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Americans With Disabilities Act. In compliance with the Americans With Disabilities Act, the American Board of Foot and Ankle Surgery® will make reasonable accommodations for individuals with disabilities if written request is made no later than thirty (30) days prior to the date(s) of the examination for which appropriate application has been made, fees paid, and credentialing completed. Candidates seeking an accommodation should request the ABFAS “Policies and Procedures for Examination Candidates Requesting Accommodation for Disabilities” at least ninety (90) days prior to the examination dates.
American Board of Foot and Ankle Surgery
Maintenance of Certification

The Board of Directors of the American Board of Foot and Ankle Surgery (ABFAS) has approved a Maintenance of Certification Program (MOC). This MOC Program will replace the current ABFAS Recertification process in the future. Other certification boards, including all of the boards of the American Board of Medical Specialties, are adopting an MOC program. Through MOC, physicians demonstrate that they can assess the quality of care they provide compared with peers and national benchmarks, and use this information to improve patient care. The ABFAS believes our change to MOC will allow us to stay current with other certification boards and ensure continued competency among our Diplomates. In the spring of 2012, the Centers for Medicare and Medicaid Services (CMS) approved the ABFAS MOC program. To read about the CMS MOC incentive program go to: CMS Requirements for Medicare Incentives.

THE ABFAS MOC PROGRAM

All Diplomates issued a time-limited certificate are required to participate in the MOC program to maintain certification. Diplomates issued a lifetime certificate are encouraged to participate in the MOC program, but cannot lose their certification if they do not successfully complete the process.

MOC is currently voluntary for ABFAS Recertification. It will become mandatory and will replace ABFAS Recertification in the future. The process will be implemented according to each Diplomate’s 10-year recertification cycle.

In summary, the ABFAS MOC program consists of the following requirements (see detailed explanation beginning on page 5):

I. Maintain a valid, unrestricted podiatric license in the United States or Canada (current ABFAS requirement).

II. Maintain active surgical privileges at either an accredited hospital or surgical center (current ABFAS requirement).

III. Participate in educational and self-assessment programs that require an evaluation of material learned. The ABFAS requires 200 continuing education credits per 10-year cycle, with 20 of the credits to include a self-assessment component (new requirement).

IV. Complete a formalized, secure examination consisting of the fundamental diagnostic skills, medical knowledge, and clinical judgment to provide quality care during every 10-year cycle (current ABFAS requirement).
V. Successfully complete a Practice Assessment consisting of patient surveys, chart review for approved quality measures, peer review surveys, and a practice improvement plan every 10-year cycle (new requirement).

The timeline for implementation of the MOC process:

1. Is voluntary from the current time.
2. Will replace recertification and become mandatory in the future for Diplomates holding time-limited certificates.
   a. Implementation will occur in the Diplomates' existing recertification examination cycle.
   b. Practice assessment must be completed prior to taking examination.
   c. Continuing education credits will be prorated per year.

To qualify for CMS incentive, Diplomates must submit a yearly application to maintain their MOC status. This application must include state licensure information, attestation to CME credits, and practice assessment results.

ABFAS MOC Requirements

I. Maintain a valid, unrestricted podiatric license in the United States or Canada.

All Diplomates must maintain a valid and unrestricted license within the United States or Canada. The ABFAS will collect license validation information for each Diplomate for the state(s) in which he/she practices. Currently, the ABFAS updates this information in conjunction with each state’s licensing cycle. Diplomates are required to report to ABFAS any change in their licensing status.

II. Maintain active surgical privileges at an ABFAS-recognized accredited healthcare facility.¹

III. Participate in educational and self-assessment programs that require an evaluation of material learned.

¹ An ABFAS-recognized accredited healthcare facility includes, but is not limited to, a facility that is accredited by The Joint Commission, the Accreditation Association for Ambulatory Health Care (AAAHC), the American Osteopathic Association (AOA), or the American Association for Accreditation of Ambulatory Surgery Facilities, Inc. (AAAASF).
Diplomates must participate in 200 hours of Category 1 or CPME-approved continuing education (CE) credits per 10-year cycle, 20 hours of which must include a self-assessment component. All continuing education must be pertinent to the practice of podiatric medicine and/or Surgery and cannot include practice management. Risk management credits are allowed. It is the Diplomate’s responsibility to obtain documentation of continuing education credits, not the organization that offers the program. Diplomates may submit continuing education credits only for programs in which they actively participated.

Diplomates must attest to their continuing education credits, and the ABFAS will perform audits to ensure the accuracy of the submitted data.

The Diplomate’s continuing education credits must be current to take the MOC examination.

To fulfill the more frequent requirement for the CMS incentive, the Diplomate must complete 25 continuing education credits per year, with 2.5 credits to include a self-assessment component. ABFAS requires a yearly application to attest to completion of the more frequent requirement.

IV. Complete a formalized, secure examination that demonstrates the physician has the fundamental diagnostic skills, medical knowledge, and clinical judgment to provide quality care.

Diplomates must take a secure examination within 10-year cycles. All four other components of the MOC process must be current for the Diplomate to take the examination. The computerized examination is administered at regional, secure computer sites.

Diplomates may take the examination in the eighth, ninth, or 10th year of their MOC cycle. Examinations taken and failed in the eighth or ninth year may be retaken. Failure of the examination in the 10th year will result in loss of certification. Diplomates are encouraged not to wait until their 10th year to sit for the examination.
The content of the examinations comprises:

**MOC FOOT AND ANKLE EXAMINATION**
(Self-assessment and MOC)

**Purpose:** The Foot and Ankle MOC Examination assesses current level of knowledge (strengths and weaknesses). For MOC purposes, the examination will have a measurable passing score. The same examination will serve for those Diplomates who choose to use it for self-assessment.

**Test Specifications:** The Foot and Ankle MOC examination involves diagnostic, intraoperative, and perioperative care of the podiatric surgical patient encompassing the foot and ankle. Like the recertification examinations, the MOC will emphasize generally accepted procedures and technology related to the practitioner’s daily practice. However, because the self-assessment examination also serves as an educational tool, newer or more-focused content areas may be included. The examination contains a maximum of 125 questions.

**Examination Content Map**

<table>
<thead>
<tr>
<th>Major Subject Area</th>
<th>%</th>
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<tbody>
<tr>
<td>A. Problem-focused History and Physical</td>
<td>10</td>
</tr>
<tr>
<td>B. Diagnostic Studies/Medical Imaging</td>
<td>10</td>
</tr>
<tr>
<td>C. Differential Diagnosis</td>
<td>10</td>
</tr>
<tr>
<td>D. Surgical Principles</td>
<td>15</td>
</tr>
<tr>
<td>E. Surgical Procedures/Techniques</td>
<td>15</td>
</tr>
<tr>
<td>F. Procedural Perioperative Management</td>
<td>15</td>
</tr>
<tr>
<td>G. Complications</td>
<td>15</td>
</tr>
<tr>
<td>H. General Medical</td>
<td>10</td>
</tr>
<tr>
<td><strong>TOTAL:</strong></td>
<td>100</td>
</tr>
</tbody>
</table>
MOC FOOT SURGERY EXAMINATION

**Purpose:** The MOC Examination in Foot Surgery measures the clinical surgical knowledge, skills, and judgment associated with the maintenance of an acceptable level of practice of foot surgery.

**Test Specifications:** The MOC Examination in Foot Surgery involves diagnostic and perioperative care of the podiatric surgical patient encompassing the foot and ankle. Intraoperative technical aspects will include reconstructive and non-reconstructive procedures of the forefoot and non-reconstructive procedures of the rearfoot/ankle. The examination emphasizes generally accepted procedures and technology related to the practitioner’s daily practice. The examination contains a maximum of 125 computer-adaptive administered questions.

**Examination Content Map**

<table>
<thead>
<tr>
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<td>10</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>
MOC RECONSTRUCTIVE REARFOOT/ANKLE SURGERY EXAMINATION

**Purpose:** The MOC Examination in Reconstructive Rearfoot and Ankle Surgery measures the clinical surgical knowledge, skills, and judgment associated with the maintenance of an acceptable level of practice.

**Test Specifications:** The MOC Examination in Reconstructive Rearfoot/Ankle Surgery involves diagnostic and perioperative care of the podiatric surgical patient who requires reconstructive rearfoot and ankle procedures. This examination emphasizes generally accepted procedures and technology related to the practitioner’s daily practice. The fixed-form examination contains a maximum of 100 questions.

### Examination Content Map

<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>B.  Diagnostic Studies/Medical Imaging</td>
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<tr>
<td>C.  Differential Diagnosis</td>
<td>10</td>
</tr>
<tr>
<td>D.  Surgical Principles</td>
<td>15</td>
</tr>
<tr>
<td>E.  Surgical Procedures/Techniques</td>
<td>25</td>
</tr>
<tr>
<td>F.  Procedural Perioperative Management</td>
<td>20</td>
</tr>
<tr>
<td>G.  Complications</td>
<td>20</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>100</strong></td>
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</table>
V. Successfully complete a qualified maintenance of certification program practice assessment.

Diplomates must perform a practice survey at least once during their 10-year MOC cycle. (CMS requires yearly practice assessment for incentive payments.) The components include:

1. Chart review: ABFAS provides a list of specific performance measures. Diplomates must select two measures from the list and review 25 charts for each measure to evaluate if they meet the standards. Based on the results, the Diplomate must establish a plan for practice improvement as well as provide evidence that the plan is instituted and measured.

2. Patient surveys: Obtain 25 patient surveys. This component must include a plan for practice improvement based on the results of the survey as well as provide evidence that the plan is instituted and measured.

3. Peer review surveys: Submit the name of two current ABFAS Diplomates to serve as peer reviewers.

4. Action plan: Develop action plan to correct any deficiencies discovered from the chart review and patient surveys.

Chart Review

Diplomates must perform a chart review by selecting two quality measures from the list of ABFAS-approved measures. (The ABFAS selected the following measurements from the list of CMS-approved measures from the Physician Quality Reporting System [PQRS].) Twenty-five charts must be reviewed for each measure. Some charts may qualify for more than one quality measure. The chart review, as part of the practice assessment, must be performed at least once during the 10-year MOC cycle and before sitting for the MOC examination. The ABFAS annually publishes the performance measures.

The Diplomate must submit the results of the review on the ABFAS web form and must attest that the information is accurate. The data must be available for audit. After completing the chart review, the Diplomate must prepare an action plan for practice improvement and be prepared to address the results of the review and provide evidence that he/she has instituted the practice plan and has measured it to ensure improvement of practice standards.
Quality Measures

1. **Timing of Prophylactic Parenteral Antibiotics**

   **Description:** Percentage of surgical patients aged 18 years and older undergoing procedures with the indications for prophylactic parenteral antibiotics, who have an order for prophylactic antibiotic to be given within one hour (if fluoroquinolone or vancomycin, two hours), prior to the surgical incision (or start of procedure when no incision is required).

   **Population Included:** All surgical patients aged 18 years and older undergoing procedures with the indications for prophylactic parenteral antibiotics.

   **Requirements:** There must be documentation of order (written order, verbal order, or standing order/protocol) specifying that antibiotic is to be given within one hour (if fluoroquinolone or vancomycin, two hours) prior to the surgical incision (or start of procedure when no incision is required) or documentation that antibiotic has been given within one hour (if fluoroquinolone or vancomycin, two hours) prior to the surgical incision (or start of procedure when no incision is required).

   **Exclusions:** Documentation of medical reason(s) for not ordering antibiotics to be given within one hour (if fluoroquinolone or vancomycin, two hours) prior to the surgical incision (or start of procedure when no incision is required).

   **NQF#:** 0270  
   **PQRS#:** 20  
   **Steward:** AMA

2. **Selection of Prophylactic Antibiotic: First- OR Second-generation Cephalosporin**

   **Description:** Percentage of surgical patients aged 18 years and older undergoing procedures with the indications for a first- or second-generation cephalosporin prophylactic antibiotic, who had an order for cefazolin OR cefuroxime for antimicrobial prophylaxis.

   **Population Included:** Surgical patients who had an order for cefazolin or cefuroxime for antimicrobial prophylaxis.

   **Requirements:** There must be documentation of order (written order, verbal order, or standing order/protocol) for cefazolin or cefuroxime for antimicrobial prophylaxis or documentation that cefazolin or cefuroxime was given.

   **Exclusions:** Documentation of medical reason(s) for not ordering cefazolin or cefuroxime for antimicrobial prophylaxis.

   **NQF#:** 0268  
   **PQRS#:** 21  
   **Steward:** AMA
3. **Osteoarthritis (OA): Function and Pain Assessment**

   **Description:** Percentage of patients with OA who were assessed for function and pain.

   **Population Included:** All patient visits for patients aged 21 and older with a diagnosis of OA.

   **Requirements:** Patient visits with assessment for function and pain documented. Medical record must include documentation of the patient’s satisfaction or dissatisfaction with function and pain or documentation of the use of a standardized scale or completion of an assessment questionnaire (e.g., SF-36, AAOS Hip and Knee Questionnaire). Or CPT-II code: 1006F Osteoarthritis symptoms and functional status assessed.

   **Exclusions:** None

   **NQF#:** 0050  
   **PQRS#:** 109  
   **Steward:** AMA

4. **Diabetic Foot and Ankle Care, Peripheral Neuropathy – Neurological Evaluation**

   **Description:** Percentage of patients 18 years and older with diabetes, who had a lower-extremity neurological examination with risk categorization performed and a treatment plan established at least once within 12 months of a diagnosis of diabetes mellitus, who had a neurological examination of their lower extremities during one or more office visits within 12 months.

   **Population Included:** All patients aged 18 years and older with a diagnosis of diabetes mellitus.

   **Requirements:** A lower-extremity neurological examination consists of a documented evaluation of motor and sensory abilities including reflexes, vibratory, proprioception, sharp/dull, and 5.07-filament detection.

   **Exclusions:** Clinician documented that patient was not an eligible candidate for lower-extremity neurological examination measure, for example, patient bilateral amputee.

   **NQF#:** 0417  
   **PQRS#:** 126  
   **Steward:** APMA
5. **Diabetic Foot and Ankle Care, Ulcer Prevention – Evaluation of Footwear**

**Description:** Percentage of patients aged 18 years and older with a diagnosis of diabetes mellitus, who were evaluated for proper footwear and sizing during one or more office visits within 12 months.

**Population Included:** All patients aged 18 years and older with a diagnosis of diabetes mellitus.

**Requirements:** Evaluation for proper footwear includes a foot examination documenting the vascular, neurological, dermatological, and structural/biomechanical findings. The foot should be measured using a standard measuring device. Counseling on appropriate footwear should be based on risk categorization.

**Exclusions:** Footwear evaluation not performed for documented reasons, for example, patient bilateral amputee.

**NQF#:** 0416  
**PQRS#:** 127  
**Steward:** APMA

6. **Universal Documentation and Verification of Current Medications in the Medical Record**

**Description:** Percentage of patients aged 18 years and older with a list of current medications with dosages (includes prescription, over-the-counter [OTC], herbal, vitamin/mineral/dietary [nutritional] supplements) and verified with the patient or authorized representative documented by the provider.

**Population Included:** Patients 18 years of age and older.

**Requirements:** Current medications with dosages and verification with patient or authorized representative documented by the provider.

**Exclusions:** Not eligible – A patient is not eligible if one or more of the following condition(s) exist:

- Patient refuses to participate.
- Patient is in an urgent or emergent medical situation where time is of the essence and to delay treatment would jeopardize the patient’s health status.
- Patient cognitively impaired and no authorized representative available.

**NQF#:** 0419  
**PQRS#:** 130  
**Steward:** Centers for Medicare and Medicaid Services
7. Pain Assessment Prior to Initiation of Patient Therapy

**Description:** Percentage of patients with documentation of a pain assessment (if pain is present, including location, intensity, and description) through discussion with the patient, including the use of a standardized tool on each initial evaluation prior to initiation of therapy and documentation of a follow-up plan.

**Population Included:** Patients 18 years of age and older during reporting period.

**Requirements:** Patient’s pain assessment prior to initiation of treatment is documented through discussion with the patient, including the use of a standardized tool, and a follow-up plan is documented.

**Exclusions:** Not eligible – A patient is not eligible if the following condition(s) exist:

- Patient refuses to participate.
- Severe mental and/or physical incapacity where the person is unable to express himself/herself in a manner understood by others; for example, cases where pain cannot be accurately assessed through use of nationally recognized standardized pain assessment tools.

**NQF#:** 0420  
**PQRS#:** 131  
**Steward:** Centers for Medicare and Medicaid Services

8. Diabetes: Foot Examination

**Description:** Percentage of adult patients with diabetes aged 18 to 75 years who received a foot examination (visual inspection, sensory examination with monofilament, or pulse examination).

**Population Included:** Patients aged 18 to 75 years as of December 31 of the measurement year who had a diagnosis of diabetes (type 1 or type 2). Patients with diabetes may be identified during the measurement year, or year prior to the measurement year through:

- Pharmacy data: Patients who were prescribed insulin or oral hypoglycemics/antihyperglycemics on an ambulatory basis. Prescriptions to identify patients with diabetes include: insulin prescriptions (drug list is available) and oral hypoglycemics/antihyperglycemics prescriptions (drug list is available).
- A diagnosis of diabetes on the Problem List or at least two visits with diabetes listed as a diagnosis.

**Requirements:** Patients who received a foot exam (visual inspection, sensory examination with monofilament, or pulse examination) during the measurement year. Indication of a test result and date must be documented.

**Exclusions:** Exclude patients with a diagnosis of polycystic ovaries on the Problem List who did not also have a diagnosis of diabetes on the Problem List during the measurement year or year prior to the measurement year. Exclude patients with a
9. Adoption of Health Information Technology

**Description:** Documents whether provider has adopted and is using health information technology. To qualify, the provider must have adopted and is using a certified/qualified electronic health record (EHR).

**Population Included:** All patient encounters.

**Requirements:** Patient encounter documentation substantiates use of certified/qualified EHR (G8447 or G8448).

**Exclusions:** None

**NQF#: 0488**

**PQRS#: 124**

**Steward:** Centers for Medicare and Medicaid Services

10. Venous Thromboembolism (VTE) Prophylaxis

**Description:** Percentage of patients aged 18 years and older undergoing procedures for which VTE prophylaxis is indicated in all patients, who had an order for low-molecular-weight Heparin (LMWH), low-dose unfractionated Heparin (LDUH), adjusted-dose warfarin, fondaparinux, or mechanical prophylaxis to be given within 24 hours prior to incision time or within 24 hours after surgery end time.

**Population Included:** All surgical patients aged 18 years and older undergoing procedures for which VTE prophylaxis is indicated.

**Requirements:** Surgical patients who had an order for VTE prophylaxis (LMWH, LDUH, adjusted-dose warfarin, fondaparinux, or mechanical prophylaxis) to be given within 24 hours prior to incision time or within 24 hours after surgery end time.

**Exclusions:** Documentation of medical reason(s) for patient not receiving any accepted form of VTE prophylaxis (LMWH, LDUH, adjusted-dose warfarin, fondaparinux, or mechanical prophylaxis) within 24 hours prior to incision time or 24 hours after surgery end time.

**NQF#: 0239**

**PQRS#: 23**

**Steward:** AMA
11. **Osteoarthritis (OA): Assessment for Use of Anti-inflammatory or Analgesic OTC Medications**

**Description:** Percentage of patient visits with assessment for use of anti-inflammatory or analgesic OTC medications.

**Population Included:** All visits for patients with OA who are older than 21 years of age.

**Patient Selection:**
ICD-9-CM codes for OA: 715.00-715.98

**Requirements:**
- Patient visits with assessment for use of anti-inflammatory or analgesic OTC medications documented (drug list is available). Assessment may include:
  - Documentation of current medications, continue same medications, change in medication dose, documentation indicating that the patient was asked about OTC medication use.
  - Or
  - CPT-II code: 1007F Use of anti-inflammatory or analgesic OTC medications assessed.

**Exclusions:** None

**NQF#: 0051**
**PQRS#: 142**
**Steward: AMA**

12. **Measure Pair: a. Tobacco Use Assessment, b. Tobacco Cessation Intervention**

**Description:** Percentage of patients who were queried about tobacco use one or more times during the two-year measurement period. Percentage of patients identified as tobacco users who received cessation intervention during the two-year measurement period.

**Population Included:** All patients older than 18 years of age at the beginning of the two-year measurement period.

**Requirements:**
- a: Patients who were queried about tobacco use one or more times.
- b: Patients identified as tobacco users who received cessation intervention.

Cessation intervention may include smoking cessation counseling (e.g., advise to quit, referral for counseling) and/or pharmacologic therapy.

**Exclusions:** None

**NQF#: 0028**
**PQRS#: 226**
**Steward: AMA**
13. **Adult Weight Screening and Follow-up**

**Description:** Percentage of patients aged 18 years and older with a calculated body mass index (BMI) documented in the medical record and if the most recent BMI is outside the parameters, a follow-up plan is documented.  
Parameters: age 65 and older, BMI 30 and over or less than 22; age 18 to 64, BMI 25 and over or less than 18.5.  
**Population Included:** Patients 18 years and older.  
**Requirements:** Patients with BMI calculated in the past six months and a follow-up plan documented if the BMI is outside parameters. Patients may be considered ineligible in the following situations:  
- There is documentation in medical record that patient is overweight or underweight and is managed by another provider.  
- If patient has a terminal illness.  
- If patient refuses BMI measurement.  
- If there is any other reason documented in medical record by provider explaining why BMI measurement was not appropriate.  
- Patient is in an urgent or emergent medical situation where time is of the essence and delaying treatment would jeopardize the patient’s health status.  
**NQF#:** 0421  
**PQRS#:** 128  
**Steward:** Centers for Medicare and Medicaid Services

14. **Functional Status Change for Patients with Foot/Ankle Impairments**

**Description:** Functional status change in patients aged 18 or older with a foot/ankle impairment associated with a functional deficit, who had their functional status assessed at the beginning and end of rehabilitation.  
**Population Included:** All patients in a 12-month period with functional status deficits related to foot or ankle impairments for whom the value of the functional status scale at start or resumption of care was abnormal; for example, the patient’s foot or ankle functional status was less than 90 (i.e., it was possible that his/her functional status would improve). This measure is appropriate for patients with foot or ankle impairments, including but not limited to: soft-tissue disorders of muscle, synovium, tendon, bursa, plantar fasciitis, or enthesopathies, including unspecified sprain or strain; fractures (ICD-9 823-826, including ankle, tarsal, metatarsal bones, or phalanges of foot); arthropathies (ICD-9 codes 710-719, including osteoarthoses, rheumatoid arthritis); disorders of the bone and cartilage (ICD-9 codes 730-739); uncomplicated postsurgical (CPT codes 29894-29899, including arthroscopy of the ankle); and gait abnormality (ICD-9 code 781.2).
**Requirements:** Total sum of risk-adjusted, residual discharge, functional-status scores in patients who were treated by a clinician in a 12-month period because the patients were identified (intake measure taken) at start or resumption of care to have functional status deficits related to foot or ankle impairments (i.e., scale ranging from 0 to 100, with higher scores meaning higher functional abilities), were treated for the clinical goal of improving the functional status deficit, had their functional status assessed at the end of their episode of therapy, and are now ready for discharge from therapy.

**Exclusions:** Patients who do not have a functional deficit related to a foot/ankle impairment (scale value more than 90):
- Less than 18 years of age.
- Medical condition inappropriate for therapy.

The foot/ankle functional status change measure is commonly risk adjusted by the following variables: intake functional status, age, symptom acuity, surgical history, payer source, gender, fear-avoidance of physical activities if the patient has pain, and number of functional co-morbidities. Risk adjustment models are found at www.fotoinc.com.

**NQF#:** 0424
**PQRS#:** 219
**Steward:** Focus on Therapeutic Outcomes, Inc.
Patient Surveys

Diplomates will be required to obtain 25 patient surveys. The ABFAS will provide appropriate survey forms. Alternative surveys may be used if preapproved by the ABFAS. Patient surveys must be performed at least once during the 10-year MOC cycle and before taking the MOC examination. **CMS requires yearly practice assessment for incentive payments.**

The Diplomate must submit results of the surveys on the ABFAS web form and must attest that the information is accurate. The data must be available for audit.

After obtaining the patient surveys, the Diplomate must prepare an action plan for practice improvement to address survey results. The Diplomate must provide evidence that the practice plan is instituted and measured to ensure improvement of practice standards.

Peer-review Surveys

Diplomates must submit to the ABFAS the name of two current ABFAS Diplomates who have knowledge of the Diplomates’ competence. The ABFAS will contact the references for a confidential survey of the Diplomates’ competence. The ABFAS will notify Diplomates of successful completion of the peer-review surveys.

Action Plan for Practice Improvement

The action plan should be based on results of both the chart review and patient surveys. It is the Diplomate’s responsibility to set the standards by which the action plan is developed. The ABFAS requires that any quality measure from the chart review that falls below a 100 percent compliance rate and patient survey items that score on average below satisfactory must be included in the plan.

Once the Diplomate determines which quality measures or patient survey items require remediation, an action plan to correct the deficiencies must be prepared. The plan must then be measured, usually by repeating a chart review or obtaining additional patient surveys. The plan should be repeated or revamped until its quality is brought up to standard.

If all quality measures and patient survey items meet the standard, the practice plan may state that the practice will maintain the same operational procedures and standards.
Example 1:
Twenty-five charts were reviewed to assess presence of quality measure number 6, Universal Documentation and Verification of Current Medications in the Medical Record. It was found that only 65 percent of charts reviewed complied with this standard. (Note: The practice plan should address how best to correct this deficiency in the individual practice.)
**Plan:** A sticker will be placed on all charts to remind the office staff to check on current medications and have the patient sign and verify that medications are correct.
**Measure:** A random audit of 25 charts will be performed in two months to document correction of this deficiency.

Example 2:
Twenty-five patient surveys were performed, and it was found that all items scored 3 (good) or above except point number C1, “Your phone calls were answered promptly.” C1 scored an average of 2.
**Plan:** An extra phone line will be added at front desk and all office staff will be educated on the need to answer the phone promptly.
**Measure:** An additional 25 patient surveys will be completed in two months to monitor the progress of the deficiency.
CMS Requirements for Medicare Incentives

Diplomates who successfully participate in the ABFAS MOC program may qualify to collect a 0.5 percent incentive from Medicare billings in addition to the PQRS 0.5 percent incentive.

Diplomates must meet the following requirements to qualify for the incentive:

1. Satisfactorily submit data, without regard to method, on quality measures under PQRS, for a 12-month reporting period, either as an individual physician or as a member of a selected group practice.
2. Participate in the ABFAS MOC program more frequently than is required. ABFAS defines the “more-frequent requirement” as:
   a. Occurs within the 10-year cycle of the recertification examination.
   b. Completes 25 hours of continuing education credits per year, with five of those credits to include a self-assessment component.
   c. Completes a yearly Practice Assessment, as defined above by ABFAS.