Chronic Kidney Disease (CKD) Measures Group

PQRI Data Collection Sheet*

☐ Male ☐ Female

Patient's Name | Practice Medical Record Number (MRN) | Birth Date (mm/dd/yyyy)

National Provider Identifier (NPI) | Date of Encounter

Step 1 Preliminary reporting requirements

You must identify your intent to report the CKD Measures Group by submitting the G-code specified for this measures group on the first patient claim (G8487: I intend to report the CKD Measures Group). You do not need to resubmit the measures group-specific G-code on more than one claim.

Step 2 Determine patient eligibility

*(Codes determining a patient's eligibility must be reported on the **same claim** as the quality code(s) identified in Step 3 below.)*

	Yes	No	
Patient is aged 18 years and older on date of encounter.	☐	☐	Refer to date of birth listed above or on claim form.
Patient has a line item diagnosis of CKD.	☐	☐	585.4, 585.5
There is a CPT Code for an office visit or office consultation.	☐	☐	99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215

If **No** is checked for any of the above, STOP. This patient is not eligible for reporting on this measures group. Do not report a G-code or CPT category II code.

Step 3 Complete individual measures

Blood Pressure (BP) Management		Report one code for BP level < 130/80 OR one code for BP NOT assessed. If BP is elevated, you will also need to report one code for plan of care documented OR an additional code for plan of care NOT documented.	
PQRI Measure #122 • *measure target: <130/80 mmHg* • *reporting frequency: BP (and plan of care, if appropriate) must be assessed and reported a minimum of once during the month(s) the patient is included in the sample population* • *most recent BP should be reported* • *plan of care should include one or more of the following: recheck BP at specified future date; initiate or alter pharmacologic or non-pharmacologic therapy; documented review of patient's home BP log which indicates that patient's BP is or is not well controlled*	BP level and plan of care, if appropriate	Systolic BP < 130 mmHg AND Diastolic BP < 80 mmHg	☐ G8476
		Elevated BP (ie, systolic BP ≥ 130 mmHg or diastolic BP ≥ 80 mmHg) AND plan of care documented	☐ G8477 AND 0513F
		OR *(Report one of the following options)*	
		BP NOT assessed	☐ G8478
		Elevated BP AND plan of care NOT documented	☐ G8477 AND 0513F–8P

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*For additional information on the PQRI program and reporting on measures groups, please visit the CMS Web site at http://www.cms.hhs.gov/pqri.

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Laboratory Testing *[including serum levels of calcium, phosphorus, intact Parathyroid Hormone (iPTH) and lipid profile]*		Report one of the following laboratory testing codes OR one code for NOT ordered.	
PQRI Measure #121 • *reporting frequency: laboratory testing must be completed and reported within 12 months of the date of encounter*		Ordered	☐ 3278F
		Not ordered for medical reasons† • Document reason in medical chart	☐ 3278F–1P
		Not ordered for patient reasons† • Document reason in medical chart	☐ 3278F–2P
		OR	
		Laboratory testing NOT ordered	☐ 3278F–8P
Hemoglobin (Hb) Management for Patients Receiving Erythropoiesis – Stimulating Agents (ESA)		Report one code for ESA therapy status. If patient is receiving ESA therapy, you will also need to report one code for Hb level or one code for Hb level NOT assessed. If Hb ≥ 13 g/dL, you will also need to report one code for plan of care documented OR one code for NOT documented.	
PQRI Measure #123 • *reporting frequency: Hb (and plan of care, if appropriate) must be assessed and reported for patients receiving ESA therapy a minimum of once during the month(s) the patient is included in the sample population* • *plan of care should include reducing the ESA dose and repeating hemoglobin at a specified future date*	Hb level for patients receiving ESA therapy and plan of care, if appropriate	Patient not receiving ESA therapy	☐ 4172F
		Patient receiving ESA therapy AND Hb < 11 g/dL	☐ 4171F AND 3281F
		Patient receiving ESA therapy AND Hb 11 g/dL to 12.9 g/dL	☐ 4171F AND 3280F
		Patient receiving ESA therapy AND Hb ≥ 13 g/dL AND plan of care documented	☐ 4171F AND 3279F AND 0514F
		OR *(Report one of the following options)*	
		Patient receiving ESA therapy AND Hb level NOT assessed	☐ 4171F AND 3281F–8P
		Patient receiving ESA therapy AND Hb ≥ 13 g/dL AND plan of care NOT documented	☐ 4171F AND 3279F AND 0514F–8P
Influenza Immunization		Report one of the following influenza immunization codes OR one code for NOT ordered or administered.	
PQRI Measure #135 • *reporting frequency: influenza immunization must be ordered or administered during the flu season*[1] *(September through February) and reported once during the calendar year (see instructions below)*		Ordered or administered during the flu season[1]	☐ 4037F
		Not ordered or administered for medical reasons† • Document reason in medical chart	☐ 4037F–1P
		Not ordered or administered for patient reasons† • Document reason in medical chart	☐ 4037F–2P
		Not ordered or administered for system reasons† • Document reason in medical chart	☐ 4037F–3P
		OR	
		Influenza immunization NOT ordered or administered	☐ 4037F–8P

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[1]If reporting this measure between January 1, 2010 and August 31, 2010, CPT Category II code 4037F should be reported when the influenza vaccination is ordered or administered to the patient during the months of September, October, November, and December of 2009 or January and February of 2010 for the flu season ending February 28, 2010.

If reporting this measure between September 1, 2010 and December 31, 2010, CPT Category II code 4037F should be reported when the influenza vaccination is ordered or administered to the patient during the months of September, October, November, and December of 2010 for the flu season ending February 28, 2011.

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

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Referral for Arteriovenous (AV) Fistula	Report one of the following referral for AV fistula codes OR one code for patient NOT referred.	
PQRI Measure #153 • *reporting frequency: patient must be referred for AV fistula and this referral reported once during the calendar year*	Patient referred for AV Fistula	☐ 4051F
	Not referred for medical reasons† • Document reason in medical chart	☐ 4051F–1P
	Not referred for patient reasons† • Document reason in medical chart	☐ 4051F–2P
	OR	
	Patient NOT referred for AV Fistula	☐ 4051F–8P

Step 4 Reporting Instructions

This measure can be reported for each eligible patient in one of two ways:

1. Report the corresponding G-code or CPT category II code(s) as selected above for each of the five measures in the CKD Measures Group (Note: Report measures #122 and #123 a minimum of once during the month(s) the patient is included in the sample population).

   OR

2. If **all** quality actions for the patient have been performed for each of the five measures in the CKD Measures Group, **G8495** may be reported. *Note: G8495 is not appropriate for this patient if any of the following codes have been selected from Step 3: G8478, any CPT category II code with the 8P modifier.*

†Medical reasons (eg, not indicated, contraindicated, other medical reason); Patient reasons (eg, patient declined, economic, social, religious, other patient reason)