Gastroesophageal Reflux Disease (GERD)

Upper Endoscopy for Patients with Alarm Symptoms

*This measure is to be reported for all patients aged 18 years and older with GERD — a minimum of **once** per reporting period.*

Measure description

Percentage of patients aged 18 years and older with a diagnosis of GERD, seen for an initial evaluation, with at least one alarm symptom who were either referred for upper endoscopy or had an upper endoscopy performed

What will you need to report for each patient with a diagnosis of GERD for this measure?

If you select this measure for reporting, you will need to determine:

- Whether or not the patient is being seen for an initial evaluation of GERD

If the patient is being seen for an intitial evaluation of GERD, you will then need to report:

- Whether or not alarm symptoms (involuntary weight loss, dysphagia, or gastrointestinal bleeding) were present

If the patient has one or more alarm symptoms, you will then need to report:

- Whether or not an upper gastrointestinal endoscopy was performed

  OR

- Whether or not patient was referred for an upper gastrointestinal endoscopy

What if this process or outcome of care is not appropriate for your patient?

There may be times when it is not appropriate to refer OR perform an upper gastrointestinal endoscopy, due to:

- Medical reasons (eg, not indicated, contraindicated, other medical reason) OR
- Patient reasons (eg, patient declined, economic, social, religious, other patient reason) OR
- System reasons (eg, resources to perform the services not available, insurance coverage/payer-related limitations, other reason attributable to health care delivery system)

In these cases, you will need to indicate which reason applies, specify the reason on the worksheet and in the medical chart. The office/billing staff will then report a code with a modifier that represents these valid reasons (also called exclusions).

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PQRI Data Collection Sheet

Patient's Name	Practice Medical Record Number (MRN)	Birth Date (mm/dd/yyyy) / /	Gender ☐ Male ☐ Female
National Provider Identifier (NPI)		Date of Service	

Clinical Information			Billing Information
Step 1 Is patient eligible for this measure?			
	Yes	**No**	**Code Required on Claim Form**
Patient is aged 18 years and older.	☐	☐	Verify date of birth on claim form.
Patient has a diagnosis of GERD.	☐	☐	Refer to coding specifications document for list of applicable codes.
There is a CPT E/M Service Code for this visit.	☐	☐	
If **No** is checked for any of the above, STOP. Do not report a CPT category II code.			
Step 2 Does patient also have the other requirements for this measure?			
	Yes	**No**	**Code to be Reported on Line 24D of Paper Claim Form (or Service Line 24 of Electronic Claim Form)**
Is the patient being seen for an initial evaluation of GERD?	☐	☐	If **No,** report 1071F–8P and STOP. If **Yes,** proceed to the next question.
Does the patient have one or more alarm[1] symptoms present?	☐	☐	If **No** (ie, none present), report 1070F and STOP. If **Yes** (ie, one or more alarm symptoms present), report 1071F and proceed to Step 3.
Step 3 Does patient meet or have an acceptable reason for not meeting the measure?			
Upper Gastrointestinal Endoscopy	**Yes**	**No**	**Code to be Reported on Line 24D of Paper Claim Form, if *Yes* (or Service Line 24 of Electronic Claim Form)**
Performed	☐	☐	3130F
Referred	☐	☐	3132F
Not performed or referred for one of the following reasons: • Medical (eg, not indicated, contraindicated, other medical reason)	☐	☐	3130F–1P OR 3132F–1P
• Patient (eg, patient declined, economic, social, religious, other patient reason)	☐	☐	3130F–2P OR 3132F–2P
• System (eg, resources to perform the services not available, other reason attributable to health care delivery system)	☐	☐	3130F–3P OR 3132F–3P
Document reason here and in medical chart. _____ _____			If **No** is checked for **all** of the above, report 3130F–8P or 3132F–8P (Referral for or completion of an upper gastrointestinal endoscopy was not documented, reason not otherwise specified.)

[1]Alarm symptoms for GERD include involuntary weight loss, dysphagia, and GI bleeding.

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Coding Specifications

Code required to document patients has GERD and a visit occurred:

An ICD-9 diagnosis code for GERD and a CPT E/M service code are required to identify patients to be included in this measure.

GERD ICD-9 diagnosis codes

- 530.10, 530.11, 530.12, 530.19, 530.81 (disease of esophagus/GERD)

AND

CPT E/M service codes

- 99201, 99202, 99203, 99204, 99205 (office-new patient),
- 99212, 99213, 99214, 99215 (office-established patient),
- 99241, 99242, 99243, 99244, 99245 (outpatient consult)

Quality codes for this measure (at least one of the following for every eligible patient):

CPT II Code descriptors

(Data collection sheet should be used to determine appropriate combination of codes.)

- ***CPT II 1070F:*** Alarm symptoms (involuntary weight loss, dysphagia, or gastrointestinal bleeding) assessed; none present
- ***CPT II 1071F:*** Alarm symptoms (involuntary weight loss, dysphagia, or gastrointestinal bleeding) assessed; one or more present
- ***CPT II 1071F–8P:*** Initial evaluation of GERD occurred prior to the reporting period
- ***CPT II 3130F:*** Upper gastrointestinal endoscopy performed
- ***CPT II 3132F:*** Documentation of referral for upper gastrointestinal endoscopy
- ***CPT II 3130F–1P*** OR ***3132F–1P:*** Documentation of medical reason(s) for not referring for or not performing an upper gastrointestinal endoscopy
- ***CPT II 3130F–2P*** OR ***3132F–2P:*** Documentation of patient reason(s) for not referring for or not performing an upper gastrointestinal endoscopy
- ***CPT II 3130F–3P*** OR ***3132F–3P:*** Documentation of system reason(s) for not referring for or not performing an upper gastrointestinal endoscopy
- ***CPT II 3130F–8P*** OR ***3132F–8P:*** Referral for or completion of an upper gastrointestinal endoscopy was not documented, reason not otherwise specified