Chronic Kidney Disease (CKD) Measures Group

Physician Quality Reporting System Data Collection Sheet*

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

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 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.	
Physician Quality Reporting System Measure #122 • *Measure target: < 130/80 mmHg* • *reporting frequency: one time per patient during the reporting month that brings the patient into the CKD measures group sample population* • *If multiple blood pressure measurements are taken at a single visit, use the most recent measurement taken at that visit* • *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*	BP level and plan of care, if appropriate	Most recent blood pressure has a systolic measurement of <130 mmHg AND a diastolic measurement of <80 mmHg	☐ G8476
		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	☐ G8477 AND 0513F
		OR *(Report one of the following options)*	
		Blood pressure measurement not performed or documented, reason not specified	☐ G8478
		Most recent blood pressure has a systolic measurement of ≥130 mmHg and/or a diastolic measurement of ≥80 mmHg AND no documentation of elevated blood pressure plan of care, reason not otherwise specified	☐ G8477 AND 0513F–8P

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*For additional information on the Physician Quality Reporting System 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.	
Physician Quality Reporting System Measure #121 • *reporting frequency: a minimum of once during the reporting period* • *laboratory testing must be completed and reported within 12 months of the date of encounter*	Laboratory Testing	Serum levels of calcium, phosphorus, intact Parathyroid Hormone (iPTH) and lipid profile ordered	☐ 3278F
		Laboratory testing not ordered, documentation of medical reason(s) for not ordering serum levels of calcium, phosphorus, intact Parathyroid Hormone (iPTH) and lipid profile	☐ 3278F–1P
		Laboratory testing not ordered, documentation of patient reason(s) for not ordering serum levels of calcium, phosphorus, intact Parathyroid Hormone (iPTH) and lipid profile	☐ 3278F–2P
		OR	
		Serum levels of calcium, phosphorus, intact Parathyroid Hormone (iPTH) and lipid profile not ordered, reason not otherwise specified	☐ 3278F–8P
Plan of Care — Elevated Hemoglobin 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.	
Physician Quality Reporting System Measure #123 • *reporting frequency: one time per patient during the reporting month that brings the patient into the CKD measures group sample population* • *Documented Plan of Care — Should include reducing the ESA dose and repeating hemoglobin at a specified future date* • *Erythropoiesis Stimulating Agents (ESA) — includes epoetin or darbepoetin*	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 for elevated hemoglobin documented for patients receiving ESA Therapy	☐ 4171F AND 3279F AND 0514F
		OR *(Report one of the following options)*	
		Patient receiving ESA therapy AND Hemoglobin level measurement not documented, reason not otherwise specified	☐ 4171F AND 3281F–8P
		Patient receiving ESA therapy AND Hb ≥ 13 g/dL AND Plan of care for elevated hemoglobin level not documented for patient receiving ESA therapy, reason not otherwise specified	☐ 4171F AND 3279F AND 0514F–8P

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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.	
Physician Quality Reporting System Measure #153 • *reporting frequency: a minimum of once during reporting period*	Patient referred for AV Fistula	☐ 4051F
	Documentation of medical reason(s) for not referring for an AV fistula	☐ 4051F–1P
	Documentation of patient reason(s) for not referring for an AV fistula	☐ 4051F–2P
	OR	
	AV fistula NOT referred, reason not otherwise specified	☐ 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 four 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 four 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.*