

## 2011 Physician Quality Reporting System (Physician Quality Reporting) Measures Groups Specifications Manual

This manual contains specific guidance for reporting 2011 Physician Quality Reporting System Measures Groups ("Physician Quality Reporting," formerly known as Physician Quality Reporting Initiative or PQRI). Measures Groups are a subset of four or more Physician Quality Reporting measures that have a particular clinical condition or focus in common. Only those measures groups defined in this document can be utilized when reporting the measures group options. All other individual measures that are included in Physician Quality Reporting but not defined in this manual as included in a measures group cannot be grouped together to define a measures group.

14 measures groups have been established for 2011 Physician Quality Reporting: Diabetes Mellitus, Chronic Kidney Disease (CKD), Preventive Care, Coronary Artery Bypass Graft (CABG), Rheumatoid Arthritis (RA), Perioperative Care, Back Pain, Hepatitis C, Heart Failure (HF), Coronary Artery Disease (CAD), Ischemic Vascular Disease (IVD), HIV/AIDS, Community-Acquired Pneumonia (CAP), and Asthma. These 14 groups, combined, include measures established for use in the 2011 Physician Quality Reporting, as required by applicable statutes, through formal notice-and-comment rulemaking in 2010. An eligible professional may choose to report one or more measures groups through claims-based and/or registry-based submission. Note that denominator coding has been modified from the original individual measures specified by the measure developer to allow for implementation in Physician Quality Reporting as a measures group. An overview for each measures group is included in this manual followed by specific reporting instructions for each measure within the group.

There are two reporting periods available for eligible professionals to report 2011 Physician Quality Reporting measures groups: a) 12-month reporting period from January 1 through December 31, 2011 (available for the 30 Patient Sample Method, the 50% Patient Sample Method via Claims, and the 80% Patient Sample Method via Registry) **OR** b) a 6-month reporting period from July 1 through December 31, 2011 (available only for the 50% Patient Sample Method via Claims and the 80% Patient Sample Method via Registry). The 6-month reporting period allows those eligible professionals who may have decided to participate later in the year to begin reporting. Those eligible professionals who satisfactorily report quality data under the measures groups reporting option may earn an incentive payment equal to 1.0% of their total estimated allowed charges for Medicare Part B Physician Fee Schedule (PFS) covered professional services furnished during the applicable reporting period.

Please note, eligible professionals may choose to pursue more than one 2011 Physician Quality Reporting option. However, an eligible professional who satisfactorily reports under more than one reporting option will earn a maximum of one incentive payment equal to 1.0% of their total estimated allowed charges for Medicare Part B PFS covered professional services furnished during the longest reporting period for which he or she satisfied reporting requirements. This manual describes how to implement 2011 reporting of Physician Quality Reporting measures groups to facilitate satisfactory reporting of quality-data by eligible professionals who wish to participate under this reporting alternative. Additional information describing how to implement 2011 measures groups can be found in the *Getting Started with 2011 Physician Quality Reporting of Measures Groups* and *Physician Quality Reporting Made Simple - Reporting the Preventive Care Measures Group* at: [http://www.cms.gov/PQRI/30\\_EducationalResources.asp#TopOfPage](http://www.cms.gov/PQRI/30_EducationalResources.asp#TopOfPage).

### **Measures Group Reporting via Claims and Registry:**

The Diabetes Mellitus, CKD, Preventive Care, RA, Perioperative Care, Back Pain, Hepatitis C, IVD, CAP and Asthma measures groups can be submitted through claims or a qualified registry. To select a measures group reporting option via claims, the first step requires that eligible professionals identify their intent to report a measures group by submitting a measures group-specific intent G-code on a claim for covered professional services furnished to a patient enrolled in Medicare Part B PFS. The submission of the intent G-code serves as

## 2011 Physician Quality Reporting System (Physician Quality Reporting) Measures Groups Specifications Manual

the indication that an eligible professional is choosing to report on a measures group and will initiate measures group analysis. It is not necessary to submit the measures group-specific intent G-code on more than one claim. If the G-code for a given group is submitted multiple times during the reporting period, only the submission with the earliest date of service will be included in the Physician Quality Reporting analyses; subsequent submissions of that code will be ignored.

G8485: I intend to report the Diabetes Mellitus Measures Group  
G8487: I intend to report the Chronic Kidney Disease (CKD) Measures Group  
G8486: I intend to report the Preventive Care Measures Group  
G8490: I intend to report the Rheumatoid Arthritis Measures Group  
G8492: I intend to report the Perioperative Care Measures Group  
G8493: I intend to report the Back Pain Measures Group  
G8545: I intend to report the Hepatitis C Measures Group  
G8547: I intend to report the Ischemic Vascular Disease (IVD) Measures Group  
G8546: I intend to report the Community-Acquired Pneumonia (CAP) Measures Group  
G8645: I intend to report the Asthma Measures Group

### Measures Group Reporting via Registry-only:

The CABG, HF, CAD and HIV/AIDS measures groups can only be submitted through a qualified registry. It is not necessary to submit the measures group-specific intent G-code for registry-based submissions. However, the measures group specific intent G-codes have been created for registry only measures groups for use by registries that utilize claims data.

G8544: I intend to report the Coronary Artery Bypass Graft (CABG) Measures Group  
G8548: I intend to report the Heart Failure (HF) Measures Group  
G8489: I intend to report the Coronary Artery Disease (CAD) Measures Group  
G8491: I intend to report the HIV/AIDS Measures Group

### Measures Groups Reporting Methods:

There are two reporting methods for submission of measures groups:

#### 1) 30 Patient Sample Method – 12-month reporting period only:

- For **claims-based** and **registry-based** submissions, a participating eligible professional must report on all applicable measures within the selected measures group when billing measure-eligible claims for a minimum sample of 30 unique Medicare Part B FFS patients who meet patient sample criteria for the measures group (include Medicare Secondary Payer claims and claims for Railroad Retirement beneficiaries; exclude Medicare Advantage beneficiaries). If the eligible professional does not have a minimum of 30 unique Medicare Part B FFS patients who meet patient sample criteria for the measures group, the eligible professional will need to choose another measures group or choose another reporting option. Please refer to the *Getting Started with 2011 Physician Quality Reporting of Measures Groups* to determine the proper reporting option.
  - For **claims-based** submissions, the measures group-specific intent G-code must be submitted once during the reporting period to indicate the eligible professional's selection of the measures group.
- For both claims-based and registry-based submissions, all the applicable measures within the group must be reported at least once for each patient within the sample population seen by the eligible professional during the reporting period (January 1 through December 31, 2011),

## 2011 Physician Quality Reporting System (Physician Quality Reporting) Measures Groups Specifications Manual

according to each measures group's reporting instructions contained within each group's overview section.

OR

2) 50% Patient Sample Method via Claims or 80% Patient Sample Method via Registry – 12-month and 6-month reporting periods available:

- For claims-based submissions, a participating eligible professional must report on all applicable measures within the selected measures group on claims for at least 50% of all Medicare Part B FFS patients seen during the entire reporting period (January 1 through December 31, 2011 **OR** July 1 through December 31, 2011) who meet the measures group patient sample criteria.
  - For **claims-based** submissions, the eligible professional must report the measures group-specific intent G-code once during the reporting period to indicate the eligible professional's selection of the measures group that the eligible professional intends to report.
- For registry-based submissions, a participating eligible professional must report on all applicable measures within the selected measures group for at least 80% of all Medicare Part B FFS patients seen during the entire reporting period (January 1 through December 31, 2011 **OR** July 1 through December 31, 2011) who meet the measures group patient sample criteria.
- Minimum Patient Sample Size
  - For the 12-month reporting period, a minimum of 15 Medicare Part B FFS patients must meet the measures group patient sample criteria to report satisfactorily. For the 6-month reporting period, a minimum of 8 Medicare Part B FFS patients must meet the measures group patient sample criteria to report satisfactorily. If an eligible professional does not have the minimum number of patients for inclusion in the patient sample for the reporting period that eligible professional should report either another measures group or select reporting of individual measures that are applicable to the eligible professional's practice. If the minimum number of patients does not meet the measures group patient sample criteria, the eligible professional is not incentive eligible.
- For both claims-based and registry-based submissions, all applicable measures within the group must be reported according to each measures group's reporting instructions contained within each group's overview section.

The patient sample for the 30 Patient Sample Method, the 50% Patient Sample Method via claims and the 80% Patient Sample Method via registry are determined by diagnosis and/or specific encounter parameters common to all measures within a selected measures group. All applicable measures within a group must be reported for each patient within the sample that meets the criteria (eg, age or gender) required in accordance with this manual. For example, if an eligible professional is reporting on the Preventive Care Measures Group, the *Screening or Therapy for Osteoporosis* measure would only need to be reported on women within the eligible professional's patient sample.

**2011 Physician Quality Reporting System (Physician Quality Reporting)**  
**Measures Groups Specifications Manual**  
**Table of Contents**

Measure Number	Measure Title	Reporting Options	Page
	<b>Diabetes Mellitus Measures Group</b>	C, R	
	Diabetes Mellitus Measures Group Overview		8
1	Diabetes Mellitus: Hemoglobin A1c Poor Control in Diabetes Mellitus		10
2	Diabetes Mellitus: Low Density Lipoprotein (LDL-C) Control in Diabetes Mellitus		11
3	Diabetes Mellitus: High Blood Pressure Control in Diabetes Mellitus		12
117	Diabetes Mellitus: Dilated Eye Exam in Diabetic Patient		13
119	Diabetes Mellitus: Urine Screening for Microalbumin or Medical Attention for Nephropathy in Diabetic Patients		14
163	Diabetes Mellitus: Foot Exam		15
	<b>Chronic Kidney Disease (CKD) Measures Group</b>	C, R	
	Chronic Kidney Disease (CKD) Measures Group Overview		16
121	Chronic Kidney Disease (CKD): Laboratory Testing (Calcium, Phosphorus, Intact Parathyroid Hormone (iPTH) and Lipid Profile)		18
122	Chronic Kidney Disease (CKD): Blood Pressure Management		19
123	Chronic Kidney Disease (CKD): Plan of Care - Elevated Hemoglobin for Patients Receiving Erythropoiesis-Stimulating Agents (ESA)		21
153	Chronic Kidney Disease (CKD): Referral for Arteriovenous (AV) Fistula		23
	<b>Preventive Care Measures Group</b>	C, R	
	Preventive Care Measures Group Overview		24
39	Screening or Therapy for Osteoporosis for Women Aged 65 Years and Older		26
48	Urinary Incontinence: Assessment of Presence or Absence of Urinary Incontinence in Women Aged 65 Years and Older		27
110	Preventive Care and Screening: Influenza Immunization for Patients $\geq$ 50 Years Old		28
111	Preventive Care and Screening: Pneumonia Vaccination for Patients 65 years and Older		29
112	Preventive Care and Screening: Screening Mammography		30
113	Preventive Care and Screening: Colorectal Cancer Screening		31
128	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up		32
173	Preventive Care and Screening: Unhealthy Alcohol Use – Screening		34
226	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention		35

**2011 Physician Quality Reporting System (Physician Quality Reporting)**  
**Measures Groups Specifications Manual**  
**Table of Contents**

Measure Number	Measure Title	Reporting Options	Page
	<b>Coronary Artery Bypass Graft (CABG) Measures Group</b>	R	
	Coronary Artery Bypass Graft (CABG) Measures Group Overview		36
43	Coronary Artery Bypass Graft (CABG): Use of Internal Mammary Artery (IMA) in Patients with Isolated CABG Surgery		38
44	Coronary Artery Bypass Graft (CABG): Preoperative Beta-Blocker in Patients with Isolated CABG Surgery		39
164	Coronary Artery Bypass Graft (CABG): Prolonged Intubation (Ventilation)		40
165	Coronary Artery Bypass Graft (CABG): Deep Sternal Wound Infection Rate		41
166	Coronary Artery Bypass Graft (CABG): Stroke/Cerebrovascular Accident (CVA)		42
167	Coronary Artery Bypass Graft (CABG): Postoperative Renal Insufficiency		43
168	Coronary Artery Bypass Graft (CABG): Surgical Re-exploration		44
169	Coronary Artery Bypass Graft (CABG): Antiplatelet Medications at Discharge		45
170	Coronary Artery Bypass Graft (CABG): Beta-Blockers Administered at Discharge		46
171	Coronary Artery Bypass Graft (CABG): Lipid Management and Counseling		47
	<b>Rheumatoid Arthritis (RA) Measures Group</b>	C, R	
	Rheumatoid Arthritis (RA) Measures Group Overview		48
108	Rheumatoid Arthritis (RA): Disease Modifying Anti-Rheumatic Drug (DMARD) Therapy		50
176	Rheumatoid Arthritis (RA): Tuberculosis Screening		51
177	Rheumatoid Arthritis (RA): Periodic Assessment of Disease Activity		53
178	Rheumatoid Arthritis (RA): Functional Status Assessment		54
179	Rheumatoid Arthritis (RA): Assessment and Classification of Disease Prognosis		55
180	Rheumatoid Arthritis (RA): Glucocorticoid Management		56
	<b>Perioperative Care Measures Group</b>	C, R	
	Perioperative Care Measures Group Overview		58
20	Perioperative Care: Timing of Antibiotic Prophylaxis – Ordering Physician		60
21	Perioperative Care: Selection of Prophylactic Antibiotic – First OR Second Generation Cephalosporin		62
22	Perioperative Care: Discontinuation of Prophylactic Antibiotics (Non-Cardiac Procedures)		63
23	Perioperative Care: Venous Thromboembolism (VTE) Prophylaxis (When Indicated in ALL Patients)		65

**2011 Physician Quality Reporting System (Physician Quality Reporting)**  
**Measures Groups Specifications Manual**  
**Table of Contents**

Measure Number	Measure Title	Reporting Options	Page
	<b>Back Pain Measures Group</b>	C, R	
	Back Pain Measures Group Overview		66
148	Back Pain: Initial Visit		69
149	Back Pain: Physical Exam		72
150	Back Pain: Advice for Normal Activities		74
151	Back Pain: Advice Against Bed Rest		75
	<b>Hepatitis C Measures Group</b>	C, R	
	Hepatitis C Measures Group Overview		76
84	Hepatitis C: Ribonucleic Acid (RNA) Testing Before Initiating Treatment		78
85	Hepatitis C: HCV Genotype Testing Prior to Treatment		80
86	Hepatitis C: Antiviral Treatment Prescribed		81
87	Hepatitis C: HCV Ribonucleic Acid (RNA) Testing at Week 12 of Treatment		82
89	Hepatitis C: Counseling Regarding Risk of Alcohol Consumption		84
90	Hepatitis C: Counseling Regarding Use of Contraception Prior to Antiviral Therapy		85
183	Hepatitis C: Hepatitis A Vaccination in Patients with HCV		87
184	Hepatitis C: Hepatitis B Vaccination in Patients with HCV		88
	<b>Heart Failure (HF) Measures Group</b>	R	
	Heart Failure (HF) Measures Group Overview		89
5	Heart Failure: Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD)		91
8	Heart Failure: Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)		93
198	Heart Failure: Left Ventricular Function (LVF) Assessment		94
199	Heart Failure: Patient Education		95
226	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention		96
	<b>Coronary Artery Disease (CAD) Measures Group</b>	R	
	Coronary Artery Disease (CAD) Measures Group Overview		97
6	Coronary Artery Disease (CAD): Oral Antiplatelet Therapy Prescribed for Patients with CAD		99
196	Coronary Artery Disease (CAD): Symptom and Activity Assessment		100
197	Coronary Artery Disease (CAD): Drug Therapy for Lowering LDL-Cholesterol		101
226	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention		102

**2011 Physician Quality Reporting System (Physician Quality Reporting)**  
**Measures Groups Specifications Manual**  
**Table of Contents**

Measure Number	Measure Title	Reporting Options	Page
	<b>Ischemic Vascular Disease (IVD) Measures Group</b>	C, R	
	Ischemic Vascular Disease (IVD) Measures Group Overview		103
201	Ischemic Vascular Disease (IVD): Blood Pressure Management Control		105
202	Ischemic Vascular Disease (IVD): Complete Lipid Profile		106
203	Ischemic Vascular Disease (IVD): Low Density Lipoprotein (LDL-C) Control		107
204	Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic		108
226	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention		109
	<b>HIV/AIDS Measures Group</b>	R	
	HIV/AIDS Measures Group Overview		110
159	HIV/AIDS: CD4 + Cell Count or CD4 + Percentage		112
160	HIV/AIDS: Pneumocystis Jiroveci Pneumonia (PCP) Prophylaxis		113
161	HIV/AIDS: Adolescent and Adult Patients with HIV/AIDS Who Are Prescribed Potent Antiretroviral Therapy		114
162	HIV/AIDS: HIV RNA Control After Six Months of Potent Antiretroviral Therapy		116
205	HIV/AIDS: Sexually Transmitted Disease Screening for Chlamydia and Gonorrhea		118
206	HIV/AIDS: Screening for High Risk Sexual Behaviors		119
207	HIV/AIDS: Screening for Injection Drug Use		120
208	HIV/AIDS: Sexually Transmitted Disease Screening for Syphilis		121
	<b>Community-Acquired Pneumonia (CAP) Measures Group</b>	C, R	
	Community-Acquired Pneumonia (CAP) Measures Group Overview		122
56	Community-Acquired Pneumonia (CAP): Vital Signs		124
57	Community-Acquired Pneumonia (CAP): Assessment of Oxygen Saturation		125
58	Community-Acquired Pneumonia (CAP): Assessment of Mental Status		126
59	Community-Acquired Pneumonia (CAP): Empiric Antibiotic		127
	<b>Asthma Measures Group</b>	C, R	
	Asthma Measures Group Overview		128
53	Asthma: Pharmacologic Therapy		130
64	Asthma: Asthma Assessment		132
231	Asthma: Tobacco Use: Screening - Ambulatory Care Setting		133
232	Asthma: Tobacco Use: Intervention - Ambulatory Care Setting		134
	Symbol and Copyright Information		136

## DIABETES MELLITUS MEASURES GROUP OVERVIEW

### 2011 PHYSICIAN QUALITY REPORTING OPTIONS FOR MEASURES GROUPS: CLAIMS, REGISTRY

#### 2011 PHYSICIAN QUALITY REPORTING MEASURES IN DIABETES MELLITUS MEASURES GROUP:

- #1. Diabetes Mellitus: Hemoglobin A1c Poor Control in Diabetes Mellitus
- #2. Diabetes Mellitus: Low Density Lipoprotein (LDL-C) Control in Diabetes Mellitus
- #3. Diabetes Mellitus: High Blood Pressure Control in Diabetes Mellitus
- #117. Diabetes Mellitus: Dilated Eye Exam in Diabetic Patient
- #119. Diabetes Mellitus: Urine Screening for Microalbumin or Medical Attention for Nephropathy in Diabetic Patients
- #163. Diabetes Mellitus: Foot Exam

#### INSTRUCTIONS FOR REPORTING: (These instructions apply to both Claims and Registry reporting, unless otherwise specified.)

- Indicate your intention to report the Diabetes Mellitus Measures Group by submitting the measures group-specific intent G-code at least once during the reporting period when billing a patient claim for both the 30 Patient Sample and the 50% Patient Sample Methods. It is not necessary to submit the measures group-specific intent G-code on more than one claim. It is not necessary to submit the measures group-specific intent G-code for registry-based submissions.

**G8485:** I intend to report the Diabetes Mellitus Measures Group

- Select patient sample method:  
**30 Patient Sample Method:** 30 unique Medicare Part B FFS (fee for service) patients meeting patient sample criteria for the measures group.  
**OR**  
**50% Patient Sample Method via Claims or 80% Patient Sample Method via Registry:** All patients meeting patient sample criteria for the measure group during the entire reporting period (January 1 through December 31, 2011 **OR** July 1 through December 31, 2011). For the 12-month reporting period, a minimum of 15 Medicare Part B FFS patients must meet the measures group patient sample criteria to report satisfactorily. For the 6-month reporting period, a minimum of 8 Medicare Part B FFS patients must meet the measures group patient sample criteria to report satisfactorily.
- Patient sample criteria for the Diabetes Mellitus Measures Group are patients aged 18 through 75 years with a specific diagnosis of diabetes accompanied by a specific patient encounter:

**One of the following diagnosis codes indicating diabetes:** 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

**Accompanied by**

**One of the following patient encounter codes:** 97802, 97803, 97804, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309,



## ***SPECIFICATION FOR MEASURES GROUP REPORTING ONLY***

99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, G0270, G0271

- Report quality-data codes on **all** measures within the Diabetes Mellitus Measures Group for each patient within the sample.
- Instructions for quality-data code reporting for each of the measures within the Diabetes Mellitus Measures Group are displayed on the next several pages. If all quality actions for the patient have been performed for all the measures within the group, the following composite G-code may be reported in lieu of the individual quality-data codes for each of the measures within the group. Please note that Measure #1 (Diabetes Mellitus: Hemoglobin A1c Poor Control in Diabetes Mellitus) is a poor control or inverse measure, therefore, the **composite G-code should only be reported** when the patient's **Most Recent Hemoglobin A1c Level  $\leq$  9.0%** and all of the other quality actions for this measures group have been performed. It is not necessary to submit the following composite G-code for registry-based submissions.

**Composite G-code G8494:** All quality actions for the applicable measures in the Diabetes Mellitus Measures Group have been performed for this patient

- To report satisfactorily the Diabetes Mellitus Measures Group requires **all** measures for each patient within the eligible professional's patient sample to be reported a minimum of once during the reporting period.
- When using the 30 Patient Sample Method, report all measures for the 30 unique Medicare Part B FFS patients seen. When using the 50% Patient Sample Method via Claims, report all measures on at least 50% of the patient sample for the eligible professional for the 12-month or 6-month reporting period. When using the 80% Patient Sample Method via Registry, report all measures on at least 80% of the patient sample for the eligible professional for the 12-month or 6-month reporting period.
- For claims-based submissions, the Carrier/MAC remittance advice notice sent to the practice will show a denial remark code (N365) for the line item on the claim containing G8485 (and G8494 if reported) as well as all other line items containing QDCs. N365 indicates the code is not payable and is used for reporting/informational purposes only. Other services/codes on the claim will not be affected by the addition of a measures group-specific intent G-code or other QDCs. The N365 remark code does NOT indicate whether the QDC is accurate for that claim or for the measure the eligible professional is attempting to report, but does indicate that the QDC was processed and transmitted to the NCH.

*NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2011 Physician Quality Reporting Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS Physician Quality Reporting website.*

**SPECIFICATION FOR MEASURES GROUP REPORTING ONLY**

**♦ Measure #1: Diabetes Mellitus: Hemoglobin A1c Poor Control in Diabetes Mellitus**

**DESCRIPTION:**

Percentage of patients aged 18 through 75 years with diabetes mellitus who had most recent hemoglobin A1c greater than 9.0%

**NUMERATOR:**

Patients with most recent hemoglobin A1c level > 9.0%

**Numerator Instructions:** For performance, a lower rate indicates better performance/control.

**NUMERATOR NOTE:** *The performance period for this measure is 12 months.*

**Numerator Quality-Data Coding Options for Reporting Satisfactorily:**

**Most Recent Hemoglobin A1c Level > 9.0%**

CPT II 3046F: Most recent hemoglobin A1c level > 9.0%

**OR**

**Hemoglobin A1c not Performed**

Append a reporting modifier (**8P**) to CPT Category II code **3046F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

**3046F with 8P:** Hemoglobin A1c level was not performed during the performance period (12 months)

**OR**

**Most Recent Hemoglobin A1c Level ≤ 9.0%**

CPT II 3044F: Most recent hemoglobin A1c (HbA1c) level < 7.0%

**OR**

CPT II 3045F: Most recent hemoglobin A1c (HbA1c) level 7.0 to 9.0%

*NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2011 Physician Quality Reporting Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS Physician Quality Reporting website.*

SPECIFICATION FOR MEASURES GROUP REPORTING ONLY

♦ Measure #2: Diabetes Mellitus: Low Density Lipoprotein (LDL-C) Control in Diabetes Mellitus

**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)

**NUMERATOR:**

Patients with most recent LDL-C < 100 mg/dL

*NUMERATOR NOTE: The performance period for this measure is 12 months.*

**Numerator Quality-Data Coding Options for Reporting Satisfactorily:**

Most Recent LDL-C Level < 100 mg/dL

CPT II 3048F: Most recent LDL-C < 100 mg/dL

**OR**

Most Recent LDL-C Level ≥ 100 mg/dL

CPT II 3049F: Most recent LDL-C 100-129 mg/dL

**OR**

CPT II 3050F: Most recent LDL-C ≥ 130 mg/dL

**OR**

LDL-C Level not Performed

Append a reporting modifier (**8P**) to CPT Category II code **3048F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

**3048F with 8P:** LDL-C was not performed during the performance period (12 months)

**Note:** *If unable to calculate LDL-C due to high triglycerides, CPT Category II code **3048F with 8P** should be reported*

*NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2011 Physician Quality Reporting Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS Physician Quality Reporting website.*

♦ Measure #3: Diabetes Mellitus: High Blood Pressure Control in Diabetes Mellitus

**DESCRIPTION:**

Percentage of patients aged 18 through 75 years with diabetes mellitus who had most recent blood pressure in control (less than 140/90 mmHg)

**NUMERATOR:**

Patients whose most recent blood pressure < 140/90 mmHg

**Numerator Instructions:** 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.

**NUMERATOR NOTE:** *The performance period for this measure is 12 months.*

**Numerator Quality-Data Coding Options for Reporting Satisfactorily:**

**Most Recent Blood Pressure Measurement Performed**

*Systolic codes (Select one (1) code from this section):*

CPT II 3074F: Most recent systolic blood pressure < 130 mmHg

**OR**

CPT II 3075F: Most recent systolic blood pressure 130 - 139 mmHg

**OR**

CPT II 3077F: Most recent systolic blood pressure ≥ 140 mmHg

**AND**

*Diastolic code (Select one (1) code from this section):*

CPT II 3078F: Most recent diastolic blood pressure < 80 mmHg

**OR**

CPT II 3079F: Most recent diastolic blood pressure 80 - 89 mmHg

**OR**

CPT II 3080F: Most recent diastolic blood pressure ≥ 90 mmHg

**OR**

**Blood Pressure Measurement not Performed**

Append a reporting modifier (8P) to CPT Category II code 2000F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

2000F *with* 8P: No documentation of blood pressure measurement

*NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2011 Physician Quality Reporting Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS Physician Quality Reporting website.*

♦ Measure #117: Diabetes Mellitus: Dilated Eye Exam in Diabetic Patient

**DESCRIPTION:**

Percentage of patients aged 18 through 75 years with a diagnosis of diabetes mellitus who had a dilated eye exam

**NUMERATOR:**

Patients who had a dilated eye exam for diabetic retinal disease at least once within 12 months

**Numerator Instructions:** This measure includes patients with diabetes 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.

**Numerator Quality-Data Coding Options for Reporting Satisfactorily:**

**Dilated Eye Exam Performed by an Eye Care Professional**

**CPT II 2022F:** Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed

**OR**

**CPT II 2024F:** Seven standard field stereoscopic photos with interpretation by an ophthalmologist or optometrist documented and reviewed

**OR**

**CPT II 2026F:** Eye imaging validated to match diagnosis from seven standard field stereoscopic photos results documented and reviewed

**OR**

**CPT II 3072F:** Low risk for retinopathy (no evidence of retinopathy in the prior year)

**OR**

**Dilated Eye Exam not Performed, Reason not Specified**

Append a reporting modifier (8P) to CPT Category II code **2022F or 2024F or 2026F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

**2022F or 2024F or 2026F with 8P:** Dilated eye exam was not performed, reason not otherwise specified

*NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2011 Physician Quality Reporting Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS Physician Quality Reporting website.*

**SPECIFICATION FOR MEASURES GROUP REPORTING ONLY**

**♦ Measure #119: Diabetes Mellitus: Urine Screening for Microalbumin or Medical Attention for Nephropathy in Diabetic Patients**

**DESCRIPTION:**

Percentage of patients aged 18 through 75 years with diabetes mellitus who received urine protein screening or medical attention for nephropathy during at least one office visit within 12 months

**NUMERATOR:**

Patients who have a nephropathy screening during at least one office visit within 12 months

**Numerator Instructions:** This measure is looking for a nephropathy screening test or evidence of nephropathy.

**Numerator Quality-Data Coding Options for Reporting Satisfactorily:**

**Nephropathy Screening Performed**

CPT II 3060F: Positive microalbuminuria test result documented and reviewed

**OR**

CPT II 3061F: Negative microalbuminuria test result documented and reviewed

**OR**

CPT II 3062F: Positive macroalbuminuria test result documented and reviewed

**OR**

CPT II 3066F: 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**

G8506: Patient receiving angiotensin converting enzyme (ACE) inhibitor or angiotensin receptor blocker (ARB) therapy

**OR**

**Nephropathy Screening not Performed, Reason not Specified**

Append a reporting modifier (8P) to CPT Category II code 3060F or 3061F or 3062F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

3060F or 3061F or 3062F *with* 8P: Nephropathy screening was not performed, reason not otherwise specified

*NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2011 Physician Quality Reporting Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS Physician Quality Reporting website.*

♦ Measure #163: Diabetes Mellitus: Foot Exam

**DESCRIPTION:**

The percentage of patients aged 18 through 75 years with diabetes who had a foot examination

**NUMERATOR:**

Patients who received a foot exam (visual inspection, sensory exam with monofilament, or pulse exam)

***NUMERATOR NOTE:*** Patients who received a foot exam at least once within the prior 12 months.

**Numerator Quality-Data Coding Options for Reporting Satisfactorily:**

**Foot Exam Performed**

**CPT II 2028F:** Foot examination performed (includes examination through visual inspection, sensory exam with monofilament, and pulse exam – report when any of the three components are completed)

**OR**

**Foot Exam not Performed for Medical Reason**

Append a modifier (**1P**) to CPT Category II code **2028F** to report documented circumstances that appropriately exclude patients from the denominator.

**2028F with 1P:** Documentation of medical reason for not performing foot exam (i.e., patient with bilateral foot/leg amputation)

**OR**

**Foot Exam not Performed, Reason not Specified**

Append a reporting modifier (**8P**) to CPT Category II code **2028F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

**2028F with 8P:** Foot exam was not performed, reason not otherwise specified

*NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2011 Physician Quality Reporting Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS Physician Quality Reporting website.*

## CHRONIC KIDNEY DISEASE (CKD) MEASURES GROUP OVERVIEW

### 2011 PHYSICIAN QUALITY REPORTING OPTIONS FOR MEASURES GROUPS: CLAIMS, REGISTRY

#### 2011 PHYSICIAN QUALITY REPORTING MEASURES IN THE CHRONIC KIDNEY DISEASE (CKD) MEASURES GROUP:

- #121. Chronic Kidney Disease (CKD): Laboratory Testing (Calcium, Phosphorus, Intact Parathyroid Hormone (iPTH) and Lipid Profile)
- #122. Chronic Kidney Disease (CKD): Blood Pressure Management
- #123. Chronic Kidney Disease (CKD): Plan of Care - Elevated Hemoglobin for Patients Receiving Erythropoiesis - Stimulating Agents (ESA)
- #153. Chronic Kidney Disease (CKD): Referral for Arteriovenous (AV) Fistula

#### INSTRUCTIONS FOR REPORTING: (These instructions apply to both Claims and Registry reporting, unless otherwise specified.)

- Indicate your intention to report the CKD Measures Group by submitting the measures group-specific intent G-code at least once during the reporting period when billing a patient claim for both the 30 Patient Sample and the 50% Patient Sample Methods. It is not necessary to submit the measures group-specific intent G-code on more than one claim. It is not necessary to submit the measures group-specific intent G-code for registry-based submissions.

**G8487:** I intend to report the Chronic Kidney Disease (CKD) Measures Group

- Select patient sample method:  
**30 Patient Sample Method:** 30 unique Medicare Part B FFS (fee for service) patients meeting patient sample criteria for the measures group.  
**OR**  
**50% Patient Sample Method via Claims or 80% Patient Sample Method via Registry:** All patients meeting patient sample criteria for the measure group during the entire reporting period (January 1 through December 31, 2011 **OR** July 1 through December 31, 2011). For the 12-month reporting period, a minimum of 15 Medicare Part B FFS patients must meet the measures group patient sample criteria to report satisfactorily. For the 6-month reporting period, a minimum of 8 Medicare Part B FFS patients must meet the measures group patient sample criteria to report satisfactorily.

- Patient sample criteria for the CKD Measures Group are patients aged 18 years and older with a specific diagnosis of CKD accompanied by a specific patient encounter:

**One of the following diagnosis codes indicating CKD:** 585.4, 585.5

**Accompanied by**

**One of the following patient encounter codes:** 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215

- Report quality-data codes on **all** measures within the CKD Measures Group for each patient within the eligible professional's patient sample. Report measures #122 and #123 once during the month the patient is included in the patient sample population. For these measures, subsequent months do not need to be reported.



## ***SPECIFICATION FOR MEASURES GROUP REPORTING ONLY***

- Instructions for quality-data code reporting for each of the measures within the CKD Measures Group are displayed on the next several pages. If all quality actions for the patient have been performed for all the measures within the group, the following composite G-code may be reported in lieu of the individual quality-data codes for each of the measures within the group. It is not necessary to submit the following composite G-code for registry-based submissions.

**Composite G-code G8495:** All quality actions for the applicable measures in the CKD Measures Group have been performed for this patient

- To report satisfactorily the CKD Measures Group requires all measures for each patient within the eligible professional's patient sample to be reported a minimum of once during the reporting period.
- When using the 30 Patient Sample Method, report all measures for the 30 unique Medicare Part B FFS patients seen. When using the 50% Patient Sample Method via Claims, report all measures on at least 50% of the patient sample for the eligible professional for the 12-month or 6-month reporting period. When using the 80% Patient Sample Method via Registry, report all measures on at least 80% of the patient sample for the eligible professional for the 12-month or 6-month reporting period.
- For claims-based submissions, the Carrier/MAC remittance advice notice sent to the practice will show a denial remark code (N365) for the line item on the claim containing G8487 (and G8495 if reported) as well as all other line items containing QDCs. N365 indicates that the code is not payable and is used for reporting/informational purposes only. Other services/codes on the claim will not be affected by the addition of a measures group-specific intent G-code or other QDCs. The N365 remark code does NOT indicate whether the QDC is accurate for that claim or for the measure the eligible professional is attempting to report, but does indicate that the QDC was processed and transmitted to the NCH.

*NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2011 Physician Quality Reporting Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS Physician Quality Reporting website.*

**SPECIFICATION FOR MEASURES GROUP REPORTING ONLY**

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

**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 within 12 months: serum levels of calcium, phosphorus and intact PTH, and lipid profile

**NUMERATOR:**

Patients 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

**Numerator Quality-Data Coding Options for Reporting Satisfactorily:**

**Serum Levels of Calcium, Phosphorus, Intact Parathyroid Hormone (iPTH) and Lipid Profile Ordered**

**CPT II 3278F:** Serum levels of calcium, phosphorus, intact Parathyroid Hormone (iPTH) and lipid profile ordered

**OR**

**Serum Levels of Calcium, Phosphorus, Intact Parathyroid Hormone (iPTH) and Lipid Profile not Ordered for Medical or Patient Reasons**

Append a modifier (**1P** or **2P**) to CPT Category II code **3278F** to report documented circumstances that appropriately exclude patients from the denominator

**3278F with 1P:** Documentation of medical reason(s) for not ordering serum levels of calcium, phosphorus, intact Parathyroid Hormone (iPTH) and lipid profile

**3278F with 2P:** Documentation of patient reason(s) for not ordering serum levels of calcium, phosphorus, intact Parathyroid Hormone (iPTH) and lipid profile

**OR**

**Serum Levels of Calcium, Phosphorus, Intact Parathyroid Hormone (iPTH) and Lipid Profile not Ordered, Reason not Specified**

Append a reporting modifier (**8P**) to CPT Category II code **3278F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

**3278F with 8P:** Serum levels of calcium, phosphorus, intact Parathyroid Hormone (iPTH) and lipid profile not ordered, reason not otherwise specified

*NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2011 Physician Quality Reporting Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS Physician Quality Reporting website.*

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

**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

**MEASURES GROUPS REPORTING INSTRUCTIONS:**

Report this measure one time per patient during the reporting month that brings the patient into the CKD measures group sample population

**NUMERATOR:**

Patients visits with blood pressure <130/80 mmHg OR ≥130/80 mmHg with a documented plan of care

**Numerator Instructions:** If multiple blood pressure measurements are taken at a single visit, use the most recent measurement taken at that visit.

**Definition:**

**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.

**NUMERATOR NOTE:** *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.*

**Numerator Quality-Data Coding Options for Reporting Satisfactorily:**

**Patient Visits with Blood Pressure < 130/80 mmHg**

*(One G-code [G8476] is required on the claim form to submit this numerator option)*

**G8476:** Most recent blood pressure has a systolic measurement of <130 mmHg and a diastolic measurement of <80 mmHg

OR

**Blood Pressure Plan of Care Documented for Patient Visits with Systolic Blood Pressure ≥ 130 mmHg and/or Diastolic Blood Pressure ≥ 80 mmHg** (If either systolic blood pressure is ≥ 130 mmHg OR diastolic blood pressure is ≥ 80 mmHg, patient requires a plan of care)

*(One G-code & one CPT II code [G8477 & 0513F] are required on the claim form to submit this numerator option)*

**G8477:** Most recent blood pressure has a systolic measurement of ≥130 mmHg and/or a diastolic measurement of ≥80 mmHg

**AND**

**CPT II 0513F:** Elevated blood pressure plan of care documented

**OR**

**SPECIFICATION FOR MEASURES GROUP REPORTING ONLY**

**Blood Pressure Measurement not Performed, Reason not Specified**

*(One G-code [G8478] is required on the claim form to submit this numerator option)*

**G8478:** Blood pressure measurement not performed or documented, reason not specified

**OR**

**Elevated Blood Pressure Plan of Care not Documented for Patient Visits with Systolic Blood Pressure  $\geq 130$  mmHg and/or Diastolic Blood Pressure  $\geq 80$  mmHg, Reason not Specified**

*(One CPT II code & one G-code [0513F-8P & G8477] are required on the claim form to submit this numerator option)*

Append a reporting modifier (**8P**) to CPT Category II code **0513F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

**0513F with 8P:** No documentation of elevated blood pressure plan of care, reason not otherwise specified

**AND**

**G8477:** Most recent blood pressure has a systolic measurement of  $\geq 130$  mmHg and/or a diastolic measurement of  $\geq 80$  mmHg

*NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2011 Physician Quality Reporting Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS Physician Quality Reporting website.*

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

**DESCRIPTION:**

Percentage of 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

**MEASURES GROUPS REPORTING INSTRUCTIONS:**

Report this measure one time per patient during the reporting month that brings the patient into the CKD measures group sample population

**NUMERATOR:**

Number of calendar months during which patients with a hemoglobin level of < 13 g/dL OR patients whose hemoglobin level is ≥ 13 g/dL have a documented plan of care

**Definitions:**

**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

**NUMERATOR NOTE:** *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.*

**Numerator Quality-Data Coding Options for Reporting Satisfactorily:**

**Hemoglobin level < 13 g/dL**

*(Two CPT II codes [3281F & 4171F] are required on the claim form to submit this numerator option)*

**CPT II 3281F:** Hemoglobin level less than 11 g/dL

**OR**

**CPT II 3280F:** Hemoglobin level 11 g/dL to 12.9 g/dL

**AND**

**CPT II 4171F:** Patient receiving Erythropoiesis-Stimulating Agents (ESA) therapy

**OR**

**Hemoglobin level ≥ 13 g/dL with a Documented Plan of Care**

*(Three CPT II codes [3279F & 0514F & 4171F] are required on the claim form to submit this numerator option)*

**CPT II 3279F:** Hemoglobin level greater than or equal to 13 g/dL

**AND**

**CPT II 0514F:** Plan of care for elevated hemoglobin level documented for patient receiving Erythropoiesis-Stimulating Agent (ESA) therapy

**AND**

**CPT II 4171F:** Patient receiving Erythropoiesis-Stimulating Agents (ESA) therapy

**OR**

**SPECIFICATION FOR MEASURES GROUP REPORTING ONLY**

If patient is not eligible for this measure because, patient was not receiving erythropoiesis-stimulating agent (ESA) therapy, report:  
(One CPT II code [4172F] is required on the claim form to submit this numerator option)  
CPT II 4172F: Patient not receiving Erythropoiesis-Stimulating Agents (ESA) therapy

**OR**

**Hemoglobin Level Measurement not Performed, Reason not Specified**  
(Two CPT II codes [3281F-8P & 4171F] are required on the claim form to submit this numerator option)  
Append a reporting modifier (8P) to CPT Category II code 3281F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.  
3281F **with** 8P: Hemoglobin level measurement not documented, reason not otherwise specified

**AND**

CPT II 4171F: Patient receiving Erythropoiesis-Stimulating Agents (ESA) therapy

**OR**

**Plan of Care for Elevated Hemoglobin Level not Documented for Patient Receiving Erythropoiesis-Stimulating Agent (ESA) Therapy, Reason not Specified**  
(Three CPT II codes [0514F-8P & 3279F & 4171F] are required on the claim form to submit this numerator option)  
Append a reporting modifier (8P) to CPT Category II code 0514F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.  
0514F **with** 8P: Plan of care for elevated hemoglobin level not documented for patient receiving Erythropoiesis-Stimulating Agent (ESA) therapy, reason not otherwise specified

**AND**

CPT II 3279F: Hemoglobin level greater than or equal to 13 g/dL

**AND**

CPT II 4171F: Patient receiving Erythropoiesis-Stimulating Agents (ESA) therapy

*NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2011 Physician Quality Reporting Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS Physician Quality Reporting website.*

**▲ Measure #153: Chronic Kidney Disease (CKD): Referral for Arteriovenous (AV) Fistula**

**DESCRIPTION:**

Percentage of patients aged 18 years and older with the diagnosis of advanced CKD (stage 4 or 5, not receiving Renal Replacement Therapy [RRT]), who were referred for AV fistula at least once during the 12-month reporting period

**NUMERATOR:**

Patients who were referred for AV fistula at least once during the 12 month reporting period

**Numerator Quality-Data Coding Options for Reporting Satisfactorily:**

**AV Fistula Referred**

CPT II 4051F: Referred for an arteriovenous (AV) fistula

**OR**

**AV Fistula not Referred for Medical or Patient Reasons**

Append a modifier (1P or 2P) to CPT Category II code 4051F to report documented circumstances that appropriately exclude patients from the denominator.

**4051F with 1P:** Documentation of medical reason(s) for not referring for an AV fistula

**4051F with 2P:** Documentation of patient reason(s) for not referring for an AV fistula

**OR**

**AV Fistula not Referred, Reason not Specified**

Append a reporting modifier (8P) to CPT Category II code 4051F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

**4051F with 8P:** AV fistula not referred, reason not otherwise specified

*NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2011 Physician Quality Reporting Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS Physician Quality Reporting website.*

## PREVENTIVE CARE MEASURES GROUP OVERVIEW

### 2011 PHYSICIAN QUALITY REPORTING OPTIONS FOR MEASURES GROUPS: CLAIMS, REGISTRY

#### 2011 PHYSICIAN QUALITY REPORTING MEASURES IN THE PREVENTIVE CARE MEASURES GROUP:

- # 39. Screening or Therapy for Osteoporosis for Women Aged 65 Years and Older
- # 48. Urinary Incontinence: Assessment of Presence or Absence of Urinary Incontinence in Women Aged 65 Years and Older
- #110. Preventive Care and Screening: Influenza Immunization for Patients  $\geq 50$  Years Old
- #111. Preventive Care and Screening: Pneumonia Vaccination for Patients 65 years and Older
- #112. Preventive Care and Screening: Screening Mammography
- #113. Preventive Care and Screening: Colorectal Cancer Screening
- #128. Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up
- #173. Preventive Care and Screening: Unhealthy Alcohol Use – Screening
- #226. Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention

#### INSTRUCTIONS FOR REPORTING: (These instructions apply to both Claims and Registry reporting, unless otherwise specified.)

- Indicate your intention to report the Preventive Care Measures Group by submitting the measures group-specific intent G-code at least once during the reporting period when billing a patient claim for both the 30 Patient Sample and the 50% Patient Sample Methods. It is not necessary to submit the measures group-specific intent G-code on more than one claim. It is not necessary to submit the measures group-specific intent G-code for registry-based submissions.

**G8486:** I intend to report the Preventive Care Measures Group

- Select patient sample method:  
**30 Patient Sample Method:** 30 unique Medicare Part B FFS (fee for service) patients meeting patient sample criteria for the measures group.  
**OR**  
**50% Patient Sample Method via Claims or 80% Patient Sample Method via Registry:** All patients meeting patient sample criteria for the measure group during the entire reporting period (July 1 through December 31, 2008). For the 12-month reporting period, a minimum of 15 Medicare Part B FFS patients must meet the measures group patient sample criteria to report satisfactory. For the 6-month reporting period, a minimum of 8 Medicare Part B FFS patients must meet the measures group patient sample criteria to report satisfactory.
- Patient sample criteria for the Preventive Care Measures Group are for patients aged 50 years and older with a specific patient encounter:  
**One of the following patient encounter codes:** 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215
- Report quality-data codes on all applicable measures within the Preventive Care Measures Group for each patient within the eligible professional's patient sample.

Applicable measures contain patient demographic criteria specific to the measure. For example, Screening or Therapy for Osteoporosis is applicable to *women aged 65 years and older* within the sample population, while the Influenza Vaccination measure within this group is applicable to *all patients* aged 50 years and older. eligible professionals may find it more



## SPECIFICATION FOR MEASURES GROUP REPORTING ONLY

efficient to report all measures in the group for each patient within their sample. Reporting measure(s) from the group that are inapplicable to an individual patient will not affect the eligible provider's reporting or performance rate.

Preventive Measures Group Demographic Criteria		
Age	Measures for Male Patients	Measures for Female Patients
<50 years	Patient does not qualify for measures group analysis	Patient does not qualify for measures group analysis
50-64 years	110, 113, 128, 173, 226	110, 112, 113, 128, 173, 226
65-69 years	110, 111, 113, 128, 173, 226	39, 48, 110, 111, 112, 113, 128, 173, 226
70-75 years	110, 111, 113, 128, 173, 226	39, 48, 110, 111, 113, 128, 173, 226
≥76 years	110, 111, 128, 173, 226	39, 48, 110, 111, 128, 173, 226

- Instructions for quality-data code reporting for each of the measures within the Preventive Care Measures Group are displayed on the next several pages. If all quality actions for the patient have been performed for all the measures within the group, the following composite G-code may be reported in lieu of the individual quality-data codes for each of the measures within the group. It is not necessary to submit the following composite G-code for registry-based submissions.

**Composite G-code G8496:** All quality actions for the applicable measures in the Preventive Care Measures Group have been performed for this patient

- To report satisfactorily the Preventive Care Measures Group, it requires all applicable measures for each patient within the eligible professional's patient sample to be reported a minimum of once during the reporting period.
- When using the 30 Patient Sample Method, report all applicable measures for the 30 unique Medicare Part B FFS patients seen. When using the 50% Patient Sample Method via Claims, report all applicable measures on at least 50% of the patient sample for the eligible professional for the 12-month or 6-month reporting period. When using the 80% Patient Sample Method via Registry, report all applicable measures on at least 80% of the patient sample for the eligible professional for the 12-month or 6-month reporting period.
- For claims-based submissions, the Carrier/MAC remittance advice notice sent to the practice will show a denial remark code (N365) for the line item on the claim containing G8486 (and G8496 if reported) as well as all other line items containing QDCs. N365 indicates that the code is not payable and is used for reporting/informational purposes only. Other services/codes on the claim will not be affected by the addition of a measures group-specific intent G-code or other QDCs. The N365 remark code does NOT indicate whether the QDC is accurate for that claim or for the measure the eligible professional is attempting to report, but does indicate that the QCD was processed and transmitted to the NCH.

*NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2011 Physician Quality Reporting Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS Physician Quality Reporting website.*

**SPECIFICATION FOR MEASURES GROUP REPORTING ONLY**

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

**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

**NUMERATOR:**

Patients who had a central DXA measurement ordered or performed at least once since age 60 or pharmacologic therapy prescribed within 12 months

**Definitions:**

**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.

**Numerator Quality-Data Coding Options for Reporting Satisfactorily:**

**Central DXA Measurement Ordered or Performed or Pharmacologic Therapy Prescribed**

**G8399:** Patient with central Dual-energy X-Ray Absorptiometry (DXA) results documented or ordered or pharmacologic therapy (other than minerals/vitamins) for osteoporosis prescribed

**OR**

**Central DXA Measurement not Ordered or Performed or Pharmacologic Therapy not Prescribed for Documented Reasons**

**G8401:** Clinician documented that patient was not an eligible candidate for screening or therapy for osteoporosis for women measure

**OR**

**Central DXA Measurement not Ordered or Performed or Pharmacologic Therapy not Prescribed, Reason not Specified**

**G8400:** 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

*NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2011 Physician Quality Reporting Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS Physician Quality Reporting website.*

**SPECIFICATION FOR MEASURES GROUP REPORTING ONLY**

**\*Measure #48: Urinary Incontinence: Assessment of Presence or Absence of Urinary Incontinence in Women Aged 65 Years and Older**

**DESCRIPTION:**

Percentage of female patients aged 65 years and older who were assessed for the presence or absence of urinary incontinence within 12 months

**NUMERATOR:**

Patients who were assessed for the presence or absence of urinary incontinence within 12 months

**Definition:**

**Urinary Incontinence** – Any involuntary leakage of urine.

**Numerator Quality-Data Coding Options for Reporting Satisfactorily:**

**Presence or Absence of Urinary Incontinence Assessed**

**CPT II 1090F:** Presence or absence of urinary incontinence assessed

**OR**

**Presence or Absence of Urinary Incontinence not Assessed for Medical Reasons**

Append a modifier (**1P**) to CPT Category II code **1090F** to report documented circumstances that appropriately exclude patients from the denominator.

**1090F with 1P:** Documentation of medical reason(s) for not assessing for the presence or absence of urinary incontinence

**OR**

**Presence or Absence of Urinary Incontinence not Assessed, Reason not Specified**

Append a reporting modifier (**8P**) to CPT Category II code **1090F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

**1090F with 8P:** Presence or absence of urinary incontinence not assessed, reason not otherwise specified

*NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2011 Physician Quality Reporting Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS Physician Quality Reporting website.*

**▲ Measure #110: Preventive Care and Screening: Influenza Immunization for Patients ≥ 50 Years Old**

**DESCRIPTION:**

Percentage of patients aged 50 years and older who received an influenza immunization during the flu season (September through February)

**NUMERATOR:**

Patients who received an influenza immunization during the flu season (September through February)

**Numerator Instructions:**

- If reporting this measure between January 1, 2011 and August 31, 2011, G-code G8482 should be reported when the influenza vaccination is ordered or administered to the patient during the months of September, October, November, December of 2010 or January and February of 2011 for the flu season ending February 28, 2011.
- If reporting this measure between September 1, 2011 and December 31, 2011, G-code G8482 should be reported when the influenza vaccination is ordered or administered to the patient during the months of September, October, November, and December of 2011 for the flu season ending February 28, 2012.

**Numerator Quality-Data Coding Options for Reporting Satisfactorily:**

**Influenza Immunization Administered**

**G8482:** Influenza immunization was ordered or administered

**OR**

**Influenza Immunization not Administered for Documented Reasons**

**G8483:** Influenza immunization was not ordered or administered for reasons documented by clinician

**OR**

**Influenza Immunization not Administered, Reason not Specified**

**G8484:** Influenza immunization was not ordered or administered, reason not specified

*NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2011 Physician Quality Reporting Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS Physician Quality Reporting website.*

**SPECIFICATION FOR MEASURES GROUP REPORTING ONLY**

**♦ Measure #111: Preventive Care and Screening: Pneumonia Vaccination for Patients 65 Years and Older**

**DESCRIPTION:**

Percentage of patients aged 65 years and older who have ever received a pneumococcal vaccine

**NUMERATOR:**

Patients who have ever received a pneumococcal vaccination

**Numerator Quality-Data Coding Options for Reporting Satisfactorily:**

**Pneumonia Vaccination Administered or Previously Received**

CPT II 4040F: Pneumococcal vaccine administered or previously received

**OR**

**Pneumonia Vaccination not Administered or Previously Received for Medical Reasons**

Append a modifier (1P) to CPT Category II code **4040F** to report documented circumstances that appropriately exclude patients from the denominator.

**4040F with 1P:** Documentation of medical reason(s) for not administering or previously receiving pneumococcal vaccination

**OR**

**Pneumonia Vaccination not Administered or Previously Received, Reason not Specified**

Append a reporting modifier (8P) to CPT Category II code **4040F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

**4040F with 8P:** Pneumococcal vaccine was not administered or previously received, reason not otherwise specified

*NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2011 Physician Quality Reporting Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS Physician Quality Reporting website.*

♦ Measure #112: Preventive Care and Screening: Screening Mammography

**DESCRIPTION:**

Percentage of women aged 40 through 69 years who had a mammogram to screen for breast cancer within 24 months

**NUMERATOR:**

Patients who had a mammogram at least once within 24 months

**Numerator Quality-Data Coding Options for Reporting Satisfactorily:**

**Mammogram Performed**

CPT II 3014F: Screening mammography results documented and reviewed

**OR**

**Mammogram not Performed for Medical Reasons**

Append a modifier (1P) to CPT Category II code 3014F to report documented circumstances that appropriately exclude patients from the denominator

**3014F with 1P:** Documentation of medical reason(s) for not performing a mammogram (i.e., women who had a bilateral mastectomy or two unilateral mastectomies).

**OR**

**Mammogram not Performed, Reason not Specified**

Append a reporting modifier (8P) to CPT Category II code 3014F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

**3014F with 8P:** Screening mammography results were not documented and reviewed, reason not otherwise specified

*NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2011 Physician Quality Reporting Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS Physician Quality Reporting website.*

♦ Measure #113: Preventive Care and Screening: Colorectal Cancer Screening

**DESCRIPTION:**

Percentage of patients aged 50 through 75 years who received the appropriate colorectal cancer screening

**NUMERATOR:**

Patients who had at least one or more screenings for colorectal cancer during or prior to the reporting period

**Numerator Instructions:** Patients are considered to have appropriate screening for colorectal cancer if any of the following are documented:

- Fecal occult blood test (FOBT) within the last 12 months
- Flexible sigmoidoscopy 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

**Numerator Quality-Data Coding Options for Reporting Satisfactorily:**

**Colorectal Cancer Screening**

CPT II 3017F: Colorectal cancer screening results documented and reviewed

**OR**

**Colorectal Cancer Screening not Performed for Medical Reasons**

Append a modifier (1P) to CPT Category II code 3017F to report documented circumstances that appropriately exclude patients from the denominator

**3017F with 1P:** Documentation of medical reason(s) for not performing a colorectal cancer screening

**OR**

**Colorectal Cancer Screening not Performed, Reason not Specified**

Append a reporting modifier (8P) to CPT Category II code 3017F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

**3017F with 8P:** Colorectal cancer screening results were not documented and reviewed, reason not otherwise specified

*NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2011 Physician Quality Reporting Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS Physician Quality Reporting website.*

♦ Measure #128: Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up

**DESCRIPTION:**

Percentage of patients aged 18 years and older with a calculated BMI in the past six months or during the current visit documented in the medical record AND if the most recent BMI is outside of normal parameters, a follow-up plan is documented

Normal Parameters: Age 65 and older BMI  $\geq 23$  and  $< 30$   
Age 18 – 64 BMI  $\geq 18.5$  and  $< 25$

**NUMERATOR:**

Patients with BMI calculated within the past six months or during the current visit and a follow-up plan documented if the BMI is outside of parameters

**Definitions:**

**BMI** – Body mass index (BMI), expressed as weight/height (BMI; kg/m<sup>2</sup>), is commonly used to classify overweight (BMI 25.0-29.9), obesity (BMI greater than or equal to 30.0) and extreme obesity (BMI greater than or equal to 40) among adults (CDC). BMI is calculated either as weight in pounds divided by height in inches squared multiplied by 703, or as weight in kilograms divided by height in meters squared. The National Institutes of Health (NIH) provides a BMI calculator table at [www.nhlbi.nih.gov/guidelines/obesity/bmi\\_tbl.htm](http://www.nhlbi.nih.gov/guidelines/obesity/bmi_tbl.htm). (AHRQ Preventive Guidelines 2009)

**Elderly BMI** – Most experts suggest use of a higher BMI threshold for underweight elderly individuals, compared to what is used for the general population (Chernoff, Cook, Mahan). *International Dietetics and Nutrition Terminology* defines underweight in persons >65 years of age as a BMI of  $< 23$ . This BMI value is one indicator of malnutrition when forming a nutrition diagnosis for the elderly population (American Dietetic Association). A BMI of  $< 23$  classifies an older adult (older than age 65) as underweight and may require nutrition intervention.

**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 (such as, a registered dietician, nutritionist, occupational therapy, primary care physician, exercise physiologist, mental health professional, surgeon, etc.), prescription/administration of medications/dietary supplements, etc.

**Not eligible/Not Appropriate for BMI Measurement** – Patients can be considered not eligible in the following situations:

- There is documentation in the medical record that the patient is over or under weight and is being managed by another provider
- If the patient has a terminal illness – life expectancy less than 6 months
- 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



**SPECIFICATION FOR MEASURES GROUP REPORTING ONLY**

**Numerator Quality-Data Coding Options for Reporting Satisfactorily:**

**BMI Calculated, No Follow-up Plan Needed or BMI Calculated, Follow-up Plan Documented**

**G8420:** Calculated BMI within normal parameters and documented

**OR**

**G8417:** Calculated BMI above the upper parameter and a follow-up plan was documented in the medical record

**OR**

**G8418:** Calculated BMI below the lower parameter and a follow-up plan was documented in the medical record

**OR**

**Patient not Eligible for BMI Calculation for Documented Reasons**

**G8422:** Patient not eligible for BMI calculation

**OR**

**BMI not Performed and/or Calculated BMI Outside of Normal Parameters, Follow-up Plan not Documented, Reason not Specified**

**G8421:** BMI not calculated

**OR**

**G8419:** Calculated BMI outside normal parameters, no follow-up plan documented in the medical record

*NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2011 Physician Quality Reporting Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS Physician Quality Reporting website.*

**▲ Measure #173: Preventive Care and Screening: Unhealthy Alcohol Use – Screening**

**DESCRIPTION:**

Percentage of patients aged 18 years and older who were screened for unhealthy alcohol use using a systematic screening method within 24 months

**NUMERATOR:**

Patients who were screened for unhealthy alcohol use using a systematic screening method within 24 months

**Definition:**

**Unhealthy Alcohol Use** – Covers a spectrum that is associated with varying degrees of risk to health. Categories representing unhealthy alcohol use include risky use, problem drinking, harmful use, and alcohol abuse, and the less common but more severe alcoholism and alcohol dependence. Risky use is defined as > 7 standard drinks per week or > 3 drinks per occasion for women and persons > 65 years of age; > 14 standard drinks per week or > 4 drinks per occasion for men ≤ 65 years of age.

**Numerator Quality-Data Coding Options for Reporting Satisfactorily:**

**Unhealthy Alcohol Use Screening Performed**

**CPT II 3016F:** Patient screened for unhealthy alcohol use using a systematic screening method

**OR**

**Unhealthy Alcohol Use Screening not Performed, for Medical Reasons**

Append a modifier (1P) to CPT Category II code **3016F** to report documented circumstances that appropriately exclude patients from the denominator.

**3016F with 1P:** Documentation of medical reason(s) for not screening for unhealthy alcohol use (eg, limited life expectancy)

**OR**

**Unhealthy Alcohol Use Screening not Performed, Reason not Specified**

Append a reporting modifier (8P) to CPT Category II code **3016F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

**3016F with 8P:** Unhealthy alcohol use screening not performed, reason not otherwise specified

*NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2011 Physician Quality Reporting Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS Physician Quality Reporting website.*

**▲ Measure #226: Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention**

**DESCRIPTION:**

Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation counseling intervention if identified as a tobacco user

**NUMERATOR:**

Patients who were screened for tobacco use at least once within 24 months AND who received tobacco cessation counseling intervention if identified as a tobacco user

**Definitions:**

**Tobacco Use** – Includes any type of tobacco

**Cessation Counseling Intervention** – Includes counseling or pharmacotherapy

**Numerator Quality-Data Coding Options for Reporting Satisfactorily:**

**Patient Screened for Tobacco Use**

**CPT II 4004F:** Patient screened for tobacco use AND received tobacco cessation counseling, if identified as a tobacco user

**OR**

**Patient Screened for Tobacco Use and Identified as a Non-User of Tobacco**

**CPT II 1036F:** Current tobacco non-user

**OR**

**Tobacco Screening not Performed for Medical Reasons**

Append a modifier (**1P**) to CPT Category II code **4004F** to report documented circumstances that appropriately exclude patients from the denominator

**4004F with 1P:** Documentation of medical reason(s) for not screening for tobacco use (eg, limited life expectancy)

**OR**

**Tobacco Screening not Performed Reason Not Specified**

Append a reporting modifier (**8P**) to CPT Category II code 4004F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

**4004F with 8P:** Tobacco Screening not performed, reason not otherwise specified

*NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2011 Physician Quality Reporting Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS Physician Quality Reporting website.*

## CORONARY ARTERY BYPASS GRAFT (CABG) MEASURES GROUP OVERVIEW

### 2011 PHYSICIAN QUALITY REPORTING OPTIONS FOR MEASURES GROUPS: REGISTRY ONLY

#### 2011 PHYSICIAN QUALITY REPORTING MEASURES IN CORONARY ARTERY BYPASS GRAFT (CABG) MEASURES GROUP:

- #43. Coronary Artery Bypass Graft (CABG): Use of Internal Mammary Artery (IMA) in Patients with Isolated CABG Surgery
- #44. Coronary Artery Bypass Graft (CABG): Preoperative Beta-Blocker in Patients with Isolated CABG Surgery
- #164. Coronary Artery Bypass Graft (CABG): Prolonged Intubation (Ventilation)
- #165. Coronary Artery Bypass Graft (CABG): Deep Sternal Wound Infection Rate
- #166. Coronary Artery Bypass Graft (CABG): Stroke/Cerebrovascular Accident (CVA)
- #167. Coronary Artery Bypass Graft (CABG): Postoperative Renal Insufficiency
- #168. Coronary Artery Bypass Graft (CABG): Surgical Re-exploration
- #169. Coronary Artery Bypass Graft (CABG): Anti-platelet Medications at Discharge
- #170. Coronary Artery Bypass Graft (CABG): Beta-Blockers Administered at Discharge
- #171. Coronary Artery Bypass Graft (CABG): Lipid Management and Counseling

#### **INSTRUCTIONS FOR REPORTING: (These instructions apply to registry reporting. Do not report this measures group via claims.)**

- It is not necessary to submit the measures group-specific intent G-code for registry-based submissions. However, the measures group-specific intent G-code has been created for registry only measures groups for use by registries that utilize claims data.

**G8544:** I intend to report the Coronary Artery Bypass Graft (CABG) Measures Group

- Select patient sample method:  
**30 Patient Sample Method:** 30 unique Medicare Part B FFS (fee for service) patients meeting patient sample criteria for the measures group.  
**OR**  
**80% Patient Sample Method:** All patients meeting patient sample criteria for the measure group during the entire reporting period (January 1 through December 31, 2011 **OR** July 1 through December 31, 2011). For the 12-month reporting period, a minimum of 15 Medicare Part B FFS patients must meet the measures group patient sample criteria to report satisfactory. For the 6-month reporting period, a minimum of 8 Medicare Part B FFS patients must meet the measures group patient sample criteria to report satisfactory.

- Patient sample criteria for the CABG Measures Group are patients aged 18 years and older that have a specific procedure for isolated CABG performed:

**One of the following procedure codes indicating CABG:** 33510, 33511, 33512, 33513, 33514, 33516, 33517, 33518, 33519, 33521, 33522, 33523, 33533, 33534, 33535, 33536

- Measure #166 need only be reported when the patient does not have a history of a prior CVA. Measure #167 need only be reported when the patient does not have a history renal insufficiency or a baseline serum creatinine > 2.0. Measure #169, #170, and #171 need only be reported when the patient is not deceased prior to discharge. Therefore, these measures are only applicable to a patient when these additional criteria are indicated.

## ***SPECIFICATION FOR MEASURES GROUP REPORTING ONLY***

- Report a numerator option on **all applicable** measures within the CABG Measures Group for each patient within the eligible professional's patient sample.
- Instructions for qualifying numerator option reporting for each of the measures within the CABG Measures Group are displayed on the next several pages. The following composite G-code has been created for registry only measures groups for use by registries that utilize claims data. This composite G-code may be reported in lieu of the individual quality-data codes for each of the measures within the group, if all quality actions for the patient have been performed for all the measures within the group. However, it is not necessary to submit the following composite G-code for registry-based submissions.

**Composite G-code G8497:** All quality actions for the applicable measures in the Coronary Artery Bypass Graft (CABG) Measures Group have been performed for this patient

- To report satisfactorily the CABG Measures Group it requires **all applicable** measures for each patient within the eligible professional's patient sample to be reported each time an isolated CABG procedure is performed during the reporting period.
- When using the 30 Patient Sample Method, report all applicable measures for the 30 unique Medicare Part B FFS patients seen during the reporting period. When using the 80% Patient Sample Method, report all applicable measures on at least 80% of the patient sample for the eligible professional for the 12-month or 6-month reporting period.

*NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2011 Physician Quality Reporting Measure Specifications Manual for Claims and Registry Reporting of Individual Measures" available for download from the CMS Physician Quality Reporting website.*

**SPECIFICATION FOR MEASURES GROUP REPORTING ONLY**

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

**DESCRIPTION:**

Percentage of patients aged 18 years and older undergoing isolated CABG surgery using an IMA graft

**NUMERATOR:**

Patients who received an IMA graft in isolated CABG

**Numerator Quality-Data Coding Options for Reporting Satisfactorily:**

**IMA Graft Performed**

CPT II 4110F: Internal mammary artery graft performed for primary, isolated coronary artery bypass graft procedure

**OR**

**IMA Graft not Performed for Medical Reasons**

Append a modifier (1P) to the CPT Category II code 4110F to report documented circumstances that appropriately exclude patients from the denominator.

4110F **with** 1P: Documentation of medical reason(s) for not performing an internal mammary artery graft for primary, isolated coronary artery bypass graft procedure

**OR**

**IMA Graft not Performed, Reason not Specified**

Append a reporting modifier (8P) to CPT Category II code 4110F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

4110F **with** 8P: Internal mammary artery graft not performed for primary, isolated coronary artery bypass graft procedure, reason not otherwise specified

*NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2011 Physician Quality Reporting Measure Specifications Manual for Claims and Registry Reporting of Individual Measures" available for download from the CMS Physician Quality Reporting website.*

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

**DESCRIPTION:**

Percentage of patients aged 18 years and older undergoing isolated CABG surgery who received a beta-blocker within 24 hours prior to surgical incision

**NUMERATOR:**

Patients undergoing isolated CABG who received a beta-blocker within 24 hours prior to surgical incision

**Numerator Quality-Data Coding Options for Reporting Satisfactorily:**

**Preoperative Beta-blocker Received**

CPT II 4115F: Beta blocker administered within 24 hours prior to surgical incision

**OR**

**Preoperative Beta-blocker not Received for Medical Reasons**

Append a modifier (1P) to the CPT Category II code 4115F to report documented circumstances that appropriately exclude patients from the denominator.

4115F **with** 1P: Documentation of medical reason(s) for not administering beta blocker within 24 hours prior to surgical incision

**OR**

**Preoperative Beta-blocker not Received, Reason not Specified**

Append a reporting modifier (8P) to CPT Category II code 4115F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

4115F **with** 8P: Beta blocker not administered within 24 hours prior to surgical incision, reason not otherwise specified

*NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2011 Physician Quality Reporting Measure Specifications Manual for Claims and Registry Reporting of Individual Measures" available for download from the CMS Physician Quality Reporting website.*

□ Measure #164: Coronary Artery Bypass Graft (CABG): Prolonged Intubation (Ventilation)

**DESCRIPTION:**

Percentage of patients aged 18 years and older undergoing isolated CABG surgery who require intubation > 24 hours

**NUMERATOR:**

Patients undergoing isolated CABG who require intubation > 24 hours

**Numerator Instructions:** For performance, a lower rate indicates better performance.

**Numerator Options:**

Prolonged intubation (> 24 hrs) required (G8569)

**OR**

Prolonged intubation (> 24 hrs) not required (G8570)

*NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2011 Physician Quality Reporting Measure Specifications Manual for Claims and Registry Reporting of Individual Measures" available for download from the CMS Physician Quality Reporting website.*



Measure #165: Coronary Artery Bypass Graft (CABG): Deep Sternal Wound Infection Rate

**DESCRIPTION:**

Percentage of patients aged 18 years and older undergoing isolated CABG surgery who developed deep sternal wound infection (involving muscle, bone, and/or mediastinum requiring operative intervention) within 30 days postoperatively

**NUMERATOR:**

Patients who developed a deep sternal wound infection within 30 days postoperatively (must have ALL of the following conditions: wound opened with excision of tissue [incision and drainage] or re-exploration of mediastinum, positive culture and treatment with antibiotics)

**Numerator Instructions:** For performance, a lower rate indicates better performance.

**Numerator Options:**

Development of deep sternal wound infection within 30 days postoperatively (G8571)

**OR**

No deep sternal wound infection (G8572)

*NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2011 Physician Quality Reporting Measure Specifications Manual for Claims and Registry Reporting of Individual Measures" available for download from the CMS Physician Quality Reporting website.*

□ Measure #166: Coronary Artery Bypass Graft (CABG): Stroke/Cerebrovascular Accident (CVA)

**DESCRIPTION:**

Percentage of patients aged 18 years and older undergoing isolated CABG surgery who had a stroke/CVA within 24 hours postoperatively

**NUMERATOR:**

Patients who have a stroke/CVA within 24 hours postoperatively

**Numerator Instructions:** For performance, a lower rate indicates better performance.

**Numerator Options:**

Stroke/CVA following isolated CABG surgery (G8573)

**OR**

No stroke/CVA following isolated CABG surgery (G8574)

*NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2011 Physician Quality Reporting Measure Specifications Manual for Claims and Registry Reporting of Individual Measures" available for download from the CMS Physician Quality Reporting website.*

□ Measure #167: Coronary Artery Bypass Graft (CABG): Postoperative Renal Insufficiency

**DESCRIPTION:**

Percentage of patients aged 18 years and older undergoing isolated CABG surgery who develop postoperative renal insufficiency or require dialysis

**NUMERATOR:**

Patients who develop postop renal insufficiency or require dialysis (indicate whether the patient had acute or worsening renal insufficiency resulting in one or more of the following: 1) increase of serum creatinine to > 2.0, and 2x most recent preoperative creatinine level; 2) a new requirement for dialysis postoperatively)

**Numerator Instructions:** For performance, a lower rate indicates better performance.

**Numerator Options:**

Developed postoperative renal insufficiency or required dialysis (G8575)

**OR**

No postoperative renal insufficiency/dialysis not required (G8576)

*NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2011 Physician Quality Reporting Measure Specifications Manual for Claims and Registry Reporting of Individual Measures" available for download from the CMS Physician Quality Reporting website.*

Measure #168: Coronary Artery Bypass Graft (CABG): Surgical Re-exploration

**DESCRIPTION:**

Percentage of patients aged 18 years and older undergoing isolated CABG surgery who require a return to the operating room (OR) for mediastinal bleeding/tamponade, graft occlusion (due to acute closure, thrombosis, technical or embolic origin), or other cardiac reason

**NUMERATOR:**

Patients who require a return to the OR for bleeding/tamponade, graft occlusion, or other cardiac reason

**Numerator Instructions:** For performance, a lower rate indicates better performance.

**Numerator Options:**

Reoperation required due to bleeding/tamponade, graft occlusion or other cardiac reason (G8577)

**OR**

Reoperation not required due to bleeding/tamponade, graft occlusion or other cardiac reason (G8578)

*NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2011 Physician Quality Reporting Measure Specifications Manual for Claims and Registry Reporting of Individual Measures" available for download from the CMS Physician Quality Reporting website.*

SPECIFICATION FOR MEASURES GROUP REPORTING ONLY

Measure #169: Coronary Artery Bypass Graft (CABG): Antiplatelet Medications at Discharge

**DESCRIPTION:**

Percentage of patients aged 18 years and older undergoing isolated CABG surgery who have antiplatelet medication at discharge

**NUMERATOR:**

Patients who were discharged on antiplatelet medication

**Numerator Options:**

Antiplatelet medication at discharge (G8579)

**OR**

Antiplatelet medication contraindicated/not indicated (G8580)

**OR**

No antiplatelet medication at discharge (G8581)

*NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2011 Physician Quality Reporting Measure Specifications Manual for Claims and Registry Reporting of Individual Measures" available for download from the CMS Physician Quality Reporting website.*

Measure #170: Coronary Artery Bypass Graft (CABG): Beta-Blockers Administered at Discharge

**DESCRIPTION:**

Percentage of patients aged 18 years and older undergoing isolated CABG surgery who were discharged on beta-blockers

**NUMERATOR:**

Patients who were discharged on beta-blockers

**Numerator Options:**

Beta-blocker at discharge (G8582)

**OR**

Beta-blocker contraindicated/not indicated (G8583)

**OR**

No beta-blocker at discharge (G8584)

*NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2011 Physician Quality Reporting Measure Specifications Manual for Claims and Registry Reporting of Individual Measures" available for download from the CMS Physician Quality Reporting website.*

Measure #171: Coronary Artery Bypass Graft (CABG): Lipid Management and Counseling

**DESCRIPTION:**

Percentage of patients aged 18 years and older undergoing isolated CABG surgery who have anti-lipid treatment at discharge

**NUMERATOR:**

Patients with an anti-lipid treatment at discharge

**Numerator Options:**

Anti-lipid treatment at discharge (G8585)

**OR**

Anti-lipid treatment contraindicated/not indicated (G8586)

**OR**

No anti-lipid treatment at discharge (G8587)

*NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2011 Physician Quality Reporting Measure Specifications Manual for Claims and Registry Reporting of Individual Measures" available for download from the CMS Physician Quality Reporting website.*

## RHEUMATOID (RA) ARTHRITIS MEASURES GROUP OVERVIEW

### 2011 PHYSICIAN QUALITY REPORTING OPTIONS FOR MEASURES GROUPS: CLAIMS, REGISTRY

#### 2011 PHYSICIAN QUALITY REPORTING MEASURES IN RHEUMATOID ARTHRITIS (RA) MEASURES GROUP:

- #108. Rheumatoid Arthritis (RA): Disease Modifying Anti-Rheumatic Drug (DMARD) Therapy
- #176. Rheumatoid Arthritis (RA): Tuberculosis Screening
- #177. Rheumatoid Arthritis (RA): Periodic Assessment of Disease Activity
- #178. Rheumatoid Arthritis (RA): Functional Status Assessment
- #179. Rheumatoid Arthritis (RA): Assessment and Classification of Disease Prognosis
- #180. Rheumatoid Arthritis (RA): Glucocorticoid Management

#### INSTRUCTIONS FOR REPORTING: (These instructions apply to both Claims and Registry reporting, unless otherwise specified.)

- Indicate your intention to report the RA Measures Group by submitting the measures group-specific intent G-code at least once during the reporting period when billing a patient claim for both the 30 Patient Sample and the 50% Patient Sample Methods. It is not necessary to submit the measures group-specific intent G-code on more than one claim. It is not necessary to submit the measures group-specific intent G-code for registry-based submissions.

**G8490:** I intend to report the Rheumatoid Arthritis Measures Group

- Select patient sample method:  
**30 Patient Sample Method:** 30 unique Medicare Part B FFS (fee for service) patients meeting patient sample criteria for the measures group.  
**OR**  
**50% Patient Sample Method via Claims or 80% Patient Sample Method via Registry:** All patients meeting patient sample criteria for the measure group during the entire reporting period (January 1 through December 31, 2011 **OR** July 1 through December 31, 2011). For the 12-month reporting period, a minimum of 15 Medicare Part B FFS patients must meet the measures group patient sample criteria to report satisfactory. For the 6-month reporting period, a minimum of 8 Medicare Part B FFS patients must meet the measures group patient sample criteria to report satisfactory.

- Patient sample criteria for the RA Measures Group are patients aged 18 years and older with a specific diagnosis of RA accompanied by a specific patient encounter:

**One of the following diagnosis codes indicating RA:** 714.0, 714.1, 714.2, 714.81

**Accompanied by**

**One of the following patient encounter codes:** 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350

- Report quality-data codes on **all** measures within the RA Measures Group for each patient within the eligible professional's patient sample.
- Instructions for quality-data code reporting for each of the measures within the RA Measures Group are displayed on the next several pages. If all quality actions for the patient have been performed for all the measures within the group, the following composite G-code may be



## ***SPECIFICATION FOR MEASURES GROUP REPORTING ONLY***

reported in lieu of the individual quality-data codes for each of the measures within the group. It is not necessary to submit the following composite G-code for registry-based submissions.

**Composite G-code G8499:** All quality actions for the applicable measures in the Rheumatoid Arthritis Measures Group have been performed for this patient

- To report satisfactorily the RA Measures Group it requires **all** measures for each patient within the eligible professional's patient sample to be reported a minimum of once during the reporting period.
- When using the 30 Patient Sample Method, report all measures for the 30 unique Medicare Part B FFS patients seen. When using the 50% Patient Sample Method via Claims, report all measures on at least 50% of the patient sample for the eligible professional for the 12-month or 6-month reporting period. When using the 80% Patient Sample Method via Registry, report all measures on at least 80% of the patient sample for the eligible professional for the 12-month or 6-month reporting period.
- For claims-based submissions, the Carrier/MAC remittance advice notice sent to the practice will show a denial remark code (N365) for the line item on the claim containing G8490 (and G8499 if reported) as well as all other line items containing QDCs. N365 indicates that the code is not payable and is used for reporting/informational purposes only. Other services/codes on the claim will not be affected by the addition of a measures group-specific intent G-code or other QDCs. The N365 remark code does NOT indicate whether the QDC is accurate for that claim or for the measure the eligible professional is attempting to report, but does indicate that the QDC was processed and transmitted to the NCH.

*NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2011 Physician Quality Reporting Measure Specifications Manual for Claims and Registry Reporting of Individual Measures" available for download from the CMS Physician Quality Reporting website.*

**SPECIFICATION FOR MEASURES GROUP REPORTING ONLY**

**◆ Measure #108: Rheumatoid Arthritis (RA): Disease Modifying Anti-Rheumatic Drug (DMARD) Therapy**

**DESCRIPTION:**

Percentage of patients aged 18 years and older who were diagnosed with RA and were prescribed, dispensed, or administered at least one ambulatory prescription for a DMARD

**NUMERATOR:**

Patients who were prescribed, dispensed, or administered at least one disease modifying anti-rheumatic drug (DMARD)

**Definitions:**

**Prescribed** – May include prescription given to the patient for DMARD therapy at one or more visits in the 12-month period OR patient already taking DMARD therapy as documented in current medication list.

**Biologic DMARD Therapy** – Includes Adalimumab, Etanercept, Infliximab, Abatacept, Anakinra and Rituximab

**Numerator Quality-Data Coding Options for Reporting Satisfactorily:**

**DMARD Prescribed, Dispensed, or Administered**

**CPT II 4187F:** Disease modifying anti-rheumatic drug therapy prescribed, dispensed, or administered

**OR**

**DMARD not Prescribed, Dispensed, or Administered for Medical Reasons**

Append a modifier (1P) to CPT Category II code **4187F** to report documented circumstances that appropriately exclude patients from the denominator.

**4187F with 1P:** Documentation of medical reason(s) for not prescribing, dispensing, or administering disease modifying anti-rheumatic drug therapy

**OR**

**DMARD not Prescribed, Dispensed, or Administered, Reason not Specified**

Append a reporting modifier (8P) to CPT Category II code **4187F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

**4187F with 8P:** Disease modifying anti-rheumatic drug therapy was not prescribed, dispensed, or administered, reason not otherwise specified

*NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2011 Physician Quality Reporting Measure Specifications Manual for Claims and Registry Reporting of Individual Measures" available for download from the CMS Physician Quality Reporting website.*

⌘ Measure #176: Rheumatoid Arthritis (RA): Tuberculosis Screening

**DESCRIPTION:**

Percentage of patients aged 18 years and older with a diagnosis of RA who have documentation of a tuberculosis (TB) screening performed and results interpreted within 6 months prior to receiving a first course of therapy using a biologic disease-modifying anti-rheumatic drug (DMARD)

**NUMERATOR:**

Patients for whom a TB screening was performed and results interpreted within six months prior to receiving a first course of therapy using a biologic disease-modifying anti-rheumatic drug (DMARD)

**Numerator Instructions:** Patients are considered to be receiving a first course of therapy using a biologic DMARD only if they have never previously been prescribed or dispensed a biologic DMARD.

**Definition:**

**Biologic DMARD Therapy** – Includes Adalimumab, Etanercept, Infliximab, Abatacept, Anakinra (Rituximab is excluded)

**NUMERATOR NOTE:** *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.*

**Numerator Quality-Data Coding Options for Reporting Satisfactorily:**

**Tuberculosis Screening Performed and Results Interpreted**

*(Two CPT II codes [3455F & 4195F] are required on the claim form to submit this numerator option)*

**CPT II 3455F:** TB screening performed and results interpreted within six months prior to initiation of first-time biologic disease modifying anti-rheumatic drug therapy for RA

**AND**

**CPT II 4195F:** Patient receiving first-time biologic disease modifying anti-rheumatic drug therapy for rheumatoid arthritis

**OR**

**TB Screening not Performed or Results not Interpreted for Medical Reasons**

*(Two CPT II codes [3455F-1P & 4195F] are required on the claim form to submit this numerator option)*

Append a modifier (1P) to CPT Category II code 3455F to report documented circumstances that appropriately exclude patients from the denominator.

**3455F with 1P:** Documentation of medical reason for not screening for TB or interpreting results (i.e., patient positive for TB and documentation of past treatment; patient has recently completed a course of anti-TB therapy)

**AND**

**CPT II 4195F:** Patient receiving first-time biologic disease modifying anti-rheumatic drug therapy for rheumatoid arthritis

OR

**SPECIFICATION FOR MEASURES GROUP REPORTING ONLY**

If patient does not meet denominator inclusion because biologic DMARD prescription is Rituximab or this is not the first course of biologic DMARD therapy for RA, report:

*(One CPT II code [4196F] is required on the claim form to submit this numerator option)*

**CPT II 4196F:** Patient not receiving first-time biologic disease modifying anti-rheumatic drug therapy for rheumatoid arthritis

**OR**

**TB Screening not Performed or Results not Interpreted, Reason not Specified**

*(Two CPT II codes [3455F-8P & 4195F] are required on the claim form to submit this numerator option)*

Append a reporting modifier (**8P**) to CPT Category II code **3455F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

**3455F with 8P:** TB screening not performed or results not interpreted, reason not otherwise specified

**AND**

**CPT II 4195F:** Patient receiving first-time biologic disease modifying anti-rheumatic drug therapy for rheumatoid arthritis

*NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2011 Physician Quality Reporting Measure Specifications Manual for Claims and Registry Reporting of Individual Measures" available for download from the CMS Physician Quality Reporting website.*

**⌘ Measure #177: Rheumatoid Arthritis (RA): Periodic Assessment of Disease Activity**

**DESCRIPTION:**

Percentage of patients aged 18 years and older with a diagnosis of RA who have an assessment and classification of disease activity within 12 months

**NUMERATOR:**

Patients with disease activity assessed by a standardized descriptive or numeric scale or composite index and classified into one of the following categories: low, moderate or high, at least once within 12 months

**Definition:**

**Assessment and Classification of Disease Activity** – Assesses if physicians are utilizing a standardized, systematic approach for evaluating the level of disease activity. The scales/instruments listed are examples of how to define activity level and cut-off points can differ by scale. Standardized descriptive or numeric scales and/or composite indexes could include but are not limited to: DAS28, SDAI, CDAI, RADAI, RAPID.

**Numerator Quality-Data Coding Options for Reporting Satisfactorily:**

**Disease Activity Assessed and Classified**

CPT II 3470F: Rheumatoid arthritis (RA) disease activity, low

**OR**

CPT II 3471F: Rheumatoid arthritis (RA) disease activity, moderate

**OR**

CPT II 3472F: Rheumatoid arthritis (RA) disease activity, high

**OR**

**Disease Activity not Assessed and Classified, Reason not Specified**

Append a reporting modifier (**8P**) to CPT Category II code **3470F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

**3470F with 8P:** Disease activity not assessed and classified, reason not otherwise specified

*NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2011 Physician Quality Reporting Measure Specifications Manual for Claims and Registry Reporting of Individual Measures" available for download from the CMS Physician Quality Reporting website.*

⌘ Measure #178: Rheumatoid Arthritis (RA): Functional Status Assessment

**DESCRIPTION:**

Percentage of patients aged 18 years and older with a diagnosis of RA for whom a functional status assessment was performed at least once within 12 months

**NUMERATOR:**

Patients for whom a functional status assessment was performed at least once within 12 months

**Definitions:**

**Functional Status Assessment** – This measure assesses if physicians are using a standardized descriptive or numeric scale, standardized questionnaire, or notation of assessment of the impact of RA on patient activities of daily living. Examples of tools used to assess functional status include but are not limited to: Health Assessment Questionnaire (HAQ), Modified HAQ, HAQ-2; American College of Rheumatology's Classification of Functional Status in Rheumatoid Arthritis.

**Activities of Daily Living** – Could include a description of any of the following: dressing/grooming, rising from sitting, walking/running/ability to ambulate, stair climbing, reaching, gripping, shopping/running errands/house or yard work.

**Numerator Quality-Data Coding Options for Reporting Satisfactorily:**

**Functional Status Assessed**

CPT II 1170F: Functional status assessed

**OR**

**Functional Status not Assessed, Reason not Specified**

Append a reporting modifier (8P) to CPT Category II code 1170F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

1170F *with* 8P: Functional status not assessed, reason not otherwise specified

*NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2011 Physician Quality Reporting Measure Specifications Manual for Claims and Registry Reporting of Individual Measures" available for download from the CMS Physician Quality Reporting website.*

**⌘ Measure #179: Rheumatoid Arthritis (RA): Assessment and Classification of Disease Prognosis**

**DESCRIPTION:**

Percentage of patients aged 18 years and older with a diagnosis of RA who have an assessment and classification of disease prognosis at least once within 12 months

**NUMERATOR:**

Patients with at least one documented assessment and classification (good/poor) of disease prognosis utilizing clinical markers of poor prognosis at least once within 12 months

**Numerator Instructions:** This measure evaluates if physicians are assessing and classifying disease prognosis using a standardized, systematic approach. Disease prognosis should be classified as either poor or good.

**Definitions:**

**Poor Prognosis** – RA patients with features of poor prognosis have active disease with high tender and swollen joint counts, often have evidence of radiographic erosions, elevated levels of rheumatoid factor (RF) and/or anti-cyclic citrullinated peptide (anti-CCP) antibodies, and an elevated erythrocyte sedimentation rate, and an elevated C-reactive protein level.

**Clinically Important Markers of Poor Prognosis** – Classification should be based upon at a minimum the following: functional limitation (e.g., HAQ Disability Index), extraarticular disease (e.g. vasculitis, Sjorgen's syndrome, RA lung disease, rheumatoid nodules), RF positivity, positive anti-CCP antibodies (both characterized dichotomously, per CEP recommendation), and/or bony erosions by radiography.

**Numerator Quality-Data Coding Options for Reporting Satisfactorily:**

**Disease Prognosis Assessed and Classified**

CPT II 3475F: Disease prognosis for rheumatoid arthritis assessed, poor prognosis documented

**OR**

CPT II 3476F: Disease prognosis for rheumatoid arthritis assessed, good prognosis documented

**OR**

**Disease Prognosis not Assessed and Classified, Reason not Specified**

Append a reporting modifier (8P) to CPT Category II code 3475F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

**3475F with 8P:** Disease prognosis for rheumatoid arthritis not assessed and classified, reason not otherwise specified

*NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2011 Physician Quality Reporting Measure Specifications Manual for Claims and Registry Reporting of Individual Measures" available for download from the CMS Physician Quality Reporting website.*

**⌘ Measure #180: Rheumatoid Arthritis (RA): Glucocorticoid Management**

**DESCRIPTION:**

Percentage of patients aged 18 years and older with a diagnosis of RA who have been assessed for glucocorticoid use and, for those on prolonged doses of prednisone  $\geq 10$  mg daily (or equivalent) with improvement or no change in disease activity, documentation of glucocorticoid management plan within 12 months

**NUMERATOR:**

Patients who have been assessed for glucocorticoid use and for those on prolonged doses of prednisone  $\geq 10$  mg daily (or equivalent) with improvement or no change in disease activity, documentation of a glucocorticoid management plan within 12 months

**Definitions:**

**Prolonged Dose** – Doses > 6 months in duration

**Prednisone Equivalents** – Determine using the following:

1 mg of prednisone = 1 mg of prednisolone; 5 mg of cortisone; 4 mg of hydrocortisone; 0.8 mg of triamcinolone; 0.8 mg of methylprednisolone; 0.15 mg of dexamethasone; 0.15 mg of betamethasone

**Glucocorticoid Management Plan** – Includes documentation of attempt to taper steroids OR documentation of a new prescription for a non-glucocorticoid disease-modifying antirheumatic drug (DMARD) OR increase in dose of non-glucocorticoid DMARD dose for persistent RA disease activity at current or reduced dose

**NUMERATOR NOTE:** *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.*

**Numerator Quality-Data Coding Options for Reporting Satisfactorily:**

**Glucocorticoid Use Assessed**

*(One CPT II code [419xF] is required on the claim form to submit this numerator option)*

**CPT II 4192F:** Patient not receiving glucocorticoid therapy

**OR**

**CPT II 4193F:** Patient receiving < 10 mg daily prednisone (or equivalent), or RA disease activity is worsening, or glucocorticoid use is for less than 6 months

**OR**

**Glucocorticoid Use Assessed and Management Plan Documented**

*(Two CPT II codes [4194F and 0540F] are required on the claim form to submit this numerator option)*

**CPT II 4194F:** Patient receiving  $\geq 10$  mg daily prednisone (or equivalent) for longer than 6 months, and improvement or no change in disease activity

**AND**

**CPT II 0540F:** Glucocorticoid Management Plan documented

**OR**



**SPECIFICATION FOR MEASURES GROUP REPORTING ONLY**

**Glucocorticoid Plan not Documented for Medical Reasons**

*(Two CPT II codes [0540F-1P and 4194F] are required on the claim form to submit this numerator option)*

Append a modifier (1P) to CPT Category II code **0540F** to report documented circumstances that appropriately exclude patients from the denominator.

**0540F with 1P:** Documentation of medical reason(s) for not documenting glucocorticoid dose and documenting management plan (i.e., glucocorticoid prescription is for a medical condition other than RA)

**AND**

**CPT II 4194F:** Patient receiving  $\geq 10$  mg daily prednisone (or equivalent) for longer than 6 months, and improvement or no change in disease activity

**OR**

**Glucocorticoid Dose not Documented, Reason not Specified**

*(One CPT II code [4194F-8P] is required on the claim form to submit this category)*

Append a reporting modifier (8P) to CPT Category II code **4194F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

**4194F with 8P:** Glucocorticoid dose was not documented, reason not otherwise specified

**OR**

**Glucocorticoid Plan not Documented, Reason not Specified**

*(Two CPT II codes [0540F-8P and 4194F] are required on the claim form to submit this numerator option)*

Append a reporting modifier (8P) to CPT Category II code **0540F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

**0540F with 8P:** Glucocorticoid plan not documented, reason not otherwise specified

**AND**

**CPT II 4194F:** Patient receiving  $\geq 10$  mg daily prednisone (or equivalent) for longer than 6 months, and improvement or no change in disease activity

*NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2011 Physician Quality Reporting Measure Specifications Manual for Claims and Registry Reporting of Individual Measures" available for download from the CMS Physician Quality Reporting website.*

## PERIOPERATIVE CARE MEASURES GROUP OVERVIEW

### 2011 PHYSICIAN QUALITY REPORTING OPTIONS FOR MEASURES GROUPS: CLAIMS, REGISTRY

#### 2011 PHYSICIAN QUALITY REPORTING MEASURES IN PERIOPERATIVE CARE MEASURES GROUP:

- #20. Perioperative Care: Timing of Antibiotic Prophylaxis – Ordering Physician
- #21. Perioperative Care: Selection of Prophylactic Antibiotic – First OR Second Generation Cephalosporin
- #22. Perioperative Care: Discontinuation of Prophylactic Antibiotics (Non-Cardiac Procedures)
- #23. Perioperative Care: Venous Thromboembolism (VTE) Prophylaxis (When Indicated in ALL Patients)

#### INSTRUCTIONS FOR REPORTING: (These instructions apply to both Claims and Registry reporting, unless otherwise specified.)

- Indicate your intention to report the Perioperative Care Measures Group by submitting the measures group-specific intent G-code at least once during the reporting period when billing a patient claim for both the 30 Patient Sample and the 50% Patient Sample Methods. It is not necessary to submit the measures group-specific intent G-code on more than one claim. It is not necessary to submit the measures group-specific intent G-code for registry-based submissions.

**G8492:** I intend to report the Perioperative Care Measures Group

- Select patient sample method:  
**30 Patient Sample Method:** 30 unique Medicare Part B FFS (fee for service) patients meeting patient sample criteria for the measures group.  
**OR**  
**50% Patient Sample Method via Claims or 80% Patient Sample Method via Registry:** All patients meeting patient sample criteria for the measure group during the entire reporting period (January 1 through December 31, 2011 **OR** July 1 through December 31, 2011). For the 12-month reporting period, a minimum of 15 Medicare Part B FFS patients must meet the measures group patient sample criteria to report satisfactory. For the 6-month reporting period, a minimum of 8 Medicare Part B FFS patients must meet the measures group patient sample criteria to report satisfactory.
- Patient sample criteria for the Perioperative Care Measures Group are patients aged 18 years and older that have a specific surgical procedure performed:

**One of the following surgical procedure codes:** 19260, 19271, 19272, 19301, 19302, 19303, 19304, 19305, 19306, 19307, 19361, 19364, 19366, 19367, 19368, 19369, 22558, 22600, 22612, 22630, 27125, 27130, 27132, 27134, 27137, 27138, 27235, 27236, 27244, 27245, 27269, 27440, 27441, 27442, 27443, 27445, 27446, 27447, 39545, 39561, 43045, 43100, 43101, 43107, 43108, 43112, 43113, 43116, 43117, 43118, 43121, 43122, 43123, 43124, 43130, 43135, 43300, 43305, 43310, 43312, 43313, 43320, 43325, 43327, 43328, 43330, 43331, 43332, 43333, 43334, 43335, 43336, 43337, 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, 43653, 43800, 43810, 43820, 43825, 43830, 43832, 43840, 43843, 43845, 43846, 43847, 43848, 43850, 43855, 43860, 43865, 43870, 44005, 44010,

## SPECIFICATION FOR MEASURES GROUP REPORTING ONLY

44020, 44021, 44050, 44055, 44120, 44125, 44126, 44127, 44130, 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, 48520, 48540, 48545, 48547, 48548, 48554, 48556, 49215, 50320, 50340, 50360, 50365, 50370, 50380, 60521, 60522, 61313, 61510, 61512, 61518, 61548, 61697, 61700, 62230, 63015, 63020, 63047, 63056, 63081, 63267, 63276

**NOTE:** 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. Both surgeons participating in Physician Quality Reporting will be fully accountable for the clinical action described in the measure.

- Report quality-data codes on **all** measures within the Perioperative Care Measures Group for each patient within the eligible professional's patient sample.
- Instructions for quality-data code reporting for each of the measures within the Perioperative Care Measures Group are displayed on the next several pages. If all quality actions for the patient have been performed for all the measures within the group, the following composite G-code may be reported in lieu of the individual quality-data codes for each of the measures within the group. It is not necessary to submit the following composite G-code for registry-based submissions.

**Composite G-code G8501:** All quality actions for the applicable measures in the Perioperative Care Measures Group have been performed for this patient

- To report satisfactorily the Perioperative Care Measures Group it requires **all** measures for each patient within the eligible professional's patient sample to be reported each time a surgical procedure is performed during the reporting period.
- When using the 30 Patient Sample Method, report all measures for 30 unique Medicare Part B FFS patients seen. When using the 50% Patient Sample Method via Claims, report all measures on at least 50% of the patient sample for the eligible professional for the 12-month or 6-month reporting period. When using the 80% Patient Sample Method via Registry, report all measures on at least 80% of the patient sample for the eligible professional for the 12-month or 6-month reporting period.
- For claims-based submissions, the Carrier/MAC remittance advice notice sent to the practice will show a denial remark code (N365) for the line item on the claim containing G8492 (and G8501 if reported) as well as all other line items containing QDCs. N365 indicates that the code is not payable and is used for reporting/informational purposes only. Other services/codes on the claim will not be affected by the addition of a measures group-specific intent G-code or other QDCs. The N365 remark code does NOT indicate whether the QDC is accurate for that claim or for the measure the eligible professional is attempting to report, but does indicate that the QDC was processed and transmitted to the NCH.

*NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2011 Physician Quality Reporting Measure Specifications Manual for Claims and Registry Reporting of Individual Measures" available for download from the CMS Physician Quality Reporting website.*

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

**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 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)

**NUMERATOR:**

Surgical patients who have an order for prophylactic 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)

**Numerator Instructions:** There must be documentation of order (written order, verbal order, or standing order/protocol) specifying that prophylactic parenteral 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 prophylactic parenteral 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).

**Note:** *In the event surgery is delayed, as long as the patient is redosed (if clinically appropriate) the numerator coding should be applied.*

**Numerator Quality-Data Coding Options for Reporting Satisfactorily:**

*Table 1A: The antimicrobial drugs listed below are considered prophylactic parenteral antibiotics for the purposes of this measure. G8632 should be reported when antibiotics from this table were not ordered.*

<ul style="list-style-type: none"> <li>• Ampicillin/sulbactam</li> <li>• Aztreonam</li> <li>• Cefazolin</li> <li>• Cefmetazole</li> <li>• Cefotetan</li> <li>• Cefoxitin</li> </ul>	<ul style="list-style-type: none"> <li>• Cefuroxime</li> <li>• Ciprofloxacin</li> <li>• Clindamycin</li> <li>• Ertapenem</li> <li>• Erythromycin base</li> <li>• Gatifloxacin</li> </ul>	<ul style="list-style-type: none"> <li>• Gentamicin</li> <li>• Levofloxacin</li> <li>• Metronidazole</li> <li>• Moxifloxacin</li> <li>• Neomycin</li> <li>• Vancomycin</li> </ul>
---	--	---

**Documentation of Order for Prophylactic Parenteral Antibiotic (written order, verbal order, or standing order/protocol)**

**G8629:** Documentation of order for prophylactic parenteral 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 Parenteral Antibiotic has been Given within One Hour Prior to the Surgical Incision (or start of procedure when no incision is required)**

**G8630:** Documentation that administration of prophylactic parenteral antibiotic was initiated within one hour (if fluoroquinolone or vancomycin, two hours) prior to surgical incision (or start of procedure when no incision is required), as ordered

**OR**

**SPECIFICATION FOR MEASURES GROUP REPORTING ONLY**

**Order for Prophylactic Parenteral Antibiotic not Given for Medical Reasons**

**G8631:** Clinician documented that patient was not an eligible candidate for ordering prophylactic parenteral 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)

**OR**

**Order for Administration of Prophylactic Parenteral Antibiotic not Given, Reason not Specified**

**G8632:** Prophylactic parenteral antibiotics were not ordered to be given or given within one hour (if fluoroquinolone or vancomycin, two hours) prior to the surgical incision (or start of procedure when no incision is required), reason not otherwise specified

*NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2011 Physician Quality Reporting Measure Specifications Manual for Claims and Registry Reporting of Individual Measures" available for download from the CMS Physician Quality Reporting website.*

**SPECIFICATION FOR MEASURES GROUP REPORTING ONLY**

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

**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

**NUMERATOR:**

Surgical patients who had an order for cefazolin OR cefuroxime for antimicrobial prophylaxis

**Numerator Instructions:** 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*.

**Note:** *In the event surgery is delayed, as long as the patient is redosed (if clinically appropriate) the numerator coding should be applied.*

**Numerator Quality-Data Coding Options for Reporting Satisfactorily:**

**Acceptable First and Second Generation Cephalosporin Prophylactic Antibiotics**

First generation cephalosporin: cefazolin

Second generation cephalosporin: cefuroxime

**Documentation of order for cefazolin OR cefuroxime for antimicrobial prophylaxis (written order, verbal order, or standing order/protocol)**

**CPT II 4041F:** Documentation of order for cefazolin OR cefuroxime for antimicrobial prophylaxis

**Note:** *CPT Category II code 4041F is provided for antibiotic ordered or antibiotic given. Report CPT Category II code 4041F if cefazolin OR cefuroxime was given for antimicrobial prophylaxis.*

**OR**

**Order for First or Second Generation Cephalosporin not Ordered for Medical Reasons**

Append a modifier (1P) to CPT Category II code 4041F to report documented circumstances that appropriately exclude patients from the denominator.

**4041F with 1P:** Documentation of medical reason(s) for not ordering cefazolin OR cefuroxime for antimicrobial prophylaxis

**OR**

**Order for First or Second Generation Cephalosporin not Ordered, Reason not Specified**

Append a reporting modifier (8P) to CPT Category II code 4041F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

**4041F with 8P:** Order for cefazolin OR cefuroxime for antimicrobial prophylaxis was not documented, reason not otherwise specified

*NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2011 Physician Quality Reporting Measure Specifications Manual for Claims and Registry Reporting of Individual Measures" available for download from the CMS Physician Quality Reporting website.*

**SPECIFICATION FOR MEASURES GROUP REPORTING ONLY**

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

**DESCRIPTION:**

Percentage of non-cardiac surgical patients aged 18 years and older undergoing procedures with the indications for prophylactic parenteral antibiotics AND who received a prophylactic parenteral antibiotic, who have an order for discontinuation of prophylactic parenteral antibiotics within 24 hours of surgical end time

**NUMERATOR:**

Non-cardiac surgical patients who have an order for discontinuation of prophylactic parenteral antibiotics within 24 hours of surgical end time

**Numerator Instructions:** There must be documentation of order (written order, verbal order, or standing order/protocol) specifying that prophylactic parenteral 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 for "one time" IV dose orders) OR documentation that prophylactic parenteral was discontinued within 24 hours of surgical end time.

**NUMERATOR NOTE:** *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.*

**Numerator Quality-Data Coding Options for Reporting Satisfactorily:**

**Documentation of Order for Discontinuation of Prophylactic Parenteral Antibiotics (written order, verbal order, or standing order/protocol) Within 24 Hours of Surgical End Time**

*(Two CPT II codes [4049F & 4046F] are required on the claim form to submit this numerator option)*

**CPT II 4049F:** Documentation that order was given to discontinue prophylactic antibiotics within 24 hours of surgical end time, non-cardiac procedure

**Note:** *CPT Category II code 4049F is provided for documentation that antibiotic discontinuation was ordered or that antibiotic discontinuation was accomplished. Report CPT Category II code 4049F if antibiotics were discontinued within 24 hours.*

**AND**

**CPT II 4046F:** Documentation that prophylactic antibiotics were given within 4 hours prior to surgical incision or given intraoperatively

**OR**

**Prophylactic Parenteral Antibiotics not Discontinued for Medical Reasons**

*(Two CPT II codes [4049F-1P & 4046F] are required on the claim form to submit this numerator option)*

Append a modifier (1P) to CPT Category II code 4049F to report documented circumstances that appropriately exclude patients from the denominator.

**4049F with 1P:** Documentation of medical reason(s) for not discontinuing prophylactic antibiotics within 24 hours of surgical end time

**AND**

**SPECIFICATION FOR MEASURES GROUP REPORTING ONLY**

**CPT II 4046F:** Documentation that prophylactic antibiotics were given within 4 hours prior to surgical incision or given intraoperatively

**OR**

**If patient is not eligible for this measure because patient did not receive prophylactic parenteral antibiotics within specified timeframe, report:**  
*(One CPT II code [4042F] is required on the claim form to submit this numerator option)*  
**CPT II 4042F:** Documentation that prophylactic antibiotics were neither given within 4 hours prior to surgical incision nor given intraoperatively

**OR**

**Prophylactic Parenteral Antibiotics not Discontinued, Reason not Specified**  
(Two CPT II codes [4049F-8P & 4046F] are required on the claim form to submit this numerator option)  
Append a reporting modifier (**8P**) to CPT Category II code **4049F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.  
**4049F with 8P:** Order was not given to discontinue prophylactic antibiotics within 24 hours of surgical end time, non-cardiac procedure, reason not otherwise specified

**AND**

**CPT II 4046F:** Documentation that prophylactic antibiotics were given within 4 hours prior to surgical incision or given intraoperatively

*NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2011 Physician Quality Reporting Measure Specifications Manual for Claims and Registry Reporting of Individual Measures" available for download from the CMS Physician Quality Reporting website.*



**SPECIFICATION FOR MEASURES GROUP REPORTING ONLY**

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

**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

**NUMERATOR:**

Surgical patients who had an order for LMWH, 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

**Numerator Instructions:** There must be documentation of order (written order, verbal order, or standing order/protocol) for VTE prophylaxis OR documentation that VTE prophylaxis was given.

**Definition:**

**Mechanical Prophylaxis** – Does not include TED hose.

**Numerator Quality-Data Coding Options for Reporting Satisfactorily:**

**Appropriate VTE Prophylaxis Ordered**

**CPT II 4044F:** 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

**Note:** A single CPT Category II code is provided for VTE prophylaxis ordered or VTE prophylaxis given. If VTE prophylaxis is given, report 4044F.

**OR**

**VTE Prophylaxis not Ordered for Medical Reasons**

Append a modifier (1P) to CPT Category II code **4044F** to report documented circumstances that appropriately exclude patients from the denominator.

**4044F with 1P:** 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

**OR**

**VTE Prophylaxis not Ordered, Reason not Specified**

Append a reporting modifier (8P) to CPT Category II code **4044F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

**4044F with 8P:** Order was not given for venous thromboembolism (VTE) prophylaxis to be given within 24 hours prior to incision time or 24 hours after surgery end time, reason not otherwise specified

*NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2011 Physician Quality Reporting Measure Specifications Manual for Claims and Registry Reporting of Individual Measures" available for download from the CMS Physician Quality Reporting website.*

## BACK PAIN MEASURES GROUP OVERVIEW

### 2011 PHYSICIAN QUALITY REPORTING OPTIONS FOR MEASURES GROUPS: CLAIMS, REGISTRY

#### 2011 PHYSICIAN QUALITY REPORTING MEASURES IN BACK PAIN MEASURES GROUP:

- #148. Back Pain: Initial Visit
- #149. Back Pain: Physical Exam
- #150. Back Pain: Advice for Normal Activities
- #151. Back Pain: Advice Against Bed Rest

#### INSTRUCTIONS FOR REPORTING: (These instructions apply to both Claims and Registry reporting, unless otherwise specified.)

- Indicate your intention to report the Back Pain Measures Group by submitting the measures group-specific intent G-code at least once during the reporting period when billing a patient claim for both the 30 Patient Sample and the 50% Patient Sample Methods. It is not necessary to submit the measures group-specific intent G-code on more than one claim. It is not necessary to submit the measures group-specific intent G-code for registry-based submissions.

**G8493:** I intend to report the Back Pain Measures Group

- Select patient sample method:  
**30 Patient Sample Method:** 30 unique Medicare Part B FFS (fee for service) patients meeting patient sample criteria for the measures group.  
**OR**  
**50% Patient Sample Method via Claims or 80% Patient Sample Method via Registry:** All patients meeting patient sample criteria for the measure group during the entire reporting period (January 1 through December 31, 2011 **OR** July 1 through December 31, 2011). For the 12-month reporting period, a minimum of 15 patients must meet the measures group patient sample criteria to report satisfactory. For the 6-month reporting period, a minimum of 8 patients must meet the measures group patient sample criteria to report satisfactory.
- Patient sample criteria for the Back Pain Measures Group are patients aged 18 through 79 years with a specific diagnosis for back pain accompanied by a specific patient encounter **OR** patients aged 18-79 years that have a specific back surgical procedure performed:

**One of the following diagnosis codes indicating back pain:** 721.3, 721.41, 721.42, 721.90, 722.0, 722.10, 722.11, 722.2, 722.30, 722.31, 722.32, 722.39, 722.4, 722.51, 722.52, 722.6, 722.70, 722.71, 722.72, 722.73, 722.80, 722.81, 722.82, 722.83, 722.90, 722.91, 722.92, 722.93, 723.0, 724.00, 724.01, 724.02, 724.09, 724.2, 724.3, 724.4, 724.5, 724.6, 724.70, 724.71, 724.79, 738.4, 738.5, 739.3, 739.4, 756.12, 846.0, 846.1, 846.2, 846.3, 846.8, 846.9, 847.2

#### Accompanied by

**One of the following patient encounter codes:** 97001, 97002, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215

**OR**

## **SPECIFICATION FOR MEASURES GROUP REPORTING ONLY**

**One of the following back surgical procedure codes:** 22210, 22214, 22220, 22222, 22224, 22226, 22532, 22533, 22534, 22548, 22554, 22556, 22558, 22585, 22590, 22595, 22600, 22612, 22614, 22630, 22632, 22818, 22819, 22830, 22840, 22841, 22842, 22843, 22844, 22845, 22846, 22847, 22848, 22849, 63001, 63003, 63005, 63011, 63012, 63015, 63016, 63017, 63020, 63030, 63035, 63040, 63042, 63043, 63044, 63045, 63046, 63047, 63048, 63055, 63056, 63057, 63064, 63066, 63075, 63076, 63077, 63078, 63081, 63082, 63085, 63086, 63087, 63088, 63090, 63091, 63101, 63102, 63103, 63170, 63172, 63173, 63180, 63182, 63185, 63190, 63191, 63194, 63195, 63196, 63197, 63198, 63199, 63200

- Report quality-data codes on **all** measures within the Back Pain Measures Group for each patient within the eligible professional's patient sample.
- Instructions for quality-data code reporting for each of the measures within the Back Pain Measures Group are displayed on the next several pages. If all quality actions for the patient have been performed for all the measures within the group, the following composite G-code may be reported in lieu of the individual quality-data codes for each of the measures within the group. It is not necessary to submit the following composite G-code for registry-based submissions.

**Composite G-code G8502:** All quality actions for the applicable measures in the Back Pain Measures Group have been performed for this patient

- To satisfactorily report the Back Pain Measures Group for the 30 Patient Sample Method it requires **all** measures for each patient within the sample to be reported where the initial visit to the clinician for each episode of back pain or each surgery for back pain that occurred during the corresponding reporting period. If the patient's initial visit for this episode of back pain occurred prior to the beginning of the reporting period, report that the visit in the sample is a subsequent visit for the episode and this will **not** count toward the 30 patient sample. This measures group may be reported by more than one clinician if multiple clinicians evaluate or treat the patient for the back pain episode.
- To satisfactorily report the Back Pain Measures Group for the 50% Patient Sample Method via Claims or the 80% Patient Sample Method via Registry it requires **all** measures for each patient within the eligible professional's patient sample to be reported on the first visit to the clinician for each episode of back pain or each surgery for back pain occurring during the corresponding reporting period. If the patient's initial visit for this episode of back pain occurred prior to the beginning of the corresponding reporting period, report that the first visit of the reporting period is a subsequent visit for the episode. This measures group may be reported by more than one clinician if multiple clinicians evaluate or treat the patient for the back pain episode.
- When using the 30 Patient Sample Method, report all measures for 30 unique Medicare Part B FFS patients seen. When using the 50% Patient Sample Method via Claims, report all measures on at least 50% of the patient sample for the eligible professional for the 12-month or 6-month reporting period. When using the 80% Patient Sample Method via Registry, report all measures on at least 80% of the patient sample for the eligible professional for the 12-month or 6-month reporting period.
- For claims-based submissions, the Carrier/MAC remittance advice notice sent to the practice will show a denial remark code (N365) for the line item on the claim containing G8493 (and G8502 if reported) as well as all other line items containing QDCs. N365 indicates that the code is not payable and is used for reporting/informational purposes only. Other services/codes on the claim will not be affected by the addition of a measures group-specific intent G-code or other QDCs. The N365 remark code does NOT indicate whether the QDC is

## ***SPECIFICATION FOR MEASURES GROUP REPORTING ONLY***

accurate for that claim or for the measure the eligible professional is attempting to report, but does indicate that the QDC was processed and transmitted to the NCH.

*NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2011 Physician Quality Reporting Measure Specifications Manual for Claims and Registry Reporting of Individual Measures" available for download from the CMS Physician Quality Reporting website.*

♦ **Measure #148: Back Pain: Initial Visit**

**DESCRIPTION:**

The percentage of patients aged 18 through 79 years with a diagnosis of back pain or undergoing back surgery who had back pain and function assessed during the initial visit to the clinician for the episode of back pain

**NUMERATOR:**

Patients who had all five of the following components assessed at the initial visit to the clinician for an episode of back pain: pain assessment, functional status, patient history (including notation of presence or absence of warning signs), assessment of prior treatment and response, and employment status

**Definitions:**

**Pain Assessment** – Must use any of the following assessment tools:

- SF-36
- Oswestry Low Back Pain Disability Questionnaire
- Roland-Morris Disability Questionnaire
- Quebec Pain Disability Scale
- Sickness Impact Profile
- Multidimensional Pain Inventory

**OR**

If none of the above tools are used, documentation of any of the following pain scales is acceptable:

- McGill Pain Questionnaire
- Visual analog scale
- Brief pain inventory
- Chronic pain grade
- Neuropathic pain scale
- Numerical rating scale (e.g., pain intensity 1–10)
- Verbal descriptive scale (e.g., pt. report: “burning, shooting, stabbing”)
- Faces pain scale

**Functional Status Assessment** – Must use any of the following assessment tools:

- SF-36
- Oswestry Low Back Pain Disability Questionnaire
- Roland-Morris Disability Questionnaire
- Quebec Pain Disability Scale
- Sickness Impact Profile
- Multidimensional Pain Inventory

**OR**

If none of the above tools are used, there must be documentation that activities of daily living (ADL) were assessed. Assessment of all of the following ADLs must be documented:

- Eating
- Bathing
- Using the toilet
- Dressing

## ***SPECIFICATION FOR MEASURES GROUP REPORTING ONLY***

- Getting up from bed or a chair

**Patient History** – Documentation necessary to satisfy assessment for red flags, which can include the following:

- Indication/notation of presence or absence of red flags
- Notation of specific symptoms that may indicate the presence of red flags (examples noted below)
  - "Red Flags" include:
    - History of cancer or unexplained weight loss
    - Current infection or immunosuppression
    - Fracture or suspected fracture
      - Motor vehicle accident or industrial injury with suspicion of fracture
      - Major fall with suspicion of fracture
    - Cauda equina syndrome or progressive neurologic deficit
      - Saddle anesthesia
      - Recent onset bladder dysfunction (urine retention, increased frequency, overflow incontinence)
      - Recent onset fecal incontinence (loss of bowel control)
      - Major motor weakness

**Assessment of Prior Treatment and Response** – If applicable, documentation that patient has been queried about back pain episode(s), treatment and response. Notation could include the following:

- No prior back pain
- Diagnosis and dates of back pain reports for the previous two years, or as far back as the patient is able to provide information
- Report from referring physician with summary of back pain history
- Patient report of history and attempted treatments, including diagnostic tests (e.g., imaging)

**Employment Status** – Use of either of the following assessment tools will satisfy this requirement:

- Sickness Impact Profile
- Multidimensional Pain Inventory

**OR**

Variables of an employment assessment can count. These variables must include documentation of the following:

- Type of work, including job tasks that may affect back pain management
- Work status (e.g., out of work, part-time work, work with or without limitations)
- If patient is not working or limited in work capacity, length of time for work limitations
- Workers' compensation or litigation involvement

**Episode** – Patient with back pain who has not been seen or treated for back pain by any practitioner during the 4 months prior to the first clinical encounter with a diagnosis of back pain. If a patient has a four-month period without treatment, and then sees both a primary

## ***SPECIFICATION FOR MEASURES GROUP REPORTING ONLY***

care physician and a specialist, both visits are considered the initial visit with that clinician. A new episode can either be a recurrence for a patient with prior back pain or a patient with a new onset of back pain. The first clinical encounter after the four months without being seen or treated for back pain is considered the beginning of the new episode.

**Initial Visit** – First visit to the clinician during an episode of back pain. There can only be one initial visit with each clinician, but there can be more than one initial visit for a patient, if multiple clinicians evaluate or treat the patient for the back pain episode. Report the appropriate Quality Data Codes on the claim for each initial visit. For each subsequent encounter after the initial visit with that clinician, or if the initial visit with that clinician occurred prior to the start of the reporting period, then report 0526F as described below.

### **Numerator Quality-Data Coding Options for Reporting Satisfactorily:**

#### **Back Pain and Function Assessed**

**CPT II 1130F:** Back pain and function assessed, including all of the following: Pain assessment AND functional status AND patient history, including notation of presence or absence of “red flags” (warning signs) AND assessment of prior treatment and response, AND employment status

**OR**

**If patient is not eligible for this measure because back pain episode began prior to the reporting period, report:**

**CPT II 0526F:** Subsequent visit for episode

**OR**

#### **Back Pain and Function not Assessed, Reason not Specified**

Append a reporting modifier (**8P**) to CPT Category II code **1130F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

**1130F with 8P:** Back pain and function was not assessed during the initial visit, reason not otherwise specified

*NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2011 Physician Quality Reporting Measure Specifications Manual for Claims and Registry Reporting of Individual Measures" available for download from the CMS Physician Quality Reporting website.*

♦Measure #149: Back Pain: Physical Exam

**DESCRIPTION:**

Percentage of patients aged 18 through 79 years with a diagnosis of back pain or undergoing back surgery who received a physical examination at the initial visit to the clinician for the episode of back pain

**NUMERATOR:**

Patients who had a physical examination at the initial visit to the clinician for a new episode of back pain

**Definitions:**

**Physical Examination** – For patients with radicular symptoms, documentation of physical exam must include the following, at a minimum:

- Indication of straight leg raise test
- AND**
- Notation of completion of neurovascular exam (a neurovascular exam must include ankle and knee reflexes; quadriceps; ankle and great toe dorsiflexion strength; plantar flexion; muscle strength; motor testing; pulses in lower extremities; and sensory exam)

For patients **without** radicular symptoms, documentation of physical exam must include the following:

- Documentation of straight leg raise, neurovascular exam or clear notation of absence or presence of neurologic deficits

**Episode** – Patient with back pain who has not been seen or treated for back pain by any practitioner during the 4 months prior to the first clinical encounter with a diagnosis of back pain. If a patient has a four-month period without treatment, and then sees both a primary care physician and a specialist, both visits are considered the initial visit with that clinician. A new episode can either be a recurrence for a patient with prior back pain or a patient with a new onset of back pain. The first clinical encounter after the four months without being seen or treated for back pain is considered the beginning of the new episode.

**Initial Visit** – First visit to the clinician during an episode of back pain. There can only be one initial visit with each clinician, but there can be more than one initial visit for a patient, if multiple clinicians evaluate or treat the patient for the back pain episode. Report the appropriate Quality Data Codes on the claim for each initial visit. For each subsequent encounter after the initial visit with that clinician, or if the initial visit with that clinician occurred prior to the start of the reporting period, then report 0526F as described below.

**Numerator Quality-Data Coding Options for Reporting Satisfactorily:**

**Physical Exam Performed**

CPT II 2040F: Physical examination on the date of the initial visit for low back pain performed, in accordance with specifications

**OR**

**If patient is not eligible for this measure because back pain episode began prior to the reporting period, report:**

CPT II 0526F: Subsequent visit for episode

**OR**



***SPECIFICATION FOR MEASURES GROUP REPORTING ONLY***

**Physical Exam not Performed, Reason not Specified**

Append a reporting modifier (**8P**) to CPT Category II code **2040F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

**2040F with 8P:** Physical exam was not performed during the initial visit, reason not otherwise specified

*NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2011 Physician Quality Reporting Measure Specifications Manual for Claims and Registry Reporting of Individual Measures" available for download from the CMS Physician Quality Reporting website.*

♦ Measure #150: Back Pain: Advice for Normal Activities

**DESCRIPTION:**

The percentage of patients aged 18 through 79 years with a diagnosis of back pain or undergoing back surgery who received advice for normal activities at the initial visit to the clinician for the episode of back pain

**NUMERATOR:**

Patients with documentation of advice to maintain or resume normal activities at the initial visit to the clinician for a new episode of back pain

**Definitions:**

**Episode** – Patient with back pain who has not been seen or treated for back pain by any practitioner during the 4 months prior to the first clinical encounter with a diagnosis of back pain. If a patient has a four-month period without treatment, and then sees both a primary care physician and a specialist, both visits are considered the initial visit with that clinician. A new episode can either be a recurrence for a patient with prior back pain or a patient with a new onset of back pain. The first clinical encounter after the four months without being seen or treated for back pain is considered the beginning of the new episode.

**Initial Visit** – First visit to the clinician during an episode of back pain. There can only be one initial visit with each clinician, but there can be more than one initial visit for a patient, if multiple clinicians evaluate or treat the patient for the back pain episode. Report the appropriate Quality Data Codes on the claim for each initial visit. For each subsequent encounter after the initial visit with that clinician, or if the initial visit with that clinician occurred prior to the start of the reporting period, then report 0526F as described below.

**Numerator Quality-Data Coding Options for Reporting Satisfactorily:**

**Advice for Normal Activities Performed**

CPT II 4245F: Patient counseled during the initial visit to maintain or resume normal activities

**OR**

**If patient is not eligible for this measure because back pain episode began prior to the reporting period, report:**

CPT II 0526F: Subsequent visit for the episode

**OR**

**Advice for Normal Activities not Performed, Reason not Specified**

Append a reporting modifier (**8P**) to CPT Category II code **4245F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

**4245F with 8P:** Advice for normal activities was not performed during the initial visit, reason not otherwise specified

*NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2011 Physician Quality Reporting Measure Specifications Manual for Claims and Registry Reporting of Individual Measures" available for download from the CMS Physician Quality Reporting website.*

◆ Measure #151: Back Pain: Advice Against Bed Rest

**DESCRIPTION:**

The percentage of patients aged 18 through 79 years with a diagnosis of back pain or undergoing back surgery who received advice against bed rest lasting four days or longer at the initial visit to the clinician for the episode of back pain

**NUMERATOR:**

Patients with documentation of advice against bed rest lasting four days or longer at the initial visit to the clinician for an episode of back pain

**Definitions:**

**Episode** – Patient with back pain who has not been seen or treated for back pain by any practitioner during the 4 months prior to the first clinical encounter with a diagnosis of back pain. If a patient has a four-month period without treatment, and then sees both a primary care physician and a specialist, both visits are considered the initial visit with that clinician. A new episode can either be a recurrence for a patient with prior back pain or a patient with a new onset of back pain. The first clinical encounter after the four months without being seen or treated for back pain is considered the beginning of the new episode.

**Initial Visit** – First visit to the clinician during an episode of back pain. There can only be one initial visit with each clinician, but there can be more than one initial visit for a patient, if multiple clinicians evaluate or treat the patient for the back pain episode. Report the appropriate Quality Data Codes on the claim for each initial visit. For each subsequent encounter after the initial visit with that clinician, or if the initial visit with that clinician occurred prior to the start of the reporting period, then report 0526F as described below.

**Numerator Quality-Data Coding Options for Reporting Satisfactorily:**

**Advice Against Bed Rest Performed**

CPT II 4248F: Patient counseled during the initial visit for an episode of back pain against bed rest lasting 4 days or longer

**OR**

**If patient is not eligible for this measure because back pain episode began prior to the reporting period, report:**

CPT II 0526F: Subsequent visit for episode

**OR**

**Advice Against Bed Rest not Performed, Reason not Specified**

Append a reporting modifier (**8P**) to CPT Category II code **4248F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

**4248F with 8P:** Advice against bed rest was not performed during the initial visit, reason not otherwise specified

*NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2011 Physician Quality Reporting Measure Specifications Manual for Claims and Registry Reporting of Individual Measures" available for download from the CMS Physician Quality Reporting website.*

## HEPATITIS C MEASURES GROUP OVERVIEW

### 2011 PHYSICIAN QUALITY REPORTING OPTIONS FOR MEASURES GROUPS: CLAIMS, REGISTRY

#### 2011 PHYSICIAN QUALITY REPORTING MEASURES IN HEPATITIS C MEASURES GROUP:

- #84. Hepatitis C: Ribonucleic Acid (RNA) Testing Before Initiating Treatment
- #85. Hepatitis C: HCV Genotype Testing Prior to Treatment
- #86. Hepatitis C: Antiviral Treatment Prescribed
- #87. Hepatitis C: HCV Ribonucleic Acid (RNA) Testing at Week 12 of Treatment
- #89. Hepatitis C: Counseling Regarding Risk of Alcohol Consumption
- #90. Hepatitis C: Counseling Regarding Use of Contraception Prior to Antiviral Therapy
- #183. Hepatitis C: Hepatitis A Vaccination in Patients with HCV
- #184. Hepatitis C: Hepatitis B Vaccination in Patients with HCV

#### **INSTRUCTIONS FOR REPORTING: (These instructions apply to both Claims and Registry reporting, unless otherwise specified.)**

- Indicate your intention to report the Hepatitis C Measures Group by submitting the measures group-specific intent G-code at least once during the reporting period when billing a patient claim for both the 30 Patient Sample and the 50% Patient Sample Methods. It is not necessary to submit the measures group-specific intent G-code on more than one claim. It is not necessary to submit the measures group-specific intent G-code for registry-based submissions.

**G8545:** I intend to report the Hepatitis C Measures Group

- Select patient sample method:  
**30 Patient Sample Method:** 30 unique Medicare Part B FFS (fee for service) patients meeting patient sample criteria for the measures group.  
**OR**  
**50% Patient Sample Method via Claims or 80% Patient Sample Method via Registry:** All patients meeting patient sample criteria for the measure group during the entire reporting period (January 1 through December 31, 2011 **OR** July 1 through December 31, 2011). For the 12-month reporting period, a minimum of 15 Medicare Part B FFS patients must meet the measures group patient sample criteria to report satisfactory. For the 6-month reporting period, a minimum of 8 Medicare Part B FFS patients must meet the measures group patient sample criteria to report satisfactory.
- Patient sample criteria for the Hepatitis C Measures Group are patients aged 18 years and older with a specific diagnosis of chronic hepatitis C accompanied by a specific patient encounter:

**One of the following diagnosis code indicating chronic hepatitis C: 070.54**

**Accompanied by**

**One of the following patient encounter codes: 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215**

- Report quality-data codes on **all applicable** measures within the Hepatitis C Measures Group for each patient within the eligible professional's patient sample.

## ***SPECIFICATION FOR MEASURES GROUP REPORTING ONLY***

Applicable measures contain patient demographic criteria specific to the measure. For example, Counseling Regarding Use of Contraception Prior to Antiviral Therapy is applicable to female patients *aged 18 through 44 years and all men aged 18 years and older* within the sample population, while the Antiviral Treatment Prescribed measure within this group is applicable to *all patients* aged 18 years and older. eligible professionals may find it more efficient to report all measures in the group for each patient within their sample. Reporting measure(s) from the group that are inapplicable to an individual patient will not affect the eligible provider's reporting or performance rate.

- Instructions for quality-data code reporting for each of the measures within the Hepatitis C Measures Group are displayed on the next several pages. If all quality actions for the patient have been performed for all measures within the group, the following composite G-code may be reported in lieu of the individual quality-data codes for each of the measures within the group. It is not necessary to submit the following composite G-code for registry-based submissions.

**Composite G-code G8549:** All quality actions for the applicable measures in the Hepatitis C Measures Group have been performed for this patient

- To report satisfactorily the Hepatitis C Measures Group it requires **all applicable** measures for each patient within the eligible professional's patient sample to be reported a minimum of once during the reporting period.
- When using the 30 Patient Sample Method, report all applicable measures for the 30 unique Medicare Part B FFS patients seen. When using the 50% Patient Sample Method via Claims, report all applicable measures on at least 50% of the patient sample for the eligible professional for the 12-month or 6-month reporting period. When using the 80% Patient Sample Method via Registry, report all applicable measures on at least 80% of the patient sample for the eligible professional for the 12-month or 6-month reporting period.
- For claims-based submissions, the Carrier/MAC remittance advice notice sent to the practice will show a denial remark code (N365) for the line item on the claim containing G8545 (and G8549 if reported) as well as all other line items containing QDCs. N365 indicates that the code is not payable and is used for reporting/informational purposes only. Other services/codes on the claim will not be affected by the addition of a measures group-specific intent G-code or other QDCs. The N365 remark code does NOT indicate whether the QDC is accurate for that claim or for the measure the eligible professional is attempting to report, but does indicate that the QDC was processed and transmitted to the NCH.

*NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2011 Physician Quality Reporting Measure Specifications Manual for Claims and Registry Reporting of Individual Measures" available for download from the CMS Physician Quality Reporting website.*

**SPECIFICATION FOR MEASURES GROUP REPORTING ONLY**

**▲ Measure #84: Hepatitis C: Ribonucleic Acid (RNA) Testing Before Initiating Treatment**

**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 antiviral treatment

**NUMERATOR:**

Patients for whom quantitative HCV RNA testing was performed within 6 months prior to initiation of antiviral treatment

***NUMERATOR NOTE:** 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.*

**Numerator Quality-Data Coding Options for Reporting Satisfactorily:**

**RNA Testing Performed within Six Months**

*(Two CPT II codes [3218F & 4150F] are required on the claim form to submit this numerator option)*

**CPT II 3218F:** RNA testing for Hepatitis C documented as performed within six months prior to initiation of antiviral treatment for Hepatitis C

**AND**

**CPT II 4150F:** Patient receiving antiviral treatment for Hepatitis C

**OR**

**RNA Testing not Performed within Six Months for Medical Reason**

*(Two CPT II codes [3218F-1P & 4150F] are required on the claim form to submit this numerator option)*

Append a modifier (1P) to CPT Category II code **3218F** to report documented circumstances that appropriately exclude patients from the denominator.

**3218F with 1P:** Documentation of medical reason(s) for not performing RNA testing within six months prior to initiation of antiviral treatment for Hepatitis C (eg, if patient is first seen by physician after initiation of treatment)

**AND**

**CPT II 4150F:** Patient receiving antiviral treatment for Hepatitis C

**OR**

**If patient is not eligible for this measure because patient is not receiving antiviral treatment, report:**

*(One CPT II code [4151F] is required on the claim form to submit this numerator option)*

**CPT II 4151F:** Patient not receiving antiviral treatment for Hepatitis C

**OR**

**SPECIFICATION FOR MEASURES GROUP REPORTING ONLY**

**RNA Testing not Performed within Six Months, Reason not Specified**

*(Two CPT II codes [3218F-8P & 4150F] are required on the claim form to submit this numerator option)*

Append a reporting modifier (**8P**) to CPT Category II code **3218F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

**3218F with 8P:** RNA testing for Hepatitis C was not documented as performed within six months prior to initiation of antiviral treatment for Hepatitis C, reason not otherwise specified

**AND**

**CPT II 4150F:** Patient receiving antiviral treatment for Hepatitis C

*NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2011 Physician Quality Reporting Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS Physician Quality Reporting website.*

▲ Measure #85: Hepatitis C: HCV Genotype Testing Prior to Treatment

**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 antiviral treatment

**NUMERATOR:**

Patients for whom HCV genotype testing was performed within 6 months prior to initiation of antiviral treatment

***NUMERATOR NOTE:** 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.*

**Numerator Quality-Data Coding Options for Reporting Satisfactorily:**

**Hepatitis C Genotype Testing Performed**

*(One CPT II code & one G-code [3266F & G8459] are required on the claim form to submit this numerator option)*

**CPT II 3266F:** Hepatitis C genotype testing documented as performed prior to initiation of antiviral treatment for Hepatitis C

**AND**

**G8459:** Clinician documented that patient is receiving antiviral treatment for Hepatitis C

**OR**

**If patient is not eligible for this measure because patient is not receiving antiviral treatment, report:**

*(One G-code [G8458] is required on the claim form to submit this numerator option)*

**G8458:** Clinician documented that patient is not an eligible candidate for genotype testing; patient not receiving antiviral treatment for Hepatitis C

**OR**

**Genotype Testing not Performed, Reason not Specified**

*(One CPT II code & one G-code [3266F-8P & G8459] are required on the claim form to submit this numerator option)*

Append a reporting modifier (**8P**) to CPT Category II code **3266F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

**3266F with 8P:** Hepatitis C genotype testing was not documented as performed prior to initiation of antiviral treatment for Hepatitis C, reason not otherwise specified

**AND**

**G8459:** Clinician documented that patient is receiving antiviral treatment for Hepatitis C

*NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2011 Physician Quality Reporting Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS Physician Quality Reporting website.*



**SPECIFICATION FOR MEASURES GROUP REPORTING ONLY**

**▲ Measure #86: Hepatitis C: Antiviral Treatment Prescribed**

**DESCRIPTION:**

Percentage of patients aged 18 years and older with a diagnosis of chronic hepatitis C who were prescribed peginterferon and ribavirin therapy within the 12-month reporting period

**NUMERATOR:**

Patients who were prescribed peginterferon and ribavirin therapy within the 12 month reporting period

**Definition:**

**Prescribed** – May include prescription given to the patient for peginterferon and ribavirin therapy at one or more visits in the 12-month period OR patient already taking peginterferon and ribavirin therapy as documented in current medication list.

**Numerator Quality-Data Coding Options for Reporting Satisfactorily:**

**Peginterferon and Ribavirin Therapy Prescribed**

CPT II 4153F: Combination peginterferon and ribavirin therapy prescribed

**OR**

**Peginterferon and Ribavirin Therapy not Prescribed for Medical, Patient or System Reasons**

Append a modifier (1P, 2P or 3P) to CPT Category II code 4153F to report documented circumstances that appropriately exclude patients from the denominator.

**4153F with 1P:** Documentation of medical reason(s) for not prescribing peginterferon and ribavirin therapy within 12 month reporting period (eg, patient was not a candidate for therapy, could not tolerate).

**4153F with 2P:** Documentation of patient reason(s) for not prescribing peginterferon and ribavirin therapy within 12 month reporting period (eg, patient declined).

**4153F with 3P:** Documentation of system reason(s) for not prescribing peginterferon and ribavirin therapy within 12 month reporting period (eg, patient has no insurance coverage, therapy not covered).

**OR**

**Peginterferon and Ribavirin Therapy not Prescribed, Reason not Specified**

Append a reporting modifier (8P) to CPT Category II code 4153F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

**4153F with 8P:** Combination peginterferon and ribavirin therapy was not prescribed, reason not otherwise specified

*NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2011 Physician Quality Reporting Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS Physician Quality Reporting website.*

**▲ Measure #87: Hepatitis C: HCV Ribonucleic Acid (RNA) Testing at Week 12 of Treatment**

**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

**NUMERATOR:**

Patients for whom quantitative HCV RNA testing was performed at 12 weeks from the initiation of antiviral treatment

**Definition:**

**12 Weeks from Initiation** – Patients for whom testing was performed between 11-13 weeks from the initiation of antiviral treatment will meet the numerator for this measure.

**NUMERATOR NOTE:** *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.*

**Numerator Quality-Data Coding Options for Reporting Satisfactorily:**

**Hepatitis C Quantitative RNA Testing at 12 weeks**

*(One CPT II code & one G-code [3220F & G8461] are required on the claim form to submit this numerator option)*

**CPT II 3220F:** Hepatitis C quantitative RNA testing documented as performed at 12 weeks from initiation of antiviral treatment

**AND**

**G8461:** Patient receiving antiviral treatment for Hepatitis C

**OR**

**Hepatitis C Quantitative RNA Testing not Performed at 12 Weeks for Medical or Patient Reasons**

*(One CPT II code & one G-code [3220F-xP & G8461] are required on the claim form to submit this numerator option)*

Append a modifier (**1P** or **2P**) to CPT Category II code **3220F** to report documented circumstances that appropriately exclude patients from the denominator.

**3220F with 1P:** Documentation of medical reason(s) for not performing quantitative HCV RNA at 12 weeks from initiation of antiviral treatment

**3220F with 2P:** Documentation of patient reason(s) for not performing quantitative HCV RNA at 12 weeks from initiation of antiviral treatment

**AND**

**G8461:** Patient receiving antiviral treatment for Hepatitis C

**OR**

**If patient is not eligible for this measure because patient is not receiving antiviral treatment, report:**

*(One G-code [G8460] is required on the claim form to submit this numerator option)*

**G8460:** Clinician documented that patient is not an eligible candidate for quantitative RNA testing at week 12; patient not receiving antiviral treatment for Hepatitis C

**SPECIFICATION FOR MEASURES GROUP REPORTING ONLY**

**OR**

**Hepatitis C Quantitative RNA Testing not Performed at 12 Weeks, Reason not Specified**

*(One CPT II code & one G-code [3220F-8P & G8461] are required on the claim form to submit this numerator option)*

Append a reporting modifier (**8P**) to CPT Category II code **3220F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

**3220F with 8P:** Hepatitis C quantitative RNA testing was not documented as performed at 12 weeks from initiation of antiviral treatment, reason not otherwise specified

**AND**

**G8461:** Patient receiving antiviral treatment for Hepatitis C

*NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2011 Physician Quality Reporting Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS Physician Quality Reporting website.*

**SPECIFICATION FOR MEASURES GROUP REPORTING ONLY**

**▲ Measure #89: Hepatitis C: Counseling Regarding Risk of Alcohol Consumption**

**DESCRIPTION:**

Percentage of patients aged 18 years and older with a diagnosis of hepatitis C who were counseled about the risks of alcohol use at least once within 12-months

**NUMERATOR:**

Patients who were counseled about the risks of alcohol use at least once within the 12 month reporting period

**Definition:**

**Counseling** – May include documentation of a discussion regarding the risks of alcohol, or notation to decrease or abstain from alcohol intake.

**Numerator Quality-Data Coding Options for Reporting Satisfactorily:**

**Counseling Regarding Risk of Alcohol Consumption**

CPT II 4158F: Patient counseled about risks of alcohol use

**OR**

**Counseling Regarding Risk of Alcohol Consumption not Performed, Reason not Specified**

Append a reporting modifier (**8P**) to CPT Category II code **4158F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

**4158F with 8P:** Patient counseled about risks of alcohol use not performed, reason not otherwise specified

*NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2011 Physician Quality Reporting Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS Physician Quality Reporting website.*

**SPECIFICATION FOR MEASURES GROUP REPORTING ONLY**

**▲ Measure #90 Hepatitis C: Counseling Regarding Use of Contraception Prior to Antiviral Therapy**

**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

**NUMERATOR:**

Patients who were counseled regarding contraception prior to the initiation of treatment

***NUMERATOR NOTE:** 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.*

**Numerator Quality-Data Coding Options for Reporting Satisfactorily:**

**Counseling Regarding Contraception Received**

*(One CPT II code & one G-code [4159F & G8463] are required on the claim form to submit this numerator option)*

**CPT II 4159F:** Counseling regarding contraception received prior to initiation of antiviral treatment

**AND**

**G8463:** Patient receiving antiviral treatment for Hepatitis C documented

**OR**

**Counseling Regarding Contraception not Received for Medical Reason**

*(One CPT II code & one G-code [4159F-1P & G8463] are required on the claim form to submit this numerator option)*

Append a modifier (1P) to CPT Category II code 4159F to report documented circumstances that appropriately exclude patients from the denominator.

**4159F with 1P:** Documentation of medical reason(s) for not counseling patient regarding contraception

**AND**

**G8463:** Patient receiving antiviral treatment for Hepatitis C documented

**OR**

**If patient is not eligible for this measure because patient is not receiving antiviral treatment, report:**

*(One G-code [G8462] is required on the claim form to submit this numerator option)*

**G8462:** 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

**OR**

**SPECIFICATION FOR MEASURES GROUP REPORTING ONLY**

**Counseling Regarding Contraception not Received, Reason not Specified**

*(One CPT II code & one G-code [4159F-8P & G8463] are required on the claim form to submit this numerator option)*

Append a reporting modifier (**8P**) to CPT Category II code **4159F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

**4159F with 8P:** Counseling regarding contraception not received prior to initiation of antiviral treatment, reason not otherwise specified

**AND**

**G8463:** Patient receiving antiviral treatment for Hepatitis C documented

*NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2011 Physician Quality Reporting Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS Physician Quality Reporting website.*

▲ Measure #183: Hepatitis C: Hepatitis A Vaccination in Patients with HCV

**DESCRIPTION:**

Percentage of patients aged 18 years and older with a diagnosis of hepatitis C who received at least one injection of hepatitis A vaccine, or who have documented immunity to hepatitis A

**NUMERATOR:**

Patients who have received at least one injection of hepatitis A vaccine, or who have documented immunity to hepatitis A

**Numerator Quality-Data Coding Options for Reporting Satisfactorily:**

**Hepatitis A Vaccine Injection Received or Patient Has Documented Immunity to Hepatitis A**

CPT II 4148F: Hepatitis A vaccine injection administered or previously received

**OR**

CPT II 3215F: Patient has documented immunity to Hepatitis A

**OR**

**Hepatitis A Vaccine Injection not Received for Medical or Patient Reasons**

Append a modifier (1P or 2P) to CPT Category II code 4148F to report documented circumstances that appropriately exclude patients from the denominator.

**4148F with 1P:** Documentation of medical reason(s) for not administering at least one injection of hepatitis A vaccine

**4148F with 2P:** Documentation of patient reason(s) for not administering at least one injection of hepatitis A vaccine

**OR**

**Hepatitis A Vaccine Injection not Received, Reason not Specified**

Append a reporting modifier (8P) to CPT Category II code 4148F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

**4148F with 8P:** Hepatitis A Vaccine not received, reason not otherwise specified

*NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2011 Physician Quality Reporting Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS Physician Quality Reporting website.*

▲ Measure #184: Hepatitis C: Hepatitis B Vaccination in Patients with HCV

**DESCRIPTION:**

Percentage of patients aged 18 years and older with a diagnosis of hepatitis C who received at least one injection of hepatitis B vaccine, or who have documented immunity to hepatitis B

**NUMERATOR:**

Patients who have received at least one injection of hepatitis B vaccine or who have documented immunity to hepatitis B

**Numerator Quality-Data Coding Options for Reporting Satisfactorily:**

**Hepatitis B Vaccine Injection Received or Patient Has Documented Immunity to Hepatitis B**

CPT II 4149F: Hepatitis B vaccine injection administered or previously received

**OR**

CPT II 3216F: Patient has documented immunity to Hepatitis B

**OR**

**Hepatitis B Vaccine Injection not Received for Medical or Patient Reasons**

Append a modifier (1P or 2P) to CPT Category II code 4149F to report documented circumstances that appropriately exclude patients from the denominator.

**4149F with 1P:** Documentation of medical reason(s) for not administering at least one injection of hepatitis B vaccine

**4149F with 2P:** Documentation of patient reason(s) for not administering at least one injection of Hepatitis B vaccine

**OR**

**Hepatitis B Vaccine not Received, Reason not Specified**

Append a reporting modifier (8P) to CPT Category II code 4149F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

**4149F with 8P:** Hepatitis B Vaccine not received, reason not otherwise specified

*NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2011 Physician Quality Reporting Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS Physician Quality Reporting website.*



## HEART FAILURE (HF) MEASURES GROUP OVERVIEW

### 2011 PHYSICIAN QUALITY REPORTING OPTIONS FOR MEASURES GROUPS: REGISTRY ONLY

#### 2011 PHYSICIAN QUALITY REPORTING MEASURES IN HEART FAILURE (HF) MEASURES GROUP:

- #5. Heart Failure: Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD)
- # 8. Heart Failure: Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)
- #198. Heart Failure: Left Ventricular Function (LVF) Assessment
- #199. Heart Failure: Patient Education
- #226. Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention

#### INSTRUCTIONS FOR REPORTING: (These instructions apply to registry reporting. Do not report this measures group via claims.)

- It is not necessary to submit the measures group-specific intent G-code for registry-based submissions. However, the measures group-specific intent G-code has been created for registry only measures groups for use by registries that utilize claims data.

**G8548:** I intend to report the Heart Failure (HF) Measures Group

- Select patient sample method:  
**30 Patient Sample Method:** 30 unique Medicare Part B FFS (fee for service) patients meeting patient sample criteria for the measures group.  
**OR**  
**80% Patient Sample Method:** All patients meeting patient sample criteria for the measure group during the entire reporting period (January 1 through December 31, 2011 **OR** July 1 through December 31, 2011). For the 12-month reporting period, a minimum of 15 Medicare Part B FFS patients must meet the measures group patient sample criteria to report satisfactory. For the 6-month reporting period, a minimum of 8 Medicare Part B FFS patients must meet the measures group patient sample criteria to report satisfactory.
- Patient sample criteria for the HF Measures Group are patients aged 18 years and older with a specific diagnosis of HF accompanied by a specific patient encounter:

**One of the following diagnosis codes indicating HF:** 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

#### Accompanied by

**One of the following patient encounter codes:** 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

- Report a numerator option on **all applicable** measures within the HF Measures Group for each patient within the eligible professional's patient sample.
- Instructions for qualifying numerator option reporting for each of the measures within the HF Measures Group are displayed on the next several pages. The following composite G-code has been created for registry only measures groups for use by registries that utilize claims

## ***SPECIFICATION FOR MEASURES GROUP REPORTING ONLY***

data. This composite G-code may be reported in lieu of the individual quality-data codes for each of the measures within the group, if all quality actions for the patient have been performed for all the measures within the group. However, it is not necessary to submit the following composite G-code for registry-based submissions.

**Composite G-code G8551:** All quality actions for the applicable measures in the Heart Failure (HF) Measures Group have been performed for this patient

- To report satisfactorily the HF Measures Group it requires **all applicable** measures for each patient within the eligible professional's patient sample to be reported a minimum of once during the reporting period.
- When using the 30 Patient Sample Method, report all applicable measures for the 30 unique Medicare Part B FFS patients seen. When using the 80% Patient Sample Method, report all applicable measures on at least 80% of the patient sample for the eligible professional for the 12-month or 6-month reporting period.

*NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2011 Physician Quality Reporting Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS Physician Quality Reporting website.*

**SPECIFICATION FOR MEASURES GROUP REPORTING ONLY**

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

**DESCRIPTION:**

Percentage of patients aged 18 years and older with a diagnosis of heart failure and LVSD (LVEF < 40%) who were prescribed ACE inhibitor or ARB therapy

**NUMERATOR:**

Patients who were prescribed ACE inhibitor or ARB therapy

**Numerator Instructions:** The LVSD may be determined by quantitative or qualitative assessment, which may be current or historical. Examples of a quantitative or qualitative assessment may include an echocardiogram: 1) that provides a numerical value of LVSD or 2) that uses descriptive terms such as moderately or severely depressed left ventricular systolic function. Any current or prior ejection fraction study documenting LVSD can be used to identify patients.

**Definition:**

**Prescribed** – May include prescription given to the patient for ACE inhibitor or ARB therapy at one or more visits in the 12-month period OR patient already taking ACE inhibitor or ARB therapy as documented in current medication list.

**Numerator Options:**

**ACE Inhibitor or ARB Therapy Prescribed**

Angiotensin converting enzyme (ACE) inhibitor or angiotensin receptor blocker (ARB) therapy prescribed (4009F)

**AND**

Left ventricular ejection fraction (LVEF) < 40% or documentation of moderately or severely depressed left ventricular systolic function (3021F)

**OR**

Documentation of medical reason(s) for not prescribing angiotensin converting enzyme (ACE) inhibitor or angiotensin receptor blocker (ARB) therapy (4009F *with* 1P)

**OR**

Documentation of patient reason(s) for not prescribing angiotensin converting enzyme (ACE) inhibitor or angiotensin receptor blocker (ARB) therapy (4009F *with* 2P)

**OR**

Documentation of system reason(s) for not prescribing angiotensin converting enzyme (ACE) inhibitor or angiotensin receptor blocker (ARB) therapy (4009F *with* 3P)

**AND**

Left ventricular ejection fraction (LVEF) < 40% or documentation of moderately or severely depressed left ventricular systolic function (3021F)

**OR**

***SPECIFICATION FOR MEASURES GROUP REPORTING ONLY***

Left ventricular ejection fraction (LVEF)  $\geq$  40% or documentation as normal or mildly depressed left ventricular systolic function (3022F)

**OR**

Left ventricular ejection fraction (LVEF) not performed or documented (3021F *with* 8P)

**OR**

Angiotensin converting enzyme (ACE) inhibitor or angiotensin receptor blocker (ARB) therapy was not prescribed, reason not otherwise specified (4009F *with* 8P)

**AND**

Left ventricular ejection fraction  $<$  40% or documentation of moderately or severely depressed left ventricular systolic function (3021F)

*NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2011 Physician Quality Reporting Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS Physician Quality Reporting website.*

**▲ Measure #8: Heart Failure: Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)**

**DESCRIPTION:**

Percentage of patients aged 18 years and older with a diagnosis of heart failure who also have LVSD (LVEF < 40%) and who were prescribed beta-blocker therapy

**NUMERATOR:**

Patients who were prescribed beta-blocker therapy

**Numerator Instructions:** The LVSD may be determined by quantitative or qualitative assessment, which may be current or historical. Examples of a quantitative or qualitative assessment may include an echocardiogram: 1) that provides a numerical value of LVSD or 2) that uses descriptive terms such as moderately or severely depressed left ventricular systolic function. Any current or prior ejection fraction study documenting LVSD can be used to identify patients.

**Definition:**

**Prescribed** – May include prescription given to the patient for beta-blocker therapy at one or more visits in the 12-month period OR patient already taking beta-blocker therapy as documented in current medication list.

**Numerator Options:**

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**

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 (G8451)

**OR**

Left ventricular ejection fraction (LVEF)  $\geq$  40% or documentation as normal or mildly depressed left ventricular systolic function (G8395)

**OR**

Left ventricular ejection fraction (LVEF) not performed or documented (G8396)

**OR**

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)

*NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2011 Physician Quality Reporting Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS Physician Quality Reporting website.*

▲ Measure #198: Heart Failure: Left Ventricular Function (LVF) Assessment

**DESCRIPTION:**

Percentage of patients aged 18 years and older with a diagnosis of Heart Failure who have quantitative or qualitative results of LVF assessment recorded

**NUMERATOR:**

Patients with quantitative or qualitative results of LVF assessment recorded

**Numerator Instructions:** The left ventricular systolic dysfunction may be determined by quantitative or qualitative assessment, which may be current or historical. Examples of a quantitative or qualitative assessment may include an echocardiogram: 1) that provides a numerical value of left ventricular systolic function or 2) that uses descriptive terms such as moderately or severely depressed left ventricular systolic function.

**Numerator Options:**

Left ventricular function (LVF) assessment (eg, echocardiography, nuclear test, or ventriculography) documented in the medical record (Includes: Quantitative or qualitative assessment results) (3020F)

**OR**

Quantitative or qualitative results of LVF assessment not Performed or Assessed, Reason Not Specified (3020F *with* 8P)

*NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2011 Physician Quality Reporting Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS Physician Quality Reporting website.*

**SPECIFICATION FOR MEASURES GROUP REPORTING ONLY**

**▲ Measure #199: Heart Failure: Patient Education**

**DESCRIPTION:**

Percentage of patients aged 18 years and older with a diagnosis of heart failure who were provided with patient education on disease management and health behavior changes during one or more visit(s) within 12 months

**NUMERATOR:**

Patients who were provided with patient education on disease management and health behavior changes\* during one or more visits within 12 months

**Definition:** \*Patient education should include one or more of the following: Weight monitoring; Diet (sodium restriction); Symptom management; Physical activity; Smoking cessation; Medication instruction; Minimizing or avoiding use of NSAIDs; Referral for visiting nurse, or specific educational or management programs; Prognosis/end-of-life issues

**Numerator Options:**

Patient education, written/oral, appropriate for patients with heart failure performed (4003F)

**OR**

Patient education, written/oral, appropriate for patients with heart failure not performed, Reason Not Specified (4003F *with* 8P)

*NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2011 Physician Quality Reporting Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS Physician Quality Reporting website.*

**▲ Measure #226: Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention**

**DESCRIPTION:**

Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation counseling intervention if identified as a tobacco user

**NUMERATOR:**

Patients who were screened for tobacco use at least once within 24 months AND who received tobacco cessation counseling intervention if identified as a tobacco user

**Definitions:**

**Tobacco Use** – Includes any type of tobacco

**Cessation Counseling Intervention** – Includes counseling or pharmacotherapy

**Numerator Quality-Data Coding Options for Reporting Satisfactorily:**

**Patient Screened for Tobacco Use**

**CPT II 4004F:** Patient screened for tobacco use AND received tobacco cessation counseling, if identified as a tobacco user

**OR**

**Patient Screened for Tobacco Use and Identified as a Non-User of Tobacco**

**CPT II 1036F:** Current tobacco non-user

**OR**

**Tobacco Screening not Performed for Medical Reasons**

Append a modifier (**1P**) to CPT Category II code **4004F** to report documented circumstances that appropriately exclude patients from the denominator

**4004F with 1P:** Documentation of medical reason(s) for not screening for tobacco use (eg, limited life expectancy)

**OR**

**Tobacco Screening not Performed Reason Not Specified**

Append a reporting modifier (**8P**) to CPT Category II code 4004F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

**4004F with 8P:** Tobacco Screening not performed, reason not otherwise specified

*NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2011 Physician Quality Reporting Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS Physician Quality Reporting website.*



## CORONARY ARTERY DISEASE (CAD) MEASURES GROUP OVERVIEW

### 2011 PHYSICIAN QUALITY REPORTING OPTIONS FOR MEASURES GROUPS: REGISTRY ONLY

#### 2011 PHYSICIAN QUALITY REPORTING MEASURES IN CORONARY ARTERY DISEASE (CAD) MEASURES GROUP:

- #6. Coronary Artery Disease (CAD): Oral Antiplatelet Therapy Prescribed for Patients with CAD
- #196. Coronary Artery Disease (CAD): Symptom and Activity Assessment
- #197. Coronary Artery Disease (CAD): Drug Therapy for Lowering LDL-Cholesterol
- #226. Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention

#### INSTRUCTIONS FOR REPORTING: (These instructions apply to registry reporting. Do not report this measures group via claims.)

- It is not necessary to submit the measures group-specific intent G-code for registry-based submissions. However, the measures group specific intent G-code has been created for registry only measure groups for use by registries that utilize claims data.

**G8489:** I intend to report the Coronary Artery Disease (CAD) Measures Group

- Select patient sample method:  
**30 Patient Sample Method:** 30 unique Medicare Part B FFS (fee for service) patients meeting patient sample criteria for the measures group.  
**OR**  
**80% Patient Sample Method:** All patients meeting patient sample criteria for the measure group during the entire reporting period (January 1 through December 31, 2011 **OR** July 1 through December 31, 2011). For the 12-month reporting period, a minimum of 15 Medicare Part B FFS patients must meet the measures group patient sample criteria to report satisfactory. For the 6-month reporting period, a minimum of 8 Medicare Part B FFS patients must meet the measures group patient sample criteria to report satisfactory.
- Patient sample criteria for the CAD Measures Group are patients aged 18 years and older with a specific diagnosis of CAD accompanied by a specific patient encounter:

**One of the following diagnosis codes indicating CAD:** 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

#### Accompanied by

**One of the following patient encounter codes:** 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

- Report a numerator option on **all applicable** measures within the CAD Measures Group for each patient within the eligible professional's patient sample.
- Instructions for qualifying numerator option reporting for each of the measures within the CAD Measures Group are displayed on the next several pages. The following composite G-code

## ***SPECIFICATION FOR MEASURES GROUP REPORTING ONLY***

has been created for registry only measures groups for use by registries that utilize claims data. This composite G-code may be reported in lieu of the individual quality-data codes for each of the measures within the group, if all quality actions for the patient have been performed for all the measures within the group. However, it is not necessary to submit the following composite G-code for registry-based submissions.

**Composite G-code G8498:** All quality actions for the applicable measures in the Coronary Artery Disease (CAD) Measures Group have been performed for this patient

- To report satisfactorily for the CAD Measures Group it requires **all applicable** measures for each patient within the eligible professional's patient sample to be reported a minimum of once during the reporting period.
- When using the 30 Patient Sample Method, report all applicable measures for the 30 unique Medicare Part B FFS patients seen. When using the 80% Patient Sample Method, report all applicable measures on at least 80% of the patient sample for the eligible professional for the 12-month or 6-month reporting period.

*NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2011 Physician Quality Reporting Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS Physician Quality Reporting website.*

**▲ Measure #6: Coronary Artery Disease (CAD): Oral Antiplatelet Therapy Prescribed for Patients with CAD**

**DESCRIPTION:**

Percentage of patients aged 18 years and older with a diagnosis of CAD who were prescribed oral antiplatelet therapy

**NUMERATOR:**

Patients who were prescribed oral antiplatelet therapy

**Numerator Instructions:** Oral antiplatelet therapy consists of aspirin, clopidogrel or combination of aspirin and extended release dipyridamole.

**Definition:**

**Prescribed** – May include prescription given to the patient for aspirin or clopidogrel at one or more visits in the 12-month period OR patient already taking aspirin or clopidogrel as documented in current medication list.

**Numerator Quality-Data Coding Options for Reporting Satisfactorily:**

**Oral Antiplatelet Therapy Prescribed**

CPT II 4011F: Oral antiplatelet therapy prescribed

**OR**

**Oral Antiplatelet Therapy not Prescribed for Medical, Patient, or System Reasons**

Append a modifier (1P, 2P or 3P) to Category II code 4011F to report documented circumstances that appropriately exclude patients from the denominator.

**4011F with 1P:** Documentation of medical reason(s) for not prescribing oral antiplatelet therapy

**4011F with 2P:** Documentation of patient reason(s) for not prescribing oral antiplatelet therapy

**4011F with 3P:** Documentation of system reason(s) for not prescribing oral antiplatelet therapy

**OR**

**Oral Antiplatelet Therapy not Prescribed, Reason not Specified**

Append a reporting modifier (8P) to CPT Category II code 4011F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

**4011F with 8P:** Oral antiplatelet therapy was not prescribed, reason not otherwise specified

*NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2011 Physician Quality Reporting Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS Physician Quality Reporting website.*

**Measure #196: Coronary Artery Disease (CAD): Symptom and Activity Assessment**

**DESCRIPTION:**

Percentage of patients aged 18 years and older with a diagnosis of CAD who were evaluated for both level of activity and anginal symptoms during one or more visits.

**NUMERATOR:**

Patients evaluated for both level of activity and anginal symptoms during one or more office visits

**Numerator Options:**

Anginal symptoms and level of activity assessed (1002F)

**OR**

Anginal symptoms and level of activity assessed not assessed, reason not specified (1002F *with* 8P)

*NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2011 Physician Quality Reporting Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS Physician Quality Reporting website.*

▲ Measure #197: Coronary Artery Disease (CAD): Drug Therapy for Lowering LDL-Cholesterol

**DESCRIPTION:**

Percentage of patients aged 18 years and older with a diagnosis of CAD who were prescribed a lipid-lowering therapy (based on current ACC/AHA guidelines)

**NUMERATOR:**

Patients who were prescribed lipid-lowering therapy

**NUMERATOR NOTE:** For those registries that utilize claims data, the quality-data code 4002F may be used for this measure.

**Definition:**

**Prescribed** – May include prescription given to the patient for a lipid-lowering therapy at one or more visits in the 12 month period OR patient already taking a lipid-lowering therapy as documented in the current medication list.

**Numerator Options:**

Lipid-lowering therapy prescribed

**OR**

Lipid-lowering therapy not prescribed for medical reason

**OR**

Lipid-lowering therapy not prescribed for patient reason

**OR**

Lipid-lowering therapy not prescribed for system reason

**OR**

Lipid-lowering therapy not prescribed, reason not specified

*NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2011 Physician Quality Reporting Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS Physician Quality Reporting website.*

**▲ Measure #226: Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention**

**DESCRIPTION:**

Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation counseling intervention if identified as a tobacco user

**NUMERATOR:**

Patients who were screened for tobacco use at least once within 24 months AND who received tobacco cessation counseling intervention if identified as a tobacco user

**Definitions:**

**Tobacco Use** – Includes any type of tobacco

**Cessation Counseling Intervention** – Includes counseling or pharmacotherapy

**Numerator Quality-Data Coding Options for Reporting Satisfactorily:**

**Patient Screened for Tobacco Use**

**CPT II 4004F:** Patient screened for tobacco use AND received tobacco cessation counseling, if identified as a tobacco user

**OR**

**Patient Screened for Tobacco Use and Identified as a Non-User of Tobacco**

**CPT II 1036F:** Current tobacco non-user

**OR**

**Tobacco Screening not Performed for Medical Reasons**

Append a modifier (**1P**) to CPT Category II code **4004F** to report documented circumstances that appropriately exclude patients from the denominator

**4004F with 1P:** Documentation of medical reason(s) for not screening for tobacco use (eg, limited life expectancy)

**OR**

**Tobacco Screening not Performed Reason Not Specified**

Append a reporting modifier (**8P**) to CPT Category II code 4004F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

**4004F with 8P:** Tobacco Screening not performed, reason not otherwise specified

*NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2011 Physician Quality Reporting Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS Physician Quality Reporting website.*

## ISCHEMIC VASCULAR DISEASE (IVD) MEASURES GROUP OVERVIEW

### 2011 PHYSICIAN QUALITY REPORTING OPTIONS FOR MEASURES GROUPS: CLAIMS, REGISTRY

#### 2011 PHYSICIAN QUALITY REPORTING MEASURES IN ISCHEMIC VASCULAR DISEASE (IVD) MEASURES GROUP:

- #201. Ischemic Vascular Disease (IVD): Blood Pressure Management Control
- #202. Ischemic Vascular Disease (IVD): Complete Lipid Profile
- #203. Ischemic Vascular Disease (IVD): Low Density Lipoprotein (LDL-C) Control
- #204. Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic
- #226. Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention

#### INSTRUCTIONS FOR REPORTING: (These instructions apply to both Claims and Registry reporting, unless otherwise specified.)

- Indicate your intention to report the IVD Measures Group by submitting the measures group-specific intent G-code at least once during the reporting period when billing a patient claim for both the 30 Patient Sample and the 50% Patient Sample Methods. It is not necessary to submit the measures group-specific intent G-code on more than one claim. It is not necessary to submit the measures group-specific intent G-code for registry-based submissions.

**G8547:** I intend to report the Ischemic Vascular Disease (IVD) Measures Group

- Select patient sample method:  
**30 Patient Sample Method:** 30 unique Medicare Part B FFS (fee for service) patients meeting patient sample criteria for the measures group.

**OR**

**50% Patient Sample Method via Claims or 80% Patient Sample Method via Registry:** All patients meeting patient sample criteria for the measure group during the entire reporting period (January 1 through December 31, 2011 **OR** July 1 through December 31, 2011). For the 12-month reporting period, a minimum of 15 Medicare Part B FFS patients must meet the measures group patient sample criteria to report satisfactory. For the 6-month reporting period, a minimum of 8 Medicare Part B FFS patients must meet the measures group patient sample criteria to report satisfactory.

- Patient sample criteria for the IVD Measures Group are patients aged 18 years and older with a specific diagnosis of IVD accompanied by a specific patient encounter **OR** patients aged 18 years and older with a coronary artery bypass graft (CABG) or percutaneous transluminal coronary angioplasty (PTCA) surgical procedure:

**One of the following diagnosis codes indicating IVD:** 410.11, 410.21, 410.31, 410.41, 410.51, 410.61, 410.71, 410.81, 410.91, 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, 429.2, 433.00, 433.01, 433.10, 433.11, 433.20, 433.21, 433.30, 433.31, 433.80, 433.81, 433.90, 433.91, 434.00, 434.01, 434.10, 434.11, 434.90, 434.91, 440.1, 440.20, 440.21, 440.22, 440.23, 440.24, 440.29, 440.4, 444.0, 444.1, 444.21, 444.22, 444.81, 444.89, 444.9, 445.01, 445.02, 445.81, 445.89

**Accompanied by**

## SPECIFICATION FOR MEASURES GROUP REPORTING ONLY

One of the following patient encounter codes: 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99217, 99218, 99219, 99220, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, 99455, 99456

OR

One of the following coronary artery bypass graft (CABG) or percutaneous transluminal coronary angioplasty (PTCA) surgical procedure codes: 33140, 33510, 33511, 33512, 33513, 33514, 33516, 33517, 33518, 33519, 33521, 33522, 33523, 33533, 33534, 33535, 33536, 92980, 92982, 92995

- Report quality-data codes on **all applicable** measures within the IVD Measures Group for each patient within the eligible professional's patient sample.
- Instructions for quality-data code reporting for each of the measures within the IVD Measures Group are displayed on the next several pages. If all quality actions for the patient have been performed for all the measures within the group, the following composite G-code may be reported in lieu of the individual quality-data codes for each of the measures within the group. It is not necessary to submit the following composite G-code for registry-based submissions.

**Composite G code G8552:** All quality actions for the applicable measures in the Ischemic Vascular Disease (IVD) Measures Group have been performed for this patient

- To report satisfactorily the IVD Measures Group requires **all applicable** measures for each patient within the eligible professional's patient sample to be reported a minimum of once during the reporting period.
- When using the 30 Patient Sample Method, report all applicable measures for the 30 unique Medicare Part B FFS patients seen. When using the 50% Patient Sample Method via Claims, report all applicable measures on at least 50% of the patient sample for the eligible professional for the 12-month or 6-month reporting period. When using the 80% Patient Sample Method via Registry, report all applicable measures on at least 80% of the patient sample for the eligible professional for the 12-month or 6-month reporting period.
- For claims-based submissions, the Carrier/MAC remittance advice notice sent to the practice will show a denial remark code (N365) for the line item on the claim containing G8547 (and G8552 if reported) as well as all other line items containing QDCs. N365 indicates that the code is not payable and is used for reporting/informational purposes only. Other services/codes on the claim will not be affected by the addition of a measures group-specific intent G-code or other QDCs. The N365 remark code does NOT indicate whether the QDC is accurate for that claim or for the measure the eligible professional is attempting to report, but does indicate that the QDC was processed and transmitted to the NCH.

*NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2011 Physician Quality Reporting Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS Physician Quality Reporting website.*



♦ Measure #201: Ischemic Vascular Disease (IVD): Blood Pressure Management Control

**DESCRIPTION:**

Percentage of patients aged 18 years and older with Ischemic Vascular Disease (IVD) who had most recent blood pressure in control (less than 140/90 mmHg)

**NUMERATOR:**

Patients whose most recent blood pressure < 140/90 mmHg

**Numerator Instructions:** To describe both systolic and diastolic blood pressure values, each must be reported separately. 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.

**NUMERATOR NOTE:** *The performance period for this measure is 12 months*

**Numerator Quality-Data Coding Options for Reporting Satisfactorily:**

**Most Recent Blood Pressure Measurement Performed**

*Systolic Pressure (Select one (1) code from this section):*

G8588: Most recent systolic blood pressure < 140 mmHg

**OR**

G8589: Most recent systolic blood pressure ≥ 140 mmHg

**AND**

*Diastolic Pressure (Select one (1) code from this section):*

G8590: Most recent diastolic blood pressure < 90 mmHg

**OR**

G8591: Most recent diastolic blood pressure ≥ 90 mmHg

**OR**

**Blood Pressure Measurement not Documented, Reason not Specified**

G8592: No documentation of blood pressure measurement

*NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2011 Physician Quality Reporting Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS Physician Quality Reporting website.*

**SPECIFICATION FOR MEASURES GROUP REPORTING ONLY**

**♦ Measure #202: Ischemic Vascular Disease (IVD): Complete Lipid Profile**

**DESCRIPTION:**

Percentage of patients aged 18 years and older with Ischemic Vascular Disease (IVD) who received at least one lipid profile within 12 months

**NUMERATOR:**

Patients who received at least one lipid profile (or ALL component tests)

**Numerator Quality-Data Coding Options for Reporting Satisfactorily:**

**Lipid Profile Performed**

**G8593:** Lipid profile results documented and reviewed (must include total cholesterol, HDL-C, triglycerides and calculated LDL-C)

**Note:** *If LDL-C could not be calculated due to high triglycerides, count as complete lipid profile.*

**OR**

**Lipid Profile not Performed, Reason not Specified**

**G8594:** Lipid profile not performed, reason not otherwise specified

*NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2011 Physician Quality Reporting Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS Physician Quality Reporting website.*

SPECIFICATION FOR MEASURES GROUP REPORTING ONLY

♦ Measure #203: Ischemic Vascular Disease (IVD): Low Density Lipoprotein (LDL-C) Control

**DESCRIPTION:**

Percentage of patients aged 18 years and older with Ischemic Vascular Disease (IVD) who had most recent LDL-C level in control (less than 100 mg/dl)

**NUMERATOR:**

Patients with most recent LDL-C < 100 mg/dL

*NUMERATOR NOTE: The performance period for this measure is 12 months.*

**Numerator Quality-Data Coding Options for Reporting Satisfactorily:**

Most Recent LDL-C <100 mg/dL

G8595: Most recent LDL-C < 100 mg/dL

**OR**

LDL-C was not Performed

G8596: LDL-C was not performed

**OR**

Most Recent LDL-C ≥100 mg/dL

G8597: Most recent LDL-C ≥ 100 mg/dL

*NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2011 Physician Quality Reporting Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS Physician Quality Reporting website.*

**SPECIFICATION FOR MEASURES GROUP REPORTING ONLY**

**♦ Measure #204: Ischemic Vascular Disease (IVD): Use Aspirin or Another Antithrombotic**

**DESCRIPTION:**

Percentage of patients aged 18 years and older with Ischemic Vascular Disease (IVD) with documented use of aspirin or other antithrombotic

**NUMERATOR:**

Patients who are using aspirin or another antithrombotic therapy

**Numerator Instructions:** Oral antithrombotic therapy consists of aspirin, clopidogrel or combination of aspirin and extended release dipyridamole

**NUMERATOR NOTE:** *The performance period for this measure is 12 months*

**Numerator Quality-Data Coding Options for Reporting Satisfactorily:**

**Aspirin or Another Antithrombotic Therapy Used**

**G8598:** Aspirin or another antithrombotic therapy used

**OR**

**Aspirin or Another Antithrombotic Therapy not Used, Reason not Specified**

**G8599:** Aspirin or another antithrombotic therapy not used, reason not otherwise specified

*NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2011 Physician Quality Reporting Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS Physician Quality Reporting website.*

**▲ Measure #226: Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention**

**DESCRIPTION:**

Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation counseling intervention if identified as a tobacco user

**NUMERATOR:**

Patients who were screened for tobacco use at least once within 24 months AND who received tobacco cessation counseling intervention if identified as a tobacco user

**Definitions:**

**Tobacco Use** – Includes any type of tobacco

**Cessation Counseling Intervention** – Includes counseling or pharmacotherapy

**Numerator Quality-Data Coding Options for Reporting Satisfactorily:**

**Patient Screened for Tobacco Use**

**CPT II 4004F:** Patient screened for tobacco use AND received tobacco cessation counseling, if identified as a tobacco user

**OR**

**Patient Screened for Tobacco Use and Identified as a Non-User of Tobacco**

**CPT II 1036F:** Current tobacco non-user

**OR**

**Tobacco Screening not Performed for Medical Reasons**

Append a modifier (**1P**) to CPT Category II code **4004F** to report documented circumstances that appropriately exclude patients from the denominator

**4004F with 1P:** Documentation of medical reason(s) for not screening for tobacco use (eg, limited life expectancy)

**OR**

**Tobacco Screening not Performed Reason Not Specified**

Append a reporting modifier (**8P**) to CPT Category II code 4004F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

**4004F with 8P:** Tobacco Screening not performed, reason not otherwise specified

*NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2011 Physician Quality Reporting Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS Physician Quality Reporting website.*

## HIV/AIDS MEASURES GROUP OVERVIEW

### 2011 PHYSICIAN QUALITY REPORTING OPTIONS FOR MEASURES GROUPS: REGISTRY ONLY

#### 2011 PHYSICIAN QUALITY REPORTING MEASURES IN HIV/AIDS MEASURES GROUP:

- #159. HIV/AIDS: CD4+ Cell Count or CD4+ Percentage
- #160. HIV/AIDS: Pneumocystis Jiroveci Pneumonia (PCP) Prophylaxis
- #161. HIV/AIDS: Adolescent and Adult Patients with HIV/AIDS Who Are Prescribed Potent Antiretroviral Therapy
- #162. HIV/AIDS: HIV RNA Control After Six Months of Potent Antiretroviral Therapy
- #205. HIV/AIDS: Sexually Transmitted Disease Screening for Chlamydia and Gonorrhea
- #206. HIV/AIDS: Screening for High Risk Sexual Behaviors
- #207. HIV/AIDS: Screening for Injection Drug Use
- #208. HIV/AIDS: Sexually Transmitted Disease Screening for Syphilis

#### **INSTRUCTIONS FOR REPORTING: (These instructions apply to registry reporting. Do not report this measures group via claims.)**

- It is not necessary to submit the measures group-specific intent G-code for registry-based submissions. However, the measures group-specific intent G-code has been created for registry only measures groups for use by registries that utilize claims data.

**G8491:** I intend to report the HIV/AIDS Measures Group

- Select patient sample method:  
**30 Patient Sample Method:** 30 unique Medicare Part B FFS (fee for service) patients meeting patient sample criteria for the measures group.  
**OR**  
**80% Patient Sample Method:** All patients meeting patient sample criteria for the measure group during the entire reporting period (January 1 through December 31, 2011 **OR** July 1 through December 31, 2011). For the 12-month reporting period, a minimum of 15 Medicare Part B FFS patients must meet the measures group patient sample criteria to report satisfactory. For the 6-month reporting period, a minimum of 8 Medicare Part B FFS patients must meet the measures group patient sample criteria to report satisfactory.
- Patient sample criteria for the HIV/AIDS Measures Group are patients aged 13 years and older with a specific diagnosis of HIV/AIDS accompanied by a specific patient encounter:

**One of the following diagnosis codes indicating HIV/AIDS:** 042, 079.53, V08

**Accompanied by**

**One of the following patient encounter codes:** 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215

- Report a numerator option on **all** measures within the HIV/AIDS Measures Group for each patient within the eligible professional's patient sample.
- Instructions for qualifying numerator option reporting for each of the measures within the HIV/AIDS Measures Group are displayed on the next several pages. The following composite G-code has been created for registry only measures groups for use by registries that utilize claims data. This composite G-code may be reported in lieu of the individual quality-data codes for each of the measures within the group, if all quality actions for the patient have been

## ***SPECIFICATION FOR MEASURES GROUP REPORTING ONLY***

performed for all the measures within the group. However, it is not necessary to submit the following composite G-code for registry-based submissions.

**Composite G code G8500:** All quality actions for the applicable measures in the HIV/AIDS Measures Group have been performed for this patient

- To report satisfactorily for the HIV/AIDS Measures Group it requires all measures for each patient within the eligible professional's patient sample to be reported a minimum of once during the reporting period. Measure #159 will be reported once during the reporting period for measures group purposes.
- When using the 30 Patient Sample Method, report all measures for the 30 unique Medicare Part B FFS patients seen. When using the 80% Patient Sample Method, report all measures on at least 80% of the patient sample for the eligible professional for the 12-month or 6-month reporting period.

*NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2011 Physician Quality Reporting Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS Physician Quality Reporting website.*

**SPECIFICATION FOR MEASURES GROUP REPORTING ONLY**

<b>□ Measure #159: HIV/AIDS: CD4+ Cell Count or CD4+ Percentage</b>
---

**DESCRIPTION:**

Percentage of patients aged 6 months and older with a diagnosis of HIV/AIDS for whom a CD4+ cell count or CD4+ cell percentage was performed at least once every 6 months

**NUMERATOR:**

Patients with CD4+ cell count or CD4+ cell percentage performed at least once every 6 months

***NUMERATOR NOTE:** Report this measure once during the reporting period for measures group purposes*

**Numerator Options:**

CD4+ cell count or CD4+ cell percentage documented as performed (3500F)

**OR**

CD4+ cell count or percentage not documented as performed, reason not specified (3500F with 8P)

*NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2011 Physician Quality Reporting Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS Physician Quality Reporting website.*



**SPECIFICATION FOR MEASURES GROUP REPORTING ONLY**

**□ Measure #160: HIV/AIDS: Pneumocystis Jiroveci Pneumonia (PCP) Prophylaxis**

**DESCRIPTION:**

Percentage of patients aged 6 years and older with a diagnosis of HIV/AIDS and CD4+ cell count <200 cells/mm<sup>3</sup> who were prescribed PCP prophylaxis within 3 months of low CD4+ cell count

**NUMERATOR:**

Patients who were prescribed PCP prophylaxis within 3 months of low CD4+ cell count

**Definition:**

**Prescribed** – May include prescription given to the patient for PCP prophylaxis therapy at one or more visits in the 12-month period OR patient already taking PCP prophylaxis therapy as documented in current medication list.

**Numerator Options:**

Pneumocystis jiroveci pneumonia prophylaxis prescribed within 3 months of low CD4+ cell count or percentage (4280F)

**AND**

CD4+ cell count <200 cells/mm<sup>3</sup> (3494F)

**OR**

Pneumocystis jiroveci pneumonia prophylaxis not prescribed within 3 months of low CD4+ cell count or percentage for medical reason (4280F *with* 1P)

(i.e., patient's CD4+ cell count above threshold within 3 months after CD4+ cell count below threshold, indicating that the patient's CD4+ levels are within an acceptable range and the patient does not require PCP prophylaxis)

**AND**

CD4+ cell count <200 cells/mm<sup>3</sup> (3494F)

**OR**

CD4+ cell count 200 – 499 cells/mm<sup>3</sup> (3495F)

**OR**

CD4+ cell count ≥500 cells/mm<sup>3</sup> (3496F)

**OR**

CD4+ cell count not performed, reason not specified (3494F *with* 8P)

**OR**

PCP prophylaxis was not prescribed within 3 months of low CD4+ cell count, reason not specified (4280F *with* 8P)

**AND**

CD4+ cell count <200 cells/mm<sup>3</sup> (3494F)

*NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2011 Physician Quality Reporting Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS Physician Quality Reporting website.*

**□Measure #161: HIV/AIDS: Adolescent and Adult Patients with HIV/AIDS Who Are Prescribed Potent Antiretroviral Therapy**

**DESCRIPTION:**

Percentage of patients with a diagnosis of HIV/AIDS aged 13 years and older: who have a history of a nadir CD4+ cell count below 350/mm<sup>3</sup> or who have a history of an AIDS-defining condition, regardless of CD4+ cell count; who were prescribed potent antiretroviral therapy

**NUMERATOR:**

Patients who were prescribed potent antiretroviral therapy

**Numerator Instructions:** Nadir (lowest ever) CD4+ cell count may be the present count

**Definitions:**

**Potent Antiretroviral Therapy** – Potent antiretroviral therapy is described as any antiretroviral therapy that has demonstrated optimal efficacy and results in durable suppression of HIV as shown by prior clinical trials. For potent antiretroviral therapy recommendations, refer to current DHHS guidelines available for download at the following address as of 11/3/08 - <http://www.aids.gov>.

**AIDS-defining Condition** – Conditions included in the 1993 AIDS surveillance case definition:

- Candidiasis of bronchi, trachea, or lungs;
- Candidiasis, esophageal;
- Cervical cancer, invasive;
- Coccidioidomycosis, disseminated or extrapulmonary;
- Cryptococcosis, extrapulmonary;
- Cryptosporidiosis, chronic intestinal (greater than 1 month's duration);
- Cytomegalovirus disease (other than liver, spleen, or nodes);
- Cytomegalovirus retinitis (with loss of vision);
- Encephalopathy, HIV-related;
- Herpes simplex: chronic ulcer(s) (greater than 1 month's duration);
- Bronchitis, pneumonitis, or esophagitis;
- Histoplasmosis, disseminated or extrapulmonary;
- Isosporiasis, chronic intestinal (greater than 1 month's duration);
- Kaposi's sarcoma;
- Lymphoma, Burkitt's (or equivalent term);
- Lymphoma, immunoblastic (or equivalent term);
- Lymphoma, primary, of brain;
- Mycobacterium avium complex or M. kansasii, disseminated or extrapulmonary;
- Mycobacterium tuberculosis, any site (pulmonary or extrapulmonary);
- Mycobacterium, other species or unidentified species, disseminated or extrapulmonary;
- Pneumocystis carinii pneumonia;
- Pneumonia, recurrent;
- Progressive multifocal leukoencephalopathy;
- Salmonella septicemia, recurrent;

**SPECIFICATION FOR MEASURES GROUP REPORTING ONLY**

- Toxoplasmosis of brain;
- Wasting syndrome due to HIV. (NYSDOH, 2007)

**Prescribed** – May include prescription given to the patient for potent antiretroviral therapy at one or more visits in the 12-month period OR patient already taking potent antiretroviral therapy as documented in current medication list.

**Numerator Options:**

Potent antiretroviral therapy prescribed (4276F)

**AND**

History of nadir CD4+ cell count <350 cells/mm<sup>3</sup> (3492F)

**OR**

History of AIDS-defining condition (3490F)

**OR**

No history of nadir CD4+ cell count <350 cells/mm<sup>3</sup> AND no history of AIDS-defining condition (3493F)

**OR**

Potent antiretroviral therapy not prescribed, reason not specified (4276F *with* 8P)

**AND**

History of nadir CD4+ cell count < 350 cells/mm<sup>3</sup> (3492F)

**OR**

History of AIDS-defining condition (3490F)

*NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2011 Physician Quality Reporting Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS Physician Quality Reporting website.*

**SPECIFICATION FOR MEASURES GROUP REPORTING ONLY**

**□ Measure #162: HIV/AIDS: HIV RNA Control After Six Months of Potent Antiretroviral Therapy**

**DESCRIPTION:**

Percentage of patients aged 13 years and older with a diagnosis of HIV/AIDS who are receiving potent antiretroviral therapy, who have a viral load below limits of quantification after at least 6 months of potent antiretroviral therapy or patients whose viral load is not below limits of quantification after at least 6 months of potent antiretroviral therapy and have documentation of a plan of care

**NUMERATOR:**

Patients with viral load below limits of quantification or patients with viral load not below limits of quantification who have a documented plan of care

**Numerator Instructions:** Viral load below limits of quantification is determined using laboratory cutoff levels for reference laboratory used by clinic or provider

**Definitions:**

**Potent Antiretroviral Therapy** – Potent antiretroviral therapy is described as any antiretroviral therapy that has demonstrated optimal efficacy and results in durable suppression of HIV as shown by prior clinical trials. For potent antiretroviral therapy recommendations, refer to current DHHS guidelines available for download at the following address as of 11/3/08 - <http://www.aids.gov>.

**Plan of Care** – May include altering the therapy regimen, reaffirming to the patient the importance of high adherence to the regimen, or reassessment of viral load at a specified future date

**Numerator Options:**

HIV RNA viral load below limits of quantification (3502F)

**AND**

Patient receiving potent antiretroviral therapy for 6 months or longer (4270F)

**OR**

HIV RNA viral load not below limits of quantification (3503F)

**AND**

HIV RNA control plan of care, documented (0575F)

**AND**

Patient receiving potent antiretroviral therapy for 6 months or longer (4270F)

**OR**

Patient receiving potent antiretroviral therapy for less than 6 months or not receiving potent antiretroviral therapy (4271F)

**OR**

Viral load not performed or documented, reason not specified (3502F *with* 8P)

**AND**

Patient receiving potent antiretroviral therapy for 6 months or longer (4270F)

**OR**

***SPECIFICATION FOR MEASURES GROUP REPORTING ONLY***

Plan of care for viral load not below limits of quantification was not documented, reason not specified (0575F *with* 8P)

**AND**

HIV RNA viral load not below limits of quantification (3503F)

**AND**

Patient receiving potent antiretroviral therapy for 6 months or longer (4270F)

*NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2011 Physician Quality Reporting Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS Physician Quality Reporting website.*

SPECIFICATION FOR MEASURES GROUP REPORTING ONLY

□ Measure #205: HIV/AIDS: Sexually Transmitted Disease Screening for Chlamydia and Gonorrhea

**DESCRIPTION:**

Percentage of patients aged 13 years and older with a diagnosis of HIV/AIDS for whom chlamydia and gonorrhea screenings were performed at least once since the diagnosis of HIV infection

**NUMERATOR:**

Patients with chlamydia and gonorrhea screenings performed at least once since the diagnosis of HIV infection

**Numerator Options:**

Chlamydia and gonorrhea screenings documented as performed (3511F)

**OR**

Chlamydia and gonorrhea screenings not documented as performed, due to patient reason (3511F *with* 2P)

**OR**

Chlamydia and gonorrhea screenings not documented as performed, reason not specified (3511F *with* 8P)

*NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2011 Physician Quality Reporting Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS Physician Quality Reporting website.*

**SPECIFICATION FOR MEASURES GROUP REPORTING ONLY**

**□ Measure #206: HIV/AIDS: Screening for High Risk Sexual Behaviors**

**DESCRIPTION:**

Percentage of patients aged 13 years and older with a diagnosis of HIV/AIDS who were screened for high risk sexual behaviors at least once within 12 months

**NUMERATOR:**

Patients who were screened for high risk sexual behaviors at least once within 12 months

**Numerator Options:**

Patient screened for high risk sexual behavior (4293F)

**OR**

Patient not screened for high risk sexual behaviors, reason not specified (4293F *with* 8P)

*NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2011 Physician Quality Reporting Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS Physician Quality Reporting website.*

*SPECIFICATION FOR MEASURES GROUP REPORTING ONLY*

**□ Measure #207: HIV/AIDS: Screening for Injection Drug Use**

**DESCRIPTION:**

Percentage of patients aged 13 years and older with a diagnosis of HIV/AIDS who were screened for injection drug use at least once within 12 months

**NUMERATOR:**

Patients who were screened for injection drug use at least once within 12 months

**Numerator Options:**

Patient screened for injection drug use (4290F)

**OR**

Patient not screened for injection drug use, reason not specified (4290F *with* 8P)

*NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2011 Physician Quality Reporting Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS Physician Quality Reporting website.*



**SPECIFICATION FOR MEASURES GROUP REPORTING ONLY**

<b>□ Measure #208: HIV/AIDS: Sexually Transmitted Disease Screening for Syphilis</b>
--

**DESCRIPTION:**

Percentage of patients aged 13 years and older with a diagnosis of HIV/AIDS who were screened for syphilis at least once within 12 months

**NUMERATOR:**

Patients who were screened for syphilis at least once within 12 months

**Numerator Options:**

Syphilis screening documented as performed (3512F)

**OR**

Syphilis screening not documented as performed, due to patient reason (3512F *with* 2P)

**OR**

Syphilis screening not documented as performed, reason not specified (3512F *with* 8P)

*NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2011 Physician Quality Reporting Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS Physician Quality Reporting website.*

## COMMUNITY-ACQUIRED PNEUMONIA (CAP) MEASURES GROUP OVERVIEW

### 2011 PHYSICIAN QUALITY REPORTING OPTIONS FOR MEASURES GROUPS: CLAIMS, REGISTRY

#### 2011 PHYSICIAN QUALITY REPORTING MEASURES IN COMMUNITY-ACQUIRED PNEUMONIA (CAP) MEASURES GROUP:

- #56. Community-Acquired Pneumonia (CAP): Vital Signs
- #57. Community-Acquired Pneumonia (CAP): Assessment of Oxygen Saturation
- #58. Community-Acquired Pneumonia (CAP): Assessment of Mental Status
- #59. Community-Acquired Pneumonia (CAP): Empiric Antibiotic

#### INSTRUCTIONS FOR REPORTING: (These instructions apply to both Claims and Registry reporting, unless otherwise specified.)

- Indicate your intention to report the CAP Measures Group by submitting the measures group-specific intent G-code at least once during the reporting period when billing a patient claim for both the 30 Patient Sample and the 50% Patient Sample Methods. It is not necessary to submit the measures group-specific intent G-code on more than one claim. It is not necessary to submit the measures group-specific intent G-code for registry-based submissions.

**G8546:** I intend to report the Community-Acquired Pneumonia (CAP) Measures Group

- Select patient sample method:  
**30 Patient Sample Method:** 30 unique Medicare Part B FFS (fee for service) patients meeting patient sample criteria for the measures group.  
**OR**  
**50% Patient Sample Method via Claims or 80% Patient Sample Method via Registry:** All patients meeting patient sample criteria for the measure group during the entire reporting period (January 1 through December 31, 2011 **OR** July 1 through December 31, 2011). For the 12-month reporting period, a minimum of 15 Medicare Part B FFS patients must meet the measures group patient sample criteria to report satisfactory. For the 6-month reporting period, a minimum of 8 Medicare Part B FFS patients must meet the measures group patient sample criteria to report satisfactory.
- Patient sample criteria for the CAP Measures Group are patients aged 18 years and older with a specific diagnosis of CAP accompanied by a specific patient encounter:

**The following diagnosis codes indicating CAP:** 481, 482.0, 482.1, 482.2, 482.30, 482.31, 482.32, 482.39, 482.40, 482.41, 482.42, 482.49, 482.81, 482.82, 482.83, 482.84, 482.89, 482.9, 483.0, 483.1, 483.8, 485, 486, 487.0

#### **Accompanied by**

**One of the following patient encounter codes:** 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99281, 99282, 99283, 99284, 99285, 99291\*, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350

*\*Clinicians utilizing the critical care code (99291) must indicate the emergency department place of service (23) on the Part B claim form in order to report this measure.*

- Report quality-data codes on all measures within the CAP Measures Group for each patient within the eligible professional's patient sample.

## SPECIFICATION FOR MEASURES GROUP REPORTING ONLY

- Instructions for quality-data code reporting for each of the measures within the CAP Measures Group are displayed on the next several pages. If all quality actions for the patient have been performed for all measures within the group, the following composite G-code may be reported in lieu of the individual quality-data codes for each of the measures within the group. It is not necessary to submit the following composite G-code for registry-based submissions.

**Composite G code G8550:** All quality actions for the applicable measures in the Community-Acquired Pneumonia (CAP) Measures Group have been performed for this patient

- To report satisfactorily for the CAP Measures Group it requires all measures for each patient within the eligible professional's patient sample to be reported once during each occurrence of CAP. Each unique occurrence is defined as a 45-day period from onset of community-acquired bacterial pneumonia.
- When using the 30 Patient Sample Method, report all measures for the 30 Medicare patients seen. When using the 50% Patient Sample Method via Claims, report all measures on at least 50% of the patient sample for the eligible professional for the 12-month or 6-month reporting period. When using the 80% Patient Sample Method via Registry, report all measures on at least 80% of the patient sample for the eligible professional for the 12-month or 6-month reporting period.
- For claims-based submissions, the Carrier/MAC remittance advice notice sent to the practice will show a denial remark code (N365) for the line item on the claim containing G8546 (and G8550 if reported) as well as all other line items containing QDCs. N365 indicates that the code is not payable and is used for reporting/informational purposes only. Other services/codes on the claim will not be affected by the addition of a measures group-specific intent G-code or other QDCs. The N365 remark code does NOT indicate whether the QDC is accurate for that claim or for the measure the eligible professional is attempting to report, but does indicate that the QDC was processed and transmitted to the NCH.

*NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2011 Physician Quality Reporting Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS Physician Quality Reporting website.*

**\*Measure #56: Community-Acquired Pneumonia (CAP): Vital Signs**

**DESCRIPTION:**

Percentage of patients aged 18 years and older with a diagnosis of community-acquired bacterial pneumonia with vital signs documented and reviewed

**NUMERATOR:**

Patients with vital signs (temperature, pulse, respiratory rate, and blood pressure) documented and reviewed

**Definitions:**

**Vital Signs** – Are defined as temperature, pulse, respiratory rate, and blood pressure

**Documented and Reviewed** – May include one of the following: Clinician documentation 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

**Numerator Quality-Data Coding Options for Reporting Satisfactorily:**

**Vital Signs Documented and Reviewed**

**CPT II 2010F:** Vital signs (temperature, pulse, respiratory rate, and blood pressure) documented and reviewed

**OR**

**Vital Signs not Documented and Reviewed, Reason not Specified**

Append a reporting modifier (8P) to CPT Category II code 2010F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

**2010F with 8P:** Vital signs (temperature, pulse, respiratory rate, and blood pressure) not documented and reviewed, reason not otherwise specified

*NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2011 Physician Quality Reporting Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS Physician Quality Reporting website.*

**\*Measure #57: Community-Acquired Pneumonia (CAP): Assessment of Oxygen Saturation**

**DESCRIPTION:**

Percentage of patients aged 18 years and older with a diagnosis of community-acquired bacterial pneumonia with oxygen saturation documented and reviewed

**NUMERATOR:**

Patients with oxygen saturation documented and reviewed

**Definitions:**

**Oxygen Saturation** – Includes assessment through pulse oximetry or arterial blood gas measurement

**Documented and Reviewed** – May include one of the following: Clinician documentation 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

**Numerator Quality-Data Coding Options for Reporting Satisfactorily:**

**Oxygen Saturation Documented and Reviewed**

**CPT II 3028F:** Oxygen saturation results documented and reviewed (includes assessment through pulse oximetry or arterial blood gas measurement)

**OR**

**Oxygen Saturation not Documented and Reviewed for Medical, Patient, or System Reasons**

Append a modifier (**1P**, **2P** or **3P**) to CPT Category II code **3028F** to report documented circumstances that appropriately exclude patients from the denominator.

**3028F with 1P:** Documentation of medical reason(s) for not documenting and reviewing oxygen saturation

**3028F with 2P:** Documentation of patient reason(s) for not documenting and reviewing oxygen saturation

**3028F with 3P:** Documentation of system reason(s) for not documenting and reviewing oxygen saturation

**OR**

**Oxygen Saturation not Documented and Reviewed, Reason not Specified**

Append a reporting modifier (**8P**) to CPT Category II code **3028F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

**3028F with 8P:** Oxygen saturation results not documented and reviewed, reason not otherwise specified

*NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2011 Physician Quality Reporting Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS Physician Quality Reporting website.*

**SPECIFICATION FOR MEASURES GROUP REPORTING ONLY**

**\*Measure #58: Community-Acquired Pneumonia (CAP): Assessment of Mental Status**

**DESCRIPTION:**

Percentage of patients aged 18 years and older with a diagnosis of community-acquired bacterial pneumonia with mental status assessed

**NUMERATOR:**

Patients for whom mental status was assessed

**Definition:**

**Assessed** – May include: Documentation by clinician that patient's mental status was noted (e.g., patient is oriented or disoriented).

**Numerator Quality-Data Coding Options for Reporting Satisfactorily:**

**Mental Status Assessed**

CPT II 2014F: Mental status assessed

**OR**

**Mental Status not Assessed, Reason not Specified**

Append a reporting modifier (8P) to CPT Category II code 2014F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

**2014F *with* 8P:** Mental status not assessed, reason not otherwise specified

*NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2011 Physician Quality Reporting Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS Physician Quality Reporting website.*

**\*Measure #59: Community-Acquired Pneumonia (CAP): Empiric Antibiotic**

**DESCRIPTION:**

Percentage of patients aged 18 years and older with a diagnosis of community-acquired bacterial pneumonia with an appropriate empiric antibiotic prescribed

**NUMERATOR:**

Patients with appropriate empiric antibiotic prescribed

**Definitions:**

**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.

**Numerator Quality-Data Coding Options for Reporting Satisfactorily:**

**Appropriate Empiric Antibiotic Prescribed**

CPT II 4045F: Appropriate empiric antibiotic prescribed

**OR**

**Appropriate Empiric Antibiotic not Prescribed for Medical, Patient, or System Reasons**

Append a modifier (1P, 2P or 3P) to CPT Category II code 4045F to report documented circumstances that appropriately exclude patients from the denominator.

**4045F with 1P:** Documentation of medical reason(s) for not prescribing appropriate empiric antibiotic

**4045F with 2P:** Documentation of patient reason(s) for not prescribing appropriate empiric antibiotic

**4045F with 3P:** Documentation of system reason(s) for not prescribing appropriate empiric antibiotic

**OR**

**Appropriate Empiric Antibiotic not Prescribed, Reason not Specified**

Append a reporting modifier (8P) to CPT Category II code 4045F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

**4045F with 8P:** Appropriate empiric antibiotic not prescribed, reason not otherwise specified

*NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2011 Physician Quality Reporting Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS Physician Quality Reporting website.*

## ASTHMA MEASURES GROUP OVERVIEW

### 2011 PHYSICIAN QUALITY REPORTING OPTIONS FOR MEASURES GROUPS: CLAIMS, REGISTRY

#### 2011 PHYSICIAN QUALITY REPORTING MEASURES IN ASTHMA MEASURES GROUP:

- #53. Asthma: Pharmacologic Therapy
- #64. Asthma: Asthma Assessment
- #231. Asthma: Tobacco Use: Screening - Ambulatory Care Setting
- #232. Asthma: Tobacco Use: Intervention - Ambulatory Care Setting

#### INSTRUCTIONS FOR REPORTING: (These instructions apply to both Claims and Registry reporting, unless otherwise specified.)

- Indicate your intention to report the Asthma Measures Group by submitting the measures group-specific intent G-code at least once during the reporting period when billing a patient claim for both the 30 Patient Sample and the 50% Patient Sample Methods. It is not necessary to submit the measures group-specific intent G-code on more than one claim. It is not necessary to submit the measures group-specific intent G-code for registry-based submissions.

**G8645:** I intend to report the Asthma Measures Group

- Select patient sample method:  
**30 Patient Sample Method:** 30 unique Medicare Part B FFS (fee for service) patients meeting patient sample criteria for the measures group.  
**OR**  
**50% Patient Sample Method via Claims or 80% Patient Sample Method via Registry:** All patients meeting patient sample criteria for the measure group during the entire reporting period (January 1 through December 31, 2011 **OR** July 1 through December 31, 2011). For the 12-month reporting period, a minimum of 15 Medicare Part B FFS patients must meet the measures group patient sample criteria to report satisfactory. For the 6-month reporting period, a minimum of 8 Medicare Part B FFS patients must meet the measures group patient sample criteria to report satisfactory.

- Patient sample criteria for the Asthma Measures Group are patients aged 5 through 50 years with a specific diagnosis of Asthma accompanied by a specific patient encounter:

**The following diagnosis codes indicating Asthma:** 493.00, 493.02, 493.10, 493.12, 493.20, 493.22, 493.82, 493.90, 493.92

**Accompanied by**

**One of the following patient encounter codes:** 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215

- Report quality-data codes on all measures within the Asthma Measures Group for each patient within the eligible professional's patient sample.
- Instructions for quality-data code reporting for each of the measures within the Asthma Measures Group are displayed on the next several pages. If all quality actions for the patient have been performed for all measures within the group, the following composite G-code may be reported in lieu of the individual quality-data codes for each of the measures within the



## ***SPECIFICATION FOR MEASURES GROUP REPORTING ONLY***

group. It is not necessary to submit the following composite G-code for registry-based submissions.

**Composite G code G8646:** All quality actions for the applicable measures in the Asthma Measures Group have been performed for this patient

- To report satisfactorily for the Asthma Measures Group it requires **all** measures for each patient within the eligible professional's patient sample to be reported a minimum of once during the reporting period.
- When using the 30 Patient Sample Method, report all measures for the 30 Medicare Part B FFS patients seen. When using the 50% Patient Sample Method via Claims, report all measures on at least 50% of the patient sample for the eligible professional for the 12-month or 6-month reporting period. When using the 80% Patient Sample Method via Registry, report all measures on at least 80% of the patient sample for the eligible professional for the 12-month or 6-month reporting period.
- For claims-based submissions, the Carrier/MAC remittance advice notice sent to the practice will show a denial remark code (N365) for the line item on the claim containing G8546 (and G8550 if reported) as well as all other line items containing QDCs. N365 indicates that the code is not payable and is used for reporting/informational purposes only. Other services/codes on the claim will not be affected by the addition of a measures group-specific intent G-code or other QDCs. The N365 remark code does NOT indicate whether the QDC is accurate for that claim or for the measure the eligible professional is attempting to report, but does indicate that the QDC was processed and transmitted to the NCH.

*NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2011 Physician Quality Reporting Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS Physician Quality Reporting website.*

▲ Measure #53: Asthma: Pharmacologic Therapy

**DESCRIPTION:**

Percentage of patients aged 5 through 50 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

**NUMERATOR:**

Patients who were prescribed *either* the preferred long-term control medication (inhaled corticosteroid or inhaled corticosteroid with long-acting inhaled beta<sub>2</sub>-agonist) or an acceptable alternative treatment (leukotriene modifiers, cromolyn sodium, nedocromil sodium, or sustained-released methylxanthines)

**Numerator Instructions:** Documentation of persistent asthma must be present. One method of identifying persistent asthma is at least daily use of short-acting bronchodilators.

**Definition:**

**Prescribed** – May include prescription given to the patient for long-term control medication (inhaled corticosteroid or inhaled corticosteroid with long-acting inhaled beta<sub>2</sub>-agonist) or an acceptable alternative treatment (leukotriene modifiers, cromolyn sodium, nedocromil sodium, or sustained-released methylxanthines) at one or more visits in the 12-month period or patient already taking long-term control medication or an acceptable alternative treatment as documented in current medication list.

***NUMERATOR NOTE:*** *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.*

**Numerator Quality-Data Coding Options for Reporting Satisfactorily:**

**Preferred Long-Term Control Medication or Acceptable Alternative Treatment Prescribed**

*(Two CPT II codes [4015F & 1038F] are required on the claim form to submit this numerator option)*

**CPT II 4015F:** Persistent asthma, preferred long term control medication or acceptable alternative treatment prescribed

**AND**

**CPT II 1038F:** Persistent asthma (mild, moderate or severe)

**OR**

**SPECIFICATION FOR MEASURES GROUP REPORTING ONLY**

**Preferred Long-Term Control Medication or Acceptable Alternative Treatment not Prescribed for Patient Reasons**

*(Two CPT II codes [4015F-2P & 1038F] are required on the claim form to submit this numerator option)*

Append a modifier (2P) to CPT Category II code 4015F to report documented circumstances that appropriately exclude patients from the denominator.

**4015F with 2P:** Documentation of patient reason(s) for not prescribing either the preferred long-term control medication (inhaled corticosteroid or inhaled corticosteroid with long-acting inhaled beta2-agonist) or an acceptable alternative treatment (leukotriene modifiers, cromolyn sodium, nedocromil sodium, or sustained-released methylxanthines)

**AND**

**CPT II 1038F:** Persistent asthma (mild, moderate or severe)

**OR**

If patient is not eligible for this measure because patient does not have persistent asthma, report:

*(One CPT II code [1039F] is required on the claim form to submit this numerator option)*

**CPT II 1039F:** Intermittent asthma

**OR**

**Preferred Long-Term Control Medication or Acceptable Alternative Treatment not Prescribed, Reason not Specified**

*(Two CPT II codes [4015F-8P & 1038F] are required on the claim form to submit this numerator option)*

Append a reporting modifier (8P) to CPT Category II code 4015F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

**4015F with 8P:** Persistent asthma, preferred long term control medication or acceptable alternative treatment not prescribed, reason not otherwise specified

**AND**

**CPT II 1038F:** Persistent asthma (mild, moderate or severe)

*NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2011 Physician Quality Reporting Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS Physician Quality Reporting website.*

▲ Measure #64: Asthma: Asthma Assessment

**DESCRIPTION:**

Percentage of patients aged 5 through 50 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

**NUMERATOR:**

Patients who were evaluated during at least one office visit within 12 months for the frequency (numeric) of daytime and nocturnal asthma symptoms

**Numerator Instructions:** To be counted in calculation 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.

**Numerator Quality-Data Coding Options for Reporting Satisfactorily:**

**Asthma Symptom Frequency Evaluated**

**CPT II 1005F:** Asthma symptoms evaluated (includes physician documentation of numeric frequency of symptoms or patient completion of an asthma assessment tool/survey/questionnaire)

**OR**

**Asthma Symptom Frequency not Evaluated, Reason not Specified**

Append a reporting modifier (8P) to CPT Category II code 1005F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

**1005F with 8P:** *Asthma symptoms not evaluated, reason not otherwise specified*

*NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2011 Physician Quality Reporting Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS Physician Quality Reporting website.*

□ Measure #231: Asthma: Tobacco Use: Screening - Ambulatory Care Setting

**DESCRIPTION:**

Percentage of patients aged 5 through 50 years with a diagnosis of asthma who were queried about tobacco use and exposure to second hand smoke in their home environment at least once within 12 months

**NUMERATOR:**

Patients who were queried about tobacco use and exposure to second hand smoke in their home environment at least once within 12 months

**Numerator Instructions:** Information regarding tobacco exposure for patients under 18 obtained from a parent or guardian is valid for reporting the numerator. In order to meet the measure, there must be a note in the medical record documenting that the patient was queried about both smoking status AND exposure to environmental smoke in the home environment.

**NUMERATOR NOTE:** For the purpose of this measure, "tobacco user" refers to tobacco smokers and "tobacco non-user" refers to non-smokers (including non-smoker tobacco users e.g. chew, snuff).

**Numerator Quality-Data Coding Options for Reporting Satisfactorily:**

**Tobacco Use Assessed, Including Exposure to Secondhand Smoke**

**Current Tobacco Smoker OR Current Exposure to Secondhand Smoke**

**G8686: Currently a Tobacco Smoker OR Current Exposure to Secondhand Smoke**

**OR**

**Current Tobacco Non-User AND No Exposure to Secondhand Smoke**

**G8687: Currently a Tobacco Non-User AND No Exposure to Secondhand Smoke**

**OR**

**Tobacco Use not Assessed, Reason Not Specified**

**G8689: Tobacco Use not assessed, reason not otherwise specified**

*NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2011 Physician Quality Reporting Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS Physician Quality Reporting website.*

**SPECIFICATION FOR MEASURES GROUP REPORTING ONLY**

**□ Measure #232: Asthma: Tobacco Use: Intervention - Ambulatory Care Setting**

**DESCRIPTION:**

Percentage of patients aged 5 through 50 years with a diagnosis of asthma who were identified as tobacco users (patients who currently use tobacco AND patients who do not currently use tobacco, but are exposed to second hand smoke in their home environment) who received tobacco cessation intervention within 12 months

**NUMERATOR:**

Patients who received tobacco use cessation intervention

**Numerator Instructions:** Practitioners providing tobacco cessation interventions to a pediatric patient's primary caregiver are still numerator complaint even if the primary caregiver is not the source of second hand smoke in the home.

**Definitions:**

**Tobacco Users** – Tobacco users include patients who currently use tobacco AND patients who do not currently use tobacco, but are exposed to second hand smoke in their home environment.

**Tobacco Use Cessation Intervention** – May include brief counseling (3 minutes or less) and/or pharmacotherapy.

**NUMERATOR NOTE:** *For the purpose of this measure, "tobacco user" refers to tobacco smokers and "tobacco non-user" refers to non-smokers (including non-smoker tobacco users e.g. chew, snuff).*

**Numerator Quality-Data Coding Options for Reporting Satisfactorily:**

**Patients who Received Tobacco Use Cessation Intervention**

CPT II 4000F: Tobacco Use Cessation Intervention, Counseling

**OR**

CPT II 4001F: Tobacco Use Cessation Intervention, Pharmacologic Therapy

**AND**

**Current Tobacco Smoker OR Current Exposure to Secondhand Smoke**

**G8690: Current Tobacco Smoker OR Current Exposure to Secondhand Smoke**

**OR**

**If patient is not eligible for this measure because patient is a non tobacco user AND Has No Exposure to Secondhand Smoke, report:**

**G8691: Current Tobacco Non-User AND No Exposure to Secondhand Smoke**

**OR**

**Tobacco Use not Assessed, Reason Not Specified**

**G8693: Tobacco Use not assessed, reason not specified**

**OR**

***SPECIFICATION FOR MEASURES GROUP REPORTING ONLY***

**Tobacco Use Cessation Intervention not Performed, Reason Not Specified**

Append a reporting modifier (**8P**) to CPT Category II code **4000F OR 4001F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

**4000F with 8P:** Tobacco Use Cessation Intervention, Counseling, not performed, reason not otherwise specified

**OR**

**4001F with 8P:** Tobacco Use Cessation Intervention, Pharmacologic Therapy, not performed, reason not otherwise specified

**AND**



**Current Tobacco Smoker OR Current Exposure to Secondhand Smoke**

**G8690:** Current Tobacco Smoker OR Current Exposure to Secondhand Smoke

*NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2011 Physician Quality Reporting Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS Physician Quality Reporting website.*

## SPECIFICATION FOR MEASURES GROUP REPORTING ONLY

### Symbol and Copyright Information

 The following notice applies to each of the measures that contain an asterisk (  ) before the title:

Physician Performance Measures (Measures) and related data specifications, developed by the American Medical Association (AMA) in collaboration with the Physician Consortium for Performance Improvement (the Consortium) and the National Committee for Quality Assurance (NCQA) pursuant to government sponsorship under subcontract 6205-05-054 with Mathematica Policy Research, Inc. under contract 500-00-0033 with Centers for Medicare & Medicaid Services.

These performance Measures are not clinical guidelines and do not establish a standard of medical care, and have not been tested for all potential applications.

The Measures, while copyrighted, can be reproduced and distributed, without modification, for noncommercial purposes, e.g., use by health care providers in connection with their practices. Commercial use is defined as the sale, license, or distribution of the Measures for commercial gain, or incorporation of the Measures into a product or service that is sold, licensed or distributed for commercial gain. Commercial uses of the Measures require a license agreement between the user and the AMA, (on behalf of the Consortium) or NCQA. Neither the AMA, NCQA, Consortium nor its members shall be responsible for any use of the Measures.



**THE MEASURES AND SPECIFICATIONS ARE PROVIDED “AS IS” WITHOUT WARRANTY OF ANY KIND.**

© 2004-6 American Medical Association and National Committee for Quality Assurance. All Rights Reserved.

Limited proprietary coding is contained in the Measure specifications for convenience. Users of the proprietary code sets should obtain all necessary licenses from the owners of these code sets. The AMA, NCQA, the Consortium and its members disclaim all liability for use or accuracy of any Current Procedural Terminology (CPT®) or other coding contained in the specifications.

CPT® contained in the Measures specifications is copyright 2008 American Medical Association; G codes and associated descriptions included in these Measure specifications are in the public domain.

---

 The following notice applies to each of the measures that contain a triangle (  ) before the title:

Physician Performance Measures (Measures) and related data specifications, developed by the Physician Consortium for Performance Improvement® (the Consortium), are intended to facilitate quality improvement activities by physicians.

These Measures are intended to assist physicians in enhancing quality of care. Measures are designed for use by any physician who manages the care of a patient for a specific condition or for prevention. These performance Measures are not clinical guidelines and do not establish a standard of medical care. The Consortium has not tested its Measures for all potential applications. The Consortium encourages the testing and evaluation of its Measures.

Measures are subject to review and may be revised or rescinded at any time by the Consortium. The Measures may not be altered without the prior written approval of the Consortium. Measures developed by the Consortium, while copyrighted, can be reproduced and distributed, without modification, for noncommercial purposes, e.g., use by health care providers in connection with their practices. Commercial use is defined as the sale, license, or distribution of the Measures for commercial gain, or incorporation of the Measures into a product or service that is sold, licensed or distributed for commercial gain. Commercial uses of the Measures require a license agreement between the user and American Medical Association, on behalf of the Consortium. Neither the Consortium nor its members shall be responsible for any use of these Measures.

**THE MEASURES ARE PROVIDED "AS IS" WITHOUT WARRANTY OF ANY KIND.**

© 2007 American Medical Association. All Rights Reserved

Limited proprietary coding is contained in the Measure specifications for convenience. Users of the proprietary code sets should obtain all necessary licenses from the owners of these code sets. The AMA, the Consortium and its members disclaim all liability for use or accuracy of any Current Procedural Terminology (CPT®) or other coding contained in the specifications.

**THE SPECIFICATIONS ARE PROVIDED “AS IS” WITHOUT WARRANTY OF ANY KIND.**

CPT® contained in the Measures specifications is copyright 2008 American Medical Association.



## SPECIFICATION FOR MEASURES GROUP REPORTING ONLY

---

◆ The following notice applies to each of the measures that contain a diamond (◆) before the title:

NCQA Notice of Use. Broad public use and dissemination of these measures is encouraged and the measure developers have agreed with NQF that noncommercial uses do not require the consent of the measure developer. Use by health care providers in connection with their own practices is not commercial use. Commercial use of a measure does require the prior written consent of the measure developer. As used herein, a "commercial use" refers to any sale, license, or distribution of a measure for commercial gain, or incorporation of a measure into any product or service that is sold, licensed, or distributed for commercial gain, (even if there is no actual charge for inclusion of the measure.)

These performance measures were developed and are owned by the National Committee for Quality Assurance ("NCQA"). These performance measures are not clinical guidelines and do not establish a standard of medical care. NCQA makes no representations, warranties, or endorsement about the quality of any organization or physician that uses or reports performance measures and NCQA has no liability to anyone who relies on such measures. NCQA holds a copyright in this measure and can rescind or alter this measure at any time. Users of the measure shall not have the right to alter, enhance, or otherwise modify the measure and shall not disassemble, recompile, or reverse engineer the source code or object code relating to the measure. Anyone desiring to use or reproduce the measure without modification for a noncommercial purpose may do so without obtaining any approval from NCQA. All commercial uses must be approved by NCQA and are subject to a license at the discretion of NCQA. ©2004 National Committee for Quality Assurance, all rights reserved.

Performance measures developed by NCQA for CMS may look different from the measures solely created and owned by NCQA.

---

♠ The following notice applies to each of the measures that contain a spade (♠) before the title:

These measures were developed by Quality Insights of Pennsylvania as a special project under the Quality Insights' Medicare Quality Improvement Organization (QIO) contract HHSM-500-2005-PA001C with the Centers for Medicare & Medicaid Services. These measures are in the public domain.

---

Ω The following notice applies to each of the measures that contain an Omega (Ω) before the title:  
These measures are owned by The Society of Thoracic Surgeons (STS).

---

⌘ Physician Performance Measures (Measures) and related data specifications developed by the American Medical Association (AMA) in collaboration with the Physician Consortium for Performance Improvement® (PCPI) and the National Committee for Quality Assurance (NCQA), pursuant to government sponsorship under Subcontract No. 6414-07-089 with Mathematica Policy Research under Contract HHSM-500-2005-000251(0004) with Centers for Medicare and Medicaid Services. These performance Measures are not clinical guidelines and do not establish a standard of medical care, and have not been tested for all potential applications.

The Measures, while copyrighted, can be reproduced and distributed, without modification, for noncommercial purposes, e.g., use by health care providers in connection with their practices. Commercial use is defined as the sale, license, or distribution of the Measures for commercial gain, or incorporation of the Measures into a product or service that is sold, licensed or distributed for commercial gain. Commercial uses of the Measures require a license agreement between the user and the AMA, (on behalf of the PCPI) or NCQA. Neither the AMA, NCQA, PCPI nor its members shall be responsible for any use of the Measures.

**THE MEASURES AND SPECIFICATIONS ARE PROVIDED "AS IS" WITHOUT WARRANTY OF ANY KIND.**

© 2008 American Medical Association and National Committee for Quality Assurance. All Rights Reserved. Limited proprietary coding is contained in the Measure specifications for convenience. Users of the proprietary code sets should obtain all necessary licenses from the owners of these code sets. The AMA, NCQA, the PCPI and its members disclaim all liability for use or accuracy of any Current Procedural Terminology (CPT®) or other coding contained in the specifications.

CPT® contained in the Measures specifications is copyright 2007 American Medical Association. LOINC® copyright 2004 Regenstrief Institute, Inc. SNOMED CLINICAL TERMS (SNOMED CT®) copyright 2004 College of American Pathologists (CAP). All Rights Reserved. Use of SNOMED CT® is only authorized within the United States.

---

## ***SPECIFICATION FOR MEASURES GROUP REPORTING ONLY***

☐ The following notice applies to each of the measures that contain a square (☐) before the title:

Physician Performance Measures (Measures) and related data specifications have been developed by the American Medical Association (AMA) in collaboration with the Physician Consortium for Performance Improvement<sup>TM</sup> (the Consortium) and the National Committee for Quality Assurance (NCQA).

These performance measures are not clinical guidelines and do not establish a standard of medical care, and have not been tested for all potential applications.

The Measures, while copyrighted, can be reproduced and distributed, without modification, for noncommercial purposes, e.g., use by health care providers in connection with their practices. Commercial use is defined as the sale, license, or distribution of the Measures for commercial gain, or incorporation of the Measures into a product or service that is sold, licensed or distributed for commercial gain. Commercial uses of the Measures require a license agreement between the user and American Medical Association, (on behalf of the Consortium) or NCQA. Neither the AMA, NCQA, Consortium nor its members shall be responsible for any use of the Measures.

**THE MEASURES AND SPECIFICATIONS ARE PROVIDED "AS IS" WITHOUT WARRANTY OF ANY KIND.**

© 2007 American Medical Association and National Committee for Quality Assurance. All Rights Reserved

Limited proprietary coding is contained in the Measure specifications for convenience. Users of the proprietary code sets should obtain all necessary licenses from the owners of these code sets. The AMA, the Consortium and its members disclaim all liability for use or accuracy of any Current Procedural Terminology (CPT<sup>®</sup>) or other coding contained in the specifications.

**THE SPECIFICATIONS ARE PROVIDED "AS IS" WITHOUT WARRANTY OF ANY KIND.**