CODING FOR QUALITY

A HANDBOOK FOR PQRI PARTICIPATION

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Section I
Introduction

Handbook Purpose

This Handbook is provided to promote understanding about how to implement 2008 PQRI measures in clinical practice and to facilitate successful reporting of quality data by eligible professionals who wish to participate in PQRI.

The Handbook is organized into sections. Section I discusses basic factors and issues that eligible professionals may wish to consider when selecting measures and preparing to report. Section II reviews PQRI coding and reporting principles for the claims-based submission of quality-data codes (QDCs). Section III provides a list of 2008 PQRI measures arranged in alphabetical order by clinical condition.

Handbook Content

The Handbook includes information to assist eligible professionals to:

- Identify eligible cases by denominator codes, usually ICD-9-CM and CPT Category I codes
- Choose QDC(s) to report in the form of numerator CPT Category II code(s) and temporary G-code(s)
- Use CPT Category II code performance exclusion modifiers 1P, 2P, and 3P
- Use the CPT Category II code reporting modifier 8P or a temporary reporting G-code if applicable

2008 PQRI Measures and Specifications

There are 119 measures that have been identified for 2008 PQRI. These measures address various aspects of care, such as prevention, chronic- and acute-care management, procedure-related care, resource utilization, and care coordination.

The CMS PQRI Quality Measures Specifications document, posted on the CMS website at www.cms.hhs.gov/PQRI, contains detailed descriptions for each PQRI quality measure. The list is arranged in numerical order and includes instructions for how to code each measure's numerator and denominator using diagnosis codes from the International Classification of Diseases, 9th Revision-Clinical Modification (ICD-9-CM) and Current Procedural Terminology (CPT) codes from the Healthcare Common Procedure Coding System (HCPCS).

PQRI Measure Selection

Measure selection begins with a review of PQRI 2008 measures. At a minimum, the following factors should be considered when selecting measures for reporting:

- Conditions usually treated
- Types of care typically provided – *e.g.,* preventive, chronic, acute
- Settings where care is usually delivered – *e.g.,* office, ED, surgical suite
- Quality improvement goals for 2008

Review the Specifications for each measure under consideration and select measures that apply to services most frequently provided to Medicare patients by the practice.

Section II
PQRI Measure Coding and Reporting Principles

PQRI Measure Denominators and Numerators

Each PQRI measure consists of two major components:

1) A denominator that describes the eligible cases for a measure (the eligible patient population associated with a measure's numerator)
2) A numerator that describes the clinical action required by the measure for reporting and performance

Measure denominators and numerators are further specified by specific codes, usually ICD-9-CM and CPT Category I codes for denominators and CPT Category II code(s) or G-code(s) for numerators. Each measure is unique, so it is important to review and understand each measure's specifications, which provide definitions and specific instructions for coding and reporting measure components.

Use of CPT I Modifiers

Surgical procedures billed by an assistant surgeon(s) will be excluded from the denominator population so their performance rates will not be negatively impacted for PQRI. PQRI analyses will exclude otherwise PQRI-eligible CPT Category I codes, when submitted with assistant surgeon modifiers 80, 81, or 82. The primary surgeon, not the assistant surgeon, is responsible for performing and reporting the quality action(s) in applicable PQRI measures.

PQRI-eligible CPT Category I procedure codes, billed by surgeons performing surgery on the same patient, submitted with modifier 62 (indicating two surgeons, i.e. dual procedures) will be included in the denominator population for applicable PQRI measure(s). Both surgeons participating in PQRI will be fully accountable for the clinical action(s) described in the PQRI measure(s).

Reporting Frequency and Performance Timeframes

Each measure's specification includes a *reporting frequency* requirement for each denominator-eligible patient seen during the reporting period. The reporting frequency is described in the instructions and may be stated as:

- Report at least once for the specified timeframe
- Report once for each procedure performed, using date of service
- Report once for each acute care episode
- Report each time the patient is seen by an eligible professional

A measure's *performance timeframe* is defined in the measure's description and is distinct from the reporting frequency requirement. The performance timeframe, unique to each measure, delineates the timeframe in which the clinical action described in the numerator may be accomplished.

Performance timeframes vary for each measure. Performance timeframes for measures tied to a specific clinical process may be stated as, "once within a given reporting period," or "most recent." This means that:

- The clinical action in the numerator needs to be performed only once during a given reporting period for each patient seen during the reporting period.
- QDC(s) need to be reported only one time for each patient by each eligible professional caring for the patient who has chosen to report that measure during the reporting period.

- If the measure calls for a clinical test result, then the most recent test result only needs to be obtained, assessed, and reported one time per reporting period. A test does not need to have been performed within the reporting period, nor does it need to have been performed by the same eligible professional.

Quality-Data Codes

QDCs are HCPCS codes comprised of specified CPT Category II codes and/or G-codes that describe the clinical action required by a measure. Clinical actions can apply to more than one condition, and therefore can also apply to more than one measure.

CPT Category II Codes

CPT Category II or CPT II codes, developed through the CPT Editorial Panel for use in performance measurement, serve to encode the clinical action(s) described in a measure's numerator. CPT II codes consist of five alphanumeric characters in a string ending with the letter "F." CPT II codes are published annually in the CPT code manual. Updates to CPT II codes are published every January and July and are available on the CPT II web pages at the American Medical Association's website:
http://www.ama-assn.org/ama/pub/category/10616.html

Use of CPT II Modifiers

CPT II modifiers are unique to CPT II codes and may be used to report PQRI measures by appending the appropriate modifier to a CPT II code as specified for a given measure. The modifiers for a code are mutually exclusive and their use is guided by the measure's coding instructions, which are included in the numerator coding section of the PQRI Measure Specifications. Use of the modifiers is unique to CPT II codes and may not be used with other types of CPT codes. Only CPT II modifiers may be appended to CPT II codes. Descriptions of each modifier are provided below to help identify circumstances when the use of an exclusion modifier may be appropriate. Note that in a pay-for-reporting model, accurate reporting on all selected applicable measures counts the same, whether reporting that the clinical action was performed or not.

CPT II code modifiers fall into two categories, *exclusion modifiers* and the 8P *reporting modifier*.

1) Exclusion modifiers may be appended to a CPT II code to indicate that an action specified in the measure was not provided due to medical, patient, or system reason(s) documented in the medical record. These modifiers serve as denominator exclusions for the purpose of measuring performance. Some measures do not provide for performance exclusions. Reasons for appending a performance measure exclusion modifier fall into one of three categories:
   - **1P** exclusion modifier due to *medical reasons*
     Examples include: not indicated (absence of organ/limb, already received/performed); contraindicated (patient allergic history, potential adverse drug interaction)
   - **2P** exclusion modifier due to *patient reasons*
     Examples include: patient declined; economic, social, or religious reasons
   - **3P** exclusion modifier due to *system reasons*
     Examples include: resources to perform the services not available; insurance or coverage/payer-related limitations; other reasons attributable to health care delivery system

2) Reporting modifier 8P is available for use only with CPT II codes to facilitate reporting an eligible case when an action described in a measure is not performed and the reason is not specified. Instructions for appending this modifier to CPT Category II codes are included in applicable measures. Use of the 8P reporting modifier indicates that the patient is eligible for the measure; however, there is no indication in the record that the action described in the measure was performed, nor was there any documented reason attributable to the exclusion modifiers.
   - **8P** reporting modifier - action not performed, reason not otherwise specified

The 8P modifier facilitates reporting an eligible case on a given measure when the clinical action does not apply to a specific encounter. Eligible professionals can use the 8P modifier to receive credit for successful reporting but will not receive credit for performance.

For example, a clinician has selected and submitted QDCs during the reporting period for 2008 PQRI Measure #6, Oral Antiplatelet Therapy. The clinician sees a patient at an encounter and the claim for services for that encounter contains ICD-9-CM and CPT codes that will draw the patient into the measures' denominator during analysis. The 8P modifier serves to include the patient in the numerator when reporting rates are calculated for PQRI.

Claims-Based Reporting Principles

The following principles apply to the reporting of QDCs for PQRI measures:

- The CPT Category II code(s) and/or G-code(s), which supplies the numerator, must be reported on the same claim form as the payment codes, usually ICD-9-CM and CPT Category I codes, which supply the denominator.
- QDCs must be submitted with a line item charge of zero dollars ($0.00) at the time the associated covered service is performed.
  - The submitted charge field cannot be blank.
  - The line item charge should be $0.00.
  - If a system does not allow a $0.00 line item charge, use a small amount such as $0.01.
  - Entire claims with a zero charge will be rejected. (Total charge for the claim cannot be $0.00.)
  - Quality-data code line items will be denied for payment, but are then passed through the claims processing system for PQRI analysis. Eligible professionals will receive a Remittance Advice (N365) as confirmation that the QDC(s) passed into the National Claims History file.
- Multiple eligible professionals' QDCs can be reported on the same claim using their individual NPI.
- Some measures require the submission of more than one QDC in order to properly report the measure.
- Eligible professionals may submit multiple codes for more than one measure on a single claim.
- Multiple CPT Category II and/or G-codes for multiple measures that are applicable to a patient visit can be reported on the same claim, as long as the corresponding denominator codes are also line items on that claim.
- The individual NPI of the participating eligible professional(s) must be properly used on the claim.
- Claims may not be resubmitted simply to add QDC(s).

Submission through Carriers/Medicare Administrative Contractors (MACs)

QDCs shall be submitted to carriers/MACs either through:

Electronic submission, which is accomplished using the **ASC X 12N Health Care Claim Transaction (Version 4010A1).**

- CPT Category II and/or temporary G-codes should be submitted in the **SV101-2** "Product/Service ID" Data Element on the **SV1** "Professional Service" Segment of the **2400 "Service Line" Loop**.
  - It is also necessary to identify in this segment that a HCPCS code is being supplied by submitting the HC in data element SV101-1 within the SV1 "Professional Service" Segment.
  - Diagnosis codes are submitted at the claim level, **Loop 2300, in data element HI01**, and if there are multiple diagnosis codes, in **HI02 through HI08** as needed.
  - In general for group billing, report the NPI for the rendering provider in **Loop 2310B** (Rendering Provider Name, claim level) or **2420A** (Rendering Provider Name, line level), using data elements **NM108 and NM109**.

OR

Paper-based submission, which is accomplished by using the **CMS 1500 claim form (version 08-05).** Relevant ICD-9-CM diagnosis codes are entered in **Field 21. Service codes** (including CPT, HCPCS, CPT Category II and/or G-codes) with any associated modifiers are entered in **Field 24D** with the diagnosis pointer in **Field 24E**.

- For group billing, the **National Provider Identifier (NPI)** of the rendering provider is entered in **Field 24J**.
- The **Tax Identification Number (TIN)** of the employer is entered in **Field 25**.

Individual/Group NPI Submission

Your individual National Provider Identifier (NPI) must be included on the claim line items for the quality-data codes you submit as well as the line items for the services to which the quality-data code is applicable. The PQRI quality-data code must be included on the same claim that is submitted for payment at the time the claim is initially submitted in order to be included in PQRI analysis.

If a group NPI is used at the claim level, the individual rendering physician's NPI must be placed on each line item, including all allowed-charge and quality-data line items.

Timeliness of Quality Data Submission

Claims processed by the Carrier/MAC must reach the national Medicare claims system data warehouse (National Claims History file) by February 28, 2009 to be included in the analysis. Claims for services furnished toward the end of the reporting period should be filed promptly. Claims that are resubmitted only to add quality-data codes will not be included in the analysis.

Section III
Successful Reporting of PQRI Measures

PQRI measures and their components are arranged alphabetically by clinical condition in this section of the Handbook to facilitate review and selection of measures.

Informational items taken from the 2008 PQRI Measure Specifications are provided in the following sequence:

- Measure title and description with reporting frequency and performance timeframe requirements specific to the measure
- Identification of eligible cases as described in the denominator and ICD-9 diagnosis and CPT I codes that describe the patient population associated with the numerator
- Instructions for how to code and report the clinical action described in the measure's numerator using CPT II codes and/or G-codes:
    1) The measure requirement was met,
    2) The measure requirement was not met due to documented allowable performance exclusions (using performance exclusion modifiers), and
    3) The measure requirement was not met and the reason is not documented in the medical record (using the 8P reporting modifier).
- Implementation Guidelines are provided for each measure. The guidelines are an additional resource to assist eligible professionals in successfully reporting PQRI measures.

2008 PQRI Measure Taxonomy

TOPIC	CLINICAL CONDITION	MEASURE NUMBER	MEASURE TITLE	PAGE
Care Coordination	Advance Care Plan	47	Advance Care Plan	16
Management of Chronic Conditions	Arthritis-Osteoarthritis	109	Patients with Osteoarthritis who have an Assessment of Their Pain and Function	18
Management of Chronic Conditions	Arthritis-Rheumatoid	108	Disease Modifying Anti-Rheumatic Drug Therapy in Rheumatoid Arthritis	20
Management of Chronic Conditions	Asthma	53	Asthma: Pharmacologic Therapy	22
Management of Chronic Conditions	Asthma	64	Asthma Assessment	24
Management of Chronic Conditions	Breast Cancer	71	Hormonal Therapy for Stage IC - III ER/PR Positive Breast Cancer	26
Management of Chronic Conditions	Breast Cancer	74	Radiation Therapy Recommended for Invasive Breast Cancer Patients Who Have Undergone Breast Conserving Surgery	29
Acute Episode of Care	Breast Cancer	99	Breast Cancer Patients who have a pT and pN Category and Histologic Grade for Their Cancer	31
Prevention	Breast Cancer	112	Screening Mammography	33
Acute Episode of Care	Bronchitis	116	Inappropriate Antibiotic Treatment for Adults with Acute Bronchitis	35
Procedure-Related	CABG	43	Use of Internal Mammary Artery (IMA) in Coronary Artery Bypass Graft (CABG) Surgery	37
Procedure-Related	CABG	44	Pre-Operative Beta-blocker in Patients with Isolated Coronary Artery Bypass Graft (CABG) Surgery	39
Management of Chronic Conditions	CAD	118	Angiotensin Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Patients with Coronary Artery Disease and Diabetes Mellitus and/or Left Ventricular Systolic Dysfunction (LVSD)	41
Management of Chronic Conditions	CAD	6	Oral Antiplatelet Therapy Prescribed for Patients with Coronary Artery Disease	44

TOPIC	CLINICAL CONDITION	MEASURE NUMBER	MEASURE TITLE	PAGE
Management of Chronic Conditions	CAD	7	Beta-blocker Therapy for Coronary Artery Disease Patients with Prior Myocardial Infarction (MI)	46
Management of Chronic Conditions	Chemotherapy	73	Plan for Chemotherapy Documented Before Chemotherapy Administered	48
Acute Episode of Care	Chest Pain	54	Electrocardiogram Performed for Non-Traumatic Chest Pain	50
Management of Chronic Conditions	Chronic Kidney Disease	120	ACE Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy in Patients with CKD	52
Management of Chronic Conditions	Chronic Kidney Disease	121	Chronic Kidney Disease (CKD): Laboratory Testing (Calcium, Phosphorus, Intact Parathyroid Hormone (iPTH) and Lipid Profile)	54
Management of Chronic Conditions	Chronic Kidney Disease	122	Chronic Kidney Disease (CKD): Blood Pressure Management	56
Management of Chronic Conditions	Chronic Kidney Disease	123	Chronic Kidney Disease (CKD): Plan of Care: Elevated Hemoglobin for Patients Receiving Erythropoiesis-Stimulating Agents (ESA)	58
Management of Chronic Conditions	Colon Cancer	72	Chemotherapy for Stage III Colon Cancer Patients	60
Acute Episode of Care	Colorectal Cancer	100	Colorectal Cancer Patients who have a pT and pN Category and Histologic Grade for Their Cancer	63
Prevention	Colorectal Cancer	113	Colorectal Cancer Screening	65
Management of Chronic Conditions	COPD	51	Chronic Obstructive Pulmonary Disease (COPD): Spirometry Evaluation	67
Management of Chronic Conditions	COPD	52	Chronic Obstructive Pulmonary Disease (COPD): Bronchodilator Therapy	69
Prevention	CRBSI	76	Prevention of Catheter-Related Bloodstream Infections (CRBSI) – Central Venous Catheter Insertion Protocol	71
Acute Episode of Care	Depression	9	Antidepressant Medication During Acute Phase for Patients with New Episode of Major Depression	73
Acute Episode of Care	Depression	106	Patients who have Major Depression Disorder who meet DSM IV Criteria	75

TOPIC	CLINICAL CONDITION	MEASURE NUMBER	MEASURE TITLE	PAGE
Acute Episode of Care	Depression	107	Patients who have Major Depression Disorder who are Assessed for Suicide Risks	77
Management of Chronic Conditions	Diabetes	1	Hemoglobin A1c Poor Control in Type 1 or 2 Diabetes Mellitus	79
Management of Chronic Conditions	Diabetes	2	Low Density Lipoprotein Control in Type 1 or 2 Diabetes Mellitus	81
Management of Chronic Conditions	Diabetes	3	High Blood Pressure Control in Type 1 or 2 Diabetes Mellitus	83
Management of Chronic Conditions	Diabetes	18	Diabetic Retinopathy: Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy	85
Management of Chronic Conditions	Diabetes	19	Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care	87
Management of Chronic Conditions	Diabetes	117	Dilated Eye Exam in Diabetic Patient	89
Management of Chronic Conditions	Diabetes	119	Urine Screening for Microalbumin or Medical Attention for Nephropathy in Diabetic Patients	91
Management of Chronic Conditions	Diabetes	126	Diabetic Foot and Ankle Care, Peripheral Neuropathy: Neurological Evaluation	93
Management of Chronic Conditions	Diabetes	127	Diabetic Foot and Ankle Care, Ulcer Prevention: Evaluation of Footwear	95
Management of Chronic Conditions	ESRD	78	Vascular Access for Patients Undergoing Hemodialysis	97
Prevention	ESRD	79	Influenza Vaccination in Patients with End Stage Renal Disease (ESRD)	99
Management of Chronic Conditions	ESRD	80	Plan of Care for ESRD Patients with Anemia	101
Management of Chronic Conditions	ESRD	81	Plan of Care for Inadequate Hemodialysis in ESRD Patients	103
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TOPIC	CLINICAL CONDITION	MEASURE NUMBER	MEASURE TITLE	PAGE
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Acute Episode of Care	Glaucoma	12	Primary Open Angle Glaucoma: Optic Nerve Evaluation	111
Management of Chronic Conditions	Heart Failure	5	Heart Failure: Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD)	113
Management of Chronic Conditions	Heart Failure	8	Heart Failure: Beta-blocker Therapy for Left Ventricular Systolic Dysfunction	116
Management of Chronic Conditions	Hepatitis C	83	Testing of Patients with Chronic Hepatitis C (HCV) for Hepatitis C Viremia	118
Management of Chronic Conditions	Hepatitis C	84	Initial Hepatitis C RNA Testing	120
Management of Chronic Conditions	Hepatitis C	85	HCV Genotype Testing Prior to Therapy	122
Management of Chronic Conditions	Hepatitis C	86	Consideration for Antiviral Therapy in HCV Patients	124
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Management of Chronic Conditions	Hepatitis C	89	Counseling Patients with HCV Regarding Use of Alcohol	130
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Prevention	Influenza	129	Universal Influenza Vaccine Screening and Counseling	144
Management of Chronic Conditions	Leukemia (CLL)	70	Chronic Lymphocytic Leukemia (CLL): Baseline Flow Cytometry	146
Management of Chronic Conditions	Macular Degeneration	14	Age-Related Macular Degeneration: Dilated Macular Examination	148
Management of Chronic Conditions	MDS	67	Myelodysplastic Syndrome (MDS) and Acute Leukemias: Baseline Cytogenetic Testing Performed on Bone Marrow	150
Management of Chronic Conditions	MDS	68	Myelodysplastic Syndrome (MDS): Documentation of Iron Stores in Patients Receiving Erythropoietin Therapy	152
Care Coordination	Medication Management	46	Medication Reconciliation	154
Care Coordination	Medication Management	130	Universal Documentation and Verification of Current Medications in the Medical Record	156
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Prevention	Mental Health	134	Screening for Clinical Depression	160
Management of Chronic Conditions	Myeloma	69	Multiple Myeloma: Treatment with Bisphosphonates	162
Acute Episode of Care	Myocardial Infarction	28	Aspirin at Arrival for Acute Myocardial Infarction (AMI)	164
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TOPIC	CLINICAL CONDITION	MEASURE NUMBER	MEASURE TITLE	PAGE
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Acute Episode of Care	Otitis	91	Acute Otitis Externa (AOE): Topical Therapy	176
Acute Episode of Care	Otitis	92	Acute Otitis Externa (AOE): Pain Assessment	178
Acute Episode of Care	Otitis	93	Acute Otitis Externa (AOE): Systemic Antimicrobial Therapy – Avoidance of Inappropriate Use	180
Acute Episode of Care	Otitis	94	Otitis Media with Effusion (OME): Diagnostic Evaluation – Assessment of Tympanic Membrane Mobility	182
Acute Episode of Care	Otitis	95	Otitis Media with Effusion (OME): Hearing Testing	184
Acute Episode of Care	Otitis	96	Otitis Media with Effusion (OME): Antihistamines or Decongestants – Avoidance of Inappropriate Use	186
Acute Episode of Care	Otitis	97	Otitis Media with Effusion (OME): Systemic Antimicrobials – Avoidance of Inappropriate Use	188
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Acute Episode of Care	Pain Management	131	Pain Assessment Prior to Initiation of Patient Treatment	192
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TOPIC	CLINICAL CONDITION	MEASURE NUMBER	MEASURE TITLE	PAGE
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Procedure-Related	Perioperative	30	Perioperative Care: Timing of Prophylactic Antibiotics – Administering Physician	204
Procedure-Related	Perioperative	45	Perioperative Care: Discontinuation of Prophylactic Antibiotics (Cardiac Procedures)	206
Acute Episode of Care	Pharyngitis	66	Appropriate Testing for Children with Pharyngitis	208
Care Coordination	Plan of Care	132	Patient Co-Development of Treatment Plan/Plan of Care	210
Acute Episode of Care	Pneumonia	56	Vital Signs for Community-Acquired Bacterial Pneumonia	212
Acute Episode of Care	Pneumonia	57	Assessment of Oxygen Saturation for Community-Acquired Bacterial Pneumonia	214
Acute Episode of Care	Pneumonia	58	Assessment of Mental Status for Community-Acquired Bacterial Pneumonia	216
Acute Episode of Care	Pneumonia	59	Empiric Antibiotic for Community-Acquired Bacterial Pneumonia	218
Acute Episode of Care	Pneumonia	75	Prevention of Ventilator-Associated Pneumonia – Head Elevation	220
Prevention	Pneumonia, Pneumococcal	111	Pneumonia Vaccination for Patients 65 Years and Older	222
Acute Episode of Care	Prostate Cancer	101	Appropriate Initial Evaluation of Patients with Prostate Cancer	224
Acute Episode of Care	Prostate Cancer	102	Inappropriate Use of Bone Scan for Staging Low-Risk Prostate Cancer Patients	226
Acute Episode of Care	Prostate Cancer	103	Review of Treatment Options in Patients with Clinically Localized Prostate Cancer	228

Measure #47: Advance Care Plan

- **Reporting Description:** Percentage of patients aged 65 years and older seen by the clinician and an applicable CPT Category II code reported a minimum of once during the reporting period
- **Performance Description:** Percentage of patients aged 65 years and older who have an advance care plan or surrogate decision maker documented in the medical record or documentation in the medical record that an advance care plan was discussed but the patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan in the medical record

Eligible Cases:	
Patient aged ≥ 65 years on date of encounter **AND** Patient encounter during reporting period (CPT) **Clinicians indicating the place of service as the emergency department (POS = 23) will not be included in this measure.*	99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99218, 99219, 99220, 99221, 99222, 99223, 99231, 99232, 99233, 99234, 99235, 99236, 99291*, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350

Quality Data Code Reporting Options:	
Successful Reporting & Performance: Advance Care Planning discussed and documented; advance care plan or surrogate decision maker documented in the medical record **OR** Advance Care Planning discussed and documented in the medical record; patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan	1123F **OR** 1124F

OR

Successful Reporting & Excluded from Performance: There are no allowable performance exclusions for this measure.	NONE

OR

Successful Reporting & Performance Not Met: Surrogate decision maker or advance care planning not documented, reason not specified	1123F-8P

Implementation Guidelines:

- There is no diagnosis associated with this measure. This measure must be reported a minimum of once for all patients aged 65 years and older seen during the reporting period (January 1 through December 31, 2008).
- This measure is appropriate for use in all healthcare settings (e.g., inpatient, nursing home, ambulatory, except the emergency department). Clinicians indicating the place of service as the emergency department will not be included in this measure.
- Review clinical data regarding the presence or absence of documentation of an advance care plan at an encounter occurring during the reporting period. Select and submit the appropriate CPT Category II code corresponding to the measure.
- For the purposes of this measure, "documentation that patient did not wish or was not able to name a surrogate decision or provide an advance care plan" may also include, as appropriate, the following:
  - That the patient's cultural and/or spiritual beliefs preclude a discussion of advance care planning, as it would be viewed as harmful to the patient's beliefs and thus harmful to the physician-patient relationship
- If patient's cultural and/or spiritual beliefs preclude a discussion of advance care planning, report 1124F.
- Each eligible patient seen during the reporting period will be counted once when calculating the eligible professional's reporting rate for this measure. The measure may be reported again at a subsequent visit during the reporting period. If the measure is reported more than once for an eligible patient during the reporting period, the single instance of reporting most advantageous to performance will be used when calculating the eligible professional's performance rate for this measure.
- Failure to report an applicable CPT Category II code in an eligible case will result in both a reporting and performance failure.
- Medical record documentation is required for all clinical actions described in a measure.

Measure #109: Patients with Osteoarthritis who have an Assessment of Their Pain and Function

- **Reporting Description:** Percentage of patient visits for patients aged 21 years and older with osteoarthritis (OA) and an applicable CPT Category II code reported at each visit during the reporting period
- **Performance Description:** Percentage of patient visits for patients aged 21 years and older with a diagnosis of osteoarthritis (OA) with assessment for function and pain

Eligible Cases:	
Patient aged ≥ 21 years on date of encounter **AND** Diagnosis of OA (ICD-9) **AND** Patient encounter during reporting period (CPT)	715.00, 715.04, 715.09, 715.10, 715.11, 715.12, 715.13, 715.14, 715.15, 715.16, 715.17, 715.18, 715.20, 715.21, 715.22, 715.23, 715.24, 715.25, 715.26, 715.27, 715.28, 715.30, 715.31, 715.32, 715.33, 715.34, 715.35, 715.36, 715.37, 715.38, 715.80, 715.89, 715.90, 715.91, 715.92, 715.93, 715.94, 715.95, 715.96, 715.97, 715.98 **AND** 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245

Quality Data Code Reporting Options:	
Successful Reporting & Performance: Osteoarthritis symptoms and functional status assessed (may include the use of a standardized scale or the completion of an assessment questionnaire, such as an SF-36, AAOS Hip & Knee Questionnaire)	1006F

OR

Successful Reporting & Excluded from Performance: There are no allowable performance exclusions for this measure.	NONE

OR

Successful Reporting & Performance Not Met: Osteoarthritis symptoms and functional status not assessed, reason not specified	1006F-8P

Implementation Guidelines:

- Review clinical data regarding the assessment of function and pain due to osteoarthritis at an encounter occurring during the reporting period (January 1 through December 31, 2008). Select and submit the appropriate CPT Category II code corresponding to the measure.
- Each visit for an eligible patient with osteoarthritis occurring during the reporting period will be counted when calculating the reporting and performance rates.
- Failure to report an applicable CPT Category II code in an eligible case will result in both a reporting and performance failure.
- Medical record documentation is required for all clinical actions described in a measure.

Measure #108: Disease Modifying Anti-Rheumatic Drug Therapy in Rheumatoid Arthritis

- **Reporting Description:** Percentage of patients aged 18 years and older with rheumatoid arthritis and an applicable CPT Category II code reported a minimum of once during the reporting period
- **Performance Description:** Percentage of patients aged 18 years and older who were diagnosed with rheumatoid arthritis and were prescribed, dispensed, or administered at least one ambulatory prescription for a disease modifying anti-rheumatic drug (DMARD)

Eligible Cases:	
Patient aged ≥ 18 years on date of encounter **AND** Diagnosis of rheumatoid arthritis (ICD-9) **AND** Patient encounter during reporting period (CPT)	714.0, 714.1, 714.2, 714.81 **AND** 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99217, 99218, 99219, 99220, 99241, 99242, 99243, 99244, 99245, 99455, 99456

Quality Data Code Reporting Options:	
Successful Reporting & Performance: Disease modifying anti-rheumatic drug therapy prescribed, dispensed, or administered	4187F

OR

Successful Reporting & Excluded from Performance: Documentation of medical reason(s) for not prescribing, dispensing, or administering disease modifying anti-rheumatic drug therapy	4187F-1P

OR

Successful Reporting & Performance Not Met: DMARD not prescribed, dispensed, or administered, reason not specified	4187F-8P

Implementation Guidelines:

- Review clinical data to determine the presence or absence of a current ambulatory care prescription, dispension, or administration of a disease modifying anti-rheumatic drug (DMARD) at an encounter occurring during the reporting period (January 1 through December 31, 2008). Select and submit the appropriate CPT Category II code corresponding to the measure.
- "Prescribed" includes patients who are currently receiving medication(s) that follow the treatment plan recommended at an encounter during the reporting period, even if the prescription for that medication was ordered prior to the encounter.
- Each eligible patient seen during the reporting period will be counted once when calculating the eligible professionals reporting rate for this measure. The measure may be reported again at a subsequent visit during the reporting period. If the measure is reported more than once for an eligible patient during the reporting period, the single instance of reporting most advantageous to performance will be used when calculating the eligible professional's performance rate for this measure.
- Failure to report an applicable CPT Category II code in an eligible case will result in both a reporting and performance failure.
- Medical record documentation is required for all clinical actions described in a measure.

Measure #53: Asthma: Pharmacologic Therapy

- **Reporting Description:** Percentage of patients aged 5 through 40 years with asthma and applicable CPT Category II code(s) reported a minimum of once during the reporting period
- **Performance Description:** Percentage of patients aged 5 through 40 years with a diagnosis of mild, moderate, or severe persistent asthma who were prescribed either the preferred long-term control medication (inhaled corticosteroid) or an acceptable alternative treatment

Eligible Cases:	
Patient aged ≥ 5 and ≤ 40 years on date of encounter **AND** Diagnosis of asthma (ICD-9) **AND** Patient encounter during reporting period (CPT)	493.00, 493.01, 493.02, 493.10, 493.11, 493.12, 493.20, 493.21, 493.22, 493.81, 493.82, 493.90, 493.91, 493.92 **AND** 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245

Quality Data Code Reporting Options:	
Successful Reporting & Performance: Persistent asthma, preferred long term control medication or acceptable alternative treatment prescribed **AND** Persistent asthma (mild, moderate or severe)	4015F **AND** 1038F

OR

Successful Reporting & Excluded from Performance: Documentation of patient reasons for not prescribing either the preferred long-term control medication (inhaled corticosteroid or inhaled corticosteroid with long-acting inhaled beta$_2$-agonist) or an acceptable alternative treatment (leukotriene modifiers, cromolyn sodium, nedocromil sodium, or sustained-released methylaxanthines) **AND** Persistent asthma (mild, moderate or severe) **OR** Intermittent Asthma	4015F-2P **AND** 1038F **OR** 1039F

OR

Successful Reporting & Performance Not Met: Preferred long-term control medication or acceptable alternative treatment not prescribed, reason not specified **AND** Persistent asthma (mild, moderate or severe)	4015F-8P **AND** 1038F

Implementation Guidelines:

- The correct combination of numerator code(s) must be reported on the claim form in order to properly report this measure. The "correct combination" of codes may require the submission of multiple numerator codes.
- This measure must be reported a minimum of once per reporting period for ALL asthma patients.
- At an encounter occurring during the reporting period (January 1 through December 31, 2008), review clinical data to determine whether asthma is persistent or intermittent. For persistent cases, preferred long-term control medication or acceptable alternative treatment should be prescribed. Select and submit the appropriate CPT Category II code(s) corresponding to the measure.
- One method of identifying persistent asthma is at least daily use of short-acting bronchodilators.
- "Prescribed" includes patients who are currently receiving medication(s) that follow the treatment plan recommended at an encounter during the reporting period, even if the prescription for that medication was ordered prior to the encounter.
- Each eligible patient seen during the reporting period will be counted once when calculating the eligible professional's reporting rate for this measure. The measure may be reported again at a subsequent visit during the reporting period. If the measure is reported more than once for an eligible patient during the reporting period, the single instance of reporting most advantageous to performance will be used when calculating the eligible professional's performance rate for this measure.
- Failure to report applicable CPT Category II code(s) in an eligible case will result in both a reporting and performance failure.
- Medical record documentation is required for all clinical actions described in a measure.

Measure #64: Asthma Assessment

- **Reporting Description:** Percentage of patients aged 5 through 40 years with asthma and an applicable CPT Category II code reported a minimum of once during the reporting period
- **Performance Description:** Percentage of patients aged 5 through 40 years with a diagnosis of asthma who were evaluated during at least one office visit within 12 months for the frequency (numeric) of daytime and nocturnal asthma symptoms

Eligible Cases:	
Patient aged ≥ 5 and ≤ 40 years on date of encounter **AND** Diagnosis of asthma (ICD-9) **AND** Patient encounter during reporting period (CPT)	493.00, 493.01, 493.02, 493.10, 493.11, 493.12, 493.20, 493.21, 493.22, 493.81, 493.82, 493.90, 493.91, 493.92 **AND** 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245

Quality Data Code Reporting Options:	
Successful Reporting & Performance: Asthma symptoms evaluated (includes physician documentation of numeric frequency of symptoms or patient completion of an asthma assessment tool/survey/questionnaire)	1005F

OR

Successful Reporting & Excluded from Performance: There are no allowable performance exclusions for this measure.	NONE

OR

Successful Reporting & Performance Not Met: Asthma symptom frequency not evaluated, reason not specified	1005F-8P

Implementation Guidelines:

- Review clinical data (within the last 12 months of this encounter) regarding the presence or absence of the most recent asthma assessment performed at an encounter occurring during the reporting period (January 1 through December 31, 2008). Select and submit the appropriate CPT Category II code corresponding to the measure.
- To be counted in calculations of this measure, symptom frequency must be numerically quantified. Measure may also be met by clinician documentation or patient completion of an asthma assessment tool/survey/questionnaire. Assessment tool may include the Quality Metric Asthma Control Test™, National Asthma Education & Prevention Program (NAEPP) Asthma Symptoms and Peak Flow Diary.
- Each eligible patient seen during the reporting period will be counted once when calculating the eligible professional's reporting rate for this measure. The measure may be reported again at a subsequent visit during the reporting period. If the measure is reported more than once for an eligible patient during the reporting period, the single instance of reporting most advantageous to performance will be used when calculating the eligible professional's performance rate for this measure.
- Failure to report an applicable CPT Category II code in an eligible case will result in both a reporting and performance failure.
- Medical record documentation is required for all clinical actions described in a measure.

Measure #71: Hormonal Therapy for Stage IC - III ER/PR Positive Breast Cancer

- **Reporting Description:** Percentage of female patients aged 18 years and older with breast cancer and applicable CPT Category II code(s) reported a minimum of once during the reporting period
- **Performance Description:** Percentage of female patients aged 18 years and older with Stage IC through IIIC, estrogen receptor (ER) or progesterone receptor (PR) positive breast cancer who were prescribed tamoxifen or aromatase inhibitor (AI) during the 12-month reporting period

Eligible Cases:

Patient aged ≥ 18 years on date of encounter **AND** Diagnosis of breast cancer (ICD-9) **AND** Patient encounter during reporting period (CPT)	174.0, 174.1, 174.2, 174.3, 174.4, 174.5, 174.6, 174.8, 174.9 **AND** 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215

Quality Data Code Reporting Options:

Successful Reporting & Performance: Tamoxifen or aromatase inhibitor (AI) prescribed **AND** AJCC Cancer Stage IC, documented **OR** AJCC Cancer Stage IIA, documented **OR** AJCC Cancer Stage IIB, documented **OR** AJCC Cancer Stage IIIA, documented **OR** AJCC Cancer Stage IIIB, documented **OR** AJCC Cancer Stage IIIC, documented **AND** Estrogen receptor (ER) or progesterone receptor (PR) positive breast cancer	4179F **AND** 3305F **OR** 3306F **OR** 3307F **OR** 3309F **OR** 3310F **OR** 3311F **AND** 3315F

OR

Successful Reporting & Excluded from Performance: Documentation of medical, patient, or system reason(s) for not prescribing tamoxifen or aromatase inhibitor **AND** AJCC Cancer Stage IC, documented **OR** AJCC Cancer Stage IIA, documented **OR** AJCC Cancer Stage IIB, documented **OR** AJCC Cancer Stage IIIA, documented **OR** AJCC Cancer Stage IIIB, documented **OR** AJCC Cancer Stage IIIC, documented **AND** Estrogen receptor (ER) or progesterone receptor (PR) positive breast cancer	4179F-1P **OR** 4179F-2P **OR** 4179F-3P **AND** 3305F **OR** 3306F **OR** 3307F **OR** 3309F **OR** 3310F **OR** 3311F **AND** 3315F
OR AJCC Cancer Stage 0, documented **OR** AJCC Cancer Stage IA, documented **OR** AJCC Cancer Stage IV, documented **OR** Estrogen receptor (ER) and progesterone receptor (PR) negative breast cancer	**OR** 3302F **OR** 3303F **OR** 3312F **OR** 3316F
OR No documentation of cancer stage **OR** No documentation of estrogen receptor (ER) and progesterone receptor (PR) status	**OR** 3305F-8P **OR** 3316F-8P

OR

Successful Reporting & Performance Not Met: Tamoxifen or aromatase inhibitor not prescribed, reason not otherwise specified **AND** AJCC Cancer Stage IC, documented **OR** AJCC Cancer Stage IIA, documented **OR** AJCC Cancer Stage IIB, documented **OR** AJCC Cancer Stage IIIA, documented **OR** AJCC Cancer Stage IIIB, documented **OR** AJCC Cancer Stage IIIC, documented **AND** Estrogen receptor (ER) or progesterone receptor (PR) positive breast cancer	4179F-8P **AND** 3305F **OR** 3306F **OR** 3307F **OR** 3309F **OR** 3310F **OR** 3311F **AND** 3315F

Implementation Guidelines:

- The correct combination of numerator code(s) must be reported on the claim form in order to properly report this measure. The "correct combination" of codes may require the submission of multiple numerator codes.
- This measure must be reported a minimum of once per reporting period for ALL female patients with breast cancer.
- At an encounter during the reporting period (January 1 through December 31, 2008), review clinical data to determine the breast cancer stage and whether or not the ER/PR test is positive. For patients with Stage IC through IIIC and ER/PR positive breast cancer, tamoxifen or aromatase inhibitor should be prescribed. Select and submit the appropriate CPT Category II code(s) corresponding to the measure.
- Closely review the reporting options if the patient is not eligible for this measure to select and submit the appropriate CPT Category II code(s).
- Each eligible patient seen during the reporting period will be counted once when calculating the eligible professional's reporting rate for this measure. The measure may be reported again at a subsequent visit during the reporting period. If the measure is reported more than once for an eligible patient during the reporting period, the single instance of reporting most advantageous to performance will be used when calculating the eligible professional's performance rate for this measure.
- Examples for not prescribing tamoxifen or aromatase inhibitor may include: Medical reason(s) such as patient's disease has progressed to metastatic; patient is receiving a gonadotropin-releasing hormone analogue, patient has received oophorectomy, patient is receiving radiation or chemotherapy, patient's diagnosis date was ≥ 5 years from reporting date; Patient reason(s) such as patient refusal; System reason(s) such as patient is currently enrolled in a clinical trial
- Report 3305F for the Stage T1c Breast Cancer - Tumor more than 1 cm but not more than 2 cm in greatest dimension
- Report 3303F for the following Stage I Breast Cancers:
  - T1a - Tumor more than 0.1 cm but not more than 0.5 cm in greatest dimension
  - T1b - Tumor more than 0.5 cm but not more than 1 cm in greatest dimension
- Failure to report applicable CPT Category II code(s) in an eligible case will result in both a reporting and performance failure.
- Medical record documentation is required for all clinical actions described in a measure.

Measure #74: Radiation Therapy Recommended for Invasive Breast Cancer Patients Who Have Undergone Breast Conserving Surgery

- **Reporting Description:** Percentage of patients aged 18 years and older with breast cancer and an applicable G-code reported a minimum of once during the reporting period
- **Performance Description:** Percentage of invasive female breast cancer patients aged 18 through 70 years old who have undergone breast conserving surgery and who have received recommendation for radiation therapy within 12 months of the first office visit

Eligible Cases:	
Patient aged ≥ 18 years and ≤ 70 years on date of encounter **AND** Diagnosis of invasive breast cancer (ICD-9) **AND** Patient encounter during reporting period (CPT)	174.0, 174.1, 174.2, 174.3, 174.4, 174.5, 174.6, 174.8, 174.9 **AND** 99241, 99242, 99243, 99244, 99245

Quality Data Code Reporting Options:	
Successful Reporting & Performance: Documentation of radiation therapy recommended within 12 months of first office visit	G8379

OR

Successful Reporting & Excluded from Performance: Clinician documentation that patient was not an eligible candidate for radiation therapy measure	G8378

OR

Successful Reporting & Performance Not Met: No documentation of radiation therapy recommended within 12 months of first office visit	G8383

Implementation Guidelines:

- Review clinical data regarding the recommendation of radiation therapy at an encounter occurring during the reporting period (January 1 through December 31, 2008). Select and submit the appropriate G-code corresponding to the measure.
- Radiation therapy may include external beam radiation or brachytherapy.
- The numerator code should be reported at the time of radiation therapy services.
- Each eligible patient seen during the reporting period will be counted once when calculating the eligible professional's reporting rate for this measure. The measure may be reported again at a subsequent visit during the reporting period. If the measure is reported more than once for an eligible patient during the reporting period, the single instance of reporting most advantageous to performance will be used when calculating the eligible professional's performance rate for this measure.
- Failure to report an applicable G-code in an eligible case will result in both a reporting and performance failure.
- Medical record documentation is required for all clinical actions described in a measure.

Measure #99: Breast Cancer Patients who have a pT and pN Category and Histologic Grade for Their Cancer

- **Reporting Description:** Percentage of breast cancer patients receiving resection surgical pathology procedures and an applicable CPT Category II code reported for each resection procedure performed during the reporting period
- **Performance Description:** Percentage of breast cancer resection pathology reports that include the pT category (primary tumor), the pN category (regional lymph nodes), and the histologic grade

Eligible Cases:	
Patients of ALL ages **AND** Diagnosis of breast cancer (ICD-9) **AND** Resection surgical pathology procedure (excluding biopsy) performed during reporting period (CPT)	174.0, 174.1, 174.2, 174.3, 174.4, 174.5, 174.6, 174.8, 174.9, 175.0, 175.9 **AND** 88307, 88309

Quality Data Code Reporting Options:	
Successful Reporting & Performance: pT category (primary tumor), pN category (regional lymph nodes), and histologic grade documented in pathology report	3260F

OR

Successful Reporting & Excluded from Performance: Documentation of medical reason(s) for not including pT category, pN category, and histologic grade in the pathology report (e.g., re-excision without residual tumor; non-carcinomas)	3260F-1P

OR

Successful Reporting & Performance Not Met: pT category, pN category, and histologic grade not documented, reason not specified	3260F-8P

Implementation Guidelines:

- Review clinical data regarding the presence or absence of the pT category (primary tumor), the pN category (regional lymph nodes), and the histologic grade on the pathology report for each breast cancer resection (excluding biopsies) procedure occurring during the reporting period (January 1 through December 31, 2008). Select and submit the appropriate CPT Category II code corresponding to the measure.
- Each breast cancer resection (excluding biopsies) surgical pathology procedure performed during the reporting period will be counted when calculating the reporting and performance rates.
- Failure to report an applicable CPT Category II code in an eligible case will result in both a reporting and performance failure.
- Medical record documentation is required for all clinical actions described in a measure.

Measure #112: Screening Mammography

- **Reporting Description:** Percentage of women aged 40 through 69 years and an applicable CPT Category II code reported a minimum of once during the reporting period
- **Performance Description:** Percentage of women aged 40 through 69 years who had a mammogram to screen for breast cancer within 24 months

Eligible Cases:	
Female patient aged ≥ 40 years and ≤ 69 years on date of encounter **AND** Patient encounter during reporting period (CPT)	99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245

Quality Data Code Reporting Options:	
Successful Reporting & Performance: Screening mammography results documented and reviewed	3014F

OR

Successful Reporting & Excluded from Performance: Documentation of medical reason(s) for not performing a mammogram (i.e., women who had a bilateral mastectomy or two unilateral mastectomies)	3014F-1P

OR

Successful Reporting & Performance Not Met: Mammogram not performed, reason not specified	3014F-8P

Implementation Guidelines:

- There is no diagnosis associated with this measure. This measure must be reported a minimum of once for all female patients aged 40 through 69 years seen during the reporting period (January 1 through December 31, 2008).
- Review clinical data regarding whether or not a mammogram to screen for breast cancer was performed within 24 months of an encounter occurring during the reporting period. Select and submit the appropriate CPT Category II code corresponding to the measure.
- Breast cancer screening is to be performed at least once within 24 months prior to the date of service. Performance for this measure is not limited to the reporting period.
- Each eligible patient seen during the reporting period will be counted once when calculating the eligible professionals reporting rate for this measure. The measure may be reported again at a subsequent visit during the reporting period. If the measure is reported more than once for an eligible patient during the reporting period, the single instance of reporting most advantageous to performance will be used when calculating the eligible professional's performance rate for this measure.
- Failure to report an applicable CPT Category II code in an eligible case will result in both a reporting and performance failure.
- Medical record documentation is required for all clinical actions described in a measure.

Measure #116: Inappropriate Antibiotic Treatment for Adults with Acute Bronchitis

- **Reporting Description:** Percentage of adults aged 18 through 64 years with acute bronchitis and an applicable CPT Category II code reported at each visit during the reporting period
- **Performance Description:** Percentage of adults aged 18 through 64 years with a diagnosis of acute bronchitis who were not prescribed or dispensed an antibiotic prescription on or within 3 days of the initial date of service

Eligible Cases:	
Patient aged ≥ 18 years and ≤ 64 years on date of encounter **AND** Diagnosis of acute bronchitis (ICD-9) **AND** Patient encounter during reporting period (CPT)	466.0 **AND** 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99217, 99218, 99219, 99220, 99241, 99242, 99243, 99244, 99245, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350

Quality Data Code Reporting Options:	
Successful Reporting & Performance: Antibiotic neither prescribed nor dispensed	4124F

OR

Successful Reporting & Excluded from Performance: Documentation of medical reason(s) for prescribing or dispensing antibiotic	4120F-1P

OR

Successful Reporting & Performance Not Met: Antibiotic prescribed or dispensed (Reason not specified)	4120F

Implementation Guidelines:

- Review clinical data to determine the presence or absence of a current antibiotic prescription dispensed on or three days after the initial date of service for an acute episode of bronchitis occurring during the reporting period (January 1 through December 31, 2008). Select and submit the appropriate CPT Category II code corresponding to the measure.
- For performance, the measure will be calculated as the number of patients for whom antibiotics were neither prescribed nor dispensed on or within 3 days of the initial date of service over the number of patients in the denominator (patients aged 18 through 64 years with acute bronchitis). A higher score indicates appropriate treatment of patients with acute bronchitis (e.g., the proportion for whom antibiotics *were not* prescribed or dispensed on or three days after the initial date of service).
- Report this measure at each eligible encounter during the reporting period. Each episode of acute bronchitis in an eligible patient occurring during the reporting period will be counted when calculating the reporting and performance rates.
- Part B claims data will be analyzed to determine episodes.
- Failure to report an applicable CPT Category II code in an eligible case will result in both a reporting and performance failure.
- Medical record documentation is required for all clinical actions described in a measure.

Procedure - Related

CABG

Measure #43: Use of Internal Mammary Artery (IMA) in Coronary Artery Bypass Graft (CABG) Surgery

- **Reporting Description:** Percentage of patients aged 18 years and older undergoing isolated coronary artery bypass surgery and an applicable CPT Category II code reported each time an isolated CABG is performed during the reporting period
- **Performance Description:** Percentage of patients aged 18 years and older undergoing isolated coronary artery bypass graft (CABG) surgery using an internal mammary artery (IMA)

Eligible Cases:	
Patient aged ≥ 18 years on date of encounter **AND** Isolated CABG surgery performed during reporting period (CPT)	33510, 33511, 33512, 33513, 33514, 33516, 33517, 33518, 33519, 33521, 33522, 33523, 33533, 33534, 33535, 33536

Quality Data Code Reporting Options:	
Successful Reporting & Performance: Internal mammary artery graft performed for primary, isolated coronary artery bypass graft procedure	4110F

OR

Successful Reporting & Excluded from Performance: Documentation of medical reason(s) for not performing an internal mammary artery graft for primary, isolated coronary artery bypass graft procedure	4110F-1P

OR

Successful Reporting & Performance Not Met: IMA graft not performed, reason not specified	4110F-8P

Implementation Guidelines:

- Review clinical data regarding the use of an IMA graft for each isolated CABG surgery occurring during the reporting period (January 1 through December 31, 2008). Select and submit the appropriate CPT Category II code corresponding to the measure.
- This measure should only be reported for "isolated" CABG procedures using arterial and/or venous grafts only. This measure does not include patients undergoing a repeat CABG.
- Each isolated CABG surgical procedure occurring during the reporting period will be counted when calculating the reporting and performance rates.
- Part B claims data will be analyzed to determine each "isolated" CABG procedure.
- Failure to report an applicable CPT Category II code in an eligible case will result in both a reporting and performance failure.
- Medical record documentation is required for all clinical actions described in a measure.

Procedure - Related

CABG

Measure #44: Pre-Operative Beta-Blocker in Patients with Isolated Coronary Artery Bypass Graft (CABG) Surgery

- **Reporting Description:** Percentage of patients aged 18 years and older undergoing isolated CABG surgery and an applicable CPT Category II code reported each time an isolated CABG is performed during the reporting period
- **Performance Description:** Percentage of patients aged 18 years and older undergoing isolated coronary artery bypass (CABG) surgery who received a beta-blocker pre-operatively

Eligible Cases:	
Patient aged ≥ 18 years on date of encounter **AND** Isolated CABG surgery performed during reporting period (CPT)	33510, 33511, 33512, 33513, 33514, 33516, 33517, 33518, 33519, 33521, 33522, 33523, 33533, 33534, 33535, 33536

Quality Data Code Reporting Options:	
Successful Reporting & Performance: Beta blocker administered within 24 hours prior to surgical incision	4115F

OR

Successful Reporting & Excluded from Performance: Documentation of medical reason(s) for not administering beta blocker within 24 hours prior to surgical incision	4115F-1P

OR

Successful Reporting & Performance Not Met: Pre-operative beta-blocker not received, reason not specified	4115F-8P

Implementation Guidelines:

- Review clinical data regarding the presence or absence of pre-operative beta-blocker for each isolated CABG surgery occurring during the reporting period (January 1 through December 31, 2008). Select and submit the appropriate CPT Category II code corresponding to the measure.
- Each isolated CABG surgical procedure occurring during the reporting period will be counted when calculating the reporting and performance rates.
- This measure should only be reported for "isolated" CABG procedures using arterial and/or venous grafts only. Claims data will be used to determine isolated CABG procedures.
- Part B claims data will be analyzed to determine each "isolated" CABG procedure.
- Failure to report an applicable CPT Category II code in an eligible case will result in both a reporting and performance failure.
- Medical record documentation is required for all clinical actions described in a measure.

Measure #118: Angiotensin Converting Enzyme Inhibitor (ACE) or Angiotensin Receptor Blocker (ARB) Therapy for Patients with Coronary Artery Disease and Diabetes and/or Left Ventricular Systolic Dysfunction (LVSD)

- **Reporting Description:** Percentage of patients aged 18 years and older with coronary artery disease (CAD) who also have diabetes mellitus and/or LVSD and an applicable G-code reported a minimum of once during the reporting period
- **Performance Description:** Percentage of patients aged 18 years and older with a diagnosis of coronary artery disease (CAD) who also have diabetes mellitus and/or left ventricular systolic dysfunction (LVSD) who were prescribed ACE Inhibitor or ARB therapy

Eligible Cases *for REPORTING OPTION #1:*

Patient aged ≥ 18 years on date of encounter **AND** Diagnosis of CAD (ICD-9) **AND** Patient encounter during reporting period (CPT)	410.00, 410.01, 410.02, 410.10, 410.11, 410.12, 410.20, 410.21, 410.22, 410.30, 410.31, 410.32, 410.40, 410.41, 410.42, 410.50, 410.51, 410.52, 410.60, 410.61, 410.62, 410.70, 410.71, 410.72, 410.80, 410.81, 410.82, 410.90, 410.91, 410.92, 411.0, 411.1, 411.81, 411.89, 413.0, 413.1, 413.9, 414.00, 414.01, 414.02, 414.03, 414.04, 414.05, 414.06, 414.07, 414.8, 414.9, V45.81, V45.82 **AND** 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350

Quality Data Code Reporting Option *#1*:

Successful Reporting & Performance: Angiotensin converting enzyme (ACE) inhibitor or angiotensin receptor blocker (ARB) therapy prescribed for patients with a left ventricular ejection fraction (LVEF) <40% or documentation of moderately or severely depressed left ventricular systolic function	G8468

OR

Successful Reporting & Excluded from Performance: Clinician documented that patient with a left ventricular ejection fraction (LVEF) <40% or documentation of moderately or severely depressed left ventricular systolic function was not an eligible candidate for angiotensin converting enzyme (ACE) inhibitor or angiotensin receptor blocker (ARB) therapy **OR** Patient with left ventricular ejection fraction (LVEF) ≥40% or documentation as normal or mildly depressed left ventricular systolic function **OR** Left ventricular ejection fraction (LVEF) was not performed or documented	G8469 **OR** G8470 **OR** G8471

OR

Successful Reporting & Performance Not Met: ACE inhibitor or ARB therapy not prescribed for patients with LVSD, reason not specified	G8472

OR

Eligible Cases *for REPORTING OPTION #2:*	
Patient aged ≥ 18 years on date of encounter **AND** Diagnosis of CAD (ICD-9) **AND** Diagnosis of diabetes mellitus (ICD-9) **AND** Patient encounter during reporting period (CPT)	410.00, 410.01, 410.02, 410.10, 410.11, 410.12, 410.20, 410.21, 410.22, 410.30, 410.31, 410.32, 410.40, 410.41, 410.42, 410.50, 410.51, 410.52, 410.60, 410.61, 410.62, 410.70, 410.71, 410.72, 410.80, 410.81, 410.82, 410.90, 410.91, 410.92, 411.0, 411.1, 411.81, 411.89, 413.0, 413.1, 413.9, 414.00, 414.01, 414.02, 414.03, 414.04, 414.05, 414.06, 414.07, 414.8, 414.9, V45.81, V45.82 **AND** 250.00, 250.01, 250.02, 250.03, 250.10, 250.11, 250.12, 250.13, 250.20, 250.21, 250.22, 250.23, 250.30, 250.31, 250.32, 250.33, 250.40, 250.41, 250.42, 250.43, 250.50, 250.51, 250.52, 250.53, 250.60, 250.61, 250.62, 250.63, 250.70, 250.71, 250.72, 250.73, 250.80, 250.81, 250.82, 250.83, 250.90, 250.91, 250.92, 250.93, 648.00, 648.01, 648.02, 648.03, 648.04 **AND** 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350

Quality Data Code Reporting Option *#2*:	
Successful Reporting & Performance: Angiotensin converting enzyme (ACE) inhibitor or angiotensin receptor blocker (ARB) therapy prescribed	G8473

OR

Successful Reporting & Excluded from Performance: Angiotensin converting enzyme (ACE) inhibitor or angiotensin receptor blocker (ARB) therapy not prescribed for reasons documented by the clinician	G8474

OR

Successful Reporting & Performance Not Met: ACE inhibitor or ARB therapy not prescribed, reason not specified	G8475

Implementation Guidelines:

- There are two reporting options for this measure:
  (1) Patients who are 18 years and older with a diagnosis of CAD who also have LVSD who are prescribed ACE Inhibitor or ARB therapy
  OR
  (2) Patients who are 18 years and older with a diagnosis of CAD who are also diabetic who are prescribed ACE Inhibitor or ARB therapy.
- Either option may be reported to satisfy this measure, as long as the applicable G-codes are submitted with the corresponding eligible case coding.
- At an encounter during the reporting period (January 1 through December 31, 2008), review clinical data to determine which of the following option(s) apply to the patient: 1) LVEF is < 40% or documented as moderately or severely depressed indicating LVSD; 2) LVEF is ≥ 40% or documented as normal or mildly depressed left ventricular systolic function; or 3) LVEF was not performed or documented, reason not otherwise specified, 4) patient has diagnosis of diabetes mellitus. For patients with CAD and LVSD or with CAD and diabetes, ACE Inhibitor or ARB therapy should be prescribed. Select and submit the appropriate G-code corresponding to the measure.
- LVSD may be determined by quantitative or qualitative assessment. Examples of a quantitative or qualitative assessment may include an echocardiogram: 1) that provides a numerical value of left ventricular systolic dysfunction or 2) that uses descriptive terms such as moderately or severely depressed left ventricular dysfunction.
- Each eligible patient seen during the reporting period will be counted once when calculating the eligible professional's reporting rate for this measure. The measure may be reported again at a subsequent visit during the reporting period. If the measure is reported more than once for an eligible patient during the reporting period, the single instance of reporting most advantageous to performance will be used when calculating the eligible professional's performance rate for this measure.
- Failure to report an applicable G-code in an eligible case will result in both a reporting and performance failure.
- Medical record documentation is required for all clinical actions described in a measure.

Measure #6: Oral Antiplatelet Therapy Prescribed for Patients with Coronary Artery Disease

- **Reporting Description:** Percentage of patients aged 18 years and older with coronary artery disease (CAD) and an applicable CPT Category II code reported a minimum of once during the reporting period
- **Performance Description:** Percentage of patients aged 18 years and older with a diagnosis of coronary artery disease who were prescribed oral antiplatelet therapy

Eligible Cases:	
Patient aged ≥ 18 years on date of encounter **AND** Diagnosis of CAD (ICD-9) **AND** Patient encounter during reporting period (CPT)	410.00, 410.01, 410.02, 410.10, 410.11, 410.12, 410.20, 410.21, 410.22, 410.30, 410.31, 410.32, 410.40, 410.41, 410.42, 410.50, 410.51, 410.52, 410.60, 410.61, 410.62, 410.70, 410.71, 410.72, 410.80, 410.81, 410.82, 410.90, 410.91, 410.92, 411.0, 411.1, 411.81, 411.89, 412, 413.0, 413.1, 413.9, 414.00, 414.01, 414.02, 414.03, 414.04, 414.05, 414.06, 414.07, 414.8, 414.9, V45.81, V45.82 **AND** 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99238, 99239, 99241, 99242, 99243, 99244, 99245, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350

Quality Data Code Reporting Options:	
Successful Reporting & Performance: Oral antiplatelet therapy prescribed (e.g., aspirin, clopidogrel/Plavix, or combination of aspirin and dipyridamole/Aggrenox)	4011F

OR

Successful Reporting & Excluded from Performance: Documentation of medical, patient, or system reason(s) for not prescribing oral antiplatelet therapy (e.g., aspirin, clopidogrel/Plavix, or combination of aspirin and dipyridamole/Aggrenox)	4011F-1P **OR** 4011F-2P **OR** 4011F-3P

OR

Successful Reporting & Performance Not Met: Oral antiplatelet therapy not prescribed, reason not specified	4011F-8P

Implementation Guidelines:

- Review clinical data to determine the presence or absence of a current oral antiplatelet prescription on the date of an encounter occurring during the reporting period (January 1 through December 31, 2008). Select and submit the appropriate CPT Category II code corresponding to the measure.
- Oral antiplatelet therapy consists of aspirin, clopidogrel/Plavix, or combination of aspirin and dipyridamole/Aggrenox.
- "Prescribed" includes patients who are currently receiving medication(s) that follow the treatment plan recommended at an encounter during the reporting period, even if the prescription for that medication was ordered prior to the encounter.
- Each eligible patient seen during the reporting period will be counted once when calculating the eligible professional's reporting rate for this measure. The measure may be reported again at a subsequent visit during the reporting period. If the measure is reported more than once for an eligible patient during the reporting period, the single instance of reporting most advantageous to performance will be used when calculating the eligible professional's performance rate for this measure.
- Failure to report an applicable CPT Category II code in an eligible case will result in both a reporting and performance failure.
- Medical record documentation is required for all clinical actions described in a measure.

Measure #7: Beta-blocker Therapy for Coronary Artery Disease Patients with Prior Myocardial Infarction (MI)

- **Reporting Description:** Percentage of patients aged 18 years and older with coronary artery disease (CAD) and a prior MI and an applicable CPT Category II code reported a minimum of once during the reporting period
- **Performance Description:** Percentage of patients aged 18 years and older with a diagnosis of coronary artery disease and prior myocardial infarction (MI) who were prescribed beta-blocker therapy

Eligible Cases:

Patient aged ≥ 18 years on date of encounter **AND** Diagnosis of CAD* (**Eligible cases for this measure require the presence of a prior MI diagnosis AND at least one E/M code during the measurement period. Diagnosis codes for Coronary Artery Disease (which include MI diagnosis codes) may also accompany the MI diagnosis code, but are not required for inclusion in the measure.*) (ICD-9) **AND** Diagnosis of prior MI at any time (ICD-9) **AND** Patient encounter during reporting period (CPT)	411.0, 411.1, 411.81, 411.89, 413.0, 413.1, 413.9, 414.00, 414.01, 414.02, 414.03, 414.04, 414.05, 414.06, 414.07, 414.8, 414.9, V45.81, V45.82, 410.00*, 410.01*, 410.02*, 410.10*, 410.11*, 410.12*, 410.20*, 410.21*, 410.22*, 410.30*, 410.31*, 410.32*, 410.40*, 410.41*, 410.42*, 410.50*, 410.51*, 410.52*, 410.60*, 410.61*, 410.62*, 410.70, 410.71*, 410.72*, 410.80*, 410.81*, 410.82*, 410.90*, 410.91*, 410.92*, 412* **AND** 410.00, 410.01, 410.02, 410.10, 410.11, 410.12, 410.20, 410.21, 410.22, 410.30, 410.31, 410.32, 410.40, 410.41, 410.42, 410.50, 410.51, 410.52, 410.60, 410.61, 410.62, 410.70, 410.71, 410.72, 410.80, 410.81, 410.82, 410.90, 410.91, 410.92, 412 **AND** 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99238, 99239, 99241, 99242, 99243, 99244, 99245, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350

Quality Data Code Reporting Options:

Successful Reporting & Performance: Beta-blocker therapy prescribed	4006F

OR

Successful Reporting & Excluded from Performance: Documentation of medical, patient, or system reason(s) for not prescribing beta-blocker therapy	4006F-1P **OR** 4006F-2P **OR** 4006F-3P

OR

Successful Reporting & Performance Not Met: Beta-blocker therapy not prescribed, reason not specified	4006F-8P

Implementation Guidelines:

- Review clinical data regarding the presence or absence of a current beta-blocker prescription on the date of an encounter occurring during the reporting period (January 1 through December 31, 2008). Select and submit the appropriate CPT Category II code corresponding to the measure.
- Denominator inclusion for this measure requires the presence of a prior MI diagnosis and at least one E/M code during the measurement period. Diagnosis codes for coronary artery disease (which include MI diagnosis codes) may also accompany the MI diagnosis code, but are not required for inclusion in the measure.
- "Prescribed" includes patients who are currently receiving medication(s) that follow the treatment plan recommended at an encounter during the reporting period, even if the prescription for that medication was ordered prior to the encounter.
- Each eligible patient seen during the reporting period will be counted once when calculating the eligible professional's reporting rate for this measure. The measure may be reported again at a subsequent visit during the reporting period. If the measure is reported more than once for an eligible patient during the reporting period, the single instance of reporting most advantageous to performance will be used when calculating the eligible professional's performance rate for this measure.
- Failure to report an applicable CPT Category II code in an eligible case will result in both a reporting and performance failure.
- Medical record documentation is required for all clinical actions described in a measure.

Measure #73: Plan for Chemotherapy Documented Before Chemotherapy Administered

- **Reporting Description:** Percentage of patients of ALL ages with breast, colon, or rectal cancer and an applicable CPT Category II code reported a minimum of once during the reporting period
- **Performance Description:** Percentage of patients, regardless of age, with a diagnosis of breast, colon, or rectal cancer who are receiving intravenous chemotherapy for whom the planned chemotherapy regimen (which includes, at a minimum: drug(s) prescribed, dose, and duration) is documented prior to the initiation of a new treatment regimen

Eligible Cases:

Patients of ALL ages **AND** Diagnosis of breast, colon, or rectal cancer (ICD-9) **AND** Patient encounter during reporting period (CPT) **AND** Intravenous chemotherapy administration (CPT)	153.0, 153.1, 153.2, 153.3, 153.4, 153.5, 153.6, 153.7, 153.8, 153.9, 154.0, 154.1, 154.2, 154.3, 154.8, 174.0, 174.1, 174.2, 174.3, 174.4, 174.5, 174.6, 174.8, 174.9 **AND** 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215 **AND** 96401, 96402, 96405, 96406, 96409, 96411, 96413, 96415, 96416, 96417, 96420, 96422, 96423, 96425, 96440, 96445, 96450, 96521, 96522, 96523, 96542, 96549

Quality Data Code Reporting Options:

Successful Reporting & Performance: Planned chemotherapy regimen, including at a minimum: drug(s) prescribed, dose, and duration, documented prior to initiation of a new treatment regimen	0519F

OR

Successful Reporting & Excluded from Performance: There are no allowable performance exclusions for this measure.	NONE

OR

Successful Reporting & Performance Not Met: Plan for chemotherapy not documented, reason not specified	0519F-8P

Implementation Guidelines:

- Review clinical data regarding the presence or absence of a plan for chemotherapy (which includes, at a minimum: drug(s) prescribed, dose, and duration) at an encounter occurring during the reporting period (January 1 through December 31, 2008). Select and submit the appropriate CPT Category II code corresponding to the measure.
- Each eligible patient seen during the reporting period will be counted once when calculating the eligible professional's reporting rate for this measure. The measure may be reported again at a subsequent visit during the reporting period. If the measure is reported more than once for an eligible patient during the reporting period, the single instance of reporting most advantageous to performance will be used when calculating the eligible professional's performance rate for this measure.
- Failure to report an applicable CPT Category II code in an eligible case will result in both a reporting and performance failure.
- Medical record documentation is required for all clinical actions described in a measure.

Measure #54: Electrocardiogram Performed for Non-Traumatic Chest Pain

- **Reporting Description:** Percentage of patients aged 40 years and older with an emergency department discharge diagnosis of non-traumatic chest pain and an applicable CPT Category II code for each episode of non-traumatic chest pain occurring during the reporting period
- **Performance Description:** Percentage of patients aged 40 years and older with an emergency department discharge diagnosis of non-traumatic chest pain who had a 12-lead electrocardiogram (ECG) performed

Eligible Cases:

Patient aged ≥ 40 years on date of encounter **AND** Place of Service (POS) = Emergency Dept (23) **AND** Discharge diagnosis of non-traumatic chest pain (ICD-9) **AND** Patient encounter during reporting period (CPT)	23 **AND** 413.0, 413.1, 413.9, 786.50, 786.51, 786.52, 786.59 **AND** 99281, 99282, 99283, 99284, 99285, 99291

Quality Data Code Reporting Options:

Successful Reporting & Performance: 12-Lead ECG performed	3120F

OR

Successful Reporting & Excluded from Performance: Documentation of medical or patient reason(s) for not performing a 12-lead ECG	3120F-1P **OR** 3120F-2P

OR

Successful Reporting & Performance Not Met: 12-Lead ECG not performed, reason not specified	3120F-8P

Implementation Guidelines:

- Review clinical data regarding the presence or absence of a 12-lead ECG for each episode of non-traumatic chest pain at each emergency department discharge occurring during the reporting period (January 1 through December 31, 2008). Select and submit the appropriate CPT Category II code corresponding to the measure.
- Each episode of an emergency department discharge diagnosis of non-traumatic chest pain in an eligible patient occurring during the reporting period will be counted when calculating the reporting and performance rates.
- The Part B claim form place-of-service (POS) field must indicate that the encounter has taken place in the emergency department (POS 23 = ED).
- Claims data will be analyzed to determine the emergency department discharge.
- Failure to report an applicable CPT Category II code in an eligible case will result in both a reporting and performance failure.
- Medical record documentation is required for all clinical actions described in a measure.

Measure #120: ACE Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy in Patients with CKD

- **Reporting Description:** Percentage of patients aged 18 years and older with advanced chronic kidney disease (CKD) (stage 4 or 5, not receiving Renal Replacement Therapy [RRT]), and hypertension and proteinuria and an applicable G-code reported a minimum of once during the reporting period
- **Performance Description:** Percentage of patients aged 18 years and older with a diagnosis of advanced chronic kidney disease (CKD) (stage 4 or 5, not receiving Renal Replacement Therapy [RRT]), and hypertension and proteinuria who were prescribed angiotensin converting enzyme (ACE) inhibitor or angiotensin receptor blocker (ARB) therapy during the 12-month reporting period

Eligible Cases:	
Patient aged ≥ 18 years on date of encounter **AND** Diagnosis of CKD (ICD-9) **AND** Diagnosis of hypertension (ICD-9) **AND** Diagnosis of proteinuria (ICD-9) **AND** Patient encounter during reporting period (CPT)	585.4, 585.5 **AND** 401.0, 401.1, 401.9, 402.00, 402.01, 402.10, 402.11, 402.90, 402.91, 403.00, 403.01, 403.10, 403.11, 403.90, 403.91, 404.00, 404.01, 404.02, 404.03, 404.10, 404.11, 404.12, 404.13, 404.90, 404.91, 404.92, 404.93 **AND** 791.0 **AND** 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245

Reporting Options:	
Successful Reporting & Performance: Clinician prescribed angiotensin converting enzyme (ACE) inhibitor or angiotensin receptor blocker (ARB) therapy	G8479

OR

Successful Reporting & Excluded from Performance: Clinician documented that patient was not an eligible candidate for angiotensin converting enzyme (ACE) inhibitor or angiotensin receptor blocker (ARB) therapy	G8480

OR

Successful Reporting & Performance Not Met: Clinician did not prescribe angiotensin converting enzyme (ACE) inhibitor or angiotensin receptor blocker (ARB) therapy, reason not specified	G8481

Implementation Guidelines:

- Review clinical data regarding the presence or absence of a prescription for ACE inhibitors or ARB therapy at an encounter during the reporting period (January 1 through December 31, 2008). Select and submit the appropriate G-code corresponding to the measure.
- Each eligible patient seen during the reporting period will be counted once when calculating the eligible professional's reporting and performance rates. The measure may be reported again at a subsequent visit during the reporting period. If the measure is reported more than once for an eligible patient during the reporting period, the single instance of reporting most advantageous to performance will be used when calculating the eligible professional's performance rate for this measure.
- Failure to report an applicable G-code in an eligible case will result in both a reporting and performance failure.
- Medical record documentation is required for all clinical actions described in a measure.

Measure #121: Chronic Kidney Disease (CKD): Laboratory Testing (Calcium, Phosphorus, Intact Parathyroid Hormone (iPTH) and Lipid Profile)

- **Reporting Description:** Percentage of patients aged 18 years and older with advanced CKD (stage 4 or 5, not receiving Renal Replacement Therapy [RRT]) and an applicable CPT Category II code reported a minimum of once during the reporting period
- **Performance Description:** Percentage of patients aged 18 years and older with a diagnosis of advanced CKD (stage 4 or 5, not receiving Renal Replacement Therapy [RRT]), who had the following laboratory testing ordered at least once during the 12-month reporting period: serum levels of calcium, phosphorus and intact PTH, and lipid profile

Eligible Cases:

Patient aged ≥ 18 years on date of encounter **AND** Diagnosis of advanced CKD (stage 4 or 5, not receiving RRT) (ICD-9) **AND** Patient encounter during reporting period (CPT)	585.4, 585.5 **AND** 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245

Quality Data Code Reporting Options:

Successful Reporting & Performance: Serum levels of calcium, phosphorus, intact Parathyroid Hormone (iPTH) and lipid profile ordered	3278F

OR

Successful Reporting & Excluded from Performance: Documentation of medical or patient reason(s) for not ordering serum levels of calcium, phosphorus, intact Parathyroid Hormone (iPTH) and lipid profile	3278F-1P **OR** 3278F-2P

OR

Successful Reporting & Performance Not Met: Serum levels of calcium, phosphorus, intact Parathyroid Hormone (iPTH) and lipid profile not ordered, reason not specified	3278F-8P

Implementation Guidelines:

- Review clinical data (within the last 12 months of this encounter) regarding the presence or absence of order(s) for or results of laboratory tests at an encounter during the reporting period (January 1 through December 31, 2008). Select and submit the appropriate CPT Category II code corresponding to the measure.
- Each eligible patient seen during the reporting period will be counted once when calculating the eligible professional's reporting and performance rates. The measure may be reported again at a subsequent visit during the reporting period. If the measure is reported more than once for an eligible patient during the reporting period, the single instance of reporting most advantageous to performance will be used when calculating the eligible professional's performance rate for this measure.
- Failure to report an applicable CPT Category II code in an eligible case will result in both a reporting and performance failure.
- Medical record documentation is required for all clinical actions described in a measure.

Measure #122: Chronic Kidney Disease (CKD): Blood Pressure Management

- **Reporting Description:** Percentage of patients aged 18 years and older with advanced CKD (stage 4 or 5, not receiving Renal Replacement Therapy [RRT]) and applicable CPT Category II code and/or G-code reported at each visit during the reporting period
- **Performance Description:** Percentage of patient visits for patients aged 18 years and older with a diagnosis of advanced CKD (stage 4 or 5, not receiving Renal Replacement Therapy [RRT]), with a blood pressure < 130/80 mmHg OR blood pressure ≥ 130/80 mmHg with a documented plan of care

Eligible Cases:

Patient aged ≥ 18 years on date of encounter **AND** Diagnosis of advanced CKD (stage 4 or 5, not receiving RRT) (ICD-9) **AND** Patient encounter during reporting period (CPT)	585.4, 585.5 **AND** 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245

Quality Data Code Reporting Options:

Successful Reporting & Performance: Most recent blood pressure has a systolic measurement of <130 mmHg and a diastolic measurement of <80 mmHg **OR** Most recent blood pressure has a systolic measurement of ≥130 mmHg and/or a diastolic measurement of ≥80 mmHg **AND** Elevated blood pressure plan of care documented	G8476 **OR** G8477 **AND** 0513F

OR

Successful Reporting & Excluded from Performance: There are no allowable performance exclusions for this measure.	NONE

OR

Successful Reporting & Performance Not Met: Blood pressure measurement not performed or documented, reason not specified **OR** Elevated blood pressure plan of care not documented, reason not specified **AND** Most recent blood pressure has a systolic measurement of ≥130 mmHg and/or a diastolic measurement of ≥80 mmHg	G8478 **OR** 0513F-8P **AND** G8477

Implementation Guidelines:

- The correct combination of numerator code(s) must be reported on the claim form in order to properly report this measure. The "correct combination" of codes may require the submission of multiple numerator codes.
- Review clinical data regarding blood pressure measurement and plan of care if needed at each visit occurring during the reporting period (January 1 through December 31, 2008). Select and submit the appropriate CPT Category II code and/or G-code corresponding to the measure.
- If multiple blood pressures are taken at a single visit, use the most recent measurement taken at that visit.
- A documented plan of care should include one or more of the following: recheck blood pressure at specified future date; initiate or alter pharmacologic therapy; initiate or alter non-pharmacologic therapy; documented review of patient's home blood pressure log which indicates that patient's blood pressure is or is not well controlled.
- Each eligible patient encounter during the reporting period will be counted when calculating the eligible professional's reporting and performance rates.
- Failure to report applicable CPT Category II code and/or G-code in an eligible case will result in both a reporting and performance failure.
- Medical record documentation is required for all clinical actions described in a measure.

Measure #123: Chronic Kidney Disease (CKD): Plan of Care: Elevated Hemoglobin for Patients Receiving Erythropoiesis-Stimulating Agents (ESA)

- **Reporting Description:** Percentage of patient calendar months during the 12-month reporting period in which patients aged 18 years and older with advanced CKD (stage 4 or 5, not receiving Renal Replacement Therapy [RRT]), receive ESA therapy and applicable CPT Category II code(s) reported each calendar month the patient is seen during the reporting period
- **Performance Description:** Percentage of patient calendar months during the 12-month reporting period in which patients aged 18 years and older with a diagnosis of advanced CKD (stage 4 or 5, not receiving Renal Replacement Therapy [RRT]), receiving ESA therapy, have a hemoglobin < 13 g/dL OR patients whose hemoglobin is ≥ 13 g/dL and have a documented plan of care

Eligible Cases:

Patient aged ≥ 18 years on date of encounter **AND** Diagnosis of advanced CKD (stage 4 or 5, not receiving RRT) (ICD-9) **AND** Patient encounter during reporting period (CPT)	585.4, 585.5 **AND** 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245

Quality Data Code Reporting Options:

Successful Reporting & Performance: Hemoglobin level less than 11 g/dL **OR** Hemoglobin level 11 g/dL to 12.9 g/dL **AND** Patient receiving Erythropoiesis-Stimulating Agent (ESA) therapy	3281F **OR** 3280F **AND** 4171F
OR	**OR**
Hemoglobin level greater than or equal to 13 g/dL **AND** Plan of care for elevated hemoglobin level documented for patient receiving Erythropoiesis-Stimulating Agent (ESA) therapy **AND** Patient receiving Erythropoiesis-Stimulating Agent (ESA) therapy	3279F **AND** 0514F **AND** 4171F

OR

Successful Reporting & Excluded from Performance: Patient not receiving Erythropoiesis-Stimulating Agent (ESA) therapy	4172F

OR

Successful Reporting & Performance Not Met: Hemoglobin level measurement not performed, reason not specified **AND** Patient receiving Erythropoiesis-Stimulating Agent (ESA) therapy **OR** Plan of care for elevated hemoglobin level not documented for patient receiving Erythropoiesis-Stimulating Agent (ESA) therapy, reason not specified **AND** Hemoglobin level greater than or equal to 13 g/dL **AND** Patient receiving Erythropoiesis-Stimulating Agent (ESA) therapy	3281F-8P **AND** 4171F **OR** 0514F-8P **AND** 3279F **AND** 4171F

Implementation Guidelines:

- The correct combination of numerator code(s) must be reported on the claim form in order to properly report this measure. The "correct combination" of codes may require the submission of multiple numerator codes.
- This measure is to be reported each calendar month the patient is seen with a diagnosis of advanced CKD (stage 4 or 5) during the reporting period.
- At a minimum of one encounter per month in which the patient is seen during the reporting period (January 1 through December 31, 2008), review clinical data regarding the hemoglobin level and whether or not the patient is receiving ESA therapy. For patients with hemoglobin greater than or equal to 13 g/dL and receiving ESA therapy, there should be a documented plan of care for elevated hemoglobin. Select and submit the appropriate CPT Category II code(s) corresponding to the measure.
- A documented plan of care should include reducing the ESA dose and repeating hemoglobin at a specified future date.
- Each eligible calendar month that the patient is seen during the reporting period will be counted when calculating the eligible professional's reporting and performance rates. The measure may be reported again at a subsequent visit during the eligible month. If the measure is reported more than once for an eligible patient during the month, the single instance of reporting most advantageous to performance will be used when calculating the eligible professional's performance rate for this measure.
- Failure to report applicable CPT Category II code(s) in an eligible case will result in both a reporting and performance failure.
- Medical record documentation is required for all clinical actions described in a measure.

Measure #72: Chemotherapy for Stage III Colon Cancer Patients

- **Reporting Description:** Percentage of patients aged 18 years and older with colon cancer and applicable CPT Category II code(s) reported a minimum of once during the reporting period
- **Performance Description:** Percentage of patients aged 18 years and older with Stage IIIA through IIIC colon cancer who are prescribed or who have received adjuvant chemotherapy during the 12-month reporting period

Eligible Cases:

Patient aged ≥ 18 years on date of encounter **AND** Diagnosis of colon cancer (ICD-9) **AND** Patient encounter during reporting period (CPT)	153.0, 153.1, 153.2, 153.3, 153.4, 153.5, 153.6, 153.7, 153.8, 153.9 **AND** 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215

Quality Data Code Reporting Options:

Successful Reporting & Performance: Adjuvant chemotherapy prescribed or previously received for Stage IIIA through Stage IIIC colon cancer **AND** AJCC Cancer Stage IIIA, documented **OR** AJCC Cancer Stage IIIB, documented **OR** AJCC Cancer Stage IIIC, documented	4180F **AND** 3309F **OR** 3310F **OR** 3311F

OR

Successful Reporting & Excluded from Performance: Documentation of medical, patient, or system reason(s) for not performing prescribing adjuvant chemotherapy **AND** AJCC Cancer Stage IIIA, documented **OR** AJCC Cancer Stage IIIB, documented **OR** AJCC Cancer Stage IIIC, documented **OR** AJCC Cancer Stage 0, documented **OR** AJCC Cancer Stage IB, documented **OR** AJCC Cancer Stage IIA, documented **OR** AJCC Cancer Stage IIB, documented **OR** AJCC Cancer Stage IV, documented **OR** No documentation of cancer stage	4180F-1P **OR** 4180F-2P **OR** 4180F-3P **AND** 3309F **OR** 3310F **OR** 3311F **OR** 3302F **OR** 3304F **OR** 3306F **OR** 3307F **OR** 3312F **OR** 3309F-8P

OR

Successful Reporting & Performance Not Met: Adjuvant chemotherapy not prescribed or previously received, reason not specified **AND** AJCC Cancer Stage IIIA, documented **OR** AJCC Cancer Stage IIIB, documented **OR** AJCC Cancer Stage IIIC, documented	4180F-8P **AND** 3309F **OR** 3310F **OR** 3311F

Implementation Guidelines:

- The correct combination of numerator code(s) must be reported on the claim form in order to properly report this measure. The "correct combination" of codes may require the submission of multiple numerator codes.
- This measure must be reported a minimum of once per reporting period for ALL patients with colon cancer.
- At an encounter during the reporting period (January 1 through December 31, 2008), review clinical data to determine the colon cancer stage. For patients with Stage IIIA through IIIC, adjuvant chemotherapy should be prescribed or previously received. Select and submit the appropriate CPT Category II code(s) corresponding to the measure.

- Each eligible patient seen during the reporting period will be counted once when calculating the eligible professional's reporting rate for this measure. The measure may be reported again at a subsequent visit during the reporting period. If the measure is reported more than once for an eligible patient during the reporting period, the single instance of reporting most advantageous to performance will be used when calculating the eligible professional's performance rate for this measure.
- According to current NCCN guidelines, the following therapies are recommended: 5-fluorouracil/leucovorin or capecitabine, or 5-fluorouracil/leucovorin/ oxaliplatin.
- Examples for not prescribing adjuvant chemotherapy may include: Medical reason(s) such as medical comorbidities, diagnosis date more than 5 years prior to the current visit date; patient's cancer has metastasized; medical contraindication/allergy, poor performance status; Patient reason(s) such as patient refusal; System reason(s) such as instances when the patient is currently enrolled in a clinical trial that precludes prescription of chemotherapy.
- Report 3304F for all Stage I colon cancers.
- Failure to report applicable CPT Category II code(s) in an eligible case will result in both a reporting and performance failure.
- Medical record documentation is required for all clinical actions described in a measure.

Measure #100: Colorectal Cancer Patients who have a pT and pN Category and Histologic Grade for Their Cancer

- **Reporting Description:** Percentage of colon and rectum cancer patients receiving resection surgical pathology procedures and an applicable CPT Category II code reported for each resection procedure performed during the reporting period
- **Performance Description:** Percentage of colon and rectum cancer resection pathology reports that include the pT category (primary tumor), the pN category (regional lymph nodes) and the histologic grade

Eligible Cases:	
Patients of ALL ages **AND** Diagnosis of colon or rectum cancer (ICD-9) **AND** Resection surgical pathology procedure performed during reporting period (CPT)	153.0, 153.1, 153.2, 153.3, 153.4, 153.5, 153.6, 153.7, 153.8, 153.9, 154.0, 154.1, 154.8 **AND** 88309

Quality Data Code Reporting Options:	
Successful Reporting & Performance: pT category (primary tumor), pN category (regional lymph nodes), and histologic grade documented in pathology report	3260F

OR

Successful Reporting & Excluded from Performance: Documentation of medical reason(s) for not including pT category, pN category and histologic grade in the pathology report (e.g., non-carcinomas; anal canal)	3260F-1P

OR

Successful Reporting & Performance Not Met: pT category, pN category and histologic grade not documented, reason not specified	3260F-8P

Implementation Guidelines:

- Review clinical data regarding the presence or absence of the pT category (primary tumor), the pN category (regional lymph nodes), and the histologic grade on the pathology report for each colorectal cancer resection procedure occurring during the reporting period (January 1 through December 31, 2008). Select and submit the appropriate CPT Category II code corresponding to the measure.
- Each colorectal cancer resection surgical pathology procedure performed during the reporting period will be counted when calculating the reporting and performance rates.
- Failure to report an applicable CPT Category II code in an eligible case will result in both a reporting and performance failure.
- Medical record documentation is required for all clinical actions described in a measure

Measure #113: Colorectal Cancer Screening

- **Reporting Description:** Percentage of patients aged 50 through 80 years and an applicable CPT Category II code reported a minimum of once during the reporting period
- **Performance Description:** Percentage of patients aged 50 through 80 years who received the appropriate colorectal cancer screening

Eligible Cases:	
Patient aged ≥ 50 years and ≤ 80 years on date of encounter **AND** Patient encounter during reporting period (CPT)	99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337

Quality Data Code Reporting Options:	
Successful Reporting & Performance: Colorectal cancer screening results documented and reviewed	3017F

OR

Successful Reporting & Excluded from Performance: Documentation of medical reason(s) for not performing a colorectal cancer screening	3017F-1P

OR

Successful Reporting & Performance Not Met: Colorectal cancer screening not performed, reason not specified	3017F-8P

Implementation Guidelines:

- There is no diagnosis associated with this measure. This measure must be reported a minimum of once for all patients aged 50 through 80 years seen during the reporting period (January 1 through December 31, 2008).
- Review clinical data regarding appropriate colorectal screening at an encounter during the reporting period. Select and submit the appropriate CPT Category II code corresponding to the measure.
- Performance for this measure is not limited to the reporting period, but is based on appropriate screening as defined in this measure.
- Patients are considered to have appropriate screening for colorectal cancer if any of the following are documented:
    - Fecal occult blood test (FOBT) during the reporting period
    - Flexible sigmoidoscopy during the reporting period or the four years prior to the reporting period
    - Double contrast barium enema (DCBE) or air contrast barium enema during the reporting period or the four years prior to the reporting period
    - Colonoscopy during the reporting period or the nine years prior to the reporting period
- Each eligible patient seen during the reporting period will be counted once when calculating the eligible professional's reporting rate for this measure. The measure may be reported again at a subsequent visit during the reporting period. If the measure is reported more than once for an eligible patient during the reporting period, the single instance of reporting most advantageous to performance will be used when calculating the eligible professional's performance rate for this measure.
- Failure to report an applicable CPT Category II code in an eligible case will result in both a reporting and performance failure.
- Medical record documentation is required for all clinical actions described in a measure.

Measure #51: Chronic Obstructive Pulmonary Disease (COPD): Spirometry Evaluation

- **Reporting Description:** Percentage of patients aged 18 years and older with COPD and an applicable CPT Category II code reported a minimum of once during the reporting period
- **Performance Description:** Percentage of patients aged 18 years and older with a diagnosis of COPD who had spirometry evaluation results documented

Eligible Cases:

Patient aged ≥ 18 years on date of encounter **AND** Diagnosis of COPD (ICD-9) **AND** Patient encounter during reporting period (CPT)	491.0, 491.1, 491.20, 491.21, 491.22, 491.8, 491.9, 492.0, 492.8, 496 **AND** 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245

Quality Data Code Reporting Options:

Successful Reporting & Performance: Spirometry results documented and reviewed	3023F

OR

Successful Reporting & Excluded from Performance: Documentation of medical, patient, or system reasons for not documenting and reviewing spirometry results	3023F-1P **OR** 3023F-2P **OR** 3023F-3P

OR

Successful Reporting & Performance Not Met: Spirometry results not documented and reviewed, reason not specified	3023F-8P

Implementation Guidelines:

- Review clinical data regarding the presence or absence of spirometry evaluation results at an encounter occurring during the reporting period (January 1 through December 31, 2008). Select and submit the appropriate CPT Category II code corresponding to the measure.
- Look for most recent documentation of spirometry evaluation results in the medical record; do not limit the search for spirometry evaluation results to the reporting period.
- Each eligible patient seen during the reporting period will be counted once when calculating the eligible professional's reporting rate for this measure. The measure may be reported again at a subsequent visit during the reporting period. If the measure is reported more than once for an eligible patient during the reporting period, the single instance of reporting most advantageous to performance will be used when calculating the eligible professional's performance rate for this measure.
- Failure to report an applicable CPT Category II code in an eligible case will result in both a reporting and performance failure.
- Medical record documentation is required for all clinical actions described in a measure.

Measure #52: Chronic Obstructive Pulmonary Disease (COPD): Bronchodilator Therapy

- **Reporting Description:** Percentage of patients aged 18 years and older with COPD and applicable CPT Category II code(s) reported a minimum of once during the reporting period
- **Performance Description:** Percentage of patients aged 18 years and older with a diagnosis of COPD and who have an FEV_1/FVC less than 70% and have symptoms who were prescribed an inhaled bronchodilator

Eligible Cases:

Patient aged ≥ 18 years on date of encounter AND Diagnosis of COPD (ICD-9) **AND** Patient encounter during reporting period (CPT)	491.0, 491.1, 491.20, 491.21, 491.22, 491.8, 491.9, 492.0, 492.8, 496 **AND** 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245

Quality Data Code Reporting Options:

Successful Reporting & Performance: Inhaled bronchodilator prescribed **AND** Spirometry test results demonstrate FEV_1/FVC < 70% with COPD symptoms (e.g., dyspnea, cough/sputum, wheezing)	4025F **AND** 3025F

OR

Successful Reporting & Excluded from Performance: Documentation of medical, patient, or system reasons for not prescribing an inhaled bronchodilator **AND** Spirometry test results demonstrate FEV_1/FVC < 70% with COPD symptoms (e.g., dyspnea, cough/sputum, wheezing) **OR** Spirometry test results demonstrate FEV_1/FVC ≥ 70% or patient does not have COPD symptoms **OR** Spirometry test not performed or documented, reason not specified	4025F-1P **OR** 4025F-2P **OR** 4025F-3P **AND** 3025F **OR** 3027F **OR** 3025F-8P

OR

Successful Reporting & Performance Not Met: Inhaled bronchodilator not prescribed, reason not specified **AND** Spirometry test results demonstrate $FEV_1/FVC < 70\%$ with COPD symptoms (e.g., dyspnea, cough/sputum, wheezing)	4025F-8P **AND** 3025F

Implementation Guidelines:

- The correct combination of numerator code(s) must be reported on the claim form in order to properly report this measure. The "correct combination" of codes may require the submission of multiple numerator codes.
- This measure must be reported a minimum of once per reporting period for ALL COPD patients.
- At an encounter occurring during the reporting period (January 1 through December 31, 2008), review clinical data to determine which of these three options applies to the patient: 1) Spirometry test results demonstrate $FEV_1/FVC < 70\%$ with COPD symptoms (e.g., dyspnea, cough/sputum, wheezing), 2) Spirometry test results demonstrate $FEV_1/FVC \geq 70\%$ or patient does not have COPD symptoms, or 3) Spirometry test results not performed or documented, reason not specified. For patients where spirometry test results demonstrate $FEV_1/FVC < 70\%$ with COPD symptoms (e.g., dyspnea, cough/sputum, wheezing), inhaled bronchodilator should be prescribed. Select and submit the appropriate CPT Category II code(s) corresponding to the measure.
- "Prescribed" includes patients who are currently receiving medication(s) that follow the treatment plan recommended at an encounter during the reporting period, even if the prescription for that medication was ordered prior to the encounter.
- Each eligible patient seen during the reporting period will be counted once when calculating the eligible professional's reporting rate for this measure. The measure may be reported again at a subsequent visit during the reporting period. If the measure is reported more than once for an eligible patient during the reporting period, the single instance of reporting most advantageous to performance will be used when calculating the eligible professional's performance rate for this measure.
- Failure to report applicable CPT Category II code(s) in an eligible case will result in both a reporting and performance failure.
- Medical record documentation is required for all clinical actions described in a measure.

Measure #76: Prevention of Catheter-Related Bloodstream Infections (CRBSI) – Central Venous Catheter Insertion Protocol

- **Reporting Description:** Percentage of patients, regardless of age, undergoing a central venous catheter (CVC) insertion and an applicable CPT Category II code reported each time a CVC insertion is performed during the reporting period
- **Performance Description:** Percentage of patients, regardless of age, who undergo central venous catheter (CVC) insertion for whom CVC was inserted with all elements of maximal sterile barrier technique (cap AND mask AND sterile gown AND sterile gloves AND a large sterile sheet AND hand hygiene AND 2% chlorhexidine for cutaneous antisepsis) followed

Eligible Cases:	
Patient of ALL ages **AND** CVC insertion performed during reporting period (CPT)	36555, 36556, 36557, 36558, 36560, 36561, 36563, 36565, 36566, 36568, 36569, 36570, 36571, 36578, 36580, 36581, 36582, 36583, 36584, 36585

Quality Data Code Reporting Options:	
Successful Reporting & Performance: All elements of maximal sterile barrier technique including: cap AND mask AND sterile gown AND sterile gloves AND a large sterile sheet AND hand hygiene AND 2% chlorhexidine for cutaneous antisepsis, followed	6030F

OR

Successful Reporting & Excluded from Performance: Documentation of medical reason(s) for not following all elements of maximal sterile barrier technique during CVC insertion (including CVC insertion performed on emergency basis)	6030F-1P

OR

Successful Reporting & Performance Not Met: All elements of maximal sterile barrier technique not followed, reason not specified	6030F-8P

Implementation Guidelines:

- There is no diagnosis associated with this measure. This measure must be reported each time a CVC insertion is performed during the reporting period (January 1 through December 31, 2008).
- Review clinical data regarding all elements of maximal sterile barrier technique followed during CVC insertion(s) occurring within the reporting period. Select and submit the appropriate CPT Category II code corresponding to the measure.
- For purposes of this measure, maximal sterile barrier technique during CVC insertion is defined to include use of: cap AND mask AND sterile gown AND sterile gloves AND a large sterile sheet AND hand hygiene AND 2% chlorhexidine for cutaneous antisepsis.
- Each CVC insertion performed during the reporting period will be counted when calculating the reporting and performance rates.
- Failure to report an applicable CPT Category II code in an eligible case will result in both a reporting and performance failure.
- Medical record documentation is required for all clinical actions described in a measure.

Measure #9: Antidepressant Medication During Acute Phase for Patients with New Episode of Major Depression

- **Reporting Description:** Percentage of patients aged 18 years and older with major depressive disorder (MDD) and an applicable G-code reported with each new occurrence of MDD during the reporting period
- **Performance Description:** Percentage of patients aged 18 years and older diagnosed with new episode of major depressive disorder (MDD) and documented as treated with antidepressant medication during the entire 84-day (12 week) acute treatment phase

Eligible Cases:	
Patient aged ≥ 18 years on date of encounter **AND** Diagnosis of major depression (ICD-9) **AND** Patient encounter during reporting period (CPT)	296.20, 296.21, 296.22, 296.23, 296.24, 296.30, 296.31, 296.32, 296.33, 296.34, 298.0, 300.4, 309.1, 311 **AND** 90801, 90802, 90804, 90805, 90806, 90807, 90808, 90809, 90862, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350

Quality Data Code Reporting Options:	
Successful Reporting & Performance: Patient with new episode of MDD documented as being treated with antidepressant medication during the entire 12 week acute treatment phase	G8126

OR

Successful Reporting & Excluded from Performance: Clinician documented that patient with a new episode of MDD was not an eligible candidate for antidepressant medication treatment or patient did not have a new episode of MDD	G8128

OR

Successful Reporting & Performance Not Met: Patient with new episode of MDD not documented as being treated with antidepressant medication during the entire 12 week acute treatment phase	G8127

Implementation Guidelines:

- Review clinical data regarding the patient's antidepressant medication status on the date of an encounter during the reporting period (January 1 through December 31, 2008). Select and submit the appropriate G-code corresponding to the antidepressant medication status.
- Report G8126: 1) For all patients with a diagnosis of Major Depression, New Episode who were prescribed a full 12 week course of antidepressant medication OR 2) At the completion of a 12 week course of antidepressant medication.
- A "new episode" is defined as a patient with major depression who has not been seen or treated for major depression by any practitioner in the prior 4 months. A new episode can either be a recurrence for a patient with prior major depression or a patient with a new onset of major depression.
- Each eligible patient seen during the reporting period will be counted once when calculating the reporting and performance rates.
- Failure to report an applicable G-code in an eligible case will result in both a reporting and performance failure.
- Medical record documentation is required for all clinical actions described in a measure.

Measure #106: Patients who have Major Depression Disorder who meet DSM IV Criteria

- **Reporting Description:** Percentage of patients aged 18 years and older with a new diagnosis or recurrent episode of major depressive disorder (MDD) and applicable CPT Category II code and/or G-code reported once for each occurrence of a new diagnosis or recurrent episode of MDD during the reporting period
- **Performance Description:** Percentage of patients aged 18 years and older with a new diagnosis or recurrent episode of major depressive disorder (MDD) who met the DSM-IV™ criteria during the visit in which the new diagnosis or recurrent episode was identified during the measurement period

Eligible Cases:	
Patient aged ≥ 18 years on date of encounter **AND** Diagnosis of MDD (ICD-9) **AND** Patient encounter during reporting period (CPT)	296.20, 296.21, 296.22, 296.23, 296.24, 296.30, 296.31, 296.32, 296.33, 296.34 **AND** 90801, 90802, 90804, 90805, 90806, 90807, 90808, 90809, 90810, 90811, 90812, 90813, 90814, 90815, 90845, 90862, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245

Quality Data Code Reporting Options:	
Successful Reporting & Performance: DSM-IV™ criteria for major depressive disorder documented at the initial evaluation **AND** Documentation of new diagnosis of initial or recurrent episode of major depressive disorder	1040F **AND** G8467

OR

Successful Reporting & Excluded from Performance: Patient is not eligible for this measure because their MDD is in remission.	G8466

OR

Successful Reporting & Performance Not Met: DSM-IV™ criteria for major depressive disorder not documented, reason not specified **AND** Documentation of new diagnosis of initial or recurrent episode of major depressive disorder	1040F-8P **AND** G8467

Implementation Guidelines:

- The correct combination of numerator code(s) must be reported on the claim form in order to properly report this measure. The "correct combination" of codes may require the submission of multiple numerator codes. This includes patients whose occurrences of MDD began prior to the reporting period and are still receiving treatment for an occurrence of MDD.
- At an encounter during the reporting period (January 1 through December 31, 2008), review clinical data to determine whether the MDD is a new diagnosis (initial) or recurrent episode. Patients with documentation of new diagnosis of initial or recurrent episode of major depressive disorder should have the DSM-IV™ criteria for major depressive disorder documented at the initial evaluation. Select and submit the appropriate CPT Category II code and/or G-code corresponding to the measure
- DSM-IV™ criteria includes presence of depressed mood, marked diminished interest/pleasure, significant weight loss or weight gain, insomnia or hypersomnia, psychomotor agitation or retardation, fatigue or loss of energy, feelings of worthlessness, diminished ability to concentrate and recurrent suicidal ideation.
- Patient is considered to be in remission if he/she no longer meets DSM-IV™ criteria.
- Each occurrence of a new diagnosis or recurrent episode of MDD in an eligible patient occurring prior to or during the reporting period will be counted when calculating the reporting and performance rates. An occurrence of a new diagnosis or recurrent episode of MDD and DSM-IV™ diagnostic evaluation will be identified through the submission of CPT II code 1040F and G-code G8467 for an individual patient. The CPT II code for diagnostic evaluation should be reported once until remission occurs. At the time of remission, G-code G8466 should be reported to indicate the current occurrence of MDD has been resolved.
- Failure to report applicable CPT Category II code and/or G-code in an eligible case will result in both a reporting and performance failure.
- Medical record documentation is required for all clinical actions described in a measure.

Acute Episode of Care

DEPRESSION

Measure #107: Patients who have Major Depression Disorder who are Assessed for Suicide Risks

- **Reporting Description:** Percentage of patients aged 18 years and older with a new diagnosis or recurrent episode of major depressive disorder (MDD) and applicable CPT Category II code(s) reported at each visit during the reporting period
- **Performance Description:** Percentage of patients aged 18 years and older with a new diagnosis or recurrent episode of major depressive disorder (MDD) who had a suicide risk assessment completed at each visit during the measurement period

Eligible Cases:	
Patient aged ≥ 18 years on date of encounter **AND** Diagnosis of MDD (ICD-9) **AND** Patient encounter during reporting period (CPT)	296.20, 296.21, 296.22, 296.23, 296.24, 296.30, 296.31, 296.32, 296.33, 296.34 **AND** 90801, 90802, 90804, 90805, 90806, 90807, 90808, 90809, 90810, 90811, 90812, 90813, 90814, 90815, 90845, 90862, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245

Quality Data Code Reporting Options:	
Successful Reporting & Performance: Suicide risk assessed **AND** Documentation of new diagnosis of initial or recurrent episode of major depressive disorder	3085F **AND** 3093F

OR

Successful Reporting & Excluded from Performance: Major depressive disorder, in remission	3092F

OR

Successful Reporting & Performance Not Met: Suicide risk not assessed, reason not specified **AND** Documentation of new diagnosis of initial or recurrent episode of major depressive disorder	3085F-8P **AND** 3093F

Implementation Guidelines:

- The correct combination of numerator code(s) must be reported on the claim form in order to properly report this measure. The "correct combination" of codes may require the submission of multiple numerator codes.
- At an encounter during the reporting period (January 1 through December 31, 2008), review clinical data to determine whether the MDD is a new diagnosis (initial) or recurrent episode. Patients with documentation of new diagnosis of initial or recurrent episode of major depressive disorder should have suicide risk assessed. Select and submit the appropriate CPT Category II code(s) corresponding to the measure
- Each visit for an episode of a new diagnosis or recurrent episode of MDD in an eligible patient occurring prior to or during the reporting period will be counted when calculating the reporting and performance rates. An occurrence of a new diagnosis or recurrent episode of MDD will be identified through the submission of CPT II code 3093F for an individual patient. The CPT II code for suicide risk assessment 3085F should be reported at each visit with CPT II code 3093F until remission occurs. At the time of remission, CPT II code 3092F should be reported to indicate the current episode of MDD has been resolved.
- Failure to report applicable CPT Category II code(s) in an eligible case will result in both a reporting and performance failure.
- Medical record documentation is required for all clinical actions described in a measure.

Measure #1: Hemoglobin A1c Poor Control in Type 1 or 2 Diabetes Mellitus

- **Reporting Description:** Percentage of patients aged 18 through 75 years with diabetes mellitus and an applicable CPT Category II code reported a minimum of once during the reporting period
- **Performance Description:** Percentage of patients aged 18 through 75 years with diabetes mellitus who had most recent hemoglobin A1c greater than 9.0%

Eligible Cases:

Patient aged ≥ 18 and ≤ 75 years on date of encounter **AND** Diagnosis of diabetes mellitus (ICD-9) **AND** Patient encounter during reporting period (CPT or HCPCS)	250.00, 250.01, 250.02, 250.03, 250.10, 250.11, 250.12, 250.13, 250.20, 250.21, 250.22, 250.23, 250.30, 250.31, 250.32, 250.33, 250.40, 250.41, 250.42, 250.43, 250.50, 250.51, 250.52, 250.53, 250.60, 250.61, 250.62, 250.63, 250.70, 250.71, 250.72, 250.73, 250.80, 250.81, 250.82, 250.83, 250.90, 250.91, 250.92, 250.93, 648.00, 648.01, 648.02, 648.03, 648.04 **AND** 97802, 97803, 97804, 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, G0270, G0271

Quality Data Code Reporting Options:

Successful Reporting & Increases Performance Rate: Most recent hemoglobin A1c level > 9.0% *[This is a poor control measure. A lower rate indicates better performance (e.g., low rates of poor control indicate better care)]*	3046F

OR

Successful Reporting & Excluded from Performance: Hemoglobin A1c not performed	3046F-8P

OR

Successful Reporting & Lowers Performance Rate: Most recent hemoglobin A1c level < 7.0% **OR** Most recent hemoglobin A1c level 7.0% to 9.0%	3044F **OR** 3045F

Implementation Guidelines:

- **This is a poor control measure. A lower performance rate indicates better performance** (e.g., low rates of poor control indicate better care).
- The performance timeframe for this measure is 12 months
- Review clinical data (within the last 12 months of this encounter) regarding the most recent hemoglobin A1c at an encounter occurring during the reporting period (January 1 through December 31, 2008). Select and submit the appropriate CPT Category II code corresponding to the most recent A1c level.
- Each eligible patient seen during the reporting period will be counted once when calculating the eligible professional's reporting and performance rates. The most recent quality-data code submitted will be used for performance calculations.
- Failure to report an applicable CPT Category II code in an eligible case will result in a reporting failure but will increase the performance rate since this is a poor control measure.
- Medical record documentation is required for all clinical actions described in a measure.

Measure #2: Low Density Lipoprotein Control in Type 1 or 2 Diabetes Mellitus

- **Reporting Description:** Percentage of patients aged 18 through 75 years with diabetes mellitus and an applicable CPT Category II code reported a minimum of once during the reporting period
- **Performance Description:** Percentage of patients aged 18 through 75 years with diabetes mellitus who had most recent LDL-C level in control (less than 100 mg/dl)

Eligible Cases:	
Patient aged ≥ 18 and ≤ 75 years on date of encounter **AND** Diagnosis of diabetes mellitus (ICD-9) **AND** Patient encounter during reporting period (CPT or HCPCS)	250.00, 250.01, 250.02, 250.03, 250.10, 250.11, 250.12, 250.13, 250.20, 250.21, 250.22, 250.23, 250.30, 250.31, 250.32, 250.33, 250.40, 250.41, 250.42, 250.43, 250.50, 250.51, 250.52, 250.53, 250.60, 250.61, 250.62, 250.63, 250.70, 250.71, 250.72, 250.73, 250.80, 250.81, 250.82, 250.83, 250.90, 250.91, 250.92, 250.93, 648.00, 648.01, 648.02, 648.03, 648.04 **AND** 97802, 97803, 97804, 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, G0270, G0271

Quality Data Code Reporting Options:	
Successful Reporting & Performance: Most recent LDL-C <100 mg/dL	3048F

OR

Successful Reporting & Excluded from Performance: LDL-C level not performed	3048F-8P

OR

Successful Reporting & Performance Not Met: Most recent LDL-C 100-129 mg/dL **OR** Most recent LDL-C ≥ 130 mg/dL	3049F **OR** 3050F

Implementation Guidelines:

- Review clinical data (within the last 12 months of this encounter) regarding the latest LDL-C level at an encounter occurring during the reporting period (January 1 through December 31, 2008). Select and submit the appropriate CPT Category II code corresponding to the most recent LDL-C level.
- Each eligible patient seen during the reporting period will be counted once when calculating the eligible professional's reporting and performance rates. The most recent quality-data code submitted will be used for performance calculations.
- Failure to report an applicable CPT Category II code in an eligible case will result in both a reporting and performance failure.
- Medical record documentation is required for all clinical actions described in a measure.

Measure #3: High Blood Pressure Control in Type 1 or 2 Diabetes Mellitus

- **Reporting Description:** Percentage of patients aged 18 through 75 years with diabetes mellitus and applicable CPT Category II code(s) reported a minimum of once during the reporting period
- **Performance Description:** Percentage of patients aged 18 through 75 years with diabetes mellitus who had most recent blood pressure in control (less than 140/80 mmHg)

Eligible Cases:

Patient aged ≥ 18 and ≤ 75 years on date of encounter **AND** Diagnosis of diabetes mellitus (ICD-9) **AND** Patient encounter during reporting period (CPT or HCPCS)	250.00, 250.01, 250.02, 250.03, 250.10, 250.11, 250.12, 250.13, 250.20, 250.21, 250.22, 250.23, 250.30, 250.31, 250.32, 250.33, 250.40, 250.41, 250.42, 250.43, 250.50, 250.51, 250.52, 250.53, 250.60, 250.61, 250.62, 250.63, 250.70, 250.71, 250.72, 250.73, 250.80, 250.81, 250.82, 250.83, 250.90, 250.91, 250.92, 250.93, 648.00, 648.01, 648.02, 648.03, 648.04 **AND** 97802, 97803, 97804, 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, G0270, G0271

Quality Data Code Reporting Options:

Successful Reporting & Performance: Most recent systolic blood pressure < 130 mmHg **OR** Most recent systolic blood pressure 130 to 139 mmHg **AND** Most recent diastolic blood pressure < 80 mmHg	3074F **OR** 3075F **AND** 3078F

OR

Successful Reporting & Excluded from Performance: No documentation of blood pressure measurement	2000F-8P

OR

Successful Reporting & Performance Not Met: Most recent systolic blood pressure ≥ 140 mmHg **AND** Most recent diastolic blood pressure < 80 mmHg **OR** Most recent diastolic blood pressure 80-89 mmHg **OR** Most recent diastolic blood pressure ≥ 90 mmHg **OR** Most recent diastolic blood pressure 80-89 mmHg **OR** Most recent diastolic blood pressure ≥ 90 mmHg **AND** Most recent systolic blood pressure < 130 mmHg **OR** Most recent systolic blood pressure 130 to 139 mmHg	3077F **AND** 3078F **OR** 3079F **OR** 3080F **OR** 3079F **OR** 3080F **AND** 3074F **OR** 3075F

Implementation Guidelines:

- Successful reporting depends on the correct combination of coding as demonstrated in the boxes above.
- Review clinical data (within the last 12 months of this encounter) regarding the latest blood pressure measurement at an encounter occurring during the reporting period (January 1 through December 31, 2008). Select and submit the appropriate CPT Category II code(s) corresponding to the most recent blood pressure measurement.
- To describe both systolic and diastolic blood pressure values, two CPT II codes must be reported – 1) One to describe the systolic value; AND 2) One to describe the diastolic value. If there are multiple blood pressures on the same date of service, use the lowest systolic and lowest diastolic blood pressure on that date as the representative blood pressure.
- Each eligible patient seen during the reporting period will be counted once when calculating the eligible professional's reporting and performance rates. The most recent quality-data code submitted will be used for performance calculations.
- Failure to report applicable CPT Category II code(s) in an eligible case will result in both a reporting and performance failure.
- Medical record documentation is required for all clinical actions described in a measure.

Measure #18: Diabetic Retinopathy: Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy

- **Reporting Description:** Percentage of patients aged 18 years and older with diabetic retinopathy and an applicable CPT Category II code reported a minimum of once during the reporting period
- **Performance Description:** Percentage of patients aged 18 years and older with a diagnosis of diabetic retinopathy who had a dilated macular or fundus exam performed which included documentation of the level of severity of retinopathy and the presence or absence of macular edema during one or more office visits within 12 months

Eligible Cases:

Patient aged ≥ 18 years on date of encounter **AND** Diagnosis of diabetic retinopathy (ICD-9) **AND** Patient encounter during reporting period (CPT)	362.01, 362.02, 362.03, 362.04, 362.05, 362.06 **AND** 92002, 92004, 92012, 92014, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337

Quality Data Code Reporting Options:

Successful Reporting & Performance: Dilated macular or fundus exam performed, including documentation of the presence or absence of macular edema AND level of severity of retinopathy	2021F

OR

Successful Reporting & Excluded from Performance: Documentation of medical, patient, or system reason(s) for not performing a dilated macular or fundus examination	2021F-1P **OR** 2021F-2P **OR** 2021F-3P

OR

Successful Reporting & Performance Not Met: Macular or fundus exam not performed, reason not specified	2021F-8P

Implementation Guidelines:

- Review clinical data (within the last 12 months of this encounter) regarding the presence or absence of documentation related to macular edema and level of severity of retinopathy at an encounter occurring during the reporting period (January 1 through December 31, 2008). Select and submit the appropriate CPT Category II code corresponding to the measure.
- Medical record must include: Documentation of the level of severity of retinopathy (e.g., background diabetic retinopathy, proliferative diabetic retinopathy, nonproliferative diabetic retinopathy) AND documentation of whether macular edema was present or absent.
- Each eligible patient seen during the reporting period will be counted once when calculating the eligible professional's reporting rate for this measure. The measure may be reported again at a subsequent visit during the reporting period. If the measure is reported more than once for an eligible patient during the reporting period, the single instance of reporting most advantageous to performance will be used when calculating the eligible professional's performance rate for this measure.
- The system exclusion may be used if a clinician is asked to report on this measure but is not the clinician providing the primary management for diabetic retinopathy.
- Failure to report an applicable CPT Category II code in an eligible case will result in both a reporting and performance failure.
- Medical record documentation is required for all clinical actions described in a measure.

Measure #19: Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care

- **Reporting Description:** Percentage of patients aged 18 years and older with diabetic retinopathy and applicable CPT Category II code and/or G-code reported a minimum of once during the reporting period
- **Performance Description:** Percentage of patients aged 18 years and older with a diagnosis of diabetic retinopathy who had a dilated macular or fundus exam performed with documented communication to the physician who manages the ongoing care of the patient with diabetes mellitus regarding the findings of the macular or fundus exam at least once within 12 months

Eligible Cases:

Patient aged ≥ 18 years on date of encounter **AND** Diagnosis of diabetic retinopathy (ICD-9) **AND** Patient encounter during reporting period (CPT)	362.01, 362.02, 362.03, 362.04, 362.05, 362.06 **AND** 92002, 92004, 92012, 92014, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337

Quality Data Code Reporting Options:

Successful Reporting & Performance: Findings of dilated macular or fundus exam communicated to the physician managing the diabetes care **AND** Dilated macular or fundus exam performed, including documentation of the presence or absence of macular edema AND level of severity of retinopathy	5010F **AND** G8397

OR

Successful Reporting & Excluded from Performance: Documentation of patient or system reason(s) for not communicating the findings of the dilated macular or fundus exam to the physician who manages the ongoing care of the patient with diabetes **AND** Dilated macular or fundus exam performed, including documentation of the presence or absence of macular edema AND level of severity of retinopathy **OR** Dilated macular or fundus exam not performed	5010F-2P **OR** 5010F-3P **AND** G8397 **OR** G8398

OR

Successful Reporting & Performance Not Met: Dilated macular or fundus exam findings not communicated, reason not specified **AND** Dilated macular or fundus exam performed, including documentation of the presence or absence of macular edema AND level of severity of retinopathy	5010F-8P **AND** G8397

Implementation Guidelines:

- The correct combination of numerator code(s) must be reported on the claim form in order to properly report this measure. The "correct combination" of codes may require the submission of multiple numerator codes.
- At an encounter during the reporting period (January 1 through December 31, 2008), review clinical data (within the last 12 months of this encounter) to determine whether a dilated macular or fundus exam was performed (including documentation of the presence or absence of macular edema AND level of severity of retinopathy) or patient did not have a dilated macular or fundus exam performed. For patients where a dilated macular or fundus exam was performed, the findings of dilated macular or fundus exam should be communicated to the physician managing the diabetes care. Select and submit the appropriate CPT Category II code and/or G-code corresponding to the measure.
- Communication may include: Documentation in the medical record indicating that the results of the dilated macular or fundus exam were communicated (e.g., verbally, by letter) with the clinician managing the patient's diabetic care OR a copy of a letter in the medical record to the clinician managing the patient's diabetic care outlining the findings of the dilated macular or fundus exam.
- Each eligible patient seen during the reporting period will be counted once when calculating the eligible professional's reporting rate for this measure. The measure may be reported again at a subsequent visit during the reporting period. If the measure is reported more than once for an eligible patient during the reporting period, the single instance of reporting most advantageous to performance will be used when calculating the eligible professional's performance rate for this measure.
- The system exclusion may be used if a clinician is asked to report on this measure but is not the clinician providing the primary management for diabetic retinopathy.
- Failure to report applicable CPT Category II code and/or G-code in an eligible case will result in both a reporting and performance failure.
- Medical record documentation is required for all clinical actions described in a measure.

Measure #117: Dilated Eye Exam in Diabetic Patient

- **Reporting Description:** Percentage of patients aged 18 through 75 years with diabetes mellitus and an applicable CPT Category II code reported a minimum of once during the reporting period
- **Performance Description:** Percentage of patients aged 18 through 75 years with a diagnosis of diabetes mellitus who had a dilated eye exam

Eligible Cases:	
Patient aged ≥ 18 years and ≤ 75 years on date of encounter **AND** Diagnosis of diabetes mellitus (ICD-9) **AND** Patient encounter during reporting period (CPT)	250.00, 250.01, 250.02, 250.03, 250.10, 250.11, 250.12, 250.13, 250.20, 250.21, 250.22, 250.23, 250.30, 250.31, 250.32, 250.33, 250.40, 250.41, 250.42, 250.43, 250.50, 250.51, 250.52, 250.53, 250.60, 250.61, 250.62, 250.63, 250.70, 250.71, 250.72, 250.73, 250.80, 250.81, 250.82, 250.83, 250.90, 250.91, 250.92, 250.93, 357.2, 362.01, 362.02, 362.03, 362.04, 362.05, 362.06, 362.07, 366.41, 648.00, 648.01, 648.02, 648.03, 648.04 **AND** 92002, 92004, 92012, 92014, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99217, 99218, 99219, 99220, 99241, 99242, 99243, 99244, 99245, 99455, 99456

Quality Data Code Reporting Options:	
Successful Reporting & Performance: Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed **OR** Seven standard field stereoscopic photos with interpretation by an ophthalmologist or optometrist documented and reviewed **OR** Eye imaging validated to match diagnosis from seven standard field stereoscopic photos results documented and reviewed **OR** Low risk for retinopathy (no evidence of retinopathy in the prior year)	2022F **OR** 2024F **OR** 2026F **OR** 3072F

OR

Successful Reporting & Excluded from Performance: There are no allowable performance exclusions for this measure.	NONE

OR

Successful Reporting & Performance Not Met: Dilated eye exam not performed, reason not specified	2022F-8P **OR** 2024F-8P **OR** 2026F-8P

Implementation Guidelines:

- Review clinical data (within the last 12 months of this encounter) regarding the presence or absence of documentation related to dilated eye exam at an encounter occurring during the reporting period (January 1 through December 31, 2008). Select and submit the appropriate CPT Category II code corresponding to the measure.
- This includes patients with diabetes mellitus who had one of the following: A retinal or dilated eye exam by an eye care professional (optometrist or ophthalmologist) during the reporting period, *or a* negative retinal exam (no evidence of retinopathy) by an eye care professional in the year prior to the reporting period. For dilated eye exams performed 12 months prior to the reporting period, an automated result must be available.
- Each eligible patient seen during the reporting period will be counted once when calculating the eligible professional's reporting rate for this measure. The measure may be reported again at a subsequent visit during the reporting period. If the measure is reported more than once for an eligible patient during the reporting period, the single instance of reporting most advantageous to performance will be used when calculating the eligible professional's performance rate for this measure.
- Failure to report an applicable CPT Category II code in an eligible case will result in both a reporting and performance failure.
- Medical record documentation is required for all clinical actions described in a measure.

Measure #119: Urine Screening for Microalbumin or Medical Attention for Nephropathy in Diabetic Patients

- **Reporting Description:** Percentage of patients aged 18 through 75 years of age with diabetes mellitus and an applicable CPT Category II code reported a minimum of once during the reporting period
- **Performance Description:** Percentage of patients aged 18 through 75 years of age with diabetes mellitus who received urine protein screening or medical attention for nephropathy during at least one office visit within 12 months

Eligible Cases:	
Patient aged ≥ 18 years and ≤ 75 years on date of encounter **AND** Diagnosis of diabetes mellitus (ICD-9) **AND** Patient encounter during reporting period (CPT)	250.00, 250.01, 250.02, 250.03, 250.10, 250.11, 250.12, 250.13, 250.20, 250.21, 250.22, 250.23, 250.30, 250.31, 250.32, 250.33, 250.40, 250.41, 250.42, 250.43, 250.50, 250.51, 250.52, 250.53, 250.60, 250.61, 250.62, 250.63, 250.70, 250.71, 250.72, 250.73, 250.80, 250.81, 250.82, 250.83, 250.90, 250.91, 250.92, 250.93, 357.2, 362.01, 362.02, 362.03, 362.04, 362.05, 362.06, 362.07, 648.00, 648.01, 648.02, 648.03, 648.04 **AND** 92002, 92004, 92012, 92014, 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99217, 99218, 99219, 99220, 99241, 99242, 99243, 99244, 99245, 99455, 99456

Quality Data Code Reporting Options:	
Successful Reporting & Performance: Positive microalbuminuria test result documented and reviewed **OR** Negative microalbuminuria test result documented and reviewed **OR** Positive macroalbuminuria test result documented and reviewed **OR** Documentation of treatment for nephropathy (eg, patient receiving dialysis, patient being treated for ESRD, CRF, ARF, or renal insufficiency, any visit to a nephrologist) **OR** Angiotensin converting enzyme (ACE) inhibitor or angiotensin receptor blocker (ARB) therapy prescribed	3060F **OR** 3061F **OR** 3062F **OR** 3066F **OR** 4009F

OR

Successful Reporting & Excluded from Performance: There are no allowable performance exclusions for this measure.	NONE

OR

Successful Reporting & Performance Not Met: Nephropathy screening not performed, reason not specified	3060F-8P **OR** 3061F-8P **OR** 3062F-8P

Implementation Guidelines:

- Review clinical data regarding the presence or absence of urine protein screening or documentation of treatment for nephropathy or prescribed ACE inhibitors or ARB therapy at an encounter during the reporting period (January 1 through December 31, 2008). Select and submit the appropriate CPT Category II code corresponding to the measure.
- This measure is looking for a nephropathy screening test *or* evidence of nephropathy.
- Each eligible patient seen during the reporting period will be counted once when calculating the eligible professional's reporting and performance rates. The measure may be reported again at a subsequent visit during the reporting period. If the measure is reported more than once for an eligible patient during the reporting period, the single instance of reporting most advantageous to performance will be used when calculating the eligible professional's performance rate for this measure.
- Failure to report an applicable CPT Category II code in an eligible case will result in both a reporting and performance failure.
- Medical record documentation is required for all clinical actions described in a measure.

Measure #126: Diabetic Foot and Ankle Care, Peripheral Neuropathy: Neurological Evaluation

- **Reporting Description:** Percentage of patients aged 18 years and older with diabetes mellitus and an applicable G-code reported a minimum of once during the reporting period
- **Performance Description:** Percentage of patients aged 18 years and older with a diagnosis of diabetes mellitus who had a neurological examination of their lower extremities

Eligible Cases:	
Patient aged ≥ 18 years on date of encounter **AND** Diagnosis of diabetes mellitus (ICD-9) **AND** Patient encounter during reporting period (CPT)	250.00, 250.01, 250.02, 250.03, 250.10, 250.11, 250.12, 250.13, 250.20, 250.21, 250.22, 250.23, 250.30, 250.31, 250.32, 250.33, 250.40, 250.41, 250.42, 250.43, 250.50, 250.51, 250.52, 250.53, 250.60, 250.61, 250.62, 250.63, 250.70, 250.71, 250.72, 250.73, 250.80, 250.81, 250.82, 250.83, 250.90, 250.91, 250.92, 250.93 **AND** 10060, 10061, 10180, 11000, 11040, 11041, 11042, 11043, 11044, 11055, 11056, 11057, 11719, 11720, 11721, 11730, 11740, 97001, 97002, 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350

Quality Data Code Reporting Options:	
Successful Reporting & Performance: Lower extremity neurological exam performed and documented	G8404

OR

Successful Reporting & Excluded from Performance: Clinician documented that patient was not an eligible candidate for lower extremity neurological exam measure	G8406

OR

Successful Reporting & Performance Not Met: Lower extremity neurological exam not performed	G8405

Implementation Guidelines:

- This measure may be reported by non-MD/DO clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.
- Review clinical data regarding the presence or absence of a neurological examination of the lower extremities performed at a visit occurring during the reporting period (January 1 through December 31, 2008). Select and submit the appropriate G-code corresponding to the measure.
- A lower extremity neurological exam consists of a documented evaluation of motor and sensory abilities including reflexes, vibratory, proprioception, sharp/dull and 5.07 filament detection.
- Each eligible patient seen during the reporting period will be counted once when calculating the eligible professional's reporting and performance rates. The measure may be reported again at a subsequent visit during the reporting period. If the measure is reported more than once for an eligible patient during the reporting period, the single instance of reporting most advantageous to performance will be used when calculating the eligible professional's performance rate for this measure.
- Failure to report an applicable G-code in an eligible case will result in both a reporting and performance failure.
- Medical record documentation is required for all clinical actions described in a measure.

Measure #127: Diabetic Foot and Ankle Care, Ulcer Prevention: Evaluation of Footwear

- **Reporting Description:** Percentage of patients aged 18 years and older with diabetes mellitus and an applicable G-code reported a minimum of once during the reporting period
- **Performance Description:** Percentage of patients aged 18 years and older with a diagnosis of diabetes mellitus who were evaluated for proper footwear and sizing

Eligible Cases:

Patient aged ≥ 18 years on date of encounter **AND** Diagnosis of diabetes mellitus (ICD-9) **AND** Patient encounter during reporting period (CPT)	250.00, 250.01, 250.02, 250.03, 250.10, 250.11, 250.12, 250.13, 250.20, 250.21, 250.22, 250.23, 250.30, 250.31, 250.32, 250.33, 250.40, 250.41, 250.42, 250.43, 250.50, 250.51, 250.52, 250.53, 250.60, 250.61, 250.62, 250.63, 250.70, 250.71, 250.72, 250.73, 250.80, 250.81, 250.82, 250.83, 250.90, 250.91, 250.92, 250.93 **AND** 10060, 10061, 10180, 11000, 11040, 11041, 11042, 11043, 11044, 11055, 11056, 11057, 11719, 11720, 11721, 11730, 11740, 97001, 97002, 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350

Quality Data Code Reporting Options:

Successful Reporting & Performance: Footwear evaluation performed and documented	G8410

OR

Successful Reporting & Excluded from Performance: Clinician documented that patient was not an eligible candidate for footwear evaluation measure	G8416

OR

Successful Reporting & Performance Not Met: Footwear evaluation was not performed	G8415

Implementation Guidelines:

- This measure may be reported by non-MD/DO clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.
- Review clinical data regarding the presence or absence of the evaluation for proper footwear and sizing at a visit occurring during the reporting period (January 1 through December 31, 2008). Select and submit the appropriate G-code corresponding to the measure.
- 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 and counseling on appropriate footwear should be based on risk categorization.
- Each eligible patient seen during the reporting period will be counted once when calculating the eligible professional's reporting and performance rates. The measure may be reported again at a subsequent visit during the reporting period. If the measure is reported more than once for an eligible patient during the reporting period, the single instance of reporting most advantageous to performance will be used when calculating the eligible professional's performance rate for this measure.
- Failure to report an applicable G-code in an eligible case will result in both a reporting and performance failure.
- Medical record documentation is required for all clinical actions described in a measure.

Measure #78: Vascular Access for Patients Undergoing Hemodialysis

- **Reporting Description:** Percentage of patients aged 18 years and older with end stage renal disease (ESRD) and receiving hemodialysis and applicable CPT Category II code(s) reported a minimum of once during the reporting period
- **Performance Description:** Percentage of patients aged 18 years and older with a diagnosis of end stage renal disease (ESRD) and receiving hemodialysis who have a functioning AV fistula OR patients who are referred for an AV fistula at least once during the 12-month reporting period

Eligible Cases:	
Patient aged ≥ 18 years on date of encounter **AND** Diagnosis of ESRD (ICD-9) **AND** Hemodialysis performed during reporting period (CPT or HCPCS)	585.6 **AND** 90935, 90937, G0314, G0315, G0316, G0317, G0318, G0319

Quality Data Code Reporting Options:	
Successful Reporting & Performance: Hemodialysis via functioning arterio-venous (AV) fistula **OR** Referred for an arterio-venous (AV) fistula **AND** Hemodialysis via catheter	4052F **OR** 4051F **AND** 4054F

OR

Successful Reporting & Excluded from Performance: Documentation of medical or patient reason(s) for not referring for an AV fistula **AND** Hemodialysis via catheter **OR** Hemodialysis via functioning arterio-venous (AV) graft	4051F-1P **OR** 4051F-2P **AND** 4054F **OR** 4053F

OR

Successful Reporting & Performance Not Met: Patient not referred for AV fistula, reason not specified **AND** Hemodialysis via catheter	4051F-8P **AND** 4054F

Implementation Guidelines:

- The correct combination of numerator code(s) must be reported on the claim form in order to properly report this measure. The "correct combination" of codes may require the submission of multiple numerator codes.
- At an encounter during the reporting period (January 1 through December 31, 2008), review clinical data to determine which of the following three options applies to the patient: 1) Hemodialysis via functioning arterio-venous (AV) fistula, 2) Hemodialysis via catheter, or 3) Hemodialysis via functioning arterio-venous (AV) graft. Patients with hemodialysis via catheter should be referred for an AV fistula. Select and submit the appropriate CPT Category II code(s) corresponding to the measure.
- Each eligible patient seen during the reporting period will be counted once when calculating the eligible professionals reporting rate for this measure. The measure may be reported again at a subsequent visit during the reporting period. If the measure is reported more than once for an eligible patient during the reporting period, the single instance of reporting most advantageous to performance will be used when calculating the eligible professional's performance rate for this measure.
- Failure to report applicable CPT Category II code(s) in an eligible case will result in both a reporting and performance failure.
- Medical record documentation is required for all clinical actions described in a measure.

Measure #79: Influenza Vaccination in Patients with End Stage Renal Disease (ESRD)

- **Reporting Description:** Percentage of patients aged 18 years and older with ESRD and receiving dialysis and an applicable CPT Category II code reported a minimum of once during the reporting period
- **Performance Description:** Percentage of patients aged 18 years and older with a diagnosis of ESRD and receiving dialysis who received the influenza immunization during the flu season (September through February)

Eligible Cases:	
Patient aged ≥ 18 years on date of encounter **AND** Diagnosis of ESRD (ICD-9) **AND** Dialysis performed during reporting period (CPT or HCPCS)	585.6 **AND** 90935, 90937, 90945, 90947, G0314, G0315, G0316, G0317, G0318, G0319, G0322, G0323, G0326, G0327

Quality Data Code Reporting Options:	
Successful Reporting & Performance: Influenza immunization ordered or administered	4037F

OR

Successful Reporting & Excluded from Performance: Documentation of medical, patient or system reason(s) for patient not receiving the influenza immunization	4037F-1P **OR** 4037F-2P **OR** 4037F-3P

OR

Successful Reporting & Performance Not Met: Influenza immunization not received, reason not specified	4037F-8P

Implementation Guidelines:

- Review clinical data regarding influenza immunization ordered or administered at an encounter occurring during the reporting period (January 1 through December 31, 2008). Select and submit the appropriate CPT Category II code corresponding to the measure.
- This measure is intended to determine whether or not ESRD patients receiving dialysis received or had an order for influenza immunization during the flu season (September through February).
- Each eligible patient seen during the reporting period will be counted once when calculating the eligible professional's reporting rate for this measure. The measure may be reported again at a subsequent visit during the reporting period. If the measure is reported more than once for an eligible patient during the reporting period, the single instance of reporting most advantageous to performance will be used when calculating the eligible professional's performance rate for this measure.
- Failure to report an applicable CPT Category II code in an eligible case will result in both a reporting and performance failure.
- Medical record documentation is required for all clinical actions described in a measure.

Measure #80: Plan of Care for ESRD Patients with Anemia

- **Reporting Description:** Percentage of patient calendar months in which patients aged 18 years and older with end stage renal disease (ESRD) who receive dialysis and applicable CPT Category II code(s) reported each calendar month dialysis is received during the reporting period
- **Performance Description:** Percentage of patient calendar months during the 12-month reporting period in which patients aged 18 years and older with a diagnosis of end stage renal disease (ESRD) who are receiving dialysis have a Hgb ≥ 11g/dL OR have a Hgb < 11 g/dL with a documented plan of care for anemia

Eligible Cases:

Patient aged ≥ 18 years on date of encounter **AND** Diagnosis of ESRD (ICD-9) **AND** Dialysis performed during reporting period (CPT or HCPCS)	585.6 **AND** 90935, 90937, 90945, 90947, G0314, G0315, G0316, G0317, G0318, G0319, G0322, G0323, G0326, G0327

Quality Data Code Reporting Options:

Successful Reporting & Performance: Hemoglobin level greater than or equal to 13 g/dL **OR** Hemoglobin level 11 g/dL to 12.9 g/dL **OR** Hemoglobin less than 11 g/dL **AND** Anemia plan of care documented	3279F **OR** 3280F **OR** 3281F **AND** 0516F

OR

Successful Reporting & Excluded from Performance: There are no allowable performance exclusions for this measure.	NONE

OR

Successful Reporting & Performance Not Met: Hemoglobin level not performed or documented **OR** Patient has hemoglobin level < 11 g/dL without a documented plan of care, reason not specified **AND** Hemoglobin less than 11g/dL	3279F-8P **OR** 0516F-8P **AND** 3281F

Implementation Guidelines:

- The correct combination of numerator code(s) must be reported on the claim form in order to properly report this measure. The "correct combination" of codes may require the submission of multiple numerator codes.
- At a minimum of one encounter per month in which the patient is receiving dialysis during the reporting period (January 1 through December 31, 2008), review clinical data regarding the hemoglobin level. For patients with hemoglobin < 11 g/dL, there should be a documented plan of care for anemia. Select and submit the appropriate CPT Category II code(s) corresponding to the measure.
- Each calendar month dialysis is performed on ESRD patients occurring during the reporting period will be counted when calculating the reporting and performance rates. The measure may be reported again at a subsequent visit during the eligible month. If the measure is reported more than once for an eligible patient during the month, the single instance of reporting most advantageous to performance will be used when calculating the eligible professional's performance rate for this measure.
- Failure to report applicable CPT Category II code(s) in an eligible case will result in both a reporting and performance failure.
- Medical record documentation is required for all clinical actions described in a measure.

Measure #81: Plan of Care for Inadequate Hemodialysis in ESRD Patients

- **Reporting Description:** Percentage of patient calendar months in which patients aged 18 years and older with end stage renal disease (ESRD) who receive hemodialysis and applicable CPT Category II code(s) reported each calendar month hemodialysis is received during the reporting period
- **Performance Description:** Percentage of patient calendar months during the 12-month reporting period in which patients aged 18 years and older with a diagnosis of end stage renal disease (ESRD) receiving hemodialysis have a Kt/V ≥1.2 OR patients who have a Kt/V <1.2 with a documented plan of care for inadequate hemodialysis

Eligible Cases:

Patient aged ≥ 18 years on date of encounter **AND** Diagnosis of ESRD (ICD-9) **AND** Hemodialysis performed during reporting period (CPT or HCPCS)	585.6 **AND** 90935, 90937, G0314, G0315, G0316, G0317, G0318, G0319

Quality Data Code Reporting Options:

Successful Reporting & Performance: Kt/V equal to or greater than 1.2 and less than 1.7 [Clearance of urea (Kt)/volume(V)] **OR** Kt/V greater than or equal to 1.7 [Clearance of urea (Kt)/volume(V)] **OR** Kt/V less than 1.2 [Clearance of urea (Kt)/volume(V)] **AND** Hemodialysis plan of care documented	3083F **OR** 3084F **OR** 3082F **AND** 0505F

OR

Successful Reporting & Excluded from Performance: There are no allowable performance exclusions for this measure.	NONE

OR

Successful Reporting & Performance Not Met: Kt/V measurement not performed or documented **OR** Patient has Kt/V < 1.2 without a documented plan of care, reason not specified **AND** Kt/V less than 1.2 [Clearance of urea (Kt)/volume(V)]	3084F-8P **OR** 0505F-8P **AND** 3082F

Implementation Guidelines:

- The correct combination of numerator code(s) must be reported on the claim form in order to properly report this measure. The "correct combination" of codes may require the submission of multiple numerator codes.
- At a minimum of one encounter per month in which patient receives hemodialysis during the reporting period (January 1 through December 31, 2008), review clinical data regarding the Kt/V value. For patients with Kt/V <1.2, there should be a documented plan of care for inadequate hemodialysis. Select and submit the appropriate CPT Category II code(s) corresponding to the measure.
- A documented plan of care may include checking for adequacy of the AV access, increasing the blood flow, increasing the dialyzer size, increasing the times of dialysis sessions, adjusting dialysis prescription, or documenting residual renal function.
- Each calendar month hemodialysis is performed on ESRD patients occurring during the reporting period will be counted when calculating the reporting and performance rates. The measure may be reported again at a subsequent visit during the eligible month. If the measure is reported more than once for an eligible patient during the month, the single instance of reporting most advantageous to performance will be used when calculating the eligible professional's performance rate for this measure.
- Failure to report applicable CPT Category II code(s) in an eligible case will result in both a reporting and performance failure.
- Medical record documentation is required for all clinical actions described in a measure.

Measure #82: Plan of Care for Inadequate Peritoneal Dialysis

- **Reporting Description:** Percentage of patients aged 18 years and older with end stage renal disease (ESRD) receiving peritoneal dialysis and applicable CPT Category II code(s) reported up to three times during the reporting period
- **Performance Description:** Percentage of patients aged 18 years and older with a diagnosis of end stage renal disease (ESRD) receiving peritoneal dialysis who have a Kt/V ≥ 1.7 OR patients who have a Kt/V <1.7 with a documented plan of care for inadequate peritoneal dialysis at least three times during the 12-month reporting period

Eligible Cases:

Patient aged ≥ 18 years on date of encounter **AND** Diagnosis of ESRD (ICD-9) **AND** Peritoneal dialysis performed during reporting period (CPT or HCPCS)	585.6 **AND** 90945, 90947, G0322, G0323, G0326, G0327

Quality Data Code Reporting Options:

Successful Reporting & Performance: Kt/V ≥1.7 [Clearance of urea (Kt)/volume(V)]	3084F
OR	**OR**
Kt/V equal to or greater than 1.2 and less than 1.7 [Clearance of urea (Kt)/volume(V)] **OR** Kt/V < 1.2 [Clearance of urea (Kt)/volume(V)]	3083F **OR** 3082F
AND Peritoneal dialysis plan of care documented	**AND** 0507F

OR

Successful Reporting & Excluded from Performance: There are no allowable performance exclusions for this measure.	NONE

OR

Successful Reporting & Performance Not Met: Kt/V not performed or documented **OR** Patient has Kt/V < 1.7 without a documented plan of care, reason not specified **AND** Kt/V less than 1.2 [Clearance of urea (Kt)/volume(V)] **OR** Kt/V equal to or greater than 1.2 and less than 1.7 [Clearance of urea (Kt)/volume(V)]	3084F-8P **OR** 0507F-8P **AND** 3082F **OR** 3083F

Implementation Guidelines:

- The correct combination of numerator code(s) must be reported on the claim form in order to properly report this measure. The "correct combination" of codes may require the submission of multiple numerator codes.
- At an encounter during the reporting period (January 1 through December 31, 2008), review clinical data regarding the Kt/V value. For patients with Kt/V <1.7, there should be a documented plan of care for inadequate peritoneal dialysis. Select and submit the appropriate CPT Category II code(s) corresponding to the measure.
- A documented plan of care may include assessing for non-adherence with the peritoneal prescription, sampling, and collection; assessing for error in the peritoneal dialysis prescription and/or inadequate monitoring of the delivered dose; performing peritoneal equilibrium testing; assessing for inadequate patient education; increasing the exchange volume; increasing the number of exchanges per 24 hours; assessing for modality (CAPD or CCPD).
- This measure may be reported up to three times within the reporting year that peritoneal dialysis is performed on ESRD patients.
- The number of reporting instances will be based on the reporting frequencies below, depending on the number of months during the reporting period a patient receives peritoneal dialysis:
  - 1-4 months- report once during the reporting period
  - 5-8 months- report twice during the reporting period
  - 9-12 months- report three times during the reporting period.

  This frequency will be counted when calculating the reporting and performance rates.
- Failure to report applicable CPT Category II code(s) in an eligible case will result in both a reporting and performance failure.
- Medical record documentation is required for all clinical actions described in a measure.

Measure #4: Screening for Future Fall Risk

- **Reporting Description:** Percentage of patients aged 65 years and older seen by the clinician and an applicable CPT Category II code reported a minimum of once during the reporting period
- **Performance Description:** Percentage of patients aged 65 years and older who were screened for future fall risk (patients are considered at risk for future falls if they have had 2 or more falls in the past year or any fall with injury in the past year) at least once within 12 months

Eligible Cases:	
Patient aged ≥ 65 years on date of encounter **AND** Patient encounter during reporting period (CPT)	97001, 97002, 97003, 97004, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350

Quality Data Code Reporting Options:	
Successful Reporting & Performance: Patient screened for future fall risk; documentation of two or more falls in the past year or any fall with injury in the past year **OR** Patient screened for future fall risk; documentation of no falls in the past year or only one fall without injury in the past year	1100F **OR** 1101F

OR

Successful Reporting & Excluded from Performance: Documentation of medical reason(s) for not screening for future fall risk (e.g., patient is not ambulatory)	1100F-1P **OR** 1101F-1P

OR

Successful Reporting & Performance Not Met: Screening for future fall risk not performed, reason not specified	1100F-8P

Implementation Guidelines:

- There is no diagnosis associated with this measure. This measure must be reported a minimum of once for all patients aged 65 years and older seen during the reporting period (January 1 through December 31, 2008).
- Review clinical data (within the last 12 months of this encounter) regarding the presence or absence of documentation of a falls risk assessment at an encounter during the reporting period. Select and submit the appropriate CPT Category II code corresponding to the measure.
- Patients are considered at risk for future falls if they have had two or more falls in the past year or any fall with injury in the past year.
- A fall is defined as a sudden, unintentional change in position causing an individual to land at a lower level, on an object, the floor, or the ground, other than as a consequence of sudden onset of paralysis, epileptic seizure, or overwhelming external force (Tinetti).
- Each eligible patient seen during the reporting period will be counted once when calculating the eligible professional's reporting rate for this measure. The measure may be reported again at a subsequent visit during the reporting period. If the measure is reported more than once for an eligible patient during the reporting period, the single instance of reporting most advantageous to performance will be used when calculating the eligible professional's performance rate for this measure.
- Failure to report an applicable CPT Category II code in an eligible case will result in both a reporting and performance failure.
- Medical record documentation is required for all clinical actions described in a measure.

Measure #77: Assessment of GERD Symptoms in Patients Receiving Chronic Medication for GERD

- **Reporting Description:** Percentage of patients aged 18 years and older with gastroesophageal reflux disease (GERD) and applicable CPT Category II code(s) reported a minimum of once during the reporting period
- **Performance Description:** Percentage of patients aged 18 years and older with the diagnosis of gastroesophageal reflux disease (GERD) who have been prescribed continuous proton pump inhibitor (PPI) or histamine H_2 receptor antagonist (H_2RA) therapy who received an annual assessment of their GERD symptoms after 12 months of therapy

Eligible Cases:

Patient aged ≥ 18 years on date of encounter **AND** Diagnosis of GERD (ICD-9) **AND** Patient encounter during reporting period (CPT)	530.10, 530.11, 530.12, 530.19, 530.81 **AND** 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245

Quality Data Code Reporting Options:

Successful Reporting & Performance: GERD symptoms assessed after 12 months of therapy **AND** Continuous (12-months) therapy with proton pump inhibitor (PPI) or histamine H2 receptor antagonist (H_2RA) received	1118F **AND** 4185F

OR

Successful Reporting & Excluded from Performance: Documentation of medical reason(s) for not assessing GERD symptoms **AND** Continuous (12-months) therapy with proton pump inhibitor (PPI) or histamine H2 receptor antagonist (H_2RA) received **OR** No continuous (12-months) therapy with either proton pump inhibitor (PPI) or histamine H_2 receptor antagonist (H_2RA) received	1118F-1P **AND** 4185F **OR** 4186F

OR

Successful Reporting & Performance Not Met: GERD symptoms not assessed, reason not specified **AND** Continuous (12-months) therapy with proton pump inhibitor (PPI) or histamine H2 receptor antagonist (H_2RA) received	1118F-8P **AND** 4185F

Implementation Guidelines:

- The correct combination of numerator code(s) must be reported on the claim form in order to properly report this measure. The "correct combination" of codes may require the submission of multiple numerator codes.
- This measure must be reported a minimum of once per reporting period for ALL GERD patients.
- At an encounter during the reporting period (January 1 through December 31, 2008), review clinical data to determine continuous proton pump inhibitor (PPI) or histamine H_2 receptor antagonist (H_2RA) therapy was received. For patients receiving continuous proton pump inhibitor (PPI) or histamine H_2 receptor antagonist (H_2RA) therapy, GERD symptoms should be assessed after 12 months of therapy. Select and submit the appropriate CPT Category II code(s) corresponding to the measure.
- Continuous medication therapy is defined as any patient receiving proton pump inhibitor (PPI) or histamine H_2 receptor antagonist (H_2RA) therapy lasting 12 months or more to treat GERD.
- Each eligible patient seen during the reporting period will be counted once when calculating the eligible professionals reporting rate for this measure. The measure may be reported again at a subsequent visit during the reporting period. If the measure is reported more than once for an eligible patient during the reporting period, the single instance of reporting most advantageous to performance will be used when calculating the eligible professional's performance rate for this measure.
- Failure to report applicable CPT Category II code(s) in an eligible case will result in both a reporting and performance failure.
- Medical record documentation is required for all clinical actions described in a measure.

Measure #12: Primary Open Angle Glaucoma: Optic Nerve Evaluation

- **Reporting Description:** Percentage of patients aged 18 years and older with primary open-angle glaucoma and an applicable CPT Category II code reported a minimum of once during the reporting period
- **Performance Description:** Percentage of patients aged 18 years and older with a diagnosis of primary open-angle glaucoma (POAG) who have an optic nerve head evaluation during one or more office visits within 12 months

Eligible Cases:

Patient aged ≥ 18 years on date of encounter **AND** Diagnosis of primary open-angle glaucoma (ICD-9) **AND** Patient encounter during reporting period (CPT)	365.01, 365.10, 365.11, 365.12, 365.15 **AND** 92002, 92004, 92012, 92014, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337

Quality Data Code Reporting Options:

Successful Reporting & Performance: Optic nerve head evaluation performed	2027F

OR

Successful Reporting & Excluded from Performance: Documentation of medical or system reason(s) for not performing an optic nerve head evaluation	2027F-1P **OR** 2027F-3P

OR

Successful Reporting & Performance Not Met: Optic nerve head evaluation not performed, reason not specified	2027F-8P

Implementation Guidelines:

- Review clinical data (within the last 12 months of this encounter) regarding the presence or absence of documentation of an optic nerve head evaluation at an encounter during the reporting period (January 1 through December 31, 2008). Select and submit the appropriate CPT Category II code corresponding to the measure.
- Each eligible patient seen during the reporting period will be counted once when calculating the eligible professional's reporting rate for this measure. The measure may be reported again at a subsequent visit during the reporting period. If the measure is reported more than once for an eligible patient during the reporting period, the single instance of reporting most advantageous to performance will be used when calculating the eligible professional's performance rate for this measure.
- The system exclusion may be used if a clinician is asked to report on this measure but is not the clinician providing the primary management for primary open-angle glaucoma.
- Failure to report an applicable CPT Category II code in an eligible case will result in both a reporting and performance failure.
- Medical record documentation is required for all clinical actions described in a measure.

Measure #5: Heart Failure: Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD)

- **Reporting Description:** Percentage of patients aged 18 years and older with heart failure and applicable CPT Category II code(s) reported a minimum of once during the reporting period
- **Performance Description:** Percentage of patients aged 18 years and older with a diagnosis of heart failure and left ventricular systolic dysfunction (LVSD) who were prescribed ACE inhibitor or ARB therapy

Eligible Cases:

Patient aged ≥ 18 years on date of encounter **AND** Diagnosis of heart failure (ICD-9) **AND** Patient encounter during reporting period (CPT)	402.01, 402.11, 402.91, 404.01, 404.03, 404.11, 404.13, 404.91, 404.93, 428.0, 428.1, 428.20, 428.21, 428.22, 428.23, 428.30, 428.31, 428.32, 428.33, 428.40, 428.41, 428.42, 428.43, 428.9 **AND** 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99238, 99239, 99241, 99242, 99243, 99244, 99245, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350

Quality Data Code Reporting Options:

Successful Reporting & Performance: Angiotensin converting enzyme (ACE) inhibitor or angiotensin receptor blocker (ARB) therapy prescribed **AND** Left ventricular ejection fraction (LVEF) < 40% or documentation of moderately or severely depressed left ventricular systolic function	4009F **AND** 3021F

OR

Successful Reporting & Excluded from Performance: Documentation of medical, patient, or system reason(s) for not prescribing angiotensin converting enzyme (ACE) inhibitor or angiotensin receptor blocker (ARB) therapy **AND** Left ventricular ejection fraction (LVEF) < 40% or documentation of moderately or severely depressed left ventricular systolic function **OR** Left ventricular ejection fraction (LVEF) ≥ 40% or documentation as normal or mildly depressed left ventricular systolic function **OR** Left ventricular ejection fraction (LVEF) not performed or documented	4009F-1P **OR** 4009F-2P **OR** 4009F-3P **AND** 3021F **OR** 3022F **OR** 3021F-8P

OR

Successful Reporting & Performance Not Met: ACE inhibitor or ARB therapy not prescribed, reason not specified **AND** Left ventricular ejection fraction < 40% or documentation of moderately or severely depressed left ventricular systolic dysfunction	4009F-8P **AND** 3021F

Implementation Guidelines:

- The correct combination of numerator code(s) must be reported on the claim form in order to properly report this measure. The "correct combination" of codes may require the submission of multiple numerator codes.
- This measure must be reported a minimum of once per reporting period for ALL heart failure patients.
- At an encounter during the reporting period (January 1 through December 31, 2008), review clinical data to determine which of the following three options applies to the patient: 1) LVEF is < 40% indicating LVSD, 2) LVEF is ≥ 40% or documentation as normal or mildly depressed left ventricular systolic function, or 3) LVEF was not performed or documented, reason not otherwise specified. For patients with LVSD, ACE inhibitor or ARB therapy should be prescribed. Select and submit the appropriate CPT Category II code(s) corresponding to the measure.
- "Prescribed" includes patients who are currently receiving medication(s) that follow the treatment plan recommended at an encounter during the reporting period, even if the prescription for that medication was ordered prior to the encounter.
- The left ventricular systolic dysfunction may be determined by quantitative or qualitative assessment. Examples of a quantitative or qualitative assessment may include an echocardiogram: 1) that provides a numerical value of left ventricular systolic dysfunction or 2) that uses descriptive terms such as moderately or severely depressed left ventricular dysfunction.
- Each eligible patient seen during the reporting period will be counted once when calculating the eligible professional's reporting rate for this measure. The measure may be reported again at a subsequent visit during the reporting period. If the measure is reported more than once for an eligible patient during the reporting period, the single instance of reporting most advantageous to performance will be used when calculating the eligible professional's performance rate for this measure.
- Failure to report applicable CPT Category II code(s) in an eligible case will result in both a reporting and performance failure.
- Medical record documentation is required for all clinical actions described in a measure.

Measure #8: Heart Failure: Beta-blocker Therapy for Left Ventricular Systolic Dysfunction

- **Reporting Description:** Percentage of patients aged 18 years and older with heart failure and an applicable G-code reported a minimum of once during the reporting period
- **Performance Description:** Percentage of patients aged 18 years and older with a diagnosis of heart failure who also have left ventricular systolic dysfunction (LVSD) and who were prescribed beta blocker therapy

Eligible Cases:

Patient aged ≥ 18 years on date of encounter **AND** Diagnosis of heart failure (ICD-9) **AND** Patient encounter during reporting period (CPT)	402.01, 402.11, 402.91, 404.01, 404.03, 404.11, 404.13, 404.91, 404.93, 428.0, 428.1, 428.20, 428.21, 428.22, 428.23, 428.30, 428.31, 428.32, 428.33, 428.40, 428.41, 428.42, 428.43, 428.9 **AND** 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350

Quality Data Code Reporting Options:

Successful Reporting & Performance: Beta-blocker therapy prescribed for patients with left ventricular ejection fraction (LVEF) <40% or documentation as moderately or severely depressed left ventricular systolic function	G8450

OR

Successful Reporting & Excluded from Performance: Clinician documented patient with left ventricular ejection fraction (LVEF) <40% or documentation as moderately or severely depressed left ventricular systolic function was not eligible candidate for beta-blocker therapy **OR** Left ventricular ejection fraction (LVEF) ≥ 40% or documentation as normal or mildly depressed left ventricular systolic function **OR** Left ventricular ejection fraction (LVEF) not performed or documented	G8451 **OR** G8395 **OR** G8396

OR

Successful Reporting & Performance Not Met: Beta-blocker therapy not prescribed for patients with left ventricular ejection fraction (LVEF) <40% or documentation as moderately or severely depressed left ventricular systolic function	G8452

Implementation Guidelines:

- This measure must be reported a minimum of once per reporting period for ALL heart failure patients.
- At an encounter during the reporting period (January 1 through December 31, 2008), review clinical data to determine which of the following three options applies to the patient: 1) LVEF is < 40% indicating LVSD, 2) LVEF is ≥ 40% or documentation as normal or mildly depressed left ventricular systolic function, or 3) LVEF was not performed or documented, reason not otherwise specified. For patients with LVSD, beta-blocker therapy should be prescribed. Select and submit the appropriate G-code corresponding to the measure.
- "Prescribed" includes patients who are currently receiving medication(s) that follow the treatment plan recommended at an encounter during the reporting period, even if the prescription for that medication was ordered prior to the encounter.
- The left ventricular systolic dysfunction may be determined by quantitative or qualitative assessment. Examples of a quantitative or qualitative assessment may include an echocardiogram: 1) that provides a numerical value of left ventricular systolic dysfunction or 2) that uses descriptive terms such as moderately or severely depressed left ventricular dysfunction.
- Each eligible patient seen during the reporting period will be counted once when calculating the eligible professional's reporting rate for this measure. The measure may be reported again at a subsequent visit during the reporting period. If the measure is reported more than once for an eligible patient during the reporting period, the single instance of reporting most advantageous to performance will be used when calculating the eligible professional's performance rate for this measure.
- Failure to report an applicable G-code in an eligible case will result in both a reporting and performance failure.
- Medical record documentation is required for all clinical actions described in a measure.

Measure #83: Testing of Patients with Chronic Hepatitis C (HCV) for Hepatitis C Viremia

- **Reporting Description:** Percentage of patients aged 18 years and older with hepatitis C and applicable CPT Category II code(s) reported a minimum of once during the reporting period
- **Performance Description:** Percentage of patients aged 18 years and older with a diagnosis of hepatitis C seen for an initial evaluation who had HCV RNA testing ordered or previously performed

Eligible Cases:

Patient aged ≥ 18 years on date of encounter **AND** Diagnosis of Hepatitis C (ICD-9) **AND** Patient encounter during reporting period (CPT)	070.51, 070.54, 070.70 **AND** 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245

Quality Data Code Reporting Options:

Successful Reporting & Performance: Ribonucleic acid (RNA) testing for Hepatitis C viremia ordered or results documented **AND** Initial evaluation for condition	3265F **AND** 1119F

OR

Successful Reporting & Excluded from Performance: Documentation of medical or patient reason(s) for not ordering or performing RNA testing for HCV **AND** Initial evaluation for condition **OR** Subsequent evaluation for condition	3265F-1P **OR** 3265F-2P **AND** 1119F **OR** 1121F

OR

Successful Reporting & Performance Not Met: RNA testing not ordered or results not documented, reason not specified **AND** Initial evaluation for condition	3265F-8P **AND** 1119F

Implementation Guidelines:

- The correct combination of numerator code(s) must be reported on the claim form in order to properly report this measure. The "correct combination" of codes may require the submission of multiple numerator codes.
- This measure should be reported on the first visit occurring during the reporting period for ALL hepatitis C patients.
- At an encounter during the reporting period (January 1 through December 31, 2008), review clinical data to determine whether the encounter is an initial or subsequent evaluation for Hepatitis C. For an initial evaluation of Hepatitis C, RNA testing for Hepatitis C viremia should be ordered or results documented. Select and submit the appropriate CPT Category II code(s) corresponding to the measure.
- If the current encounter is not the initial evaluation for Hepatitis C during this reporting period, then quality-data code 1121F (subsequent evaluation for Hepatitis C) should be reported for this measure.
- Each eligible patient seen during the reporting period will be counted once when calculating the eligible professional's reporting rate for this measure. The measure may be reported again at a subsequent visit during the reporting period. If the measure is reported more than once for an eligible patient during the reporting period, the first encounter during the reporting period will be used when calculating the eligible professional's performance rate for this measure.
- Failure to report applicable CPT Category II code(s) in an eligible case will result in both a reporting and performance failure.
- Medical record documentation is required for all clinical actions described in a measure.

Measure #84: Initial Hepatitis C RNA Testing

- **Reporting Description:** Percentage of patients aged 18 years and older with chronic hepatitis C and applicable CPT Category II code(s) reported a minimum of once during the reporting period
- **Performance Description:** Percentage of patients aged 18 years and older with a diagnosis of chronic hepatitis C who are receiving antiviral treatment for whom quantitative HCV RNA testing was performed within 6 months prior to initiation of treatment

Eligible Cases:	
Patient aged ≥ 18 years on date of encounter **AND** Diagnosis of chronic Hepatitis C (ICD-9) **AND** Patient encounter during reporting period (CPT)	070.54 **AND** 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245

Quality Data Code Reporting Options:	
Successful Reporting & Performance: RNA testing for Hepatitis C documented as performed within six months prior to initiation of antiviral treatment for Hepatitis C **AND** Patient receiving antiviral treatment for Hepatitis C	3218F **AND** 4150F

OR

Successful Reporting & Excluded from Performance: Documentation of medical reason(s) for not performing RNA testing within six months prior to initiation of antiviral treatment for Hepatitis C **AND** Patient receiving antiviral treatment for Hepatitis C **OR** Patient not receiving antiviral treatment for Hepatitis C	3218F-1P **AND** 4150F **OR** 4151F

OR

Successful Reporting & Performance Not Met: RNA testing not performed within six months, reason not specified **AND** Patient receiving antiviral treatment for Hepatitis C	3218F-8P **AND** 4150F

Implementation Guidelines:

- The correct combination of numerator code(s) must be reported on the claim form in order to properly report this measure. The "correct combination" of codes may require the submission of multiple numerator codes.
- This measure must be reported a minimum of once per reporting period for ALL chronic hepatitis C patients.
- At an encounter during the reporting period (January 1 through December 31, 2008), review clinical data to determine whether or not patient is receiving antiviral treatment for Hepatitis C. Patients receiving antiviral treatment should have RNA testing for Hepatitis C documented as performed within six months prior to initiation of antiviral treatment. Select and submit the appropriate CPT Category II code(s) corresponding to the measure.
- Each eligible patient seen during the reporting period will be counted once when calculating the eligible professional's reporting rate for this measure. The measure may be reported again at a subsequent visit during the reporting period. If the measure is reported more than once for an eligible patient during the reporting period, the single instance of reporting most advantageous to performance will be used when calculating the eligible professional's performance rate for this measure.
- Failure to report applicable CPT Category II code(s) in an eligible case will result in both a reporting and performance failure.
- Medical record documentation is required for all clinical actions described in a measure.

Measure #85: HCV Genotype Testing Prior to Therapy

- **Reporting Description:** Percentage of patients aged 18 years and older with chronic hepatitis C and applicable CPT Category II code and/or G-code reported a minimum of once during the reporting period
- **Performance Description:** Percentage of patients aged 18 years and older with a diagnosis of chronic hepatitis C who are receiving antiviral treatment for whom HCV genotype testing was performed prior to initiation of treatment

Eligible Cases:	
Patient aged ≥ 18 years on date of encounter **AND** Diagnosis of chronic hepatitis C (ICD-9) **AND** Patient encounter during reporting period (CPT)	070.54 **AND** 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245

Quality Data Code Reporting Options:	
Successful Reporting & Performance: Hepatitis C genotype testing documented as performed prior to initiation of antiviral treatment for hepatitis C **AND** Clinician documented that patient is receiving antiviral treatment for Hepatitis C	3266F **AND** G8459

OR

Successful Reporting & Excluded from Performance: Clinician documented that patient is not an eligible candidate for genotype testing; patient not receiving antiviral treatment for Hepatitis C	G8458

OR

Successful Reporting & Performance Not Met: Genotype testing not performed, reason not specified **AND** Clinician documented that patient is receiving antiviral treatment for Hepatitis C	3266F-8P **AND** G8459

Implementation Guidelines:

- The correct combination of numerator code(s) must be reported on the claim form in order to properly report this measure. The "correct combination" of codes may require the submission of multiple numerator codes.
- This measure must be reported a minimum of once per reporting period for ALL chronic Hepatitis C patients.
- At an encounter during the reporting period (January 1 through December 31, 2008), review clinical data to determine whether or not patient is receiving antiviral treatment for Hepatitis C. Patients receiving antiviral treatment should have HCV genotype testing performed prior to initiation of antiviral treatment. Select and submit the appropriate CPT Category II code and/or G-code corresponding to the measure.
- Each eligible patient seen during the reporting period will be counted once when calculating the eligible professional's reporting rate for this measure. The measure may be reported again at a subsequent visit during the reporting period. If the measure is reported more than once for an eligible patient during the reporting period, the single instance of reporting most advantageous to performance will be used when calculating the eligible professional's performance rate for this measure.
- Failure to report an applicable CPT Category II code and/or G-code in an eligible case will result in both a reporting and performance failure.
- Medical record documentation is required for all clinical actions described in a measure.

Measure #86: Consideration for Antiviral Therapy in HCV Patients

- **Reporting Description:** Percentage of patients aged 18 years and older with chronic hepatitis C and applicable CPT Category II code reported a minimum of once during the reporting period
- **Performance Description:** Percentage of patients aged 18 years and older with a diagnosis of chronic hepatitis C who were considered for peginterferon and ribavirin therapy within the 12-month reporting period

Eligible Cases:	
Patient aged ≥ 18 years on date of encounter **AND** Diagnosis of chronic hepatitis C (ICD-9) **AND** Patient encounter during reporting period (CPT)	070.54 **AND** 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245

Quality Data Report Reporting Options:	
Successful Reporting & Performance: Documentation that combination peginterferon and ribavirin therapy considered **OR** Combination peginterferon and ribavirin therapy prescribed	4152F **OR** 4153F

OR

Successful Reporting & Excluded from Performance: There are no allowable performance exclusions for this measure.	NONE

OR

Successful Reporting & Performance Not Met: Peginterferon and ribavirin therapy not considered or prescribed, reason not specified	4152F-8P

Implementation Guidelines:

- At an encounter during the reporting period (January 1 through December 31, 2008), review clinical data to determine whether or not patient was considered for peginterferon and ribavirin therapy within the 12-month reporting period. Patients with a diagnosis of chronic hepatitis C should have documentation of consideration for or be receiving peginterferon and ribavirin therapy. Select and submit the appropriate CPT Category II code corresponding to the measure.
- Each eligible patient seen during the reporting period will be counted once when calculating the eligible professional's reporting rate for this measure. The measure may be reported again at a subsequent visit during the reporting period. If the measure is reported more than once for an eligible patient during the reporting period, the single instance of reporting most advantageous to performance will be used when calculating the eligible professional's performance rate for this measure.
- Failure to report an applicable CPT Category II code in an eligible case will result in both a reporting and performance failure.
- Medical record documentation is required for all clinical actions described in a measure.

Measure #87: HCV RNA Testing at Week 12 of Therapy

- **Reporting Description:** Percentage of patients aged 18 years and older with chronic hepatitis C and applicable CPT Category II code and/or G-code reported a minimum of once during the reporting period
- **Performance Description:** Percentage of patients aged 18 years and older with a diagnosis of chronic hepatitis C who are receiving antiviral treatment for whom quantitative HCV RNA testing was performed at 12 weeks from the initiation of antiviral treatment

Eligible Cases:	
Patient aged ≥ 18 years on date of encounter **AND** Diagnosis of chronic Hepatitis C (ICD-9) **AND** Patient encounter during reporting period (CPT)	070.54 **AND** 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245

Quality Data Code Reporting Options:	
Successful Reporting & Performance: Hepatitis C quantitative RNA testing documented as performed at 12 weeks from initiation of antiviral treatment **AND** Patient receiving antiviral treatment for Hepatitis C	3220F **AND** G8461

OR

Successful Reporting & Excluded from Performance: Documentation of medical and patient reason(s) for not performing quantitative HCV RNA at 12 weeks from initiation of antiviral treatment **AND** Patient receiving antiviral treatment for Hepatitis C **OR** Clinician documented that patient is not an eligible candidate for quantitative RNA testing at week 12; patient not receiving antiviral treatment for Hepatitis C	3220F-1P **OR** 3220F-2P **AND** G8461 **OR** G8460

OR

Successful Reporting & Performance Not Met: Hepatitis C quantitative RNA testing not performed at 12 weeks, reason not specified **AND** Patient receiving antiviral treatment for Hepatitis C	3220F-8P **AND** G8461

Implementation Guidelines:

- The correct combination of numerator code(s) must be reported on the claim form in order to properly report this measure. The "correct combination" of codes may require the submission of multiple numerator codes.
- This measure must be reported a minimum of once per reporting period for ALL chronic Hepatitis C patients.
- At an encounter during the reporting period (January 1 through December 31, 2008), review clinical data to determine whether or not the patient is receiving antiviral treatment for chronic Hepatitis C. Patients receiving antiviral treatment should have quantitative HCV RNA testing performed at 12 weeks from the initiation of antiviral treatment. Select and submit the appropriate CPT Category II code and/or G-code corresponding to the measure.
- Patients for whom testing was performed between 11-13 weeks from the initiation of antiviral treatment will meet the numerator for this measure.
- Each eligible patient seen during the reporting period will be counted once when calculating the eligible professional's reporting rate for this measure. The measure may be reported again at a subsequent visit during the reporting period. If the measure is reported more than once for an eligible patient during the reporting period, the single instance of reporting most advantageous to performance will be used when calculating the eligible professional's performance rate for this measure.
- Failure to report an applicable CPT Category II code and/or G-code in an eligible case will result in both a reporting and performance failure.
- Medical record documentation is required for all clinical actions described in a measure.

Measure #88: Hepatitis A and B Vaccination in Patients with HCV

- **Reporting Description:** Percentage of patients aged 18 years and older with hepatitis C and applicable CPT Category II code reported a minimum of once for each reporting option (Hepatitis A and Hepatitis B) during the reporting period
- **Performance Description:** Percentage of patients aged 18 years and older with a diagnosis of hepatitis C who were recommended to receive or who have received hepatitis A vaccination or who have documented immunity to hepatitis A AND who were recommended to receive or have received hepatitis B vaccination or who have documented immunity to hepatitis B

Eligible Cases:	
Patient aged ≥ 18 years on date of encounter **AND** Diagnosis of Hepatitis C (ICD-9) **AND** Patient encounter during reporting period (CPT)	070.51, 070.54, 070.70 **AND** 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245

Hepatitis A Quality Data Code Reporting Options:	
Successful Reporting & Performance: Hepatitis A vaccine series recommended **OR** Hepatitis A vaccine series previously received **OR** Patient has documented immunity to Hepatitis A	4154F **OR** 4155F **OR** 3215F

OR

Successful Reporting & Excluded from Performance: Documentation of medical reason(s) for not recommending or administering hepatitis A vaccine series	4154F-1P

OR

Successful Reporting & Performance Not Met: Hepatitis A vaccine not recommended, reason not specified	4154F-8P

AND

Hepatitis B **Quality Data Code Reporting Options:**	
Successful Reporting & Performance: Hepatitis B vaccine series recommended **OR** Hepatitis B vaccine series previously received **OR** Patient has documented immunity to Hepatitis B	4156F **OR** 4157F **OR** 3216F

OR

Successful Reporting & Excluded from Performance: Documentation of medical reason(s) for not recommending or administering hepatitis B vaccine series	4156F-1P

OR

Successful Reporting & Performance Not Met: Hepatitis B vaccine not recommended, reason not specified	4156F-8P

Implementation Guidelines:

- Review clinical data regarding the status of Hepatitis A and Hepatitis B vaccination or immunity at an encounter occurring during the reporting period (January 1 through December 31, 2008). Select and submit the appropriate CPT Category II code corresponding to each reporting option for the measure.
- **Two CPT II codes are required when reporting this measure.** Report one code for Hepatitis A Vaccine series and one code for Hepatitis B Vaccine series
- Each eligible patient seen during the reporting period will be counted once when calculating the eligible professional's reporting rate for this measure. The measure may be reported again at a subsequent visit during the reporting period. If the measure is reported more than once for an eligible patient during the reporting period, the single instance of reporting most advantageous to performance will be used when calculating the eligible professional's performance rate for this measure.
- Failure to report applicable CPT Category II codes in an eligible case will result in both a reporting and performance failure.
- Medical record documentation is required for all clinical actions described in a measure.

Measure #89: Counseling Patients with HCV Regarding Use of Alcohol

- **Reporting Description:** Percentage of patients aged 18 years and older with hepatitis C and an applicable CPT Category II code reported a minimum of once during the reporting period
- **Performance Description:** Percentage of patients aged 18 years and older with a diagnosis of hepatitis C who received education regarding the risk of alcohol consumption at least once within the 12-month reporting period

Eligible Cases:	
Patient aged ≥ 18 years on date of encounter **AND** Diagnosis of Hepatitis C (ICD-9) **AND** Patient encounter during reporting period (CPT)	070.51, 070.54, 070.70 **AND** 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245

Quality Data Code Reporting Options:	
Successful Reporting & Performance: Patient education regarding risk of alcohol consumption performed	4158F

OR

Successful Reporting & Excluded from Performance: There are no allowable performance exclusions for this measure.	NONE

OR

Successful Reporting & Performance Not Met: Education regarding risk of alcohol consumption not performed, reason not specified	4158F-8P

Implementation Guidelines:

- Review clinical data to determine whether education was received regarding the risk of alcohol consumption at an encounter occurring during the reporting period (January 1 through December 31, 2008). Select and submit the appropriate CPT Category II code corresponding to the measure.
- Each eligible patient seen during the reporting period will be counted once when calculating the eligible professionals reporting rate for this measure. The measure may be reported again at a subsequent visit during the reporting period. If the measure is reported more than once for an eligible patient during the reporting period, the single instance of reporting most advantageous to performance will be used when calculating the eligible professional's performance rate for this measure.
- Failure to report an applicable CPT Category II code in an eligible case will result in both a reporting and performance failure.
- Medical record documentation is required for all clinical actions described in a measure.

Measure #90: Counseling of Patients Regarding Use of Contraception Prior to Starting Antiviral Therapy

- **Reporting Description:** Percentage of female patients aged 18 through 44 years and all men aged 18 years and older with chronic hepatitis C and applicable CPT Category II code and/or G-code reported a minimum of once during the reporting period
- **Performance Description:** Percentage of female patients aged 18 through 44 years and all men aged 18 years and older with a diagnosis of chronic hepatitis C who are receiving antiviral treatment who were counseled regarding contraception prior to the initiation of treatment

Eligible Cases:

Female patient aged ≥ 18 and ≤ 44 years on date of encounter **OR** Male patient aged ≥ 18 years on date of encounter **AND** Diagnosis of chronic Hepatitis C (ICD-9) **AND** Patient encounter during reporting period (CPT)	070.54 **AND** 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245

Quality Data Code Reporting Options:

Successful Reporting & Performance: Counseling regarding contraception received prior to initiation of antiviral treatment **AND** Patient receiving antiviral treatment for Hepatitis C documented	4159F **AND** G8463

OR

Successful Reporting & Excluded from Performance: Documentation of medical reason(s) for not counseling patient regarding contraception **AND** Patient receiving antiviral treatment for Hepatitis C documented **OR** Clinician documented that patient is not an eligible candidate for counseling regarding contraception prior to antiviral treatment; patient not receiving antiviral treatment for Hepatitis C	4159F-1P **AND** G8463 **OR** G8462

OR

Successful Reporting & Performance Not Met: Education regarding contraception not received, reason not specified **AND** Patient receiving antiviral treatment for Hepatitis C documented	4159F-8P **AND** G8463

Implementation Guidelines:

- The correct combination of numerator code(s) must be reported on the claim form in order to properly report this measure. The "correct combination" of codes may require the submission of multiple numerator codes.
- This measure must be reported a minimum of once per reporting period for ALL chronic Hepatitis C patients.
- At an encounter during the reporting period (January 1 through December 31, 2008), review clinical data to determine whether or not patient is receiving antiviral treatment for chronic Hepatitis C. Patients receiving antiviral treatment should be counseled regarding contraception prior to the initiation of treatment. Select and submit the appropriate CPT Category II code and/or G-code corresponding to the measure.
- Each eligible patient seen during the reporting period will be counted once when calculating the eligible professionals reporting rate for this measure. The measure may be reported again at a subsequent visit during the reporting period. If the measure is reported more than once for an eligible patient during the reporting period, the single instance of reporting most advantageous to performance will be used when calculating the eligible professional's performance rate for this measure.
- Failure to report applicable CPT Category II code and/or G-code in an eligible case will result in both a reporting and performance failure.
- Medical record documentation is required for all clinical actions described in a measure.

Structural Measure

HIT

Measure #124: HIT- Adoption/Use of Health Information Technology (Electronic Health Records)

Structural Measure Description: Documents whether provider has adopted and is using health information technology. To qualify, the provider must have adopted a qualified electronic medical record (EMR). For the purpose of this measure, a qualified EMR can either be a Certification Commission for Healthcare Information Technology (CCHIT) certified EMR or, if not CCHIT certified, the system must be capable of all of the following:

- Generating a medication list
- Generating a problem list
- Entering laboratory tests as discrete searchable data elements

Eligible Cases:

Patient aged ≥ 18 years on date of encounter **AND** Patient encounter during reporting period (CPT or HCPCS)	90801, 90802, 90804, 90805, 90806, 90807, 90808, 90809, 92002, 92004, 92012, 92014, 96150, 96151, 96152, 97001, 97002, 97003, 97004, 97750, 97802, 97803, 97804, 98940, 98941, 98942, 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, D7140, D7210, G0101, G0108, G0109, G0270, G0271

Quality Data Code Reporting Options:

Successful Reporting & Performance: Patient encounter was documented using a CCHIT certified EMR **OR** Patient encounter was documented using a non-CCHIT certified EMR. To qualify, the system must be capable of all of the following: • Generating a medication list • Generating a problem list • Entering laboratory tests as discrete searchable data elements	G8447 **OR** G8448

OR

Successful Reporting & Excluded from Performance: Patient encounter was not documented using an EMR due to system reasons such as, the system being inoperable at the time of the visit. Use of this code implies that an EMR is in place and generally available	G8449

Implementation Guidelines:

- This measure is only to be reported by eligible professionals with a qualified EMR system.
- Each eligible patient visit occurring during the reporting period (January 1 through December 31, 2008) will be counted once when calculating the eligible professional's reporting rate for this measure.
- **Health Information Technology (HIT) -** A system that incorporates both computer hardware and software that deals with the storage, retrieval, sharing, and use of health care information, data, and knowledge for communication and decision making.
- **CCHIT -** The Certification Commission for Healthcare Information Technology (www.cchit.org) – an independent, nonprofit organization that has been recognized by the federal government as an official certification body for electronic health record products.
- **Discrete searchable data elements -** Laboratory data that can be recorded in predefined fields in predefined formats within the EMR that allow for reports to be generated, such as trends of a specific element over time. This cannot be easily done if data is entered via a free text format or by merely scanning a report into the EMR.
- Failure to report an applicable G-code in an eligible case will result in both a reporting and performance failure.
- Medical record documentation is required to support reporting of this measure.

Structural Measure

HIT

Measure #125: HIT- Adoption/Use of e-Prescribing

Structural Measure Description: Documents whether provider has adopted a qualified e-Prescribing system and the extent of use in the ambulatory setting. To qualify this system must be capable of **ALL** of the following:

- Generating a complete active medication list incorporating electronic data received from applicable pharmacy drug plan(s) if available
- Selecting medications, printing prescriptions, electronically transmitting prescriptions, and conducting all safety checks (defined below)
- Providing information related to the availability of lower cost, therapeutically appropriate alternatives (if any)
- Providing information on formulary or tiered formulary medications, patient eligibility, and authorization requirements received electronically from the patient's drug plan

Eligible Cases:	
Patient aged ≥ 18 years on date of encounter **AND** Patient encounter during reporting period (CPT or HCPCS)	90801, 90802, 90804, 90805, 90806, 90807, 90808, 90809, 92002, 92004, 92012, 92014, 96150, 96151, 96152, 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, G0101, G0108, G0109

Quality Data Code Reporting Options:	
Successful Reporting & Performance: All prescriptions created during the encounter were generated using a qualified e-Prescribing system	G8443

OR

Successful Reporting & Excluded from Performance: No prescriptions were generated during the encounter. Provider does have access to a qualified e-Prescribing system **OR** Some or all prescriptions generated during the encounter were handwritten or phoned in due to one of the following: required by state law, patient request, or qualified e-Prescribing system being temporarily inoperable	G8445 **OR** G8446

Implementation Guidelines:

- This measure is only to be reported by eligible professionals with an e-Prescribing system.
- Each eligible patient visit occurring during the reporting period (January 1 through December 31, 2008) will be counted once when calculating the eligible professional's reporting rate for this measure.
- **Qualified e-Prescribing system –** an e-Prescribing system that is capable of ALL of the following:
    - Generating a complete active medication list incorporating electronic data received from applicable pharmacy drug plan(s) if available
    - Selecting medications, printing prescriptions, electronically transmitting prescriptions, and conducting all safety checks (defined below)
    - Providing information related to the availability of lower cost, therapeutically appropriate alternatives (if any)
    - Providing information on formulary or tiered formulary medications, patient eligibility, and authorization requirements received electronically from the patient's drug plan
- **e-Prescribing –** Entering a prescription for a medication into an automated data entry system that generates a prescription electronically instead of handwriting the prescription on paper
- **Safety checks –** Automated prompts that offer the provider information on the drug being prescribed, potentially inappropriate dose or route of administration of a drug, drug-drug interactions, allergy concerns, or warnings and cautions
- Failure to report an applicable G-code in an eligible case will result in both a reporting and performance failure.
- Medical record documentation is required to support reporting of this measure.

Measure #10: Stroke and Stroke Rehabilitation: Computed Tomography (CT) or Magnetic Resonance Imaging (MRI) Reports

- **Reporting Description:** Percentage of patients aged 18 years and older with ischemic stroke or transient ischemic attack (TIA) or intracranial hemorrhage or at least one documented symptom consistent with ischemic stroke or TIA or intracranial hemorrhage undergoing CT or MRI and applicable CPT Category II code(s) reported for each CT or MRI study performed during the reporting period
- **Performance Description:** Percentage of final reports for CT or MRI studies of the brain performed within 24 hours of arrival to the hospital for patients aged 18 years and older with either a diagnosis of ischemic stroke or transient ischemic attack (TIA) or intracranial hemorrhage or at least one documented symptom consistent with ischemic stroke or TIA or intracranial hemorrhage that includes documentation of the presence or absence of each of the following: hemorrhage and mass lesion and acute infarction

Eligible Cases:

Patient aged ≥ 18 years on date of CT or MRI study **AND** Diagnosis of stroke, TIA or hemorrhage or qualifying symptom code (ICD-9) **AND** CT or MRI performed during the reporting period (CPT)	368.12, 368.2, 386.2, 431, 433.01, 433.11, 433.21, 433.31, 433.81, 433.91, 434.01, 434.11, 434.91, 435.0, 435.1, 435.2, 435.3, 435.8, 435.9, 437.7, 780.02, 781.3, 781.4, 781.94, 782.0, 784.3, 784.5 **AND** 0042T, 70450, 70460, 70470, 70551, 70552, 70553

Quality Data Code Reporting Options:

Successful Reporting & Performance: Presence or absence of hemorrhage and mass lesion and acute infarction documented in final CT or MRI report **AND** CT or MRI of the brain performed within 24 hours of arrival to the hospital	3110F **AND** 3111F

OR

Successful Reporting & Excluded from Performance: CT or MRI of the brain performed greater than 24 hours after arrival to the hospital	3112F

OR

Successful Reporting & Performance Not Met: Presence/absence of hemorrhage, mass lesion, and acute infarction not documented, reason not specified **AND** CT or MRI of the brain within 24 hours of arrival to the hospital	3110F-8P **AND** 3111F

Implementation Guidelines:

- The correct combination of numerator code(s) must be reported on the claim form in order to properly report this measure. The "correct combination" of codes may require the submission of multiple numerator codes.
- Clinicians may submit this measure from either the hospital or outpatient setting.
- At each encounter where a CT or MRI is performed during the reporting period (January 1 through December 31, 2008), review clinical data to determine whether the CT or MRI of the brain was performed within 24 hours of arrival to the hospital or the CT or MRI of the brain was performed greater than 24 hours after arrival to the hospital. For patients where a CT or MRI of the brain was performed within 24 hours of arrival to the hospital, the presence or absence of hemorrhage and mass lesion and acute infarction should be documented in the final CT or MRI report. Select and submit the appropriate CPT Category II code(s) corresponding to the measure.
- Equivalent terms or synonyms for hemorrhage, mass lesion, or infarction, if documented in the CT or MRI report, would meet the measure.
- For purposes of this measure, the listed symptoms will be considered “documented symptoms consistent” with ischemic stroke or TIA or intracranial hemorrhage. Each of the listed symptoms corresponds to a specific ICD-9 code in the code table below. NOTE: Use of symptom codes is limited to the following:
    - Transient visual loss (368.12)
    - Diplopia (double vision) (368.2)
    - Vertigo of central origin (386.2)
    - Transient global amnesia (437.7)
    - Transient alteration of awareness (780.02)
    - Lack of coordination (781.3)
    - Transient paralysis of limb (781.4)
    - Facial weakness (781.94)
    - Disturbance of skin sensation (782.0)
    - Aphasia (784.3)
    - Slurred speech (784.5)
- Each CT or MRI performed during the reporting period will be counted when calculating the reporting and performance rates.
- Failure to report applicable CPT Category II code(s) in an eligible case will result in both a reporting and performance failure.
- Medical record documentation is required for all clinical actions described in a measure.

Measure #11: Stroke and Stroke Rehabilitation: Carotid Imaging Reports

- **Reporting Description:** Percentage of patients aged 18 years and older with ischemic stroke or transient ischemic attack (TIA) undergoing carotid imaging and an applicable CPT Category II code reported for each carotid imaging study performed during the reporting period
- **Performance Description:** Percentage of final reports for carotid imaging studies (neck MR angiography [MRA], neck CT angiography [CTA], neck duplex ultrasound, carotid angiogram) performed for patients aged 18 years and older with the diagnosis of ischemic stroke or transient ischemic attack (TIA) that include direct or indirect reference to measurements of distal internal carotid diameter as the denominator for stenosis measurement

Eligible Cases:

Patient aged ≥ 18 years on date of carotid imaging study **AND** Diagnosis of ischemic stroke or TIA (ICD-9) **AND** Carotid imaging study performed during reporting period (CPT)	433.01, 433.11, 433.21, 433.31, 433.81, 433.91, 434.01, 434.11, 434.91, 435.0, 435.1, 435.2, 435.3, 435.8, 435.9 **AND** 70498, 70547, 70548, 70549, 75660, 75662, 75665, 75671, 75676, 75680, 93880, 93882

Quality Data Code Reporting Options:

Successful Reporting & Performance: Carotid image study report includes direct or indirect reference to measurements of distal internal carotid diameter as the denominator for stenosis measurement	3100F

OR

Successful Reporting & Excluded from Performance: Documentation of medical reason(s) for not including direct or indirect reference to measurements of distal internal carotid diameter	3100F-1P

OR

Successful Reporting & Performance Not Met: Measurements of distal internal carotid diameter not referenced, reason not specified	3100F-8P

Implementation Guidelines:

- Review clinical data regarding the patient's carotid imaging study's report performed during the reporting period (January 1 through December 31, 2008). Select and submit the appropriate CPT Category II code corresponding to the contents of the final report.
- Clinicians may submit this measure from either the hospital or outpatient setting.
- "Direct or indirect reference to measurements of distal internal carotid diameter as the denominator for stenosis measurement" includes direct angiographic stenosis calculations based on the distal lumen as the denominator for stenosis measurement OR an equivalent validated method referenced to the above method (e.g., for duplex ultrasound studies, velocity parameters that correlate the residual internal carotid lumen with methods based on the distal internal carotid lumen)
- Each carotid imaging study performed during the reporting period will be counted when calculating the reporting and performance rates.
- Failure to report an applicable CPT Category II code in an eligible case will result in both a reporting and performance failure.
- Medical record documentation is required for all clinical actions described in a measure.

Measure #110: Influenza Vaccination for Patients ≥ 50 Years Old

- **Reporting Description:** Percentage of patients aged 50 years and older and an applicable G-code reported a minimum of once during the reporting period
- **Performance Description:** Percentage of patients aged 50 years and older who received an influenza immunization during the flu season (September through February)

Eligible Cases:	
Patient aged ≥ 50 years on date of encounter **AND** Patient encounter during reporting period (CPT)	99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245

Quality Data Code Reporting Options:	
Successful Reporting & Performance: Influenza immunization was ordered or administered	G8482

OR

Successful Reporting & Excluded from Performance: Influenza immunization was not ordered or administered for reasons documented by clinician	G8483

OR

Successful Reporting & Performance Not Met: Influenza immunization not ordered or administered, reason not specified	G8484

Implementation Guidelines:

- There is no diagnosis associated with this measure. This measure must be reported a minimum of once for ALL patients aged 50 years and older seen during the reporting period (January 1 through December 31, 2008).
- Review clinical data regarding the status of influenza immunization at an encounter occurring during the reporting period. Select and submit the appropriate G-code corresponding to the measure.
- This measure is intended to determine whether or not all patients aged 50 years and older received or had an order for influenza immunization during the flu season (September through February).
- Each eligible patient seen during the reporting period will be counted once when calculating the eligible professionals reporting rate for this measure. The measure may be reported again at a subsequent visit during the reporting period. If the measure is reported more than once for an eligible patient during the reporting period, the single instance of reporting most advantageous to performance will be used when calculating the eligible professional's performance rate for this measure.
- Failure to report an applicable G-code in an eligible case will result in both a reporting and performance failure.
- Medical record documentation is required for all clinical actions described in a measure.

Measure #129: Universal Influenza Vaccine Screening and Counseling

- **Reporting Description:** Percentage of patients aged 50 years and older with an applicable G-code reported at each eligible visit during the months of January, February, March, October, November and December
- **Performance Description:** Percentage of patients aged 50 years and older that were screened and counseled about the influenza vaccine during the months of January, February, March, October, November and December

Eligible Cases:

Patient aged ≥ 50 years on date of encounter **AND** Patient encounter during reporting period (CPT or HCPCS)	00140, 00142, 00170, 00400, 00402, 00810, 00832, 00851, 00910, 00920, 01380, 01382, 01400, 01732, 01810, 01820, 01829, 97802, 97803, 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, G0101, G0108, G0270

Quality Data Code Reporting Options:

Successful Reporting & Performance: Documented that patient was screened and either influenza vaccination status is current or patient was counseled	G8423

OR

Successful Reporting & Excluded from Performance: Documented that patient was not appropriate for screening and/or counseling about the influenza vaccine (e.g., allergy to eggs)	G8426

OR

Successful Reporting & Performance Not Met: Influenza vaccine status was not screened **OR** Influenza vaccine status screened, patient not current and counseling was not provided	G8424 **OR** G8425

Implementation Guidelines:

- There is no diagnosis associated with this measure.
- This measure may be reported by non-MD/DO clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.
- Review clinical data regarding the presence or absence of influenza screening and counseling at each encounter occurring in January, February, March, October, November and December during the reporting period (January 1 through December 31, 2008). Select and submit the appropriate G-code corresponding to the measure.
- **Screening** – Testing done on people at risk of developing a certain disease, even if they have no symptoms. Screening tests can predict the likelihood of someone having or developing a particular disease. This measure looks for the test being done in the practitioner's office that is filing the code.
- **Counseling** – Providing information or advice related to the applicable measure such as including ways to stay healthy, implementing lifestyle modifications, and/or improving health status. In this measure, the advice constitutes recommendation to receive vaccine unless contraindicated.
- Each eligible patient visit during the months of January, February, March, October, November and December will be counted once when calculating the eligible professional's reporting rate for this measure. The measure may be reported again at a subsequent visit during the reporting period.
- Failure to report an applicable G-code in an eligible case will result in both a reporting and performance failure.
- Medical record documentation is required for all clinical actions described in a measure.

Measure #70: Chronic Lymphocytic Leukemia (CLL): Baseline Flow Cytometry

- **Reporting Description:** Percentage of patients aged 18 years and older with CLL and an applicable CPT Category II code reported a minimum of once during the reporting period
- **Performance Description:** Percentage of patients aged 18 years and older with a diagnosis of CLL who had baseline flow cytometry studies performed

Eligible Cases:

Patient aged ≥ 18 years on date of encounter **AND** Diagnosis of CLL (ICD-9) **AND** Patient encounter during reporting period (CPT)	204.10 **AND** 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245

Quality Data Code Reporting Options:

Successful Reporting & Performance: Flow cytometry studies performed at time of diagnosis or prior to initiating treatment	3170F

OR

Successful Reporting & Excluded from Performance: Documentation of medical, patient, or system reason(s) for not performing baseline flow cytometry studies	3170F-1P **OR** 3170F-2P **OR** 3170F-3P

OR

Successful Reporting & Performance Not Met: Baseline flow cytometry studies not performed, reason not specified	3170F-8P

Implementation Guidelines:

- Review clinical data regarding the presence or absence of baseline flow cytometry test at an encounter occurring during the reporting period (January 1 through December 31, 2008). Select and submit the appropriate CPT Category II code corresponding to the measure.
- Each eligible patient seen during the reporting period will be counted once when calculating the eligible professional's reporting rate for this measure. The measure may be reported again at a subsequent visit during the reporting period. If the measure is reported more than once for an eligible patient during the reporting period, the single instance of reporting most advantageous to performance will be used when calculating the eligible professional's performance rate for this measure.
- Baseline flow cytometry studies refer to testing that is performed at time of diagnosis or prior to initiating treatment for that diagnosis; do not limit the search for baseline flow cytometry studies to the reporting period to qualify for this measure.
- Treatment may include anti-neoplastic therapy.
- Failure to report an applicable CPT Category II code in an eligible case will result in both a reporting and performance failure.
- Medical record documentation is required for all clinical actions described in a measure.

Measure #14: Age-Related Macular Degeneration: Dilated Macular Examination

- **Reporting Description:** Percentage of patients aged 50 years and older with age-related macular degeneration and an applicable CPT Category II code reported a minimum of once during the reporting period
- **Performance Description:** Percentage of patients aged 50 years and older with a diagnosis of age-related macular degeneration who had a dilated macular examination performed which included documentation of the presence or absence of macular thickening or hemorrhage AND the level of macular degeneration severity during one or more office visits within 12 months

Eligible Cases:	
Patient aged ≥ 50 years on date of encounter **AND** Diagnosis of age-related macular degeneration (ICD-9) **AND** Patient encounter during reporting period (CPT)	362.50, 362.51, 362.52 **AND** 92002, 92004, 92012, 92014, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337

Quality Data Code Reporting Options:	
Successful Reporting & Performance: Dilated macular exam performed, including documentation of the presence or absence of macular thickening or hemorrhage AND the level of macular degeneration severity	2019F

OR

Successful Reporting & Excluded from Performance: Documentation of medical, patient, or system reason(s) for not performing a dilated macular examination	2019F-1P **OR** 2019F-2P **OR** 2019F-3P

OR

Successful Reporting & Performance Not Met: Dilated macular examination not performed, reason not specified	2019F-8P

Implementation Guidelines:

- Review clinical data (within the last 12 months of this encounter) regarding the presence or absence of a dilated macular examination at an encounter occurring during the reporting period (January 1 through December 31, 2008). Select and submit the appropriate CPT Category II code corresponding to the measure.
- Each eligible patient seen during the reporting period will be counted once when calculating the eligible professional's reporting rate for this measure. The measure may be reported again at a subsequent visit during the reporting period. If the measure is reported more than once for an eligible patient during the reporting period, the single instance of reporting most advantageous to performance will be used when calculating the eligible professional's performance rate for this measure.
- The system exclusion may be used if a clinician is asked to report on this measure but is not the clinician providing the primary management for age-related macular degeneration.
- Failure to report an applicable CPT Category II code in an eligible case will result in both a reporting and performance failure.
- Medical record documentation is required for all clinical actions described in a measure.

Measure #67: Myelodysplastic Syndrome (MDS) and Acute Leukemias: Baseline Cytogenetic Testing Performed on Bone Marrow

- **Reporting Description:** Percentage of patients aged 18 years and older with MDS or acute leukemia and an applicable CPT Category II code reported a minimum of once during the reporting period
- **Performance Description:** Percentage of patients aged 18 years and older with a diagnosis of MDS or an acute leukemia who had baseline cytogenetic testing performed on bone marrow

Eligible Cases:	
Patient aged ≥ 18 years on date of encounter **AND** Diagnosis of MDS or acute leukemia (ICD-9) **AND** Patient encounter during reporting period (CPT)	204.00, 205.00, 206.00, 207.00, 207.20, 208.00, 238.72, 238.73, 238.74, 238.75 **AND** 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245

Quality Data Code Reporting Options:	
Successful Reporting & Performance: Cytogenetic testing performed on bone marrow at time of diagnosis or prior to initiating treatment	3155F

OR

Successful Reporting & Excluded from Performance: Documentation of medical, patient, or system reason(s) for not performing baseline cytogenetic testing on bone marrow	3155F-1P **OR** 3155F-2P **OR** 3155F-3P

OR

Successful Reporting & Performance Not Met: Baseline cytogenetic testing not performed, reason not specified	3155F-8P

Implementation Guidelines:

- Review clinical data regarding the presence or absence of a baseline cytogenetic test for eligible patients at an encounter occurring during the reporting period (January 1 through December 31, 2008). Select and submit the appropriate CPT Category II code corresponding to the measure.
- Baseline cytogenetic testing refers to testing that is performed at time of diagnosis or prior to initiating treatment (transfusion, growth factors, or antineoplastic therapy) for that diagnosis; do not limit the search for baseline cytogenetic testing to the reporting period to qualify for this measure.
- Each eligible patient seen during the reporting period will be counted once when calculating the eligible professional's reporting rate for this measure. The measure may be reported again at a subsequent visit during the reporting period. If the measure is reported more than once for an eligible patient during the reporting period, the single instance of reporting most advantageous to performance will be used when calculating the eligible professional's performance rate for this measure.
- Failure to report an applicable CPT Category II code in an eligible case will result in both a reporting and performance failure.
- Medical record documentation is required for all clinical actions described in a measure.

Measure #68: Myelodysplastic Syndrome (MDS): Documentation of Iron Stores in Patients Receiving Erythropoietin Therapy

- **Reporting Description:** Percentage of patients aged 18 years and older with MDS and applicable CPT Category II code(s) reported a minimum of once during the reporting period
- **Performance Description:** Percentage of patients aged 18 years and older with a diagnosis of MDS who are receiving erythropoietin therapy with documentation of iron stores prior to initiating erythropoietin therapy

Eligible Cases:

Patient aged ≥ 18 years on date of encounter **AND** Diagnosis of MDS (ICD-9) **AND** Patient encounter during reporting period (CPT)	238.72, 238.73, 238.74, 238.75 **AND** 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245

Quality Data Code Reporting Options:

Successful Reporting & Performance: Documentation of iron stores prior to initiating erythropoietin therapy **AND** Patient receiving erythropoietin therapy	3160F **AND** 4090F

OR

Successful Reporting & Excluded from Performance: Documentation of system reason(s) for not documenting iron stores prior to initiating erythropoietin therapy **AND** Patient receiving erythropoietin therapy **OR** Patient not receiving erythropoietin therapy	3160F-3P **AND** 4090F **OR** 4095F

OR

Successful Reporting & Performance Not Met: Documentation of iron stores prior to initiating erythropoietin therapy not performed, reason not specified **AND** Patient receiving erythropoietin therapy	3160F-8P **AND** 4090F

Implementation Guidelines:

- The correct combination of numerator code(s) must be reported on the claim form in order to properly report this measure. The "correct combination" of codes may require the submission of multiple numerator codes.
- This measure must be reported a minimum of once per reporting period for ALL MDS patients.
- At an encounter occurring during the reporting period (January 1 through December 31, 2008), review clinical data to determine whether the patient was or was not receiving erythropoietin therapy. For patients receiving erythropoietin therapy, documentation of iron stores prior to initiating erythropoietin therapy should be performed. Select and submit the appropriate CPT Category II code(s) corresponding to the measure.
- For the purpose of this measure erythropoietin therapy includes the following medications: epoetin and darbepoetin.
- Documentation of iron stores includes either: Bone marrow examination including iron stain OR Serum iron measurement by ferritin or serum iron and TIBC.
- Documentation of iron stores refers to findings that are recognized prior to initiating erythropoietin treatment; do not limit the search for iron stores to the reporting period to qualify for this measure.
- Each eligible patient seen during the reporting period will be counted once when calculating the eligible professional's reporting rate for this measure. The measure may be reported again at a subsequent visit during the reporting period. If the measure is reported more than once for an eligible patient during the reporting period, the single instance of reporting most advantageous to performance will be used when calculating the eligible professional's performance rate for this measure.
- Failure to report applicable CPT Category II code(s) in an eligible case will result in both a reporting and performance failure.
- Medical record documentation is required for all clinical actions described in a measure.

Measure #46: Medication Reconciliation

- **Reporting Description:** Percentage of patients aged 65 years and older seen by the clinician during the reporting period AND within 60 days of an inpatient discharge and applicable CPT Category II codes reported once for each inpatient discharge
- **Performance Description:** Percentage of patients aged 65 years and older discharged from any inpatient facility (e.g., hospital, skilled nursing facility, or rehabilitation facility) and seen within 60 days following discharge in the office by the physician providing on-going care who had a reconciliation of the discharge medications with the current medication list in the medical record documented

Eligible Cases:	
Patient aged ≥ 65 years on date of encounter **AND** Patient encounter during reporting period (CPT)	99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215

Quality Data Code Reporting Options:	
Successful Reporting & Performance: Discharge medications reconciled with the current medication list in outpatient medical record **AND** Patient discharged from an inpatient facility (e.g. hospital, skilled nursing facility, or rehabilitation facility) within the last 60 days	1111F **AND** 1110F

OR

Successful Reporting & Excluded from Performance: There are no allowable performance exclusions for this measure.	NONE

OR

Successful Reporting & Performance Not Met: Discharge medication not reconciled with current medication list in the medical record, reason not specified **AND** Patient discharged from an inpatient facility (e.g. hospital, skilled nursing facility, or rehabilitation facility) within the last 60 days	1111F-8P **AND** 1110F

Implementation Guidelines:

- The correct combination of numerator code(s) must be reported on the claim form in order to properly report this measure. The "correct combination" of codes may require the submission of multiple numerator codes.
- There is no diagnosis associated with this measure.
- At an encounter occurring during the reporting period (January 1 through December 31, 2008), review clinical data to determine whether the patient was discharged from an inpatient facility (e.g. hospital, skilled nursing facility, or rehabilitation facility) within the last 60 days or the patient was not discharged from an inpatient facility within the last 60 days. For patients who were discharged from an inpatient facility within the last 60 days, discharge medications should be reconciled with the current medication list in outpatient medical record. Select and submit the appropriate CPT Category II code(s) corresponding to the measure.
- This measure is not to be reported unless a patient has been discharged from an inpatient facility within 60 days prior to the outpatient visit.
- The medical record must indicate that the clinician is aware of the inpatient facility discharge medications and will either keep the inpatient facility discharge medications or change the inpatient facility discharge medications or the dosage of an inpatient facility discharge medication.
- Each eligible patient seen during the reporting period and within 60 days of an inpatient discharge will be counted when calculating the reporting and performance rates. Report this measure once following each inpatient discharge. If multiple claims are submitted within 60 days of inpatient discharge, only one instance of reporting will be counted.
- Part B claims will be analyzed to determine the inpatient facility discharge date.
- Failure to report applicable CPT Category II code(s) in an eligible case will result in both a reporting and performance failure.
- Medical record documentation is required for all clinical actions described in a measure.

Measure #130: Universal Documentation and Verification of Current Medications in the Medical Record

- **Reporting Description:** Percentage of patients aged 18 years and older with an applicable G-code reported at each eligible visit during the reporting period
- **Performance Description:** Percentage of patients aged 18 years and older with written provider documentation that current medications with dosages (includes prescription, over-the-counter, herbals, vitamin/mineral/dietary [nutritional] supplements) were verified with the patient or authorized representative

Eligible Cases:	
Patient aged ≥ 18 years on date of encounter **AND** Patient encounter during reporting period (CPT or HCPCS)	00140, 00142, 00170, 00400, 00402, 00810, 00832, 00851, 00910, 00920, 01380, 01382, 01400, 01732, 01810, 01820, 01829, 90801, 90802, 96116, 96150, 96152, 97001, 97002, 97003, 97004, 97802, 97803, G0101, G0108, G0270

Quality Data Code Reporting Options:	
Successful Reporting & Performance: Written provider documentation was obtained confirming that current medications with dosages (includes prescription, over-the-counter, herbals, vitamin/mineral/dietary [nutritional] supplements) were verified with the patient or authorized representative or patient assessed and is not currently on any medications	G8427

OR

Successful Reporting & Excluded from Performance: Documentation that patient is not eligible for medication assessment	G8430

OR

Successful Reporting & Performance Not Met: Current medications with dosages (includes prescription, over-the-counter, herbals, vitamin/mineral/dietary [nutritional] supplements) were documented without documented patient verification **OR** Incomplete or no documentation that patient's current medications with dosages (includes prescription, over-the-counter, herbals, vitamin/mineral/dietary [nutritional] supplements) were assessed	G8428 **OR** G8429

Implementation Guidelines:

- There is no diagnosis associated with this measure.
- This measure may be reported by non-MD/DO clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.
- Review clinical data regarding the presence or absence of medication documentation and patient verification at each encounter occurring during the reporting period (January 1 through December 31, 2008). Select and submit the appropriate G-code corresponding to the measure.
- **Authorized representative** – A person who is acting on the patient's behalf and who does not have a conflict of interest with the patient, when the patient is temporarily or permanently unable to act for himself or herself. This person should have the patient's best interests at heart and should be reasonably expected to act in a manner that is protective of the person and the rights of the patient. Preferably, this individual is appointed by the patient.
- **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
- **Current medications** – All medications (includes prescription, over-the-counter, herbals, vitamin/mineral/dietary [nutritional] supplements) a patient may be taking routinely and/or on a PRN basis
- Each eligible patient visit during the reporting period will be counted once when calculating the eligible professional's reporting rate for this measure.
- Failure to report an applicable G-code in an eligible case will result in both a reporting and performance failure.
- Medical record documentation is required for all clinical actions described in a measure.

Measure #133: Screening for Cognitive Impairment

- **Reporting Description:** Percentage of patients aged 65 years and older with an applicable G-code reported a minimum of once during the reporting period
- **Performance Description:** Percentage of patients aged 65 years and older who have documentation of results of a screening for cognitive impairment using a standardized tool

Eligible Cases:	
Patient aged ≥ 65 years on date of encounter **AND** Patient encounter during reporting period (CPT)	90801, 90802, 96150, 97003

Quality Data Code Reporting Options:	
Successful Reporting & Performance: Documentation of cognitive impairment screening using a standardized tool	G8434

OR

Successful Reporting & Excluded from Performance: Patient not eligible/not appropriate for cognitive impairment screening	G8436

OR

Successful Reporting & Performance Not Met: No documentation of cognitive impairment screening using a standardized tool	G8435

Implementation Guidelines:

- There is no diagnosis associated with this measure.
- This measure may be reported by non-MD/DO clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.
- Review clinical data regarding the presence or absence of cognitive impairment screening during the reporting period (January 1 through December 31, 2008). Select and submit the appropriate G-code corresponding to the measure.
- **Screening –** Testing done on people at risk of developing a certain disease, even if they have no symptoms. Screening tests can predict the likelihood of someone having or developing a particular disease. This measure looks for the test being done in the practitioner's office that is filing the code.
- **Standardized tool –** An assessment tool that has been appropriately normalized and validated for the population in which it is used. Some examples of cognitive impairment screening tools include: Clinical Dementia Rating Scale, Mini Mental Status Examination (MMSE), Global Deterioration Scale, Short Portable Mental Status Questionnaire, Clock Drawing Test, Modified MMSE, Mini-Cog, Hopkins Verbal Learning Test, and 7-Minute Screen.
- **Cognitive impairment –** Impairment of mental activities associated with thinking, learning, and memory.
- **Not eligible/not appropriate –** A patient is not eligible/not appropriate if one or more of the following conditions exist:
  - Patient refuses to participate
  - Patient is in an urgent or emergent situation where time is of the essence and to delay treatment would jeopardize the patient's health status
  - Patient was referred with a diagnosis of cognitive impairment
  - Patient has been participating in ongoing treatment with screening of cognitive impairment in a preceding reporting period
  - Patient is not appropriate for cognitive impairment screening due to physical capacity
- Each eligible patient seen during the reporting period will be counted once when calculating the eligible professional's reporting rate for this measure. The measure may be reported again at a subsequent visit during the reporting period. If the measure is reported more than once for an eligible patient during the reporting period, the single instance of reporting most advantageous to performance will be used when calculating the eligible professional's performance rate for this measure.
- Failure to report an applicable G-code in an eligible case will result in both a reporting and performance failure.
- Medical record documentation is required for all clinical actions described in a measure.

Measure #134: Screening for Clinical Depression

- **Reporting Description:** Percentage of patients aged 18 years and older with an applicable G-code reported a minimum of once during the reporting period
- **Performance Description:** Percentage of patients aged 18 years and older screened for clinical depression using a standardized tool

Eligible Cases:	
Patient aged ≥ 18 years on date of encounter **AND** Patient encounter during reporting period (CPT)	90801, 90802, 90804, 90805, 90806, 90807, 90808, 90809, 97003

Quality Data Code Reporting Options:	
Successful Reporting & Performance: Documentation of clinical depression screening using a standardized tool	G8431

OR

Successful Reporting & Excluded from Performance: Patient not eligible/not appropriate for clinical depression screening	G8433

OR

Successful Reporting & Performance Not Met: No documentation of clinical depression screening using a standardized tool	G8432

Implementation Guidelines:

- There is no diagnosis associated with this measure.
- This measure may be reported by non-MD/DO clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.
- Review clinical data regarding the presence or absence of clinical depression screening during the reporting period (January 1 through December 31, 2008). Select and submit the appropriate G-code corresponding to the measure.
- **Screening –** Testing done on people at risk of developing a certain disease, even if they have no symptoms. Screening tests can predict the likelihood of someone having or developing a particular disease.
- **Standardized tool –** An assessment tool that has been appropriately normalized and validated for the population in which it is used. Some examples of depression screening tools include: Patient Health Questionnaire (PHQ9), Beck Depression Inventory (BDI or BDI-II), Center for Epidemiologic Studies Depression Scale (CES-D), Depression Scale (DEPS), Duke Anxiety-Depression Scale (DADS), Geriatric Depression Scale (GDS), GDS - Short Version, Hopkins Symptom Checklist (HSCL), The Zung Self-Rating Depression Scale (SDS), and Cornell Scale Screening (this is a screening tool which is used in situations where the patient has cognitive impairment and is administered through the caregiver).
- **Not eligible/not appropriate –** A patient is not eligible/not appropriate if one or more of the following conditions exist:
  - Patient refuses to participate
  - Patient is in an urgent or emergent situation where time is of the essence and to delay treatment would jeopardize the patient's health status
  - Situations where the patient's motivation to improve may impact the accuracy of results of nationally recognized standardized depression assessment tools. For example: certain court appointed cases
  - Patient has been participating in ongoing treatment with screening of cognitive impairment in a preceding reporting period
  - Patient was referred with a diagnosis of depression
  - Patient has been participating in ongoing treatment with screening of clinical depression in a preceding reporting period
  - Severe mental and/or physical incapacity where the person is unable to express himself/herself in a manner understood by others. For example: cases such as delirium or severe cognitive impairment, where depression cannot be accurately assessed through use of nationally recognized standardized depression assessment tools
- Each eligible patient seen during the reporting period will be counted once when calculating the eligible professional's reporting rate for this measure. The measure may be reported again at a subsequent visit during the reporting period. If the measure is reported more than once for an eligible patient during the reporting period, the single instance of reporting most advantageous to performance will be used when calculating the eligible professional's performance rate for this measure.
- Failure to report an applicable G-code in an eligible case will result in both a reporting and performance failure.
- Medical record documentation is required for all clinical actions described in a measure.

Measure #69: Multiple Myeloma: Treatment with Bisphosphonates

- **Reporting Description:** Percentage of patients aged 18 years and older with multiple myeloma and an applicable CPT Category II code reported a minimum of once during the reporting period
- **Performance Description:** Percentage of patients aged 18 years and older with a diagnosis of multiple myeloma, not in remission, who were prescribed or received intravenous bisphosphonate therapy within the 12-month reporting period

Eligible Cases:

Patient aged ≥ 18 years on date of encounter **AND** Diagnosis of multiple myeloma (ICD-9) **AND** Patient encounter during reporting period (CPT)	203.00 **AND** 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245

Quality Data Code Reporting Options:

Successful Reporting & Performance: Bisphosphonate therapy, intravenous, ordered or received	4100F

OR

Successful Reporting & Excluded from Performance: Documentation of medical or patient reason(s) for not prescribing bisphosphonates	4100F-1P **OR** 4100F-2P

OR

Successful Reporting & Performance Not Met: Intravenous bisphosphonate therapy not prescribed, reason not specified	4100F-8P

Implementation Guidelines:

- Review clinical data regarding the presence or absence of an order for or receipt of bisphosphonate therapy at an encounter occurring during the reporting period (January 1 through December 31, 2008). Select and submit the appropriate CPT Category II code corresponding to the measure.
- For the purpose of this measure bisphosphonate therapy includes the following medications: pamidronate and zoledronate.
- Each eligible patient seen during the reporting period will be counted once when calculating the eligible professional's reporting rate for this measure. The measure may be reported again at a subsequent visit during the reporting period. If the measure is reported more than once for an eligible patient during the reporting period, the single instance of reporting most advantageous to performance will be used when calculating the eligible professional's performance rate for this measure.
- Failure to report an applicable CPT Category II code in an eligible case will result in both a reporting and performance failure.
- Medical record documentation is required for all clinical actions described in a measure.

Measure #28: Aspirin at Arrival for Acute Myocardial Infarction (AMI)

- **Reporting Description:** Percentage of patients, regardless of age, with an emergency department discharge diagnosis of AMI and an applicable CPT Category II code reported at each discharge during the reporting period
- **Performance Description:** Percentage of patients, regardless of age, with an emergency department discharge diagnosis of AMI who had documentation of receiving aspirin within 24 hours before emergency department arrival or during emergency department stay

Eligible Cases:

Patients of ALL ages **AND** Place of Service (POS) = Emergency Dept (23) **AND** Emergency department discharge diagnosis of AMI (ICD-9) **AND** Patient encounter during reporting period (CPT)	23 **AND** 410.01, 410.11, 410.21, 410.31, 410.41, 410.51, 410.61, 410.71, 410.81, 410.91 **AND** 99281, 99282, 99283, 99284, 99285, 99291

Quality Data Code Reporting Options:

Successful Reporting & Performance: Aspirin received within 24 hours before emergency department arrival or during emergency department stay	4084F

OR

Successful Reporting & Excluded from Performance: Documentation of medical or patient reason(s) for not receiving or taking aspirin within 24 hours before emergency department arrival or during emergency department stay	4084F-1P **OR** 4084F-2P

OR

Successful Reporting & Performance Not Met: Aspirin not received or taken 24 hours before emergency department arrival or during emergency department stay, reason not specified	4084F-8P

Implementation Guidelines:

- Review clinical data regarding the presence or absence of an AMI as the emergency department discharge diagnosis and aspirin administration occurring during the reporting period (January 1 through December 31, 2008). Select and submit the appropriate CPT Category II code corresponding to the measure.
- Each emergency department discharge diagnosis of AMI occurring during the reporting period will be counted when calculating the reporting and performance rates.
- The Part B claim form place-of-service (POS) field must indicate that the encounter has taken place in the emergency department (POS 23 = ED).
- Failure to report an applicable CPT Category II code in an eligible case will result in both a reporting and performance failure.
- Medical record documentation is required for all clinical actions described in a measure.

Measure #128: Universal Weight Screening and Follow-up

- **Reporting Description:** Percentage of patients aged 65 years and older with an applicable G-code reported a minimum of once during the reporting period
- **Performance Description:** Percentage of patients aged 65 years and older with a calculated Body Mass Index (BMI) within the past six months or during the current visit that is documented in the medical record and if the most recent BMI is ≥ 30 or < 22, a follow-up plan is documented

Eligible Cases:	
Patient aged ≥ 65 years on date of encounter **AND** Patient encounter during reporting period (CPT or HCPCS)	00140, 00142, 00170, 00400, 00402, 00810, 00832, 00851, 00910, 00920, 01380, 01382, 01400, 01732, 01810, 01820, 01829, 90801, 90802, 90804, 90805, 90806, 90807, 90808, 90809, 92002, 92004, 92012, 92014, 97001, 97003, 97802, 97803, 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, D7140, D7210, G0101, G0108, G0270

Quality Data Code Reporting Options:	
Successful Reporting & Performance: BMI < 30 AND ≥ 22 was calculated and documented **OR** BMI ≥ 30 was calculated and a follow-up plan was documented in the medical record **OR** BMI < 22 was calculated and a follow-up plan was documented in the medical record	G8420 **OR** G8417 **OR** G8418

OR

Successful Reporting & Excluded from Performance: Patient not eligible for BMI calculation	G8422

OR

Successful Reporting & Performance Not Met: BMI not calculated **OR** BMI ≥ 30 OR < 22 was calculated, but no follow-up plan documented in the medical record	G8421 **OR** G8419

Implementation Guidelines:

- There is no diagnosis associated with this measure. This measure must be reported a minimum of once for all patients aged 65 years and older seen during the reporting period (January 1 through December 31, 2008).
- Review clinical data regarding the presence or absence of BMI calculation at an encounter occurring during the reporting period. Select and submit the appropriate G-code corresponding to the measure.
- BMI measured and documented in the medical record can be reported if done in the provider's office/facility or if BMI calculation within the past six months is documented in outside medical records obtained by the provider. The documentation of a follow-up plan should be based on the most recently calculated BMI.
- **BMI –** Body Mass Index (BMI) is a number calculated from a person's weight and height. BMI provides a reliable indicator of body fatness for most people and is used to screen for weight categories that may lead to health problems. BMI is calculated by dividing a person's weight (in kilograms) by his/her height (in meters, squared). BMI can also be calculated by multiplying weight (in pounds) by 705, then dividing by height (in inches) twice. A simpler method to calculate the BMI involves the use of a chart. The weight is plotted on one axis and the height is plotted on the other axis. The BMI can then be read where the two points intersect.
- **Calculated BMI –** Requires that both the height and weight are actually measured. Values merely reported by the patient cannot be used.
- **Follow-up plan –** Proposed outline of treatment to be conducted as a result of abnormal BMI measurement. Such follow-up can include documentation of a future appointment, education, referral, prescription/administration of medications/dietary supplements, etc.
- **Not eligible for BMI measurement –** Patients can be considered not eligible in the following situations:
  - If the patient already is diagnosed as over or under weight and there is documentation in the medical record that the weight problem is being managed by another provider
  - If the patient has a terminal illness
  - If the patient refuses BMI measurement
  - If there is any other reason documented in the medical record by the provider explaining why BMI measurement was not appropriate
  - 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
- Each eligible patient seen during the reporting period will be counted once when calculating the eligible professional's reporting rate for this measure. The measure may be reported again at a subsequent visit during the reporting period. The most recent quality-data code submitted will be used for performance calculations.
- Failure to report an applicable G-code in an eligible case will result in both a reporting and performance failure.
- Medical record documentation is required for all clinical actions described in a measure.

Measure #24: Osteoporosis: Communication with the Physician Managing Ongoing Care Post - Fracture

- **Reporting Description:** Percentage of patients aged 50 years and older treated for a hip, spine or distal radial fracture and applicable CPT II Category code reported after each occurrence of fracture during the reporting period
- **Performance Description:** Percentage of patients aged 50 years and older treated for a hip, spine or distal radial fracture with documentation of communication with the physician managing the patient's ongoing care that a fracture occurred and that the patient was or should be tested or treated for osteoporosis

Eligible Cases:

Patient aged ≥ 50 years on date of encounter	733.12, 733.13, 733.14, 805.00, 805.01, 805.02, 805.03, 805.04, 805.05, 805.06, 805.07, 805.08, 805.10, 805.11, 805.12, 805.13, 805.14, 805.15, 805.16, 805.17, 805.18, 805.2, 805.4, 805.6, 805.8, 813.40, 813.41, 813.42, 813.44, 813.45, 813.50, 813.51, 813.52, 813.54, 820.00, 820.01, 820.02, 820.03, 820.09, 820.10, 820.11, 820.13, 820.20, 820.21, 820.22, 820.8, 820.9
AND	
Diagnosis of fracture (ICD-9)	**AND**
AND	99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245
Patient encounter during reporting period (CPT)	**OR**
OR	22305, 22310, 22315, 22318, 22319, 22325, 22326, 22327, 22520, 22521, 22523, 22524, 25600, 25605, 25606, 25607, 25608, 25609, 27230, 27232, 27235, 27236, 27238, 27240, 27244, 27245, 27246, 27248
Procedure performed during the reporting period (CPT)	

Quality Data Code Reporting Options:

Successful Reporting & Performance: Documentation of communication that a fracture occurred and that the patient was or should be tested or treated for osteoporosis	5015F

OR

Successful Reporting & Excluded from Performance: Documentation of medical or patient reason(s) for not communicating with physician managing ongoing care of patient that a fracture occurred and that the patient was or should be tested or treated for osteoporosis)	5015F-1P **OR** 5015F-2P

OR

Successful Reporting & Performance Not Met: Post-fracture care not communicated, reason not specified	5015F-8P

Implementation Guidelines:

- Review clinical data regarding the presence or absence of communicating that a fracture (hip, spine or distal radius) occurred and that the patient was or should be tested or treated for osteoporosis during the reporting period (January 1 through December 31, 2008). Select and submit the appropriate CPT Category II code corresponding to the measure.
- This measure should be reported at one of the following two instances if management following fracture has occurred or is planned within 3 months of fracture.
  1) During an office visit with ICD-9 diagnosis code for fracture of hip, spine or distal radius OR
  2) At the time of a procedure to repair a fracture
- Prior DXA status or already on pharmacologic therapy pre-fracture meets this measure.
- Communication may include: Documentation in the medical record indicating that the clinician treating the fracture communicated (e.g., verbally, by letter, DXA report was sent) with the clinician managing the patient's on-going care OR a copy of a letter in the medical record outlining whether the patient was or should be treated for osteoporosis.
- Each occurrence of fracture during the reporting period will be counted when calculating the reporting and performance rates. Multiple fractures and/or procedures occurring on the same date of service and submitted on the same claim will be counted as one occurrence of fracture.
- Failure to report an applicable CPT Category II code in an eligible case will result in both a reporting and performance failure.
- Medical record documentation is required for all clinical actions described in a measure.

Measure #39: Screening or Therapy for Osteoporosis for Women Aged 65 Years and Older

- **Reporting Description:** Percentage of female patients aged 65 years and older seen by the clinician and an applicable G-code reported a minimum of once during the reporting period
- **Performance Description:** Percentage of female patients aged 65 years and older who have a central dual-energy X-ray absorptiometry (DXA) measurement ordered or performed at least once since age 60 or pharmacologic therapy prescribed within 12 months

Eligible Cases:	
Female patient aged ≥ 65 years on date of encounter **AND** Patient encounter during reporting period (CPT)	99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215

Quality Data Code Reporting Options:	
Successful Reporting & Performance: Patient with central Dual-energy X-Ray Absorptiometry (DXA) results documented or ordered or pharmacologic therapy (other than minerals/vitamins) for osteoporosis prescribed	G8399

OR

Successful Reporting & Excluded from Performance: Clinician documented that patient was not an eligible candidate for screening or therapy for osteoporosis for women measure	G8401

OR

Successful Reporting & Performance Not Met: Patient with central Dual-energy X-Ray Absorptiometry (DXA) results not documented or not ordered or pharmacologic therapy (other than minerals/vitamins) for osteoporosis not prescribed	G8400

Implementation Guidelines:

- There is no diagnosis associated with this measure. The measure must be reported a minimum of once for all female patients aged 65 years and older seen during the reporting period (January 1 through December 31, 2008).
- Review clinical data (within the last 12 months of this encounter) regarding the presence or absence of a central DXA measurement or pharmacologic therapy prescribed at an encounter occurring during the reporting period. Select and submit the appropriate G-code corresponding to the measure.
- Pharmacologic Therapy: U.S. Food and Drug Administration approved pharmacologic options for osteoporosis prevention and/or treatment of postmenopausal osteoporosis include, in alphabetical order: bisphosphonates (alendronate, ibandronate, and risedronate), calcitonin, estrogens (estrogens and/or hormone therapy), parathyroid hormone [PTH (1-34), teriparatide], and selective estrogen receptor modules or SERMs (raloxifene).
- "Prescribed" includes patients who are currently receiving medication(s) that follow the treatment plan recommended at an encounter during the reporting period, even if the prescription for that medication was ordered prior to the encounter.
- Each eligible patient seen during the reporting period will be counted once when calculating the eligible professional's reporting rate for this measure. The measure may be reported again at a subsequent visit during the reporting period. If the measure is reported more than once for an eligible patient during the reporting period, the single instance of reporting most advantageous to performance will be used when calculating the eligible professional's performance rate for this measure.
- Failure to report an applicable G-code in an eligible case will result in both a reporting and performance failure.
- Medical record documentation is required for all clinical actions described in a measure.

Measure #40: Osteoporosis: Management Following Fracture

- **Reporting Description:** Percentage of patients aged 50 years and older with fracture of the hip, spine or distal radius and an applicable CPT Category II code reported after each occurrence of fracture during the reporting period
- **Performance Description:** Percentage of patients aged 50 years and older with fracture of the hip, spine or distal radius who had a central dual-energy X-ray absorptiometry (DXA) measurement ordered or performed or pharmacologic therapy prescribed

Eligible Cases:

Patient aged ≥ 50 years on date of encounter **AND** Diagnosis of fracture (ICD-9)	733.12, 733.13, 733.14, 805.00, 805.01, 805.02, 805.03, 805.04, 805.05, 805.06, 805.07, 805.08, 805.10, 805.11, 805.12, 805.13, 805.14, 805.15, 805.16, 805.17, 805.18, 805.2, 805.4, 805.6, 805.8, 813.40, 813.41, 813.42, 813.44, 813.45, 813.50, 813.51, 813.52, 813.54, 820.00, 820.01, 820.02, 820.03, 820.09, 820.10, 820.11, 820.13, 820.20, 820.21, 820.22, 820.8, 820.9
AND Patient encounter during reporting period (CPT)	**AND** 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245
OR Procedure performed during the reporting period (CPT)	**OR** 22305, 22310, 22315, 22318, 22319, 22325, 22326, 22327, 22520, 22521, 22523, 22524, 25600, 25605, 25606, 25607, 25608, 25609, 27230, 27232, 27235, 27236, 27238, 27240, 27244, 27245, 27246, 27248

Reporting Options:

Successful Reporting & Performance: Central Dual-energy X-Ray Absorptiometry (DXA) ordered **OR** Central Dual-energy X-Ray Absorptiometry (DXA) results documented **OR** Pharmacologic therapy (other than minerals/vitamins) for osteoporosis prescribed	3096F **OR** 3095F **OR** 40005F

OR

Successful Reporting & Excluded from Performance: Documentation of medical, patient, or system reason(s) for not ordering or performing a central dual energy X-ray absorptiometry (DXA) measurement or not prescribing pharmacologic therapy for osteoporosis	3096F-1P **OR** 3095F-1P **OR** 4005F-1P **OR** 3096F-2P **OR** 3095F-2P **OR** 4005F-2P **OR** 3096F-3P **OR** 3095F-3P **OR** 4005F-3P

OR

Successful Reporting & Performance Not Met: Central DXA measurement not ordered or performed or pharmacologic therapy not prescribed, reason not specified	3096F-8P **OR** 3095F-8P **OR** 4005F-8P

Implementation Guidelines:

- Review clinical data regarding the presence or absence of the central DXA measurement or pharmacologic therapy at an encounter occurring during the reporting period (January 1 through December 31, 2008). Select and submit the appropriate CPT Category II code corresponding to the measure.
- This measure should be reported at one of the following two instances if management following fracture has occurred or is planned within 3 months of fracture.
  1) During an office visit with ICD-9 diagnosis code for fracture of hip, spine or distal radius OR
  2) At the time of a procedure to repair a fracture
- Pharmacologic Therapy: U.S. Food and Drug Administration approved pharmacologic options for osteoporosis prevention and/or treatment of postmenopausal osteoporosis include, in alphabetical order: bisphosphonates (alendronate, ibandronate, and risedronate), calcitonin, estrogens (estrogens and/or hormone therapy), parathyroid hormone [PTH (1-34), teriparatide], and selective estrogen receptor modules or SERMs (raloxifene).
- "Prescribed" includes patients who are currently receiving medication(s) that follow the treatment plan recommended at an encounter during the reporting period, even if the prescription for that medication was ordered prior to the encounter.
- Patients with documentation of prior central DXA measurement or already receiving pharmacologic therapy before the occurrence of the fracture would qualify to successfully report of this measure.
- Modifiers may be appended to any of the CPT Category II codes for medical reasons, patient reasons, system reasons, or reasons not otherwise specified.
- Each occurrence of fracture in an eligible patient occurring during the reporting period will be counted when calculating the reporting and performance rates. Multiple fractures and/or procedures occurring on the same date of service and submitted on the same claim will be counted as one occurrence of fracture.
- Failure to report an applicable CPT Category II code in an eligible case will result in both a reporting and performance failure.
- Medical record documentation is required for all clinical actions described in a measure.

Measure #41: Osteoporosis: Pharmacologic Therapy

- **Reporting Description:** Percentage of patients aged 50 years and older with osteoporosis and an applicable CPT Category II code reported a minimum of once during the reporting period
- **Performance Description:** Percentage of patients aged 50 years and older with a diagnosis of osteoporosis who were prescribed pharmacologic therapy within 12 months

Eligible Cases:	
Patient aged ≥ 50 years on date of encounter **AND** Diagnosis of osteoporosis (ICD-9) **AND** Patient encounter during reporting period (CPT)	733.00, 733.01, 733.02, 733.03, 733.09 **AND** 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245

Quality Data Code Reporting Options:	
Successful Reporting & Performance: Pharmacologic therapy (other than minerals/vitamins) for osteoporosis prescribed	4005F

OR

Successful Reporting & Excluded from Performance: Documentation of medical, patient, or system reason(s) for not prescribing pharmacologic therapy for osteoporosis	4005F-1P **OR** 4005F-2P **OR** 4005F-3P

OR

Successful Reporting & Performance Not Met: Pharmacologic therapy not prescribed, reason not specified	4005F-8P

Implementation Guidelines:

- Review clinical data (within the last 12 months of this encounter) regarding the presence or absence of pharmacologic therapy at an encounter occurring during the reporting period (January 1 through December 31, 2008). Select and submit the appropriate CPT Category II code corresponding to the measure.
- Pharmacologic Therapy: U.S. Food and Drug Administration approved pharmacologic options for osteoporosis prevention and/or treatment of postmenopausal osteoporosis include, in alphabetical order: bisphosphonates (alendronate, ibandronate, and risedronate), calcitonin, estrogens (estrogens and/or hormone therapy), parathyroid hormone [PTH (1-34), teriparatide], and selective estrogen receptor modules or SERMs (raloxifene).
- "Prescribed" includes patients who are currently receiving medication(s) that follow the treatment plan recommended at an encounter during the reporting period, even if the prescription for that medication was ordered prior to the encounter.
- Each eligible patient seen during the reporting period will be counted once when calculating the eligible professional's reporting rate for this measure. The measure may be reported again at a subsequent visit during the reporting period. If the measure is reported more than once for an eligible patient during the reporting period, the single instance of reporting most advantageous to performance will be used when calculating the eligible professional's performance rate for this measure.
- Failure to report an applicable CPT Category II codes in an eligible case will result in both a reporting and performance failure.
- Medical record documentation is required for all clinical actions described in a measure.

Measure #91: Acute Otitis Externa (AOE): Topical Therapy

- **Reporting Description:** Percentage of patients aged 2 years and older with AOE and an applicable CPT Category II code reported once for each episode of AOE during the reporting period
- **Performance Description:** Percentage of patients aged 2 years and older with a diagnosis of AOE who were prescribed topical preparations

Eligible Cases:	
Patient aged ≥ 2 years on date of encounter **AND** Diagnosis of AOE (ICD-9) **AND** Patient encounter during reporting period (CPT)	380.10, 380.11, 380.12, 380.13, 380.22 **AND** 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245

Quality Data Code Reporting Options:	
Successful Reporting & Performance: Topical preparations (including OTC) prescribed for acute otitis externa	4130F

OR

Successful Reporting & Excluded from Performance: Documentation of medical or patient reason(s) for not prescribing topical preparations (including OTC) for acute otitis externa	4130F-1P **OR** 4130F-2P

OR

Successful Reporting & Performance Not Met: Topical preparations (including OTC) for acute otitis externa (AOE) not prescribed, reason not specified	4130F-8P

Implementation Guidelines:

- Review clinical data to determine the presence or absence of a current prescription for topical preparations at an encounter occurring during the reporting period (January 1 through December 31, 2008). Select and submit the appropriate CPT Category II code corresponding to the measure.
- Each episode of AOE in an eligible patient occurring during the reporting period will be counted when calculating the reporting and performance rates.
- Each unique episode is defined as a 30-day period from onset of AOE.
- Claims data will be analyzed to determine unique episodes. If multiple claims are submitted within that 30-day period, only one instance of reporting will be counted.
- Failure to report an applicable CPT Category II code in an eligible case will result in both a reporting and performance failure.
- Medical record documentation is required for all clinical actions described in a measure.

Measure #92: Acute Otitis Externa (AOE): Pain Assessment

- **Reporting Description:** Percentage of patient visits for those patients aged 2 years and older with AOE and an applicable CPT Category II code reported at each visit during the reporting period
- **Performance Description:** Percentage of patient visits for those patients aged 2 years and older with a diagnosis of AOE with assessment for auricular or periauricular pain

Eligible Cases:	
Patient aged ≥ 2 years on date of encounter **AND** Diagnosis of AOE (ICD-9) **AND** Patient encounter during reporting period (CPT)	380.10, 380.11, 380.12, 380.13, 380.22 **AND** 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245

Quality Data Code Reporting Options:	
Successful Reporting & Performance: Auricular or periauricular pain assessed	1116F

OR

Successful Reporting & Excluded from Performance: Documentation of medical reason(s) for not assessing auricular or periauricular pain	1116F-1P

OR

Successful Reporting & Performance Not Met: Auricular or periauricular pain not assessed, reason not specified	1116F-8P

Implementation Guidelines:

- Review clinical data regarding the assessment for auricular or periauricular pain at an encounter occurring during the reporting period (January 1 through December 31, 2008). Select and submit the appropriate CPT Category II code corresponding to the measure.
- Each visit for an eligible patient with AOE occurring during the reporting period will be counted when calculating the reporting and performance rates.
- Failure to report an applicable CPT Category II code in an eligible case will result in both a reporting and performance failure.
- Medical record documentation is required for all clinical actions described in a measure.

Measure #93: Acute Otitis Externa (AOE): Systemic Antimicrobial Therapy – Avoidance of Inappropriate Use

- **Reporting Description:** Percentage of patients aged 2 years and older with AOE and an applicable CPT Category II code reported once for each episode of AOE during the reporting period
- **Performance Description:** Percentage of patients aged 2 years and older with a diagnosis of AOE who were not prescribed systemic antimicrobial therapy

Eligible Cases:	
Patient aged ≥ 2 years on date of encounter **AND** Diagnosis of AOE (ICD-9) **AND** Patient encounter during reporting period (CPT)	380.10, 380.11, 380.12, 380.13, 380.22 **AND** 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245

Quality Data Code Reporting Options:	
Successful Reporting & Performance: Systemic antimicrobial therapy not prescribed	4132F

OR

Successful Reporting & Excluded from Performance: Documentation of medical reason(s) for prescribing systemic antimicrobial therapy	4131F-1P

OR

Successful Reporting & Performance Not Met: Systemic antimicrobial therapy prescribed (Reason not specified)	4131F

Implementation Guidelines:

- Review clinical data to determine the presence or absence of a current prescription for systemic antimicrobial therapy at an encounter occurring during the reporting period (January 1 through December 31, 2008). Select and submit the appropriate CPT Category II code corresponding to the measure.
- Each episode of AOE in an eligible patient occurring during the reporting period will be counted when calculating the reporting and performance rates.
- Each unique episode is defined as a 30-day period from onset of AOE.
- Claims data will be analyzed to determine unique episodes. If multiple claims are submitted within that 30-day period, only one instance of reporting will be counted.
- For performance, the measure will be calculated as the number of patients for whom systemic antimicrobial therapy was not prescribed over the number of patients in the denominator (patients aged 2 years and older with acute otitis externa). A higher score indicates appropriate treatment of patients with AOE (e.g., the proportion for whom systemic antimicrobials *were not* prescribed).
- Failure to report an applicable CPT Category II code in an eligible case will result in both a reporting and performance failure.
- Medical record documentation is required for all clinical actions described in a measure.

Measure #94: Otitis Media with Effusion (OME): Diagnostic Evaluation – Assessment of Tympanic Membrane Mobility

- **Reporting Description:** Percentage of patient visits for those patients aged 2 months through 12 years with OME and an applicable CPT Category II code reported at each visit during the reporting period
- **Performance Description:** Percentage of patient visits for those patients aged 2 months through 12 years with a diagnosis of OME with assessment of tympanic membrane mobility with pneumatic otoscopy or tympanometry

Eligible Cases:	
Patient aged ≥ 2 months and ≤ 12 years on date of encounter **AND** Diagnosis of OME (ICD-9) **AND** Patient encounter during reporting period (CPT)	381.10, 381.19, 381.20, 381.29, 381.3, 381.4 **AND** 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245

Quality Data Code Reporting Options:	
Successful Reporting & Performance: Tympanic membrane mobility assessed with pneumatic otoscopy or tympanometry	2035F

OR

Successful Reporting & Excluded from Performance: Documentation of medical or patient reason(s) for not assessing tympanic membrane mobility with pneumatic otoscopy or tympanometry	2035F-1P **OR** 2035F-2P

OR

Successful Reporting & Performance Not Met: Tympanic membrane mobility not assessed, reason not specified	2035F-8P

Implementation Guidelines:

- Review clinical data regarding the assessment of tympanic membrane mobility with pneumatic otoscopy or tympanometry at an encounter occurring during the reporting period (January 1 through December 31, 2008). Select and submit the appropriate CPT Category II code corresponding to the measure.
- Each visit for an eligible patient with OME occurring during the reporting period will be counted when calculating the reporting and performance rates.
- Failure to report an applicable CPT Category II code in an eligible case will result in both a reporting and performance failure.
- Medical record documentation is required for all clinical actions described in a measure.

Measure #95: Otitis Media with Effusion (OME): Hearing Testing

- **Reporting Description:** Percentage of patients aged 2 months through 12 years with OME who received tympanostomy tube insertion and an applicable CPT Category II code reported for each tympanostomy tube insertion procedure performed during the reporting period
- **Performance Description:** Percentage of patients aged 2 months through 12 years with a diagnosis of OME who received tympanostomy tube insertion who had a hearing test performed within 6 months prior to tympanostomy tube insertion

Eligible Cases:

Patient aged ≥ 2 months and ≤ 12 years on date of encounter **AND** Diagnosis of OME (ICD-9) **AND** Tympanostomy tube insertion procedure performed during the reporting period (CPT)	381.10, 381.19, 381.20, 381.29, 381.3, 381.4 **AND** 69433, 69436

Quality Data Code Reporting Options:

Successful Reporting & Performance: Documentation that hearing test was performed within 6 months prior to tympanostomy tube insertion	3230F

OR

Successful Reporting & Excluded from Performance: Documentation of medical or system reason(s) for not performing hearing test within 6 months prior to tympanostomy tube insertion	3230F-1P **OR** 3230F-3P

OR

Successful Reporting & Performance Not Met: Hearing test not performed within 6 months prior to tympanostomy tube insertion, reason not specified	3230F-8P

Implementation Guidelines:

- Review clinical data to determine whether a hearing test was performed within 6 months prior to each tympanostomy tube insertion procedure occurring during the reporting period (January 1 through December 31, 2008). Select and submit the appropriate CPT Category II code corresponding to the measure.
- Each tympanostomy tube insertion performed on an OME patient during the reporting period will be counted when calculating the reporting and performance rates.
- Failure to report an applicable CPT Category II code in an eligible case will result in both a reporting and performance failure.
- Medical record documentation is required for all clinical actions described in a measure.

Measure #96: Otitis Media with Effusion (OME): Antihistamines or Decongestants – Avoidance of Inappropriate Use

- **Reporting Description:** Percentage of patients aged 2 months through 12 years with OME and an applicable CPT Category II code reported once for each episode of OME during the reporting period
- **Performance Description:** Percentage of patients aged 2 months through 12 years with a diagnosis of OME who were not prescribed/recommended either antihistamines or decongestants

Eligible Cases:	
Patient aged ≥ 2 months and ≤ 12 years on date of encounter **AND** Diagnosis of OME (ICD-9) **AND** Patient encounter during reporting period (CPT)	381.10, 381.19, 381.20, 381.29, 381.3, 381.4 **AND** 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245

Quality Data Code Reporting Options:	
Successful Reporting & Performance: Antihistamines or decongestants neither prescribed nor recommended	4134F

OR

Successful Reporting & Excluded from Performance: Documentation of medical reason(s) for prescribing or recommending antihistamines or decongestants	4133F-1P

OR

Successful Reporting & Performance Not Met: Antihistamines or decongestants prescribed or recommended (Reason not specified)	4133F

Implementation Guidelines:

- Review clinical data to determine the presence or absence of a current prescription or recommendation for either antihistamines or decongestants at an encounter occurring during the reporting period (January 1 through December 31, 2008). Select and submit the appropriate CPT Category II code corresponding to the measure.
- Each episode of OME in an eligible patient occurring during the reporting period will be counted when calculating the reporting and performance rates.
- Each unique episode is defined as a 90-day period from onset of OME.
- Claims data will be analyzed to determine unique episodes. If multiple claims are submitted within that 90-day period, only one instance of reporting will be counted.
- For performance, the measure will be calculated as the number of patients for whom antihistamines or decongestants were neither prescribed nor recommended over the number of patients in the denominator (patients aged 2 months through 12 years with a diagnosis of OME). A higher score indicates appropriate treatment of patients with OME (e.g., the proportion for whom antihistamines or decongestants *were neither* prescribed *nor* recommended).
- Failure to report an applicable CPT Category II code in an eligible case will result in both a reporting and performance failure.
- Medical record documentation is required for all clinical actions described in a measure.

Measure #97: Otitis Media with Effusion (OME): Systemic Antimicrobials – Avoidance of Inappropriate Use

- **Reporting Description:** Percentage of patients aged 2 months through 12 years with OME and an applicable CPT Category II code reported once for each episode of OME during the reporting period
- **Performance Description:** Percentage of patients aged 2 months through 12 years with a diagnosis of OME who were not prescribed systemic antimicrobials

Eligible Cases:	
Patient aged ≥ 2 months and ≤ 12 years on date of encounter **AND** Diagnosis of OME (ICD-9) **AND** Patient encounter during reporting period (CPT)	381.10, 381.19, 381.20, 381.29, 381.3, 381.4 **AND** 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245

Quality Data Code Reporting Options:	
Successful Reporting & Performance: Systemic antimicrobial therapy not prescribed	4132F

OR

Successful Reporting & Excluded from Performance: Documentation of medical reason(s) for prescribing systemic antimicrobial therapy	4131F-1P

OR

Successful Reporting & Performance Not Met: Systemic antimicrobial therapy prescribed (Reason not specified)	4131F

Implementation Guidelines:

- Review clinical data to determine the presence or absence of a current prescription for systemic antimicrobials at an encounter occurring during the reporting period (January 1 through December 31, 2008). Select and submit the appropriate CPT Category II code corresponding to the measure.
- Each episode of OME in an eligible patient occurring during the reporting period will be counted when calculating the reporting and performance rates.
- Each unique episode is defined as a 90-day period from onset of OME.
- Claims data will be analyzed to determine unique episodes. If multiple claims are submitted within that 90-day period, only one instance of reporting will be counted.
- For performance, the measure will be calculated as the number of patients for whom systemic antimicrobial therapy was not prescribed over the number of patients in the denominator (patients aged 2 months through 12 years with a diagnosis of OME). A higher score indicates appropriate treatment of patients with OME (e.g., the proportion for whom systemic antimicrobial therapy was *not* prescribed).
- Failure to report an applicable CPT Category II code in an eligible case will result in both a reporting and performance failure.
- Medical record documentation is required for all clinical actions described in a measure.

Measure #98: Otitis Media with Effusion (OME): Systemic Corticosteroids – Avoidance of Inappropriate Use

- **Reporting Description:** Percentage of patients aged 2 months through 12 years with OME and an applicable CPT Category II code reported once for each episode of OME during the reporting period
- **Performance Description:** Percentage of patients aged 2 months through 12 years with a diagnosis of OME who were not prescribed systemic corticosteroids

Eligible Cases:	
Patient aged ≥ 2 months and ≤ 12 years on date of encounter **AND** Diagnosis of OME (ICD-9) **AND** Patient encounter during reporting period (CPT)	381.10, 381.19, 381.20, 381.29, 381.3, 381.4 **AND** 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245

Quality Data Code Reporting Options:	
Successful Reporting & Performance: Systemic corticosteroids not prescribed	4136F

OR

Successful Reporting & Excluded from Performance: Documentation of medical reason(s) for prescribing systemic corticosteroids	4135F-1P

OR

Successful Reporting & Performance Not Met: Systemic corticosteroids prescribed (Reason not specified)	4135F

Implementation Guidelines:

- Review clinical data to determine the presence or absence of a current prescription for systemic corticosteroids at an encounter occurring during the reporting period (January 1 through December 31, 2008). Select and submit the appropriate CPT Category II code corresponding to the measure.
- Each episode of OME in an eligible patient occurring during the reporting period will be counted when calculating the reporting and performance rates.
- Each unique episode is defined as a 90-day period from onset of OME.
- Claims data will be analyzed to determine unique episodes. If multiple claims are submitted within that 90-day period, only one instance of reporting will be counted.
- For performance, the measure will be calculated as the number of patients for whom systemic corticosteroids were neither prescribed nor recommended over the number of patients in the denominator (patients aged 2 months through 12 years with a diagnosis of OME). A higher score indicates appropriate treatment of patients with OME (e.g., the proportion for whom systemic corticosteroids were *not* prescribed).
- Failure to report an applicable CPT Category II code in an eligible case will result in both a reporting and performance failure.
- Medical record documentation is required for all clinical actions described in a measure.

Measure #131: Pain Assessment Prior to Initiation of Patient Treatment

- **Reporting Description:** Percentage of patients aged 18 years and older with an applicable G-code reported at each initial evaluation for therapy occurring during the reporting period
- **Performance Description:** Percentage of patients aged 18 years and older with documentation of a pain assessment (if pain is present, including location, intensity and description) through discussion with the patient or through use of a standardized tool on each initial evaluation prior to initiation of therapy

Eligible Cases:	
Patient aged ≥ 18 years on date of encounter **AND** Patient encounter during reporting period (CPT)	90801, 90802, 96116, 96150, 97001, 97003, 98940, 98941, 98942

Quality Data Code Reporting Options:	
Successful Reporting & Performance: Documentation of pain assessment (including location, intensity and description) prior to initiation of treatment or documentation of the absence of pain as a result of assessment	G8440

OR

Successful Reporting & Excluded from Performance: Documentation that patient is not eligible for pain assessment	G8442

OR

Successful Reporting & Performance Not Met: No documentation of pain assessment (including location, intensity and description) prior to initiation of treatment	G8441

Implementation Guidelines:

- There is no diagnosis associated with this measure.
- This measure may be reported by non-MD/DO clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.
- Review clinical data regarding the presence or absence of documentation of pain assessment at each evaluation occurring during the reporting period (January 1 through December 31, 2008). Select and submit the appropriate G-code corresponding to the measure.
- **Standardized tool –** A standardized tool is a test or measure administered and scored in a consistent manner and supported by psychometric literature. Examples of tools for pain assessment include, but are not limited to, Multidimensional Pain Score and McGill Pain Questionnaire.
- **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
    - Situations where the patient's motivation to improve may impact the accuracy of results of nationally recognized standardized pain assessment tools
    - Patient is in an urgent or emergent situation where time is of the essence and to delay treatment would jeopardize the patient's health status
- Each eligible evaluation during the reporting period will be counted once when calculating the eligible professional's reporting rate for this measure.
- Failure to report an applicable G-code in an eligible case will result in both a reporting and performance failure.
- Medical record documentation is required for all clinical actions described in a measure.

Procedure - Related

PERIOPERATIVE

Measure #20: Perioperative Care: Timing of Antibiotic Prophylaxis – Ordering Physician

- **Reporting Description:** Percentage of surgical patients aged 18 years and older undergoing procedures with the indications for prophylactic parenteral antibiotics and an applicable CPT Category II code reported each time a procedure is performed during the reporting period
- **Performance 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)

Eligible Cases:

Patient aged ≥ 18 years on date of encounter **AND** Surgical procedures with indications for prophylactic antibiotic performed during reporting period (CPT)	15734, 15738, 19260, 19271, 19272, 19301, 19302, 19303, 19304, 19305, 19306, 19307, 19361, 19364, 19366, 19367, 19368, 19369, 21346, 21347, 21348, 21422, 21423, 21432, 21433, 21435, 21436, 21454, 21461, 21462, 21465, 21470, 21627, 21632, 21740, 21750, 21805, 21825, 22325, 22524, 22554, 22558, 22600, 22612, 22630, 22800, 22802, 22804, 27125, 27130, 27132, 27134, 27137, 27138, 27235, 27236, 27244, 27245, 27269, 27440, 27441, 27442, 27443, 27445, 27446, 27447, 27702, 27703, 27704, 27758, 27759, 27766, 27769, 27792, 27814, 27870, 28192, 28193, 28293, 28296, 28299, 28300, 28306, 28307, 28308, 28309, 28310, 28320, 28322, 28415, 28420, 28445, 28465, 28485, 28505, 28525, 28531, 28555, 28585, 28615, 28645, 28675, 28705, 28715, 28725, 28730, 28735, 28737, 28740, 28750, 28755, 28760, 31360, 31365, 31367, 31368, 31370, 31375, 31380, 31382, 31390, 31395, 31760, 31766, 31770, 31775, 31786, 31805, 32095, 32100, 32110, 32120, 32124, 32140, 32141, 32150, 32215, 32220, 32225, 32310, 32320, 32402, 32440, 32442, 32445, 32480, 32482, 32484, 32486, 32488, 32491, 32500, 32501, 32800, 32810, 32815, 32900, 32905, 32906, 32940, 33020, 33025, 33030, 33031, 33050, 33120, 33130, 33140, 33141, 33202, 33203, 33206, 33207, 33208, 33212, 33213, 33214, 33215, 33216, 33217, 33218, 33220, 33222, 33223, 33224, 33225, 33226, 33233, 33234, 33235, 33236, 33237, 33238, 33240, 33241, 33243, 33244, 33249, 33250, 33251, 33254, 33255, 33256, 33261, 33300, 33305, 33310, 33315, 33320, 33321, 33322, 33332, 33335, 33400, 33401, 33403, 33404, 33405, 33406, 33410, 33411, 33413, 33416, 33422, 33425, 33426, 33427, 33430, 33460, 33463, 33464, 33465, 33475, 33496, 33510, 33511, 33512, 33513, 33514, 33516, 33517, 33518, 33519, 33521, 33522, 33523, 33530, 33533, 33534, 33535, 33536, 33542, 33545, 33548, 33572, 33877, 33880, 33881, 33883, 33886, 33891, 34051, 34800, 34802, 34803, 34804, 34805, 34825, 34830, 34831, 34832, 34900, 35021, 35081, 35091, 35102, 35131, 35141, 35151, 35211, 35216, 35241, 35246, 35271, 35276, 35301, 35311, 35481, 35526, 35601, 35606, 35612, 35616, 35621, 35623, 35626, 35631, 35636, 35637, 35638, 35642, 35645, 35646, 35647, 35650, 35651, 35654, 35656, 35661, 35663, 35665, 35666, 35671, 36830, 37616, 38115, 38381, 38746, 38747, 39000, 39010, 39200, 39220, 39545, 39561, 41130, 41135, 41140, 41145, 41150, 41153, 41155, 43045, 43100, 43101, 43107, 43108, 43112, 43113, 43116, 43117, 43118, 43121, 43122, 43123, 43124, 43130, 43135, 43300, 43305, 43310, 43312, 43313, 43320, 43324, 43325, 43326, 43330, 43331, 43340, 43341, 43350, 43351, 43352, 43360, 43361, 43400, 43401, 43405, 43410, 43415, 43420, 43425, 43496, 43500, 43501, 43502, 43510, 43520, 43600, 43605, 43610, 43611, 43620, 43621, 43622, 43631, 43632, 43633, 43634, 43640, 43641, 43653, 43800, 43810, 43820, 43825, 43830, 43831, 43832, 43840, 43843, 43845, 43846, 43847, 43848, 43850, 43855, 43860, 43865, 43870, 43880, 44005, 44010, 44020, 44021, 44025, 44050, 44055, 44100, 44110, 44111, 44120, 44125, 44126, 44127, 44130, 44132, 44133, 44135, 44136, 44140, 44141, 44143, 44144, 44145, 44146, 44147, 44150, 44151, 44155, 44156, 44157, 44158, 44160, 44202, 44204, 44205, 44206, 44207, 44208, 44210, 44211, 44212, 44300, 44310,

Eligible Cases:	
	44312, 44314, 44316, 44320, 44322, 44340, 44345, 44346, 44602, 44603, 44604, 44605, 44615, 44620, 44625, 44626, 44640, 44650, 44660, 44661, 44700, 44950, 45108, 45110, 45111, 45112, 45113, 45114, 45116, 45119, 45120, 45121, 45123, 45126, 45130, 45135, 45136, 45150, 45160, 45170, 45190, 45500, 45505, 45520, 45540, 45541, 45550, 45560, 45562, 45563, 45800, 45805, 45820, 45825, 47133, 47135, 47136, 47140, 47141, 47142, 47420, 47425, 47460, 47480, 47560, 47561, 47570, 47600, 47605, 47610, 47612, 47620, 47700, 47701, 47711, 47712, 47715, 47720, 47721, 47740, 47741, 47760, 47765, 47780, 47785, 47800, 47802, 47900, 48020, 48100, 48120, 48140, 48145, 48146, 48148, 48150, 48152, 48153, 48154, 48155, 48500, 48510, 48511, 48520, 48540, 48545, 48547, 48548, 48550, 48554, 48556, 49215, 49568, 50300, 50320, 50340, 50360, 50365, 50370, 50380, 51550, 51555, 51565, 51570, 51575, 51580, 51585, 51590, 51595, 51596, 51597, 51920, 51925, 52450, 52601, 52612, 52614, 52620, 52630, 52647, 52648, 52649, 54401, 54405, 54406, 54408, 54410, 54415, 54416, 55801, 55810, 55812, 55815, 55821, 55831, 55840, 55842, 55845, 58150, 58152, 58180, 58200, 58210, 58260, 58262, 58263, 58267, 58270, 58275, 58280, 58285, 58290, 58291, 58292, 58293, 58294, 60521, 60522, 61154, 61312, 61313, 61315, 61510, 61512, 61518, 61520, 61526, 61530, 61548, 61591, 61595, 61596, 61598, 61606, 61616, 61618, 61619, 61697, 61700, 61750, 61751, 61867, 62223, 62230, 63015, 63020, 63030, 63042, 63045, 63047, 63056, 63075, 63081, 63267, 63276, 64746, 69720, 69930, 69955, 69960, 69970

Quality Data Code Reporting Options:	
Successful Reporting & Performance: Documentation of order for prophylactic antibiotics to be given within one hour (if fluoroquinolone or vancomycin, two hours) prior to surgical incision (or start of procedure when no incision is required) **OR** Documentation that prophylactic antibiotic was given within one hour (if fluoroquinolone or vancomycin, two hours) prior to surgical incision (or start of procedure when no incision is required)	4047F **OR** 4048F

OR

Successful Reporting & Excluded from Performance: 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)	4047F-1P

OR

Successful Reporting & Performance Not Met: Order for or administration of prophylactic antibiotic not given, reason not specified	4047F-8P

Implementation Guidelines:

- There is no diagnosis associated with this measure. This measure must be reported each time a qualifying procedure is performed during the reporting period (January 1 through December 31, 2008).
- Review clinical data regarding the presence or absence of antibiotic prophylaxis timing for each applicable surgical procedure performed during the reporting period. Select and submit the appropriate CPT Category II code corresponding to the measure.
- 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). In the event surgery is delayed, as long as the patient is redosed (if clinically appropriate) the numerator coding should be applied.
- Each applicable surgical procedure occurring during the reporting period will be counted when calculating the reporting and performance rates.
- If multiple surgical procedures are performed on the same date of service and submitted on the same claim form, it is not necessary for the same clinician to submit the CPT Category II code with each procedure. However, if multiple NPIs are reporting this measure on the same claim, each NPI should report the quality-data code.
- Failure to report an applicable CPT Category II code in an eligible case will result in both a reporting and performance failure.
- Medical record documentation is required for all clinical actions described in a measure.

Procedure - Related

PERIOPERATIVE

Measure #21: Perioperative Care: Selection of Prophylactic Antibiotic – First OR Second Generation Cephalosporin

- **Reporting Description:** Percentage of surgical patients aged 18 years and older undergoing procedures with the indications for a first OR second generation cephalosporin prophylactic antibiotic and an applicable CPT Category II code reported each time a procedure is performed during the reporting period
- **Performance 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

Eligible Cases:

Patient aged ≥ 18 years on date of encounter **AND** Surgical procedures with indications for first or second generation cephalosporin performed during the reporting period (CPT)	15734, 15738, 19260, 19271, 19272, 19301, 19302, 19303, 19304, 19305, 19306, 19307, 19361, 19364, 19366, 19367, 19368, 19369, 21627, 21632, 21740, 21750, 21805, 21825, 22325, 22524, 22554, 22558, 22600, 22612, 22630, 22800, 22802, 22804, 27125, 27130, 27132, 27134, 27137, 27138, 27235, 27236, 27244, 27245, 27269, 27440, 27441, 27442, 27443, 27445, 27446, 27447, 27702, 27703, 27704, 27758, 27759, 27766, 27769, 27792, 27814, 27870, 28192, 28193, 28293, 28296, 28299, 28300, 28306, 28307, 28308, 28309, 28310, 28320, 28322, 28415, 28420, 28445, 28465, 28485, 28505, 28525, 28531, 28555, 28585, 28615, 28645, 28675, 28705, 28715, 28725, 28730, 28735, 28737, 28740, 28750, 28755, 28760, 31760, 31766, 31770, 31775, 31786, 31805, 32035, 32036, 32095, 32100, 32110, 32120, 32124, 32140, 32141, 32150, 32200, 32215, 32220, 32225, 32310, 32320, 32402, 32440, 32442, 32445, 32480, 32482, 32484, 32486, 32488, 32491, 32500, 32501, 32540, 32601, 32602, 32603, 32604, 32605, 32606, 32650, 32651, 32652, 32653, 32654, 32655, 32656, 32657, 32658, 32659, 32660, 32661, 32662, 32663, 32664, 32665, 32800, 32810, 32815, 32900, 32905, 32906, 32940, 33020, 33025, 33030, 33031, 33050, 33120, 33130, 33140, 33141, 33202, 33203, 33250, 33251, 33254, 33255, 33256, 33261, 33300, 33305, 33310, 33315, 33320, 33321, 33322, 33332, 33335, 33400, 33401, 33403, 33404, 33405, 33406, 33410, 33411, 33413, 33416, 33422, 33425, 33426, 33427, 33430, 33460, 33463, 33464, 33465, 33475, 33496, 33510, 33511, 33512, 33513, 33514, 33516, 33517, 33518, 33519, 33521, 33522, 33523, 33530, 33533, 33534, 33535, 33536, 33542, 33545, 33548, 33572, 33877, 33880, 33881, 33883, 33886, 33891, 34051, 34800, 34802, 34803, 34804, 34805, 34825, 34830, 34831, 34832, 34900, 35021, 35081, 35091, 35102, 35131, 35141, 35151, 35211, 35216, 35241, 35246, 35271, 35276, 35301, 35311, 35481, 35526, 35601, 35606, 35612, 35616, 35621, 35623, 35626, 35631, 35636, 35637, 35638, 35642, 35645, 35646, 35647, 35650, 35651, 35654, 35656, 35661, 35663, 35665, 35666, 35671, 35820, 36830, 37616, 38100, 38101, 38115, 38120, 38381, 38746, 38747, 39000, 39010, 39200, 39220, 39545, 39561, 43045, 43100, 43101, 43107, 43108, 43112, 43113, 43116, 43117, 43118, 43121, 43122, 43123, 43124, 43130, 43135, 43280, 43300, 43305, 43310, 43312, 43313, 43320, 43324, 43325, 43326, 43330, 43331, 43340, 43341, 43350, 43351, 43352, 43360, 43361, 43400, 43401, 43405, 43410, 43415, 43420, 43425, 43496, 43500, 43501, 43502, 43510, 43520, 43600, 43605, 43610, 43611, 43620, 43621, 43622, 43631, 43632, 43633, 43634, 43640, 43641, 43651, 43652, 43653, 43800, 43810, 43820, 43825, 43830, 43831, 43832, 43840, 43843, 43845, 43846, 43847, 43848, 43850, 43855, 43860, 43865, 43870, 43880, 44005, 44010, 44020, 44021, 44025, 44050, 44055, 44100, 44110, 44111, 44120, 44125, 44126, 44127, 44130, 44132, 44133, 44135, 44136, 47133, 47135, 47136, 47140, 47141, 47142, 47420, 47425, 47460, 47480, 47490, 47510, 47511, 47525, 47530, 47560, 47561, 47570, 47600, 47605, 47610, 47612, 47620, 47630, 47700, 47701, 47711, 47712, 47715, 47720, 47721, 47740, 47741, 47760, 47765, 47780, 47785, 47800, 47802, 47900, 48001, 48020, 48100, 48102, 48120, 48140, 48145, 48146, 48148, 48150, 48152, 48153, 48154, 48155, 48500, 48510, 48511, 48520, 48540, 48545, 48547, 48548, 48550, 48554, 48556, 49000, 49002, 49010, 49180, 49203, 49204, 49205, 49215, 50300, 50320, 50340, 50360, 50365, 50370, 50380, 58150, 58152, 58180, 58200, 58210, 58260, 58262, 58263, 58267, 58270, 58275, 58280, 58285, 58290, 58291, 58292, 58293, 58294, 60521, 60522, 61154, 61312, 61313, 61315, 61510, 61512, 61518, 61548, 61697, 61700, 61750, 61751, 61867, 62223, 62230, 63015, 63020, 63030, 63042, 63045, 63047, 63056, 63075, 63081, 63267, 63276, 64746

Quality Data Code Reporting Options:	
Successful Reporting & Performance: Documentation of order for cefazolin OR cefuroxime for antimicrobial prophylaxis	4041F

OR

Successful Reporting & Excluded from Performance: Documentation of medical reason(s) for not ordering cefazolin OR cefuroxime for antimicrobial prophylaxis	4041F-1P

OR

Successful Reporting & Performance Not Met: First or second generation cephalosporin not ordered, reason not specified	4041F-8P

Implementation Guidelines:

- There is no diagnosis associated with this measure. This measure must be reported each time a qualifying procedure is performed during the reporting period (January 1 through December 31, 2008).
- Review clinical data regarding the presence or absence of prophylactic antibiotic selection for each applicable surgical procedure performed during the reporting period. Select and submit the appropriate CTP Category II code corresponding to the measure.
- 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*. In the event surgery is delayed, as long as the patient is redosed (if clinically appropriate) the numerator coding should be applied.
- Each applicable surgical procedure occurring during the reporting period will be counted when calculating the reporting and performance rates.
- If multiple surgical procedures are performed on the same date of service and submitted on the same claim form, it is not necessary for the same clinician to submit the CPT Category II code with each procedure. However, if multiple NPIs are reporting this measure on the same claim, each NPI should report the quality-data code.
- Failure to report an applicable CPT Category II code in an eligible case will result in both a reporting and performance failure.
- Medical record documentation is required for all clinical actions described in a measure.

Procedure - Related

PERIOPERATIVE

Measure #22: Perioperative Care: Discontinuation of Prophylactic Antibiotics (Non-Cardiac Procedures)

- **Reporting Description:** Percentage of non-cardiac surgical patients aged 18 years and older undergoing procedures with the indications for prophylactic antibiotics and applicable CPT Category II code(s) reported each time a procedure is performed during the reporting period
- **Performance Description:** Percentage of non-cardiac surgical patients aged 18 years and older undergoing procedures with the indications for prophylactic antibiotics AND who received a prophylactic antibiotic, who have an order for discontinuation of prophylactic antibiotics within 24 hours of surgical end time

Eligible Cases:

Patient aged ≥ 18 years on date of encounter **AND** Non-cardiac surgical procedures with indications for prophylactic antibiotics performed during the reporting period (CPT)	15734, 15738, 19260, 19271, 19272, 19301, 19302, 19303, 19304, 19305, 19306, 19307, 19361, 19364, 19366, 19367, 19368, 19369, 21346, 21347, 21348, 21422, 21423, 21432, 21433, 21435, 21436, 21454, 21461, 21462, 21465, 21470, 21627, 21632, 21740, 21750, 21805, 21825, 22325, 22524, 22554, 22558, 22600, 22612, 22630, 22800, 22802, 22804, 27125, 27130, 27132, 27134, 27137, 27138, 27235, 27236, 27244, 27245, 27269, 27440, 27441, 27442, 27443, 27445, 27446, 27447, 27702, 27703, 27704, 27758, 27759, 27766, 27769, 27792, 27814, 27870, 28192, 28193, 28293, 28296, 28299, 28300, 28306, 28307, 28308, 28309, 28310, 28320, 28322, 28415, 28420, 28445, 28465, 28485, 28505, 28525, 28531, 28555, 28585, 28615, 28645, 28675, 28705, 28715, 28725, 28730, 28735, 28737, 28740, 28750, 28755, 28760, 31360, 31365, 31367, 31368, 31370, 31375, 31380, 31382, 31390, 31395, 31760, 31766, 31770, 31775, 31786, 31805, 32095, 32100, 32110, 32120, 32124, 32140, 32141, 32150, 32215, 32220, 32225, 32310, 32320, 32402, 32440, 32442, 32445, 32480, 32482, 32484, 32486, 32488, 32491, 32500, 32501, 32800, 32810, 32815, 32900, 32905, 32906, 32940, 33020, 33025, 33030, 33031, 33050, 33203, 33206, 33207, 33208, 33212, 33213, 33214, 33215, 33216, 33217, 33218, 33220, 33222, 33223, 33224, 33225, 33226, 33233, 33234, 33235, 33236, 33237, 33238, 33240, 33241, 33243, 33244, 33249, 33254, 33255, 33300, 33310, 33320, 33877, 33880, 33881, 33883, 33886, 33891, 34051, 34800, 34802, 34803, 34804, 34805, 34825, 34830, 34831, 34832, 34900, 35021, 35081, 35091, 35102, 35131, 35141, 35151, 35216, 35246, 35276, 35301, 35311, 35481, 35526, 35601, 35606, 35612, 35616, 35621, 35623, 35626, 35631, 35636, 35637, 35638, 35642, 35645, 35646, 35647, 35650, 35651, 35654, 35656, 35661, 35663, 35665, 35666, 35671, 36830, 37616, 38381, 38746, 38747, 39000, 39010, 39200, 39220, 39545, 39561, 41130, 41135, 41140, 41145, 41150, 41153, 41155, 43045, 43100, 43101, 43107, 43108, 43112, 43113, 43116, 43117, 43118, 43121, 43122, 43123, 43124, 43130, 43135, 43300, 43305, 43310, 43312, 43313, 43320, 43324, 43325, 43326, 43330, 43331, 43340, 43341, 43350, 43351, 43352, 43360, 43361, 43400, 43401, 43405, 43410, 43415, 43420, 43425, 43496, 43500, 43501, 43502, 43510, 43520, 43600, 43605, 43610, 43611, 43620, 43621, 43622, 43631, 43632, 43633, 43634, 43640, 43641, 43653, 43800, 43810, 43820, 43825, 43830, 43831, 43832, 43840, 43843, 43845, 43846, 43847, 43848, 43850, 43855, 43860, 43865, 43870, 43880, 44005, 44010, 44020, 44021, 44025, 44050, 44055, 44100, 44110, 44111, 44120, 44125, 44126, 44127, 44130, 44132, 44133, 44135, 44136, 44140, 44141, 44143, 44144, 44145, 44146, 44147, 44150, 44151, 44155, 44156, 44157, 44158, 44160, 44202, 44204, 44205, 44206, 44207, 44208, 44210, 44211, 44212, 44300, 44310, 44312, 44314, 44316, 44320, 44322, 44340, 44345, 44346, 44615, 44620, 44625, 44626, 44640, 44650, 44660, 44661, 44700, 44950, 45108, 45110, 45111, 45112, 45113, 45114, 45116, 45119, 45120, 45121, 45123, 45126, 45130, 45135, 45136, 45150, 45160, 45170, 45190, 45500, 45505, 45520, 45540, 45541, 45550, 45560, 45562, 45563, 45800, 45805, 45820, 45825, 47420, 47425, 47460, 47480, 47560, 47561, 47570, 47600, 47605, 47610, 47612, 47620, 47700, 47701, 47711, 47712, 47715, 47720, 47721, 47740, 47741, 47760, 47765, 47780, 47785, 47800, 47802, 47900, 48020, 48100, 48120, 48140, 48145, 48146, 48148, 48150, 48152, 48153, 48154, 48155, 48500, 48510, 48511, 48520, 48540, 48545, 48547, 48548, 48550, 48554, 48556, 49215, 49568, 50300, 50320, 50340, 50360, 50365, 50370, 50380, 51597, 58150,

Eligible Cases:	
	58152, 58180, 58200, 58210, 58260, 58262, 58263, 58267, 58270, 58275, 58280, 58285, 58290, 58291, 58292, 58293, 58294, 60521, 60522, 61154, 61312, 61313, 61315, 61510, 61512, 61518, 61520, 61526, 61530, 61548, 61591, 61595, 61596, 61598, 61606, 61616, 61618, 61619, 61697, 61700, 61750, 61751, 61867, 62223, 62230, 63015, 63020, 63030, 63042, 63045, 63047, 63056, 63075, 63081, 63267, 63276, 64746, 69720, 69930, 69955, 69960, 69970

Quality Data Code Reporting Options:	
Successful Reporting & Performance: Documentation that order was given to discontinue prophylactic antibiotics within 24 hours of surgical end time, non-cardiac procedure **AND** Documentation that prophylactic antibiotics were given within 4 hours prior to surgical incision or given intraoperatively	4049F **AND** 4046F

OR

Successful Reporting & Excluded from Performance: Documentation of medical reason(s) for not discontinuing prophylactic antibiotics within 24 hours of surgical end time **AND** Documentation that prophylactic antibiotics were given within 4 hours prior to surgical incision or given intraoperatively **OR** Documentation that prophylactic antibiotics were neither given within 4 hours prior to surgical incision nor given intraoperatively	4049F-1P **AND** 4046F **OR** 4042F

OR

Successful Reporting & Performance Not Met: Prophylactic antibiotics not discontinued, reason not specified **AND** Documentation that prophylactic antibiotics were given within 4 hours prior to surgical incision or given intraoperatively	4049F-8P **AND** 4046F

Implementation Guidelines:

- The correct combination of numerator code(s) must be reported on the claim form in order to properly report this measure. The "correct combination" of codes may require the submission of multiple numerator codes.
- There is no diagnosis associated with this measure. This measure must be reported each time a qualifying procedure is performed during the reporting period (January 1 through December 31, 2008).
- For each non-cardiac procedure performed during the reporting period, review clinical data to determine whether there was documentation that prophylactic antibiotics were given within 4 hours prior to surgical incision or given intraoperatively or documentation that prophylactic antibiotics were neither given within 4 hours prior to surgical incision nor given intraoperatively. For non-cardiac procedures where there was documentation that prophylactic antibiotics were given within 4 hours prior to surgical incision or given intraoperatively, there should be documentation that an order was given to discontinue prophylactic antibiotics within 48 hours of surgical end time. Select and submit the appropriate CPT Category II code(s) corresponding to the measure.
- There must be documentation of order (written order, verbal order, or standing order/protocol) specifying that prophylactic antibiotic is to be discontinued within 24 hours of surgical end time OR specifying a course of antibiotic administration limited to that 24-hour period (e.g., “to be given every 8 hours for three doses”) OR documentation that prophylactic antibiotic *was* discontinued within 24 hours of surgical end time.
- For the purpose of this measure, patients may be counted as having “received a prophylactic antibiotic” if the antibiotic was received within 4 hours prior to the surgical incision (or start of procedure when no incision is required) or intraoperatively.
- Each applicable surgical procedure occurring during the reporting period will be counted when calculating the reporting and performance rates. There is no diagnosis associated with the measure.
- If multiple surgical procedures are performed on the same date of service and submitted on the same claim form, it is not necessary for the same clinician to submit the CPT Category II code with each procedure. However, if multiple NPIs are reporting this measure on the same claim, each NPI should report the quality-data code.
- Failure to report applicable CPT Category II code(s) in an eligible case will result in both a reporting and performance failure.
- Medical record documentation is required for all clinical actions described in a measure.

Procedure - Related

PERIOPERATIVE

Measure #23: Perioperative Care: Venous Thromboembolism (VTE) Prophylaxis (When Indicated in ALL Patients)

- **Reporting Description:** Percentage of patients aged 18 years and older undergoing procedures for which VTE prophylaxis is indicated and an applicable CPT Category II code reported each time a procedure is performed during the reporting period
- **Performance 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

Eligible Cases:

Patient aged ≥ 18 years on date of encounter **AND** Surgical procedures for which VTE prophylaxis is indicated and performed during reporting period (CPT)	19260, 19271, 19272, 19301, 19302, 19303, 19304, 19305, 19306, 19307, 19316, 19318, 19324, 19325, 19328, 19330, 19342, 19350, 19355, 19357, 19361, 19364, 19366, 19367, 19368, 19369, 19370, 19371, 19380, 22558, 22600, 22612, 22630, 27125, 27130, 27132, 27134, 27137, 27138, 27235, 27236, 27244, 27245, 27269, 27440, 27441, 27442, 27443, 27445, 27446, 27447, 38100, 38101, 38115, 38120, 38571, 38572, 38700, 38720, 38724, 38740, 38745, 38747, 38760, 38765, 38770, 38780, 39501, 39502, 39503, 39520, 39530, 39531, 39540, 39541, 39545, 39560, 39561, 43020, 43030, 43045, 43100, 43101, 43107, 43108, 43112, 43113, 43116, 43117, 43118, 43121, 43122, 43123, 43124, 43130, 43135, 43280, 43300, 43305, 43310, 43312, 43313, 43314, 43320, 43324, 43325, 43326, 43330, 43331, 43340, 43341, 43350, 43351, 43352, 43360, 43361, 43400, 43401, 43405, 43410, 43415, 43420, 43425, 43496, 43500, 43501, 43502, 43510, 43520, 43605, 43610, 43611, 43620, 43621, 43622, 43631, 43632, 43633, 43634, 43640, 43641, 43644, 43645, 43651, 43652, 43653, 43770, 43771, 43772, 43773, 43774, 43800, 43810, 43820, 43825, 43830, 43832, 43840, 43843, 43845, 43846, 43847, 43848, 43850, 43855, 43860, 43865, 43870, 43880, 43886, 43887, 43888, 44005, 44010, 44020, 44021, 44025, 44050, 44055, 44110, 44111, 44120, 44125, 44126, 44127, 44130, 44140, 44141, 44143, 44144, 44145, 44146, 44147, 44150, 44151, 44155, 44156, 44157, 44158, 44160, 44180, 44186, 44187, 44188, 44202, 44204, 44205, 44206, 44207, 44208, 44210, 44211, 44212, 44227, 44300, 44310, 44312, 44314, 44316, 44320, 44322, 44340, 44345, 44346, 44602, 44603, 44604, 44605, 44615, 44620, 44625, 44626, 44640, 44650, 44660, 44661, 44680, 44700, 44800, 44820, 44850, 44900, 44950, 44960, 44970, 45000, 45020, 45100, 45108, 45110, 45111, 45112, 45113, 45114, 45116, 45119, 45120, 45121, 45123, 45126, 45130, 45135, 45136, 45150, 45160, 45170, 45190, 45395, 45397, 45400, 45402, 45500, 45505, 45550, 45560, 45562, 45563, 45800, 45805, 45820, 45825, 46715, 46716, 46730, 46735, 46740, 46742, 46744, 46746, 46748, 46750, 46751, 46753, 46754, 46760, 46761, 46762, 47010, 47100, 47120, 47122, 47125, 47130, 47135, 47136, 47140, 47141, 47142, 47300, 47350, 47360, 47361, 47362, 47370, 47371, 47380, 47381, 47382, 47400, 47420, 47425, 47460, 47480, 47500, 47505, 47560, 47561, 47562, 47563, 47564, 47570, 47600, 47605, 47610, 47612, 47620, 47630, 47700, 47701, 47711, 47712, 47715, 47720, 47721, 47740, 47741, 47760, 47765, 47780, 47785, 47800, 47801, 47802, 47900, 48000, 48001, 48020, 48100, 48105, 48120, 48140, 48145, 48146, 48148, 48150, 48152, 48153, 48154, 48155, 48500, 48510, 48520, 48540, 48545, 48547, 48548, 48554, 48556, 49000, 49002, 49010, 49020, 49040, 49060, 49203, 49204, 49205, 49215, 49220, 49250, 49255, 49320, 49321, 49322, 49323, 49560, 49561, 49565, 49566, 49570, 50020, 50220, 50225, 50230, 50234, 50236, 50240, 50320, 50340, 50360, 50365, 50370, 50380, 50543, 50545, 50546, 50547, 50548, 50715, 50722, 50725, 50727, 50728, 50760, 50770, 50780, 50782, 50783, 50785, 50800, 50810, 50815, 50820, 50947, 50948, 51550, 51555, 51565, 51570, 51575, 51580, 51585, 51590, 51595, 51596, 51597, 51800, 51820, 51900, 51920, 51925, 51960, 55810, 55812, 55815, 55821, 55831, 55840, 55842, 55845, 55866, 56630, 56631, 56632, 56633, 56634, 56637, 56640, 58200, 58210, 58240, 58285, 58951, 58953, 58954, 58956, 60200, 60210, 60212, 60220, 60225, 60240, 60252, 60254, 60260, 60270, 60271, 60280, 60281, 60500, 60502, 60505, 60520, 60521, 60522, 60540, 60545, 60600, 60605, 60650, 61313, 61510, 61512, 61518, 61548, 61697, 61700, 62230, 63015, 63020, 63047, 63056, 63081, 63267, 63276

Quality Data Code Reporting Options:	
Successful Reporting & Performance: Documentation that an order was given for venous thromboembolism (VTE) prophylaxis to be given within 24 hours prior to incision time or 24 hours after surgery end time	4044F

OR

Successful Reporting & Excluded from Performance: Documentation of medical reason(s) for patient not receiving any 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	4044F-1P

OR

Successful Reporting & Performance Not Met: VTE prophylaxis not ordered, reason not specified	4044F-8P

Implementation Guidelines:

- There is no diagnosis associated with this measure. This measure must be reported each time a qualifying procedure is performed during the reporting period (January 1 through December 31, 2008).
- Review clinical data regarding the presence or absence of venous thromboembolism prophylaxis for each applicable surgical procedure performed during the reporting period. Select and submit the appropriate CPT Category II code corresponding to the measure.
- There must be documentation of order (written order, verbal order, or standing order/protocol) for VTE prophylaxis OR documentation that VTE prophylaxis was given. Mechanical prophylaxis does not include TED hose.
- Each applicable surgical procedure occurring during the reporting period will be counted when calculating the reporting and performance rates.
- If multiple surgical procedures are performed on the same date of service and submitted on the same claim form, it is not necessary for the same clinician to submit the CPT Category II code with each procedure. However, if multiple NPIs are reporting this measure on the same claim, each NPI should report the quality-data code.
- Failure to report an applicable CPT Category II code in an eligible case will result in both a reporting and performance failure.
- Medical record documentation is required for all clinical actions described in a measure.

Procedure - Related

PERIOPERATIVE

Measure #30: Perioperative Care: Timing of Prophylactic Antibiotic – Administering Physician

- **Reporting Description:** Percentage of surgical patients aged 18 and older who have an order for a parenteral 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) and an applicable CPT II code reported each time a procedure is performed during the reporting period
- **Performance Description:** Percentage of surgical patients aged 18 and older who have an order for a parenteral 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) for whom administration of prophylactic antibiotic has been initiated within one hour (if fluoroquinolone or vancomycin, two hours) prior to the surgical incision (or start of procedure when no incision is required)

Eligible Cases:	
Patients aged 18 ≥ years on date of encounter **AND** Patients who have an order for prophylactic antibiotics to be given within one hour (if fluoroquinolone or vancomycin, two hours) prior to surgical incision (or start of procedure when no incision is required) (CPT)	4047F

Quality Data Code Reporting Options:	
Successful Reporting & Performance: Documentation that prophylactic antibiotic was given within one hour (if fluoroquinolone or vancomycin, two hours) prior to surgical incision (or start of procedure when no incision is required)	4048F

OR

Successful Reporting & Excluded from Performance: There are no allowable performance exclusions for this measure.	NONE

OR

Successful Reporting & Performance Not Met: Prophylactic antibiotic not given, reason not specified	4048F-8P

Implementation Guidelines:

- Review clinical data regarding the presence or absence of antibiotic prophylaxis administration during the reporting period (January 1 through December 31, 2008). Select and submit the appropriate CPT Category II code corresponding to the measure. Note: Only CPT Category II codes are used to report this measure.
- It is anticipated that clinicians providing anesthesia care for surgical procedures with an order for prophylactic antibiotics will submit this measure.
- This measure seeks to identify the timely administration of prophylactic antibiotics. This administration should begin within one hour (if fluoroquinolone or vancomycin, two hours) prior to surgical incision.
- Each applicable procedure (indicated by CPT Category II 4047F) occurring during the reporting period will be counted when calculating the reporting and performance rates.
- Failure to report an applicable CPT Category II code in an eligible case will result in both a reporting and performance failure.
- Medical record documentation is required for all clinical actions described in a measure.

Measure #45: Perioperative Care: Discontinuation of Prophylactic Antibiotics (Cardiac Procedures)

- **Reporting Description:** Percentage of patients aged 18 years and older undergoing cardiac surgery and applicable CPT Category II code(s) reported for each cardiac surgery during the reporting period
- **Performance Description:** Percentage of cardiac surgical patients aged 18 years and older undergoing procedures with the indications for prophylactic antibiotics AND who received a prophylactic antibiotic, who have an order for discontinuation of prophylactic antibiotics within 48 hours of surgical end time

Eligible Cases:	
Patient aged ≥ 18 years on date of encounter **AND** Cardiac surgery performed during reporting period (CPT)	33120, 33130, 33140, 33141, 33202, 33250, 33251, 33256, 33261, 33305, 33315, 33321, 33322, 33332, 33335, 33400, 33401, 33403, 33404, 33405, 33406, 33410, 33411, 33413, 33416, 33422, 33425, 33426, 33427, 33430, 33460, 33463, 33464, 33465, 33475, 33496, 33510, 33511, 33512, 33513, 33514, 33516, 33517, 33518, 33519, 33521, 33522, 33523, 33530, 33533, 33534, 33535, 33536, 33542, 33545, 33548, 33572, 35211, 35241, 35271, 35820

Quality Data Code Reporting Options:	
Successful Reporting & Performance: Documentation that an order was given to discontinue prophylactic antibiotics within 48 hours of surgical end time, cardiac procedure **AND** Documentation that prophylactic antibiotics were given within 4 hours prior to surgical incision or given intraoperatively	4043F **AND** 4046F

OR

Successful Reporting & Excluded from Performance: Documentation of medical reason(s) for not discontinuing prophylactic antibiotics within 48 hours of surgical end time, cardiac procedure **AND** Documentation that prophylactic antibiotics were given within 4 hours prior to surgical incision or given intraoperatively **OR** Documentation that prophylactic antibiotics were neither given within 4 hours prior to surgical incision nor given intraoperatively	4043F-1P **AND** 4046F **OR** 4042F

OR

Successful Reporting & Performance Not Met: Prophylactic antibiotics not discontinued, reason not specified **AND** Documentation that prophylactic antibiotics were given within 4 hours prior to surgical incision or given intraoperatively	4043F-8P **AND** 4046F

Implementation Guidelines:

- The correct combination of numerator code(s) must be reported on the claim form in order to properly report this measure. The "correct combination" of codes may require the submission of multiple numerator codes.
- There is no diagnosis associated with this measure. This measure must be reported each time a qualifying procedure is performed during the reporting period (January 1 through December 31, 2008).
- At a cardiac procedure performed during the reporting period, review clinical data to determine whether there was documentation that prophylactic antibiotics were given within 4 hours prior to surgical incision or given intraoperatively or documentation that prophylactic antibiotics were neither given within 4 hours prior to surgical incision nor given intraoperatively. For cardiac procedures where there was documentation that prophylactic antibiotics were given within 4 hours prior to surgical incision or given intraoperatively, there should be documentation that an order was given to discontinue prophylactic antibiotics within 48 hours of surgical end time. Select and submit the appropriate CPT Category II code(s) corresponding to the measure.
- CPT Category II code **4043F** may be provided for documentation that antibiotic discontinuation within 48 hours was ordered or that antibiotic discontinuation was accomplished.
- There must be documentation of order (written order, verbal order, or standing order/protocol) specifying that prophylactic antibiotic is to be discontinued within 48 hours of surgical end time OR specifying a course of antibiotic administration limited to that 48-hour period (e.g., "to be given every 8 hours for three doses") OR documentation that prophylactic antibiotic *was* discontinued within 48 hours of surgical end time.
- Each cardiac surgical procedure occurring during the reporting period will be counted when calculating the reporting and performance rates. There is no specific diagnosis required to report this measure.
- If multiple surgical procedures were performed on the same date of service and submitted on the same claim form, it is not necessary to submit the CPT Category II code with each procedure.
- Failure to report applicable CPT Category II code(s) in an eligible case will result in both a reporting and performance failure.
- Medical record documentation is required for all clinical actions described in a measure.

Measure #66: Appropriate Testing for Children with Pharyngitis

- **Reporting Description:** Percentage of children aged 2 through 18 years and applicable CPT Category II code(s) reported for each new diagnosis of pharyngitis occurring during the reporting period
- **Performance Description:** Percentage of children aged 2 through 18 years with a diagnosis of pharyngitis, who were prescribed an antibiotic and who received a group A streptococcus (strep) test for the episode

Eligible Cases:	
Patient aged ≥ 2 and ≤ 18 years on date of encounter **AND** Diagnosis of pharyngitis (ICD-9) **AND** Patient encounter during reporting period (CPT)	034.0, 462, 463 **AND** 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99217, 99218, 99219, 99220, 99241, 99242, 99243, 99244, 99245

Quality Data Code Reporting Options:	
Successful Reporting & Performance: Group A Strep Test performed **AND** Antibiotic prescribed or dispensed	3210F **AND** 4120F

OR

Successful Reporting & Excluded from Performance: Documentation of medical reason(s) for not performing Group A Strep Test **AND** Antibiotic prescribed or dispensed **OR** Antibiotic neither prescribed nor dispensed	3210F-1P **AND** 4120F **OR** 4124F

OR

Successful Reporting & Performance Not Met: Group A Strep Test not performed, reason not specified **AND** Antibiotic prescribed or dispensed	3210F-8P **AND** 4120F

Implementation Guidelines:

- The correct combination of numerator code(s) must be reported on the claim form in order to properly report this measure. The "correct combination" of codes may require the submission of multiple numerator codes.
- Report this measure for each new diagnosis of pharyngitis occurring in an eligible patient during the reporting period (January 1 through December 31, 2008).
- At an encounter occurring during the reporting period, review clinical data to determine whether an antibiotic was prescribed or dispensed or was neither prescribed nor dispensed. For patients where an antibiotic was prescribed or dispensed, Group A Strep Test should be performed. Select and submit the appropriate CPT Category II code(s) corresponding to the measure.
- Each diagnosis of pharyngitis in an eligible patient occurring during the reporting period will be counted when calculating the reporting and performance rates.
- Part B claims data will be analyzed to determine unique occurrences.
- Failure to report applicable CPT Category II code(s) in an eligible case will result in both a reporting and performance failure.
- Medical record documentation is required for all clinical actions described in a measure.

Measure #132: Patient Co-Development of Treatment Plan/Plan of Care

- **Reporting Description:** Percentage of patients aged 18 years and older with an applicable G-code reported a minimum of once per unique episode of care occurring during the reporting period
- **Performance Description:** Percentage of patients aged 18 years and older identified as having actively participated in the development of the treatment plan/plan of care. Appropriate documentation includes signature of the practitioner and either co-signature of the patient or documented verbal agreement obtained from the patient or, when necessary, an authorized representative

Eligible Cases:

Patient aged ≥ 18 years on date of encounter **AND** Patient encounter during reporting period (CPT or HCPCS)	90801, 90802, 90804, 90805, 90806, 90807, 90808, 90809, 96116, 96150, 96151, 96152, 97001, 97002, 97003, 97004, 97802, 97803, G0270

Quality Data Code Reporting Options:

Successful Reporting & Performance: Documentation of clinician and patient involvement with the development of a treatment plan/plan of care including signature by the practitioner and either a co-signature by the patient or documented verbal agreement obtained from the patient or, when necessary, an authorized representative	G8437

OR

Successful Reporting & Excluded from Performance: Documentation that patient is not eligible for co-developing a treatment plan/plan of care including signature by the practitioner and either a co-signature by the patient or documented verbal agreement obtained from the patient or, when necessary, an authorized representative	G8439

OR

Successful Reporting & Performance Not Met: No documentation of clinician and patient involvement with the development of a treatment plan/plan of care including signature by the practitioner and either a co-signature by the patient or documented verbal agreement obtained from the patient or, when necessary, an authorized representative	G8438

Implementation Guidelines:

- This measure may be reported by non-MD/DO clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.
- Review clinical data regarding the presence or absence of documentation of co-development of treatment plan/ plan of care at each unique episode of care occurring during the reporting period (January 1 through December 31, 2008). Select and submit the appropriate G-code corresponding to the measure.
- **Unique episode of care –** For the purpose of this measure is defined by each unique ICD-9 code billed in combination with an appropriate CPT service code during the reporting period. Multiple diagnoses on a claim form will count as one episode.
- **Active participation -** Patient involvement in discussions, decisions, objectives determination, and goal setting to the extent that the patient is a co-author of, and responds affirmatively to, the care plan/treatment plan.
- **Care plan/treatment plan –** A roadmap or course of action involving input and approval from the patient.
- **Authorized representative –** A person who is acting on the patient's behalf and who does not have a conflict of interest with the patient, when the patient is temporarily or permanently unable to act for himself or herself, but not against the patient's wishes. This person should have the patient's best interests at heart and should be reasonably expected to act in a manner that is protective of the person and the rights of the patient. Preferably, this individual is appointed by the patient.
- **Not eligible –** A patient is not eligible if one or more of the following conditions exist:
    - Patient refuses to participate.
    - Patient is in an urgent or emergent health or crisis situation where time is of the essence and to delay treatment would jeopardize the patient's health status
    - Episode of care began either prior to or extends beyond reporting period and Treatment Plan/ Plan of Care was co-developed outside reporting period
- Each eligible unique episode of care during the reporting period will be counted once when calculating the eligible professional's reporting rate for this measure.
- Failure to report an applicable G-code in an eligible case will result in both a reporting and performance failure.
- Medical record documentation is required for all clinical actions described in a measure.

Measure #56: Vital Signs for Community-Acquired Bacterial Pneumonia

- **Reporting Description:** Percentage of patients aged 18 years and older with community-acquired bacterial pneumonia (CAP) and an applicable CPT Category II code reported once for each episode of CAP during the reporting period
- **Performance Description:** Percentage of patients aged 18 years and older with a diagnosis of community-acquired bacterial pneumonia with vital signs documented and reviewed

Eligible Cases:

Patient aged ≥ 18 years on date of encounter **AND** Diagnosis of community-acquired bacterial pneumonia (ICD-9) **AND** Patient encounter during reporting period (CPT)	481, 482.0, 482.1, 482.2, 482.30, 482.31, 482.32, 482.39, 482.40, 482.41, 482.49, 482.81, 482.82, 482.83, 482.84, 482.89, 482.9, 483.0, 483.1, 483.8, 485, 486, 487.0 **AND** 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99281, 99282, 99283, 99284, 99285, 99291* **Clinicians utilizing the critical care code (99291) must indicate the emergency department place-of-service code (POS = 23) in order to be counted in the measure's denominator.*

Quality Data Code Reporting Options:

Successful Reporting & Performance: Vital signs (temperature, pulse, respiratory rate, and blood pressure) documented and reviewed	2010F

OR

Successful Reporting & Excluded from Performance: There are no allowable performance exclusions for this measure.	NONE

OR

Successful Reporting & Performance Not Met: Vital signs not documented and reviewed, reason not specified	2010F-8P

Implementation Guidelines:

- Review clinical data regarding the presence or absence of vital signs documentation and review for each episode of CAP occurring during the reporting period (January 1 through December 31, 2008). Select and submit the appropriate CPT Category II code corresponding to the measure.
- Medical record may include one of the following: clinician documented that vital signs were reviewed, dictation by the clinician including vital signs, clinician initials in the chart that vital signs were reviewed, or other indication that vital signs had been acknowledged by the clinician.
- Clinicians utilizing the critical care code (99291) must indicate the emergency department place-of-service code (POS = 23) in order to be counted in the measure's denominator.
- Each episode of CAP in an eligible patient occurring during the reporting period will be counted when calculating the reporting and performance rates.
- Each unique occurrence is defined as a 45-day period from onset of community-acquired bacterial pneumonia.
- Claims data will be analyzed to determine unique occurrences.
- Failure to report an applicable CPT Category II code in an eligible case will result in both a reporting and performance failure.
- Medical record documentation is required for all clinical actions described in a measure.

Measure #57: Assessment of Oxygen Saturation for Community-Acquired Bacterial Pneumonia

- **Reporting Description:** Percentage of patients aged 18 years and older with community-acquired bacterial pneumonia (CAP) and an applicable CPT Category II code reported for each episode of CAP during the reporting period
- **Performance Description:** Percentage of patients aged 18 years and older with a diagnosis of community-acquired bacterial pneumonia with oxygen saturation documented and reviewed

Eligible Cases:

Patient aged ≥ 18 years on date of encounter **AND** Diagnosis of community-acquired bacterial pneumonia (ICD-9) **AND** Patient encounter during reporting period (CPT)	481, 482.0, 482.1, 482.2, 482.30, 482.31, 482.32, 482.39, 482.40, 482.41, 482.49, 482.81, 482.82, 482.83, 482.84, 482.89, 482.9, 483.0, 483.1, 483.8, 485, 486, 487.0 **AND** 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99281, 99282, 99283, 99284, 99285, 99291* **Clinicians utilizing the critical care code (99291) must indicate the emergency department place-of-service code (POS = 23) in order to be counted in the measure's denominator.*

Quality Data Code Reporting Options:

Successful Reporting & Performance: Oxygen saturation results documented and reviewed (includes assessment through pulse oximetry or arterial blood gas measurement)	3028F

OR

Successful Reporting & Excluded from Performance: Documentation of medical, patient, or system reasons for not documenting and reviewing oxygen saturation	3028F-1P **OR** 3028F-2P **OR** 3028F-3P

OR

Successful Reporting & Performance Not Met: Oxygen saturation not documented and reviewed, reason not specified	3028F-8P

Implementation Guidelines:

- Review clinical data regarding the presence or absence of oxygen saturation documentation and review for each episode of CAP occurring during the reporting period (January 1 through December 31, 2008). Select and submit the appropriate CPT Category II code corresponding to the measure.
- Medical record may include one of the following: clinician documented that oxygen saturation was reviewed, dictation by the clinician including oxygen saturation, clinician initials in the chart that oxygen saturation was reviewed, or other indication that oxygen saturation had been acknowledged by the clinician.
- Clinicians utilizing the critical care code (99291) must indicate the emergency department place-of-service code (POS = 23) in order to be counted in the measure's denominator.
- Each episode of CAP in an eligible patient occurring during the reporting period will be counted when calculating the reporting and performance rates.
- Each unique occurrence is defined as a 45-day period from onset of community-acquired bacterial pneumonia.
- Claims data will be analyzed to determine unique occurrences.
- Failure to report an applicable CPT Category II code in an eligible case will result in both a reporting and performance failure.
- Medical record documentation is required for all clinical actions described in a measure.

Measure #58: Assessment of Mental Status for Community-Acquired Bacterial Pneumonia

- **Reporting Description:** Percentage of patients aged 18 years and older with community-acquired bacterial pneumonia (CAP) and an applicable CPT Category II code reported for each episode of CAP during the reporting period
- **Performance Description:** Percentage of patients aged 18 years and older with a diagnosis of community-acquired bacterial pneumonia with mental status assessed

Eligible Cases:

Patient aged ≥ 18 years on date of encounter **AND** Diagnosis of community-acquired bacterial pneumonia (ICD-9) **AND** Patient encounter during reporting period (CPT)	481, 482.0, 482.1, 482.2, 482.30, 482.31, 482.32, 482.39, 482.40, 482.41, 482.49, 482.81, 482.82, 482.83, 482.84, 482.89, 482.9, 483.0, 483.1, 483.8, 485, 486, 487.0 **AND** 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99281, 99282, 99283, 99284, 99285, 99291* **Clinicians utilizing the critical care code (99291) must indicate the emergency department place-of-service code (POS = 23) in order to be counted in the measure's denominator.*

Quality Data Code Reporting Options:

Successful Reporting & Performance: Mental status assessed	2014F

OR

Successful Reporting & Excluded from Performance: There are no allowable performance exclusions for this measure.	NONE

OR

Successful Reporting & Performance Not Met: Mental status not assessed, reason not specified	2014F-8P

Implementation Guidelines:

- Review clinical data regarding the presence or absence of mental status assessment for each episode of CAP occurring during the reporting period (January 1 through December 31, 2008). Select and submit the appropriate CPT Category II code corresponding to the measure.
- Medical record may include documentation by clinician that patient's mental status was noted (e.g., patient is oriented or disoriented).
- Each episode of CAP in an eligible patient occurring during the reporting period will be counted when calculating the reporting and performance rates.
- Clinicians utilizing the critical care code (99291) must indicate the emergency department place-of-service code (POS = 23) in order to be counted in the measure's denominator.
- Each unique occurrence is defined as a 45-day period from onset of community-acquired bacterial pneumonia.
- Claims data will be analyzed to determine unique occurrences.
- Failure to report an applicable CPT Category II code in an eligible case will result in both a reporting and performance failure.
- Medical record documentation is required for all clinical actions described in a measure.

Measure #59: Empiric Antibiotic for Community-Acquired Bacterial Pneumonia

- **Reporting Description:** Percentage of patients aged 18 years and older with community-acquired bacterial pneumonia (CAP) and an applicable CPT Category II code reported for each episode of CAP during the reporting period
- **Performance Description:** Percentage of patients aged 18 years and older with a diagnosis of community-acquired bacterial pneumonia with an appropriate empiric antibiotic prescribed

Eligible Cases:	
Patient aged ≥ 18 years on date of encounter **AND** Diagnosis of community-acquired bacterial pneumonia (ICD-9) **AND** Patient encounter during reporting period (CPT)	481, 482.0, 482.1, 482.2, 482.30, 482.31, 482.32, 482.39, 482.40, 482.41, 482.49, 482.81, 482.82, 482.83, 482.84, 482.89, 482.9, 483.0, 483.1, 483.8, 485, 486, 487.0 **AND** 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99281, 99282, 99283, 99284, 99285, 99291* **Clinicians utilizing the critical care code (99291) must indicate the emergency department place-of-service code (POS = 23) in order to be counted in the measure's denominator.*

Quality Data Code Reporting Options:	
Successful Reporting & Performance: Appropriate empiric antibiotic prescribed	4045F
OR	
Successful Reporting & Excluded from Performance: Documentation of medical, patient, or system reasons for not prescribing appropriate empiric antibiotic	4045F-1P **OR** 4045F-2P **OR** 4045F-3P
OR	
Successful Reporting & Performance Not Met: Appropriate empiric antibiotic not prescribed, reason not specified	4045F-8P

Implementation Guidelines:

- Review clinical data regarding the presence or absence of an appropriate empiric antibiotic prescription for each episode of CAP occurring during the reporting period (January 1 through December 31, 2008). Select and submit the appropriate CPT Category II code corresponding to the measure.
- Appropriate empiric antibiotic for treatment of community-acquired bacterial pneumonia (CAP) should include any medication from one of the following four drug classes: Fluoroquinolones, Macrolides, Doxycycline, Beta Lactam with Macrolide or Doxycycline (as defined by current ATS/IDSA guidelines)
- "Prescribed" includes patients who are currently receiving medication(s) that follow the treatment plan recommended at an encounter during the reporting period, even if the prescription for that medication was ordered prior to the encounter.
- Each episode of CAP in an eligible patient occurring during the reporting period will be counted when calculating the reporting and performance rates.
- Clinicians utilizing the critical care code (99291) must indicate the emergency department place-of-service code (POS = 23) in order to be counted in the measure's denominator.
- Each unique occurrence is defined as a 45-day period from onset of community-acquired bacterial pneumonia.
- Claims data will be analyzed to determine unique occurrences.
- Failure to report an applicable CPT Category II code in an eligible case will result in both a reporting and performance failure.
- Medical record documentation is required for all clinical actions described in a measure.

Measure #75: Prevention of Ventilator-Associated Pneumonia – Head Elevation

- **Reporting Description:** Percentage of patients aged 18 years and older and applicable CPT Category II code(s) reported once for each episode of care for all critically ill patients seen during the reporting period
- **Performance Description:** Percentage of ICU patients aged 18 years and older who receive mechanical ventilation and who had an order on the first ventilator day for head of bed elevation (30-45 degrees)

Eligible Cases:	
Patient aged ≥ 18 years on date of encounter **AND** Patient critical care encounter during reporting period (CPT) **Clinicians indicating the place of service as the emergency department (POS = 23) will not be included in this measure.*	99291*

Quality Data Code Reporting Options:	
Successful Reporting & Performance: Head of bed elevation (30-45 degrees) on first ventilator day ordered **AND** Patient receiving care in the intensive care unit (ICU) and receiving mechanical ventilation, 24 hours or less	4167F **AND** 4168F

OR

Successful Reporting & Excluded from Performance: Documentation of medical reason(s) for not ordering head of bed elevation (30-45 degrees) on the first ventilator day **AND** Patient receiving care in the intensive care unit (ICU) and receiving mechanical ventilation, 24 hours or less **OR** Patient is not receiving ICU care or not receiving mechanical ventilation	4167F-1P **AND** 4168F **OR** 4169F

OR

Successful Reporting & Performance Not Met: Head of bed elevation (30-45 degrees) not ordered on first ventilator day, reason not specified **AND** Patient receiving care in the intensive care unit (ICU) and receiving mechanical ventilation, 24 hours or less	4167F-8P **AND** 4168F

Implementation Guidelines:

- The correct combination of numerator code(s) must be reported on the claim form in order to properly report this measure. The "correct combination" of codes may require the submission of multiple numerator codes.
- There is no diagnosis associated with this measure. This measure must be reported for patients 18 years and older for each critical care episode during the reporting period (January 1 through December 31, 2008).
- This measure must be reported for ALL critical care patients, excluding those with place of service as the emergency department. Clinicians utilizing the critical care code in the emergency department (POS = 23) will not be included in this measure.
- At an encounter occurring during the reporting period, review clinical data to determine if ICU patient is receiving mechanical ventilation. For patients in the ICU and receiving mechanical ventilation, it is recommended head of bed elevation on the first ventilation day be ordered. Select and submit the appropriate CPT Category II code(s) corresponding to the measure.
- For the purposes of this measure, mechanical ventilation may include pressure or volume preset ventilators for assisted or controlled breathing OR continuous positive airway pressure ventilation (CPAP).
- Each episode of care for all critically ill patients occurring during the reporting period will be counted when calculating the reporting and performance rates.
- An individual patient may have multiple ICU episodes during the same hospitalization. This measure should be reported for each new episode of care, even those that occur during the same hospitalization. Situations that define an episode include the following:

  1) The first instance 99291 is used (e.g., admission to the ICU or a new episode of critical care)
  2) Upon readmission to the ICU from another unit (e.g., discharged to a step-down unit, then readmitted to ICU due to complications)
  3) *Upon reintubation or intubation any time following admission to the ICU

  *The following is an example: For the patient initially admitted to the ICU, not receiving ventilation, CPT II 4169F would be reported. If the patient's status changes during the episode, requiring ventilation, a second CPT II code, 4168F indicating that the patient is receiving ventilation should be reported; finally, if head of bed elevation is ordered, report CPT II code 4167F.
- Failure to report applicable CPT Category II code(s) in an eligible case will result in both a reporting and performance failure.
- Medical record documentation is required for all clinical actions described in a measure.

Measure #111: Pneumonia Vaccination for Patients 65 Years and Older

- **Reporting Description:** Percentage of patients aged 65 years and older and an applicable CPT Category II code reported a minimum of once during the reporting period
- **Performance Description:** Percentage of patients aged 65 years and older who have ever received a pneumococcal vaccine

Eligible Cases:	
Patient aged ≥ 65 years on date of encounter **AND** Patient encounter during reporting period (CPT)	99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99218, 99219, 99220, 99241, 99242, 99243, 99244, 99245, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, 99356, 99357

Quality Data Code Reporting Options:	
Successful Reporting & Performance: Pneumococcal vaccine administered or previously received	4040F

OR

Successful Reporting & Excluded from Performance: Documentation of medical reason(s) for not administering or previously receiving pneumococcal vaccination	4040F-1P

OR

Successful Reporting & Performance Not Met: Pneumococcal vaccination not administered or previously received, reason not specified	4040F-8P

Implementation Guidelines:

- There is no diagnosis associated with this measure. This measure must be reported a minimum of once for all patients aged 65 years and older seen during the reporting period (January 1 through December 31, 2008).
- Review clinical data regarding the status of pneumococcal vaccination at an encounter occurring during the reporting period. Select and submit the appropriate CPT Category II code corresponding to the measure.
- Performance for this measure is not limited to the reporting period.
- Each eligible patient seen during the reporting period will be counted once when calculating the eligible professionals reporting rate for this measure. The measure may be reported again at a subsequent visit during the reporting period. If the measure is reported more than once for an eligible patient during the reporting period, the single instance of reporting most advantageous to performance will be used when calculating the eligible professional's performance rate for this measure.
- Failure to report an applicable CPT Category II code in an eligible case will result in both a reporting and performance failure.
- Medical record documentation is required for all clinical actions described in a measure.

Measure #101: Appropriate Initial Evaluation of Patients with Prostate Cancer

- **Reporting Description:** Percentage of patients, regardless of age, with prostate cancer receiving interstitial prostate brachytherapy, OR external beam radiotherapy to the prostate, OR radical prostatectomy, OR cryotherapy and an applicable CPT Category II code reported a minimum of once during the reporting period
- **Performance Description:** Percentage of patients, regardless of age, with prostate cancer receiving interstitial prostate brachytherapy, OR external beam radiotherapy to the prostate, OR radical prostatectomy, OR cryotherapy with documented evaluation of prostate-specific antigen (PSA), AND primary tumor (T) stage, AND Gleason score prior to initiation of treatment

Eligible Cases:

Patients of ALL ages **AND** Diagnosis of prostate cancer (ICD-9) **AND** Interstitial prostate brachytherapy, external beam radiotherapy to the prostate, radical prostatectomy, or cryotherapy received during reporting period (CPT)	185 **AND** 55810, 55812, 55815, 55840, 55842, 55845, 55866, 55873, 77411, 77412, 77413, 77414, 77416, 77418, 77427, 77776, 77777, 77778, 77784

Quality Data Code Reporting Options:

Successful Reporting & Performance: Prostate-specific antigen (PSA), AND primary tumor (T) stage, AND Gleason score documented prior to initiation of treatment	3268F

OR

Successful Reporting & Excluded from Performance: Documentation of medical reason(s) for not documenting prostate-specific antigen (PSA), AND primary tumor (T) stage, AND Gleason score prior to initiation of treatment	3268F-1P

OR

Successful Reporting & Performance Not Met: Prostate-specific antigen (PSA), primary tumor (T) stage, and Gleason score not documented, reason not specified	3268F-8P

Implementation Guidelines:

- Review clinical data regarding the presence or absence of the documented evaluation of prostate-specific antigen (PSA), AND primary tumor (T) stage, AND Gleason score for each interstitial prostate brachytherapy, OR external beam radiotherapy to the prostate, OR radical prostatectomy, OR cryotherapy procedure occurring during the reporting period (January 1 through December 31, 2008). Select and submit the appropriate CPT Category II code corresponding to the measure.
- Each eligible patient seen during the reporting period will be counted once when calculating the eligible professionals reporting rate for this measure. The measure may be reported again at a subsequent visit during the reporting period. If the measure is reported more than once for an eligible patient during the reporting period, the single instance of reporting most advantageous to performance will be used when calculating the eligible professional's performance rate for this measure.
- Failure to report an applicable CPT Category II code in an eligible case will result in both a reporting and performance failure.
- Medical record documentation is required for all clinical actions described in a measure.

Measure #102: Inappropriate Use of Bone Scan for Staging Low-Risk Prostate Cancer Patients

- **Reporting Description:** Percentage of patients, regardless of age, with prostate cancer receiving interstitial prostate brachytherapy, OR external beam radiotherapy to the prostate, OR radical prostatectomy, OR cryotherapy and applicable CPT Category II code(s) reported at each procedure performed during the reporting period
- **Performance Description:** Percentage of patients, regardless of age, with a diagnosis of prostate cancer at low risk of recurrence receiving interstitial prostate brachytherapy, OR external beam radiotherapy to the prostate, OR radical prostatectomy, OR cryotherapy who did *not* have a bone scan performed at any time since diagnosis of prostate cancer

Eligible Cases:

Patients of ALL ages **AND** Diagnosis of prostate cancer (ICD-9) **AND** Interstitial prostate brachytherapy, external beam radiotherapy to the prostate, radical prostatectomy, or cryotherapy received during reporting period (CPT)	185 **AND** 55810, 55812, 55815, 55840, 55842, 55845, 55866, 55873, 77411, 77412, 77413, 77414, 77416, 77418, 77427, 77776, 77777, 77778, 77784

Quality Data Code Reporting Options:

Successful Reporting & Performance: Bone scan not performed prior to initiation of treatment nor at any time since diagnosis of prostate cancer **AND** Low risk of recurrence, prostate cancer	3270F **AND** 3271F

OR

Successful Reporting & Excluded from Performance: Documentation of medical or system reason(s) for performing a bone scan (including documented pain, salvage therapy, other medical reasons) **AND** Low risk of recurrence, prostate cancer **OR** Intermediate risk of recurrence, prostate cancer **OR** High risk of recurrence, prostate cancer **OR** Prostate cancer risk of recurrence not determined or neither low, intermediate nor high	3269F-1P **OR** 3269F-3P **AND** 3271F **OR** 3272F **OR** 3273F **OR** 3274F

OR

Successful Reporting & Performance Not Met: Bone scan performed prior to initiation of treatment or at any time since diagnosis of prostate cancer **AND** Low risk of recurrence, prostate cancer	3269F **AND** 3271F

Implementation Guidelines:

- The correct combination of numerator code(s) must be reported on the claim form in order to properly report this measure. The "correct combination" of codes may require the submission of multiple numerator codes.
- At an encounter during the reporting period (January 1 through December 31, 2008), review clinical data to determine whether the patient has a low, intermediate, or high risk of recurrence for prostate cancer or the risk of recurrence for prostate cancer is not determined. Patients with a low risk of recurrence for prostate cancer should not have a bone scan performed at any time since diagnosis of prostate cancer. Select and submit the appropriate CPT Category II code(s) corresponding to the measure
- Each applicable interstitial prostate brachytherapy, OR external beam radiotherapy to the prostate, OR radical prostatectomy, OR cryotherapy procedure occurring during the reporting period will be counted when calculating the reporting and performance rates.
- Failure to report applicable CPT Category II code(s) in an eligible case will result in both a reporting and performance failure.
- Medical record documentation is required for all clinical actions described in a measure.

Acute Episode of Care

PROSTATE CANCER

Measure #103: Review of Treatment Options in Patients with Clinically Localized Prostate Cancer

- **Reporting Description:** Percentage of patients, regardless of age, with clinically localized prostate cancer receiving interstitial prostate brachytherapy, OR external beam radiotherapy to the prostate, OR radical prostatectomy, OR cryotherapy and an applicable CPT Category II code reported a minimum of once during the reporting period
- **Performance Description:** Percentage of patients, regardless of age, with clinically localized prostate cancer AND receiving interstitial prostate brachytherapy, OR external beam radiotherapy to the prostate, OR radical prostatectomy, OR cryotherapy who received counseling prior to initiation of treatment on, at a minimum, the following treatment options for clinically localized disease: active surveillance, AND interstitial prostate brachytherapy, AND external beam radiotherapy, AND radical prostatectomy

Eligible Cases:

Patients of ALL ages **AND** Diagnosis of prostate cancer WITHOUT a secondary malignant neoplasm diagnosis of a specified site (respiratory, digestive, and of other specified sites) (ICD-9) **AND** Interstitial prostate brachytherapy, external beam radiotherapy to the prostate, radical prostatectomy, or cryotherapy received during reporting period (CPT)	185 *WITHOUT* 197.0, 197.1, 197.2, 197.3, 197.4, 197.5, 197.6, 197.7, 197.8, 198.0, 198.1, 198.2, 198.3, 198.4, 198.5, 198.6, 198.7, 198.81, 198.82, 198.89 **AND** 55810, 55812, 55815, 55840, 55842, 55845, 55866, 55873, 77261, 77262, 77263

Quality Data Code Reporting Options:

Successful Reporting & Performance: Patient counseling at a minimum on all of the following treatment options for clinically localized prostate cancer: active surveillance, AND interstitial prostate brachytherapy, AND external beam radiotherapy, AND radical prostatectomy, provided prior to initiation of treatment	4163F

OR

Successful Reporting & Excluded from Performance: Documentation of medical reason(s) for not counseling patient at a minimum on all of the following treatment options for clinically localized prostate cancer: active surveillance, AND interstitial prostate brachytherapy, AND external beam radiotherapy, AND radical prostatectomy, (ie, salvage therapy)	4163F-1P

OR

Successful Reporting & Performance Not Met: Counseling on treatment options for clinically localized prostate cancer not provided, reason not specified	4163F-8P

Implementation Guidelines:

- Review clinical data regarding the presence or absence of counseling on, at a minimum, the following treatment options for clinically localized prostate cancer: active surveillance, AND interstitial prostate brachytherapy, AND external beam radiotherapy, AND radical prostatectomy prior to each interstitial prostate brachytherapy, OR external beam radiotherapy to the prostate, OR radical prostatectomy, OR cryotherapy procedure occurring during the reporting period (January 1 through December 31, 2008). Select and submit the appropriate CPT Category II code corresponding to the measure.
- Only patients with a diagnosis of prostate cancer (ICD-9 185) **WITHOUT** a secondary malignant neoplasm diagnosis of a specified site (respiratory, digestive, and of other specified sites) will be eligible for this measure.
- Each eligible patient seen during the reporting period will be counted once when calculating the eligible professionals reporting rate for this measure. The measure may be reported again at a subsequent visit during the reporting period. If the measure is reported more than once for an eligible patient during the reporting period, the single instance of reporting most advantageous to performance will be used when calculating the eligible professional's performance rate for this measure.
- Failure to report an applicable CPT Category II code in an eligible case will result in both a reporting and performance failure.
- Medical record documentation is required for all clinical actions described in a measure.

Measure #104: Adjuvant Hormonal Therapy for High-Risk Prostate Cancer Patients

- **Reporting Description:** Percentage of patients, regardless of age, with prostate cancer receiving external beam radiotherapy to the prostate and applicable CPT Category II code and/or G-code reported once for each episode of radiation therapy during the reporting period
- **Performance Description:** Percentage of patients, regardless of age, with a diagnosis of prostate cancer at high risk of recurrence receiving external beam radiotherapy to the prostate who were prescribed adjuvant hormonal therapy (GnRH agonist or antagonist)

Eligible Cases:	
Patients of ALL ages **AND** Diagnosis of prostate cancer (ICD-9) **AND** External beam radiotherapy to the prostate received during reporting period (CPT)	185 **AND** 77407, 77408, 77409, 77411, 77412, 77413, 77414, 77416, 77418, 77427

Quality Data Code Reporting Options:	
Successful Reporting & Performance: Adjuvant (i.e., in combination with external beam radiotherapy to the prostate for prostate cancer) hormonal therapy (GnRH [gonadotropin-releasing hormone] agonist or antagonist) prescribed/administered **AND** High risk of recurrence of prostate cancer	4164F **AND** G8465

OR

Successful Reporting & Excluded from Performance: Documentation of medical or patient reason(s) for not prescribing/administering adjuvant (ie, in combination with external beam radiotherapy to the prostate for prostate cancer) hormonal therapy (GnRH [gonadotropin-releasing hormone] agonist or antagonist) **AND** High risk of recurrence of prostate cancer **OR** Clinician documented that prostate cancer patient is not an eligible candidate for adjuvant hormonal therapy; Low or intermediate risk of recurrence OR risk of recurrence not determined	4164F-1P **OR** 4164F-2P **AND** G8465 **OR** G8464

OR

Successful Reporting & Performance Not Met: Adjuvant hormonal therapy not prescribed/administered, reason not specified **AND** High risk of recurrence of prostate cancer	4164F-8P **AND** G8465

Implementation Guidelines:

- The correct combination of numerator code(s) must be reported on the claim form in order to properly report this measure. The "correct combination" of codes may require the submission of multiple numerator codes.
- This measure must be reported once per episode of radiation therapy for ALL patients with prostate cancer who receive external beam radiotherapy to the prostate.
- At an encounter during the reporting period (January 1 through December 31, 2008), review clinical data to determine whether the patient has a low, intermediate, or high risk of recurrence for prostate cancer or the risk of recurrence for prostate cancer is not determined. Patients with a high risk of recurrence for prostate cancer should be prescribed adjuvant hormonal therapy (GnRH agonist or antagonist). Select and submit the appropriate CPT Category II code and/or G-code corresponding to the measure
- Each episode of radiation therapy in an eligible patient receiving external beam radiotherapy to the prostate occurring during the reporting period will be counted when calculating the reporting and performance rates.
- Claims data will be analyzed to determine unique episodes of radiation therapy.
- Failure to report applicable CPT Category II code and/or G-code in an eligible case will result in both a reporting and performance failure.
- Medical record documentation is required for all clinical actions described in a measure.

Measure #105: Three-dimensional Radiotherapy for Patients with Prostate Cancer

- **Reporting Description:** Percentage of patients, regardless of age, with clinically localized prostate cancer receiving external beam radiotherapy to the prostate and applicable CPT Category II code(s) reported for each external beam radiotherapy to the prostate procedure performed during the reporting period
- **Performance Description:** Percentage of patients, regardless of age, with prostate cancer receiving external beam radiotherapy to the prostate *only* (no metastases) who receive 3D-CRT or IMRT

Eligible Cases:

Patients of ALL ages **AND** Diagnosis of prostate cancer **WITHOUT** a secondary malignant neoplasm diagnosis of a specified site (respiratory, digestive, and of other specified sites) (ICD-9) **AND** External beam radiotherapy to the prostate received during reporting period (CPT)	185 *WITHOUT* 197.0, 197.1, 197.2, 197.3, 197.4, 197.5, 197.6, 197.7, 197.8, 198.0, 198.1, 198.2, 198.3, 198.4, 198.5, 198.6, 198.7, 198.81, 198.82, 198.89 **AND** 77401, 77402, 77403, 77404, 77406, 77407, 77408, 77409, 77411, 77412, 77413, 77414, 77416, 77418, 77427

Quality Data Code Reporting Options:

Successful Reporting & Performance: Three-dimensional conformal radiotherapy (3D-CRT) or intensity modulated radiation therapy (IMRT) received **AND** External beam radiotherapy to prostate only	4165F **AND** 4200F

OR

Successful Reporting & Excluded from Performance: External beam radiotherapy for prostate cancer to region(s) other than prostate only	4201F

OR

Successful Reporting & Performance Not Met: 3D-CRT or IMRT not received, reason not specified **AND** External beam radiotherapy to prostate only	4165F-8P **AND** 4200F

Implementation Guidelines:

- The correct combination of numerator code(s) must be reported on the claim form in order to properly report this measure. The "correct combination" of codes may require the submission of multiple numerator codes.
- Only patients with a diagnosis of prostate cancer (ICD-9 185) **WITHOUT** a secondary malignant neoplasm diagnosis of a specified site (respiratory, digestive, and of other specified sites) will be eligible for this measure.
- At an encounter during the reporting period (January 1 through December 31, 2008), review clinical data to determine whether or not the patient is receiving external beam radiotherapy to the prostate only. Patients receiving external beam radiotherapy to the prostate only should receive 3D-CRT or IMRT. Select and submit the appropriate CPT Category II code(s) corresponding to the measure
- Each applicable external beam radiotherapy to the prostate procedure occurring during the reporting period will be counted when calculating the reporting and performance rates.
- Failure to report applicable CPT Category II code(s) in an eligible case will result in both a reporting and performance failure.
- Medical record documentation is required for all clinical actions described in a measure.

Measure #31: Stroke and Stroke Rehabilitation: Deep Vein Thrombosis Prophylaxis (DVT) for Ischemic Stroke or Intracranial Hemorrhage

- **Reporting Description:** Percentage of patients aged 18 years and older with ischemic stroke or intracranial hemorrhage and applicable CPT Category II code reported a minimum of once for each hospital stay occurring during the reporting period
- **Performance Description:** Percentage of patients aged 18 years and older with a diagnosis of ischemic stroke or intracranial hemorrhage who received DVT prophylaxis by end of hospital day two

Eligible Cases:

Patients aged 18 ≥ years on date of encounter **AND** Diagnosis of ischemic stroke or intracranial hemorrhage (ICD-9) **AND** Patient encounter during reporting period (CPT)	431, 433.01, 433.11, 433.21, 433.31, 433.81, 433.91, 434.01, 434.11, 434.91 **AND** 99221, 99222, 99223, 99251, 99252, 99253, 99254, 99255, 99291

Quality Data Code Reporting Options:

Successful Reporting & Performance: Deep vein thrombosis (DVT) prophylaxis received by end of hospital day 2	4070F

OR

Successful Reporting & Excluded from Performance: Documentation of medical or patient reason(s) for not receiving DVT prophylaxis by end of hospital day 2	4070F-1P **OR** 4070F-2P

OR

Successful Reporting & Performance Not Met: DVT prophylaxis not received, reason not specified	4070F-8P

Implementation Guidelines:

- Review clinical data regarding the presence or absence of DVT prophylaxis during a hospital stay occurring within the reporting period (January 1 through December 31, 2008). Select and submit the appropriate CPT Category II code corresponding to the measure.
- For purposes of this measure, DVT prophylaxis can include Low Molecular Weight Heparin (LMWH), Low-Dose Unfractionated Heparin (LDUH), intravenous Heparin, low-dose subcutaneous heparin, or intermittent pneumatic compression devices.
- Each episode of ischemic stroke or intracranial hemorrhage occurring during the reporting period will be counted when calculating the reporting and performance rates.
- Part B Claims data will be analyzed to determine a hospital stay. Multiple qualifying diagnoses submitted on the same claim form will be counted as one episode.
- Failure to report an applicable CPT Category II code in an eligible case will result in both a reporting and performance failure.
- Medical record documentation is required for all clinical actions described in a measure.

Measure #32: Stroke and Stroke Rehabilitation: Discharged on Antiplatelet Therapy

- **Reporting Description:** Percentage of patients aged 18 years and older with ischemic stroke or transient ischemic attack (TIA) and an applicable CPT Category II code reported at discharge from a hospital during the reporting period
- **Performance Description:** Percentage of patients aged 18 years and older with a diagnosis of ischemic stroke or transient ischemic attack (TIA) who were prescribed antiplatelet therapy at discharge

Eligible Cases:

Patients aged 18 ≥ years on date of encounter **AND** Diagnosis of ischemic stroke or transient ischemic attack (TIA) (ICD-9) **AND** Patient encounter during reporting period (CPT)	433.01, 433.11, 433.21, 433.31, 433.81, 433.91, 434.01, 434.11, 434.91, 435.0, 435.1, 435.2, 435.3, 435.8, 435.9 **AND** 99238, 99239, 99251, 99252, 99253, 99254, 99255

Quality Data Code Reporting Options:

Successful Reporting & Performance: Oral antiplatelet therapy prescribed at discharge	4073F

OR

Successful Reporting & Excluded from Performance: Documentation of medical or patient reason(s) for not prescribing oral antiplatelet therapy at discharge	4073F-1P **OR** 4073F-2P

OR

Successful Reporting & Performance Not Met: Oral antiplatelet therapy prescription not prescribed, reason not specified	4073F-8P

Implementation Guidelines:

- Review clinical data regarding the presence or absence of antiplatelet therapy (at discharge) occurring during the reporting period (January 1 through December 31, 2008). Select and submit the appropriate CPT Category II code corresponding to the measure.
- Antiplatelet therapy: aspirin, combination of aspirin and extended-release dipyridamole, clopidogrel, ticlopidine
- Each episode of ischemic stroke or TIA with a discharge occurring during the reporting period will be counted when calculating the reporting and performance rates.
- Part B Claims data will be analyzed to determine a hospital discharge. Multiple qualifying diagnoses submitted on the same claim form will be counted as one episode.
- Failure to report an applicable CPT Category II code in an eligible case will result in both a reporting and performance failure.
- Medical record documentation is required for all clinical actions described in a measure.

Measure #33: Stroke and Stroke Rehabilitation: Anticoagulant Therapy Prescribed for Atrial Fibrillation at Discharge

- **Reporting Description:** Percentage of patients aged 18 years and older with ischemic stroke or transient ischemic attack (TIA) with documented permanent, persistent, or paroxysmal atrial fibrillation and an applicable CPT Category II code reported at each discharge from a hospital during the reporting period
- **Performance Description:** Percentage of patients aged 18 years and older with a diagnosis of ischemic stroke or transient ischemic attack (TIA) with documented permanent, persistent, or paroxysmal atrial fibrillation who were prescribed an anticoagulant at discharge

Eligible Cases:

Patients aged 18 ≥ years on date of encounter **AND** Diagnosis of ischemic stroke or transient ischemic attack (TIA) (ICD-9) **AND** Diagnosis of atrial fibrillation (ICD-9) **AND** Patient encounter during reporting period (CPT)	433.01, 433.11, 433.21, 433.31, 433.81, 433.91, 434.01, 434.11, 434.91, 435.0, 435.1, 435.2, 435.3, 435.8, 435.9 **AND** 427.31 **AND** 99238, 99239, 99251, 99252, 99253, 99254, 99255

Quality Data Code Reporting Options:

Successful Reporting & Performance: Anticoagulant therapy prescribed at discharge	4075F

OR

Successful Reporting & Excluded from Performance: Documentation of medical or patient reason(s) for not prescribing anticoagulant therapy at discharge	4075F-1P **OR** 4075F-2P

OR

Successful Reporting & Performance Not Met: Anticoagulant prescription not received at discharge, reason not specified	4075F-8P

Implementation Guidelines:

- At each hospital discharge for a stroke patient occurring during the reporting period (January 1 through December 31, 2008), review clinical data to determine whether atrial fibrillation (permanent, persistent, or paroxysmal) is present or absent. For patients with a presence of permanent, persistent, or paroxysmal atrial fibrillation, anticoagulant therapy is recommended following discharge. Select and submit the appropriate CPT Category II code corresponding to the measure.
- Persistent Atrial Fibrillation: recurrent atrial fibrillation, not self-terminating or terminated electrically or pharmacologically; Paroxysmal Atrial Fibrillation: recurrent atrial fibrillation, self-terminating; Permanent Atrial Fibrillation**:** long-standing atrial fibrillation (>1 year), cardioversion failed or not attempted
- Each episode of ischemic stroke or TIA with atrial fibrillation (permanent, persistent, or paroxysmal) with a hospital discharge occurring during the reporting period will be counted when calculating the reporting and performance rates.
- Part B Claims data will be analyzed to determine a hospital discharge. Multiple qualifying diagnoses submitted on the same claim form will be counted as one episode.
- Failure to report an applicable CPT Category II code in an eligible case will result in both a reporting and performance failure.
- Medical record documentation is required for all clinical actions described in a measure.

Measure #34: Stroke and Stroke Rehabilitation: Tissue Plasminogen Activator (t-PA) Considered

- **Reporting Description:** Percentage of patients aged 18 years and older with ischemic stroke and an applicable CPT Category II code reported a minimum of once for each hospital stay during the reporting period
- **Performance Description:** Percentage of patients aged 18 years and older with a diagnosis of ischemic stroke whose time from symptom onset to arrival is less than 3 hours who were considered for t-PA administration

Eligible Cases:

Patients aged 18 ≥ years on date of encounter **AND** Diagnosis of ischemic stroke (ICD-9) **AND** Patient encounter during reporting period (CPT)	433.01, 433.11, 433.21, 433.31, 433.81, 433.91, 434.01, 434.11, 434.91 **AND** 99221, 99222, 99223, 99251, 99252, 99253, 99254, 99255, 99291

Quality Data Code Reporting Options:

Successful Reporting & Performance: Documentation that tissue plasminogen activator (t-PA) administration was considered **AND** Ischemic stroke symptom onset of < 3 hours prior to arrival	4077F **AND** 1065F

OR

Successful Reporting & Excluded from Performance: Ischemic stroke symptom onset ≥ 3 hours prior to arrival	1066F

OR

Successful Reporting & Performance Not Met: t-PA administration or consideration not documented, reason not specified **AND** Ischemic stroke symptom onset of < 3 hours prior to arrival	4077F-8P **AND** 1065F

Implementation Guidelines:

- The correct combination of numerator code(s) must be reported on the claim form in order to properly report this measure. The "correct combination" of codes may require the submission of multiple numerator codes.
- This measure must be reported during each hospital stay for ALL patients under active treatment for ischemic stroke.
- At an encounter occurring during the reporting period (January 1 through December 31, 2008), review clinical data to determine timing of symptom onset to hospital arrival. For patients with symptom onset occurring less than 3 hours prior to arrival, it is recommended t-PA administration be considered. Select and submit the appropriate CPT Category II code(s) corresponding to the measure.
- For purposes of this measure, patients “considered for t-PA administration” includes patients to whom t-PA was given or patients for whom reasons for not being a candidate for t-PA therapy are documented.
- Each episode of ischemic stroke occurring during the reporting period will be counted when calculating the reporting and performance rates.
- Part B Claims data will be analyzed to determine a hospital stay. Multiple qualifying diagnoses submitted on the same claim form will be counted as one episode.
- Failure to report applicable CPT Category II code(s) in an eligible case will result in both a reporting and performance failure.
- Medical record documentation is required for all clinical actions described in a measure.

Measure #35: Stroke and Stroke Rehabilitation: Screening for Dysphagia

- **Reporting Description:** Percentage of patients aged 18 years and older with ischemic stroke or intracranial hemorrhage and applicable CPT Category II code(s) reported a minimum of once during each hospital stay within the reporting period
- **Performance Description:** Percentage of patients aged 18 years and older with a diagnosis of ischemic stroke or intracranial hemorrhage who underwent a dysphagia screening process before taking any foods, fluids or medication by mouth

Eligible Cases:

Patients aged 18 ≥ years on date of encounter **AND** Diagnosis of ischemic stroke or intracranial hemorrhage (ICD-9) **AND** Patient encounter during reporting period (CPT)	431, 433.01, 433.11, 433.21, 433.31, 433.81, 433.91, 434.01, 434.11, 434.91 **AND** 99221, 99222, 99223, 99251, 99252, 99253, 99254, 99255

Quality Data Code Reporting Options:

Successful Reporting & Performance: Dysphagia screening conducted prior to order for or receipt of any foods, fluids or medication by mouth **AND** Patient receiving or eligible to receive food, fluids or medication by mouth	6010F **AND** 6015F

OR

Successful Reporting & Excluded from Performance: Documentation of medical reason(s) for not conducting dysphagia screening prior to taking any foods, fluids or medication by mouth **AND** Patient receiving or eligible to receive food, fluids or medication by mouth **OR** NPO (nothing by mouth) ordered	6010F-1P **AND** 6015F **OR** 6020F

OR

Successful Reporting & Performance Not Met: Dysphagia screening not conducted, reason not specified **AND** Patient receiving or eligible to receive food, fluids or medication by mouth	6010F-8P **AND** 6015F

Implementation Guidelines:

- The correct combination of numerator code(s) must be reported on the claim form in order to properly report this measure. The "correct combination" of codes may require the submission of multiple numerator codes.
- This measure must be reported during each hospital stay for ALL patients under active treatment for ischemic stroke or intracranial hemorrhage.
- At an encounter occurring during the reporting period (January 1 through December 31, 2008), review clinical data to determine if patient is receiving or eligible to receive food, fluids, or medication by mouth. For patients receiving food, fluids, or medication by mouth, dysphagia screening is recommended. Select and submit the appropriate CPT Category II code(s) corresponding to the measure.
- Dysphagia Screening: use of a tested and validated dysphagia screening tool (e.g. Burke dysphagia screening test, 3 oz. water swallow test, Mann assessment of swallowing ability [MASA], standardized bedside swallowing assessment [SSA]) OR a dysphagia screening tool approved by the hospital's speech/language pathology (SLP) services.
- Each episode of ischemic stroke or intracranial hemorrhage occurring during the reporting period will be counted when calculating the reporting and performance rates.
- Part B Claims data will be analyzed to determine a hospital stay. Multiple qualifying diagnoses submitted on the same claim form will be counted as one episode.
- Failure to report applicable CPT Category II code(s) in an eligible case will result in both a reporting and performance failure.
- Medical record documentation is required for all clinical actions described in a measure.

Measure #36: Stroke and Stroke Rehabilitation: Consideration of Rehabilitation Services

- **Reporting Description:** Percentage of patients aged 18 years and older with active treatment for ischemic stroke or intracranial hemorrhage and an applicable CPT Category II code reported a minimum of once for each hospital stay occurring during the reporting period
- **Performance Description:** Percentage of patients aged 18 years and older with a diagnosis of ischemic stroke or intracranial hemorrhage for whom consideration of rehabilitation services is documented

Eligible Cases:	
Patients aged 18 ≥ years on date of encounter **AND** Diagnosis of ischemic stroke or intracranial hemorrhage (ICD-9) **AND** Patient encounter during reporting period (CPT)	431, 433.01, 433.11, 433.21, 433.31, 433.81, 433.91, 434.01, 434.11, 434.91 **AND** 99238, 99239, 99251, 99252, 99253, 99254, 99255

Quality Data Code Reporting Options:	
Successful Reporting & Performance: Documentation that rehabilitation services were considered	4079F

OR

Successful Reporting & Excluded from Performance: There are no allowable performance exclusions for this measure.	NONE

OR

Successful Reporting & Performance Not Met: Rehabilitation services not ordered or considered, reason not specified	4079F-8P

Implementation Guidelines:

- Review clinical data regarding the presence or absence of consideration of rehabilitation services during each hospital stay occurring within the reporting period (January 1 through December 31, 2008). Select and submit the appropriate CPT Category II code corresponding to the measure.
- For purposes of this measure, "consideration of rehabilitation services" includes an order for rehabilitation services or documentation that rehabilitation was not indicated.
- Each episode of ischemic stroke or intracranial hemorrhage with a hospital stay occurring during the reporting period will be counted when calculating the reporting and performance rates.
- Part B Claims data will be analyzed to determine a hospital stay. Multiple qualifying diagnoses submitted on the same claim form will be counted as one episode.
- Failure to report an applicable CPT Category II code in an eligible case will result in both a reporting and performance failure.
- Medical record documentation is required for all clinical actions described in a measure.

Measure #55: Electrocardiogram Performed for Syncope

- **Reporting Description:** Percentage of patients aged 60 years and older with an emergency department discharge diagnosis of syncope and an applicable CPT Category II code reported for each episode of syncope occurring during the reporting period
- **Performance Description:** Percentage of patients aged 60 years and older with an emergency department discharge diagnosis of syncope who had a 12-lead ECG performed

Eligible Cases:

Patient aged ≥ 60 years on date of encounter	
AND	23
Place of Service (POS) = Emergency Dept (23)	**AND**
AND	780.2
Discharge diagnosis of syncope (ICD-9)	**AND**
AND	99281, 99282, 99283, 99284, 99285, 99291
Patient encounter during reporting period (CPT)	

Quality Data Code Reporting Options:

Successful Reporting & Performance: 12-lead ECG performed	3120F

OR

Successful Reporting & Excluded from Performance: Documentation of medical or patient reasons for not performing a 12-lead ECG	3120F-1P **OR** 3120F-2P

OR

Successful Reporting & Performance Not Met: 12-lead ECG not performed, reason not specified	3120F-8P

Implementation Guidelines:

- Review clinical data regarding the presence or absence of a 12-lead ECG for each episode of an emergency department discharge diagnosis of syncope occurring during the reporting period (January 1 through December 31, 2008). Select and submit the appropriate CPT Category II code corresponding to the measure.
- Each episode of an emergency department discharge diagnosis of syncope in an eligible patient occurring during the reporting period will be counted when calculating the reporting and performance rates.
- The Part B claim form place-of-service (POS) field must indicate that the encounter has taken place in the emergency department (POS 23 = ED).
- Claims data will be analyzed to determine the emergency department discharge.
- Failure to report an applicable CPT Category II code in an eligible case will result in both a reporting and performance failure.
- Medical record documentation is required for all clinical actions described in a measure.

Measure #114: Inquiry Regarding Tobacco Use

- **Reporting Description:** Percentage of patients aged 18 years or older and applicable CPT Category II code(s) reported a minimum of once during the reporting period
- **Performance Description:** Percentage of patients aged 18 years or older who were queried about tobacco use one or more times within 24 months

Eligible Cases:	
Patient aged ≥ 18 years on date of encounter **AND** Patient encounter during reporting period (CPT)	99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215

Quality Data Code Reporting Options:	
Successful Reporting & Performance: Tobacco use assessed **AND** Current tobacco smoker **OR** Current smokeless tobacco user **OR** Current tobacco non-user	1000F **AND** 1034F **OR** 1035F **OR** 1036F

OR

Successful Reporting & Excluded from Performance: There are no allowable performance exclusions for this measure.	NONE

OR

Successful Reporting & Performance Not Met: Tobacco use not assessed, reason not specified	1000F-8P

Implementation Guidelines:

- The correct combination of numerator code(s) must be reported on the claim form in order to properly report this measure. The "correct combination" of codes may require the submission of multiple numerator codes.
- There is no diagnosis associated with this measure. This measure must be reported for all patients aged 18 years and older seen during the reporting period (January 1 through December 31, 2008).
- Review clinical data (within the last 24 months of this encounter) regarding tobacco use at an encounter during the reporting period. Select and submit the appropriate CPT Category II code(s) corresponding to the measure.
- Each eligible patient seen during the reporting period will be counted once when calculating the eligible professional's reporting rate for this measure. The measure may be reported again at a subsequent visit during the reporting period. If the measure is reported more than once for an eligible patient during the reporting period, the single instance of reporting most advantageous to performance will be used when calculating the eligible professional's performance rate for this measure.
- Failure to report applicable CPT Category II code(s) in an eligible case will result in both a reporting and performance failure.
- Medical record documentation is required for all clinical actions described in a measure.

Measure #115: Advising Smokers to Quit

- **Reporting Description:** Percentage of patients aged 18 years and older and applicable G-code(s) reported a minimum of once during the reporting period
- **Performance Description:** Percentage of patients aged 18 years and older and are smokers who received advice to quit smoking

Eligible Cases:	
Patient aged ≥ 18 years on date of encounter **AND** Patient encounter during reporting period (CPT)	99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99217, 99218, 99219, 99220, 99241, 99242, 99243, 99244, 99245

Quality Data Code Reporting Options:	
Successful Reporting & Performance: Current tobacco smoker **AND** Tobacco (smoke) use cessation intervention, counseling	G8455 **AND** G8402

OR

Successful Reporting & Excluded from Performance: Current smokeless tobacco user **OR** Tobacco non-user	G8456 **OR** G8457

OR

Successful Reporting & Performance Not Met: Current tobacco smoker **AND** Tobacco (smoke) use cessation intervention not counseled	G8455 **AND** G8403

Implementation Guidelines:

- The correct combination of numerator code(s) must be reported on the claim form in order to properly report this measure. The "correct combination" of codes may require the submission of multiple numerator codes.
- There is no diagnosis associated with this measure. This measure must be reported a minimum of once for all patients 18 years and older (whether or not they use tobacco) seen during the reporting period (January 1 through December 31, 2008).
- At an encounter during the reporting period (January 1 through December 31, 2008), review clinical data to determine tobacco use. For patients that are current tobacco smokers, tobacco (smoke) use cessation intervention should be counseled. Select and submit the appropriate CPT Category II code(s) corresponding to the measure.
- Review clinical data regarding tobacco use at an encounter during the reporting period. Select and submit the appropriate G-code(s) corresponding to the measure.
- Each eligible patient seen during the reporting period will be counted once when calculating the eligible professional's reporting rate for this measure. The measure may be reported again at a subsequent visit during the reporting period. If the measure is reported more than once for an eligible patient during the reporting period, the single instance of reporting most advantageous to performance will be used when calculating the eligible professional's performance rate for this measure.
- Failure to report applicable G-code(s) in an eligible case will result in both a reporting and performance failure.
- Medical record documentation is required for all clinical actions described in a measure.

Acute Episode of Care

URI

Measure #65: Appropriate Treatment for Children with Upper Respiratory Infection (URI)

- **Reporting Description:** Percentage of children aged 3 months through 18 years with URI and an applicable CPT Category II code reported for each diagnosis of URI occurring during the reporting period
- **Performance Description:** Percentage of children aged 3 months through 18 years with a diagnosis of upper respiratory infection (URI) who were not prescribed or dispensed an antibiotic prescription on or within 3 days of the initial date of service

Eligible Cases:	
Patient aged ≥ 3 months and ≤ 18 years on date of encounter **AND** Diagnosis of URI (ICD-9) **AND** Patient encounter during reporting period (CPT)	460, 465.0, 465.8, 465.9 **AND** 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99217, 99218, 99219, 99220, 99241, 99242, 99243, 99244, 99245

Quality Data Code Reporting Options:	
Successful Reporting & Performance: Antibiotic neither prescribed nor dispensed	4124F

OR

Successful Reporting & Excluded from Performance: Documentation of medical reason(s) for prescribing or dispensing antibiotic	4120F-1P

OR

Successful Reporting & Performance Not Met: Antibiotic prescribed or dispensed (Reason not specified)	4120F

Implementation Guidelines:

- Review clinical data for each episode of URI regarding the presence or absence of an antibiotic prescription to be dispensed or was dispensed on or three days after the date of an encounter occurring during the reporting period (January 1 through December 31, 2008). Select and submit the appropriate CPT Category II code corresponding to the measure.
- For performance, the numerator will be calculated as the difference between patients in the denominator and patients for whom a CPT Category II code was reported for antibiotic prescribed or dispensed. **A higher score indicates appropriate treatment of children with URI** (i.e., the proportion for whom antibiotics *were not* prescribed).
- Each diagnosis of URI in an eligible patient occurring during the reporting period will be counted when calculating the reporting and performance rates.
- Claims data will be analyzed to determine unique occurrences.
- Failure to report an applicable CPT Category II code in an eligible case will result in both a reporting and performance failure.
- Medical record documentation is required for all clinical actions described in a measure.

Measure #48: Assessment of Presence or Absence of Urinary Incontinence in Women Aged 65 Years and Older

- **Reporting Description:** Percentage of female patients aged 65 years and older seen by a clinician and an applicable CPT Category II code reported a minimum of once during the reporting period
- **Performance Description:** Percentage of female patients aged 65 years and older who were assessed for the presence or absence of urinary incontinence within 12 months

Eligible Cases:	
Female patient aged ≥ 65 years on date of encounter **AND** Patient encounter during reporting period (CPT)	99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215

Quality Data Code Reporting Options:	
Successful Reporting & Performance: Presence or absence of urinary incontinence assessed	1090F

OR

Successful Reporting & Excluded from Performance: Documentation of medical reason(s) for not assessing for the presence or absence of urinary incontinence	1090F-1P

OR

Successful Reporting & Performance Not Met: Presence or absence of urinary incontinence not assessed, reason not specified	1090F-8P

Implementation Guidelines:

- There is no diagnosis associated with this measure. The measure must be reported a minimum of once for all female patients aged 65 years and older seen during the reporting period (January 1 through December 31, 2008).
- Review clinical data (within the last 12 months of this encounter) regarding the presence or absence of an assessment of urinary incontinence at an encounter occurring during the reporting period (January 1 through December 31, 2008). Select and submit the appropriate CPT Category II code corresponding to the measure.
- This is considered a general screening measure.
- Urinary incontinence is defined as any involuntary leakage of urine.
- Each eligible patient seen during the reporting period will be counted once when calculating the eligible professional's reporting rate for this measure. The measure may be reported again at a subsequent visit during the reporting period. If the measure is reported more than once for an eligible patient during the reporting period, the single instance of reporting most advantageous to performance will be used when calculating the eligible professional's performance rate for this measure.
- Failure to report an applicable CPT Category II code in an eligible case will result in both a reporting and performance failure.
- Medical record documentation is required for all clinical actions described in a measure.

Measure #49: Characterization of Urinary Incontinence in Women Aged 65 Years and Older

- **Reporting Description:** Percentage of female patients aged 65 years and older with urinary incontinence and an applicable CPT Category II code reported a minimum of once during the reporting period
- **Performance Description:** Percentage of female patients aged 65 years and older with a diagnosis of urinary incontinence whose urinary incontinence was characterized at least once within 12 months

Eligible Cases:

Female patient aged ≥ 65 years on date of encounter **AND** Diagnosis of urinary incontinence (ICD-9) **AND** Patient encounter during reporting period (CPT)	307.6, 625.6, 788.30, 788.31, 788.33, 788.34, 788.35, 788.36, 788.37, 788.38, 788.39 **AND** 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245

Quality Data Code Reporting Options:

Successful Reporting & Performance: Urinary incontinence characterized (eg frequency, volume, timing, type of symptoms, how bothersome)	1091F

OR

Successful Reporting & Excluded from Performance: There are no allowable performance exclusions for this measure.	NONE

OR

Successful Reporting & Performance Not Met: Urinary incontinence not characterized (eg frequency, volume, timing, type of symptoms, how bothersome), reason not specified	1091F-8P

Implementation Guidelines:

- Review clinical data (within the last 12 months of this encounter) regarding the presence or absence of urinary incontinence characterization at an encounter occurring during the reporting period (January 1 through December 31, 2008). Select and submit the appropriate CPT Category II code corresponding to the measure.
- Each eligible patient seen during the reporting period will be counted once when calculating the eligible professional's reporting rate for this measure. The measure may be reported again at a subsequent visit during the reporting period. If the measure is reported more than once for an eligible patient during the reporting period, the single instance of reporting most advantageous to performance will be used when calculating the eligible professional's performance rate for this measure.
- Failure to report an applicable CPT Category II code in an eligible case will result in both a reporting and performance failure.
- Medical record documentation is required for all clinical actions described in a measure.

Measure #50: Plan of Care for Urinary Incontinence in Women Aged 65 Years and Older

- **Reporting Description:** Percentage of female patients aged 65 years and older with urinary incontinence and an applicable CPT Category II code reported a minimum of once during the reporting period
- **Performance Description:** Percentage of female patients aged 65 years and older with a diagnosis of urinary incontinence with a documented plan of care for urinary incontinence at least once within 12 months

Eligible Cases:	
Female patient aged ≥ 65 years on date of encounter **AND** Diagnosis of urinary incontinence (ICD-9) **AND** Patient encounter during reporting period (CPT)	307.6, 625.6, 788.30, 788.31, 788.33, 788.34, 788.35, 788.36, 788.37, 788.38, 788.39 **AND** 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245

Quality Data Code Reporting Options:	
Successful Reporting & Performance: Urinary incontinence plan of care documented	0509F

OR

Successful Reporting & Excluded from Performance: There are no allowable performance exclusions for this measure.	NONE

OR

Successful Reporting & Performance Not Met: Plan of care for urinary incontinence not documented, reason not specified	0509F-8P

Implementation Guidelines:

- Review clinical data (within the last 12 months of this encounter) regarding the presence or absence of urinary incontinence plan of care documentation at an encounter occurring during the reporting period (January 1 through December 31, 2008). Select and submit the appropriate CPT Category II code corresponding to the measure.
- Plan of care may include behavioral interventions (e.g., bladder training, pelvic floor muscle training, prompted voiding), referral to specialist, surgical treatment, reassess at follow-up visit, lifestyle interventions, addressing co-morbid factors, modification or discontinuation of medications contributing to urinary incontinence, or pharmacologic therapy.
- Each eligible patient seen during the reporting period will be counted once when calculating the eligible professional's reporting rate for this measure. The measure may be reported again at a subsequent visit during the reporting period. If the measure is reported more than once for an eligible patient during the reporting period, the single instance of reporting most advantageous to performance will be used when calculating the eligible professional's performance rate for this measure.
- Failure to report an applicable CPT Category II code in an eligible case will result in both a reporting and performance failure.
- Medical record documentation is required for all clinical actions described in a measure.

CPT Category II Codes	A set of supplemental CPT codes intended to be used for performance measurement. These codes may be used to facilitate data collection about the quality of care rendered by coding certain services, test results or clinical actions that support nationally established performance measures and that the evidence has demonstrated contribute to quality patient care.[2] For PQRI, CPT Category II codes are used to report quality measures on a claim for measurement calculation.
Denominator	The lower part of a fraction used to calculate a rate, proportion, or ratio. The denominator is associated with a given patient population that may be counted as eligible to meet a measure's inclusion requirements. **PQRI measure denominators are ICD-9, CPT I, and HCPCS codes, as well as patient demographics (age, gender, etc).**
Denominator Statement	A statement that describes the population evaluated by the performance measure. For example, "Patients aged 18 through 75 years with a diagnosis of diabetes mellitus."
Eligible Professional	The Tax Relief and Health Care Act of 2006, Section 101 defines "eligible professional" as the following: 1. Medicare physician, as defined in Social Security Act (SSA) section 1861(r) • Doctor of Medicine • Doctor of Osteopathy • Doctor of Podiatric Medicine • Doctor of Optometry • Doctor of Oral Surgery • Doctor of Dental Medicine • Chiropractor 2. Practitioners described in SSA section 1842(b)(18)(C) • Physician Assistant • Nurse Practitioner • Clinical Nurse Specialist • Certified Registered Nurse Anesthetist • Certified Nurse Midwife • Clinical Social Worker • Clinical Psychologist • Registered Dietician

	• Nutrition Professional 3. Therapists • Physical Therapist • Occupational Therapist • Qualified Speech-Language Therapist
G-codes for PQRI	A set of CMS-defined temporary HCPCS codes used to report quality measures on a claim. G-codes are maintained by CMS.
ICD-9-CM Diagnosis Codes	The International Classification of Diseases, 9th Revision, Clinical Modification[6] is used in assigning codes to diagnoses associated with inpatient, outpatient, and physician office visits for reporting in PQRI.
Measure	Performance measure • A quantitative tool (*e.g.,* rate, ratio, index, percentage) that provides an indication of performance in relation to a specified process or outcome. • See also process measure and outcome measure.[1, 7] Types of Measures • Process measure: A measure which focuses on a process which leads to a certain outcome, meaning that a scientific basis exists for believing that the process, when executed well, will increase the probability of achieving a desired outcome.[7] • Outcome measure: A measure that indicates the result of the performance (or non-performance) of a function(s) or process(es).[7] • Structure measure: A measure that assesses whether organizational resources and arrangements are in place to deliver health care, such as the number, type, and distribution of medical personnel, equipment, and facilities.[7]
Numerator	The upper portion of a fraction used to calculate a rate, proportion, or ratio. A clinical action to be counted as meeting a measure's requirements (*i.e.,* patients who received the particular service or obtained a particular outcome that is being measured).[7] PQRI measure numerators are CPT Category II codes and G-codes.
Numerator Statement	A statement that describes the clinical action that satisfies the conditions of the performance measure. For example, "Patients who were screened for future fall risk."
Performance Timeframe	A designated timeframe within which the action described in a performance measure should be completed. This timeframe is generally included in the measure description and may or may not coincide with the measure's data reporting frequency requirement.
Performance Measure	Modifiers developed exclusively for use with CPT Category II codes to indicate documented medical (1P), patient (2P), or system (3P) reasons

Exclusion Modifiers	for excluding patients from a measure's denominator.[2]
Performance Measure Reporting Modifier 8P	The 8P reporting modifier is intended to be used as a "reporting modifier" to allow the reporting of circumstances when an action described in a measure's numerator is not performed and the reason is not otherwise specified. 8P reporting modifier - action not performed, reason not otherwise specified (AMA)
Quality-Data Code (QDC)	Specified CPT Category II codes with or without modifiers and G-codes used for submission of PQRI data. CMS PQRI Quality Measures Specifications document contains all codes associated with each PQRI measure and instructions for data submission through the administrative claims system.
Rationale	A brief statement describing the evidence base and/or intent for the measure that serves to guide interpretation of results.[5]
Reporting Frequency	The number of times quality-data codes specified for a quality measure must be submitted on claims during the reporting period. The reporting frequency for each measure is described in the 2008 PQRI Quality Measures Specifications document posted on the CMS Web site, www.cms.hhs.gov/PQRI
Reporting Period	The period during which PQRI measures are to be reported for covered professional services provided. For 2008 PQRI, the reporting period is dates of service January 1, 2008 through December 31, 2008.
TRHCA	Tax Relief and Health Care Act of 2006.

Sources:

1. Agency for Health Care Research & Quality (AHRQ) National Quality Measures Clearinghouse Glossary, http://www.qualitymeasures.ahrq.gov/resources/glossary.aspx, accessed on 2/2/07.

IBID, PSNet, Patient Safety Network Glossary, http://www.psnet.ahrq.gov/glossary.aspx#S, accessed on 4/24/07.

2. American Medical Association (AMA), CPT® Appendix H, http://www.ama-assn.org/ama/pub/category/10616.html, accessed on 3/29/07.

3. CMS Medicare Learning Network, MedLearn Matters Article MM 4183, CR 4183, Physician *Voluntary Reporting Program Using G-Codes*, http://www.cms.hhs.gov/ContractorLearningResources/downloads/JA4183.pdf ; CMS Manual System, Pub 100-20, Transmittal 199, 12/30/2005, http://www.cms.hhs.gov/Transmittals/Downloads/R199OTN.pdf, accessed on 3/29/07.

4. Institute of Medicine (IOM), Performance Measurement Accelerating Improvement, Glossary, National Academies Press, http://www.nap.edu/catalog.php?record_id=11517#toc, accessed on 2/2/07.

5. Joint Commission on Accreditation of Health Care Organizations (JCAHO) http://www.jointcommission.org/NR/rdonlyres/9B31EDE2-B7CF-4927-88EE-FAB24BE03541/0/glossary.pdf.

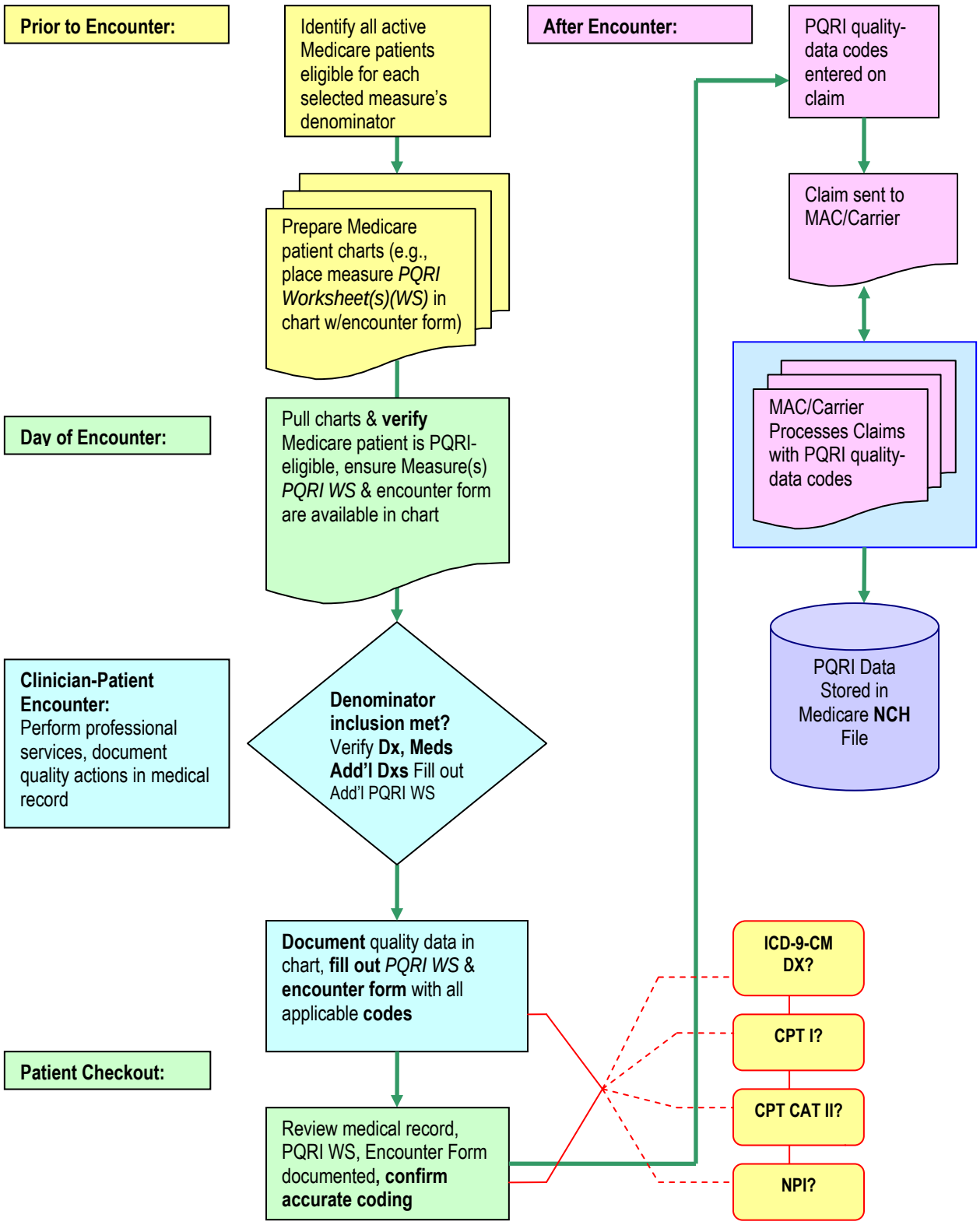
6. National Center for Health Statistics (NCHS) of the Centers for Disease Control (CDC) http://www.cds.gov/nchs/icd9.htm, accessed on 3/15/07.

7. QualityNet, QMIS Specification Manual for National Hospital Quality Measures, Appendix D-3, Glossary of Terms version 2.2, 12-31-2006, http://www.QualityNet.org, accessed 3/30/2007.

APPENDIX B

Sample Implementation Flow Chart

(A written description of this chart follows on the next page)



APPENDIX B
Sample Implementation Flow Chart- Written Description

- Sample Implementation Flow Chart, Text Box 1: Prior to Encounter Instructions: Prior to the patient encounter, complete the steps in Text Box 2 and Text Box 3. To continue with this flow, go to Text Box 2.
- Sample Implementation Flow Chart, Text Box 2: Identify all active Medicare patients eligible for each selected measure's denominator prior to encounter. To continue with this flow, go to Text Box 3.
- Sample Implementation Flow Chart, Text Box 3: Prepare Medicare patient charts (e.g., place measure PQRI Worksheet(s)(WS) in chart w/encounter form) prior to encounter. To continue with this flow, go to Text Box 4.
- Sample Implementation Flow Chart, Text Box 4: Day of Encounter Instructions: On the day of encounter, complete actions in Text Box 5. To continue with this flow, go to Text Box 5.
- Sample Implementation Flow Chart, Text Box 5: On the day of the encounter, pull charts & verify Medicare patient is PQRI-eligible, ensure Measure(s) PQRI WS & encounter forms are available in chart. To continue with this flow, go to Text Box 6.
- Sample Implementation Flow Chart, Text Box 6: Clinician-Patient Encounter Instructions: During the patient encounter, perform professional service and document quality actions in medical record. The actions performed during the patient encounter are continued in Text Box 7 and Text Box 8. To continue with this flow, go to Text Box 7.
- Sample Implementation Flow Chart, Text Box 7: During the patient encounter, perform the professional service and document the quality actions in medical record, including checking to see if the denominator inclusion is met by verifying the diagnoses, medications, etc. Fill out worksheets as appropriate. To continue with this flow, go to Text Box 8.
- Sample Implementation Flow Chart, Text Box 8: During the patient encounter, perform professional service and document quality actions in medical record, including documenting quality data in the patient chart, filling out the appropriate PQRI WS & encounter forms with all applicable codes. To continue with this flow, go to Text Box 9.
- Sample Implementation Flow Chart, Text Box 9: Patient Checkout Instructions: Perform the actions in Text Box 10 at the time of patient checkout. To continue with this flow, go to Text Box 10.
- Sample Implementation Flow Chart, Text Box 10: At the time of the patient checkout, review the medical record, PQRI WS, Encounter Form documentation, and confirm accurate coding. To continue with this flow, go to Text Box 11-14.
- Sample Implementation Flow Chart, Text Box 11, 12, 13, and 14: From the Clinician-patient encounter and the patient checkout data, enter the appropriate ICD-9 diagnosis, CPT encounter, CPT II and/or G-code quality data codes and the appropriate NPI number on the paper or electronic claim. To continue with this flow, go to Text Box 15.
- Sample Implementation Flow Chart, Text Box 15: After the Patient Encounter Instructions: The steps described in Text Box 16, Text Box 17, Text Box 18 and Text Box 19 are performed after the patient encounter. To continue with this flow, go to Text Box 16.
- Sample Implementation Flow Chart, Text Box 16: After the patient encounter, the appropriate PQRI quality-data codes are entered on claim. To continue with this flow, go to Text Box 17.
- Sample Implementation Flow Chart, Text Box 17: After the patient encounter, the claim is sent to the MAC/Carrier by the provider. To continue with this flow, go to Text Box 18.
- Sample Implementation Flow Chart, Text Box 18: After the patient encounter, the claim is sent to the MAC/Carrier and the MAC/Carrier processes the claims with PQRI quality- data codes. To continue with this flow, go to Text Box 19.
- Sample Implementation Flow Chart, Text Box 19: After the patient encounter, the claim is sent to the MAC/Carrier and the MAC/Carrier processes the claims with PQRI quality- data codes. The PQRI Data is then stored in the Medicare NCH File.
- This is the end of the flow chart.

APPENDIX C

List of Retired PQRI Measures

2007 PQRI Measure Specifications Retired Effective January 1, 2008	
Measure #	**Measure Title**
13	Age-Related Macular Degeneration: Age-Related Eye Disease Study (AREDS) Prescribed/Recommended
15	Cataracts: Assessment of Visual Functional Status
16	Cataracts: Documentation of Pre-Surgical Axial Length, Corneal Power Measurement and Method of Intraocular Lens Power Calculation
17	Cataracts: Pre-Surgical Dilated Fundus Evaluation
25	Melanoma: Patient Medical History
26	Melanoma: Complete Physical Skin Examination
27	Melanoma: Counseling on Self-Examination
29	Beta-Blocker at Time of Arrival for Acute Myocardial Infarction (AMI)
37	Dialysis Dose in End Stage Renal Disease (ESRD) Patients
38	Hematocrit Level in End Stage Renal Disease (ESRD) Patients
42	Osteoporosis: Counseling for Vitamin D, Calcium Intake, and Exercise
60	Gastroesophageal Reflux Disease (GERD): Assessment for Alarm Symptoms
61	Gastroesophageal Reflux Disease (GERD): Upper Endoscopy for Patients with Alarm Symptoms
62	Gastroesophageal Reflux Disease (GERD): Biopsy for Barrett's Esophagus
63	Gastroesophageal Reflux Disease (GERD): Barium Swallow- Inappropriate Use