performance Not Met:

G8570 Prolonged postoperative intubation (>24 hrs) not required

NQF Number: Not applicable

eCQM: Not applicable

Rationale

Prolonged intubation and/or prolonged ventilation following coronary artery bypass graft (CABG) surgery is associated with increased mortality and morbidity.ⁱ A review of the literature suggests several predictors associated with prolonged ventilation following CABG including increased incidence of pneumonia and pulmonary atelectasis, history of hypertension, COPD, kidney disease and endocarditis among others.^{i,ii} Most complications were associated with prolonged length of stay in the ICU and hospital and increased resource use.ⁱ

Physician anesthesiologists and other qualified anesthesia providers must maintain respiratory function of patients throughout the perioperative period and play a critical role in patients' respiratory care. As physician anesthesiologists and other qualified anesthesia providers control the patient breathing function, their decision-making and care related to airway management can greatly impact outcomes related to prolonged intubation and ventilation. One retrospective study found that physicians in the perioperative period are altering their management of types to reduce adverse respiratory outcomes. For example, research shows aortic aneurysm, combined and valve procedures, and preoperative renal dysfunction and stroke were strong predictors for prolonged ventilation.ⁱⁱ Changes to care and procedures to reduce adverse respiratory outcomes require the engagement of physician anesthesiologist and other qualified anesthesia provider expertise and skill to ensure appropriate patient care.

Data Source: Claims/Paper Medical Record, Registry

Measure Steward: American Society of Anesthesiologists (ASA) / Anesthesia Quality Institute (AQI)

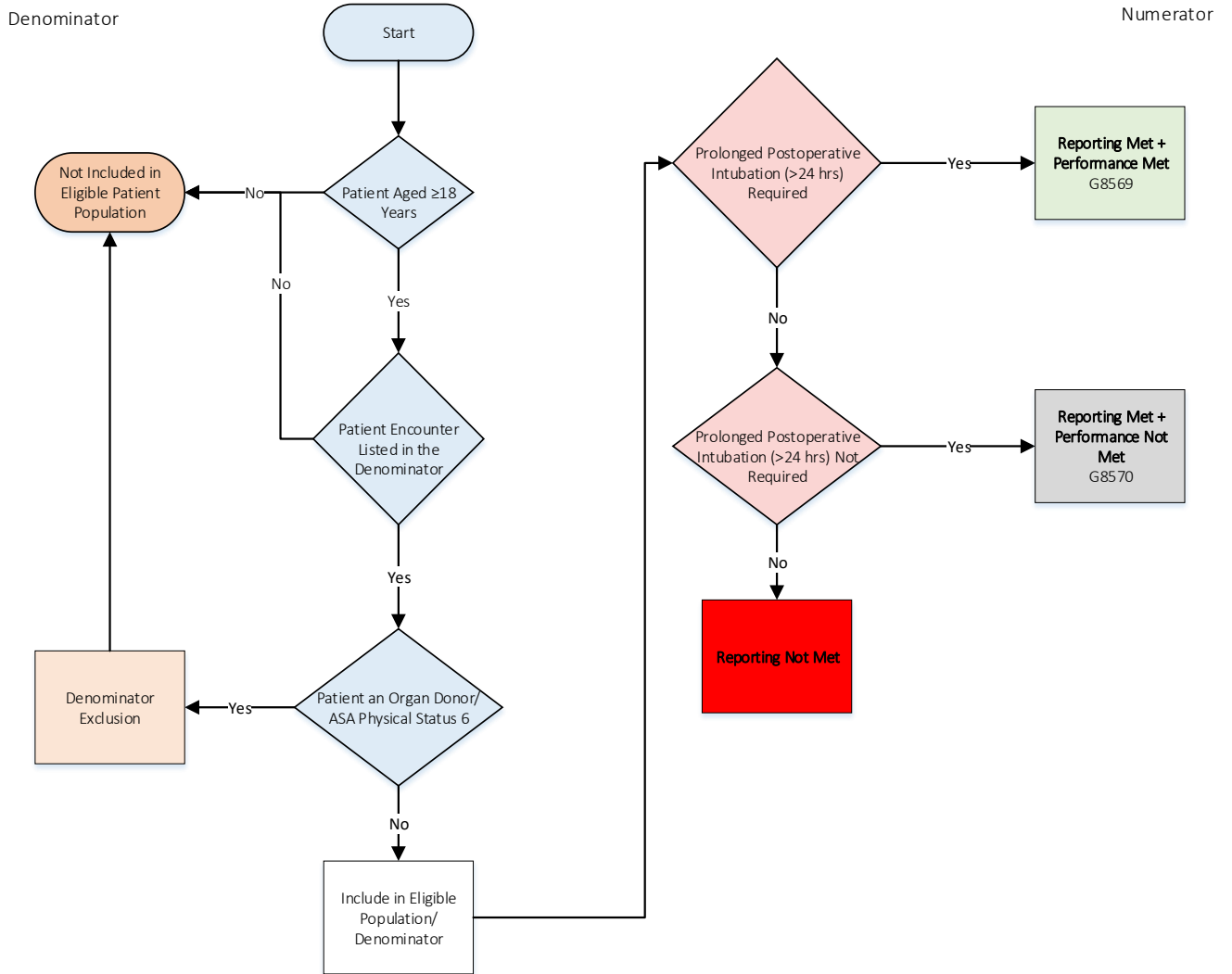
Number of Performance Rates: 1

Proportion Measure Scoring: Yes

Continuous Measure Scoring: No

Risk Adjustment: No

Coronary Artery Bypass Graft (CABG): Prolonged Intubation 2020 QCDR Measure Flow



Measure Title

AQI48: Patient-Reported Experience with Anesthesia†

Measure Description: Percentage of patients aged 18 and older, who were surveyed on their patient experience and satisfaction with anesthesia care and who reported a positive experience.

This measure will consist of two performance rates:

AQI48a: Percentage of patients, aged 18 and older, who were surveyed on their patient experience and satisfaction with anesthesia care

AQI48b: Percentage of patients, aged 18 and older, who completed a survey on their patient experience and satisfaction with anesthesia care and who report a positive experience with anesthesia care

NOTE: The measure requires that a valid survey, as defined in the numerator of 48a, be sent to patients between discharge from the facility and within 30 days of facility discharge. To report AQI 48b, a minimum number of 20 surveys, as described in the numerator of 48a, with the mandatory question completed must be reported. **In order to be scored on this measure, clinicians must report BOTH AQI48a AND AQI48b.**

NQS Domain / Meaningful Measures Area

Person and Caregiver-Centered Experience and Outcomes / Patient's Experience of Care

Measure Type

Patient-Reported Outcome

High Priority Status

Yes

Inverse Measure:

No

Instructions:

This measure consists of two performance rates: AQI48a and AQI48b. AQI48a should be reported each time a patient undergoes a procedure under anesthesia. AQI48b should be reported every time a completed survey is returned by the patient. To be scored on AQI48b, the provider must collect the individual scores received on the survey as described in AQI48a. It is anticipated that qualified anesthesia providers and eligible clinicians who provide denominator-eligible services will submit this measure.

Measure Reporting via the Qualified Clinical Data Registry

CPT codes and patient demographics are used to identify patients who are included in the measure denominator. Registry codes are used to report the measure numerator.

Rationale

Despite the implementation of CAHPS and H-CAHPS, there is a persistent gap in the ability to adequately measure patient experience on the selection of performance measures for performance-based payment programs. To provide high quality, patient-centered care in the future, anesthesiologists and other qualified anesthesia providers should measure and respond to the patients' perception of the degree to which they felt they were treated as individuals and empowered by their anesthesiology practitioners to engage in decision-making for their care. The assessment of patient satisfaction with anesthesia care provides important feedback which enables providers to improve care delivery and quality. At present there is a vast

array of tools available for practices and individuals to implement based upon local patient populations and for local quality improvement initiatives.

Data Source: Database, Registry

Measure Steward: American Society of Anesthesiologists (ASA) / Anesthesia Quality Institute (AQI)

Number of Performance Rates: 2

Overall Performance Rate for Scoring: AQI48b

Proportion Measure Scoring: Yes

Continuous Measure Scoring: No

Risk Adjusted: No

AQI48a

Description-AQI48a

Percentage of patients, aged 18 and older, who were surveyed on their patient experience and satisfaction with anesthesia care.

Denominator-AQI48a

Patients aged 18 and older, who undergo a procedure* under anesthesia

Definition: *Any procedure including surgical, therapeutic or diagnostic

Denominator Criteria (Eligible Cases):

Patient aged 18 years or older on date of encounter

AND

AQI 48a: Patient encounter during the reporting period (CPT):

00100, 00102, 00103, 00104, 00120, 00124, 00126, 00140, 00142, 00144, 00145, 00147, 00148, 00160, 00162, 00164, 00170, 00172, 00174, 00176, 00190, 00192, 00210, 00211, 00212, 00214, 00215, 00216, 00218, 00220, 00222, 00300, 00320, 00322, 00350, 00352, 00400, 00402, 00404, 00406, 00410, 00450, 00454, 00470, 00472, 00474, 00500, 00520, 00522, 00524, 00528, 00529, 00530, 00532, 00534, 00537, 00539, 00540, 00541, 00542, 00546, 00548, 00550, 00560, 00562, 00563, 00566, 00567, 00580, 00600, 00604, 00620, 00625, 00626, 00630, 00632, 00635, 00640, 00670, 00700, 00702, 00730, 00731, 00732, 00750, 00752, 00754, 00756, 00770, 00790, 00792, 00794, 00796, 00797, 00800, 00802, 00811, 00812, 00813, 00820, 00830, 00832, 00840, 00842, 00844, 00846, 00848, 00851, 00860, 00862, 00864, 00865, 00866, 00868, 00870, 00872, 00873, 00880, 00882, 00902, 00904, 00906, 00908, 00910, 00912, 00914, 00916, 00918, 00920, 00921, 00922, 00924, 00926, 00928, 00930, 00932, 00934, 00936, 00938, 00940, 00942, 00944, 00948, 00950, 00952, 01112, 01120, 01130, 01140, 01150, 01160, 01170, 01173, 01200, 01202, 01210, 01212, 01214, 01215, 01220, 01230, 01232, 01234, 01250, 01260, 01270, 01272, 01274, 01320, 01340, 01360, 01380, 01382, 01390, 01392, 01400, 01402, 01404, 01420, 01430, 01432, 01440, 01442, 01444, 01462, 01464, 01470, 01472, 01474, 01480, 01482, 01484, 01486, 01490, 01500, 01502, 01520, 01522, 01610, 01620, 01622, 01630, 01634, 01636, 01638, 01650, 01652, 01654, 01656, 01670, 01680, 01710, 01712, 01714, 01716, 01730, 01732, 01740, 01742, 01744, 01756, 01758, 01760, 01770, 01772, 01780, 01782, 01810, 01820, 01829, 01830, 01832, 01840, 01842, 01844, 01850, 01852, 01860, 01916, 01920, 01922, 01924, 01925, 01926, 01930, 01931, 01932, 01933, 01935, 01936, 01951, 01952, 01958, 01960, 01961, 01962, 01963, 01965, 01966, 01967, 01991, 01992, 20526, 20550, 20551, 20552, 20553, 20600, 20604, 20605, 20606, 20610, 20611, 27096, 36555, 36556, 36570, 36571, 36578, 36580, 36581, 36582, 36583, 36584, 36585, 62263, 62264, 62270, 62272, 62273, 62280, 62281, 62282, 62320, 62321, 62322, 62323, 62324, 62325, 62326, 62327, 62328, 62329, 62350, 62355, 62360, 62361, 62362, 62365, 62370, 63650, 63661, 63662, 63663, 63664, 63685, 63688, 64400, 64405, 64408, 64415, 64416, 64417, 64418, 64420, 64425, 64430, 64435, 64445, 64446, 64447, 64448, 64449, 64450, 64451, 64454, 64461, 64463, 64479, 64483, 64486, 64487, 64488, 64489, 64490, 64493, 64505, 64510, 64517, 64520, 64530, 64600, 64605, 64610, 64620, 64624, 64625, 64630, 64633, 64635, 64640, 64680, 64681, 72275, 93503, 95990, 95991

Denominator Exclusions-AQI48a

- Organ Donors as designated with ASA Physical Status 6
- Patient died within 30 days of the procedure: **10A11**

Numerator-AQI48a:

Patients who received a survey within 30 days of the procedure to assess their experience and satisfaction with anesthesia.

Numerator Note: The survey should be administered to the patient shortly following discharge from the facility.

Definition: Practices and eligible clinicians may customize their patient experience and satisfaction with anesthesia surveys to meet local needs but, **at a minimum**, a valid survey must include a core set of questions that address **three of the four** following criteria related to patient experience and satisfaction **and** one mandatory question described below.

1. Pre-operative Education and Preparation
2. Patient and/or Family Communication
3. Care Team Response to Comfort and Well-Being
4. Post-operative pain control and/or management

Mandatory question that must be included in each valid survey (practices must also include an option for patient to indicate “Not Applicable”):

1. On a scale of 1 to 5, where 1 indicates the worst anesthesia experience and where 5 indicates the best anesthesia experience, how would you rate your anesthesia experience?

Numerator Note: Practices and eligible clinicians may wish to supplement these questions by taking into consideration the recommendations of the ASA Committee on Performance and Outcomes Measurement work product entitled “Patient Satisfaction with Anesthesia White Paper.”

Numerator Note: Depending on local practice, practices and eligible clinicians may wish to supplement survey questions by taking into consideration the recommendations developed as part of the Perioperative Surgical Home (PSH) that are structured in five distinct components.

1. Pre-Operative Education and Preparation (Four Indicators)
 - a. Patient comfort with instructions provided about eating better
 - b. Patient comfort with instructions provided about exercise or physical therapy
 - c. Patient comfort with instructions provided about stopping smoking (if applicable)
 - d. Patient comfort with instructions provided about what to do after surgery
2. Check-In and Pre-Procedure Experience
3. Caregiver and Family Communication during Surgery
4. Care Team Response to Comfort and Well-Being
5. Post-Operative Pain Management

For more information on these resources, visit <https://www.asahq.org/psh>.

Numerator Quality-Data Coding Options for Reporting Satisfactorily: AQI48a

Performance Met:

10A12 Patient provided with a survey within 30 days of the procedure to assess their experience and satisfaction with anesthesia

OR

Denominator Exception

10A13 Documentation of patient reason(s), process reason(s) or medical reason(s) for not receiving survey (i.e. patients who are non-verbal, who are unable to be surveyed due to a medical or psychiatric reason, who are unable to be surveyed due to a language barrier, have not provided contact information,

who are discharged to assisted living, skilled nursing facility or other similar location where direct access to the patient is not available, or who decline to be surveyed.

OR

Performance Not Met:

10A14

Patient was not provided with a survey within 30 days of the procedure to assess their experience and satisfaction with anesthesia

AQI48b

Description-AQI48b

Percentage of patients who complete the survey from AQI48a on their patient experience and satisfaction with anesthesia care and report a positive experience.

Denominator-AQI48b

All patients from the numerator of AQI48a who complete a survey on their patient experience and satisfaction with anesthesia care

Denominator Note: In order to report AQI48b, the denominator must include a minimum of 20 returned surveys.

Denominator Criteria (Eligible Cases):

Patient completed a survey on their patient experience and satisfaction with anesthesia care: **10A72**

Denominator Exclusions-AQI48b

- Patient did not complete the mandatory anesthesia satisfaction question: **10A69**

Numerator- AQI 48b:

Patients who reported a positive experience with anesthesia care.

Definition: A positive experience is defined as a response of 4 or 5 on the following mandatory patient experience and satisfaction survey question:

On a scale of 1 to 5, where 1 indicates the worst anesthesia experience and where 5 indicates the best anesthesia experience, how would you rate your anesthesia experience? (*Practices must include an option for patient to indicate "Not Applicable"*)

Numerator Quality-Data Coding Options for Reporting Satisfactorily: AQI48b

Reporting note: To report this measure, the provider must report the individual patient scores. A percentage reporting a positive experience will be calculated on the provider's behalf.

Performance Met:

10A70

Patient reported a positive anesthesia experience (i.e., a 4 or 5 on the mandatory survey question)

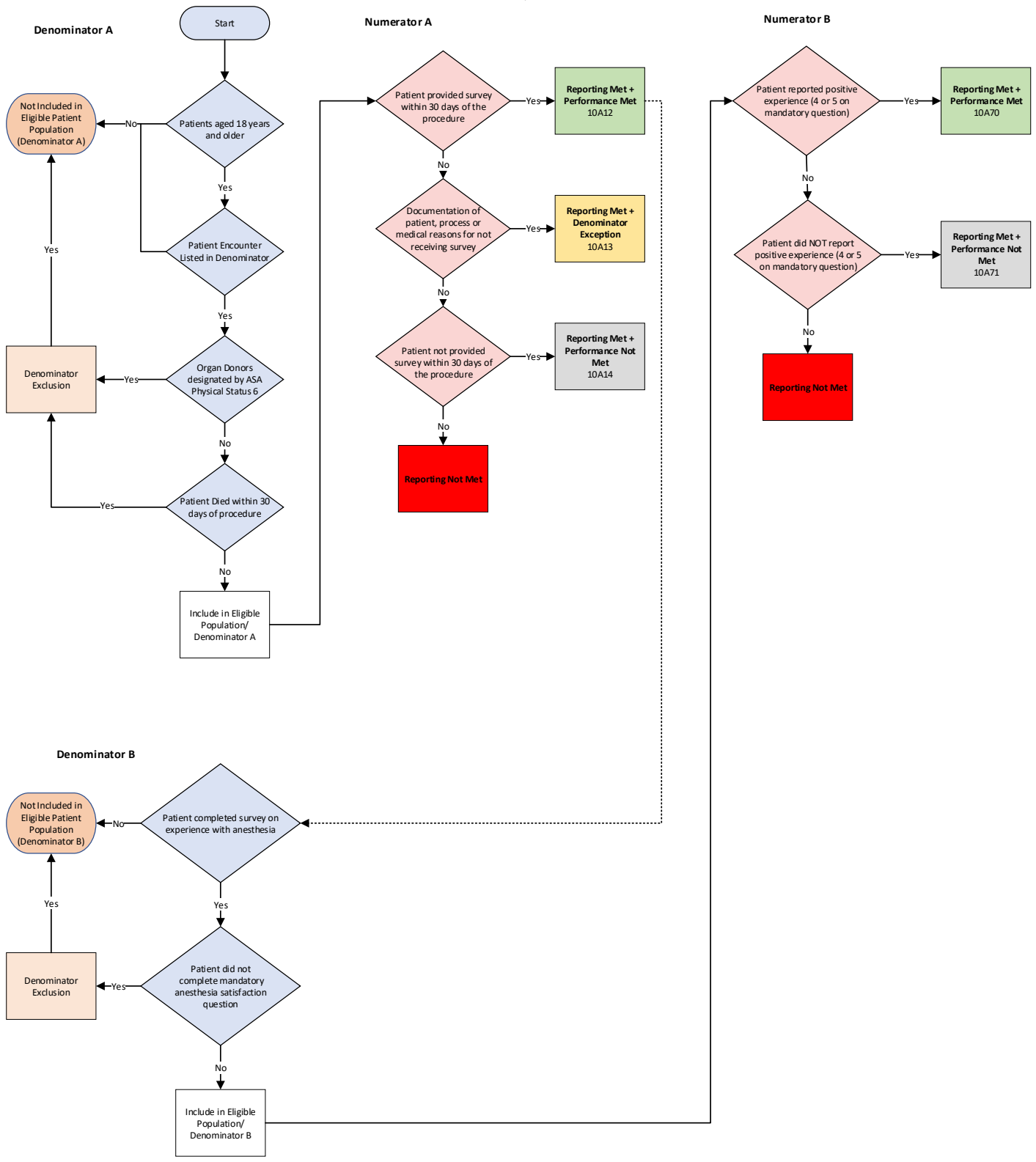
OR

Performance Not Met:

10A71

Patient did NOT report a positive anesthesia experience (i.e., a 1, 2, or 3 on the mandatory survey question)

Patient-Reported Experience with Anesthesia 2020 QCDR Measure Flow



Measure Title

AQI49: Adherence to Blood Conservation Guidelines for Cardiac Operations using Cardiopulmonary Bypass (CPB) – Composite

Measure Description

Percentage of patients aged 18 years and older, who undergo a cardiac operation using cardiopulmonary bypass for whom selected blood conservation strategies were used.

NQS Domain / Meaningful Measures Area

Effective Clinical Care / Preventable Healthcare Harm

Measure Type

Composite – Process

High Priority Status

No

Inverse Measure

No

Instructions

This measure is to be reported each time a patient undergoes a cardiac operation using cardiopulmonary bypass during the reporting period. This measure has four sub-metrics which are used to calculate the total composite score. All sub-metrics are required to report to indicate performance met or performance not met. It is anticipated that qualified anesthesia providers and eligible clinicians who provide denominator-eligible services will submit this measure.

Measure Reporting via the Qualified Clinical Data Registry

Patient demographics, CPT codes and Registry codes are used to identify patients who are included in the measure denominator. CPT Category codes and Registry codes are used to report the numerator.

Denominator

Patients aged 18 years and older, who undergo a cardiac operation using cardiopulmonary bypass.

Denominator Note: Patients undergoing a re-operation are included in the denominator to the measure

Denominator Criteria (Eligible Cases):

Patient aged 18 years or older on date of encounter

AND

Patient encounter during the reporting period (CPT): 00562, 00563, 00567, 00580

Denominator Exclusions

- Emergent cases

Numerator

Patients for whom selected blood conservation strategies were usedⁱⁱⁱ

Numerator Scoring: Each blood conservation strategy of this measure accounts for 25% of the total composite score. Each of the four blood conservation strategies must be reported to be included in the performance measurement. The total composite score will be calculated by the data source and not the individual practitioner.

1. Use of Lysine analogues

Numerator Note: As indicated by Intraoperative Antifibrinolytic med: Aminocaproic Acid or Tranexamic Acid.

Numerator Quality-Data Coding Options for Reporting Satisfactorily

Performance Met:

10A01 Patients for whom lysine analogues were used.

OR

Performance Not Met:

10A02 Patients for whom lysine analogues were NOT used.

2. Use of mini-circuits or Retrograde Autologous Priming (RAP) or Ultrafiltration (Minimize hemodilution caused by cardiopulmonary bypass pump priming solution)

Numerator Note: Record the usage of retrograde autologous priming or a miniaturized circuit volume by the cardiopulmonary perfusion team prior to the onset of cardiopulmonary bypass.

Numerator Note: Capture the total volume of ultrafiltrate removed by the cardiopulmonary perfusion team during cardiopulmonary bypass and during modified ultra-hemofiltration post-CPB. Record the data in milliliters.

Numerator Quality-Data Coding Options for Reporting Satisfactorily

Performance Met:

10A03 Patients for whom mini-circuits or Retrograde Autologous Priming (RAP) or Ultrafiltration were used.

OR

Performance Not Met:

10A04 Patients for whom mini-circuits or Retrograde Autologous Priming (RAP) or Ultrafiltration were NOT used.

3. Use of red cell salvage using centrifugation

Numerator Note: Capture the volume of cell saver collected and given. Do not include autologous, allogeneic, pump-residual, or chest-tube recirculated blood.

Numerator Quality-Data Coding Options for Reporting Satisfactorily

Performance Met:

10A05 Patients for whom red cell salvage using centrifugation was used.

OR

Performance Not Met:

10A06 Patients for whom red cell salvage using centrifugation were NOT used.

4. Use of transfusion algorithm supplemented with point-of-care testing

Numerator Note: Transfusion algorithm includes SCA/STS guideline recommendations or an evidence-based algorithm formulated at the local level.

Numerator Quality-Data Coding Options for Reporting Satisfactorily

Performance Met:

10A07

Patients for whom transfusion algorithm supplemented with point-of-care testing was used.

OR

Performance Not Met:

10A08

Patients for whom transfusion algorithm supplemented with point-of-care testing was NOT used.

Composite Performance Score

Performance Score Note: This performance score is calculated by the data source and not the individual practitioner. Eligible clinicians reporting this measure must submit numerator quality codes for each of the four blood conservation strategies identified in this measure. The performance score is the cumulative sum of performance met for each blood conservation strategy listed in the numerator of this measure.

For example, for a single patient encounter, if the eligible clinician reports performance met coding for “Use of mini-circuits or RAP or Ultrafiltration”, “Use of red cell salvage using centrifugation”, and “Use of transfusion algorithm supplemented with point-of-care testing” and performance not met for “Use of lysine analogues”, the cumulative score would be calculated as 3 performance met divided by 4 possibilities of performance met that would equal 75%. This eligible clinician for this particular patient would be assessed as “Performance Not Met” because the eligible clinician had a cumulative score less than 100%.

Performance Met:

10A09

Patients for whom a cumulative score of 100% of blood conservation strategies was met

OR

Performance Not Met:

10A10

Patients for whom a cumulative score of **less than** 100% of blood conservation strategies was met.

NQF Number: Not applicable

eCQM: Not applicable

Rationale

Efforts to reduce blood product use have the potential to avoid transfusion-related complications and reduce health care costs. Implementation of a blood use initiative significantly improves postoperative morbidity, mortality, and resource utilization. Limiting intraoperative and postoperative blood product transfusion decreases adverse postoperative events and reduces health care costs.^{iv} Low-risk patients have between an 8- and 10-fold excess risk of adverse outcomes when they receive a blood transfusion. We speculate that careful preoperative assessment of transfusion risk and intervention based on this assessment could minimize operative morbidity and mortality, especially because the patients at least risk are more likely to undergo elective operations and provide time for therapeutic interventions to improve transfusion risk profiles.^v

Clinical Recommendation Statements

Perioperative Blood Transfusion and Blood Conservation in Cardiac Surgery: The Society of Thoracic Surgeons and The Society of Cardiovascular Anesthesiologists Clinical Practice Guideline^{xi}

"Lysine analogues—epsilon-aminocaproic acid (Amicar) and tranexamic acid (Cyklokapron)—reduce total blood loss and decrease the number of patients who require blood transfusion during cardiac procedures and are indicated for blood conservation. (Level of evidence A)"

"Retrograde autologous priming of the CPB circuit may be considered for blood conservation. (Level of evidence B)"

"Routine use of red cell salvage using centrifugation is helpful for blood conservation in cardiac operations using CPB. (Level of evidence A)"

"A multidisciplinary approach involving multiple stakeholders, institutional support, enforceable transfusion algorithms supplemented with point-of-care testing, and all of the already mentioned efficacious blood conservation interventions limits blood transfusion and provides optimal blood conservation for cardiac operations. (Level of evidence A)"

Data Source: Claims/Paper Medical Record, Registry

Measure Steward: American Society of Anesthesiologists (ASA) / Anesthesia Quality Institute (AQI)

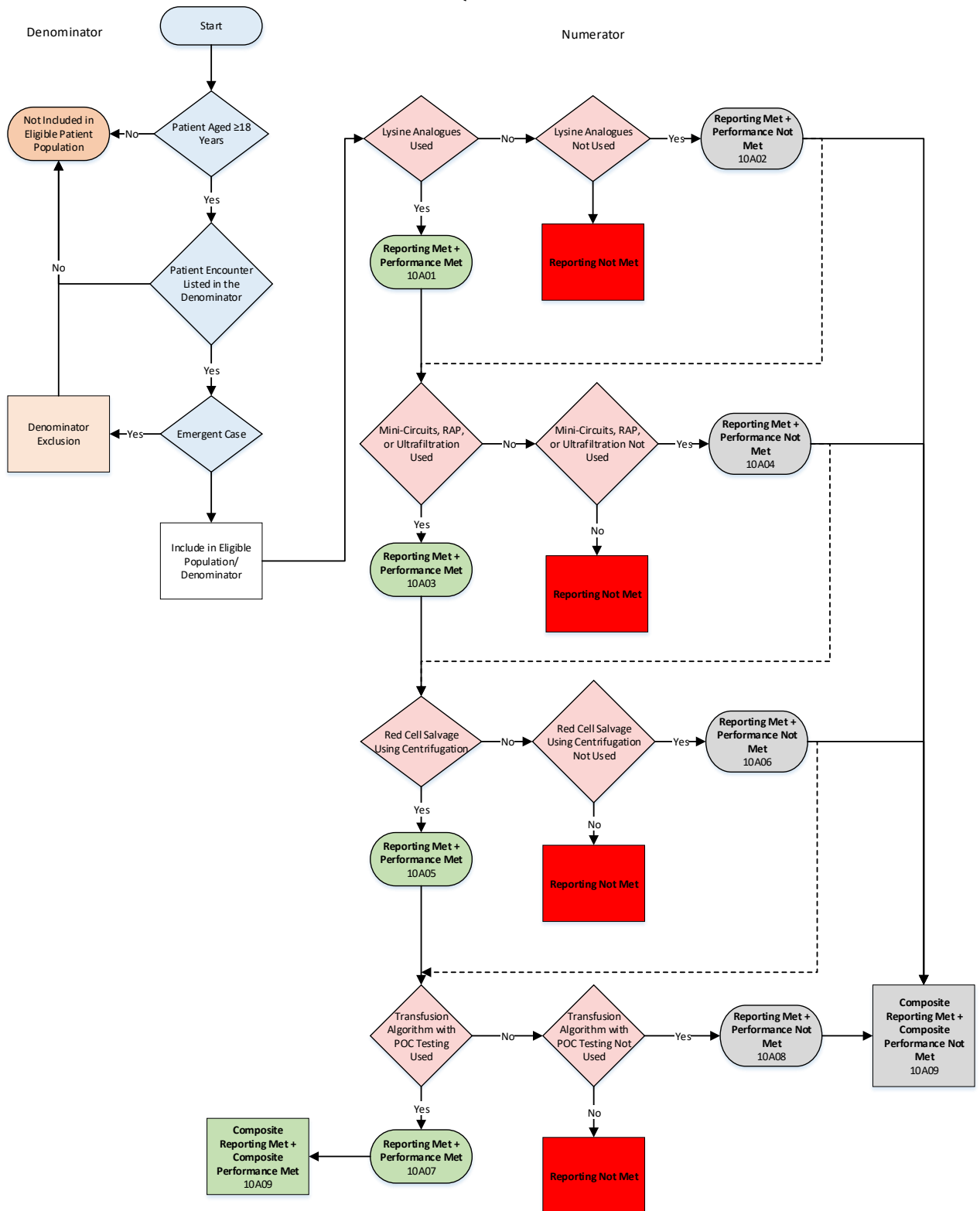
Number of Performance Rates: 1

Proportion Measure Scoring: Yes

Continuous Measure Scoring: No

Risk Adjustment: No

Adherence to Blood Conservation Guidelines for Cardiac Operations Using Cardiopulmonary Bypass (CBP)-Composite
2020 QCDR Measure Flow



Measure Title**AQI55: Team-Based Implementation of a Care-and-Communication Bundle for ICU Patients****Measure Description**

Percentage of patients, regardless of age, who are admitted to an intensive care unit (ICU) for ≥48 hours and who received critical care services who have documentation by managing physician of 1) attempted or actual identification of a surrogate decision maker, 2) an advance directive, and 3) the patient's preference for cardiopulmonary resuscitation, within 48 hours of ICU admission.

NQS Domain / Meaningful Measures Area

Communication and Care Coordination / Care is Personalized and Aligned with Patient's Goals

Measure Type

Process

High Priority Status

Yes

Inverse Measure

No

Instructions

This measure is to be reported each time a patient receives critical care services and is admitted to an intensive care unit for ≥48 hours during the reporting period. It is expected that the managing physician during the first 48 hours of the patient's intensive care unit stay will report this measure.

Measure Reporting via the Qualified Clinical Data Registry

Patient demographics, CPT codes, and registry codes are used to identify patients who are included in the measure denominator. Registry codes are used to report the numerator of the measure.

Denominator

All patients, regardless of age, who are admitted to an intensive care unit for ≥48 hours and who received critical care services

Denominator Criteria (Eligible Cases):

All patients, regardless of age

AND

Admitted to an intensive care unit for ≥48 hours: **10A58**

AND

Received critical care services (CPT): 99291, 99468, 99469, 99471, 99472, 99475, 99476

Denominator Exclusions

- None

Numerator

Patients who have documentation by managing physician of 1) attempted or actual identification of a surrogate decision maker, 2) an advance directive, and 3) the patient's preference for cardiopulmonary resuscitation, within the first 48 hours of ICU admission.

Numerator Note: To meet this measure, the managing physician must either document the required information or confirm that they have reviewed existing documentation of the information.

Numerator Quality-Data Coding Options for Reporting Satisfactorily

Performance Met:

10A59 Patient has documentation by managing physician of 1) attempted or actual identification of a surrogate decision maker, 2) an advance directive, and 3) the patient's preference for cardiopulmonary resuscitation within the first 48 hours of ICU admission

OR

Denominator Exception:

10A60 Documentation of patient reason(s) for not documenting all three required numerator elements within the first 48 hours of ICU admission (e.g., patient declines, patient unable to participate in discussion, other patient reason(s))

OR

Performance Not Met:

10A61 Patient does not have documentation by managing physician of 1) attempted or actual identification of a surrogate decision maker, 2) an advance directive, and 3) the patient's preference for cardiopulmonary resuscitation within the first 48 hours of ICU admission

NQF Number: Not Applicable

eCQM: Not Applicable

Rationale

Patient and family engagement remains an important aspect of healthcare, especially in an ICU where advanced illness and pressing time demands place an especially high emotional burden on patients, families and their caregivers. Effective communication between physicians, patients and families and other intensive care unit clinicians has the potential to prevent errors and complications as well as carry out the wishes of the patients.

Research shows that over time, physician anesthesiologists' attitudes regarding automatically suspending Do-Not-Resuscitate (DNR) orders during the perioperative period have shifted and imply that not only patients, but also more anesthesiologists, value and expect a discussion of advance directives prior to surgery.^{vi} As important members of the intensive care team, physician anesthesiologists are oftentimes responsible for or provide consultation on critically ill patients' airway management, including intubation and ventilation. Communication and documentation of patient preferences, including surrogate decision maker, advance directives and cardiopulmonary resuscitation is essential for all members of the intensive care team to appropriately deliver care and engage patients and families throughout the perioperative period.

Patient engagement strategies have been shown to be most effective when implemented together in the form of a bundle. This measure is designed to address key components of critical care that are important to patients, families and professionals. This measure is designed to align with the Care and Communication Bundle that was developed by the Society of Critical Care Medicine (SCCM) in collaboration with VHA, Inc., a national network of community-based hospitals.^{vii}

Clinical Recommendation Statement

2014 ASA Guidelines for the Practice of Critical Care by Anesthesiologists^{viii,ix}

“Due to the complex nature of critical illness, coordination of care is required. Therefore, one individual, either the critical care anesthesiologist or another physician, must assume global responsibilities for the patient to include all aspects of patient care, including communication with the patient, family and other providers.”

“The anesthesiologist-intensivist needs to be intimately involved in the ethical dilemmas that commonly develop in the intensive care unit, in appropriately communicating with patients and their families in making decisions regarding the appropriateness of treatment, and in understanding the need to maintain patient autonomy and dignity.”

Data Source: Claims/Paper Medical Record, Registry

Measure Steward: American Society of Anesthesiologists (ASA) / Anesthesia Quality Institute (AQI)

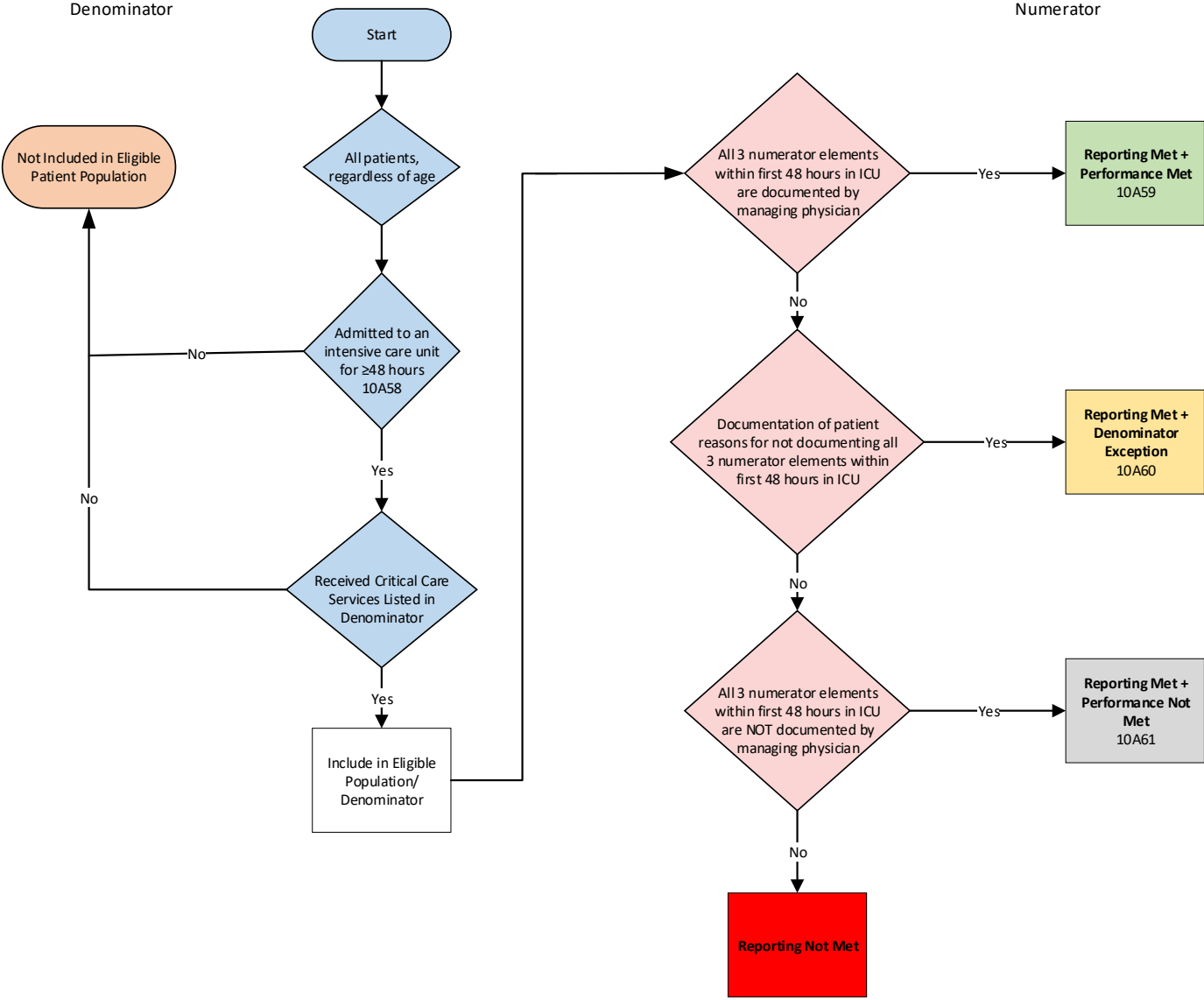
Number of Performance Rates: 1

Proportion Measure Scoring: Yes

Continuous Measure Scoring: No

Risk Adjustment: No

Team-Based Implementation of a Care-and-Communication Bundle for ICU Communication 2020 QCDR Measure Flow



Measure Title**AQI56: Use of Neuraxial Techniques and/or Peripheral Nerve Blocks for Total Knee Arthroplasty (TKA)****Measure Description**

Percentage of patients, regardless of age, that undergo primary total knee arthroplasty for whom neuraxial anesthesia and/or a peripheral nerve block is performed.

NQS Domain / Meaningful Measures Area

Effective Clinical Care / Appropriate use of Healthcare

Measure Type

Process

High Priority Status

No

Inverse Measure

No

Instructions

This measure is to be reported each time a patient undergoes primary total knee arthroplasty. It is anticipated that qualified anesthesia providers and eligible clinicians who provide denominator-eligible services will submit this measure.

Measure Reporting via the Qualified Clinical Data Registry

CPT codes are used to identify patients who are included in the measure denominator. Registry codes are used to report the numerator of the measure.

Denominator

All patients, regardless of age, who undergo primary total knee arthroplasty

Denominator Criteria (Eligible Cases):

All patients, regardless of age

AND**Patient encounter during the reporting period (CPT):**

01402

Denominator Exclusions

- Revision of TKA: CPT 27486, 27487 or **11A09**
- Prosthesis Removal: CPT 27488 or **11A10**

Numerator

Patients for whom neuraxial anesthesia and/or a peripheral nerve block is performed.

Numerator Note: For the purposes of this measure, a peripheral nerve block performed either as primary procedural anesthesia or performed for postoperative analgesia would meet the numerator.

Numerator Quality-Data Coding Options for Reporting Satisfactorily

Performance Met:

10A78 Neuraxial anesthesia and/or a peripheral nerve block was used

OR

Denominator Exception:

11A01 Documentation of patient reason(s) for not using either neuraxial anesthesia or a peripheral nerve block (e.g., patient refusal)

OR

Performance Not Met:

10A79 Neuraxial anesthesia and/or a peripheral nerve block was NOT used

NQF Number: Not Applicable

eCQM: Not Applicable

Rationale

Regional anesthesia is associated with improved patient outcomes and lower postoperative morbidity and mortality compared to general anesthesia in patients undergoing TKA.^x Patients receiving neuraxial anesthesia typically lose less blood during surgery, leading to reduced need for many blood transfusions.^{xi} Additionally, some studies support the notion that spinal anesthesia is associated with lower incidence of surgical site infection when compared to general anesthesia.^{xii} Peripheral nerve blocks (PNBs) can be used as part of a pain management protocol after knee replacement surgery when compared with systemic analgesia, patients receiving PNBs have better pain scores and use less opioids after surgery.^{xiii} By requiring fewer opioids after surgery, patients also avoid opioid-related side effect such as sedation, respiratory depression, nausea, vomiting, and constipation. They also have better functional outcomes and have overall, a better perioperative experience.^{xiv}

Strength of the evidence supporting neuraxial anesthesia and PNB is sometimes questioned as some of the supporting studies are retrospective in nature and mainly derived from analysis of administrative databases. However, evidence from randomized clinical trials either support better outcomes with regional anesthesia or show that there is no difference with the anesthesia technique.^{xv}

Clinical Recommendation Statements

2015 AAOS Evidence-Based Clinical Practice Guideline for Surgical Management of Osteoarthritis of the Knee^{xvi}

“Strong evidence supports that peripheral nerve blockade for total knee arthroplasty (TKA) decreases postoperative pain and opioid requirements. Strength of Recommendation: Strong Evidence: 4 stars”

“Moderate evidence supports that neuraxial anesthesia could be used in total knee arthroplasty (TKA) to improve select perioperative outcomes and complication rates compared to general anesthesia. Strength of Recommendation: Moderate, Evidence: 3 stars”

Data Source: Claims/Paper Medical Record, Registry

Measure Steward: American Society of Anesthesiologists (ASA) / Anesthesia Quality Institute (AQI)

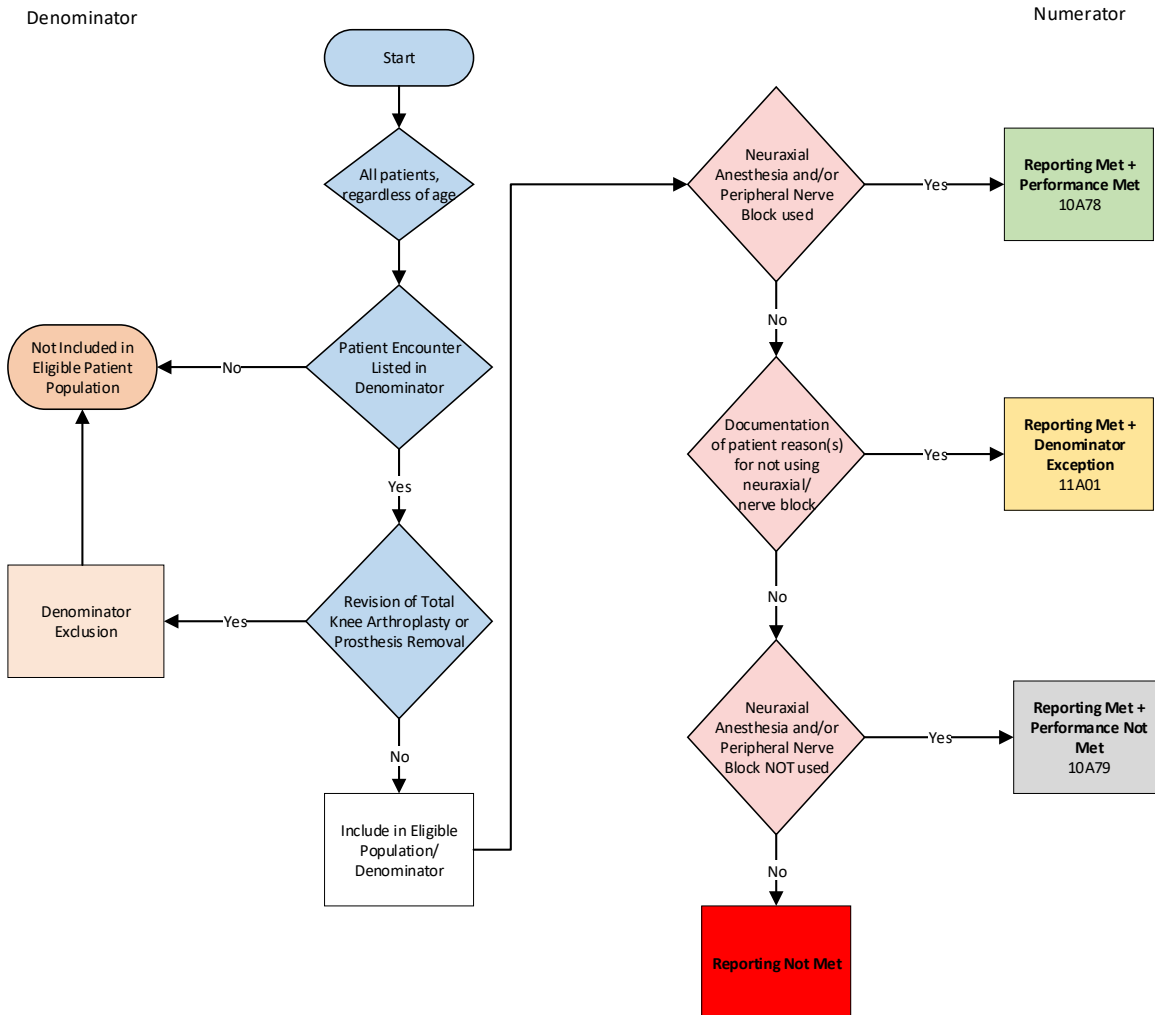
Number of Performance Rates: 1

Proportion Measure Scoring: Yes

Continuous Measure Scoring: No

Risk Adjustment: No

Use of Neuraxial Techniques and/or Peripheral Nerve Blocks for Total Knee Arthroplasty (TKA) 2020 QCDR Measure Flow



Measure Title
AQI57: Safe Opioid Prescribing Practices

Measure Description

Percentage of patients, aged 18 years and older, prescribed opioid medications for longer than six weeks' duration for whom ALL of the following opioid prescribing best practices are followed:

1. Chemical dependency screening (includes laboratory testing and/or questionnaire) within the immediate 6 months prior to the encounter
2. Co-prescription of naloxone or documented discussion regarding offer of Naloxone co-prescription, if prescription is ≥ 50 MME/day
3. Non co-prescription of benzodiazepine medications by prescribing pain physician and documentation of a discussion with patient regarding risks of concomitant use of benzodiazepine and opioid medications.

NQS Domain / Meaningful Measures Area

Effective Clinical Care / Prevention and Treatment of Opioid and Substance Use Disorders

Measure Type

Composite – Process

High Priority Status

Yes

Inverse Measure

No

Instructions

This measure is to be reported each time a patient is prescribed opioid medications for longer than six weeks' duration during the reporting period. It is anticipated that qualified anesthesia providers and eligible clinicians who provide denominator-eligible services will submit this measure.

Measure Reporting via the Qualified Clinical Data Registry

Patient demographics, G-codes and CPT codes are used to identify patients who are included in the measure denominator. Registry codes are used to report the numerator of the measure.

Denominator

All patients aged 18 years and older prescribed opioid medications for longer than six weeks' duration

Denominator Criteria (Eligible Cases):

Patients aged 18 years and older

AND

Patient encounter during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99217, 99218, 99219, 99220, 99224, 99225, 99226, 99241, 99242, 99243, 99244, 99245, 99281, 99282, 99283, 99284, 99285

AND

Patients prescribed opioids for longer than six weeks' duration: **G9561**

Denominator Exclusions

- None

Numerator

Patients for whom ALL of the following opioid prescribing best practices are followed:

1. Chemical dependency screening (includes laboratory testing and/or questionnaire) within the immediate 6 months prior to the encounter
2. Co-prescription of Naloxone, or documented discussion regarding offer of Naloxone co-prescription, if opioid prescription is ≥ 50 MME/day
3. Non co-prescription of benzodiazepine medications by prescribing pain physician and documentation of a discussion with patient regarding risks of concomitant use of benzodiazepine and opioid medications.

Numerator Note: Chemical Dependency Screening: Questionnaires for chemical dependency screening can include the Opioid Risk Tool (ORT), Screener and Opioid Assessment for Patients with Pain (SOAPP), Screener and Opioid Assessment for Patients with Pain-Revised (SOAPP-R), or the Diagnosis, Intractability, Risk, Efficacy (DIRE) tool.

Numerator Quality-Data Coding Options for Reporting Satisfactorily

Measure Scoring Note: In order to receive credit for this measure, ALL three numerator criteria must be reported. See the "Composite Performance Score" section for more details on how this measure is scored.

Criterion 1:

Performance Met:

10A92

Chemical dependency screening (including laboratory testing and/or questionnaire) was performed within the immediate 6 months prior to the encounter

OR

Performance Not Met:

10A93

Chemical dependency screening (including laboratory testing and/or questionnaire) was NOT performed within the immediate 6 months prior to the encounter

Criterion 2:

Performance Met:

10A94

Naloxone co-prescribed or documented discussion regarding offer of Naloxone co-prescription for opioid prescription ≥ 50 MME/day

OR

10A95

Not applicable, opioid prescription < 50 MME/day

OR

Performance Not Met:

10A96

Naloxone NOT co-prescribed AND discussion NOT documented regarding offer of Naloxone co-prescription for opioid prescription ≥ 50 MME/day

Criterion 3:

Performance Met:

10A97

Benzodiazepine medications NOT co-prescribed by prescribing pain physician AND documented discussion regarding risks of concomitant use of benzodiazepine and opioid medications

OR

Performance Not Met:

10A98 Benzodiazepine medications co-prescribed by prescribing pain physician AND/OR no documented discussion regarding risks of concomitant use of benzodiazepine and opioid medications

Composite Performance Score

Performance Score Note: This performance score is calculated by the data source and not the individual practitioner. Eligible clinicians reporting this measure must submit numerator quality codes for each of the three numerator criteria identified in this measure. *This measure utilizes an all-or-none scoring methodology* where failure to meet performance for ANY of the three numerator criteria will result in performance not met for the measure. The performance score is the percentage of denominator-eligible cases for which ALL three numerator criteria are met.

Performance Met:

10A92 Chemical dependency screening (including laboratory testing and/or questionnaire) was performed within the immediate 6 months prior to the encounter

AND

10A94 Naloxone co-prescribed or documented discussion regarding offer of Naloxone co-prescription for opioid prescription ≥ 50 MME/day

OR

10A95 Not applicable, opioid prescription < 50 MME/day

AND

10A97 Benzodiazepine medications NOT co-prescribed by prescribing pain physician AND documented discussion regarding risks of concomitant use of benzodiazepine and opioid medications

OR

Performance Not Met:

10A93 Chemical dependency screening (including laboratory testing and/or questionnaire) was NOT performed within the immediate 6 months prior to the encounter

AND/OR

10A96 Naloxone NOT co-prescribed AND discussion NOT documented regarding offer of Naloxone co-prescription for opioid prescription ≥ 50 MME/day

AND/OR

10A98 Benzodiazepine medications co-prescribed by prescribing pain physician AND/OR no documented discussion regarding risks of concomitant use of benzodiazepine and opioid medications

NQF Number: Not Applicable

eCQM: Not Applicable

Rationale

In 2016, more than 61 million patients had at least one opioid prescription filled or refilled, accounting for more than 214 million individual opioid prescriptions.^{xvii} Use of opioid pain medication is associated with serious risks, including overdose and opioid use disorder. Given these risks, it is essential for providers who prescribe opioid medications to carefully assess the risks and benefits of opioid therapy and to follow safe prescribing practices. Through the completion of dependency screening, the provision of Naloxone, and the avoidance of co-prescription of benzodiazepine medications, providers can help mitigate some of the most serious risks associated with opioid therapy.

Clinical Recommendation Statements

2016 CDC Guideline for Prescribing Opioids for Chronic Pain-United States^{xviii}

“When prescribing opioids for chronic pain, clinicians should use urine drug testing before starting opioid therapy and consider urine drug testing at least annually to assess for prescribed medications as well as other controlled prescription drugs and illicit drugs. (Recommendation category: B; evidence type: 4)”

“Before starting and periodically during continuation of opioid therapy, clinicians should evaluate risk factors for opioid-related harms. Clinicians should incorporate into the management plan strategies to mitigate risk, including considering offering naloxone when factors that increase risk for opioid overdose, such as history of overdose, history of substance use disorder, higher opioid dosages (≥ 50 MME/d), or concurrent benzodiazepine use, are present. (Recommendation category: A; evidence type: 4)”

“Clinicians should avoid prescribing opioid pain medication and benzodiazepines concurrently whenever possible. (Recommendation category: A; evidence type: 3)”

2017 VA/DoD Clinical Practice Guideline for Opioid Therapy for Chronic Pain^{xix}

“We recommend implementing risk mitigation strategies upon initiation of long-term opioid therapy, starting with an informed consent conversation covering the risks and benefits of opioid therapy as well as alternative therapies. The strategies and their frequency should be commensurate with risk factors and include:

- Ongoing, random urine drug testing (including appropriate confirmatory testing)
- Checking state prescription drug monitoring programs
- Monitoring for overdose potential and suicidality
- Providing overdose education
- Prescribing of naloxone rescue and accompanying education

(Strong for | Reviewed, New-replaced)”

“We recommend against the concurrent use of benzodiazepines and opioids. **(Strong against | Reviewed, New-added).**”

Data Source: Claims/Paper Medical Record, Registry

Measure Steward: American Society of Anesthesiologists (ASA) / Anesthesia Quality Institute (AQI)

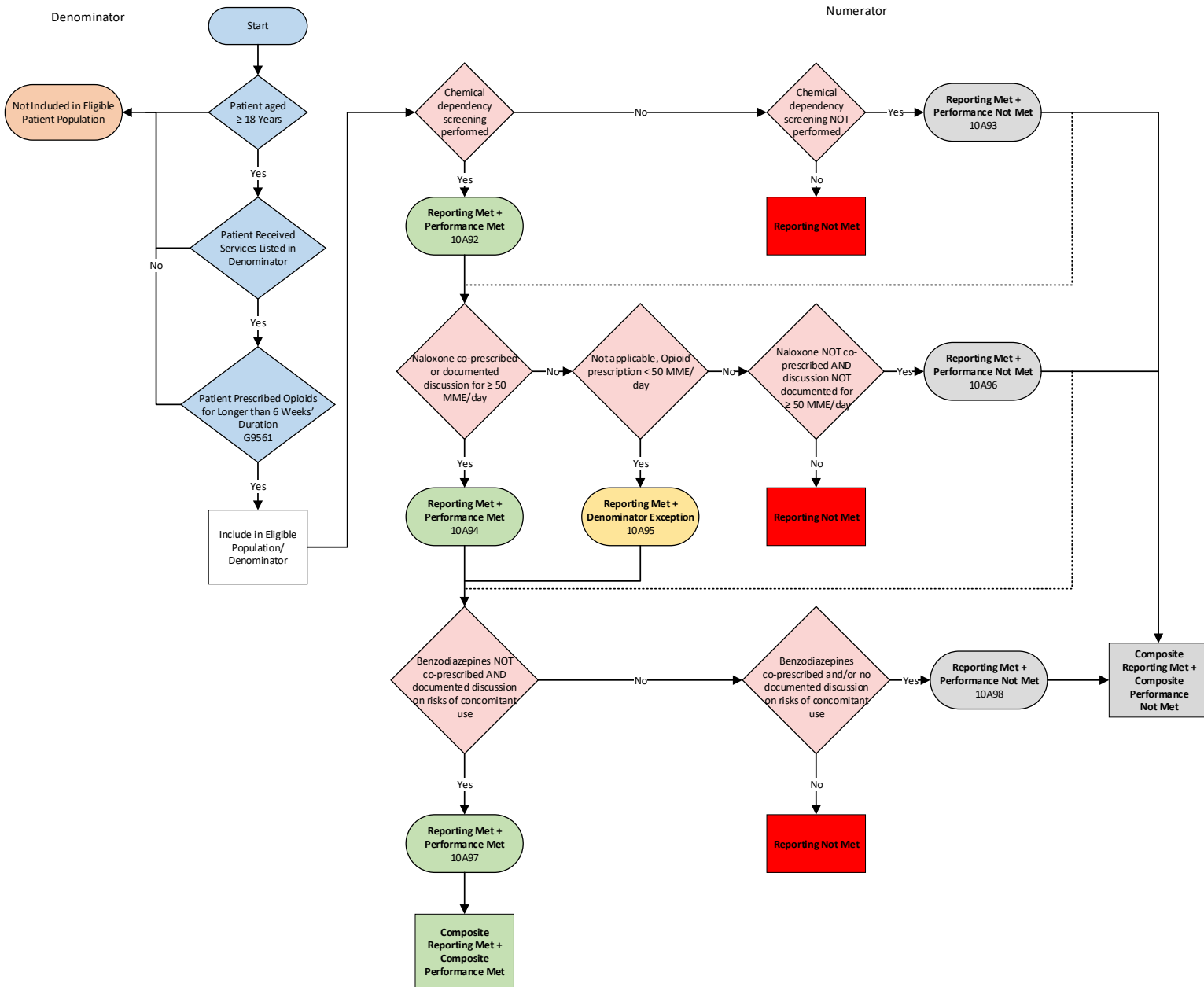
Number of Performance Rates: 1

Proportion Measure Scoring: Yes

Continuous Measure Scoring: No

Risk Adjustment: No

Safe Opioid Prescribing Practices 2020 QCDR Measure Flow



Measure Title

AQI58: Infection Control Practices for Open Interventional Pain Procedures

Measure Description

Percentage of patients, regardless of age, that undergo an open interventional pain procedure for whom ALL of the following infection control best practices are followed by anesthesiologist(s) and scrub technologist(s), in addition to standard sterile technique:

1. Double gloving (two pairs of sterile gloves are worn)
2. Chlorhexidine with alcohol used for surgical site preparation
3. Weight-based pre-operative antibiotic dosing and, if indicated by procedure duration, weight-based re-dosing
4. Administration of pre-operative antibiotics within 1 hour, or 2 hours for vancomycin, prior to surgical incision

NQS Domain / Meaningful Measures Area

Patient Safety / Healthcare-associated Infections

Measure Type

Composite - Process

High Priority Status

Yes

Inverse Measure

No

Instructions

This measure is to be reported each time a patient undergoes an open interventional pain procedure. It is anticipated that qualified anesthesia providers and eligible clinicians who provide denominator-eligible services will submit this measure.

Measure Reporting via the Qualified Clinical Data Registry

CPT codes are used to identify patients who are included in the measure denominator. Registry codes are used to report the numerator of the measure.

Denominator

All patients, regardless of age, who undergo an open interventional pain procedure

Denominator Criteria (Eligible Cases):

All patients, regardless of age

AND

Patient encounter during the reporting period (CPT): 22510, 22511, 22513, 22514, 62350, 62355, 62360, 62361, 62362, 62365, 63650, 63661, 63662, 63663, 63664, 63685, 63688

Denominator Exclusions

- None

Numerator

Patients for whom the ALL of the following infection control best practices are followed in addition to standard sterile technique:

1. Double gloving (two pairs of sterile gloves are worn)
2. Chlorhexidine with alcohol used for surgical site preparation

3. Weight-based pre-operative antibiotic dosing and, if indicated by procedure duration, weight-based re-dosing
4. Administration of pre-operative antibiotics within 1 hour, or 2 hours for vancomycin, prior to surgical incision (or start of procedure if no incision is required)

Numerator Note:

Weight-based antibiotic dosing and pre-operative antibiotic timing should be performed in accordance with the below Neurostimulation Appropriateness Consensus Committee (NACC) Recommendations:

Antibiotic	Standard intravenous dosing	Timing prior to incision	Redosing interval	Indications
Cefazolin**	1 g ≤ 80 kg	Within 30-60 min	3-4 hours (CrCl > 50 mL/min)	First-line
	2 g > 80 kg		8 hours (CrCl 20-50 mL/min)	
	3 g > 120 kg		16 hours (CrCl < 20 mL/min)	
Clindamycin	600 mg ≤ 80 kg	Within 30-60 min	6 hours (CrCl > 50 mL/min)	β-lactam allergy
	900 mg > 80 kg		6 hours (CrCl 20-50 mL/min)	
	1200 mg > 120 kg		6 hours (CrCl < 20 mL/min)	
Vancomycin	1 g ≤ 80 kg	Within 120 min	8 hours (CrCl > 50 mL/min)	β-lactam allergy Known MRSA colonization
	2 g > 80 kg		16 hours (CrCl 20-50 mL/min)	
	3 g > 120 kg		None (CrCl < 20 mL/min)	

*Modified from Bratzler et al. (89), Alexander et al. (90), and Bratzler et al. (91).
 **In an effort to simplify cefazolin weight-based dosing, the American Society of Health-System Pharmacists (ASHP) recommends 2 g for individuals weighing < 120 kg and 3 g for individuals weighing ≥ 120 kg. MRSA, methicillin-resistant *S. aureus*; CrCl, creatinine clearance.

Deer TR, Provenzano DA, Hanes M, Pope JE, Thomson SJ, Russo MA, et al. The Neurostimulation Appropriateness Consensus Committee (NACC) Recommendations for Infection Prevention and Management. *Neuromodulation*. 2017;20(1):31-50.

Numerator Quality-Data Coding Options for Reporting Satisfactorily

Measure Scoring Note: In order to receive credit for this measure, ALL four numerator criteria must be reported. See the “Composite Performance Score” section for more details on how this measure is scored.

Criterion 1:

Performance Met:

10A80 Double gloving (i.e., two pairs of sterile gloves are worn) is performed

OR

Performance Not Met:

10A81 Double gloving (i.e., two pairs of sterile gloves are worn) is NOT performed

Criterion 2:

Performance Met:

10A82 Chlorhexidine with alcohol is used for surgical site preparation

OR

10A83 Documented contraindication or allergy to chlorhexidine with alcohol

OR

Performance Not Met:

10A84 Chlorhexidine with alcohol is NOT used for surgical site preparation

Criterion 3:

Performance Met:

10A85

Weight-based preoperative antibiotic dosing and, if procedure >3 hours, weight-based re-dosing is used

OR

Performance Not Met:

10A86

Weight-based preoperative antibiotic dosing and, if procedure >3 hours, weight-based re-dosing is NOT used

Criterion 4:

Performance Met:

10A87

Pre-operative antibiotics administered within 1 hour, or 2 hours for vancomycin, prior to surgical incision (or start of procedure if no incision is required)

OR

Performance Not Met:

10A88

Pre-operative antibiotics NOT administered within 1 hour prior to surgical incision (or start of procedure if no incision is required)

Composite Performance Score

Performance Score Note: This performance score is calculated by the data source and not the individual practitioner. Eligible clinicians reporting this measure must submit numerator quality codes for each of the four numerator criteria identified in this measure. This measure utilizes an all-or-none scoring methodology where failure to meet performance for ANY of the four numerator criteria will result in performance not met for the measure. The performance score is the percentage of denominator-eligible cases for which ALL three numerator criteria are met.

Performance Met:

10A80

Double gloving (i.e., two pairs of sterile gloves are worn) is performed

AND

10A82

Chlorhexidine with alcohol is used

OR

10A83

Documented contraindication or allergy to chlorhexidine with alcohol

AND

10A85

Weight-based preoperative antibiotic dosing and, if procedure >3 hours, weight-based re-dosing is used

AND

10A87

Pre-operative antibiotics administered within 1 hour, or 2 hours for vancomycin, prior to surgical incision (or start of procedure if no incision is required)

OR

Performance Not Met:

10A81 Double gloving (i.e., two pairs of sterile gloves are worn) is NOT performed

AND/OR

10A84 Chlorhexidine with alcohol is NOT used for surgical site preparation

AND/OR

10A86 Weight-based preoperative antibiotic dosing and, if procedure >3 hours, weight-based re-dosing is NOT used

AND/OR

10A88 Pre-operative antibiotics NOT administered within 1 hour prior to surgical incision (or start of procedure if no incision is required)

NQF Number: Not Applicable

eCQM: Not Applicable

Rationale

Infections associated with open interventional pain procedures are associated with significant morbidity and healthcare costs. For implantable pain therapies, the reported infection rates range from 1 to 10%.^{xx} Two large systematic reviews on spinal cord stimulation report infection rates of 3.4 to 4.6%. The infection rates reported for implantable pain therapies are often higher than those associated with other implantable therapies including total joint replacement and cardiac pacemakers. In the field of interventional pain medicine practice deficiencies have been identified. A recent international survey of 506 physicians examining infection control practices for spinal cord stimulation highlighted the need for education. The survey demonstrated a low compliance rate for infection control recommendations that have been recommended by the Centers for Disease Control, the National Institute for Health and Care Excellence (NICE) and a Surgical Care Improvement Project.^{xxi} Only four of the 15 recommended practices surveyed demonstrated a greater than or equal to 80% compliance rates. Areas of deficiency included weight-based antibiotic dosing, hair removal strategies, double gloving, surgical dressing, skin antiseptic agent selection and inappropriate postoperative continuation of antibiotics. The compliance rates for weight-based dosing of antibiotics (47%; 95% CI: 42.6% – 51.4%), utilization of double gloving (47.8%; 95% CI: 43.4% – 52.2%), and utilization of chlorhexidine gluconate (67.7%; 95% CI: 63.6% – 71.8%) were all less than 70%.

The consequences associated with infections for implantable pain therapies and open interventional pain procedures can be devastating. For implantable pain therapy infections, the implantable device often must be removed. In addition, many patients lose therapy and are not re-implanted. A recent review of 2737 surgical site infections associated implantable pain therapies demonstrated that 77.6% were explanted.^{xxii} A recent review of claims-based data on spinal cord stimulator implants demonstrated that only 27% of patients were re-implanted and that the cost of a surgical site infection was approximate \$59,000.^{xxiii} Therefore, a surgical site infection with an implantable pain therapies is not only costly but often results in the end of the therapy. A recent analysis of the United States Anesthesia Close Claims project database examining injury and liability associated with implantable pain therapies from 1990 to 2013, demonstrated that infection was the most common damaging event. Infection represented 23% of all claims.^{xxiv}

A recent publication on quality improvement for spinal cord stimulation infection demonstrated a significant reduction in surgical site infection rates when evidence-based practices were implemented. Infection rates went from 10.4% to 1% following implementation of best practices.^{xxv}

Clinical Recommendation Statements

2016 Neurostimulation Appropriateness Consensus Committee (NACC) Recommendations for Infection Prevention and Management^{xli}

“The NACC recommends maximal sterile barrier precautions as well as double gloving for implantation of implantable pain devices.”

“The NACC recommends the use of chlorhexidine-based products combined with isopropyl alcohol for skin preparation prior to neuromodulation procedures.”

“For antimicrobial therapy to be effective, the serum and tissue levels of the agent must exceed the minimum inhibitory concentrations (MIC) prior to incision and throughout the operation. In order to exceed MIC, customized weight-based dosing is needed for each individual.”

2016 American College of Surgeons/Surgical Infection Society Surgical Site Infection Guidelines^{xxvi}

“The use of double gloves is recommended.”

“Alcohol-containing preparation should be used unless contraindication exists (e.g. fire hazard, surfaces involving mucosa, cornea, or ear).

No clear superior agent (chlorhexidine vs iodine) when combined with alcohol.

If alcohol cannot be included in the preparation, chlorhexidine should be used instead of iodine unless contraindications exist.”

“Prophylactic antibiotic dosing should be weight adjusted.

Prophylactic antibiotic should be administered within 1 hour before incision or within 2 hours for vancomycin or fluoroquinolones.”

2008 NICE Surgical Site Infections: Prevention and Treatment Clinical Guidelines^{xxvii}

“Consider wearing two pairs of sterile gloves when there is a high risk of glove perforation and the consequences of contamination may be serious.”

“Prepare the skin at the surgical site immediately before the incision using an antiseptic (aqueous or alcohol-based) preparation: povidone-iodine or chlorhexidine are most suitable.

2016 WHO Surgical Site Infection Prevention Guidelines^{xxviii}

“The panel suggests that either sterile, disposable, non-woven or sterile, reusable woven drapes and surgical gowns can be used during surgical operations for the purpose of preventing SSI. (conditional recommendation, moderate to very low quality of evidence).”

Data Source: Claims/Paper Medical Record, Registry

Measure Steward: American Society of Anesthesiologists (ASA)

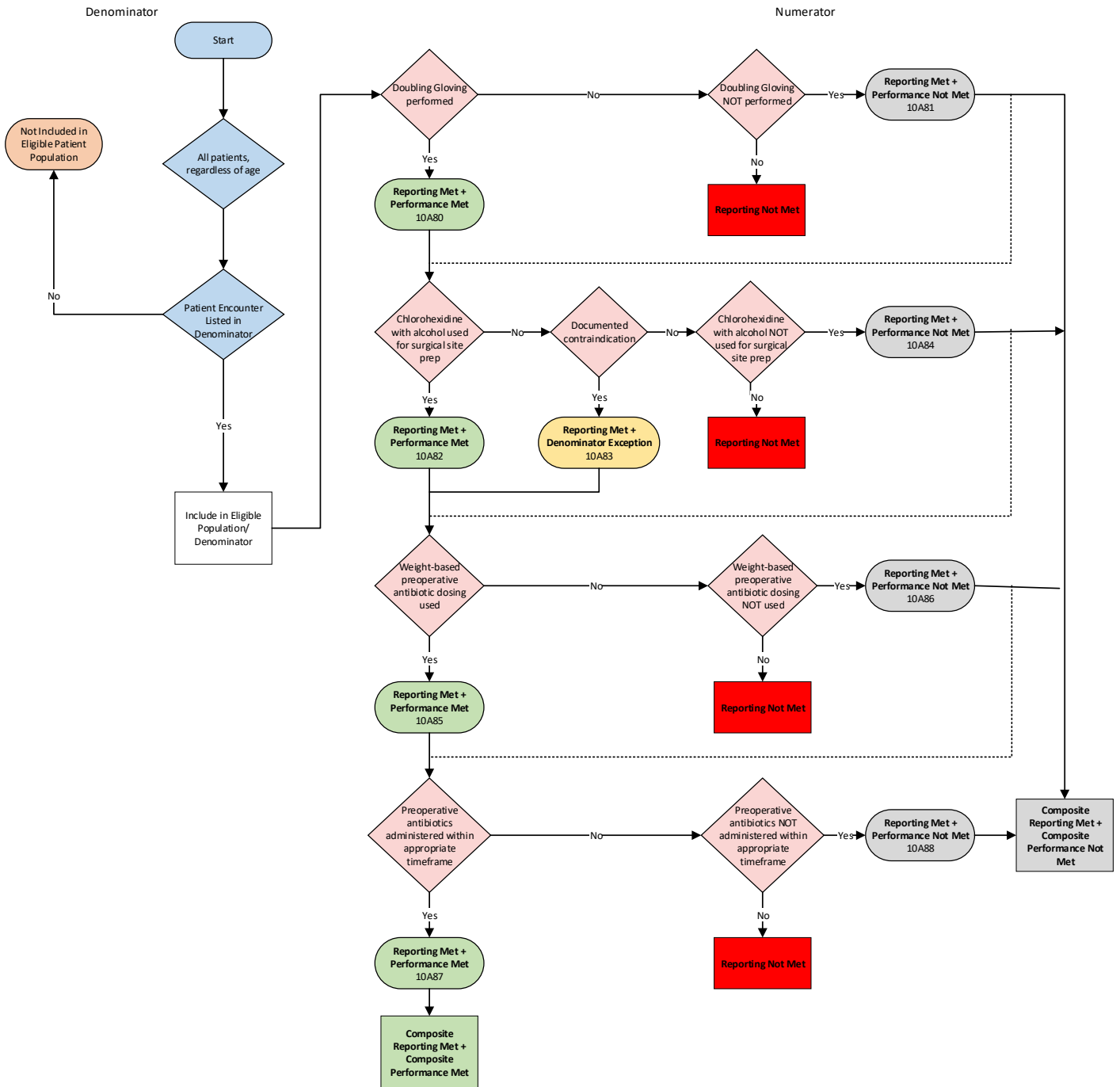
Number of Performance Rates: 1

Proportion Measure Scoring: Yes

Continuous Measure Scoring: No

Risk Adjustment: No

Infection Control Practices for Open Interventional Pain Procedures
2020 QCDR Measure Flow



Measure Title**AQI61: Ambulatory Post-Discharge Patient Follow-Up**

Measure Description: Percentage of patients, regardless of age, who received anesthesia services in an ambulatory setting whose post-discharge status was assessed within 72 hours of discharge.

NQS Domain / Meaningful Measures Area

Person and Care-giver Centered Experiences and Outcomes / Patient’s Experience of Care

Measure Type

Process

High Priority Status

Yes

Inverse Measure

No

Instructions

This measure is to be reported each time a patient undergoes a procedure in an ambulatory setting with anesthesia services during the reporting period. It is anticipated that qualified anesthesia providers and eligible clinicians who provide denominator-eligible services will submit this measure.

Measure Reporting via the Qualified Clinical Data Registry

Patient demographics, Place of Service codes and CPT codes are used to identify patients who are included in the measure denominator. Registry codes are used to report the numerator.

Denominator

Patients, regardless of age, who received anesthesia services in an ambulatory setting

Denominator Criteria (Eligible Cases):

Patients regardless of age

AND

Place of Service code: **19, 22, 24**

AND**Patient encounter during the reporting period (CPT):**

00100, 00102, 00103, 00104, 00120, 00124, 00126, 00140, 00142, 00144, 00145, 00147, 00148, 00160, 00162, 00164, 00170, 00172, 00174, 00176, 00190, 00192, 00210, 00211, 00212, 00214, 00215, 00216, 00218, 00220, 00222, 00300, 00320, 00322, 00350, 00352, 00400, 00402, 00404, 00406, 00410, 00450, 00454, 00470, 00472, 00474, 00500, 00520, 00522, 00524, 00528, 00529, 00530, 00532, 00534, 00537, 00539, 00540, 00541, 00542, 00546, 00548, 00550, 00560, 00562, 00563, 00566, 00567, 00580, 00600, 00604, 00620, 00625, 00626, 00630, 00632, 00635, 00640, 00670, 00700, 00702, 00730, 00731, 00732, 00750, 00752, 00754, 00756, 00770, 00790, 00792, 00794, 00796, 00797, 00800, 00802, 00811, 00812, 00813, 00820, 00830, 00832, 00840, 00842, 00844, 00846, 00848, 00851, 00860, 00862, 00864, 00865, 00866, 00868, 00870, 00872, 00873, 00880, 00882, 00902, 00904, 00906, 00908, 00910, 00912, 00914, 00916, 00918, 00920, 00921, 00922, 00924, 00926, 00928, 00930, 00932, 00934, 00936, 00938, 00940, 00942, 00944, 00948, 00950, 00952, 01112, 01120, 01130, 01140, 01150, 01160, 01170, 01173, 01200, 01202, 01210, 01212, 01214, 01215, 01220, 01230, 01232, 01234, 01250, 01260, 01270, 01272, 01274, 01320,

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Denominator Exclusions

- Patients who were transferred to a higher level of care: **11A34**
- Patients who were unable to be contacted or did not complete assessment after at least 2 contact attempts: **11A35**

Numerator

Patients whose post-discharge status was assessed within 72 hours of discharge. The post-discharge status assessment must address at least four of the following domains:

- *Pain Management*; including an assessment of patient satisfaction with pain control
- *Nausea/Vomiting*; including an assessment of severity.
- *Activities of Daily Living*; including an assessment of the patient's ability to return to baseline ADLs
- *Satisfaction with Care*; including an assessment of the patient's overall satisfaction with their anesthetic care
- *Questions or Concerns Regarding Discharge Instructions*; including an assessment of compliance with anesthetic discharge instructions.
- *Questions assessing complications related to anesthetic care* (e.g. possible nerve catheter infections, etc.)

Numerator Note: A post-discharge assessment can be conducted by any member of the care team via a range of communication modalities, including phone call, email, patient portal interaction, patient survey, or other means of communicating with the patient. Documentation of the assessment should include any instructions or recommendations that are given to address problems or complications that are identified. If applicable, it is appropriate for a caregiver or legal proxy to complete the assessment on the patient's behalf.

Numerator Quality-Data Coding Options for Reporting Satisfactorily

Performance Met:

11A36

Patient post-discharge status was assessed within 72 hours of discharge

OR

Performance Not Met:

11A37

Patient post-discharge status was NOT assessed within 72 hours of discharge

NQF Number: Not applicable

eCQM: Not applicable

Rationale

With increasingly complex procedures being performed in ambulatory settings, timely and comprehensive follow-up after discharge is essential to identify and manage any post-operative complications, as well as to help patients manage their recovery at home. A post-discharge conversation with the patient is also an opportunity to assess patient-reported outcomes such as pain, nausea, vomiting, and return to functional status, which can give anesthesiologists and other qualified anesthesia providers valuable information for use in ongoing practice improvement.

Data Source: Claims/Paper Medical Record, Registry

Measure Steward: American Society of Anesthesiologists (ASA)/Anesthesia Quality Institute (AQI)

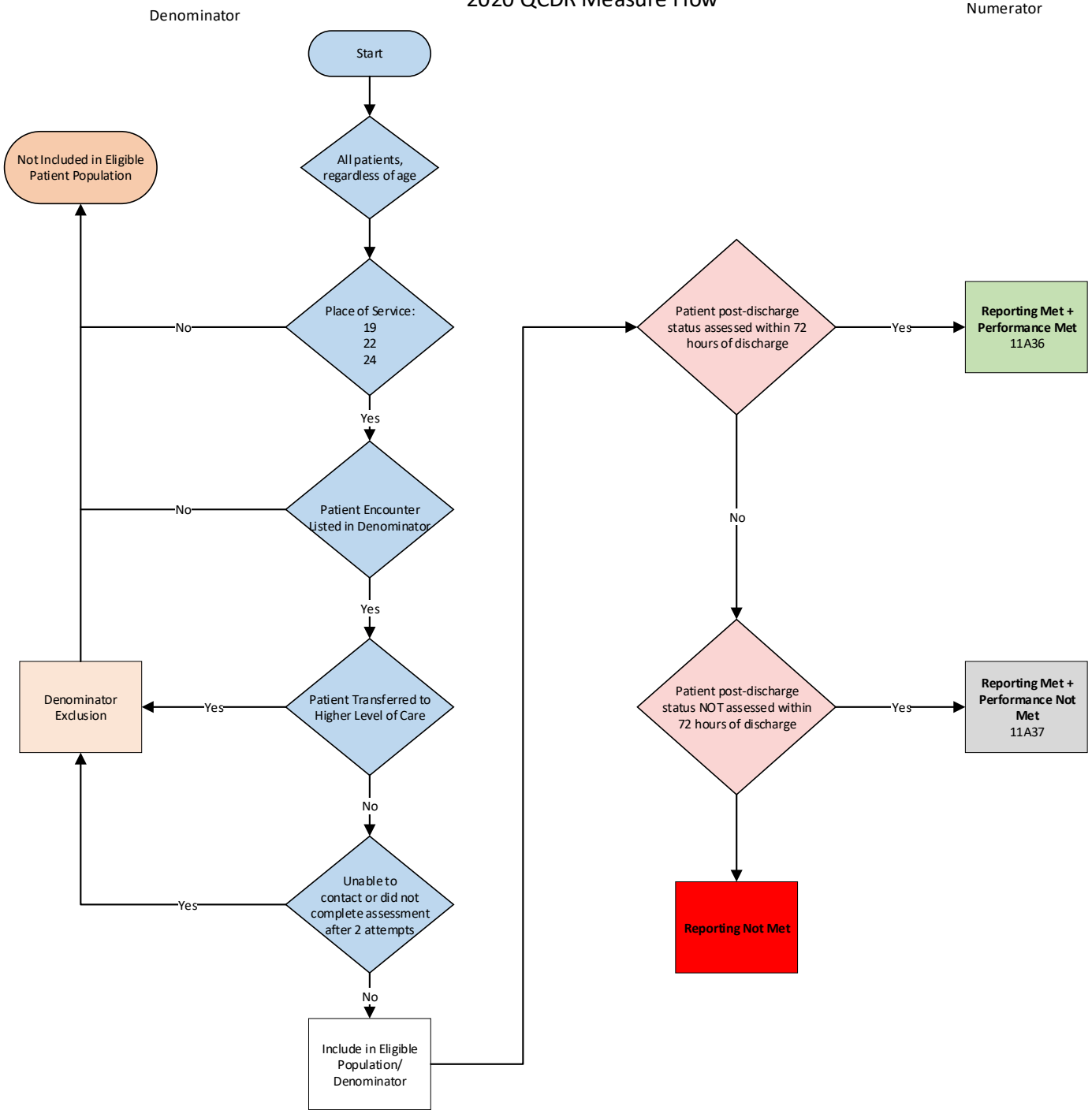
Number of Performance Rates: 1

Proportion Measure Scoring: Yes

Continuous Measure Scoring: No

Risk Adjustment: No

Ambulatory Post-Discharge Patient Follow-Up 2020 QCDR Measure Flow



Measure Title
AQI62: Obstructive Sleep Apnea: Patient Education

Measure Description: Percentage of patients aged 18 years or older, who undergo an elective procedure requiring anesthesia services who are screened for obstructive sleep apnea AND, if positive, have documentation that they received education regarding their risk for obstructive sleep apnea (OSA) prior to PACU discharge.

NQS Domain / Meaningful Measures Area
Effective Clinical Care / Management of Chronic Conditions

Measure Type
Process

High Priority Status
No

Inverse Measure
No

Instructions
This measure is to be reported each time a patient undergoes an elective procedure under anesthesia during the reporting period. It is anticipated that qualified anesthesia providers and eligible clinicians who provide denominator-eligible services will submit this measure.

Measure Reporting via the Qualified Clinical Data Registry
Patient demographics and CPT codes are used to identify patients who are included in the measure denominator. G-codes and Registry Codes are used to capture the numerator.

Denominator
All patients aged 18 years or older, who undergo an elective procedure requiring anesthesia services

Denominator Note: For the purposes of this measure, anesthesia services only include cases using general anesthesia, neuraxial anesthesia and monitored anesthesia care (MAC)

Denominator Criteria (Eligible Cases):

Patients aged 18 years and older

AND

Elective procedure: **G9643**

AND

Patient encounter during the reporting period (CPT):

00100, 00102, 00103, 00104, 00120, 00124, 00126, 00140, 00142, 00144, 00145, 00147, 00148, 00160, 00162, 00164, 00170, 00172, 00174, 00176, 00190, 00192, 00210, 00211, 00212, 00214, 00215, 00216, 00218, 00220, 00222, 00300, 00320, 00322, 00350, 00352, 00400, 00402, 00404, 00406, 00410, 00450, 00454, 00470, 00472, 00474, 00500, 00520, 00522, 00524, 00528, 00529, 00530, 00532, 00534, 00537, 00539, 00540, 00541, 00542, 00546, 00548, 00550, 00560, 00562, 00563, 00566, 00567, 00580, 00600, 00604, 00620, 00625, 00626, 00630, 00632, 00635, 00640, 00670, 00700, 00702, 00730, 00731, 00732, 00750, 00752, 00754, 00756, 00770, 00790, 00792, 00794, 00796, 00797, 00800, 00802, 00811, 00812, 00813, 00820, 00830, 00832, 00840, 00842,

00844, 00846, 00848, 00851, 00860, 00862, 00864, 00865, 00866, 00868, 00870, 00872, 00873, 00880, 00882, 00902, 00904, 00906, 00908, 00910, 00912, 00914, 00916, 00918, 00920, 00921, 00922, 00924, 00926, 00928, 00930, 00932, 00934, 00936, 00938, 00940, 00942, 00944, 00948, 00950, 00952, 01112, 01120, 01130, 01140, 01150, 01160, 01170, 01173, 01200, 01202, 01210, 01212, 01214, 01215, 01220, 01230, 01232, 01234, 01250, 01260, 01270, 01272, 01274, 01320, 01340, 01360, 01380, 01382, 01390, 01392, 01400, 01402, 01404, 01420, 01430, 01432, 01440, 01442, 01444, 01462, 01464, 01470, 01472, 01474, 01480, 01482, 01484, 01486, 01490, 01500, 01502, 01520, 01522, 01610, 01620, 01622, 01630, 01634, 01636, 01638, 01650, 01652, 01654, 01656, 01670, 01680, 01710, 01712, 01714, 01716, 01730, 01732, 01740, 01742, 01744, 01756, 01758, 01760, 01770, 01772, 01780, 01782, 01810, 01820, 01829, 01830, 01832, 01840, 01842, 01844, 01850, 01852, 01860, 01916, 01920, 01922, 01924, 01925, 01926, 01930, 01931, 01932, 01933, 01935, 01936, 01951, 01952, 01958, 01960, 01961, 01962, 01963, 01965, 01966, 01967, 01991, 01992

Denominator Exclusions

- Patient has an existing diagnosis of OSA: **G47.33 or 11A29**
- Documentation of patient reason for not providing education regarding risk for OSA (e.g., severe dementia, patient is intubated, patient is not alert or responsive enough to participate in education, other patient reason(s)): **11A30**

Numerator

Patients who are screened for obstructive sleep apnea AND, if positive, have documented education regarding their risk for obstructive sleep apnea prior to PACU discharge

Numerator Definition: Patient education regarding OSA must include documentation that a conversation addressing potential implications of OSA on the patient's perioperative course and any applicable recommendations for follow-up care and disease management occurred. Self-help materials (e.g., brochures, audio/video materials, pamphlets) alone are not sufficient to meet the numerator.

Numerator Quality-Data Coding Options for Reporting Satisfactorily

Performance Met:

11A31

Positive patient OSA screen AND documented education regarding risk for obstructive sleep apnea prior to PACU discharge

OR

Performance Met:

11A32

Negative patient screen for OSA

OR

Performance Not Met:

11A33

No patient screen for OSA OR positive OSA screen result and no documented education regarding risk for obstructive sleep apnea prior to PACU discharge

NQF Number: Not applicable

eCQM: Not applicable

Rationale

Obstructive Sleep Apnea (OSA) is a common problem in the surgical population, though many patients with OSA are undiagnosed. With improved preoperative assessment for OSA, surgery presents an important opportunity for providers to counsel patients about their risk for OSA and to educate them on the associated perioperative risks associated with the condition. This education is an opportunity to manage patient and family expectations regarding their postoperative course and is a chance to discuss anticipated complications, changes in management, and recommended follow-up care that might be appropriate.

Clinical Recommendation Statements:***2014 ASA Guidelines on Perioperative Management of Patients with Obstructive Sleep Apnea***^{lix}

“If any characteristics noted during the preoperative evaluation suggest that the patient has OSA, the anesthesiologist and surgeon should jointly decide whether to (1) manage the patient perioperatively based on clinical criteria alone or (2) obtain sleep studies, conduct a more extensive airway examination, and initiate indicated OSA treatment in advance of surgery.”

“The patient and his or her family as well as the surgeon should be informed of the potential implications of OSA on the patient’s perioperative course.”

Data Source: Claims/Paper Medical Record, Registry

Measure Steward: American Society of Anesthesiologists (ASA)/Anesthesia Quality Institute (AQI)

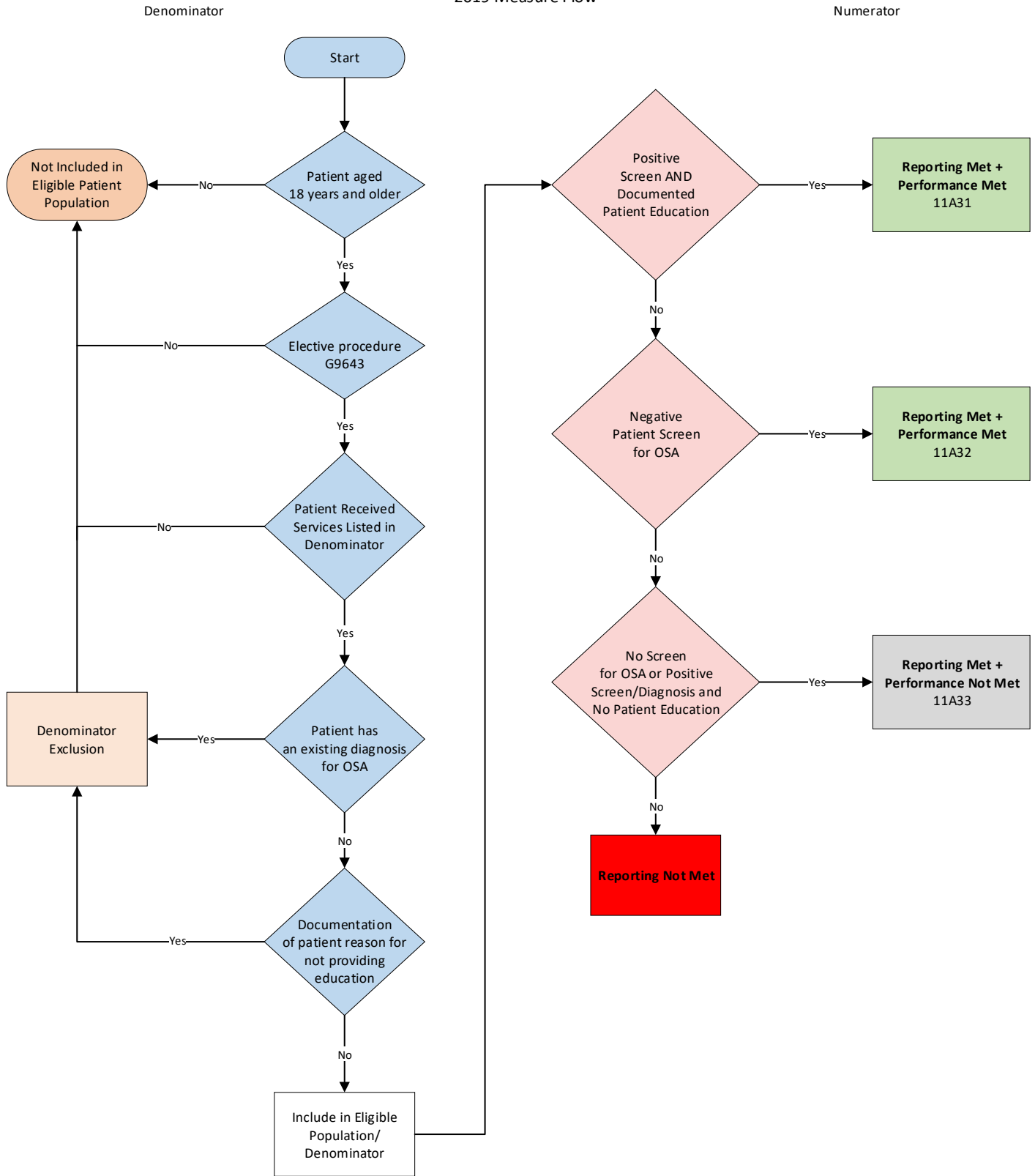
Number of Multiple Performance Rates: Not applicable

Proportion Measure Scoring: Yes

Continuous Measure Scoring: No

Risk Adjustment: No

Obstructive Sleep Apnea: Patient Education
2019 Measure Flow



Measure Title**AQI65: Avoidance of Cerebral Hyperthermia for Procedures Involving Cardiopulmonary Bypass**

Measure Description: Percentage of patients, aged 18 years and older, undergoing a procedure using cardiopulmonary bypass who did not have a documented intraoperative pulmonary artery, oropharyngeal, or nasopharyngeal temperature ≥ 37.0 degrees Celsius during the period of cardiopulmonary bypass.

NQS Domain / Meaningful Measures Area

Patient Safety / Preventable Healthcare Harm

Measure Type

Outcome

High Priority Status

Yes

Inverse Measure

No

Instructions

This measure is to be reported each time a patient undergoes a cardiac operation using cardiopulmonary bypass during the reporting period. It is anticipated that qualified anesthesia providers and eligible clinicians who provide denominator-eligible services will submit this measure.

Measure Reporting via the Qualified Clinical Data Registry

CPT codes and patient demographics are used to identify patients who are included in the measure's denominator. Registry codes are used to report the numerator.

Denominator

All patients aged 18 years or older, who undergo a procedure using cardiopulmonary bypass

Denominator Criteria (Eligible Cases):

Patient aged 18 years and older

AND

Patient encounter during the reporting period (CPT): 00562, 00563, 00567, 00580

Denominator Exclusions: None

Numerator: Patients who did not have an intraoperative pulmonary artery, oropharyngeal, or nasopharyngeal temperature ≥ 37.0 degrees Celsius during cardiopulmonary bypass

Numerator Quality-Data Coding Options for Reporting Satisfactorily**Performance Met:**

11A11

All intraoperative pulmonary artery, oropharyngeal, or nasopharyngeal temperatures < 37.0 degrees Celsius during cardiopulmonary bypass

OR

Performance Not Met:

11A12

At least one intraoperative pulmonary artery, oropharyngeal, or nasopharyngeal temperature ≥ 37.0 degrees Celsius

OR

11A13

No documented pulmonary artery, oropharyngeal, or nasopharyngeal temperatures during cardiopulmonary bypass

NQF Number: Not applicable

eCQM: Not applicable

Rationale

Appropriate temperature management in the setting of cardiopulmonary bypass (CPB) is important to avoid cerebral hyperthermia and associated cerebral injury. Studies have associated cerebral hyperthermia with complications such as cognitive dysfunction, mediastinitis, and acute kidney injury. Through careful monitoring, good communication with perfusionists, and the assurance of appropriate rewarming strategies, anesthesiologists can prevent cerebral hyperthermia.

Clinical Recommendation Statements:

2015 STS/SCA/ASECT Guidelines on Temperature Management During Cardiopulmonary Bypass^{xxix}

“Surgical teams should limit arterial outlet blood temperature to $<37^{\circ}\text{C}$ to avoid cerebral hyperthermia. (Class I, Level C)”

“Pulmonary artery or NP temperature recording is reasonable for core temperature measurement. (Class IIa, Level C)”

Data Source: Claims/Paper Medical Record, Registry

Measure Steward: American Society of Anesthesiologists (ASA) / Anesthesia Quality Institute (AQI)

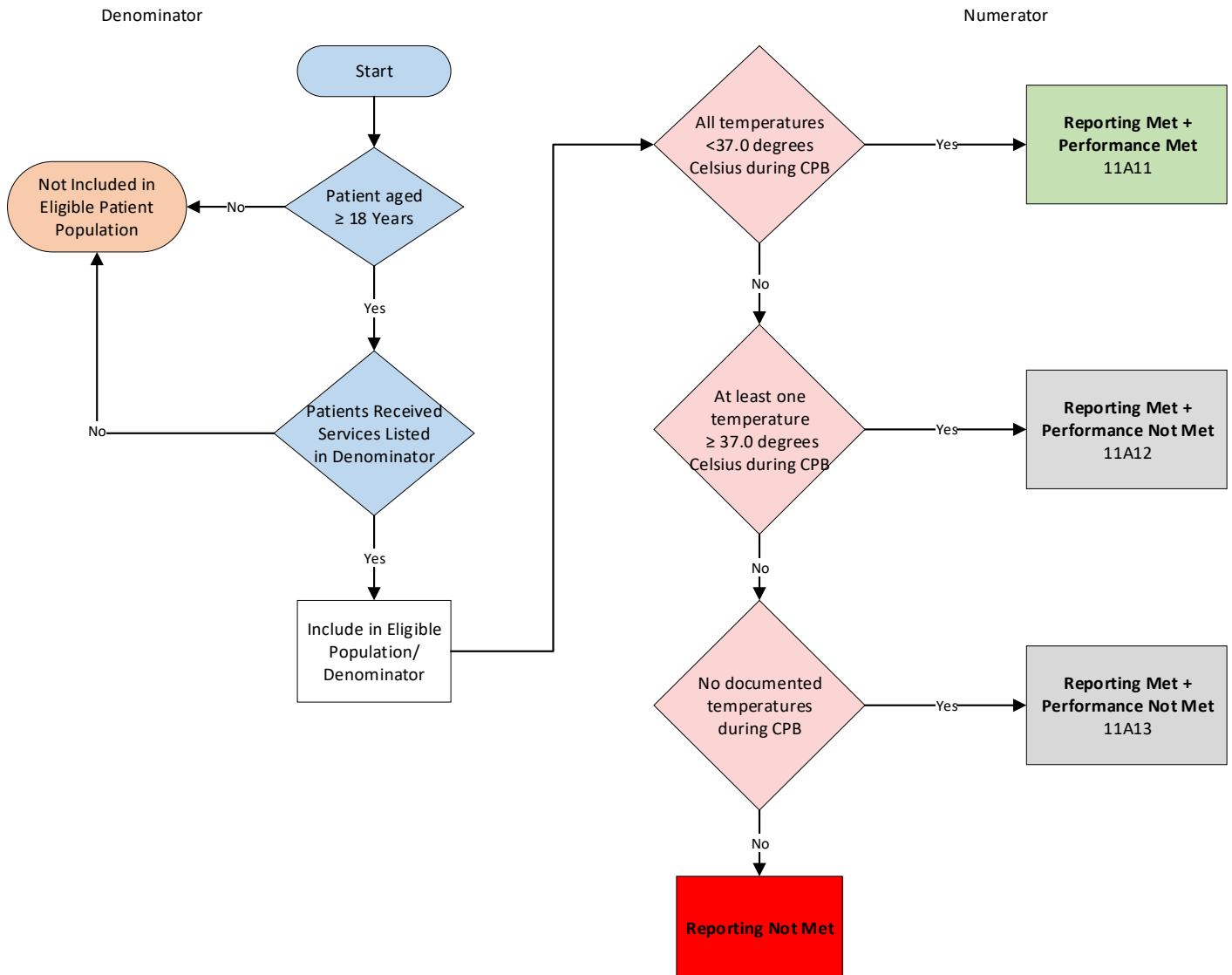
Number of Performance Rates: 1

Proportion Measure Scoring: Yes

Continuous Measure Scoring: No

Risk Adjustment: No

Avoidance of Cerebral Hyperthermia for Procedures Involving Cardiopulmonary Bypass (CPB)
2020 Measure Flow



Measure Title
AQI67: Consultation for Frail Patients

Measure Description: Percentage of patients aged 70 years or older, who undergo an inpatient procedure requiring anesthesia services and have a positive frailty screening result who receive a multidisciplinary consult or care during the hospital encounter.

NQS Domain / Meaningful Measures Area
Communication and Care Coordination / Management of Chronic Conditions

Measure Type
Process

High Priority Status
Yes

Inverse Measure
No

Instructions
This measure is to be reported each time a frail patient undergoes an inpatient procedure during the reporting period. It is anticipated that qualified anesthesia providers and eligible clinicians who provide denominator-eligible services will submit this measure.

Measure Reporting via the Qualified Clinical Data Registry
Patient demographics, Place of Service codes, CPT codes and Registry codes are used to identify patients who are included in the measure denominator. Registry codes are used to report the numerator.

Denominator: All patients aged 70 years or older, who undergo an inpatient procedure requiring anesthesia services and have a positive frailty screening result

Denominator Definition: Frailty can be screened using an established tool including but not limited to following tools:

- Fried Frailty Phenotype Criteria
- Modified Frailty Index
- The Vulnerable Elders Survey
- Initial Clinical Impression (“First Minute Impression”)

Denominator Criteria (Eligible Cases):
All patients aged 70 years and older

AND
Place of Service Code: 21

AND
Patient encounter during the reporting period (CPT):

00100, 00102, 00103, 00104, 00120, 00124, 00126, 00140, 00142, 00144, 00145, 00147, 00148, 00160, 00162, 00164, 00170, 00172, 00174, 00176, 00190, 00192, 00210, 00211, 00212, 00214, 00215, 00216, 00218, 00220, 00222, 00300, 00320, 00322, 00350, 00352, 00400, 00402, 00404, 00406, 00410, 00450, 00454, 00470, 00472, 00474, 00500, 00520, 00522, 00524, 00528, 00529, 00530, 00532, 00534, 00537, 00539, 00540, 00541, 00542, 00546, 00548, 00550, 00560, 00562, 00563, 00566, 00567, 00580, 00600, 00604, 00620, 00625, 00626, 00630, 00632, 00635, 00640,

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AND

Positive Frailty Screening Result: **11A14**

Denominator Exclusions

- Emergent cases

Numerator: Patients who receive a multidisciplinary consult and/or multidisciplinary care during the hospital encounter

Numerator Definition: A multidisciplinary consult should include documentation of a discussion of the frailty screening result and can include consultation initiated by the anesthesiologist or other qualified anesthesia provider with surgery, geriatrics, hospital medicine, palliative care, or other appropriate specialty to help manage the perioperative care of a frail patient.

Numerator Quality-Data Coding Options for Reporting Satisfactorily

Performance Met:

11A15

Patient received multidisciplinary consult and/or multidisciplinary care

OR

Performance Not Met:

11A16

Patient did not receive multidisciplinary consult or multidisciplinary care

NQF Number: Not applicable

eCQM: Not applicable

Rationale

Frailty is a health state that makes a patient particularly vulnerable to stressors, such as surgery. Among elderly surgical patients, frailty has been well-associated with post-operative complications and mortality. While evidence is still evolving regarding appropriate interventions to best manage frailty in the perioperative setting and to optimize patient outcomes, there is agreement that preoperative assessment and identification of frailty is an important first step to ensure coordinated and patient-centric care for the frail patient throughout their perioperative course. Preoperative identification of frailty and appropriate multi-disciplinary consultation allows for the care team to provide appropriate counseling regarding the anticipated outcomes of surgery, better anticipate post-operative complications, and better prepare patients and families for their postoperative course. Multi-disciplinary consultation for frail patients can also allow for the implementation of appropriate team-based care pathways to manage complications such as post-operative delirium, as well as help patients and families define their care goals and expectations.

Clinical Recommendation Statements:

2016 ACS NSQIP/AGS Guidelines on Perioperative Management of the Geriatric Patient^{xxx}

“In the immediate preoperative period the patient’s goals and treatment preferences should be confirmed and documented. Also, during this time, fasting recommendations should be followed, appropriate prophylactic medications should be given, and medications lists should be reviewed for nonessential and inappropriate medications.

The healthcare team can also take this opportunity to begin proactive, postoperative planning, especially with regard to analgesia strategies and minimization of opioids, prevention of functional decline and delirium, early multispecialty consultation where indicated, early involvement of allied health staff such as physical or occupational therapy and anticipating home health needs at discharge.”

2018 Preoperative Frailty Management Recommendations from the Society for Perioperative Assessment and Quality Improvement (SPAQI)^{xxxi}

“A positive frailty screen is best followed up with a diagnostic assessment of frailty and when feasible a comprehensive geriatric assessment with a tailored intervention, ideally by a geriatric specialist.”

“The degree of frailty will help select the target population for highly-specialized geriatric co-management programs (involving anesthesiology, surgery, and geriatric medicine) that have already been demonstrated to improve the outcomes of elderly patients in non-elective surgeries.”

Data Source: Claims/Paper Medical Record, Registry

Measure Steward: American Society of Anesthesiologists (ASA)/Anesthesia Quality Institute (AQI)

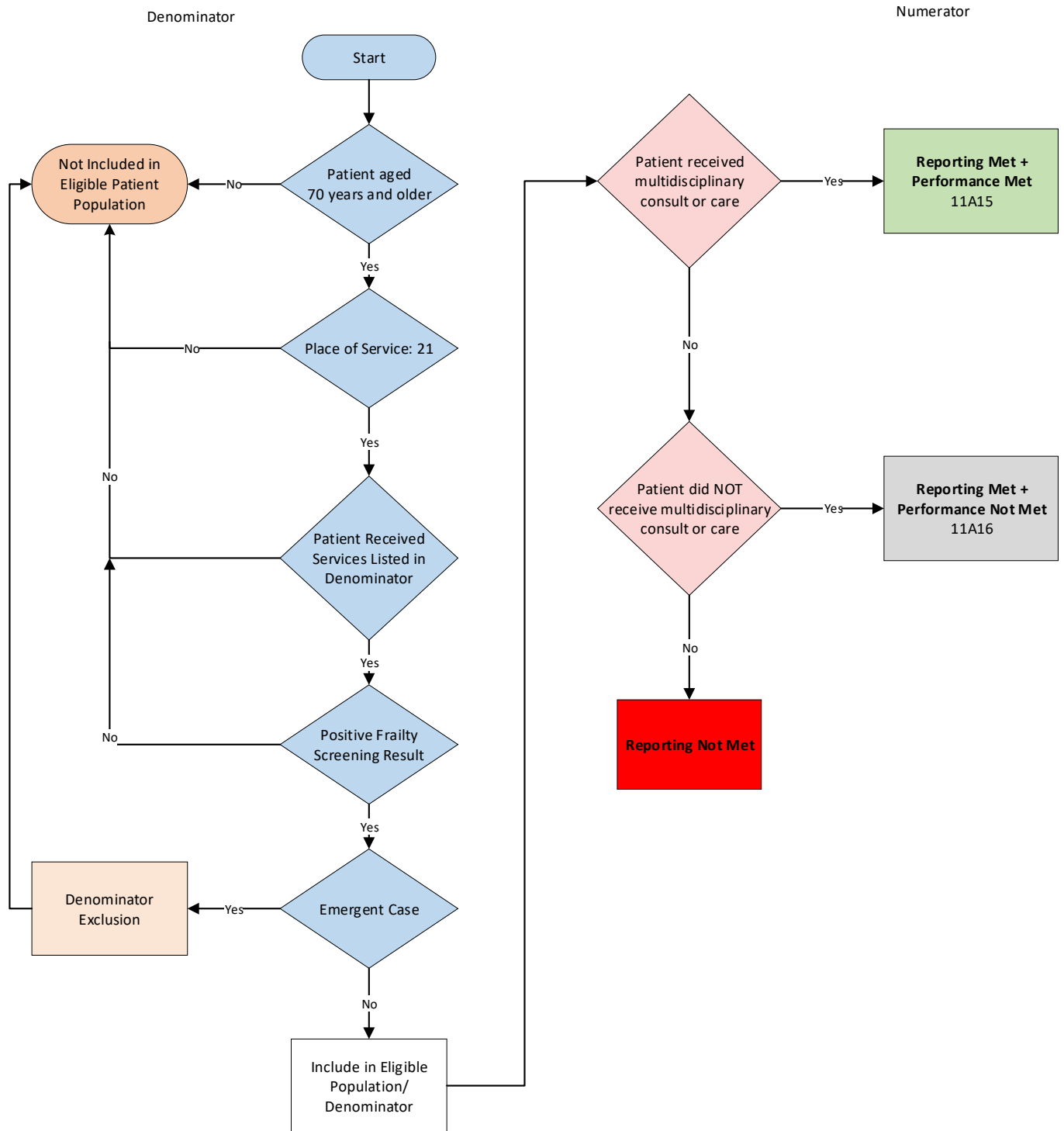
Number of Performance Rates: 1

Proportion Measure Scoring: Yes

Continuous Measure Scoring: No

Risk Adjustment: No

Consultation for Frail Patients
2020 Measure Flow



Measure Title
AQI68 Obstructive Sleep Apnea: Mitigation Strategies

Measure Description: Percentage of patients aged 18 years or older, who undergo an elective procedure requiring anesthesia services who are screened for obstructive sleep apnea (OSA) AND, if positive, for whom two or more selected mitigation strategies were used prior to PACU discharge.

NQS Domain / Meaningful Measures Area
Patient Safety / Preventable Healthcare Harm

Measure Type
Process

High Priority Status
Yes

Inverse Measure
No

Instructions

This measure is to be reported each time a patient undergoes an elective procedure under anesthesia during the reporting period. It is anticipated that qualified anesthesia providers and eligible clinicians who provide denominator-eligible services will submit this measure.

Measure Reporting via the Qualified Clinical Data Registry

Patient demographics, G-codes and CPT codes are used to identify patients who are included in the measure denominator. Registry Codes are used to capture the numerator.

Denominator: All patients aged 18 years or older, who undergo an elective procedure requiring anesthesia services

Denominator Note: For the purposes of this measure, anesthesia services only include cases using general anesthesia, neuraxial anesthesia and monitored anesthesia care (MAC)

Denominator Criteria (Eligible Cases):

Patients aged 18 years and older

AND

Elective procedure: **G9643**

AND

Patient encounter during the reporting period (CPT):

00100, 00102, 00103, 00104, 00120, 00124, 00126, 00140, 00142, 00144, 00145, 00147, 00148, 00160, 00162, 00164, 00170, 00172, 00174, 00176, 00190, 00192, 00210, 00211, 00212, 00214, 00215, 00216, 00218, 00220, 00222, 00300, 00320, 00322, 00350, 00352, 00400, 00402, 00404, 00406, 00410, 00450, 00454, 00470, 00472, 00474, 00500, 00520, 00522, 00524, 00528, 00529, 00530, 00532, 00534, 00537, 00539, 00540, 00541, 00542, 00546, 00548, 00550, 00560, 00562, 00563, 00566, 00567, 00580, 00600, 00604, 00620, 00625, 00626, 00630, 00632, 00635, 00640, 00670, 00700, 00702, 00730, 00731, 00732, 00750, 00752, 00754, 00756, 00770, 00790, 00792, 00794, 00796, 00797, 00800, 00802, 00811, 00812, 00813, 00820, 00830, 00832, 00840, 00842, 00844, 00846, 00848, 00851, 00860, 00862, 00864, 00865, 00866, 00868, 00870, 00872, 00873, 00880, 00882, 00902, 00904, 00906, 00908, 00910, 00912, 00914, 00916, 00918, 00920, 00921,

00922, 00924, 00926, 00928, 00930, 00932, 00934, 00936, 00938, 00940, 00942, 00944, 00948, 00950, 00952, 01112, 01120, 01130, 01140, 01150, 01160, 01170, 01173, 01200, 01202, 01210, 01212, 01214, 01215, 01220, 01230, 01232, 01234, 01250, 01260, 01270, 01272, 01274, 01320, 01340, 01360, 01380, 01382, 01390, 01392, 01400, 01402, 01404, 01420, 01430, 01432, 01440, 01442, 01444, 01462, 01464, 01470, 01472, 01474, 01480, 01482, 01484, 01486, 01490, 01500, 01502, 01520, 01522, 01610, 01620, 01622, 01630, 01634, 01636, 01638, 01650, 01652, 01654, 01656, 01670, 01680, 01710, 01712, 01714, 01716, 01730, 01732, 01740, 01742, 01744, 01756, 01758, 01760, 01770, 01772, 01780, 01782, 01810, 01820, 01829, 01830, 01832, 01840, 01842, 01844, 01850, 01852, 01860, 01916, 01920, 01922, 01924, 01925, 01926, 01930, 01931, 01932, 01933, 01935, 01936, 01951, 01952, 01958, 01960, 01961, 01962, 01963, 01965, 01966, 01967, 01991, 01992

Denominator Exclusions

- None

Numerator

Patients who are screened for obstructive sleep apnea AND, if positive, have documentation that two or more of the following mitigation strategies were used prior to PACU discharge:

- Preoperative initiation of continuous positive airway pressure (CPAP) or non-invasive positive pressure ventilation (NIPPV)
- Preoperative use of mandibular advancement devices or oral appliances
- Intraoperative administration of CPAP, nasopharyngeal airway, or oral appliance during sedation
- Use of major conduction anesthesia (spinal/epidural) or peripheral nerve block
- Multimodal analgesia
- Extubation while patient is awake
- Verification of full reversal of neuromuscular block
- Extubation and recovery carried out in lateral, semiupright, or other nonsupine position
- Postoperative administration of CPAP, nasopharyngeal airway, or oral appliance in the postanesthesia care unit (PACU)

Numerator Quality-Data Coding Options for Reporting Satisfactorily

Performance Met:

11A26

Positive patient screen for OSA OR existing OSA diagnosis AND documentation of two or more mitigation strategies used prior to PACU discharge

OR

Performance Met:

11A27

Negative patient screen for OSA

OR

Denominator Exception

11A38

Documentation of medical reason(s) for not screening for obstructive sleep apnea and/or documenting the use of two or more mitigation strategies (e.g., patient remains intubated postoperatively, listed mitigation strategies contraindicated, other medical reason(s))

OR

**Performance Not Met:
11A28**

No patient screen for OSA OR positive OSA screen result and Documentation of less than 2 mitigation strategies used prior to PACU discharge

NQF Number: Not applicable

eCQM: Not applicable

Rationale

Undiagnosed OSA may pose a variety of problems for anesthesiologists and qualified anesthesia providers. A number of case reports have documented an increase in the incidence of postoperative complications and deaths among patients suspected of having OSA. Untreated OSA patients are known to have a higher incidence of difficult intubation, postoperative complications, increased intensive care unit admissions, and greater duration of hospital stay. Identifying patients with OSA is the first step in preventing postoperative complications due to OSA. Moderate-to-severe sleep apnea is independently associated with a large increased risk of all-cause mortality, incident stroke, and cancer incidence and mortality in this community-based sample. With improved preoperative assessment of OSA risk, anesthesiologists are better able to tailor their care to the individual patient's needs through a variety of techniques and mitigation strategies.

Clinical Recommendation Statements:

2014 ASA Guidelines on Perioperative Management of Patients with Obstructive Sleep Apnea^{xxxii}

“Preoperative initiation of continuous positive airway pressure (CPAP) should be considered, particularly if OSA is severe.

- For patients who do not respond adequately to CPAP, NIPPV should be considered.

The preoperative use of mandibular advancement devices or oral appliances and preoperative weight loss should be considered when feasible.”

“For superficial procedures, consider the use of local anesthesia or peripheral nerve blocks, with or without moderate sedation.

If moderate sedation is used, ventilation should be continuously monitored by capnography or another automated method if feasible because of the increased risk of undetected airway obstruction in these patients.

Consider administering CPCP or using an oral appliance during sedation to patients previously treated with these modalities.”

“Major conduction anesthesia (spinal/epidural) should be considered for peripheral procedures. Unless there is a medical or surgical contraindication, patients at increased perioperative risk from OSA should be extubated while awake.

Full reversal of neuromuscular block should be verified before extubation. When possible, extubation and recovery should be carried out in the lateral, semiupright, or other nonsupine position.”

Data Source: Claims/Paper Medical Record, Registry

Measure Steward: American Society of Anesthesiologists (ASA)/Anesthesia Quality Institute (AQI)

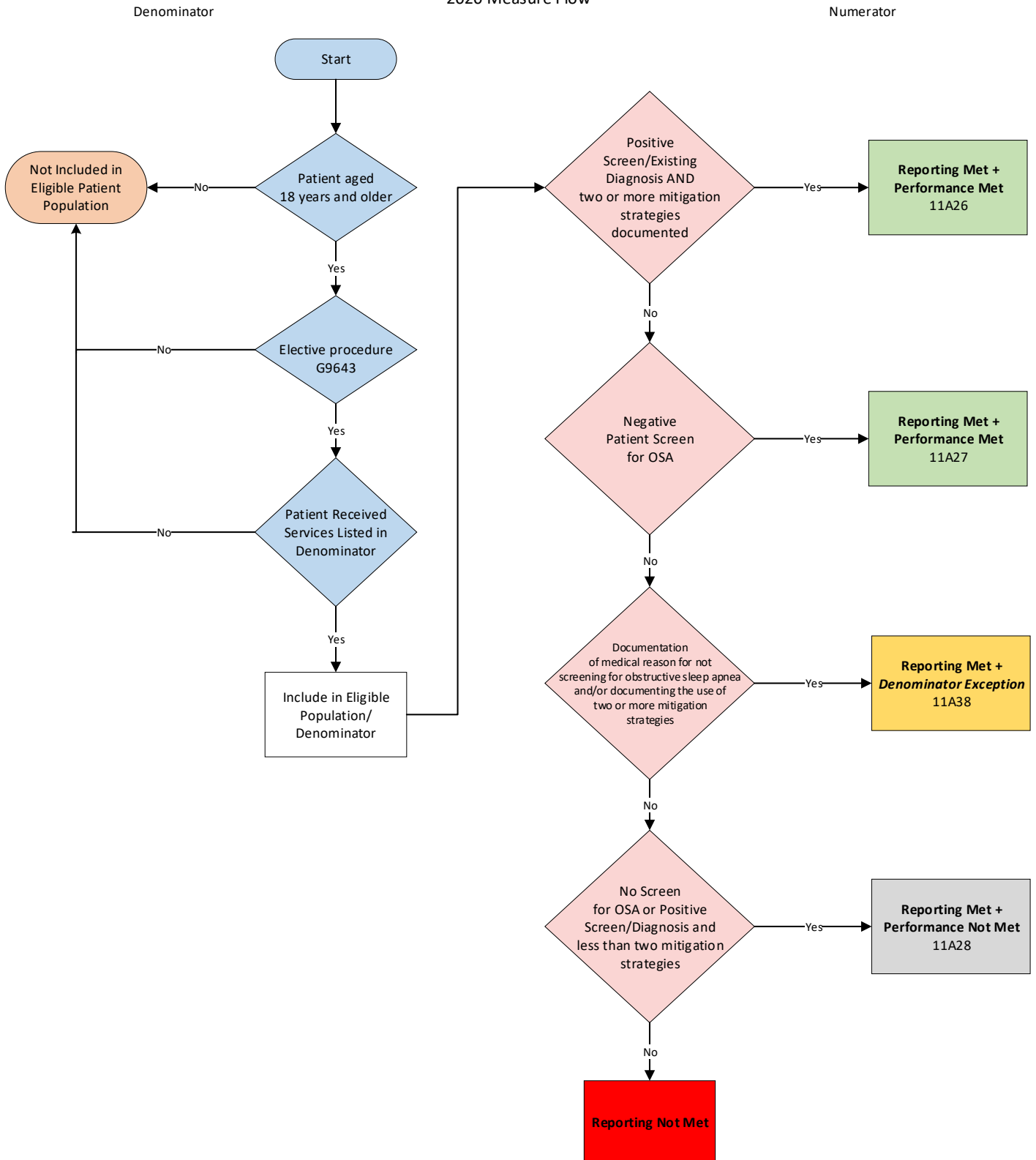
Number of Performance Rates: 1

Proportion Measure Scoring: Yes

Continuous Measure Scoring: No

Risk Adjustment: No

Obstructive Sleep Apnea: Mitigation Strategies
2020 Measure Flow



Measure Title
Quantum31: Central Line Ultrasound Guidance

ASA LICENSED THIS MEASURE FROM MEDNAX

Measure Description

Percentage of patients, regardless of age, in whom ultrasound guidance is used by the anesthesia clinician when placing a central line for those central lines that are placed in the internal jugular location.

NQS Domain / Meaningful Measures Area
Patient Safety / Preventable Healthcare Harm

Measure Type
Process

High Priority Status
Yes

Inverse Measure
No

Instructions

This measure is to be reported each time an anesthesia clinician places a central line in the internal jugular location (de novo placement). Performance of this metric requires clinician documentation that ultrasound guidance was performed at the time of central line placement.

Measure Reporting via the Qualified Clinical Data Registry

CPT codes and patient demographics are used to identify patients who are included in the measure's denominator. Registry codes are used to report the numerator of the measure.

Denominator

All patients, regardless of age, who undergo internal jugular central line placement by the anesthesia clinician.

Denominator Criteria (Eligible Cases):

All patients, regardless of age
AND

Patient encounter during the reporting period (CPT):

36555, 36556, 36557, 36558, 36560, 36561, 36563, 36565, 36566, 93503

AND

Internal jugular site insertion **10A66**

Denominator Exclusions / Exceptions

- Tunneled placement through same, existing site as previously placed and currently indwelling non - tunneled placement. **11A39**

Numerator

Use of ultrasound guidance during the central line insertion when central line is placed at the internal jugular site.

Numerator Quality-Data Coding Options for Reporting Satisfactorily

Performance Met:

10A67

Clinician used ultrasound guidance during central line placement when internal jugular site used

OR

Performance Not Met:

10A68

Clinician did not use ultrasound guidance during central line placement when internal jugular site used

NQF Number: Not Applicable

eCQM: Not Applicable

Rationale

The use of ultrasound to guide central venous cannulation has been shown to decrease adverse events including but not limited to decreased risks of cannulation failure, arterial puncture, hematoma, and hemothorax. Benefits that relate to ultrasound guidance are most appreciable for internal jugular site insertion in contrast to either subclavian or femoral insertion.^{xxxiii,xxxiv,xxxv,xxxvi}

Data Source: Claims, Medical Record, Registry

Measure Steward: MEDNAX Services, Inc.

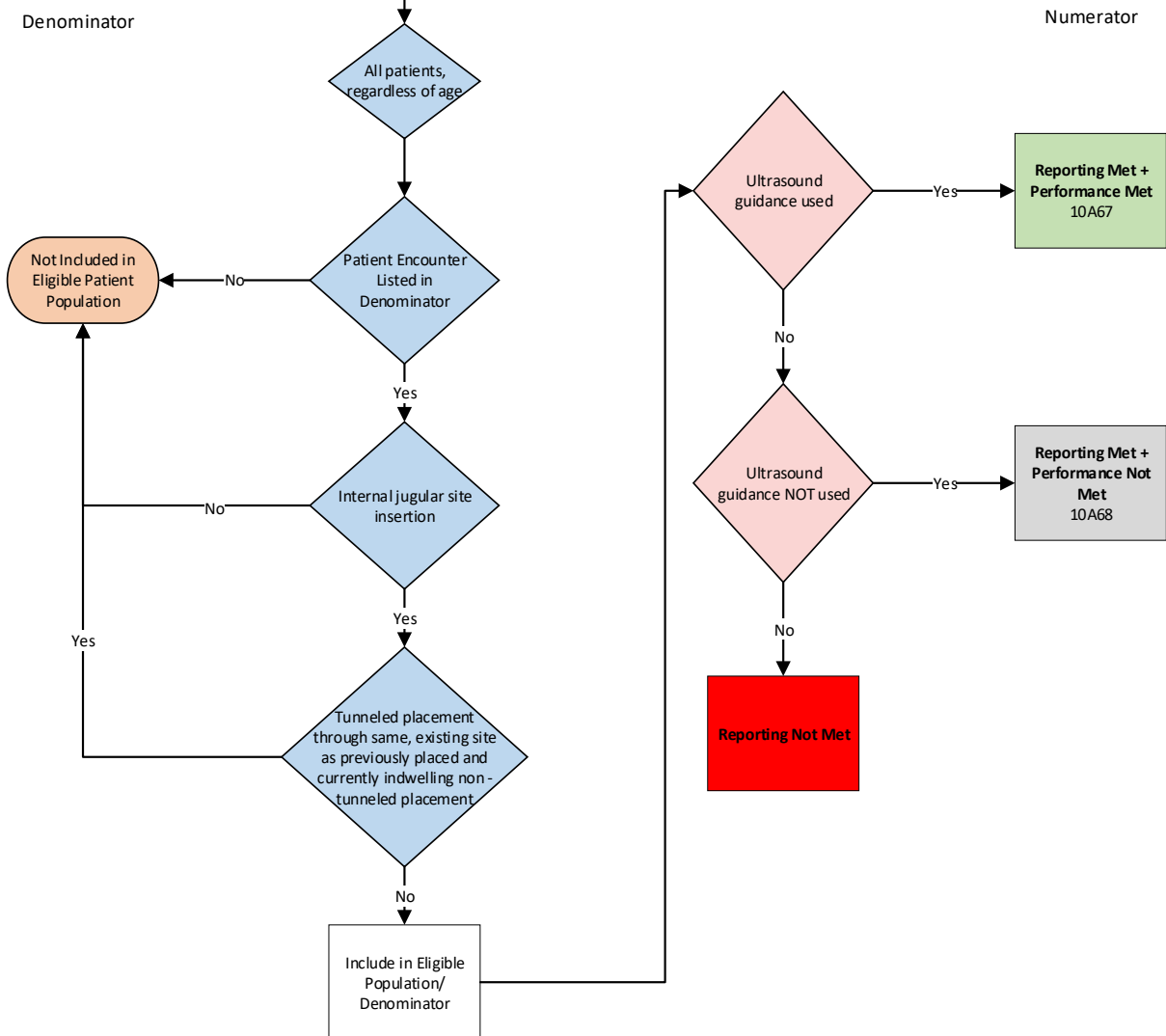
Number of Multiple Performance Rates: Not applicable

Proportion Measure Scoring: Yes

Continuous Measure Scoring: No

Risk Adjustment: No

Central Line Ultrasound Guidance 2019 QCDR Measure Flow



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