Chronic Kidney Disease (CKD)

Blood Pressure Management

PQRI Data Collection Sheet

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

Clinical Information

Step 1 Is patient eligible for this measure?

	Yes	No
Patient is aged 18 years and older on date of encounter.	☐	☐
Patient has a line item diagnosis of advanced CKD (stage 4 or 5, not receiving renal replacement therapy [RRT]).	☐	☐
There is a CPT Code for this visit.	☐	☐
If **No** is checked for any of the above, STOP. Do not report a CPT category II code or a G-code.		

Billing Information

Code Required on Claim Form

Refer to coding specifications document for list of applicable codes. Codes determining a patient's eligibility must be reported on the same claim as the quality code(s) identified below.

Step 2 Does patient also have the other requirements for this measure?

	Yes	No
Does the patient have elevated blood pressure (ie, a systolic measurement of ≥ 130 mmHg AND/OR a diastolic measurement of ≥ 80 mmHg)[1]?	☐	☐

Code to be Reported on Line 24D of Paper Claim Form (or Service Line 24 of Electronic Claim Form)

If **No** (ie, most recent blood pressure has a systolic measurement of < 130 mmHg AND a diastolic measurement of < 80 mmHg), report only G8476 and STOP.

If **Yes** (ie, most recent blood pressure has a systolic measurement of ≥ 130 mmHg AND/OR a diastolic measurement of ≥ 80 mmHg), report G8477 and proceed to Step 3.

If blood pressure measurement is not performed or documented, report G8478 and STOP.

Step 3 Does patient meet the measure?

Elevated Blood Pressure Plan of Care[2]	Yes	No
Documented	☐	☐

Code to be Reported on Line 24D of Paper Claim Form, if *Yes* (or Service Line 24 of Electronic Claim Form)

0513F

If **No** is checked for the above, report 0513F–8P (No documentation of elevated blood pressure plan of care, reason not otherwise specified.)

[1]If multiple blood pressure measurements are taken at a single visit, use the most recent measurement taken at that visit.

[2]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.