2020 MACRA Ready™ Manual

(v04/19/2020)

GRAPHIUM HEALTH™
ANESTHESIA PRACTICE SOLUTIONS

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Overview

CMS is required by law to implement a quality payment incentive program, referred to as the Quality Payment Program (QPP), which rewards value and outcomes.

1. Payment Adjustment: Each Eligible Provider (EP) - defined as any unique NPI + TIN combination - will ultimately be given a Payment Adjustment on Medicare claims ranging from a max penalty of -9% to a theoretical max bonus of +9% (but much more likely max of 4-5%). It is a function of the NPI's Composite Performance Score (CPS).

2. Composite Performance Score: The EP's Composite Performance Score ranges from 0 to 100 with 0 resulting in the max penalty and a CPS of 100 resulting in the max bonus. The CPS is determined by a complex formula consisting of weighted averages from 4 specific Performance Categories: Quality, Promoting Interoperability, Improvement Activities, and Cost.

3. Four Performance Categories: There are four performance categories that make up your final Composite Performance Score. Your final Composite Performance Score then determines what your Payment Adjustment will be.

CMS designed MIPS to update and consolidate previous programs, including: Medicare Electronic Health Records (EHR) Incentive Program for Eligible Clinicians, Physician Quality Reporting System (PQRS), and the Value-Based Payment Modifier (VBM).

MIPS was designed to tie payments to quality and cost efficient care, drive improvement in care processes and health outcomes, increase the use of healthcare information, and reduce the cost of care.

The MIPS Performance Year begins on January 1 and ends on December 31 each year. Program participants must report quality data on >70% of cases during one calendar year by March 31 of the following calendar year. For example, program participants who collected data in 2020 must report their data by March 31, 2021 to be eligible for a payment increase and to avoid a payment reduction in 2022.

Payment Adjustment

The EP's Payment Adjustment, which may be either negative (i.e. penalty) or positive (i.e bonus). This percent change will be recognized on Medicare claims filed by the NPI + TIN combination, two years after the reporting period.

Keep in mind, EPs are defined by their unique NPI + TIN combination, meaning any NPI may have several Payment Adjustments, depending on how many TINs they bill under. For example, if a given NPI files claims with CMS using 4 different TINs, they will receive 4 separate Payment Adjustments. This provides segregation between employers, such that the payment adjustment from one TIN will not affect another TIN's future claims.

The Payment Adjustment is determined by the EP's Composite Performance Score. This is a nonlinear relationship across the entire CPS range. While predicting any specific Payment Adjustment is difficult, the table below illustrates some helpful "mile markers", connecting specific payment adjustments to specific 2020 Composite Performance Scores.

Payment Adjustment	Composite Performance Score	Common Name
-9%	0	Maximum Penalty
0%	45	Performance Threshold
~2%	85	Exceptional Performer
+9% (theoretical max)*	100	Maximum Bonus

*Theoretical max bonus is a function of amount raised from the EPs paying a penalty via a negative payment adjustments. Estimates for max bonus in 2020 are closer to 4-5%.

Composite Performance Score

A CPS ranges from 0 to 100 for each Performance Year.

The CPS is determined by a complex formula consisting of weighted averages from 4 Performance Categories: Promoting Interoperability, Cost, Improvement Activities, and Quality. For "Non-Patient Facing" EPs, the weighted significance of each Performance Category is shown in the table below.

Performance Category	Weight	Notes
Promoting Interoperability	0%	• Re-weighted to 0% for non-patient facing Eligible Providers (e.g. anesthesiologists and CRNAs)
Cost	15%	• Unclear how this will be determined by CMS • No additional data submission required
Improvement Activities	15%	• Annual attestation of activities performed over the reporting period
Quality	70%	• No limit on number of measures submitted • CMS will only count your top 6 measures

In review, these 4 Performance Categories are used to determine a Composite Performance Score which is then used to determine the Payment Adjustment. Let's take a deeper dive into each of the Performance Categories.

Four Performance Categories

1. Promoting Interoperability (0% of CPS)

CMS is re-naming the Advancing Care Information performance category to Promoting Interoperability (PI) to focus on patient engagement and the electronic exchange of health information using certified electronic health record technology (CEHRT). This performance category replaced the Medicare EHR Incentive Program for EPs, commonly known as Meaningful Use.

For anesthesia practitioners, this category is re-weighted to 0%. There is no requirement for anesthesia EPs to use certified EHRs. Instead, the weight for this category is transferred to the Quality category.

2. Cost (15% of CPS)

This performance category replaces the VBM. The cost of the care you provide will be calculated by CMS based on your Medicare claims. MIPS uses cost measures to gauge the total cost of care during the year or during a hospital stay.

This is a bit of a black box, in that there is no current way to track or review this component score. Fortunately, there is no additional data submission requirement either.

3. Improvement Activities (15% of CPS)

This category includes an inventory of activities that assess how you improve your care processes, enhance patient engagement in care, and increase access to care. The inventory allows you to choose the activities appropriate to your practice from categories such as, enhancing care coordination, patient and clinician shared decision-making, and expansion of practice access.

This entails a single end-of-year attestation of the following available activities to verify to CMS that the data collected is being used to improve patient care.

The IA category accounts for 15% of the Final CPS. To earn full credit in this category, participants must attest to one of the following combinations of activities (each activity must be performed for 90 days or more during the reporting period):

- 2 high-weighted activities
- 1 high-weighted activity and 2 medium-weighted activities
- At least 4 medium-weighted activities

Activity 1: Collection and follow-up on patient experience and satisfaction data on beneficiary engagement
Description: Collection and follow-up on patient experience and satisfaction data on beneficiary engagement, including development of improvement plan.
Activity ID: IA_BE_6
Activity Weighting: High
Sub-Category: Beneficiary Engagement

Activity 2: Use of QCDR data for ongoing practice assessment and improvements
Description: Participation in a Qualified Clinical Data Registry (QCDR) and use of QCDR data for ongoing practice assessment and improvements in patient safety, including:- Performance of activities that promote use of standard practices, tools and processes for quality improvement (for example, documented preventative screening and vaccinations that can be shared across MIPS eligible clinician or groups);- Use of standard questionnaires for assessing improvements in health disparities related to functional health status (for example, use of Seattle Angina Questionnaire, MD Anderson Symptom Inventory, and/or SF-12/VR-12 functional health status assessment);- Use of standardized processes for screening for social determinants of health such as food security, employment, and housing;- Use of supporting QCDR modules that can be incorporated into the certified EHR technology; or- Use of QCDR data for quality improvement such as comparative analysis across specific patient populations for adverse outcomes after an outpatient surgical procedure and corrective steps to address adverse outcomes
Activity ID: IA_PSPA_7
Activity Weighting: Medium
Sub-Category: Patient Safety And Practice Assessment

Activity 3: Use of QCDR for feedback reports that incorporate population health
Description: Use of a QCDR to generate regular feedback reports that summarize local practice patterns and treatment outcomes, including for vulnerable populations.
Activity ID: IA_PM_7
Activity Weighting: High
Sub-Category: Population Management

Activity 4: Provide 24/7 access to eligible clinicians or groups who have real-time access to patient's medical record.
Description: Provide 24/7 access to MIPS eligible clinicians, groups, or care teams for advice about urgent and emergent care (e.g., eligible clinician and care team access to medical record, cross-coverage with access to medical record, or protocol-driven nurse line with access to medical record) that could include one or more of the following: Expanded hours in evenings and weekends with access to the patient medical record (e.g., coordinate with small practices to provide alternate hour office visits and urgent care); Use of alternatives to increase access to care team by MIPS eligible clinicians and groups, such as e-visits, phone visits, group visits, home visits and alternate locations (e.g., senior centers and assisted living centers); and/or

Provision of same-day or next-day access to a consistent MIPS eligible clinician, group or care team when needed for urgent care or transition management.
Activity ID: IA_EPA_1
Activity Weighting:High
Sub-Category Name: Expanded Practice Access

Activity 5: Participation in an AHRQ-listed patient safety organization.
Description: Participation in an AHRQ-listed patient safety organization.
Activity ID:IA_PSPA_1
Activity Weighting: Medium
Sub-Category Name: Patient Safety & Practice Assessment

NOTE: It is unnecessary to select all 5 Improvement Activities.

Keep in mind the intent of the Improvement Activities section is to incentivize you to use your QCDR quality data to improve patient care. CMS wants you to not only collect the quality data, but also analyze it and use it to inform your decisions.

4. Quality (70% of CPS)

This performance category replaces PQRS. This category covers the quality of the care you deliver, based on performance measures created by CMS, as well as medical professional and stakeholder groups. CMS will only use a maximum of 6 measures to determine your quality of care.

> ***NOTE***: While Graphium Health will report quality data for all 10 MACRA measures described below, CMS will only consider the top 6 measures. So leaving a question blank will NOT necessarily negatively impact your Payment Adjustment, *assuming there are another 6 applicable measures being recorded.*

Category Maximum Points
Each of the 6 MACRA measures is worth a max of 10 points, giving this category a maximum score of 60 points. For example, if you earn a total of 25 points from your top 6 MACRA measures, then you will have earned 41.7% (=25/60) of the Quality category.

Because the Quality Performance Category is worth 70% of the CPS, the total amount of points from this category towards CPS is 41.7% of 70 = 29.7pts.

Points per Measure
Each MACRA measure is assigned a score ranging from 0 to 10, depending on how your Performance Met for a given measure compares with the measure's national benchmark. That is, after all quality data has been collected across the country, CMS will divide a given measure's Performance Met rates into decile categories in order to create the measure's benchmark as seen in the table below for MIPS 430 (Prevention of PONV - Combo Therapy).

Decile 3	Decile 4	Decile 5	Decile 6	Decile 7	Decile 8	Decile 9	Decile 10
31.65 - 87.82	87.83 - 96.42	96.43 - 99.25	99.26 - 99.97	99.98 - 99.99	--	--	100

In this example, if your EP's Performance Met for MIPS 430 was 98.6%, then they would fall in Decile 5, thus earning a total of 5 pts for this measure.

> ***NOTE***: A Performance Rate of 69% for MACRA Measure A may actually be worth more CPS points compared to a 98% Performance Met for MACRA Measure B because the number of points earned for each measure is a function of BOTH your Performance Met AND how it compares to the measure's national benchmark.

Performance Met Percentage

In calculating any individual MACRA measures's Performance Met rate, all anesthesia cases for a given EP during the Reporting Periods are individually evaluated for all the elements required to score the MACRA measure. The individual criteria for each MACRA measure are described on the pages that follow.

Each measure for a given anesthetic case is assigned one of the following states based on the data provided by the EP:

> ***Performance Met***: Case is eligible for this measure (based on denominator criteria), and evaluation of numerator criteria resulted in successful performance
>
> ***Performance Not Met***: Case is eligible for this measure (based on denominator criteria), but evaluation of numerator criteria resulted in failed performance
>
> ***Data Completeness Not Met***: Case is eligible for this measure (based on denominator criteria) but is missing data required for numerator evaluation
>
> ***Ineligible***: Case is ineligible for this measure due to Denominator Exclusion criteria or because of missing fields. Denominator Exclusion criteria is specifically defined in each measure. For example, an ASA Physical Status of 5 may mean a given measure does not apply to a given case. "Performance Met" rate for this measure will not be affected by this case. Please review the measure definition for further details.
>
> ***Denominator Exception***: Based on denominator criteria for this measure, case was eligible, but it was ultimately excluded because it met certain additional criteria as defined by the measure. "Performance Met" rate for this measure will not be affected by this case. Please review the measure definition for further details.

Performance Met rate =

$$\frac{\#\ of\ Performance\ Met\ Cases}{\#\ of\ Performance\ Met\ Cases + \#\ of\ Performance\ NOT\ Met\ Cases}$$

Data Completeness rate =

$$\frac{\#\ of\ Performance\ Met\ Cases + \#\ of\ Performance\ NOT\ Met\ Cases}{\#\ of\ Performance\ Met\ Cases + \#\ of\ Performance\ NOT\ Met\ Cases + \#\ of\ Data\ Completeness\ NOT\ Met\ Cases}$$

Reporting Thresholds, Participation Status, & Reporting Options

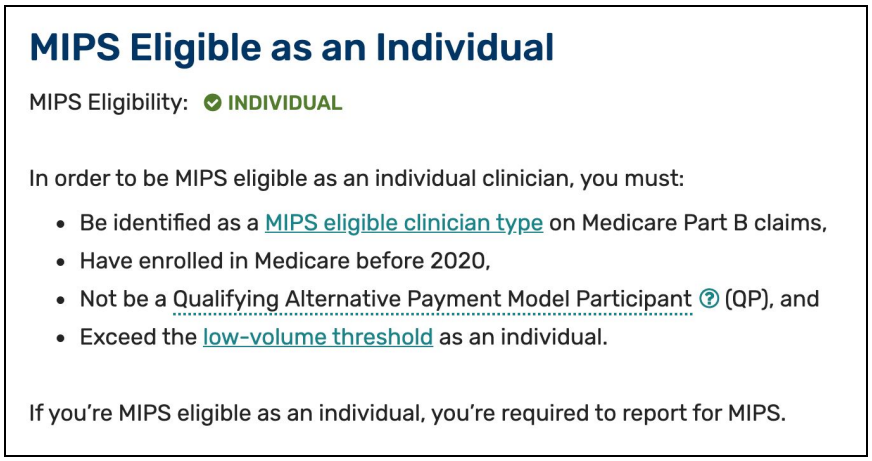
Reporting Thresholds
For the Merit-based Incentive Payment System (MIPS), CMS reviews past and current Medicare Part B Claims and Provider Enrollment, Chain, and Ownership System (PECOS) data for clinicians and practices twice for each Performance Year (each review is called a determination segment). Data from the two segments is then reconciled and released as the final eligibility determination. (Learn more: https://qpp.cms.gov/about/eligibility-determination-periods-and-snapshots?py=2020)

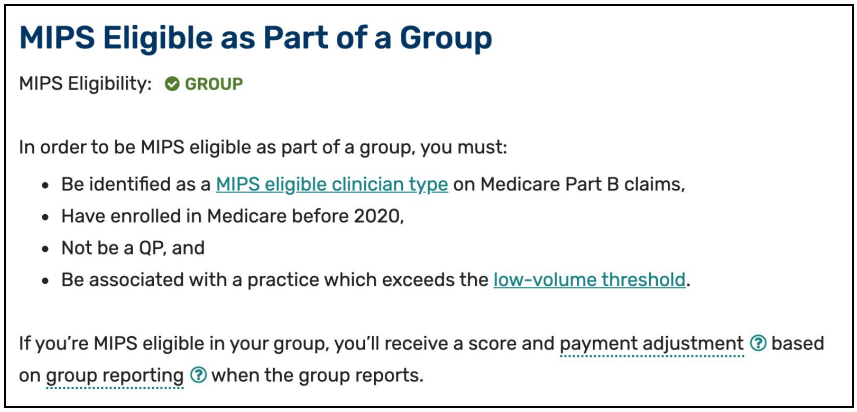
Clinicians and practices must exceed the low-volume threshold during both review periods to be eligible for MIPS.

You must participate in MIPS (unless otherwise exempt) if, in both 12-month segments of the MIPS Determination Period, you:

- Bill more than $90,000 for Part B covered professional services, and
- See more than 200 Part B patients, and;
- Provide more than 200 covered professional services to Part B patients.

Participation Status
There are different ways to become a MIPS eligible clinician, depending on whether you're reporting as an individual or part of a group.





MIPS Eligible as Part of a Group

MIPS Eligibility: GROUP

In order to be MIPS eligible as part of a group, you must:

- Be identified as a MIPS eligible clinician type on Medicare Part B claims,
- Have enrolled in Medicare before 2020,
- Not be a QP, and
- Be associated with a practice which exceeds the low-volume threshold.

If you're MIPS eligible in your group, you'll receive a score and payment adjustment based on group reporting when the group reports.

> ***NOTE***: If CMS determines a given EP is "Individual Exempt" and the EP elects to reports as an Individual, then no Payment Adjustment will be assigned, regardless of data submitted. **It is much more common for EPs to report as a Group because their group volume exceeds the low-volume threshold making them eligible to receive a positive Payment Adjustment.**

Find any EP's Participation Status at: https://qpp.cms.gov/participation-lookup

Reporting: Group vs Individual

Each TIN may report as either a "Group", "Individual", or "Both". Recall "MACRA Exempt" status is evaluated for each NPI on both an *individual* and *group* basis. That is, the "MACRA Exempt" criteria are applied at the NPI level (i.e. all cases for an NPI) and to the TIN level (i.e. all cases for a TIN). If a given NPI is deemed "Individual MACRA Exempt" by CMS and the elect to report as an Individual, then they will not receive a penalty or a bonus. Rather, CMS will label them as a "Voluntary Submitter" and while they still will receive a CPS, it will provide no financial adjustment - negative or positive.

> *Report as an Individual*
> If reporting only as an individual, the NPI's measures and activities for the given TIN will be reported to the QCDR. Composite Performance Scores will be based on individual EP's performance.
>
> *Report as a Group*
> If reporting as a group, all NPIs' measures and activities for the given TIN will be reported to the QCDR. The group's performance data across the 4 Performance Categories for a single TIN will be evaluated in aggregate. Each EP in the TIN group will then receive the same CPS based on the group's performance.
>
> **If reporting as a Group, it is important to ensure you report quality data for ALL NPIs within a given TIN.** For a complete list of all NPIs within your TIN please check your CMS portal at https://portal.cms.gov

MIPS 404: Anesthesiology Smoking Abstinence

MEASURE TYPE:
Intermediate Outcome – High Priority

DESCRIPTION:
The percentage of current smokers who abstain from cigarettes prior to anesthesia on the day of elective surgery or procedure

INSTRUCTIONS:
This measure is to be submitted each time an elective surgery, diagnostic, or pain procedure is performed under anesthesia during the performance period. There is no diagnosis associated with this measure. It is anticipated that Merit-based Incentive Payment System (MIPS) eligible clinicians who provide the listed anesthesia services as specified in the denominator coding will submit this measure.

MEASURE SUBMISSION TYPE:
Measure data may be submitted by individual MIPS eligible clinicians, groups, or third party intermediaries. The listed denominator criteria are used to identify the intended patient population. The numerator options included in this specification are used to submit the quality actions as allowed by the measure. The quality-data codes listed do not need to be submitted by MIPS eligible clinicians, groups, or third party intermediaries that utilize this modality for submissions; however, these codes may be submitted for those third party intermediaries that utilize Medicare Part B claims data. For more information regarding Application Programming Interface (API), please refer to the Quality Payment Program (QPP) website.

DENOMINATOR:
All patients aged 18 years and older who are evaluated in preparation for elective surgical, diagnostic, or pain procedure requiring anesthesia services and identified as a current smoker prior to the day of the surgery or procedure with instruction from anesthesiologist or proxy to abstain from smoking on the day of surgery or procedure.

> ***DENOMINATOR NOTE***: Preoperative smoking cessation instruction can be performed by an anesthesiologist or proxy, including but not limited to a surgeon, nursing staff, or other preoperative care team member, as part of preoperative evaluation.
>
> **Denominator Criteria (Eligible Cases)**:
> Patients aged ≥ 18 years on date of service
> **AND**
> **Patient procedure during the performance 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, 00563, 00566, 00567, 00580, 00600, 00604, 00620, 00625, 00626, 00630, 00632, 00635, 00640, 00670, 00700, 00702, 00730, 00731, 00732, 00750, 00752, 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, 01402, 01404, 01420, 01430, 01432, 01482, 01484, 01486, 01490, 01500, 01638, 01650, 01652, 01654, 01656, 01742, 01744, 01756, 01758, 01760, 01840, 01842, 01844, 01850, 01852, 01932, 01933, 01935, 01936, 01951, 62320, 62321, 62322, 62323, 62324, 64415, 64416, 64417, 64418, 64420, 64450, 64455, 64461, 64463, 64479, 64517, 64520, 64530, 0228T, 0230T, 01274, 01320, 01340, 01360, 01380, 01382, 01390, 01392, 01400, 01440, 01442, 01444, 01462, 01464, 01470, 01472, 01474, 01480, 01502, 01520, 01522, 01610, 01620, 01622, 01630, 01634, 01636, 01670, 01680, 01710, 01712, 01714, 01716, 01730, 01732, 01740, 01770, 01772, 01780, 01782, 01810, 01820, 01829, 01830, 01832, 01860, 01916, 01920, 01922, 01924, 01925, 01926, 01930, 01931, 01952, 01958, 01960, 01961, 01966, 01991, 01992, 27095, 27096, 62325, 62326, 62327, 64400, 64405, 64408, 64421, 64425, 64430, 64435, 64445, 64446, 64447, 64448, 64449, 64483, 64486, 64487, 64488, 64489, 64490, 64493, 64505, 64510

AND

Current smoker (e.g. cigarette, cigar, pipe, e-cigarette or marijuana): G9642
Elective surgery: G9643

AND

Received instruction from the anesthesiologist or proxy prior to the day of surgery to abstain from smoking on the day of surgery: G9497

NUMERATOR:

Patients who abstained from smoking prior to anesthesia on the day of surgery or procedure

Definition:
Abstinence - Defined by either patient self-report or an exhaled carbon monoxide level of < 10 ppm.

Numerator Options:
Performance Met:
Patients who abstained from smoking prior to anesthesia on the day of surgery or procedure (**G9644**)

OR

Performance Not Met:
Patients who did not abstain from smoking prior to anesthesia on the day of surgery or procedure (**G9645**)

RATIONALE:

Each year, approximately 10 million cigarette smokers require surgery and anesthesia in the U.S. Smoking is a significant independent risk factor for perioperative heart, lung, and wound-related complications. There now is good evidence that perioperative abstinence from smoking reduces the risk of heart, lung, and wound-related perioperative complications, and that the perioperative period represents a "teachable moment" for smoking cessation that improves long-term abstinence rates. While a longer duration of abstinence is associated with a greater benefit for patients, even just abstinence on the morning of surgery is associated with reduced levels of nicotine and carbon monoxide levels and a reduced risk of myocardial ischemia and surgical site infections. Evidence shows that perioperative tobacco cessation interventions can 1) increase perioperative abstinence rates in surgical patients who smoke and 2) decrease the rate of perioperative complications. Recent reviews identified a range of effective interventions, from brief counseling to the use of behavioral therapy and pharmacotherapy, that physicians who care for surgical patients (e.g., anesthesiologists and surgeons) can incorporate into their practices to improve perioperative smoking abstinence. Unfortunately, evidence also suggests that few of these physicians take advantage of the opportunity to intervene, and that many surgical patients still smoke even on the morning of surgery. If more surgical patients get help to quit smoking around the time of surgery, this will both reduce the rate of smoking-related perioperative complications such as wound infection, and lead to long-term improvements in health, as the average smoker gains 6-8 life years if they quit. Thus, this measure on abstinence on the morning of surgery not only directly affects acute surgical risk, but also serves as a marker for the provision of effective preoperative tobacco use interventions.

RELEVANT FIELDS

- Date of service
- Date of birth
- ASA CPT code
- Smoker status

- Elective case
- Received cessation instructions
- Smoked on day of procedure

REPORTING CODES

MIPS 404 Code	Definition
G9642	Current smoker (e.g. cigarette, cigar, pipe, e-cigarette or marijuana)
G9643	Elective surgery
G9497	Received instruction from the anesthesiologist or proxy prior to the day of surgery to abstain from smoking on the day of surgery
G9644	Patients who abstained from smoking prior to anesthesia on the day of surgery or procedure
G9645	Patients who did not abstain from smoking prior to anesthesia on the day of surgery or procedure

AQI 62: 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.

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

Denominator Exclusions

Patient has an existing diagnosis of OSA: G47.33 or 11A29

OR

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 Options:

Performance Met:

Positive patient OSA screen AND documented education regarding risk for obstructive sleep apnea prior to PACU discharge (**11A31**)

OR

Performance Met:

Negative patient screen for OSA (**11A32**)

OR

Performance Not Met:

No patient screen for OSA OR positive OSA screen result and no documented education regarding risk for obstructive sleep apnea prior to PACU discharge (**11A33**)

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.

RELEVANT FIELDS

- Date of service
- Date of birth
- ASA CPT code
- Elective case
- Existing OSA diagnosis
- Patient not able to receive education
- OSA screening results
- OSA education received

REPORTING CODES

AQI 62 Code	Definition
11A29	Patient has an existing diagnosis of OSA
11A30	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))
11A31	Positive patient OSA screen AND documented education regarding risk for obstructive sleep apnea prior to PACU discharge

11A32	Negative patient screen for OSA
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

AQI 68: 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.

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 Options:

Performance Met:

Positive patient screen for OSA OR existing OSA diagnosis AND documentation of two or more mitigation strategies used prior to PACU discharge (**11A26**)

OR

Performance Met:

Negative patient screen for OSA (**11A27**)

OR

Denominator Exception:

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)) (**11A38**)

OR

Performance Not Met:

No patient screen for OSA OR positive OSA screen result and Documentation of less than 2 mitigation strategies used prior to PACU discharge (**11A28**)

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.

RELEVANT FIELDS

- Date of service
- Date of birth
- ASA CPT code
- Elective case
- Existing OSA diagnosis
- OSA screening results
- ≥2 OSA mitigation strategies used

REPORTING CODES

AQI 68 Code	Definition
G9643	Elective procedure
11A26	Positive patient screen for OSA OR existing OSA diagnosis AND documentation of two or more mitigation strategies used prior to PACU discharge
11A27	Negative patient screen for OSA
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))
11A28	No patient screen for OSA OR positive OSA screen result and Documentation of less than 2 mitigation strategies used prior to PACU discharge

ABG 16: Planned use of difficult airway**

DOMAIN: Effective Clinical Care

MEASURE TYPE: Process

DESCRIPTION:
For all patients on whom difficult airway equipment is used in the operating room/procedure room, the rate with which it's use is planned ahead of time for either therapeutic or educational purposes.

INSTRUCTIONS:
Users must report at least one ABG Observation code in the intraoperative phase of care for the case to be counted in the reporting numerator. Cases with Observation code 36 will be counted in the performance numerator. Cases with Observation codes 4, 36, 37 and 38 will be counted in the performance denominator.

DENOMINATOR:

Denominator Criteria (Eligible Cases):
Patient with an encounter criteria (Eligible Cases)
AND
Excluding the following ABG observations: 002, 063, 064, 065 (case cancellations)
AND
ASA PS ≤ 4

Denominator Exclusions:
Labor Epidural (CPT codes `01960, 01967`)

NUMERATOR: Inverse Measure

Numerator Options:
Performance Met:
ABG Observation 036 (use of difficult airway equipment, planned) Reported intraoperatively

OR

Performance Not Met:
ABG Observation 037, 38 or 4 (unplanned use of difficult airway equipment, unable to intubate or failed airway). Reported intraoperatively

Denominator Exceptions: ABG Observation 4, 36, 37 OR 38 **NOT** reported

RELEVANT FIELDS

- ASA CPT code
- Case cancellation
- Difficult airway
- Planned use of difficult airway equipment
- Unplanned use of difficult airway equipment

REPORTING CODES

ABG 16 Code	Definition
002	Case cancelled
036	Planned use of difficult airway equipment
037	Unplanned use of difficult airway equipment, unable to intubate or failed airway

ABG 38: Second Provider Present for Induction/Intubation of Known or Suspected Difficult Airway**

MEASURE DESCRIPTION:
In adult patients with a known or suspected difficult airway, presence of a dedicated second provider at induction of general endotracheal anesthesia who can serve as an assistant for management of a difficult airway.

NATIONAL QUALITY STRATEGY DOMAIN: Patient Safety

MEASURE TYPE: Process

HIGH PRIORITY STATUS: Yes

INVERSE MEASURE: No

RISK ADJUSTED: No

INSTRUCTIONS:
This measure is to be reported each time an adult patient with a suspected difficult airway undergoes general anesthesia requiring placement of an endotracheal tube. At the time of induction and placement of the endotracheal tube a second dedicated provider will be present to serve as an assistant for management of a difficult airway. It is anticipated that qualified anesthesia providers and eligible clinicians who provide denominator-eligible services will submit this measure.

DENOMINATOR:
Patients, aged 18 years and older with a known or suspected difficult airway who undergo general anesthesia with an endotracheal tube (**ABG MRC 1019**)

> **Denominator Criteria (Eligible Cases):**
> **Patients aged 18 years and older**
> **AND**
> **Elective case**
> **AND**
> **Patient encounter during the reporting period:**
> 00100, 00102, 00103, 00104, 00120, 00124, 00126, 00140, 00142, 00144, 00176, 00190, 00192, 00210, 00211, 00322, 00326, 00350, 00352, 00400, 00500, 00520, 00522, 00524, 00528, 00546, 00548, 00550, 00560, 00600, 00700, 00702, 00730, 00740, 00750, 00797,

00800, 00802, 00810, 00820, 00851, 00860, 00862, 00864, 00865, 00906, 00908, 00910, 00912, 00914, 00930, 00932, 00934, 00936, 00938, 00942, 00944, 00948, 00950, 00952, 00145, 00147, 00148, 00160, 00162, 00164, 00170, 00172, 00212, 00214, 00215, 00216, 00218, 00220, 00222, 00300, 00402, 00404, 00406, 00410, 00450, 00454, 00470, 00472, 00529, 00530, 00532, 00534, 00537, 00539, 00540, 00541, 00604, 00620, 00625, 00626, 00630, 00632, 00635, 00640, 00752, 00754, 00756, 00770, 00790, 00792, 00794, 00796, 00830, 00832, 00834, 00836, 00840, 00842, 00844, 00846, 00866, 00868, 00870, 00872, 00873, 00880, 00882, 00902, 00916, 00918, 00920, 00921, 00922, 00924, 00926, 00928, 00940, 01112, 01120, 01130, 01140, 01150, 01160, 01170, 01173, 00174, 00320, 00474, 00542, 00670, 00848, 00904, 01180, 01190, 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, 01682, 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, 01924, 01925, 01926, 01930, 01931, 01932, 01933, 01935, 01936, 01951, 01952, 01961, 01962, 01963, 01965, 01966, 01992

AND

Patient having GETA with endotracheal intubation (ABG MRC 1019)

AND

Patient identified as a known or suspected difficult airway (ABG MRC 1073)

NUMERATOR:

Patient who by history or physical examination is suspected of having a difficult airway and for whom general anesthesia with an endotracheal tube is planned. The presence of a dedicated second provider for the induction and placement of the endotracheal tube shall be documented.

Numerator Note: Suspected difficult airway - A difficult airway is defined as the clinical situation in which a conventionally trained anesthesiologist experiences difficulty with facemask ventilation of the upper airway, difficulty with tracheal intubation, or both. The difficult airway represents a complex interaction between patient factors, the clinical setting, and the skills of the practitioner.

Numerator Note: Dedicated second provider - capable healthcare provider whose only responsibility at the time of induction is to provide assistance for management of difficult

airway. A dedicated second provider may include operating staff physician, certified registered nurse anesthetist, registered nurse, resident, or anesthesia technician.

Numerator Options:

Performance Met:

A dedicated second provider is present at induction and placement of the endotracheal tube (**ABG MRC 1074**)

OR

Performance Not Met:

A dedicated second provider is NOT present at induction and placement of the endotracheal tube (**ABG MRC 1075**)

RELEVANT FIELDS

- Date of procedure
- Date of birth
- ASA CPT code
- Elective case
- Difficult airway
- 2nd provider present

REPORTING CODES

ABG 38 Code	Definition
ABG MRC 1019	Known or suspected difficult airway who undergo general anesthesia with an endotracheal tube
ABG MRC 1073	Patient identified as a known or suspected difficult airway
ABG MRC 1074	A dedicated second provider is present at induction and placement of the endotracheal tube
ABG MRC 1075	A dedicated second provider is NOT present at induction and placement of the endotracheal tube

MIPS 430: Prevention of Post-Operative Nausea and Vomiting (PONV) – Combination Therapy

MEASURE TYPE:
Process – High Priority

DESCRIPTION:
Percentage of patients, aged 18 years and older, who undergo a procedure under an inhalational general anesthetic, AND who have three or more risk factors for post-operative nausea and vomiting (PONV), who receive combination therapy consisting of at least two prophylactic pharmacologic anti-emetic agents of different classes preoperatively and/or intraoperatively

INSTRUCTIONS:
This measure is to be submitted each time any procedure including surgical, therapeutic or diagnostic under an inhalational general anesthetic is performed during the performance period. There is no diagnosis associated with this measure. It is anticipated that Merit-based Incentive Payment System (MIPS) eligible clinicians who provide the listed anesthesia services as specified in the denominator coding will submit this measure.

MEASURE SUBMISSION TYPE:
Measure data may be submitted by individual MIPS eligible clinicians, groups, or third party intermediaries. The listed denominator criteria are used to identify the intended patient population. The numerator options included in this specification are used to submit the quality actions as allowed by the measure. The quality-data codes listed do not need to be submitted by MIPS eligible clinicians, groups, or third party intermediaries that utilize this modality for submissions; however, these codes may be submitted for those third party intermediaries that utilize Medicare Part B claims data. For more information regarding Application Programming Interface (API), please refer to the Quality Payment Program (QPP) website.

DENOMINATOR:
All patients, aged 18 years and older, who undergo any procedure including surgical, therapeutic or diagnostic under an inhalational general anesthetic, AND who have three or more risk factors for PONV

Definition:
PONV Risk Factors – The following are risk factors for PONV:

- Female gender
- History of PONV
- History of motion sickness

- Non-smoker
- Intended administration of opioids for post-operative analgesia. This includes use of opioids given intraoperatively and whose effects extend into the post anesthesia care unit (PACU) or post-operative period, or opioids given in the PACU, or opioids given after discharge from the PACU.

Denominator Criteria (Eligible Cases):

Patients aged ≥ 18 years on date of service

AND

Patient procedure during the performance 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, 00566, 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, 01924, 01925, 01926, 01930, 01931, 01932, 01933, 01935, 01936, 01951, 01952, 01961, 01962, 01963, 01965, 01966

AND

Patient received inhalational anesthetic agent: 4554F

AND

Patient exhibits 3 or more risk factors for post-operative nausea and vomiting: 4556F

NUMERATOR:
Patients who receive combination therapy consisting of at least two prophylactic pharmacologic anti-emetic agents of different classes preoperatively and/or intraoperatively

Definition:
Anti-emetics Therapy – The recommended first- and second-line classes of pharmacologic anti-emetics for PONV prophylaxis in patients at moderate to severe risk of PONV include (but are not limited to):

- NK-1 Receptor Antagonists
- 5-Hydroxytryptamine (5-HT3) Receptor Antagonists
- Glucocorticoids
- Phenothiazines
- Phenylethylamines
- Butyrophenones
- Antihistamines
- Anticholinergics

NOTE: The foregoing list of medications/drug names is based on clinical guidelines and other evidence. The specified drugs were selected based on the strength of evidence for their clinical effectiveness. This list of selected drugs may not be current. Physicians and other health care professionals should refer to the FDA's web site page entitled "Drug Safety Communications" for up-to-date drug recall and alert information when prescribing medications.

Numerator Options:
Performance Met:
Patient received at least 2 prophylactic pharmacologic anti- emetic agents of different classes preoperatively and/or intraoperatively (**G9775**)

OR

Denominator Exception:
Documentation of medical reason for not receiving at least 2 prophylactic pharmacologic anti-emetic agents of different classes preoperatively and/or intraoperatively (e.g., intolerance or other medical reason) (**G9776**)

OR

Performance Not Met: Patient did not receive at least 2 prophylactic pharmacologic anti-emetic agents of different classes preoperatively and/or intraoperatively (**G9777**)

RATIONALE:
Postoperative nausea and vomiting (PONV) is an important patient-centered outcome of anesthesia care. PONV is highly dis-satisfying to patients, although rarely life-threatening. A large body of scientific literature has defined risk factors for PONV; demonstrated effective prophylactic regimes based on these risk factors, and demonstrated high variability in this

outcome across individual centers and providers. Further, a number of papers have shown that performance can be assessed at the level of individual providers -- the outcome is common enough that sufficient power exists to assess variability and improvement at this level.

RELEVANT FIELDS

- Date of procedure
- Date of birth
- ASA CPT code
- Received inhalational agent
- ≥3 PONV risk factors
- Received ≥2 agents in different classes

REPORTING CODES

MIPS 430 Code	Definition
4554F	Patient received inhalational anesthetic agent
4556F	Patient exhibits 3 or more risk factors for post-operative nausea and vomiting
G9775	Patient received at least 2 prophylactic pharmacologic anti- emetic agents of different classes preoperatively and/or intraoperatively
G9776	Documentation of medical reason for not receiving at least 2 prophylactic pharmacologic anti-emetic agents of different classes preoperatively and/or intraoperatively (e.g., intolerance or other medical reason)
G9777	Performance Not Met: Patient did not receive at least 2 prophylactic pharmacologic anti-emetic agents of different classes preoperatively and/or intraoperatively

MIPS 424: Perioperative Temperature Management

MEASURE TYPE:
Outcome – High Priority

DESCRIPTION:
Percentage of patients, regardless of age, who undergo surgical or therapeutic procedures under general or neuraxial anesthesia of 60 minutes duration or longer for whom at least one body temperature greater than or equal to 35.5 degrees Celsius (or 95.9 degrees Fahrenheit) was achieved within the 30 minutes immediately before or the 15 minutes immediately after anesthesia end time

INSTRUCTIONS:
This measure is to be submitted each time any procedure including surgical, therapeutic or diagnostic is performed under general or neuraxial anesthesia during the performance period. There is no diagnosis associated with this measure. It is anticipated that Merit-based Incentive Payment System (MIPS) eligible clinicians who provide the listed anesthesia services as specified in the denominator coding will submit this measure.

MEASURE SUBMISSION TYPE:
Measure data may be submitted by individual MIPS eligible clinicians, groups, or third party intermediaries. The listed denominator criteria are used to identify the intended patient population. The numerator options included in this specification are used to submit the quality actions as allowed by the measure. The quality-data codes listed do not need to be submitted by MIPS eligible clinicians, groups, or third party intermediaries that utilize this modality for submissions; however, these codes may be submitted for those third party intermediaries that utilize Medicare Part B claims data. For more information regarding Application Programming Interface (API), please refer to the Quality Payment Program (QPP) website.

DENOMINATOR:
All patients, regardless of age, who undergo surgical or therapeutic procedures under general or neuraxial anesthesia of 60 minutes duration or longer

> **Denominator Instructions:**
> The anesthesia time used for this measure should be the time recorded in the anesthesia record.
>
> **Denominator Criteria (Eligible Cases):**
> **All patients, regardless of age**
> **AND**
> **Patient procedure during the performance 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, 00326, 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, 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, 00834, 00836, 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, 01924, 01925, 01926, 01930, 01931, 01932, 01933, 01935, 01936, 01951, 01952, 01961, 01962, 01963, 01965, 01966

AND

Anesthesia of 60 minutes duration or longer: 4255F

AND NOT

DENOMINATOR EXCLUSIONS:

Monitored Anesthesia Care (MAC): G9654

OR

Peripheral Nerve Block (PNB): G9770

NUMERATOR:

Patients for whom at least one body temperature greater than or equal to 35.5 degrees Celsius (or 95.9 degrees Fahrenheit) was achieved within the 30 minutes immediately before or the 15 minutes immediately after anesthesia end time

Numerator Options:

Performance Met:

At least 1 body temperature measurement equal to or greater than 35.5 degrees Celsius (or 95.9 degrees Fahrenheit) achieved within the 30 minutes immediately before or the 15 minutes immediately after anesthesia end time (**G9771**)

OR

Denominator Exception:

Documentation of medical reason(s) for not achieving at least 1 body temperature measurement equal to or greater than 35.5 degrees Celsius (or 95.9 degrees Fahrenheit) within the 30minutes immediately before or the 15 minutes immediately after anesthesia end time (e.g., Emergency cases, Intentional hypothermia, etc.) (**G9772**)

OR

Performance Not Met:

At least 1 body temperature measurement equal to or greater than 35.5 degrees Celsius (or 95.9 degrees Fahrenheit) not achieved within the 30 minutes immediately before or the 15 minutes immediately after anesthesia end time, Reason Not Given (**G9773**)

RATIONALE:

A drop in core temperature during surgery, known as perioperative hypothermia, can result in numerous adverse effects, which can include adverse myocardial outcomes, subcutaneous vasoconstriction, increased incidence of surgical site infection, and impaired healing of wounds. The desired outcome, reduction in adverse surgical effects due to perioperative hypothermia, is affected by maintenance of normothermia during surgery.

Unintended perioperative hypothermia occurs in up to 20% of surgical patients. An observational cohort study in a pediatric setting found that more than 50% of children experienced intraoperative hypothermia. Pediatric patients undergoing major surgery were at greater risk of intraoperative hypothermia.

RELEVANT FIELDS

- Date of procedure
- Date of birth
- ASA CPT code
- Total anesthesia time
- Primary anesthesia used
- Postop patient temperature

REPORTING CODES

MIPS 424 Code	Definition
4255F	Anesthesia of 60 minutes duration or longer
G9654	Monitored Anesthesia Care (MAC)
G9770	Peripheral Nerve Block (PNB)

G9771	At least 1 body temperature measurement equal to or greater than 35.5 degrees Celsius (or 95.9 degrees Fahrenheit) achieved within the 30 minutes immediately before or the 15 minutes immediately after anesthesia end time
G9772	Documentation of medical reason(s) for not achieving at least 1 body temperature measurement equal to or greater than 35.5 degrees Celsius (or 95.9 degrees Fahrenheit) within the 30minutes immediately before or the 15 minutes immediately after anesthesia end time (e.g., Emergency cases, Intentional hypothermia, etc.)
G9773	At least 1 body temperature measurement equal to or greater than 35.5 degrees Celsius (or 95.9 degrees Fahrenheit) not achieved within the 30 minutes immediately before or the 15 minutes immediately after anesthesia end time, Reason Not Given

MIPS 477: Multimodal Pain Management

MEASURE TYPE:
Process – High Priority

DESCRIPTION:
Percentage of patients, aged 18 years and older, undergoing selected surgical procedures that were managed with multimodal pain medicine

INSTRUCTIONS:
This measure is to be reported each time a patient undergoes a selected surgical procedure during the reporting period. It is anticipated that Merit-based Incentive Payment System (MIPS) eligible anesthesia providers and clinicians who provide denominator-eligible services will submit this measure.

MEASURE SUBMISSION TYPE:
Measure data may be submitted by individual MIPS eligible clinicians, groups, or third party intermediaries. The listed denominator criteria are used to identify the intended patient population. The numerator options included in this specification are used to submit the quality actions as allowed by the measure. The quality-data codes listed do not need to be submitted by MIPS eligible clinicians, groups, or third party intermediaries that utilize this modality for submissions; however, these codes may be submitted for those third party intermediaries that utilize Medicare Part B claims data. For more information regarding Application Programming Interface (API), please refer to the Quality Payment Program (QPP) website.

DENOMINATOR:
Patients, aged 18 years and older, who undergo selected surgical procedures

> ***DENOMINATOR NOTE*:** Selected surgical procedures include both elective and urgent open and laparoscopic intra-abdominal, spinal, pelvic, thoracic, breast, joint, head, neck, orthopedic and fracture repair surgeries.
>
> **Denominator Criteria (Eligible Cases):**
> **Patients aged 18 years and older on date of encounter**
> **AND**
> **Patient procedures during reporting period (CPT):**
> 00102, 00120, 00160, 00162, 00172, 00174, 00190, 00222, 00300, 00320, 00402, 00404, 00406, 00450, 00470, 00472, 00500, 00528, 00529, 00539, 00540, 00541, 00542, 00546, 00548, 00600, 00620, 00625, 00626, 00630, 00670, 00700, 00730, 00750, 00752, 00754, 00756, 00770, 00790, 00792, 00794, 00797, 00800, 00820, 00830,

00832, 00840, 00844, 00846, 00848, 00860, 00862, 00864, 00865, 00866, 00870, 00872, 00873, 00880, 00902, 00906, 00910, 00912, 00914, 00916, 00918, 00920, 00940, 00942, 00948, 01120, 01160, 01170, 01173, 01210, 01214, 01215, 01220, 01230, 01360, 01392, 01400, 01402, 01480, 01482, 01484, 01486, 01630, 01634, 01636, 01638, 01740, 01742, 01744, 01760, 01830, 01832, 01961

DENOMINATOR EXCLUSION:

Emergent cases: M1142

NUMERATOR:

Patients for whom multimodal pain management is administered in the perioperative period from 6 hours prior to anesthesia start time until discharged from the post-anesthesia care unit

Definition:

Multimodal pain management is defined as the use of two or more drugs and/or interventions, NOT including systemic opioids, that act by different mechanisms for providing analgesia. These drugs and/or interventions can be administered via the same route or by different routes. Opioids may be administered for pain relief when indicated but will not count toward this measure.

NUMERATOR NOTE: Documentation of qualifying medications or interventions provided from six hours prior to anesthesia start time through post-anesthesia care unit discharge count toward meeting the numerator.

Numerator Options:

Performance Met:

Multimodal pain management was used (**G2148**)

OR

Denominator Exception:

Documentation of medical reason(s) for not using multimodal pain management (e.g., allergy to multiple classes of analgesics, intubated patient, hepatic failure, patient reports no pain during PACU stay, other medical reason(s)) (**G2149**)

OR

Performance Not Met:

Multimodal pain management was not used (**G2150**)

RATIONALE:

Besides providing anesthesia care in the operating room, anesthesiologists are dedicated to providing the best perioperative pain management in order to improve patients' function and facilitate rehabilitation after surgery. In the past, pain management was limited to the use of opioids (also called narcotics). Opioids provide analgesia primarily through a unitary mechanism, and just adding more opioids does not usually lead to better pain control or improve

outcomes. In fact, opioids are responsible for a host of side effects that can be a threat to life, and increasing rates of complications after surgery can be attributed to the overuse and abuse of opioids. In 2012, the American Society of Anesthesiologists (ASA) published its guidelines for acute pain management in the perioperative setting (1), and ASA along with the American Society of Regional Anesthesia and Pain Medicine (ASRA) and American Pain Society collaborated on the 2016 clinical practice guidelines for the management of postoperative pain (2). These documents endorse the routine use of "multimodal analgesia" which means employing multiple classes of pain medications or therapies, working with different mechanisms of action, in the treatment of acute pain instead of relying on opioids alone.

While opioids may continue to be important pain medications, they must be combined with other classes of medications known to prevent and help relieve postoperative pain unless contraindicated. The list includes but is not limited to:

- **Non-steroidal anti-inflammatory drugs (NSAIDs):** Examples include ibuprofen, diclofenac, ketorolac, celecoxib, nabumetone. NSAIDs act on the prostaglandin system peripherally and work to decrease inflammation.
- **NMDA antagonists:** When administered in low dose, ketamine, magnesium, and other NMDA antagonists act on the N-methyl-D-aspartate receptors in the central nerve system to decrease acute pain and hyperalgesia.
- **Acetaminophen:** Acetaminophen acts on central prostaglandin synthesis and provides pain relief through multiple mechanisms.
- **Gabapentinoids:** Examples include gabapentin and pregabalin. These medications are membrane stabilizers that essentially decrease nerve firing.
- **Regional block:** The ASA and ASRA also strongly recommend the use of target-specific local anesthetic applications in the form of regional analgesic techniques as part of the multimodal analgesic protocol whenever indicated.
- **Steroids:** Dexamathasone during surgery has been shown to decrease pain and opioid requirements.
- **Local anesthetics:** Injection of local anesthetic in or around the surgical site by the surgeon is an example. Systemic lidocaine administered intravenously represents an alternative to regional analgesic techniques.

RELEVANT FIELDS

- Date of procedure
- Date of birth
- ASA CPT code
- Elective case
- Multimodal pain management used

REPORTING CODES

MIPS 477 Code	Definition

M1142	Emergent case
G2148	Multimodal pain management was used
G2149	Documentation of medical reason(s) for not using multimodal pain management (e.g., allergy to multiple classes of analgesics, intubated patient, hepatic failure, patient reports no pain during PACU stay, other medical reason(s))
G2150	Multimodal pain management was not used

AQI 48: 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.

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.

OVERALL PERFORMANCE RATE FOR SCORING: AQI48b

AQI 48a

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
OR
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”):

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 Options:

Performance Met:

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

OR

Denominator Exception

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. (**10A13**)

OR

Performance Not Met:

Patient was not provided with a survey within 30 days of the procedure to assess their experience and satisfaction with anesthesia (**10A14**)

RELEVANT FIELDS

- Date of procedure

- Date of birth
- ASA CPT code
- ASA physical status
- Received a survey within 30 days

REPORTING CODES

AQI 48a Code	Definition
10A12	Patient provided with a survey within 30 days of the procedure to assess their experience and satisfaction with anesthesia
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.
10A14	Patient was not provided with a survey within 30 days of the procedure to assess their experience and satisfaction with anesthesia

AQI 48b

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 Options:**
> **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:***
> Patient reported a positive anesthesia experience (i.e., a 4 or 5 on the mandatory survey question) (**10A70**)

OR

> ***Performance Not Met:***
> Patient did NOT report a positive anesthesia experience (i.e., a 1, 2, or 3 on the mandatory survey question) (**10A71**)

RELEVANT FIELDS

- Date of procedure
- Date of birth
- ASA CPT code
- ASA physical status
- Received a survey within 30 days
- Survey response received
- Survey response answer

REPORTING CODES

AQI 48b Code	Definition
10A72	Patient completed a survey on their patient experience and satisfaction with anesthesia care
10A69	Patient did not complete the mandatory anesthesia satisfaction question
10A70	Patient reported a positive anesthesia experience (i.e., a 4 or 5 on the mandatory survey question)
10A71	Patient did NOT report a positive anesthesia experience (i.e., a 1, 2, or 3 on the mandatory survey question)

AQI 61: 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.

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, 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, 62322, 62324, 62326, 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

Patients who were transferred to a higher level of care: 11A34

OR

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 Options:
Performance Met:
Patient post-discharge status was assessed within 72 hours of discharge (**11A36**)
OR
Performance Not Met:
Patient post-discharge status was NOT assessed within 72 hours of discharge (**11A37**)

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.

RELEVANT FIELDS
- ASA CPT code
- ASA physical status
- Ambulatory or ASC facility
- Transferred to higher level of care
- Post-discharge assessment performed

REPORTING CODES

AQI 61 Code	Definition

11A34	Patients who were transferred to a higher level of care
11A35	Patients who were unable to be contacted or did not complete assessment after at least 2 contact attempts
11A36	Patient post-discharge status was assessed within 72 hours of discharge
11A37	Patient post-discharge status was NOT assessed within 72 hours of discharge

III. Disclaimer and Copyright

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