

**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

**2019 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.

**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  $\geq 13$  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):** 99201, 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)

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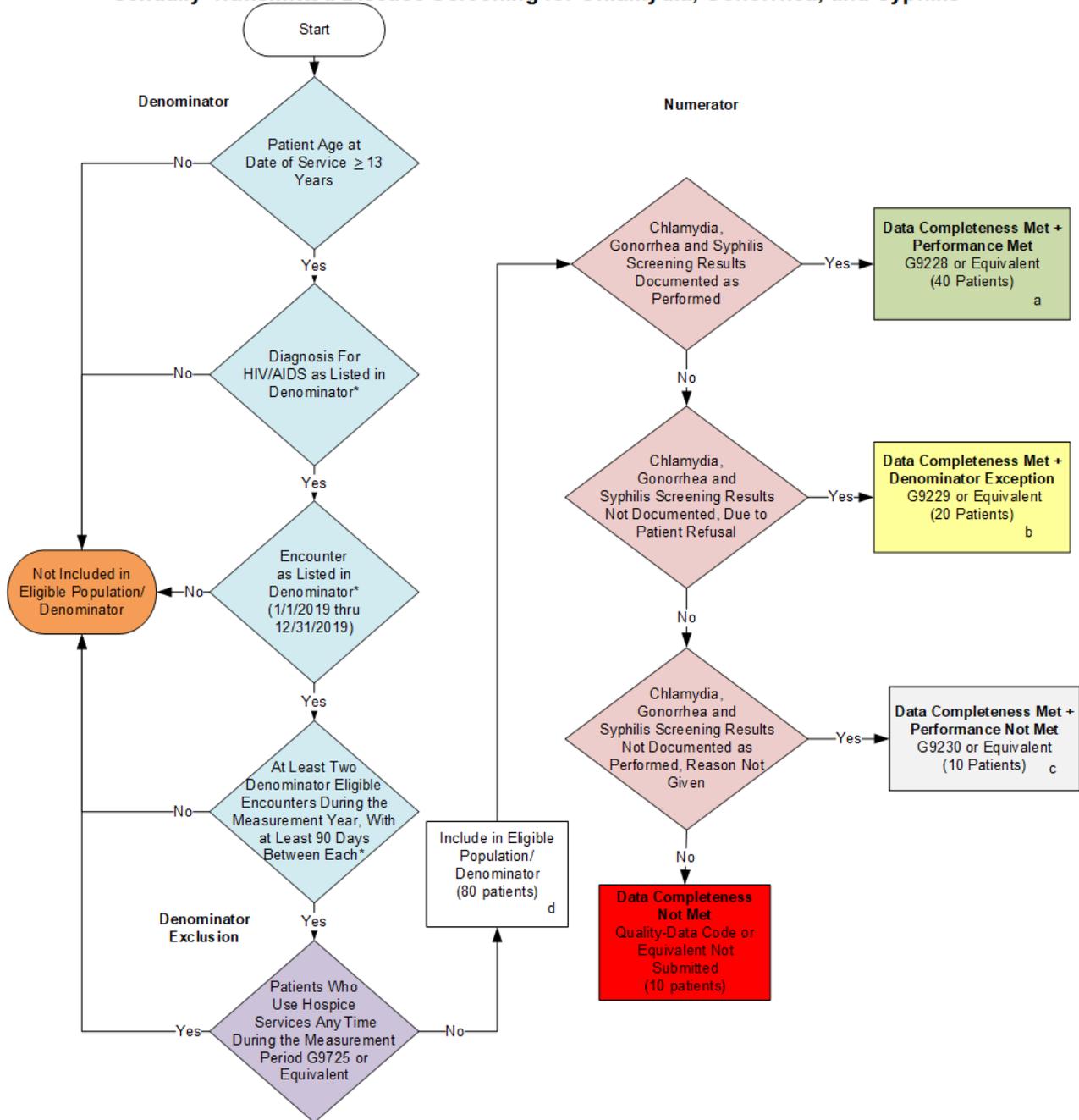
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**2019 Clinical Quality Measure Flow for Quality ID #205 NQF #0409: HIV/AIDS: Sexually Transmitted Disease Screening for Chlamydia, Gonorrhea, and Syphilis**



**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

**2019 Clinical Quality Measure Flow Narrative for Quality ID #205 NQF #0409:  
HIV/AIDS: Sexually Transmitted Disease Screening for Chlamydia, Gonorrhea, and Syphilis**

Please refer to the specific section of the specification to identify the denominator and numerator information for use in submitting this Individual Specification.

1. Start with Denominator
2. Check Patient Age:
  - a. If Patient Age is greater than or equal to 13 Years at Date of Service equals No during the measurement period, do not include in Eligible Population. Stop Processing.
  - b. If Patient Age is greater than or equal to 13 Years at Date of Service equals Yes during the measurement period, proceed to check Patient Diagnosis.
3. Check Patient Diagnosis:
  - a. If Diagnosis for HIV/AIDS as Listed In the Denominator equals No, do not include in Eligible Population. Stop Processing.
  - b. If Diagnosis for HIV/AIDS as Listed in the Denominator equals Yes, proceed to check Encounter Performed.
4. Check Encounter Performed:
  - a. If Encounter as Listed in the Denominator equals No, do not include in Eligible Population. Stop Processing.
  - b. If Encounter as Listed in the Denominator equals Yes, proceed to check 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. 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 check 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.
  - b. If Patients Who Use Hospice Services Any Time During the Measurement Period equals Yes, do not include in Eligible Population. Stop Processing.
7. Denominator Population:
  - a. 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 Screenings Documented as Performed:
  - a. If Chlamydia, Gonorrhea and Syphilis Screening Results Documented as Performed equals Yes, include in Data Completeness Met and Performance Met.

- b. Data Completeness Met and Performance Met letter is represented as Data Completeness and Performance Rate in the Sample Calculation listed at the end of this document. Letter a equals 40 patients in Sample Calculation.
  - c. If Chlamydia, Gonorrhea and Syphilis Screening Results Documented as Performed equals No, proceed to check Chlamydia, Gonorrhea and Syphilis Screening Results Not Documented, Due to Patient Refusal.
10. Check Chlamydia, Gonorrhea and Syphilis Screening Results Not Documented, Due to Patient Refusal:
- a. If Chlamydia, Gonorrhea and Syphilis Screening Results Not Documented, Due to Patient Refusal equals Yes, include in Data Completeness Met and Denominator Exception.
  - b. 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.
  - c. If Chlamydia, Gonorrhea and Syphilis Screening Results Not Documented, Due to Patient Refusal equals No, proceed to check 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.
  - b. 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.
  - c. If Chlamydia, Gonorrhea and Syphilis Screening Results Not Documented as Performed, Reason Not Given equals No, proceed to check Data Completeness Not Met.
12. Check Data Completeness Not Met:
- a. If Data Completeness Not Met, the Quality Data Code or equivalent was not submitted. 10 patients have been subtracted from the Data Completeness Numerator in the Sample Calculation.

**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=**

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