

Quality ID #205 (NQF 0409): HIV/AIDS: Sexually Transmitted Disease Screening for Chlamydia, Gonorrhea, and Syphilis

– National Quality Strategy Domain: Effective Clinical Care

– Meaningful Measure Area: Management of Chronic Conditions

2022 COLLECTION TYPE:

MIPS CLINICAL QUALITY MEASURES (CQMS)

MEASURE TYPE:

Process

DESCRIPTION:

Percentage of patients aged 13 years and older with a diagnosis of HIV/AIDS for whom chlamydia, gonorrhea, and syphilis screenings were performed at least once since the diagnosis of HIV infection.

INSTRUCTIONS:

This measure is to be submitted a minimum of **once per performance period** for patients with HIV/AIDS seen during the performance period. Only patients who had at least two visits during the performance period, with at least 90 days between each visit will be counted in the denominator for this measure. This measure is intended to reflect the quality of services provided for the primary management of patients with HIV/AIDS. This measure may be submitted by Merit-based Incentive Payment System (MIPS) eligible clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

NOTE: Patient encounters for this measure conducted via telehealth (e.g., encounters coded with GQ, GT, 95, or POS 02 modifiers) are allowable.

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 13 and older with a diagnosis of HIV/AIDS who had at least two medical visits during the measurement year, with at least 90 days between each visit

Denominator Criteria (Eligible Cases):

Patients aged ≥ 13 years of age on date of encounter

AND

Diagnosis for HIV/AIDS (ICD-10-CM): Z21, B20

AND

Patient encounters during the performance period (CPT or HCPCS): 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, G0402

AND

At Least Two Denominator Eligible Encounters During the Measurement Year, With at Least 90 days Between Each

AND NOT

DENOMINATOR EXCLUSION:

Patients who use hospice services any time during the measurement period: G9725

NUMERATOR:

Patients with chlamydia, gonorrhea, and syphilis screenings performed at least once since the diagnosis of HIV infection

NUMERATOR NOTE: *Submit G9228 when results are documented for all of the 3 screenings.*

Numerator Options:

Performance Met:

Chlamydia, gonorrhea and syphilis screening results documented (report when results are present for all of the 3 screenings) (G9228)

OR

Denominator Exception:

Chlamydia, gonorrhea, and syphilis screening results not documented (Patient refusal is the only allowed exception) (G9229)

OR

Performance Not Met:

Chlamydia, gonorrhea, and syphilis screening results not documented as performed, reason not given (G9230)

RATIONALE:

Sexually transmitted diseases that cause mucosal inflammation (such as gonorrhea and chlamydia) increase the risk for HIV-infection (as these diseases and other sexually transmitted diseases can increase the infectiousness of and a person's susceptibility to HIV) (Galvin, 2004).

CLINICAL RECOMMENDATION STATEMENTS:

All patients should be screened with laboratory tests for STDs at the initial encounter (A-II for syphilis, for trichomoniasis in women, and for chlamydial infection in women aged less than 25 years; B-II for gonorrhea and chlamydial infection in all men and women), and thereafter, depending on reported high-risk behavior, the presence of other STDs, and the prevalence of STDs in the community (B-III). (Aberg, 2004)

Consideration should be given to screening all HIV-infected men and women for gonorrhea and chlamydial infections. However, because of the cost of screening and the variability of prevalence of these infections, decisions about routine screening for these infections should be based on epidemiologic factors (including prevalence of infection in the community or the population being served), availability of tests, and cost. (Some HIV specialists also recommend type-specific serologic testing for herpes simplex virus type 2 for both men and women.) (B-II, for identifying STDs) (CDC, HRSA, NIH, HIVMA of IDSA, 2003)

COPYRIGHT:

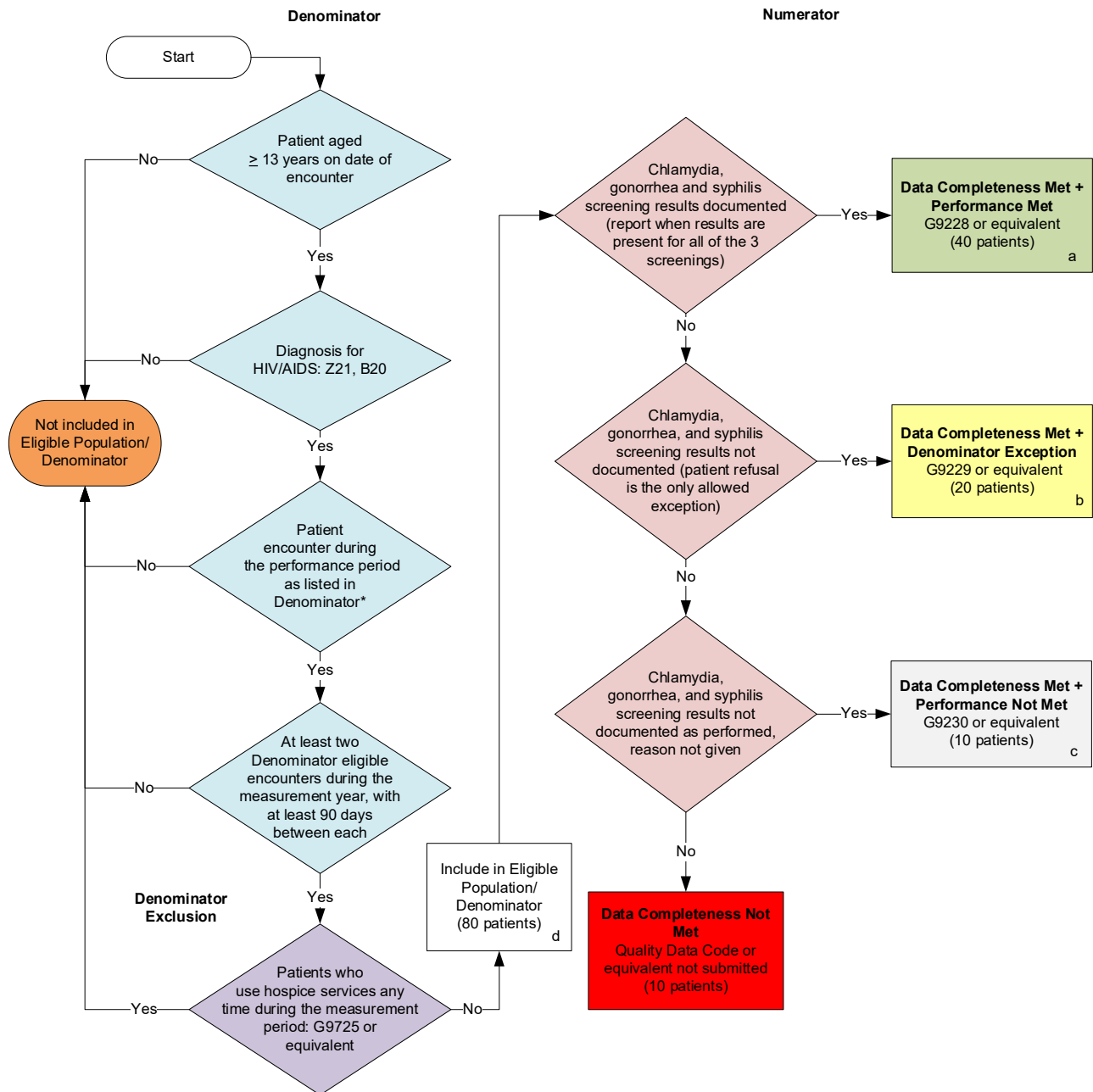
This Physician Performance Measure (Measure) and related data specifications were developed by the former PCPI® Foundation (PCPI®) and the National Committee for Quality Assurance (NCQA). Neither the American Medical Association (AMA) or NCQA shall be responsible for any use of the Measure. The Measure is not a clinical guideline and does not establish a standard of medical care and has not been tested for all potential applications. Health Resources and Services Administration (HRSA) of the U.S. Department for Health and Human Services (HHS) is the current steward of this measure. It is in the public domain.

Any modified versions may not be represented as approved, endorsed, or authorized by HRSA or HHS. 42 U.S.C. § 1320b-10. Users of modified versions should clearly explain how they deviate from HRSA's original measure.

CPT® contained in the Measure specifications is copyright 2004-2021 American Medical Association. ICD-10 copyright 2021 World Health Organization. All Rights Reserved.

**2022 Clinical Quality Measure Flow for Quality ID #205 (NQF 0409):
HIV/AIDS: Sexually Transmitted Disease Screening for Chlamydia, Gonorrhea, and Syphilis**

Disclaimer: Refer to the measure specification for specific coding and instructions to submit this measure.



SAMPLE CALCULATIONS

Data Completeness=

$$\frac{\text{Performance Met (a=40 patients)} + \text{Denominator Exception (b=20 patients)} + \text{Performance Not Met (c=10 patients)}}{\text{Eligible Population / Denominator (d=80 patients)}} = \frac{70 \text{ patients}}{80 \text{ patients}} = 87.50\%$$

Performance Rate=

$$\frac{\text{Performance Met (a=40 patients)}}{\text{Data Completeness Numerator (70 patients) - Denominator Exception (b=20 patients)}} = \frac{40 \text{ patients}}{50 \text{ patients}} = 80.00\%$$

*See the posted measure specification for specific coding and instructions to submit this measure.

NOTE: Submission Frequency: Patient-Process

CPT only copyright 2021 American Medical Association. All rights reserved.
The measure diagrams were developed by CMS as a supplemental resource to be used in conjunction with the measure specifications. They should not be used alone or as a substitution for the measure specification.

v6

**2022 Clinical Quality Measure Flow Narrative for Quality ID #205 (NQF 0409):
HIV/AIDS: Sexually Transmitted Disease Screening for Chlamydia, Gonorrhea, and Syphilis**

Disclaimer: Refer to the measure specification for specific coding and instructions to submit this measure.

1. Start with Denominator
2. Check *Patients aged greater than or equal to 13 years on date of encounter*:
 - a. If *Patients aged greater than or equal to 13 years on date of encounter* equals No, do not include in *Eligible Population/Denominator*. Stop processing.
 - b. If *Patients aged greater than or equal to 13 years on date of encounter* equals Yes, proceed to *Diagnosis for HIV/AIDS as listed in Denominator**.
3. Check *Diagnosis for HIV/AIDS as listed in Denominator**:
 - a. If *Diagnosis for HIV/AIDS as listed in Denominator** equals No, do not include in *Eligible Population/Denominator*. Stop processing.
 - b. If *Diagnosis for HIV/AIDS as listed in Denominator** equals Yes, proceed to *Patient encounter during the performance period as listed in Denominator**.
4. Check *Patient encounter during the performance period as listed in Denominator**:
 - a. If *Patient encounter during the performance period as listed in Denominator** equals No, do not include in *Eligible Population/Denominator*. Stop processing.
 - b. If *Patient encounter during the performance period as listed in Denominator** equals Yes, proceed to *At least two Denominator eligible encounters during the measurement year, with at least 90 days between each*.
5. Check *At least two Denominator eligible encounters during the measurement year, with at least 90 days between each*:
 - a. If *At least two Denominator eligible encounters during the measurement year, with at least 90 days between each* equals No, do not include in *Eligible Population/Denominator*. Stop processing.
 - b. If *At least two Denominator eligible encounters during the measurement year, with at least 90 days between each* equals Yes, proceed to *Patients who use hospice services any time during the measurement period*.
6. Check *Patients who use hospice services any time during the measurement period*:
 - a. If *Patients who use hospice services any time during the measurement period* equals No, include in *Eligible Population/Denominator*.
 - b. If *Patients who use hospice services any time during the measurement period* equals Yes, do not include in *Eligible Population/Denominator*. Stop processing.
7. Denominator Population:
 - Denominator Population is all Eligible Patients in the Denominator. Denominator is represented as Denominator in the Sample Calculation listed at the end of this document. Letter d equals 80 patients in the Sample Calculation.
8. Start Numerator
9. Check *Chlamydia, gonorrhea and syphilis screening results documented (report when results are present for all of the 3 screenings)*:
 - a. If *Chlamydia, gonorrhea and syphilis screening results documented (report when results are present for all of the 3 screenings)* equals Yes, include in *Data Completeness Met and Performance Met*.

- *Data Completeness Met and Performance Met* letter is represented as Data Completeness and Rate in the Sample Calculation listed at the end of this document. Letter a equals 40 patients in Sample Calculation.
- b. If *Chlamydia, gonorrhea and syphilis screening results documented (report when results are present for all of the 3 screenings)* equals No, proceed to *Chlamydia, gonorrhea and syphilis screening results not documented (patient refusal is the only allowed exception)*.
10. Check *Chlamydia, gonorrhea and syphilis screening results not documented (patient refusal is the only allowed exception)*:
 - a. If *Chlamydia, gonorrhea and syphilis screening results not documented (patient refusal is the only allowed exception)* equals Yes, include in *Data Completeness Met and Denominator Exception*.
 - *Data Completeness Met and Denominator Exception* letter is represented as Data Completeness and Performance Rate in the Sample Calculation listed at the end of this document. Letter b equals 20 patients in the Sample Calculation.
 - b. If *Chlamydia, gonorrhea and syphilis screening results not documented (patient refusal is the only allowed exception)* equals No, proceed to *Chlamydia, gonorrhea and syphilis screening results not documented as performed, reason not given*.
 11. Check *Chlamydia, gonorrhea and syphilis screening results not documented as performed, reason not given*:
 - a. If *Chlamydia, gonorrhea and syphilis screening results not documented as performed, reason not given* equals Yes, include in *Data Completeness Met and Performance Not Met*.
 - *Data Completeness Met and Performance Not Met* letter is represented as Data Completeness in the Sample Calculation listed at the end of this document. Letter c equals 10 patients in the Sample Calculation.
 - b. If *Chlamydia, gonorrhea and syphilis screening results not documented as performed, reason not given* equals No, proceed to *Data Completeness Not Met*.
 12. Check *Data Completeness Not Met*:
 - a. If *Data Completeness Not Met*, Quality Data Code or equivalent not submitted. 10 patients have been subtracted from the Data Completeness Numerator in the Sample Calculation.

Sample Calculations:

Data Completeness equals Performance Met (a equals 40 patients) plus Denominator Exception (b equals 20 patients) plus Performance Not Met (c equals 10 patients) divided by Eligible Population/Denominator (d equals 80 patients). All equals 70 patients divided by 80 patients. All equals 87.5 percent.

Performance Rate equals Performance Met (a equals 40 patients) divided by Data Completeness Numerator (70 patients) minus Denominator Exception (b equals 20 patients). All equals 40 patients divided by 50 patients. All equals 80 percent.

*See the posted measure specification for specific coding and instructions to submit this measure.

NOTE: Submission Frequency: Patient-Process

The measure diagrams were developed by CMS as a supplemental resource to be used in conjunction with the measure specifications. They should not be used alone or as a substitution for the measure specification.