

# 2012 Physician Quality Reporting System (Physician Quality Reporting) Measures Groups Specifications

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## 2012 Physician Quality Reporting System (Physician Quality Reporting) Measures Groups Specifications Manual

This manual contains specific guidance for reporting 2012 Physician Quality Reporting System (Physician Quality Reporting) Measures Groups. 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.

22 measures groups have been established for 2012 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), Asthma, Chronic Obstructive Pulmonary Disease (COPD), Inflammatory Bowel Disease (IBD), Sleep Apnea, Dementia, Parkinson's Disease, Hypertension, Cardiovascular Prevention and Cataracts. These 22 groups, combined, include measures established for use in the 2012 Physician Quality Reporting, as required by applicable statutes, through formal notice-and-comment rulemaking in 2011. 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 2012 Physician Quality Reporting measures groups: a) 12-month reporting period from January 1 through December 31, 2012 (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, 2012 (available only for 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. Measures groups containing a measure with a 0% performance rate will not be counted as satisfactorily reporting the measures group. Those eligible professionals who satisfactorily report quality data under the measures groups reporting option may earn an incentive payment equal to 0.5% 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 2012 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 0.5% 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 2012 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 2012 measures groups can be found in the *Getting Started with 2012 Physician Quality Reporting of Measures Groups* and *Physician Quality Reporting Made Simple - Reporting the Preventive Care Measures Group* at: [http://www.cms.gov/PQRS/30\\_EducationalResources.asp](http://www.cms.gov/PQRS/30_EducationalResources.asp).

### Measures Group Reporting via Claims and Registry:

Diabetes Mellitus (DM), Chronic Kidney Disease (CKD), Preventive Care, Rheumatoid Arthritis (RA), Perioperative Care, Back Pain, Hepatitis C, Ischemic Vascular Disease (IVD), Community Acquired

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Pneumonia (CAP), Asthma, Chronic Obstructive Pulmonary Disease (COPD) and Cardiovascular Prevention 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 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 (DM) 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 (RA) 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
- G8898: I intend to report the Chronic Obstructive Pulmonary Disease (COPD) Measures Group
- G8905: I intend to report the Cardiovascular Prevention Measures Group

### Measures Group Reporting via Registry-only:

The CABG, HF, CAD, HIV/AIDS, IBD, Sleep Apnea, Dementia, Parkinson's Disease, HTN, and Cataracts 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
- G8489: I intend to report the Coronary Artery Disease (CAD) Measures Group
- G8548: I intend to report the Heart Failure (HF) Measures Group
- G8491: I intend to report the HIV/AIDS Measures Group
- G8899: I intend to report the Inflammatory Bowel Disease (IBD) Measures Group
- G8900: I intend to report the Sleep Apnea Measures Group
- G8902: I intend to report the Dementia Measures Group
- G8903: I intend to report the Parkinson's Disease Measures Group
- G8904: I intend to report the Hypertension (HTN) Measures Group
- G8906: I intend to report the Cataracts 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

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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 2012 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 during the reporting period (January 1 through December 31, 2012), according to each measures group's reporting instructions contained within each group's overview section.
- Measures groups containing a measure with a 0% performance rate will not be counted as satisfactorily reporting the measures group.

OR

2) 50% Patient Sample Method via Claims or 80% Patient Sample Method via Registry – 12-month and 6-month reporting periods (only the registry method applies for the 6 month reporting period) 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, 2012) 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, 2012 OR July 1 through December 31, 2012) 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

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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.
- Measures groups containing a measure with a 0% performance rate will not be counted as satisfactorily reporting the measures group.

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 (e.g., 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.

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## DIABETES MELLITUS MEASURES GROUP OVERVIEW

### 2012 PHYSICIAN QUALITY REPORTING OPTIONS FOR MEASURES GROUPS: CLAIMS, REGISTRY

#### 2012 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 measures group during the entire reporting period (January 1 through December 31, 2012 **OR** July 1 through December 31, 2012). The 6-month reporting period is only applicable for the 80% Patient Sample Method via Registry. 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,

## *SPECIFICATION FOR MEASURES GROUP REPORTING ONLY*

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, 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 (QDCs) 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.
- Measures groups containing a measure with a 0% performance rate will not be counted as satisfactorily reporting the measures group. The recommended clinical quality action must be performed on at least one patient for each measure within the measures group reported by the eligible professional. When a lower rate indicates better performance, such as Measure #1, a 0% performance rate will be counted as satisfactorily reporting (100% performance rate would not be considered satisfactorily reporting). Performance exclusion quality data codes are not counted in the performance denominator. If the eligible professional submits all performance exclusion quality data codes, the performance rate would be 0/0 and would be considered satisfactorily reporting.
- 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 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.

## *SPECIFICATION FOR MEASURES GROUP REPORTING ONLY*

- 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 "2012 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 "2012 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  $\geq$  100 mg/dL

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

**OR**

CPT II 3050F: Most recent LDL-C  $\geq$  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 "2012 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 #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, Reason not Specified**

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 "2012 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 #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.

**Definition:**

**Automated Result** – Electronic system-based data that includes results generated from test or procedures. For administrative data collection automated/electronic results are necessary in order to show that the exam during the 12 months prior was negative for retinopathy.

**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 "2012 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 (e.g., 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 "2012 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 #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 "2012 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

### 2012 PHYSICIAN QUALITY REPORTING OPTIONS FOR MEASURES GROUPS: CLAIMS, REGISTRY

#### 2012 PHYSICIAN QUALITY REPORTING MEASURES IN THE CHRONIC KIDNEY DISEASE (CKD) MEASURES GROUP:

- #110. Preventive Care and Screening: Influenza Immunization
- #121. Adult Kidney Disease: Laboratory Testing (Lipid Profile)
- #122. Adult Kidney Disease: Blood Pressure Management
- #123. Adult Kidney Disease: Patients On Erythropoiesis-Stimulating Agents (ESA) - Hemoglobin Level > 12.0 g/dL

#### **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 measures group during the entire reporting period (January 1 through December 31, 2012 **OR** July 1 through December 31, 2012. The 6-month reporting period is only applicable for the 80% Patient Sample Method via Registry. 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 stage 3, 4 or 5 CKD:** 585.3, 585.4, 585.5

#### **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

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- Report quality-data codes (QDCs) 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.
- Measure #122 need only be reported when the patient also has the following diagnosis code indicating Proteinuria: 791.0.
- 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.
- Measure #110 need only be reported a minimum of once during the reporting period when the patient's visit included in the patient sample population is between January and March for the 2011-2012 influenza season **OR** between October and December for the 2012-2013 influenza season. When the patient's office visit is between April and September, Measure #110 is not applicable and will not affect the eligible provider's reporting or performance rate. Measure #110 need only be reported on patients 18 years and older.
- Measures groups containing a measure with a 0% performance rate will not be counted as satisfactorily reporting the measures group. The recommended clinical quality action must be performed on at least one patient for each measure within the measures group reported by the eligible professional. If a measure within a measures group is not applicable to a patient, the patient would not be counted in the performance denominator for that measure (e.g., Preventive Care Measures Group - Measure #39: Screening or Therapy for Osteoporosis for Women would not be applicable to male patients according to the patient sample criteria). If the measure is not applicable for all patients within the sample, the performance rate would be 0/0 and would be considered satisfactorily reporting. Performance exclusion quality data codes are not counted in the performance denominator. If the eligible professional submits all performance exclusion quality data codes, the performance rate would be 0/0 and would be considered satisfactorily reporting. When a lower rate indicates better performance, such as Measure #123, a 0% performance rate will be counted as satisfactorily reporting (100% performance rate would not be considered satisfactorily reporting).
- 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

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

Claims, report all measures on at least 50% of the patient sample for the eligible professional for the 12-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 "2012 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

**DESCRIPTION:**

Percentage of patients aged 6 months and older seen for a visit between October 1 and March 31 of the one-year measurement period who received an influenza immunization OR who reported previous receipt of an influenza immunization

**NUMERATOR:**

Patients who have received an influenza immunization OR who reported previous receipt of influenza immunization

**Numerator Instructions:**

- If reporting this measure between January 1, 2012 and March 31, 2012, G-code G8482 should be reported when the influenza immunization is ordered or administered to the patient during the months of September, October, November, December of 2011 or January, February, and March of 2012 for the flu season ending March 31, 2012.
- If reporting this measure between October 1, 2012 and December 31, 2012, G-code G8482 should be reported when the influenza immunization is ordered or administered to the patient during the months of September, October, November, and December of 2012 for the flu season ending March 31, 2013.
- Influenza immunizations administered during the month of September of a given flu season (either 2011-2012 flu season OR 2012-2013 flu season) can be reported when a visit occurs during the flu season (October 1 - March 31). In these cases, G8482 should be reported.

**Definition:**

**Previous Receipt** – May include: receipt of influenza immunization from another provider OR receipt of influenza immunization from same provider during a visit prior to October 1

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

**Influenza Immunization Administered**

**G8482:** Influenza immunization administered or previously received

**OR**

**Influenza Immunization not Administered for Documented Reasons**

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

**OR**

**Influenza Immunization Ordered or Recommended, but not Administered**

**G0919:** Influenza immunization ordered or recommended (to be given at alternate location or alternate provider); vaccine not available at time of visit

**OR**

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

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

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*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 "2012 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: Adult Kidney Disease: Laboratory Testing (Lipid Profile)**

**DESCRIPTION:**

Percentage of patients aged 18 years and older with a diagnosis of CKD (stage 3, 4 or 5, not receiving Renal Replacement Therapy [RRT]) who had a fasting lipid profile performed at least once within a 12-month period

**NUMERATOR:**

Patients who had a fasting lipid profile performed at least once within a 12-month period

**Definition:**

**RRT (Renal Replacement Therapy):** For the purposes of this measure, RRT includes hemodialysis, peritoneal dialysis, and kidney transplantation

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

**Fasting Lipid Profile Performed**

**G8725:** Fasting lipid profile performed (Triglycerides, LDL-C, HDL-C, and Total Cholesterol)

**OR**

**Fasting Lipid Profile not Performed, for Documented Reason**

**G8726:** Clinician has documented reason for not performing fasting lipid profile (e.g., patient declined, other patient reasons)

**OR**

**Fasting Lipid Profile not Performed, Reason not Specified**

**G8728:** Fasting 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 "2012 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 #122: Adult Kidney Disease: Blood Pressure Management**

**DESCRIPTION:**

Percentage of patient visits for those patients aged 18 years and older with a diagnosis of CKD (stage 3, 4 or 5, not receiving Renal Replacement Therapy [RRT]) and documented proteinuria with a blood pressure < 130/80 mmHg OR  $\geq$  130/80 mmHg with a documented plan of care

**NUMERATOR:**

Patient visits with blood pressure < 130/80 mmHg OR  $\geq$  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.

**Definitions:**

**Proteinuria:** > 300 mg of albumin in the urine per 24 hours OR albumin creatinine ratio (ACR) > 300 mcg/mg creatinine OR protein to creatinine ratio > 0.3 mg/mg creatinine

**Plan of Care:** A documented plan of care should include one or more of the following: recheck blood pressure within 90 days; initiate or alter pharmacologic therapy for blood pressure control; initiate or alter non-pharmacologic therapy (lifestyle changes) for blood pressure control; documented review of patient's home blood pressure log which indicates that patient's blood pressure is or is not well controlled

**RRT (Renal Replacement Therapy):** For the purposes of this measure, RRT includes hemodialysis, peritoneal dialysis, and kidney transplantation

**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  $\geq$  130 mmHg and/or Diastolic Blood Pressure  $\geq$  80 mmHg** (If either systolic blood pressure is  $\geq$  130 mmHg OR diastolic blood pressure is  $\geq$  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  $\geq$  130 mmHg and/or a diastolic measurement of  $\geq$  80 mmHg

**AND**

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

**OR**

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**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 "2012 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 #123: Adult Kidney Disease: Patients on Erythropoiesis-Stimulating Agent (ESA) Hemoglobin Level > 12.0 g/dL**

**DESCRIPTION:**

Percentage of calendar months within a 12-month period during which a hemoglobin level is measured for patients aged 18 years and older with a diagnosis of advanced CKD (stage 4 or 5, not receiving RRT) or ESRD (who are on hemodialysis or peritoneal dialysis) who are also receiving ESA therapy AND have a hemoglobin level > 12.0 g/dL

**NUMERATOR:**

Calendar months during which patients have a hemoglobin level > 12.0 g/dL

**Numerator Instructions:** The hemoglobin values used for this measure should be a most recent (last) hemoglobin value recorded for each calendar month

For performance, a lower rate indicates better performance/control.

**Definition:**

**RRT (Renal Replacement Therapy):** For the purposes of this measure, RRT includes hemodialysis, peritoneal dialysis, and kidney transplantation

**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:**

**Most Recent Hemoglobin level > 12.0 g/dL**

*(One Quality-Data code and one CPT II code [G0908 and 4171F] are required on the claim form to submit this numerator option)*

**G0908:** Most Recent\_Hemoglobin (Hgb) level > 12.0 g/dL

**AND**

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

**OR**

**Hemoglobin Level Measurement not Performed, Reason not Specified**

*(One Quality-Data code and one CPT II code [G0909 and 4171F] are required on the claim form to submit this numerator option)*

**G0909:** Hemoglobin level measurement not documented, reason not otherwise specified

**AND**

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

**OR**

**Documented Clinical Reason Patient is not Receiving Erythropoiesis-Stimulating Agent (ESA) Therapy, Patient is not Eligible**

*(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**

**SPECIFICATION FOR MEASURES GROUP REPORTING ONLY**

**Most Recent Hemoglobin Level  $\leq 12.0$  g/dL**

*(One Quality-Data code and one CPT II code [G0910 and 4171F] are required on the claim form to submit this numerator option)*

**G0910:** Most Recent Hemoglobin Level  $\leq 12.0$  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 "2012 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

### 2012 PHYSICIAN QUALITY REPORTING OPTIONS FOR MEASURES GROUPS: CLAIMS, REGISTRY

#### 2012 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
- #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 (January 1 through December 31, 2012 **OR** July 1 through December 31, 2012). The 6-month reporting period is only applicable for the 80% Patient Sample Method via Registry. 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



**SPECIFICATION FOR MEASURES GROUP REPORTING ONLY**

- Report quality-data codes (QDCs) 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 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.
- Measure #110 need only be reported a minimum of once during the reporting period when the patient's visit included in the patient sample population is between January and March for the 2011-2012 influenza season **OR** between October and December for the 2012-2013 influenza season. When the patient's office visit is between April and September, Measure #110 is not applicable and will not affect the eligible provider's reporting or performance rate.

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

- Measures groups containing a measure with a 0% performance rate will not be counted as satisfactorily reporting the measures group. The recommended clinical quality action must be performed on at least one patient for each measure within the measures group reported by the eligible professional. Performance exclusion quality data codes are not counted in the performance denominator. If the eligible professional submits all performance exclusion quality data codes, the performance rate would be 0/0 and would be considered satisfactorily reporting. If a measure within a measures group is not applicable to a patient, the patient would not be counted in the performance denominator for that measure (e.g., Preventive Care Measures Group - Measure #39: Screening or Therapy for Osteoporosis for Women would not be applicable to male patients according to the patient sample criteria). If the measure is not applicable for all patients within the sample, the performance rate would be 0/0 and would be considered satisfactorily reporting.
- 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 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 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 "2012 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 "2012 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 "2012 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

**DESCRIPTION:**

Percentage of patients aged 6 months and older seen for a visit between October 1 and March 31 of the one-year measurement period who received an influenza immunization OR who reported previous receipt of an influenza immunization

**NUMERATOR:**

Patients who have received an influenza immunization OR who reported previous receipt of influenza immunization

**Numerator Instructions:**

- If reporting this measure between January 1, 2012 and March 31, 2012, G-code G8482 should be reported when the influenza immunization is ordered or administered to the patient during the months of September, October, November, December of 2011 or January, February, and March of 2012 for the flu season ending March 31, 2012.
- If reporting this measure between October 1, 2012 and December 31, 2012, G-code G8482 should be reported when the influenza immunization is ordered or administered to the patient during the months of September, October, November, and December of 2012 for the flu season ending March 31, 2013.
- Influenza immunizations administered during the month of September of a given flu season (either 2011-2012 flu season OR 2012-2013 flu season) can be reported when a visit occurs during the flu season (October 1 - March 31). In these cases, G8482 should be reported.

**Definition:**

**Previous Receipt** – May include: receipt of influenza immunization from another provider OR receipt of influenza immunization from same provider during a visit prior to October 1

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

**Influenza Immunization Administered**

**G8482:** Influenza immunization administered or previously received

**OR**

**Influenza Immunization not Administered for Documented Reasons**

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

**OR**

**Influenza Immunization Ordered or Recommended, but not Administered**

**G0919:** Influenza immunization ordered or recommended (to be given at alternate location or alternate provider); vaccine not available at time of visit

**OR**

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

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

## SPECIFICATION FOR MEASURES GROUP REPORTING ONLY

*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 "2012 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 "2012 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 "2012 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 "2012 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 years and older BMI  $\geq 23$  and  $< 30$   
Age 18 – 64 years 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.

**Elderly BMI** – Most experts suggest use of a higher BMI threshold for underweight elderly individuals, compared to what is used for the general population. *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. 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 by an eligible professional or by their staff. Patient reported values 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, exercise counseling, nutrition counseling, 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 is pregnant
- 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
- If the 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 NOTE:** *The most recent quality code submitted will be used for performance calculation. The documentation of a follow-up plan should be based on the most recent calculated BMI.*

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

**BMI Calculated as Normal, No Follow-Up Plan Required**

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

**OR**

**BMI Calculated Above Upper Normal Parameters, Follow-Up Documented**

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

**OR**

**BMI Calculated Below Lower Normal Parameters, Follow-Up Documented**

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

**OR**

**BMI not Calculated, Patient not Eligible/not Appropriate**

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

**OR**

**BMI not Calculated, Reason not Specified**

**G8421:** BMI not calculated

**OR**

**BMI Calculated Outside Normal Parameters, Follow-Up Plan not Documented, Reason not Specified**

**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 "2012 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 #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 (e.g., 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 "2012 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 #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 NOTE:** In the event that a patient is screened for tobacco use and identified as a user but did not receive tobacco cessation counseling report 4004F with 8P.*

**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 (intervention, counseling, pharmacotherapy, or both), 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 (e.g., 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 "2012 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

### 2012 PHYSICIAN QUALITY REPORTING OPTIONS FOR MEASURES GROUPS: REGISTRY ONLY

#### 2012 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
- #165. Coronary Artery Bypass Graft (CABG): Deep Sternal Wound Infection Rate
- #166. Coronary Artery Bypass Graft (CABG): Stroke
- #167. Coronary Artery Bypass Graft (CABG): Postoperative Renal Failure
- #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): Anti-Lipid Treatment at Discharge

#### **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) procedures (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, 2012 **OR** July 1 through December 31, 2012). 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 #167 need only be reported when the patient does not have a history renal failure or a baseline serum creatinine  $\geq 4.0$  mg/dL. Measure #169, #170, and #171 need only be

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

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.

- Report a numerator option on **all applicable** measures within the CABG Measures Group for each procedure (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.
- Measures groups containing a measure with a 0% performance rate will not be counted as satisfactorily reporting the measures group. The recommended clinical quality action must be performed on at least one patient for each measure within the measures group reported by the eligible professional. Performance exclusion quality data codes are not counted in the performance denominator. If the eligible professional submits all performance exclusion quality data codes, the performance rate would be 0/0 and would be considered satisfactorily reporting. If a measure within a measures group is not applicable to a patient, the patient would not be counted in the performance denominator for that measure (e.g., Preventive Care Measures Group - Measure #39: Screening or Therapy for Osteoporosis for Women would not be applicable to male patients according to the patient sample criteria). If the measure is not applicable for all patients within the sample, the performance rate would be 0/0 and would be considered satisfactorily reporting. When a lower rate indicates better performance, such as Measure #164, a 0% performance rate will be counted as satisfactorily reporting (100% performance rate would not be considered satisfactorily reporting).
- When using the 30 Patient Sample Method, report all applicable measures for the 30 unique Medicare Part B FFS procedures performed (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 "2012 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 "2012 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 "2012 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 #164: Coronary Artery Bypass Graft (CABG): Prolonged Intubation**

**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 "2012 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 #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, within 30 days postoperatively, develop deep sternal wound infection (involving muscle, bone, and/or mediastinum requiring operative intervention)

**NUMERATOR:**

Patients who, within 30 days postoperatively, develop a deep sternal wound infection. Patient must have ALL of the following conditions: 1. wound opened with excision of tissue (incision and drainage) or re-exploration of mediastinum, 2. positive culture unless patient on antibiotics at time of culture or no culture obtained, and 3. treatment with antibiotics beyond perioperative prophylaxis

**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 "2012 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 #166: Coronary Artery Bypass Graft (CABG): Stroke**

**DESCRIPTION:**

Percentage of patients aged 18 years and older undergoing isolated CABG surgery who have a postoperative stroke (i.e., any confirmed neurological deficit of abrupt onset caused by a disturbance in blood supply to the brain) that did not resolve within 24 hours

**NUMERATOR:**

Patients who have a postoperative stroke (i.e., any confirmed neurological deficit of abrupt onset caused by a disturbance in blood supply to the brain) that did not resolve within 24 hours

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

**Numerator Options:**

Stroke following isolated CABG surgery (G8573)

**OR**

No stroke 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 "2012 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 #167: Coronary Artery Bypass Graft (CABG): Postoperative Renal Failure

**DESCRIPTION:**

Percentage of patients aged 18 years and older undergoing isolated CABG surgery (without pre-existing renal failure) who develop postoperative renal failure or require dialysis

**NUMERATOR:**

Patients who develop postoperative renal failure or require dialysis; (Definition of renal failure/dialysis requirement - patient had acute renal failure or worsening renal function resulting in one of the following: 1) increase of serum creatinine to  $\geq 4.0$  mg/dL, 2) 3x most recent preoperative creatinine level, or 3) a new requirement for dialysis postoperatively)

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

**Numerator Options:**

Developed postoperative renal failure or required dialysis (G8575)

**OR**

No postoperative renal failure/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 "2012 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) during the current hospitalization for mediastinal bleeding with or without tamponade, graft occlusion, valve dysfunction, or other cardiac reason

**NUMERATOR:**

Patients who require a return to the OR during the current hospitalization for mediastinal bleeding with or without tamponade, graft occlusion, valve dysfunction, or other cardiac reason

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

**Numerator Options:**

Reoperation required due to mediastinal bleeding with or without tamponade, graft occlusion, valve dysfunction, or other cardiac reason (G8577)

**OR**

Reoperation not required due to mediastinal bleeding with or without tamponade, graft occlusion, valve dysfunction, 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 "2012 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 were discharged on antiplatelet medication

**NUMERATOR:**

Patients who were discharged on antiplatelet medication

**Numerator Options:**

Antiplatelet medication at discharge (G8579)

**OR**

Antiplatelet medication contraindicated (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 "2012 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 #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 (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 "2012 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 #171: Coronary Artery Bypass Graft (CABG): Anti-Lipid Treatment at Discharge

**DESCRIPTION:**

Percentage of patients aged 18 years and older undergoing isolated CABG surgery who were discharged on a statin or other lipid-lowering regimen

**NUMERATOR:**

Patients who were discharged on a statin or other lipid-lowering regimen

**Numerator Options:**

Anti-lipid treatment at discharge (G8585)

**OR**

Anti-lipid treatment contraindicated (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 "2012 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 ARTHRITIS (RA) MEASURES GROUP OVERVIEW

### 2012 PHYSICIAN QUALITY REPORTING OPTIONS FOR MEASURES GROUPS: CLAIMS, REGISTRY

#### 2012 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, 2012 **OR** July 1 through December 31, 2012). The 6-month reporting period is only applicable for the 80% Patient Sample Method via Registry. 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 (QDCs) on **all** measures within the RA Measures Group for each patient within the eligible professional's patient sample.

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- 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 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.
- Measures groups containing a measure with a 0% performance rate will not be counted as satisfactorily reporting the measures group. The recommended clinical quality action must be performed on at least one patient for each measure within the measures group reported by the eligible professional. Performance exclusion quality data codes are not counted in the performance denominator. If the eligible professional submits all performance exclusion quality data codes, the performance rate would be 0/0 and would be considered satisfactorily reporting.
- 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 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 "2012 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 "2012 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 6 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

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**OR**

**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 "2012 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 "2012 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 “2012 Physician Quality Reporting Measure Specifications Manual for Claims and Registry Reporting of Individual Measures” available for download from the CMS Physician Quality Reporting website.*



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**⌘ 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), extra-articular 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 "2012 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

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**OR**

**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 "2012 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

### 2012 PHYSICIAN QUALITY REPORTING OPTIONS FOR MEASURES GROUPS: CLAIMS, REGISTRY

#### 2012 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) procedures (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, 2012 **OR** July 1 through December 31, 2012). The 6-month reporting period is only applicable for the 80% Patient Sample Method via Registry. 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,

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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, 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, 63075, 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 (QDCs) on **all** measures within the Perioperative Care Measures Group for each procedure (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.
- Measures groups containing a measure with a 0% performance rate will not be counted as satisfactorily reporting the measures group. The recommended clinical quality action must be performed on at least one patient for each measure within the measures group reported by the eligible professional. Performance exclusion quality data codes are not counted in the performance denominator. If the eligible professional submits all performance exclusion quality data codes, the performance rate would be 0/0 and would be considered satisfactorily reporting.

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

- When using the 30 Patient Sample Method, report all measures for 30 unique Medicare Part B FFS procedures performed (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 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 "2012 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 #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.*

|                        |                     |                 |
|------------------------|---------------------|-----------------|
| • Ampicillin/sulbactam | • Cefuroxime        | • Gentamicin    |
| • Aztreonam            | • Ciprofloxacin     | • Levofloxacin  |
| • Cefazolin            | • Clindamycin       | • Metronidazole |
| • Cefmetazole          | • Ertapenem         | • Moxifloxacin  |
| • Cefotetan            | • Erythromycin base | • Neomycin      |
| • Cefoxitin            | • Gatifloxacin      | • Vancomycin    |

**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 "2012 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 "2012 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

**SPECIFICATION FOR MEASURES GROUP REPORTING ONLY**

**AND**

**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 "2012 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 "2012 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

### 2012 PHYSICIAN QUALITY REPORTING OPTIONS FOR MEASURES GROUPS: CLAIMS, REGISTRY

#### 2012 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, 2012 **OR** July 1 through December 31, 2012). The 6-month reporting period is only applicable for the 80% Patient Sample Method via Registry. 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

**SPECIFICATION FOR MEASURES GROUP REPORTING ONLY**

**Accompanied by**

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

**OR**

**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 (QDCs) 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.

## *SPECIFICATION FOR MEASURES GROUP REPORTING ONLY*

- Measures groups containing a measure with a 0% performance rate will not be counted as satisfactorily reporting the measures group. The recommended clinical quality action must be performed on at least one patient for each measure within the measures group reported by the eligible professional.
  
- 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 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 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 "2012 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
- Getting up from bed or a chair



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

**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 care physician and a specialist, both visits are considered the initial visit with that clinician.

**SPECIFICATION FOR MEASURES GROUP REPORTING ONLY**

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 "2012 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 4 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 "2012 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 #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 4 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 "2012 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 #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 4 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 "2012 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

### 2012 PHYSICIAN QUALITY REPORTING OPTIONS FOR MEASURES GROUPS: CLAIMS, REGISTRY

#### 2012 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, 2012 **OR** July 1 through December 31, 2012). The 6-month reporting period is only applicable for the 80% Patient Sample Method via Registry. 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 codes indicating chronic hepatitis C: 070.54**

## SPECIFICATION FOR MEASURES GROUP REPORTING ONLY

### Accompanied by

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

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

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.
- Measures groups containing a measure with a 0% performance rate will not be counted as satisfactorily reporting the measures group. The recommended clinical quality action must be performed on at least one patient for each measure within the measures group reported by the eligible professional. Performance exclusion quality data codes are not counted in the performance denominator. If the eligible professional submits all performance exclusion quality data codes, the performance rate would be 0/0 and would be considered satisfactorily reporting. If a measure within a measures group is not applicable to a patient, the patient would not be counted in the performance denominator for that measure (e.g., Preventive Care Measures Group - Measure #39: Screening or Therapy for Osteoporosis for Women would not be applicable to male patients according to the patient sample criteria). If the measure is not applicable for all patients within the sample, the performance rate would be 0/0 and would be considered satisfactorily reporting.



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

- 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 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 "2012 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 (e.g., 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**

**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.

**SPECIFICATION FOR MEASURES GROUP REPORTING ONLY**

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 "2012 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 "2012 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 #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 at a minimum peginterferon and ribavirin therapy within the 12-month reporting period

**NUMERATOR:**

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

**Definition:**

**Prescribed** – May include prescription given to the patient for at a minimum peginterferon and ribavirin therapy at one or more visits in the 12-month period OR patient already taking at a minimum peginterferon and ribavirin therapy as documented in current medication list (i.e., may include additional antiviral therapy, as appropriate).

**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 (e.g., 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 (e.g., patient declined).

**4153F with 3P:** Documentation of system reason(s) for not prescribing peginterferon and ribavirin therapy within 12 month reporting period (e.g., 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 "2012 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 no greater than 12 weeks from the initiation of antiviral treatment

**NUMERATOR:**

Patients for whom quantitative HCV RNA testing was performed at no greater than 12 weeks from the initiation of antiviral treatment

**Definition:**

**12 Weeks from Initiation** – Patients for whom testing was performed between 4-12 weeks from the initiation of antiviral treatment will meet the numerator for this measure (depending upon the specific antiviral therapy used).

**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 "2012 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 "2012 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 "2012 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 "2012 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 "2012 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

### 2012 PHYSICIAN QUALITY REPORTING OPTIONS FOR MEASURES GROUPS: REGISTRY ONLY

#### 2012 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 Ejection Fraction (LVEF) Assessment
- #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, 2012 **OR** July 1 through December 31, 2012). 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

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

- 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 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.
- Measures groups containing a measure with a 0% performance rate will not be counted as satisfactorily reporting the measures group. The recommended clinical quality action must be performed on at least one patient for each measure within the measures group reported by the eligible professional. Performance exclusion quality data codes are not counted in the performance denominator. If the eligible professional submits all performance exclusion quality data codes, the performance rate would be 0/0 and would be considered satisfactorily reporting.
- 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 "2012 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 (HF) with a current or prior left ventricular ejection fraction (LVEF) < 40% who were prescribed ACE inhibitor or ARB therapy either within a 12 month period when seen in the outpatient setting OR at each hospital discharge

**NUMERATOR:**

Patients who were prescribed ACE inhibitor or ARB therapy either within a 12 month period when seen in the outpatient setting or at hospital discharge

***NUMERATOR NOTE:** For purposes of the Heart Failure Measures Group, hospital discharge codes are not included as part of the common denominator. This measure should only be reported on those patients seen in the outpatient setting.*

**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. LVEF < 40% corresponds to qualitative documentation of moderate dysfunction or severe dysfunction.

**Definition:**

**Prescribed** – May include prescription given to the patient for ACE inhibitor or ARB therapy at one or more visits in the measurement period OR patient already taking ACE inhibitor or ARB therapy as documented in current medication list.

**Numerator Options:**

Angiotensin converting enzyme (ACE) inhibitor or angiotensin receptor blocker (ARB) therapy prescribed or currently being taken (4010F)

**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 (eg, hypotensive patients who are at immediate risk of cardiogenic shock, hospitalized patients who have experienced marked azotemia) (4010F *with* 1P)

**OR**

Documentation of patient reason(s) for not prescribing angiotensin converting enzyme (ACE) inhibitor or angiotensin receptor blocker (ARB) therapy (4010F *with* 2P)

**OR**

Documentation of system reason(s) for not prescribing angiotensin converting enzyme (ACE) inhibitor or angiotensin receptor blocker (ARB) therapy (4010F *with* 3P)

**SPECIFICATION FOR MEASURES GROUP REPORTING ONLY**

**AND**

Left ventricular ejection fraction (LVEF) < 40% or documentation of moderately or severely depressed left ventricular systolic function (3021F)

**OR**

Left ventricular ejection fraction (LVEF) ≥ 40% or documentation as normal or mildly depressed left ventricular systolic function (3022F)

**OR**

Left ventricular ejection fraction (LVEF) was **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 (4010F *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 "2012 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 (HF) with a current or prior left ventricular ejection fraction (LVEF) < 40% who were prescribed beta-blocker therapy either within a 12 month period when seen in the outpatient setting OR at each hospital discharge

**NUMERATOR:**

Patients who were prescribed beta-blocker therapy either within a 12 month period when seen in the outpatient setting or at each hospital discharge

***NUMERATOR NOTE:** For purposes of the Heart Failure Measures Group, hospital discharge codes are not included as part of the common denominator. This measure should only be reported on those patients seen in the outpatient setting.*

**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 dysfunction 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. LVEF < 40% corresponds to qualitative documentation of moderate dysfunction or severe left ventricular systolic dysfunction.

**Definitions:**

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

**Beta-blocker Therapy** – should include bisoprolol, carvedilol, or sustained release metoprolol succinate.

**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) ≥ 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**

**SPECIFICATION FOR MEASURES GROUP REPORTING ONLY**

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 "2012 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 Ejection Fraction (LVEF) Assessment

**DESCRIPTION:**

Percentage of patients aged 18 years and older with a diagnosis of heart failure for whom the quantitative or qualitative result (of a recent or prior [any time in the past] LVEF assessment) is documented within a 12 month period

**NUMERATOR:**

Patients for whom the quantitative or qualitative result (of a recent or prior [any time in the past] LVEF assessment) is documented within a 12 month period

**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.

**Instructions:** Documentation must include documentation in a progress note of the results of an LVEF assessment, regardless of when the evaluation of ejection fraction was performed.

**Definitions:**

**Qualitative results correspond to numeric equivalents as follows:**

- Hyperdynamic: corresponds to LVEF greater than 70%
- Normal: corresponds to LVEF 50% to 70% (midpoint 60%)
- Mild dysfunction: corresponds to LVEF 40% to 49% (midpoint 45%)
- Moderate dysfunction: corresponds to LVEF 30% to 39% (midpoint 35%)
- Severe dysfunction: corresponds to LVEF less than 30%

**Numerator Options:**

Left ventricular ejection fraction (LVEF) < 40% or documentation as normal or mildly depressed left ventricular systolic function (G8738)

OR

Left ventricular ejection fraction (LVEF) ≥ 40% or documentation of severely or moderately depressed left ventricular systolic function (G8739)

OR

Left ventricular ejection fraction (LVEF) not performed or assessed, reason not specified (G8740)

*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 "2012 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 #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 NOTE:** In the event that a patient is screened for tobacco use and identified as a user but did not receive tobacco cessation counseling report 4004F with 8P.*

**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 (intervention, counseling, pharmacotherapy, or both), 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 "2012 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

### 2012 PHYSICIAN QUALITY REPORTING OPTIONS FOR MEASURES GROUPS: REGISTRY ONLY

#### 2012 PHYSICIAN QUALITY REPORTING MEASURES IN CORONARY ARTERY DISEASE (CAD) MEASURES GROUP:

- #6. Coronary Artery Disease (CAD): Antiplatelet Therapy
- #196. Coronary Artery Disease (CAD): Symptom and Activity Assessment
- #197. Coronary Artery Disease (CAD): Lipid Control
- #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, 2012 **OR** July 1 through December 31, 2012). 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, 414.2, 414.3, 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

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

- 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 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.
- Measures groups containing a measure with a 0% performance rate will not be counted as satisfactorily reporting the measures group. The recommended clinical quality action must be performed on at least one patient for each measure within the measures group reported by the eligible professional. Performance exclusion quality data codes are not counted in the performance denominator. If the eligible professional submits all performance exclusion quality data codes, the performance rate would be 0/0 and would be considered satisfactorily reporting.
- 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 "2012 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): Antiplatelet Therapy

**DESCRIPTION:**

Percentage of patients aged 18 years and older with a diagnosis of coronary artery disease seen within a 12 month period who were prescribed aspirin or clopidogrel

**NUMERATOR:**

Patients who were prescribed aspirin or clopidogrel

**Definition:**

**Prescribed** – May include prescription given to the patient for aspirin or clopidogrel at one or more visits in the measurement period OR patient already taking aspirin or clopidogrel as documented in current medication list.

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

**Aspirin or Clopidogrel Prescribed**

CPT II 4086F: Aspirin or clopidogrel prescribed

**OR**

**Aspirin or Clopidogrel not Prescribed for Medical, Patient, or System Reasons**

Append a modifier (1P, 2P or 3P) to Category II code 4086F to report documented circumstances that appropriately exclude patients from the denominator.

**4086F with 1P:** Documentation of medical reason(s) for not prescribing aspirin or clopidogrel (e.g., allergy, intolerance, receiving other thienopyridine therapy, receiving warfarin therapy, bleeding coagulation disorders, other medical reasons)

**4086F with 2P:** Documentation of patient reason(s) for not prescribing aspirin or clopidogrel (e.g., patient declined, other patient reasons)

**4086F with 3P:** Documentation of system reason(s) for not prescribing aspirin or clopidogrel (e.g., lack of drug availability, other reasons attributable to the health care system)

**OR**

**Aspirin or Clopidogrel not Prescribed, Reason not Specified**

Append a reporting modifier (8P) to CPT Category II code 4086F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

**4086F with 8P:** Aspirin or clopidogrel 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 "2012 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 coronary artery disease seen within a 12 month period for whom there are documented results of an evaluation of level of activity AND an evaluation of presence or absence of anginal symptoms in the medical record

**NUMERATOR:**

Patients for whom there are documented results of an evaluation of level of activity AND an evaluation of presence or absence of anginal symptoms in the medical record

**Numerator Instructions:** Evaluation of level of activity and evaluation of presence or absence of anginal symptoms should include:

- Documented assessment of Canadian Cardiovascular Society (CCS) Angina Class OR
- Completion of a disease-specific questionnaire (e.g., Seattle Angina Questionnaire or other validated questionnaire) to quantify angina and level of activity

**Definition:** Canadian Cardiovascular Society (CCS) Angina Classification

Class 0: Asymptomatic

Class 1: Angina with strenuous exercise

Class 2: Angina with moderate exertion

Class 3: Angina with mild exertion

1. Walking 1-2 level blocks at normal pace

2. Climbing 1 flight of stairs at normal pace

Class 4: Angina at any level of physical exertion

**Numerator Options:**

Severity of angina assessed by level of activity (1010F)

**AND**

Angina present (1011F)

**OR**

Angina absent (1012F)

**OR**

Severity of angina by level of activity assessed **not** assessed, reason not specified (1010F 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 "2012 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): Lipid Control

**DESCRIPTION:**

Percentage of patients aged 18 years and older with a diagnosis of coronary artery disease seen within a 12 month period who have a LDL-C result < 100 mg/dL OR patients who have a LDL-C result  $\geq$  100 mg/dL and have a documented plan of care to achieve LDL-C < 100 mg/dL, including at a minimum the prescription of a statin

**NUMERATOR:**

Patients who have a LDL-C result < 100 mg/dL OR patients who have a LDL-C result  $\geq$  100 mg/dL AND have a documented plan of care to achieve LDL-C < 100 mg/dL, including at a minimum the prescription of a statin

**Numerator Instructions:** The first numerator option can be reported for patients who have a documented LDL-C < 100 mg/dL at any time during the measurement period (if more than one result, report most current)

**Definitions:**

**Documented plan of care:** Includes the prescription of a statin and may also include: documentation of discussion of lifestyle modifications (diet, exercise) or scheduled re-assessment of LDL-C

**Prescribed:** May include prescription given to the patient for a statin at one or more visits within the measurement period OR patient already taking a statin as documented in current medication list

**Numerator Options:**

Most current LDL-C < 100 mg/dL (G8736)

OR

Most current LDL-C  $\geq$  100 mg/dL (G8737)

**AND**

Statin therapy prescribed or currently being taken (4013F)

**AND**

Plan of care to achieve lipid control documented (0556F)

**OR**

Most current LDL-C  $\geq$  100 mg/dL (G8737)

**AND**

Plan of care to achieve lipid control documented (0556F)

**AND**

Documentation of medical reason(s) for statin therapy not prescribed or currently being taken (e.g., allergy, intolerance to statin medication(s), other medical reasons) (4013F *with 1P*)

**OR**

Documentation of patient reason(s) for statin therapy not prescribed or currently being taken (e.g., patient declined, other patient reasons) (4013F *with 2P*)

**OR**

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Documentation of system reason(s) for statin therapy not prescribed or currently being taken (e.g., financial reasons, other system reasons) (4013F *with* 3P)

**OR**

Most current LDL-C  $\geq$  100 mg/dL (G8737)

**AND**

Statin therapy **not** prescribed or currently being taken, reason not specified (4013F *with* 8P)

**OR**

Most current LDL-C  $\geq$  100 mg/dL (G8737)

**AND**

Plan of care to achieve lipid control **not** documented (0556F *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 "2012 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 #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 NOTE:** In the event that a patient is screened for tobacco use and identified as a user but did not receive tobacco cessation counseling report 4004F with 8P.*

**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 (intervention, counseling, pharmacotherapy, or both), 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 (e.g., 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 "2012 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

### 2012 PHYSICIAN QUALITY REPORTING OPTIONS FOR MEASURES GROUPS: CLAIMS, REGISTRY

#### 2012 PHYSICIAN QUALITY REPORTING MEASURES IN ISCHEMIC VASCULAR DISEASE (IVD) MEASURES GROUP:

- #201. Ischemic Vascular Disease (IVD): Blood Pressure Management Control
- #204. Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic
- #226. Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention
- #241. Ischemic Vascular Disease (IVD): Complete Lipid Panel and Low Density Lipoprotein (LDL-C) Control

#### 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, 2012 **OR** July 1 through December 31, 2012). The 6-month reporting period is only applicable for the 80% Patient Sample Method via Registry. 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, 414.2, 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,

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440.21, 440.22, 440.23, 440.24, 440.29, 440.4, 444.01, 444.09, 444.1, 444.21, 444.22, 444.81, 444.89, 444.9, 445.01, 445.02, 445.81, 445.89

**Accompanied by**

**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 (QDCs) 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.
- Measures groups containing a measure with a 0% performance rate will not be counted as satisfactorily reporting the measures group. The recommended clinical quality action must be performed on at least one patient for each measure within the measures group reported by the eligible professional. Performance exclusion quality data codes are not counted in the performance denominator. If the eligible professional submits all performance exclusion quality data codes, the performance rate would be 0/0 and would be considered satisfactorily reporting.

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

- 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 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 "2012 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 #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 "2012 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 "2012 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 #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 NOTE:** In the event that a patient is screened for tobacco use and identified as a user but did not receive tobacco cessation counseling report 4004F with 8P.*

**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 (intervention, counseling, pharmacotherapy, or both), 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 "2012 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 #241: Ischemic Vascular Disease (IVD): Complete Lipid Panel and Low Density Lipoprotein (LDL-C) Control

**DESCRIPTION:**

Percentage of patients aged 18 years and older with Ischemic Vascular Disease (IVD) who received at least one lipid profile within 12 months and whose most recent LDL-C level was in control (less than 100 mg/dL)

**NUMERATOR:**

Patients who received at least one lipid profile (or ALL component tests) with most recent LDL-C < 100 mg/dL

**NUMERATOR NOTE:**

*The performance period for this measure is 12 months from the date of service.*

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

**Lipid Profile Performed and Most Recent LDL-C < 100 mg/dL**

**G8593:** Lipid panel 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.*

**AND**

**G8595:** Most recent LDL-C < 100 mg/dL

**OR**

**Lipid Profile not Performed, Reason not Specified**

**G8594:** Lipid profile not performed, reason not otherwise specified

**OR**

**Most Recent LDL-C ≥ 100 mg/dL**

**G8593:** Lipid panel results documented and reviewed (must include total cholesterol, HDL-C, triglycerides and calculated LDL-C)

**AND**

**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 "2012 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

### 2012 PHYSICIAN QUALITY REPORTING OPTIONS FOR MEASURES GROUPS: REGISTRY ONLY

#### 2012 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, 2012 **OR** July 1 through December 31, 2012). 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.

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

- 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 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.
- Measures groups containing a measure with a 0% performance rate will not be counted as satisfactorily reporting the measures group. The recommended clinical quality action must be performed on at least one patient for each measure within the measures group reported by the eligible professional. Performance exclusion quality data codes are not counted in the performance denominator. If the eligible professional submits all performance exclusion quality data codes, the performance rate would be 0/0 and would be considered satisfactorily reporting.
- 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 "2012 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 #159: HIV/AIDS: CD4+ Cell Count or CD4+ Percentage**

**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 "2012 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 "2012 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 [Aids.gov](http://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 "2012 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 [Aids.gov](http://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 "2012 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 "2012 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 "2012 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 "2012 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 #208: HIV/AIDS: Sexually Transmitted Disease Screening for Syphilis**

**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 "2012 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

### 2012 PHYSICIAN QUALITY REPORTING OPTIONS FOR MEASURES GROUPS: CLAIMS, REGISTRY

#### 2012 PHYSICIAN QUALITY REPORTING MEASURES IN COMMUNITY-ACQUIRED PNEUMONIA (CAP) MEASURES GROUP:

- #56. Emergency Medicine: Community-Acquired Pneumonia (CAP): Vital Signs
- #57. Emergency Medicine: Community-Acquired Pneumonia (CAP): Assessment of Oxygen Saturation
- #58. Emergency Medicine: Community-Acquired Pneumonia (CAP): Assessment of Mental Status
- #59. Emergency Medicine: 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) episodes (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, 2012 **OR** July 1 through December 31, 2012). The 6-month reporting period is only applicable for the 80% Patient Sample Method via Registry. 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

## SPECIFICATION FOR MEASURES GROUP REPORTING ONLY

*\*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 (QDCs) on **all** measures within the CAP Measures Group for each episode (patient) within the eligible professional's patient sample.
- 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.
- Measures groups containing a measure with a 0% performance rate will not be counted as satisfactorily reporting the measures group. The recommended clinical quality action must be performed on at least one patient for each measure within the measures group reported by the eligible professional. Performance exclusion quality data codes are not counted in the performance denominator. If the eligible professional submits all performance exclusion quality data codes, the performance rate would be 0/0 and would be considered satisfactorily reporting.
- When using the 30 Patient Sample Method, report all measures for the 30 Medicare episodes of CAP (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 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



## SPECIFICATION FOR MEASURES GROUP REPORTING ONLY

*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 "2012 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 #56: Emergency Medicine: 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 "2012 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 #57: Emergency Medicine: 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 "2012 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: Emergency Medicine: 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 "2012 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 #59: Emergency Medicine: 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 "2012 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

### 2012 PHYSICIAN QUALITY REPORTING OPTIONS FOR MEASURES GROUPS: CLAIMS, REGISTRY

#### 2012 PHYSICIAN QUALITY REPORTING MEASURES IN ASTHMA MEASURES GROUP:

- #53. Asthma: Pharmacologic Therapy for Persistent Asthma
- #64. Asthma: Assessment of Asthma Control
- #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, 2012 **OR** July 1 through December 31, 2012). The 6-month reporting period is only applicable for the 80% Patient Sample Method via Registry. 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 Asthma Measures Group are patients aged 5 through 50 years with a specific diagnosis of Asthma accompanied by a specific patient encounter: **One of the following diagnosis codes indicating asthma:** 493.00, 493.02, 493.10, 493.12, 493.20, 493.22, 493.81, 493.82, 493.90, 493.92

#### **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 (QDCs) on **all applicable** measures within the Asthma Measures Group for each patient within the sample.

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

- 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 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 G8646:** All quality actions for the applicable measures in the Asthma Measures Group have been performed for this patient

- To report satisfactorily the Asthma 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.
- Measures groups containing a measure with a 0% performance rate will not be counted as satisfactorily reporting the measures group. The recommended clinical quality action must be performed on at least one patient for each measure within the measures group reported by the eligible professional. Performance exclusion quality data codes are not counted in the performance denominator. If the eligible professional submits all performance exclusion quality data codes, the performance rate would be 0/0 and would be considered satisfactorily reporting.
- 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 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 "2012 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 for Persistent Asthma**

**DESCRIPTION:**

Percentage of patients aged 5 through 50 years with a diagnosis of persistent asthma and at least one medical encounter for asthma during the measurement year who were prescribed long-term control medication

**NUMERATOR:**

Patients who were prescribed long-term control medication

**Numerator Instructions:** Documentation of persistent asthma must be present. One method of identifying persistent asthma is at least daily use of short-acting bronchodilators.

**Definitions:**

**Long Term Control Medication Includes:**

Patients prescribed inhaled corticosteroids (the preferred long-term control medication at any step of asthma pharmacological therapy)

**OR**

Patients prescribed alternative long-term control medications (inhaled steroid combinations, anti-asthmatic combinations, antibody inhibitor, leukotriene modifiers, mast cell stabilizers, methylxanthines, long-acting inhaled beta-2 agonists, short-acting inhaled beta-2 agonists)

**Prescribed** – May include prescription given to the patient for inhaled corticosteroid OR an acceptable alternative long-term control medication at one or more visits in the 12-month period OR patient already taking inhaled corticosteroid OR an acceptable alternative long-term control medication 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:**

**Long-Term Control Medication or Acceptable Alternative Treatment Prescribed**

*(Two CPT II codes [414XF & 1038F] are required on the claim form to submit this numerator option)*

CPT II 4140F: Inhaled corticosteroids prescribed

**OR**

CPT II 4144F: Alternative long-term control medication prescribed

**AND**

CPT II 1038F: Persistent asthma (mild, moderate or severe)

**OR**

**Long-Term Control Medication or Acceptable Alternative Treatment not Prescribed for Patient Reasons**

*(Two CPT II codes [4140F-2P & 1038F] are required on the claim form to submit this numerator option)*

Append a modifier (2P) to CPT Category II code 4140F to report documented circumstances that appropriately exclude patients from the denominator.



**SPECIFICATION FOR MEASURES GROUP REPORTING ONLY**

**4140F with 2P:** Documentation of patient reason(s) for not prescribing inhaled corticosteroids

**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**

**Long-Term Control Medication or Acceptable Alternative Treatment not Prescribed, Reason not Specified**

*(Two CPT II codes [4140F-8P & 1038F] are required on the claim form to submit this numerator option)*

Append a reporting modifier (**8P**) to CPT Category II code **4140F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

**4140F with 8P:** Inhaled corticosteroids **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 "2012 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 #64: Asthma: Assessment of Asthma Control**

**DESCRIPTION:**

Percentage of patients aged 5 through 50 years with a diagnosis of asthma who were evaluated at least once for asthma control (comprising asthma impairment and asthma risk)

**NUMERATOR:**

Patients who were evaluated during at least once for asthma control

**Definition:**

**Evaluation of Asthma Control** - Documentation of an evaluation of asthma impairment which must include: daytime symptoms AND nighttime awakenings AND interference with normal activity AND short-acting beta<sub>2</sub>-agonist use for symptom control.

**AND**

Documentation of asthma risk which must include the number of asthma exacerbations requiring oral systemic corticosteroids in the prior 12 months

**Numerator Instructions:** Completion of a validated questionnaire will also meet the numerator requirement for this component of the measure. Validated questionnaires for asthma assessment include, but are not limited to the Asthma Therapy Assessment Questionnaire [ATAQ], the Asthma Control Questionnaire [ACQ], or the Asthma Control Test [ACT]

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

**Asthma Control Evaluated**

CPT II 2015F: Asthma impairment assessed

**AND**

CPT II 2016F: Asthma risk assessed

**OR**

**Asthma Control not Evaluated, Reason not Specified**

Append a reporting modifier (**8P**) to CPT Category II code **2015F** or **2016F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

**2015F with 8P:** Asthma impairment **not** assessed, reason not otherwise specified

**OR**

**2016F with 8P:** Asthma risk **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 "2012 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 (or their primary caregiver) aged 5 through 50 years with a diagnosis of asthma who were queried about tobacco use and exposure to second hand smoke within their home environment at least once during the one-year measurement period

**NUMERATOR:**

Patients (or their primary caregiver) who were queried about tobacco use and exposure to second hand smoke in their home environment at least once

**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 smokeless tobacco users e.g., chew, snuff).

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

**Tobacco Use Assessed, Including Exposure to Secondhand Smoke**

CPT II 1031F: Smoking status and exposure to secondhand smoke in the home assessed

**OR**

**Tobacco Use, Including Exposure to Secondhand Smoke not Assessed, Reason Not Specified**

Append a reporting modifier (**8P**) to CPT Category II code **1031F** to report circumstances when the action described in the numerator is **not** performed and the reason is not otherwise specified.

**1031F with 8P:** Smoking status and exposure to secondhand smoke in the home **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 "2012 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 #232: Asthma: Tobacco Use: Intervention - Ambulatory Care Setting**

**DESCRIPTION:**

Percentage of patients (or their primary caregiver) 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 at least once during the one-year measurement period

**NUMERATOR:**

Patients (or their primary caregiver) who received tobacco use cessation intervention

**Numerator Instructions:** Practitioners providing tobacco cessation interventions to a pediatric patient's primary caregiver are still numerator compliant 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 smokeless tobacco users e.g., chew, snuff).

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

**Patients who Received Tobacco Use Cessation Intervention**

*(Two CPT II codes [400XF & 1032F] are required on the claim form to submit this numerator option)*

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**

CPT II 1032F: Current Tobacco Smoker OR Currently Exposed 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:**

*(One CPT II code [1033F] is required on the claim form to submit this numerator option)*

CPT II 1033F: Current Tobacco Non-Smoker AND Not Currently Exposed to Secondhand Smoke

**OR**

**SPECIFICATION FOR MEASURES GROUP REPORTING ONLY**

**Tobacco Use, not Assessed, Reason Not Specified**

*(One G-code [G8751] is required on the claim form to submit this numerator option)*

**G8751:** Smoking Status and exposure to secondhand smoke in the home not assessed, reason not specified

**OR**

**Tobacco Use Cessation Intervention not Performed, Reason Not Specified**

*(Two CPT II codes [400XF with 8P & 1032F] are required on the claim form to submit this numerator option)*

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 Currently Exposed to Secondhand Smoke**

*(One CPT II code [1032F] is required on the claim form to submit this numerator option)*

**CPT II 1032F:** Current Tobacco Smoker OR Currently Exposed 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 "2012 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 OBSTRUCTIVE PULMONARY DISEASE (COPD) MEASURES GROUP OVERVIEW

### 2012 PHYSICIAN QUALITY REPORTING OPTIONS FOR MEASURES GROUPS: CLAIMS, REGISTRY

#### 2012 PHYSICIAN QUALITY REPORTING MEASURES IN COPD MEASURES GROUP:

- #51. Chronic Obstructive Pulmonary Disease (COPD): Spirometry Evaluation
- #52. Chronic Obstructive Pulmonary Disease (COPD): Bronchodilator Therapy
- #110. Preventive Care and Screening: Influenza Immunization
- #111. Preventive Care and Screening: Pneumonia Vaccination for Patients 65 Years and Older
- #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 COPD 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.

**G8898:** I intend to report the COPD 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, 2012 **OR** July 1 through December 31, 2012). The 6-month reporting period is only applicable for the 80% Patient Sample Method via Registry. 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 COPD Measures Group are patients aged  $\geq 18$  years with a specific diagnosis of COPD accompanied by a specific patient encounter:

**One of the following diagnosis codes indicating COPD:** 491.0, 491.1, 491.20, 491.21, 491.22, 491.8, 491.9, 492.0, 492.8, 496

**Accompanied by**

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

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

- Report quality-data codes (QDCs) on **all applicable** measures within the COPD Measures Group for each patient within the eligible professional's patient sample.
- Measure #111 is only applicable for patients aged 65 years and older.
  
- Measure #110 need only be reported a minimum of once during the reporting period when the patient's visit included in the patient sample population is between January and March for the 2011-2012 influenza season **OR** between October and December for the 2012-2013 influenza season. When the patient's office visit is between April and September, Measure #110 is not applicable and will not affect the eligible provider's reporting or performance rate. Measure #110 need only be reported on patients 18 years and older.
  
- Instructions for quality-data code reporting for each of the measures within the COPD 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 G8757:** All quality actions for the applicable measures in the COPD Measures Group have been performed for this patient

- To report satisfactorily for the COPD 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.
  
- Measures groups containing a measure with a 0% performance rate will not be counted as satisfactorily reporting the measures group. The recommended clinical quality action must be performed on at least one patient for each measure within the measures group reported by the eligible professional. Performance exclusion quality data codes are not counted in the performance denominator. If the eligible professional submits all performance exclusion quality data codes, the performance rate would be 0/0 and would be considered satisfactorily reporting. If a measure within a measures group is not applicable to a patient, the patient would not be counted in the performance denominator for that measure (e.g., Preventive Care Measures Group - Measure #39: Screening or Therapy for Osteoporosis for Women would not be applicable to male patients according to the patient sample criteria). If the measure is not applicable for all patients within the sample, the performance rate would be 0/0 and would be considered satisfactorily reporting.
  
- 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 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.

## *SPECIFICATION FOR MEASURES GROUP REPORTING ONLY*

- 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 "2012 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 #51: Chronic Obstructive Pulmonary Disease (COPD): Spirometry Evaluation

**DESCRIPTION:**

Percentage of patients aged 18 years and older with a diagnosis of COPD who had spirometry evaluation results documented

**NUMERATOR:**

Patients with documented spirometry results in the medical record (FEV<sub>1</sub> and FEV<sub>1</sub>/FVC)

**Numerator Instructions:** Look for most recent documentation of spirometry evaluation results in the medical record; do not limit the search to the reporting period.

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

**Spirometry Results Documented**

CPT II 3023F: Spirometry results documented and reviewed

**OR**

**Spirometry Results not Documented for Medical, Patient, or System Reasons**

Append a modifier (1P, 2P or 3P) to CPT Category II code 3023F to report documented circumstances that appropriately exclude patients from the denominator.

**3023F with 1P:** Documentation of medical reason(s) for not documenting and reviewing spirometry results

**3023F with 2P:** Documentation of patient reason(s) for not documenting and reviewing spirometry results

**3023F with 3P:** Documentation of system reason(s) for not documenting and reviewing spirometry results

**OR**

**Spirometry Results not Documented, Reason not Specified**

Append a reporting modifier (8P) to CPT Category II code 3023F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

**3023F with 8P:** Spirometry 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 "2012 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 #52: Chronic Obstructive Pulmonary Disease (COPD) Bronchodilator Therapy

**DESCRIPTION:**

Percentage of patients aged 18 years and older with a diagnosis of COPD and who have an FEV<sub>1</sub>/FVC less than 70% and have symptoms who were prescribed an inhaled bronchodilator

**NUMERATOR:**

Patients who were prescribed an inhaled bronchodilator

**Definition:**

**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 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 Prescribed Inhaled Bronchodilator Therapy**

*(Two CPT II codes [4025F & 3025F] are required on the claim form to submit this numerator option)*

CPT II 4025F: Inhaled bronchodilator prescribed

**AND**

CPT II 3025F: Spirometry test results demonstrate FEV<sub>1</sub>/FVC < 70% with COPD symptoms (e.g., dyspnea, cough/sputum, wheezing)

**OR**

**Patient not Documented to have Inhaled Bronchodilator Prescribed for Medical, Patient, or System Reasons**

*(Two CPT II codes [4025F-~~X~~P & 3025F] are required on the claim form to submit this numerator option)*

Append a modifier (1P, 2P or 3P) to CPT Category II code 4025F to report documented circumstances that appropriately exclude patients from the denominator.

**4025F with 1P:** Documentation of medical reason(s) for not prescribing an inhaled bronchodilator

**4025F with 2P:** Documentation of patient reason(s) for not prescribing an inhaled bronchodilator

**4025F with 3P:** Documentation of system reason(s) for not prescribing an inhaled bronchodilator

**AND**

CPT II 3025F: Spirometry test results demonstrate FEV<sub>1</sub>/FVC < 70% with COPD symptoms (e.g., dyspnea, cough/sputum, wheezing)

**OR**

**If patient is not eligible for this measure because spirometry results demonstrate FEV<sub>1</sub>/FVC ≥ 70% or patient does not have COPD symptoms, report:**

**Spirometry Results Demonstrate FEV<sub>1</sub>/FVC ≥ 70% or Patient Does not Have COPD Symptoms**

**SPECIFICATION FOR MEASURES GROUP REPORTING ONLY**

*(One CPT II code [3027F] is required on the claim form to submit this numerator option)*  
**CPT II 3027F:** Spirometry test results demonstrate  $FEV_1/FVC \geq 70\%$  or patient does not have COPD symptoms

**OR**

**Spirometry Test not Performed or Documented**

*(One CPT II code [3025F-8P] is required on the claim form to submit this numerator option)*

Append a reporting modifier (**8P**) to CPT Category II code **3025F** to report circumstances when the patient is not eligible for the measure.

**3025F with 8P:** Spirometry test not performed or documented

**OR**

**Patient not Documented to have Inhaled Bronchodilator Prescribed, Reason not Specified**

*(Two CPT II codes [4025F-8P & 3025F] are required on the claim form to submit this numerator option)*

Append a reporting modifier (**8P**) to CPT Category II code **4025F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

**4025F with 8P:** Inhaled bronchodilator not prescribed, reason not otherwise specified

**AND**

**CPT II 3025F:** Spirometry test results demonstrate  $FEV_1/FVC < 70\%$  with COPD symptoms (e.g., dyspnea, cough/sputum, wheezing)

*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 "2012 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

**DESCRIPTION:**

Percentage of patients aged 6 months and older seen for a visit between October 1 and March 31 of the one-year measurement period who received an influenza immunization OR who reported previous receipt of an influenza immunization

**NUMERATOR:**

Patients who have received an influenza immunization OR who reported previous receipt of influenza immunization

**Numerator Instructions:**

- If reporting this measure between January 1, 2012 and March 31, 2012, G-code G8482 should be reported when the influenza immunization is ordered or administered to the patient during the months of September, October, November, December of 2011 or January, February, and March of 2012 for the flu season ending March 31, 2012.
- If reporting this measure between October 1, 2012 and December 31, 2012, G-code G8482 should be reported when the influenza immunization is ordered or administered to the patient during the months of September, October, November, and December of 2012 for the flu season ending March 31, 2013.
- Influenza immunizations administered during the month of September of a given flu season (either 2011-2012 flu season OR 2012-2013 flu season) can be reported when a visit occurs during the flu season (October 1 - March 31). In these cases, G8482 should be reported.

**Definition:**

**Previous Receipt** – May include: receipt of influenza immunization from another provider OR receipt of influenza immunization from same provider during a visit prior to October 1

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

**Influenza Immunization Administered**

G8482: Influenza immunization administered or previously received

**OR**

**Influenza Immunization not Administered for Documented Reasons**

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

**OR**

**Influenza Immunization Ordered or Recommended, but not Administered**

G0919: Influenza immunization ordered or recommended (to be given at alternate location or alternate provider); vaccine not available at time of visit

**OR**

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

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

## SPECIFICATION FOR MEASURES GROUP REPORTING ONLY

*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 "2012 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 "2012 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 #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 NOTE:** *In the event that a patient is screened for tobacco use and identified as a user but did not receive tobacco cessation counseling report 4004F with 8P.*

**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 (intervention, counseling, pharmacotherapy, or both), 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 (e.g., 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 "2012 Physician Quality Reporting Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS Physician Quality Reporting website.*

## INFLAMMATORY BOWEL DISEASE (IBD) MEASURES GROUP OVERVIEW

### 2012 PHYSICIAN QUALITY REPORTING OPTIONS FOR MEASURES GROUPS: REGISTRY ONLY

#### 2012 PHYSICIAN QUALITY REPORTING MEASURES IN INFLAMMATORY BOWEL DISEASE (IBD) MEASURES GROUP:

- #269. Inflammatory Bowel Disease (IBD): Type, Anatomic Location and Activity all Documented
- #270. Inflammatory Bowel Disease (IBD): Preventive Care: Corticosteroid Sparing Therapy
- #271. Inflammatory Bowel Disease (IBD): Preventive Care: Corticosteroid Related Iatrogenic Injury – Bone Loss Assessment
- #272. Inflammatory Bowel Disease (IBD): Preventive Care: Influenza Immunization
- #273. Inflammatory Bowel Disease (IBD): Preventive Care: Pneumococcal Immunization
- #274. Inflammatory Bowel Disease (IBD): Testing for Latent Tuberculosis (TB) Before Initiating Anti-TNF (Tumor Necrosis Factor) Therapy
- #275. Inflammatory Bowel Disease (IBD): Assessment of Hepatitis B Virus (HBV) Status Before Initiating Anti-TNF (Tumor Necrosis Factor) Therapy
- #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.

**G8899:** I intend to report the Inflammatory Bowel Disease (IBD) 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, 2012 **OR** July 1 through December 31, 2012). 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 IBD Measures Group are patients aged 18 years and older with a specific diagnosis of IBD accompanied by a specific patient encounter:

**One of the following diagnosis codes indicating IBD:** 555.0, 555.1, 555.2, 555.9, 556.0, 556.1, 556.2, 556.3, 556.4, 556.5, 556.6, 556.8, 556.9

#### **Accompanied by**

**One of the following patient encounter codes:** 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99401, 99402, 99403, 99404, 99406, 99407



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

- Report a numerator option on **all** measures within the IBD 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 IBD 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 G8758:** All quality actions for the applicable measures in the Inflammatory Bowel Disease (IBD) Measures Group have been performed for this patient

- To report satisfactorily the IBD 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.
- Measures groups containing a measure with a 0% performance rate will not be counted as satisfactorily reporting the measures group. The recommended clinical quality action must be performed on at least one patient for each measure within the measures group reported by the eligible professional. Performance exclusion quality data codes are not counted in the performance denominator. If the eligible professional submits all performance exclusion quality data codes, the performance rate would be 0/0 and would be considered satisfactorily reporting.
- 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 "2012 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 #269: Inflammatory Bowel Disease (IBD): Type, Anatomic Location and Activity  
All Documented**

**DESCRIPTION:**

Percentage of patients aged 18 years and older with a diagnosis of inflammatory bowel disease who have documented the disease type, anatomic location and activity, at least once during the reporting year

**NUMERATOR:**

Patients who were assessed for disease type and anatomic location and activity

**Numerator Instructions:** Patients are considered to have appropriate documentation of inflammatory bowel disease type, anatomic location, and activity if all of the following are documented:

- a. Type of inflammatory bowel disease (Crohn's, ulcerative colitis or IBD-unclassified)
- b. Anatomic location of disease based on current or historic endoscopic and/or radiologic data (Note: this element does not prescribe frequency of studies).
- c. Luminal disease activity (quiescent, mild, moderate, severe) and presence of extraintestinal manifestations

**Numerator Options:**

Type, anatomic location, and activity all documented (G0920)

**OR**

Documentation of patient reason(s) for not being able to assess (e.g., patient refuses endoscopic and/or radiologic assessment) (G0921)

**OR**

No documentation of disease type, anatomic location and activity, reason not otherwise specified (G0922)

*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 "2012 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 #270: Inflammatory Bowel Disease (IBD): Preventive Care: Corticosteroid Sparing Therapy**

**DESCRIPTION:**

Percentage of patients aged 18 years and older with a diagnosis of inflammatory bowel disease who have been managed by corticosteroids greater than or equal to 10 mg/day for 60 or greater consecutive days that have been prescribed corticosteroid sparing therapy in the last reporting year

**NUMERATOR:**

Patients managed with corticosteroids greater than or equal to 10 mg/day for 60 or greater consecutive days AND prescribed a corticosteroid sparing therapy (e.g., thiopurines, methotrexate, or anti-TNF agents)

**Definition:**

**Corticosteroids** - Prednisone equivalents used expressly for the treatment of IBD and not for other indications (including premedication before anti-TNF therapy, non-IBD indications) can be determined 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.

**Numerator Options:**

Patient receiving corticosteroids greater than or equal to 10 mg/day for 60 or greater consecutive days (G8859)

**AND**

Corticosteroid sparing therapy prescribed (4142F)

**OR**

Patient not receiving corticosteroids greater than or equal to 10 mg/day for 60 or greater consecutive days (3750F)

**OR**

Patient receiving corticosteroids greater than or equal to 10 mg/day for 60 or greater consecutive days (G8859)

**AND**

Documentation of medical reason(s) for not treating with corticosteroid sparing therapy (e.g., benefits of continuing steroid therapy outweigh the risk of weaning patient off steroids, initiating steroid sparing therapy or patient refuses to initiate steroid sparing therapy) (4142F *with* 1P)

**OR**

Patient receiving corticosteroids greater than or equal to 10 mg/day for 60 or greater consecutive days (G8859)

**AND**

Corticosteroid sparing therapy **not** prescribed, reason not otherwise specified (4142F *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 "2012 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 #271: Inflammatory Bowel Disease (IBD): Preventive Care: Corticosteroid Related Iatrogenic Injury – Bone Loss Assessment**

**DESCRIPTION:**

Percentage of patients aged 18 years and older with a diagnosis of inflammatory bowel disease who have received dose of corticosteroids greater than or equal to 10 mg/day for 60 or greater consecutive days and were assessed for risk of bone loss once per the reporting year

**NUMERATOR:**

Patients who have received dose of corticosteroids greater than or equal to 10 mg/day for 60 or greater consecutive days and who were assessed for risk of bone loss

**Definitions:**

**Corticosteroids** - Prednisone equivalents used expressly for the treatment of IBD and not for other indications (including premedication before anti-TNF therapy, non-IBD indications) can be determined 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.

**Assessed** - Documentation that an assessment for risk of bone loss has been performed or ordered. This includes, but is not limited to, review of systems and medication history, and ordering of Central Dual-energy X-Ray Absorptiometry (DXA) scan.

**Numerator Options:**

Patients who have received dose of corticosteroids greater than or equal to 10 mg/day for 60 or greater consecutive days (G8860)

**AND**

Central Dual-energy X-Ray Absorptiometry (DXA) ordered or documented, review of systems and medication history or pharmacologic therapy (other than minerals/vitamins) for osteoporosis prescribed (G8861)

**OR**

Patients not receiving corticosteroids greater than or equal to 10 mg/day for 60 or greater consecutive days (G8862)

**OR**

Patients who have received dose of corticosteroids greater than or equal to 10 mg/day for 60 or greater consecutive days (G8860)

**AND**

Patients **not** assessed for risk of bone loss, reason not otherwise specified (G8863)

*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 "2012 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 #272: Inflammatory Bowel Disease (IBD): Preventive Care: Influenza Immunization**

**DESCRIPTION:**

Percentage of patients aged 18 years and older with inflammatory bowel disease for whom influenza immunization was recommended, administered or previously received during the reporting year

**NUMERATOR:**

Patients for whom influenza immunization was recommended, administered, or previously received

**Numerator Options:**

Influenza immunization recommended (4035F)

**OR**

Influenza immunization ordered or administered (4037F)

**OR**

Documentation of medical reason(s) for not recommending influenza immunization (e.g., patient allergic reaction, potential adverse drug reaction) (4035F with 1P)

**OR**

Documentation of medical reason(s) for not ordering or administering or having previously received influenza immunization (e.g., patient allergic reaction, potential adverse drug reaction) (4037F with 1P)

**OR**

Documentation of patient reason(s) for not recommending influenza immunization (e.g., patient refusal) (4035F with 2P)

**OR**

Documentation of patient reason(s) for not administering or having previously received influenza immunization (e.g., patient refusal) (4037F with 2P)

**OR**

Documentation of system reason(s) for not recommending influenza immunization (e.g., vaccine not available) (4035F with 3P)

**OR**

Documentation of system reason(s) for not administering or having previously received influenza immunization (e.g., vaccine not available) (4037F with 3P)

**OR**

Influenza immunization **not** recommended, reason not otherwise specified (4035F with 8P)

**OR**

Influenza immunization **not** ordered or administered, reason not otherwise specified (4037F 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 "2012 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 #273: Inflammatory Bowel Disease (IBD): Preventive Care: Pneumococcal Immunization**

**DESCRIPTION:**

Percentage of patients aged 18 years and older with a diagnosis of inflammatory bowel disease that had pneumococcal vaccination administered or previously received

**NUMERATOR:**

Patients for whom pneumococcal vaccine administered or previously received

**Numerator Options:**

Pneumococcal vaccine administered or previously received (G8864)

**OR**

Documentation of medical reason(s) for not administering or previously receiving pneumococcal vaccine (e.g., patient allergic reaction, potential adverse drug reaction) (G8865)

**OR**

Documentation of patient reason(s) for not administering or previously receiving pneumococcal vaccine (e.g., patient refusal) (G8866)

**OR**

Pneumococcal vaccine **not** administered or previously received, reason not otherwise specified (G8867)

*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 "2012 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 #274: Inflammatory Bowel Disease (IBD): Testing for Latent Tuberculosis (TB) Before Initiating Anti-TNF (Tumor Necrosis Factor) Therapy**

**DESCRIPTION:**

Percentage of patients aged 18 years and older with a diagnosis of inflammatory bowel disease (IBD) for whom a tuberculosis (TB) screening was performed and results interpreted within six months prior to receiving a first course of anti-TNF (tumor necrosis factor) therapy

**NUMERATOR:**

Patients who had TB screening performed and results interpreted, within 6 months prior to receiving a first course of anti-TNF therapy

**Definition:**

**First Course of anti-TNF therapy:** the first (ever) course of anti-TNF therapy

**Numerator Options:**

Documentation that tuberculosis (TB) screening test performed and results interpreted (3510F)

**AND**

Patients receiving a first course of anti-TNF therapy (G8868)

**OR**

Patient not receiving a first course of anti-TNF (tumor necrosis factor) therapy (6150F)

**OR**

Documentation of medical reason(s) for not performing TB screening test within 6 months prior to receiving a first course of anti-TNF therapy (e.g., patient positive for TB and documentation of past treatment; patient recently completed course of anti-TB therapy) (3510F *with* 1P)

**OR**

Documentation of patient reason(s) for not performing TB screening test within 6 months prior to receiving a first course of anti-TNF therapy (e.g., patient declined) (3510F *with* 2P)

**AND**

Patients receiving a first course of anti-TNF therapy (G8868)

**OR**

TB screening test **not** performed within 6 months prior to receiving a first course of anti-TNF therapy, reason not otherwise specified (3510F *with* 8P)

**AND**

Patients receiving a first course of anti-TNF therapy (G8868)

*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 "2012 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 #275: Inflammatory Bowel Disease (IBD): Assessment of Hepatitis B Virus (HBV) Status Before Initiating Anti-TNF (Tumor Necrosis Factor) Therapy**

**DESCRIPTION:**

Percentage of patients aged 18 years and older with a diagnosis of inflammatory bowel disease (IBD) who had Hepatitis B Virus (HBV) status assessed and results interpreted within one year prior to receiving a first course of anti-TNF (tumor necrosis factor) therapy

**NUMERATOR:**

Patients who had HBV status assessed and results interpreted within one year prior to receiving a first course of anti-TNF therapy

**Numerator Instructions:** HBV status must be assessed by one of the following:  
HBsAG, HBsAG neutralization, HBcAb total, HBcAB IgM, HBsAB

**Definition:**

**First Course of anti-TNF therapy:** the first (ever) course of anti-TNF therapy

**Numerator Options:**

Hepatitis B Virus (HBV) status assessed and results interpreted within one year prior to receiving a first course of anti-TNF (tumor necrosis factor) therapy (3517F)

**OR**

Patient has documented immunity to hepatitis B and is receiving a first course of anti-TNF therapy (G8869)

**OR**

Hepatitis B vaccine injection administered or previously received and is receiving a first course of anti-TNF therapy (G8870)

**OR**

Patient not receiving a first course of anti-TNF therapy (G8871)

**OR**

Documentation of medical reason(s) for not assessing Hepatitis B Virus (HBV) (e.g., potential drug interaction, potential for allergic reaction) status within one year prior to receiving first course of anti-TNF therapy (3517F *with* 1P)

**OR**

Documentation of patient reason(s) for not assessing Hepatitis B Virus (HBV) status (e.g., patient declined) within one year prior to receiving first course of anti-TNF therapy (3517F *with* 2P)

**OR**

Hepatitis B Virus (HBV) status **not** assessed and results interpreted within one year prior to receiving a first course of anti-TNF (tumor necrosis factor) therapy, reason not otherwise specified (3517F *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 "2012 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 NOTE:** *In the event that a patient is screened for tobacco use and identified as a user but did not receive tobacco cessation counseling report 4004F with 8P.*

**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 (intervention, counseling, pharmacotherapy, or both), 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 (e.g., 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 "2012 Physician Quality Reporting Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS Physician Quality Reporting website.*

## SLEEP APNEA MEASURES GROUP OVERVIEW

### 2012 PHYSICIAN QUALITY REPORTING OPTIONS FOR MEASURES GROUP: REGISTRY ONLY

#### 2012 PHYSICIAN QUALITY REPORTING MEASURES IN SLEEP APNEA MEASURES GROUP:

- #276. Sleep Apnea: Assessment of Sleep Symptoms
- #277. Sleep Apnea: Severity Assessment at Initial Diagnosis
- #278. Sleep Apnea: Positive Airway Pressure Therapy Prescribed
- #279. Sleep Apnea: Assessment of Adherence to Positive Airway Pressure Therapy

#### **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.

**G8900:** I intend to report the Sleep Apnea 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, 2012 **OR** July 1 through December 31, 2012). 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 Sleep Apnea Measures Group are patients aged 18 years and older with a specific diagnosis of Sleep Apnea accompanied by a specific patient encounter:

**One of the following diagnosis codes indicating Sleep Apnea:** 327.23, 780.51, 780.53, 780.57

#### **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 Sleep Apnea Measures Group for each patient within the eligible professional's patient sample.

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

- Instructions for qualifying numerator option reporting for each of the measures within the Sleep Apnea 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 G8759:** All quality actions for the applicable measures in the Sleep Apnea Measures Group have been performed for this patient

- To report satisfactorily the Sleep Apnea 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. In measures group reporting, measures that are based on patient visits need to only be reported a minimum of once per reporting period – they do not need to be reported each visit.
- Measures groups containing a measure with a 0% performance rate will not be counted as satisfactorily reporting the measures group. The recommended clinical quality action must be performed on at least one patient for each measure within the measures group reported by the eligible professional. Performance exclusion quality data codes are not counted in the performance denominator. If the eligible professional submits all performance exclusion quality data codes, the performance rate would be 0/0 and would be considered satisfactorily reporting.
- 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 "2012 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 #276: Sleep Apnea: Assessment of Sleep Symptoms**

**DESCRIPTION:**

Percentage of visits for patients aged 18 years and older with a diagnosis of obstructive sleep apnea that includes documentation of an assessment of symptoms, including presence or absence of snoring and daytime sleepiness

**NUMERATOR:**

Patient visits with an assessment of sleep symptoms documented, including presence or absence of snoring and daytime sleepiness

**Numerator Options:**

Sleep apnea symptoms assessed, including presence or absence of snoring and daytime sleepiness (G8839)

**OR**

Documentation of reason(s) for not performing an assessment of sleep symptoms (e.g., patient didn't have initial daytime sleepiness, patient visits between initial testing and initiation of therapy) (G8840)

**OR**

Sleep apnea symptoms **not** assessed, reason not otherwise specified (G8841)

*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 "2012 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 #277: Sleep Apnea: Severity Assessment at Initial Diagnosis**

**DESCRIPTION:**

Percentage of patients aged 18 years and older with a diagnosis of obstructive sleep apnea who had an apnea hypopnea index (AHI) or a respiratory disturbance index (RDI) measured at the time of initial diagnosis

**NUMERATOR:**

Patients who had an apnea hypopnea index (AHI) or a respiratory disturbance index (RDI) measured at the time of initial diagnosis

**Definitions:**

Apnea-Hypopnea Index (AHI) for polysomnography performed in a sleep lab is defined as (Total Apneas + Hypopneas per hour of sleep); Apnea-Hypopnea Index (AHI) for a home sleep study is defined as (Total Apneas + Hypopneas per hour of monitoring);

Respiratory Disturbance Index (RDI) is defined as (Total Apneas + Hypopneas + Respiratory-Effort-Related-Arousals per hour of sleep)

**Numerator Options:**

Apnea hypopnea index (AHI) or respiratory disturbance index (RDI) measured at the time of initial diagnosis (G8842)

**OR**

Documentation of reason(s) for not measuring an apnea hypopnea index (AHI) or a respiratory disturbance index (RDI) at the time of initial diagnosis (eg, abnormal anatomy, patient declined, financial, insurance coverage) (G8843)

**OR**

Apnea hypopnea index (AHI) or respiratory disturbance index (RDI) **not** measured at the time of initial diagnosis, Reason not Specified (G8844)

*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 "2012 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 #278: Sleep Apnea: Positive Airway Pressure Therapy Prescribed**

**DESCRIPTION:**

Percentage of patients aged 18 years and older with a diagnosis of moderate or severe obstructive sleep apnea who were prescribed positive airway pressure therapy

**NUMERATOR:**

Patients who were prescribed positive airway pressure therapy

**Definition:** Moderate or severe sleep apnea is defined as apnea hypopnea index (AHI) or a respiratory disturbance index (RDI) greater than or equal to 15 episodes per hour of sleep

**Numerator Options:**

Positive airway pressure therapy prescribed (G8845)

**AND**

Moderate or severe obstructive sleep apnea (apnea hypopnea index (AHI) or respiratory disturbance index (RDI) of 15 or greater) (G8846)

**OR**

Mild obstructive sleep apnea (apnea hypopnea index (AHI) or respiratory disturbance index (RDI) of less than 15) (G8848)

**OR**

Documentation of reason(s) for not prescribing positive airway pressure therapy (e.g., patient unable to tolerate, alternative therapies used, patient declined, financial, insurance coverage) (G8849)

**AND**

Moderate or severe obstructive sleep apnea (apnea hypopnea index (AHI) or respiratory disturbance index (RDI) of 15 or greater) (G8846)

**OR**

Positive airway pressure therapy **not** prescribed, reason not otherwise specified (G8850)

**AND**

Moderate or severe obstructive sleep apnea (apnea hypopnea index (AHI) or respiratory disturbance index (RDI) of 15 or greater) (G8846)

*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 "2012 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 #279: Sleep Apnea: Assessment of Adherence to Positive Airway Pressure Therapy**

**DESCRIPTION:**

Percentage of visits for patients aged 18 years and older with a diagnosis of obstructive sleep apnea who were prescribed positive airway pressure therapy who had documentation that adherence to positive airway pressure therapy was objectively measured

**NUMERATOR:**

Patient visits with documentation that adherence to positive airway pressure therapy was objectively measured

**Definition:** Objectively measured is defined as: positive airway pressure machine-generated measurement of hours of use.

**Numerator Options:**

Objective measurement of adherence to positive airway pressure therapy, documented (G8851)

**AND**

Positive airway pressure therapy prescribed (G8852)

**OR**

Positive airway pressure therapy not prescribed (G8853)

**OR**

Documentation of reason(s) for not objectively measuring adherence to positive airway pressure therapy (e.g., patient didn't bring data from continuous positive airway pressure [CPAP], therapy not yet initiated, not available on machine) (G8854)

**AND**

Positive airway pressure therapy prescribed (G8852)

**OR**

Objective measurement of adherence to positive airway pressure therapy **not** performed, reason not otherwise specified (G8855)

**AND**

Positive airway pressure therapy prescribed (G8852)

*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 "2012 Physician Quality Reporting Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS Physician Quality Reporting website.*

## DEMENTIA MEASURES GROUP OVERVIEW

### 2012 PHYSICIAN QUALITY REPORTING OPTIONS FOR MEASURES GROUPS: REGISTRY ONLY

#### 2012 PHYSICIAN QUALITY REPORTING MEASURES IN DEMENTIA MEASURES GROUP:

- #280. Dementia: Staging of Dementia
- #281. Dementia: Cognitive Assessment
- #282. Dementia: Functional Status Assessment
- #283. Dementia: Neuropsychiatric Symptom Assessment
- #284. Dementia: Management of Neuropsychiatric Symptoms
- #285. Dementia: Screening for Depressive Symptoms
- #286. Dementia: Counseling Regarding Safety Concerns
- #287. Dementia: Counseling Regarding Risks of Driving
- #288. Dementia: Caregiver Education and Support

#### **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.

**G8902:** I intend to report the Dementia 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, 2012 **OR** July 1 through December 31, 2012). 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 Dementia Measures Group are all patients regardless of age, with a specific diagnosis of dementia accompanied by a specific patient encounter:

**One of the following diagnosis codes indicating Dementia:** 094.1, 290.0, 290.10, 290.11, 290.12, 290.13, 290.20, 290.21, 290.3, 290.40, 290.41, 290.42, 290.43, 290.8, 290.9, 294.10, 294.11, 294.8, 331.0, 331.11, 331.19, 331.82

#### **Accompanied by**

**One of the following patient encounter codes:** 90801, 90802, 90804, 90805, 90806, 90807, 90808, 90809, 90810, 90811, 90812, 90813, 90814, 90815, 90816, 90817, 90818, 90819, 90821, 90822, 90823, 90824, 90826, 90827, 90828, 90829, 90862, 96116, 96118, 96119, 96120, 96150, 96151, 96152, 96154, 96155, 97003, 97004, 99201, 99202, 99203,



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

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** measures within the Dementia 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 IBD 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 G8761:** All quality actions for the applicable measures in the Dementia Measures Group have been performed for this patient

- To report satisfactorily the Dementia 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.
- Measures groups containing a measure with a 0% performance rate will not be counted as satisfactorily reporting the measures group. The recommended clinical quality action must be performed on at least one patient for each measure within the measures group reported by the eligible professional. Performance exclusion quality data codes are not counted in the performance denominator. If the eligible professional submits all performance exclusion quality data codes, the performance rate would be 0/0 and would be considered satisfactorily reporting.
- 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 "2012 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 #280: Dementia: Staging of Dementia

**DESCRIPTION:**

Percentage of patients, regardless of age, with a diagnosis of dementia whose severity of dementia was classified as mild, moderate or severe at least once within a 12 month period

**NUMERATOR:**

Patients whose severity of dementia was classified as mild, moderate or severe at least once within a 12 month period

**Numerator Instructions:** Dementia severity can be assessed using one of a number of available valid and reliable instruments available from the medical literature. Examples include, but are not limited to:

- Global Deterioration Scale (GDS)
- Functional Assessment Staging Tool (FAST)
- Clinical Dementia Rating (CDR)
- Dementia Severity Rating Scale
- Mini-Mental State Examination (MMSE) *[Note: While simple and quick to administer, the MMSE is a blunt instrument for staging Alzheimer's disease. The MMSE has not been well validated for non-Alzheimer's dementias.]*
- Formal Neuropsychological Evaluation

**Definitions:**

**Mild dementia** - Can be classified quantitatively as MMSE score of > 18, GDS or FAST stage 4, CDR of 1; qualitatively as being likely to have difficulty with balancing a checkbook, preparing a complex meal, or managing a complicated medication schedule.

**Moderate dementia** - Can be classified quantitatively as MMSE score of 10–18, GDS or FAST stages 5 and 6, CDR of 2; qualitatively as experiencing difficulties with simpler food preparation, household cleanup, and yard work and requiring assistance with some aspects of self-care (e.g., picking out the proper clothing to wear).

**Severe dementia** - Can be classified quantitatively as MMSE score of < 10, GDS or FAST stages 6 and 7, CDR of 3; qualitatively as requiring considerable or total assistance with personal care, such as dressing, bathing, and toileting.

**NUMERATOR NOTE:** *The proposed scoring cut-offs listed above are offered only as a guide and are quoted verbatim from the referenced clinical guideline. The scoring and appropriate severity cut-offs for any of these instruments must be interpreted in the context of the patient's age, education, and ethnicity.*

**Numerator Options:**

Dementia severity classified, mild (1490F)

**OR**

Dementia severity classified, moderate (1491F)

**OR**

Dementia severity classified, severe (1493F)

**OR**

Dementia severity **not** classified, reason not otherwise specified (1490F *with* 8P)

**SPECIFICATION FOR MEASURES GROUP REPORTING ONLY**

*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 "2012 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 #281: Dementia: Cognitive Assessment**

**DESCRIPTION:**

Percentage of patients, regardless of age, with a diagnosis of dementia for whom an assessment of cognition is performed and the results reviewed at least within a 12 month period

**NUMERATOR:**

Patients for whom an assessment of cognition is performed and the results reviewed at least once within a 12 month period

**Numerator Instructions:**

Cognition can be assessed by direct examination of the patient using one of a number of instruments, including several originally developed and validated for screening purposes. This can also include, where appropriate, administration to a knowledgeable informant. Examples include, but are not limited to:

- Blessed Orientation-Memory-Concentration Test (BOMC)
- Mini-Cog
- Montreal Cognitive Assessment (MoCA)
- Cognitive Assessment Screening Instrument (CASI)
- St. Louis University Mental Status Examination (SLUMS)
- Mini-Mental State Examination (MMSE) *[Note: The MMSE has not been well validated for non-Alzheimer's dementias.]*
- Short Informant Questionnaire on Cognitive Decline in the Elderly (IQCODE)
- Ascertain Dementia 8 (AD8) Questionnaire
- Minimum Data Set (MDS) Brief Interview of Mental Status (BIMS) *[Note: Validated for use with nursing home patients only]*
- Formal neuropsychological evaluation

**Numerator Options:**

Cognition assessed and reviewed (1494F)

**OR**

Documentation of medical reason(s) for not assessing and reviewing cognition (1494F *with* 1P)

**OR**

Cognition **not** assessed and reviewed, reason not otherwise specified (1494F *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 "2012 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 #282: Dementia: Functional Status Assessment**

**DESCRIPTION:**

Percentage of patients, regardless of age, with a diagnosis of dementia for whom an assessment of functional status is performed and the results reviewed at least once within a 12 month period

**NUMERATOR:**

Patients for whom an assessment of functional status is performed and the results reviewed at least once within a 12 month period

**Numerator Instructions:** Functional status can be assessed by direct examination of the patient or knowledgeable informant. An assessment of functional status should include, at a minimum, an evaluation of the patient's ability to perform instrumental activities of daily living (IADL) and basic activities of daily living (ADL). Functional status can also be assessed using one of a number of available valid and reliable instruments available from the medical literature. Examples include, but are not limited to:

- Lawton IADL Scale
- Barthel ADL Index
- Katz Index of Independence in ADL

**Numerator Options:**

Functional status for dementia assessed and results reviewed (1175F)

**OR**

Documentation of medical reason(s) for not assessing and reviewing functional status for dementia (1175F *with* 1P)

**OR**

Functional status for dementia **not** assessed and results **not** reviewed, reason not otherwise specified (1175F *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 "2012 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 #283: Dementia: Neuropsychiatric Symptom Assessment**

**DESCRIPTION:**

Percentage of patients, regardless of age, with a diagnosis of dementia and for whom an assessment of neuropsychiatric symptoms is performed and results reviewed at least once in a 12 month period

**NUMERATOR:**

Patients for whom an assessment of neuropsychiatric symptoms is performed and results reviewed at least once in a 12 month period

**Numerator Instructions:** Neuropsychiatric symptoms can be assessed by direct examination of the patient or knowledgeable informant.

Examples of reliable and valid instruments that are commonly used in research settings and that can be used to assess behavior include, but are not limited to:

- Dementia Signs and Symptoms (DSS) Scale
- Neuropsychiatric Inventory (NPI)

The assessment of behavioral status may include the assessment of Behavioral and Psychological Symptoms of Dementia (BPSD). For patients residing in nursing homes, it may include an assessment of the behavioral symptom items from the Minimum Data Set (MDS).

**Definitions:**

The following is a non-exhaustive list of dimensions (based on items included in available validated instruments) that may be evaluated during an assessment of neuropsychiatric symptoms:

*Activity disturbances:*

- agitation
- wandering
- purposeless hyperactivity
- verbal or physical aggressiveness
- resistiveness with care
- apathy
- impulsiveness
- socially inappropriate behaviors
- appetite
- eating disturbances
- sleep problems
- diurnal/sleep-wake cycle disturbances
- repetitive behavior

*Mood disturbances:*

- anxiety
- dysphoria
- euphoria
- irritability
- mood lability/fluctuations

*Thought and perceptual disturbances:*

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- having fixed false beliefs (delusions)
- hearing or seeing non-present entities (hallucinations)
- paranoia

**Numerator Options:**

Neuropsychiatric symptoms assessed and results reviewed (1181F)

**OR**

Neuropsychiatric symptoms **not** assessed and results **not** reviewed, reason not otherwise specified (1181F *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 "2012 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 #284: Dementia: Management of Neuropsychiatric Symptoms

**DESCRIPTION:**

Percentage of patients, regardless of age, with a diagnosis of dementia who have one or more neuropsychiatric symptoms who received or were recommended to receive an intervention for neuropsychiatric symptoms within a 12 month period

**NUMERATOR:**

Patients who received or were recommended to receive an intervention for neuropsychiatric symptoms within a 12 month period

**Numerator Options:**

Neuropsychiatric intervention ordered (4525F)

**OR**

Neuropsychiatric intervention received (4526F)

**OR**

Neuropsychiatric Intervention **not** ordered, reason not otherwise specified (4525F *with* 8P)

**OR**

Neuropsychiatric Intervention **not** received, reason not otherwise specified (4526F *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 "2012 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 #285: Dementia: Screening for Depressive Symptoms

**DESCRIPTION:**

Percentage of patients, regardless of age, with a diagnosis of dementia who were screened for depressive symptoms within a 12 month period

**NUMERATOR:**

Patients who were screened for depressive symptoms within a 12 month period

**Numerator Instructions:**

In addition to clinical qualitative approaches, dementia patients can be screened for depressive symptoms using one of a number of valid, reliable instruments available from the medical literature. Examples include, but are not limited to:

- Cornell Scale for Depression in Dementia
- Geriatric Depression Scale
- PHQ-9

**Definition:**

**Depressive Symptoms** - Depressive symptoms in a patient with dementia can include: anxiety, sadness, lack of reactivity to pleasant events, irritability, agitation, retardation, multiple physical complaints, acute loss of interest, appetite loss, lack of energy, diurnal variation of mood, difficulty falling asleep, multiple awakenings, during sleep, early morning awakenings, suicide, self-depreciation, pessimism, mood congruent delusions. Since patients may be unable to describe their symptoms, caregiver report of depressive symptoms should be reviewed and included in the screen for depressive symptoms.

**Numerator Options:**

Screening for depression performed (3725F)

**OR**

Screening for depression **not** performed, reason not otherwise specified (3725F *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 "2012 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 #286: Dementia: Counseling Regarding Safety Concerns

**DESCRIPTION:**

Percentage of patients, regardless of age, with a diagnosis of dementia or their caregiver(s) who were counseled or referred for counseling regarding safety concerns within in a 12 month period

**NUMERATOR:**

Patients or their caregiver(s) who were counseled or referred for counseling regarding safety concerns within a 12 month period

**Numerator Instructions:** Counseling should include a discussion with the patient and their caregiver(s) regarding one or more of the following common safety concerns and potential risks to the patient. When appropriate, it should also include a recommendation or referral for a home safety evaluation. *Note:* for nursing home patients, different safety concerns might apply.

A number of organizations have developed educational materials that are recommended to aid implementation of the measure. These materials/tools include:

- Alzheimer's Association Safety Topics. Available on the Alzheimer's Association website.
- Alzheimer's Disease Education and Referral Center's Home Safety for the Alzheimer's Patient. Available on the National Institute on Aging website.

**Definition:**

**Safety Concerns** - Safety concerns include, but are not limited to:

- Fall risk
- Gait/balance
- Medication management
- Financial management
- Home safety risks that could arise from cooking or smoking
- Physical aggression posing threat to self, family caregiver, or others
- Wandering
- Access to firearms or other weapons
- Access to potentially dangerous materials
- Being left alone in home or locked in room
- Inability to respond rapidly to crisis/household emergencies
- Driving
- Operation of hazardous equipment
- Suicidality
- Abuse or neglect

**Numerator Options:**

Safety counseling for dementia provided (6101F)

**OR**

Safety counseling for dementia ordered (6102F)

**OR**

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Documentation of medical reason(s) for not providing counseling regarding safety concerns (e.g., patient at end of life, other medical reason) (6101F *with* 1P)

**OR**

Documentation of medical reason(s) for not ordering safety counseling (e.g., patient at end of life, other medical reason) (6102F *with* 1P)

**OR**

Safety counseling for dementia **not** provided, reason not otherwise specified (6101F *with* 8P)

**OR**

Safety counseling for dementia **not** ordered, reason not otherwise specified (6102F *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 "2012 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 #287: Dementia: Counseling Regarding Risks of Driving

**DESCRIPTION:**

Percentage of patients, regardless of age, with a diagnosis of dementia or their caregiver(s) who were counseled regarding the risks of driving and the alternatives to driving at least once within a 12 month period

**NUMERATOR:**

Patients or their caregiver(s) who were counseled regarding the risks of driving and the alternatives to driving at least once within a 12 month period

**Numerator Instructions:**

One resource that includes patient and caregiver education materials that can be used to aid implementation of the measure is the *Physician's Guide to Assessing and Counseling Older Drivers*, developed by the American Medical Association in cooperation with the National Highway Traffic Safety Administration. This document is available on the AMA website.

**Numerator Options:**

Counseling provided regarding risks of driving and the alternatives to driving (6110F)

**OR**

Documentation of medical reason(s) for not counseling regarding the risks of driving (e.g., patient is no longer driving, other medical reason) (6110F *with* 1P)

**OR**

Counseling regarding risks of driving and alternatives to driving **not** performed, reason not otherwise specified (6110F *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 "2012 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 #288: Dementia: Caregiver Education and Support

**DESCRIPTION:**

Percentage of patients, regardless of age, with a diagnosis of dementia whose caregiver(s) were provided with education on dementia disease management and health behavior changes AND referred to additional resources for support within a 12 month period

**NUMERATOR:**

Patients whose caregiver(s) were provided with education on dementia disease management and health behavior changes AND referred to additional resources for support within a 12 month period

**Numerator Instructions:**

There are a number of assessment tools available for the caregiver. These should be considered as an integral component of comprehensive caregiver education and support. The American Medical Association has developed a Caregiver Health Self-assessment Questionnaire to help caregivers analyze their own behavior and health risks and, with their physician's help, make decisions that will benefit both the caregiver and the patient. This questionnaire is available on the AMA website.

**Definition:**

Education should also include advising the caregiver that he or she is at "increased risk of serious illness (including circulatory and heart conditions and respiratory disease and hypertension), increased physician visits and use of prescription medications, emotional strain, anxiety, and depression."

**Numerator Options:**

- OR Caregiver provided with education and referred to additional resources for support (4322F)
- OR Documentation of medical reason(s) for not providing the caregiver with education on disease management and health behavior changes or referring to additional sources for support (e.g., patient does not have a caregiver, other medical reason) (4322F *with* 1P)
- OR Caregiver **not** provided with education and **not** referred to additional resources for support, reason not otherwise specified (4322F *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 "2012 Physician Quality Reporting Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS Physician Quality Reporting website.*

## PARKINSON'S DISEASE MEASURE GROUP OVERVIEW

### 2012 PHYSICIAN QUALITY REPORTING OPTIONS FOR MEASURES GROUPS: REGISTRY ONLY

#### 2012 PHYSICIAN QUALITY REPORTING MEASURES IN PARKINSON'S DISEASE MEASURES GROUP:

- #289. Parkinson's Disease: Annual Parkinson's Disease Diagnosis Review
- #290. Parkinson's Disease: Psychiatric Disorders or Disturbances Assessment
- #291. Parkinson's Disease: Cognitive Impairment or Dysfunction Assessment
- #292. Parkinson's Disease: Querying about Sleep Disturbances
- #293. Parkinson's Disease: Rehabilitative Therapy Options
- #294. Parkinson's Disease: Parkinson's Disease Medical and Surgical Treatment Options Reviewed

#### **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.

**G8903:** I intend to report the Parkinson's Disease 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, 2012 **OR** July 1 through December 31, 2012). 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 Parkinson's Disease Measures Group are patients aged 18 years and older with a specific diagnosis of Parkinson's Disease accompanied by a specific patient encounter:

The following diagnosis code indicating Parkinson's disease: 332.0

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

- Report a numerator option on **all** measures within the Parkinson's Disease Measures Group for each patient within the eligible professional's patient sample.

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

- Instructions for qualifying numerator option reporting for each of the measures within the Parkinson's Disease 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 G8762:** All quality actions for the applicable measures in the Parkinson's Disease Measures Group have been performed for this patient

- To report satisfactorily the Parkinson's Disease 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.
- Measures groups containing a measure with a 0% performance rate will not be counted as satisfactorily reporting the measures group. The recommended clinical quality action must be performed on at least one patient for each measure within the measures group reported by the eligible professional. Performance exclusion quality data codes are not counted in the performance denominator. If the eligible professional submits all performance exclusion quality data codes, the performance rate would be 0/0 and would be considered satisfactorily reporting.
- 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 "2012 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 #289: Parkinson's Disease: Annual Parkinson's Disease Diagnosis Review**

**DESCRIPTION:**

All patients with a diagnosis of Parkinson's disease who had an annual assessment including a review of current medications (e.g., medications that can produce Parkinson-like signs or symptoms) and a review for the presence of atypical features (e.g., falls at presentation and early in the disease course, poor response to levodopa, symmetry at onset, rapid progression [to Hoehn and Yahr stage 3 in 3 years], lack of tremor or dysautonomia) at least annually

**NUMERATOR:**

All patients who had an annual assessment including a review of current medications and for the presence of atypical features

**Numerator Options:**

Parkinson's disease diagnosis reviewed (1400F)

**OR**

Parkinson's disease diagnosis was **not** reviewed, reason not otherwise specified (1400F 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 "2012 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 #290: Parkinson's Disease: Psychiatric Disorders or Disturbances Assessment

**DESCRIPTION:**

All patients with a diagnosis of Parkinson's disease who were assessed for psychiatric disorders or disturbances (e.g., psychosis, depression, anxiety disorder, apathy, or impulse control disorder) at least annually

**NUMERATOR:**

Patients who were assessed for psychiatric disorders or disturbances (e.g., psychosis, depression, anxiety disorder, apathy, or impulse control disorder) at least annually

**Numerator Options:**

Psychiatric disorders or disturbances assessed (3700F)

**OR**

Psychiatric disorders or disturbances **not** assessed, reason not otherwise specified (3700F *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 "2012 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 #291: Parkinson's Disease: Cognitive Impairment or Dysfunction Assessment

**DESCRIPTION:**

All patients with a diagnosis of Parkinson's disease who were assessed for cognitive impairment or dysfunction at least annually

**NUMERATOR:**

Patients who were assessed for cognitive impairment or dysfunction at least annually.

**Numerator Options:**

Cognitive impairment or dysfunction assessed (3720F)

**OR**

Cognitive impairment or dysfunction was **not** assessed, reason not otherwise specified (3720F *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 "2012 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 #292: Parkinson's Disease: Querying about Sleep Disturbances**

**DESCRIPTION:**

All patients with a diagnosis of Parkinson's disease (or caregivers, as appropriate) who were queried about sleep disturbances at least annually

**NUMERATOR:**

Patients (or caregiver(s), as appropriate) who were queried about sleep disturbances at least annually.

**Numerator Options:**

Patient (or caregiver) queried about sleep disturbances (4328F)

**OR**

Documentation of medical reason(s) for not querying about sleep disturbances (4328F *with* 1P)

**OR**

Patient (or caregiver) not queried about sleep disturbances, reason **not** otherwise specified (4328F *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 "2012 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 #293: Parkinson's Disease: Rehabilitative Therapy Options

**DESCRIPTION:**

All patients with a diagnosis of Parkinson's Disease (or caregiver(s), as appropriate) who had rehabilitative therapy options (e.g., physical, occupational, or speech therapy) discussed at least annually

**NUMERATOR:**

Patients (or caregiver(s), as appropriate) who had rehabilitative therapy options (e.g., physical, occupational, or speech therapy) discussed at least annually

**Numerator Options:**

Rehabilitative therapy options discussed with patient (or caregiver) (4400F)

**OR**

Documentation of medical reason(s) for not discussing rehabilitative therapy options with patient (or caregiver) (4400F *with* 1P)

**OR**

Rehabilitative therapy options was **not** discussed with patient (or caregiver), reason not otherwise specified (4400F *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 "2012 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 #294: Parkinson's Disease: Parkinson's Disease Medical and Surgical Treatment Options Reviewed**

**DESCRIPTION:**

All patients with a diagnosis of Parkinson's disease (or caregiver(s), as appropriate) who had the Parkinson's disease treatment options (e.g., non-pharmacological treatment, pharmacological treatment, or surgical treatment) reviewed at least once annually

**NUMERATOR:**

Patients (or caregiver(s), as appropriate) who had the Parkinson's disease treatment options (e.g., non-pharmacological treatment, pharmacological treatment, or surgical treatment) reviewed at least once annually

**Numerator Options:**

Medical and surgical treatment options reviewed with patient (or caregiver) (4325F)

**OR**

Medical and surgical treatment options not reviewed with patient (or caregiver) for medical reasons (e.g., patient is unable to respond and no informant is available) (4325F with 1P)

**OR**

Medical and surgical treatment options not reviewed with patient (or caregiver), reasons not specified (4325F 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 "2012 Physician Quality Reporting Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS Physician Quality Reporting website.*

## HYPERTENSION MEASURES GROUP OVERVIEW

### 2012 PHYSICIAN QUALITY REPORTING OPTIONS FOR MEASURES GROUPS: REGISTRY ONLY

#### 2012 PHYSICIAN QUALITY REPORTING MEASURES IN HYPERTENSION MEASURES GROUP:

- #300. Hypertension: Blood Pressure Control
- #301. Hypertension: Low Density Lipoprotein (LDL-C) Control
- #295. Hypertension: Appropriate Use of Aspirin or Other Antiplatelet or Anticoagulant Therapy
- #296. Hypertension: Complete Lipid Profile
- #297. Hypertension: Urine Protein Test
- #298. Hypertension: Annual Serum Creatinine Test
- #299. Hypertension: Diabetes Mellitus Screening Test
- #302. Hypertension: Dietary and Physical Activity Modifications Appropriately Prescribed

#### **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.

**G8904:** I intend to report the Hypertension 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, 2012 **OR** July 1 through December 31, 2012). 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 Hypertension Measures Group are patients aged 15 through 90 years with a specific diagnosis of hypertension, and without a diagnosis of stage 5 chronic kidney disease (GFR of < 15ml/min per 1.72 m<sup>2</sup> or end-stage kidney disease) accompanied by a specific patient encounter:

**One of the following diagnosis codes indicating Hypertension:** 401.0, 401.1, 401.9, 402.00, 402.01, 402.10, 402.11, 402.90, 402.91, 403.00, 403.01, 403.10, 403.11, 403.90, 403.91, 404.00, 404.01, 404.02, 404.03, 404.10, 404.11, 404.12, 404.13, 404.90, 404.91, 404.92, 404.93

**SPECIFICATION FOR MEASURES GROUP REPORTING ONLY**

**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, G0438, G0439

**AND NOT**

**Diagnosis for stage 5 chronic kidney disease (ICD-9-CM):** 585.5, 585.6

- Report a numerator option on **all** measures within the Hypertension 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 Hypertension 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 G8763:** All quality actions for the applicable measures in the Hypertension Measures Group have been performed for this patient

- To report satisfactorily the Hypertension 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.
- Measures groups containing a measure with a 0% performance rate will not be counted as satisfactorily reporting the measures group. The recommended clinical quality action must be performed on at least one patient for each measure within the measures group reported by the eligible professional. Performance exclusion quality data codes are not counted in the performance denominator. If the eligible professional submits all performance exclusion quality data codes, the performance rate would be 0/0 and would be considered satisfactorily reporting.
- 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 "2012 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 #300: Hypertension: Blood Pressure Control

**DESCRIPTION:**

Percentage of patients aged 15 through 90 years old with a diagnosis of hypertension who had most recent blood pressure level under control (at goal)

**NUMERATOR:**

Patients who had most recent blood pressure under control

**Numerator Instructions:** Patients are considered to have most recent blood pressure under control if any of the following are documented:

- < 130/80 mmHg for those with chronic kidney disease OR diabetes
- < 140/90 mmHg for those without conditions listed above

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. To be "under control", both systolic and diastolic blood pressures must be below the target values (e.g., for a diabetes patient, systolic BP =136 mmHg and diastolic BP =70 mmHg is not "under control").

Patients who have a terminal illness or for whom treatment of hypertension with standard treatment goals is not clinically appropriate should be excluded.

**Definition:**

**Terminal illness** - Patients are considered to have a terminal illness if, in the eligible professional's clinical judgment, their life expectancy is less than one year.

**Treatment of hypertension with standard treatment goals is not clinically appropriate** - Although some patients may not have a terminal illness (defined as life expectancy of less than one year), treatment of hypertension with standard goals may not be relevant, as might be the case for a patient with severe Alzheimer disease.

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

**Numerator Options:**

Most recent blood pressure under control (G8886)

**OR**

Documentation of medical reason(s) for most recent blood pressure not being under control (e.g., patients who had a terminal illness or for whom treatment of hypertension with standard treatment goals is not clinically appropriate) (G8887)

**OR**

Most recent blood pressure not under control, results documented and reviewed (G8888)

**OR**

No documentation of blood pressure measurement, reason not otherwise specified (G8889)

*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 "2012 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 #301: Hypertension: Low Density Lipoprotein (LDL-C) Control

**DESCRIPTION:**

Percentage of patients aged 15 through 90 years old with a diagnosis of hypertension who had most recent LDL cholesterol level under control (at goal)

**NUMERATOR:**

Patients who had most recent LDL-C level under control during the 24-month period

**Numerator Instructions:** Patients are considered to have most recent LDL-C level under control if any of the following are documented:

- < 100 mg/dL for those with coronary heart disease, OR stroke or transient ischemic attack, OR peripheral artery disease, OR diabetes
- < 130 mg/dL for those without conditions listed above, but with one or more additional risk factors for CHD (Low HDL (< 40 mg/dL) or on HDL-raising medication, risk age (men ≥ 45, women ≥ 55), family history of premature CHD, smoking); HDL cholesterol ≥ 60 acts as a negative risk factor
- < 160 mg/dL for those without conditions listed above, and without additional risk factors for CHD (Low HDL (< 40 mg/dL) or on HDL-raising medication, risk age (men ≥ 45, women ≥ 55), family history of premature CHD, smoking); HDL cholesterol ≥ 60 acts as a negative risk factor

Patients who have a terminal illness or for whom treatment of hypertension with standard treatment goals is not clinically appropriate should be excluded.

**Definition:**

**Terminal illness** - Patients are considered to have a terminal illness if, in the eligible professional's clinical judgment, their life expectancy is less than one year.

**Treatment of hypertension with standard treatment goals is not clinically appropriate** - Although some patients may not have a terminal illness (defined as life expectancy of less than one year), treatment of hypertension with standard goals may not be relevant, as might be the case for a patient with severe Alzheimer's disease.

**NUMERATOR NOTE:** *The performance period for this measure is 24 months.*

**Numerator Options:**

Most recent LDL-C under control, results documented and reviewed (G8890)

**OR**

Documentation of medical reason(s) for most recent LDL-C not under control (e.g., patients who had a terminal illness or for whom treatment of hypertension with standard treatment goals is not clinically appropriate) (G8891)

**OR**

Documentation of medical reason(s) for not performing LDL-C test (e.g., patients who had a terminal illness or for whom treatment of hypertension with standard treatment goals is not clinically appropriate) (G8892)

**OR**

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Most recent LDL-C not under control, results documented and reviewed (G8893)  
**OR**  
LDL-C not performed, Reason not Specified (G8894)

*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 "2012 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 #295: Hypertension: Appropriate Use of Aspirin or Other Antiplatelet or Anticoagulant Therapy

**DESCRIPTION:**

Percentage of patients aged 15 through 90 years old with a diagnosis of hypertension who were prescribed aspirin or other anticoagulant/antiplatelet therapy

**NUMERATOR:**

Patients who were prescribed aspirin or other anticoagulant/antiplatelet therapy

**Numerator Instructions:** Oral antiplatelet therapy consists of aspirin, warfarin, clopidogrel, dabigatran, or combination of aspirin and extended release dipyridamole. Diagnosis of prior coronary heart disease, prior stroke or transient ischemic attack, prior peripheral artery disease, and/or prior diabetes, and Framingham risk assessment for estimating 10-year risk of developing CHD are used to determine whether a patient should be prescribed aspirin or other anticoagulant/antiplatelet therapy.

Patients who have a terminal illness or for whom treatment of hypertension with standard treatment goals is not clinically appropriate, or under age 30, or with low risk for CHD should be excluded.

**Definition:**

**Prescribed** - May include prescription given to the patient for aspirin or other anticoagulant/antiplatelet at one or more visits in the 12 month period OR patient already taking aspirin, warfarin, clopidogrel, dabigatran, or combination of aspirin and extended release dipyridamole as documented in current medication list.

**Terminal illness** - Patients are considered to have a terminal illness if, in the eligible professional's clinical judgment, their life expectancy is less than one year.

**Treatment of hypertension with standard treatment goals is not clinically appropriate** - Although some patients may not have a terminal illness (defined as life expectancy of less than one year), treatment of hypertension with standard goals may not be relevant, as might be the case for a patient with severe Alzheimer disease.

**Low Risk** - NO prior coronary heart disease AND NO prior stroke or transient ischemic attack, AND NO prior peripheral artery disease, AND NO prior diabetes, AND 10-year risk of developing CHD less than or equal to 10% as indicated by Framingham risk score and all elements of Framingham risk calculation are complete.

**Framingham Risk Score** - A risk assessment tool which uses recent data from the Framingham Heart Study to estimate 10-year risk for "hard" coronary heart disease outcomes (myocardial infarction and coronary death). This tool is designed to estimate risk in adults aged 20 and older who do not have heart disease or diabetes.

**Numerator Options:**

Oral aspirin or other anticoagulant/antiplatelet therapy prescribed (G8895)

**OR**

Documentation of medical reason(s) for not prescribing oral aspirin or other anticoagulant/antiplatelet therapy (e.g., under age 30, or patient documented to be low risk, or patient with terminal illness or treatment of hypertension with standard treatment goals is not clinically appropriate) (G8896)

**OR**

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Oral aspirin or other anticoagulant/antiplatelet therapy was **not** prescribed, reason not otherwise specified (G8897)

*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 "2012 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 #296: Hypertension: Complete Lipid Profile

**DESCRIPTION:**

Percentage of patients aged 15 through 90 years old with a diagnosis of hypertension who received a complete lipid profile within 24 months

**NUMERATOR:**

Patients who received at least one lipid profile (including total cholesterol, HDL-C, triglycerides and calculated LDL-C) within 24 months

**Definitions:**

**Terminal illness** - Patients are considered to have a terminal illness if, in the eligible professional's clinical judgment, their life expectancy is less than one year.

**Treatment of hypertension with standard treatment goals is not clinically appropriate** - Although some patients may not have a terminal illness (defined as life expectancy of less than one year), treatment of hypertension with standard goals may not be relevant, as might be the case for a patient with severe Alzheimer's disease.

Patients who have a terminal illness or for whom treatment of hypertension with standard treatment goals is not clinically appropriate should be excluded.

**NUMERATOR NOTE:** *The performance period for this measure is 24 months.*

**Numerator Options:**

Lipid panel results documented and reviewed (must include total cholesterol, HDL-C, triglycerides and calculated LDL-C) (G8767)

Note: *If LDL-C could not be calculated due to high triglycerides, count as complete lipid profile.*

**OR**

Documentation of medical reason(s) for not performing lipid profile (e.g., patients who have a terminal illness or for whom treatment of hypertension with standard treatment goals is not clinically appropriate) (G8768)

**OR**

Lipid profile **not** performed, reason not otherwise specified (G8769)

*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 "2012 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 #297: Hypertension: Urine Protein Test

**DESCRIPTION:**

Percentage of patients aged 15 through 90 years old with a diagnosis of hypertension who either have chronic kidney disease diagnosis documented or had a urine protein test done within 36 months

**NUMERATOR:**

Patients who either have chronic kidney disease diagnosis documented OR had a urine protein test done within 36 months

**Numerator Instructions:** This measure is looking for a urine protein screening test or evidence of existing chronic kidney disease. A urine protein test consists of tests for albuminuria, microalbuminuria, or proteinuria.

**Definitions:**

**Terminal illness** - Patients are considered to have a terminal illness if, in the eligible professional's clinical judgment, their life expectancy is less than one year.

**Treatment of hypertension with standard treatment goals is not clinically appropriate** - Although some patients may not have a terminal illness (defined as life expectancy of less than one year), treatment of hypertension with standard goals may not be relevant, as might be the case for a patient with severe Alzheimer's disease.

Patients who have a terminal illness or for whom treatment of hypertension with standard treatment goals is not clinically appropriate should be excluded.

**NUMERATOR NOTE:** *The performance period for this measure is 36 months.*

**Numerator Options:**

Urine Protein test result documented and reviewed (G8770)

**OR**

Documentation of diagnosis of chronic kidney disease (G8771)

**OR**

Documentation of medical reason(s) for not performing urine protein test (e.g., patients who have a terminal illness or for whom treatment of hypertension with standard treatment goals is not clinically appropriate) (G8772)

**OR**

Urine protein test was **not** performed, reason not otherwise specified (G8773)

*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 "2012 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 #298: Hypertension: Annual Serum Creatinine Test

**DESCRIPTION:**

Percentage of patients aged 15 through 90 years old with a diagnosis of hypertension who had a serum creatinine test done within 12 months

**NUMERATOR:**

Patients who had most recent serum creatinine test done within 12 months

**Numerator Instructions:** Patients who have a terminal illness or for whom treatment of hypertension with standard treatment goals is not clinically appropriate should be excluded.

**Definitions:**

**Terminal illness** - Patients are considered to have a terminal illness if, in the eligible professional's clinical judgment, their life expectancy is less than one year.

**Treatment of hypertension with standard treatment goals is not clinically appropriate** - Although some patients may not have a terminal illness (defined as life expectancy of less than one year), treatment of hypertension with standard goals may not be relevant, as might be the case for a patient with severe Alzheimer's disease.

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

**Numerator Options:**

Serum creatinine test result documented and reviewed (G8774)

**OR**

Documentation of medical reason(s) for not performing serum creatinine test (e.g., patients who have a terminal illness or for whom treatment of hypertension with standard treatment goals is not clinically appropriate) (G8775)

**OR**

Serum creatinine test **not** performed, reason not otherwise specified (G8776)

*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 "2012 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 #299: Hypertension: Diabetes Mellitus Screening Test

**DESCRIPTION:**

Percentage of patients aged 15 through 90 years old with a diagnosis of hypertension who had a diabetes screening test within 36 months

**NUMERATOR:**

Patients who had a diabetes screening test done within 36 months

**Numerator Instructions:** Diabetes screening test consists of either a fasting glucose measurement, glycosylated hemoglobin test, or a two hour glucose tolerance test (three specimens). Patients who have a terminal illness or for whom treatment of hypertension with standard treatment goals is not clinically appropriate or patients with a diagnosis of diabetes should be excluded.

**Definitions:**

**Terminal illness** - Patients are considered to have a terminal illness if, in the eligible professional's clinical judgment, their life expectancy is less than one year.

**Treatment of hypertension with standard treatment goals is not clinically appropriate** - Although some patients may not have a terminal illness (defined as life expectancy of less than one year), treatment of hypertension with standard goals may not be relevant, as might be the case for a patient with severe Alzheimer's disease.

**NUMERATOR NOTE:** *The performance period for this measure is 36 months.*

**Numerator Options:**

Diabetes screening test performed (G8777)

**OR**

Documentation of medical reason(s) for not performing diabetes screening test (e.g., patients who have a terminal illness or for whom treatment of hypertension with standard treatment goals is not clinically appropriate, OR patients with a diagnosis of diabetes) (G8778)

**OR**

Diabetes screening test **not** performed, reason not otherwise specified (G8779)

*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 "2012 Physician Quality Reporting Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS Physician Quality Reporting website.*



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**● Measure #302: Hypertension: Dietary and Physical Activity Modifications Appropriately Prescribed**

**DESCRIPTION:**

Percentage of patients aged 15 through 90 years old with a diagnosis of hypertension who received dietary and physical activity counseling at least once within 12 months

**NUMERATOR:**

Patients who received dietary and physical activity counseling at least once within 12 months

**Numerator Instructions:** Patients who have a terminal illness or for whom treatment of hypertension with standard treatment goals is not clinically appropriate should be excluded.

**Definitions:**

**Terminal illness** - Patients are considered to have a terminal illness if, in the eligible professional's clinical judgment, their life expectancy is less than one year.

**Treatment of hypertension with standard treatment goals is not clinically appropriate** - Although some patients may not have a terminal illness (defined as life expectancy of less than one year), treatment of hypertension with standard goals may not be relevant, as might be the case for a patient with severe Alzheimer's disease.

**Counseling** – May include documentation of prescribing any of the following dietary modifications: dietary saturated fat and cholesterol restriction, calorie restriction as part of weight reduction program for overweight/obese patients, DASH eating plan, dietary sodium restriction, increased fruits, vegetables and/or soluble fiber; and documentation of activity status for active patients or discussion of increase exercise or physical activity for inactive patients.

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

**Numerator Options:**

Counseling for Diet and Physical Activity Performed (G8780)

**OR**

Documentation of medical reason(s) for patient not receiving counseling for diet and physical activity (e.g., patients who have a terminal illness or for whom treatment of hypertension with standard treatment goals is not clinically appropriate) (G8781)

**OR**

Counseling for Diet and Physical Activity **not** performed, reason not otherwise specified (G8782)

*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 "2012 Physician Quality Reporting Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS Physician Quality Reporting website.*

## CARDIOVASCULAR PREVENTION MEASURES GROUP OVERVIEW

### 2012 PHYSICIAN QUALITY REPORTING OPTIONS FOR MEASURES GROUPS: CLAIMS, REGISTRY

#### 2012 PHYSICIAN QUALITY REPORTING MEASURES IN CARDIOVASCULAR PREVENTION MEASURES GROUP:

- #2. Diabetes Mellitus: Low Density Lipoprotein (LDL-C) Control in Diabetes Mellitus
- #204. Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic
- #226. Preventive Care: Tobacco Use: Screening and Cessation Intervention
- #236. Hypertension (HTN): Controlling High Blood Pressure
- #317. Preventive Care and Screening: Screening for High Blood Pressure
- #241. Ischemic Vascular Disease (IVD): Complete Lipid Panel and Low Density Lipoprotein (LDL-C) Control

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

- Indicate your intention to report the Cardiovascular Preventive 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.

**G8905:** I intend to report the Cardiovascular Preventive 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, 2012 **OR** July 1 through December 31, 2012). The 6-month reporting period is only applicable for the 80% Patient Sample Method via Registry. 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 Cardiovascular Prevention Measures Group are patients aged  $\geq 18$  and older with a specific diagnosis of Diabetes Mellitus or Ischemic Vascular Disease and accompanied by a specific patient encounter:

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

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250.83, 250.90, 250.91, 250.92, 250.93, 357.2, 362.01, 362.02, 362.03, 362.04, 362.05, 362.06, 362.07, 366.41, 648.00, 648.01, 648.02, 648.03, 648.04

**AND/OR**

**One of the following diagnosis codes indicating ischemic vascular disease:** 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, 414.2, 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, 444.1, 444.21, 444.22, 444.81, 444.89, 444.9, 445.01, 445.02, 445.81, 445.89

**Accompanied by**

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

- Report quality-data codes (QDCs) on **all applicable** measures within the Cardiovascular Prevention Measures Group for each patient within the sample.
- Applicable measures contain patient demographic criteria specific to the measure. For example, Diabetes Mellitus criteria is applicable *only to patients 18-75 years* within the sample population, while the Tobacco Use: Screening and Cessation Intervention measure within this group applies to *all patients ≥ 18 years and older*. Reporting measure(s) from the group that are inapplicable to an individual patient will not affect the eligible provider's reporting or performance rate.
- Only patients with IVD or DM are included in this measures group.
- For patients with DM diagnosis, only need to report for those age ≥ 18 – 75 years
- If patient also has a diagnosis of HTN, measure #236 should be reported
- If a patient does not have a diagnosis of HTN, measure #317 should be reported

| Diagnosis | Has HTN<br>Diagnosis – Report<br>these measures | Does not have HTN<br>Diagnosis – Report these<br>measures |
|-----------|---|---|
| DM only * | 2, 226, 236                                     | 2, 226, 317   |
| IVD Only  | 204, 241, 226, 236                              | 204, 241 226, 317   |
| DM & IVD  | 204, 2*, 226, TBD, 236                          | 204, 2*, 226, TBD, 317                                    |

\*Only report for patients aged 18-75 years

- Instructions for quality-data code reporting for each of the measures within the Cardiovascular Prevention 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

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

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 G8764:** All quality actions for the applicable measures in the Cardiovascular Prevention Measures Group have been performed for this patient

- To report satisfactorily the Cardiovascular Prevention 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.
- Measures groups containing a measure with a 0% performance rate will not be counted as satisfactorily reporting the measures group. The recommended clinical quality action must be performed on at least one patient for each measure within the measures group reported by the eligible professional. Performance exclusion quality data codes are not counted in the performance denominator. If the eligible professional submits all performance exclusion quality data codes, the performance rate would be 0/0 and would be considered satisfactorily reporting. If a measure within a measures group is not applicable to a patient, the patient would not be counted in the performance denominator for that measure (e.g., Preventive Care Measures Group - Measure #39: Screening or Therapy for Osteoporosis for Women would not be applicable to male patients according to the patient sample criteria). If the measure is not applicable for all patients within the sample, the performance rate would be 0/0 and would be considered satisfactorily reporting.
- 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 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 "2012 Physician Quality Reporting Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS Physician Quality Reporting website.*

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◆ 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 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  $\geq$  100 mg/dL**

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

**OR**

**CPT II 3050F: Most recent LDL-C  $\geq$  130 mg/dL**

**OR**

**LDL-C Level not Performed, Reason not Specified**

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-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 "2012 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 #204: Ischemic Vascular Disease (IVD): Use of 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 from the date of service.*

**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 "2012 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 NOTE:** In the event that a patient is screened for tobacco use and identified as a user but did not receive tobacco cessation counseling report 4004F with 8P.*

**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 (intervention, counseling, pharmacotherapy, or both), 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 (e.g., 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 "2012 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 #236: Hypertension (HTN): Controlling High Blood Pressure

**DESCRIPTION:**

Percentage of patients aged 18 through 85 years who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled (< 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 Quality-Data Coding Options for Reporting Satisfactorily:**

**Most Recent Blood Pressure Measurement Performed**

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

**G8752:** Most recent systolic blood pressure < 140 mmHg

**OR**

**G8753:** Most recent systolic blood pressure ≥ 140 mmHg

**AND**

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

**G8754:** Most recent diastolic blood pressure < 90 mmHg

**OR**

**G8755:** Most recent diastolic blood pressure ≥ 90 mmHg

**OR**

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

**G8756:** No documentation of blood pressure measurement, 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 "2012 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 #317: Preventive Care and Screening: Screening for High Blood Pressure

**DESCRIPTION:**

Percentage of patients aged 18 years and older who are screened for high blood pressure

**NUMERATOR:**

Patients who were screened for high blood pressure according to defined recommended screening intervals

***Numerator Note:** For the purposes of Physician Quality Reporting, this measure only needs to be reported once per reporting period.*

**Definitions**

**Recommended screening intervals**

- Patients with the most recent blood pressure < 120/80 mmHg should be screened every 2 years
- Patients with a most recent systolic blood pressure of 120-139 mmHg or diastolic blood pressure of 80-90 mmHg should be screened every year
- Patients with 1 elevated readings of  $\geq 140$  mmHg or  $> 90$  mmHg should be re-screened in a month

**Not Eligible**

- Previous diagnosis with hypertension at any time in the patient's history OR whose two most recent systolic blood pressure  $\geq 140$  mmHg or diastolic blood pressure  $> 90$  mmHg
- Patient refuses blood pressure measurement
- Patient is in an urgent or emergent situation where time is of the essence and to delay treatment would jeopardize the patient's health status

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

**Blood Pressure Screening Performed as Recommended**

**G8783:** Blood pressure screening performed as recommended by the defined screening interval

**OR**

**Blood Pressure Screening not Performed as Recommended, Patient not Eligible**

**G8784:** Blood pressure not assessed, Patient not Eligible

**OR**

**Blood Pressure Screening not Performed as Recommended, Reason not Specified**

**G8785:** Blood pressure screening not performed as recommended by screening interval, 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 "2012 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 #241: Ischemic Vascular Disease (IVD): Complete Lipid Panel and Low Density Lipoprotein (LDL-C) Control**

**DESCRIPTION:**

Percentage of patients aged 18 years and older with Ischemic Vascular Disease (IVD) who received at least one lipid profile within 12 months and whose most recent LDL-C level was in control (less than 100 mg/dL)

**NUMERATOR :**

Patients who received at least one lipid profile (or ALL component tests) with most recent LDL-C < 100 mg/dL

*NUMERATOR NOTE: The performance period for this measure is 12 months from the date of service.*

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

**Lipid Profile Performed and Most Recent LDL-C < 100 mg/dL**

**G8593:** Lipid panel 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.*

**AND**

**G8595:** Most recent LDL-C < 100 mg/dL

**OR**

**Lipid Profile not Performed, Reason not Specified**

**G8594:** Lipid profile not performed, reason not otherwise specified

**OR**

**Most Recent LDL-C ≥ 100 mg/dL**

**G8593:** Lipid panel results documented and reviewed (must include total cholesterol, HDL-C, triglycerides and calculated LDL-C)

**AND**

**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 "2012 Physician Quality Reporting Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS Physician Quality Reporting website.*

## CATARACTS MEASURES GROUP OVERVIEW

### 2012 PHYSICIAN QUALITY REPORTING OPTIONS FOR MEASURES GROUPS: REGISTRY ONLY

#### 2012 PHYSICIAN QUALITY REPORTING MEASURES IN CATARACTS MEASURES GROUP:

- #191. Cataracts: 20/40 or Better Visual Acuity within 90 days Following Cataract Surgery
- #192. Cataracts: Complications within 30 days Following Cataract Surgery Requiring Additional Surgical Procedures
- #303. Cataracts: Improvement in Patient's Visual Function within 90 days Cataract Surgery
- #304. Cataracts: Patient Satisfaction within 90 days Following Cataract Surgery

#### **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.

**G8906:** I intend to report the Cataracts 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, 2012 **OR** July 1 through December 31, 2012). 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 Cataracts Measures Group are patients aged 18 years and older that have a specific procedure for cataract surgery performed:

**One of the following procedure codes indicating cataract surgery:** 66840, 66850, 66852, 66920, 66930, 66940, 66983, 66984

**WITHOUT**

Modifier 56 (preoperative management only)

- Measures #191 and #192 need only be reported when the patient also has a diagnosis of uncomplicated cataract. Refer to the measure specification on the following pages for specific codes indicating a diagnosis of uncomplicated cataract for each of these two measures. Measures #M77 and #M78 need **not** be reported when the cataract surgery includes a modifier 55 (postoperative management only).

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

- Report a numerator option on **all applicable** measures within the Cataracts Measures Group for each procedure (patient) within the eligible professional's patient sample.
- Instructions for qualifying numerator option reporting for each of the measures within the Cataracts 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 G8765:** All quality actions for the applicable measures in the Cataracts Measures Group have been performed for this patient

- To report satisfactorily the Cataracts Measures Group it requires **all applicable** measures for each patient within the eligible professional's patient sample to be reported each time a cataract surgery is performed during the reporting period.
- Measures groups containing a measure with a 0% performance rate will not be counted as satisfactorily reporting the measures group. The recommended clinical quality action must be performed on at least one patient for each measure within the measures group reported by the eligible professional. Performance exclusion quality data codes are not counted in the performance denominator. If the eligible professional submits all performance exclusion quality data codes, the performance rate would be 0/0 and would be considered satisfactorily reporting. If a measure within a measures group is not applicable to a patient, the patient would not be counted in the performance denominator for that measure (e.g., Preventive Care Measures Group - Measure #39: Screening or Therapy for Osteoporosis for Women would not be applicable to male patients according to the patient sample criteria). If the measure is not applicable for all patients within the sample, the performance rate would be 0/0 and would be considered satisfactorily reporting. When a lower rate indicates better performance, such as Measure #192, a 0% performance rate will be counted as satisfactorily reporting (100% performance rate would not be considered satisfactorily reporting).
- 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 "2012 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 #191: Cataracts: 20/40 or Better Visual Acuity within 90 Days Following Cataract Surgery**

**DESCRIPTION:**

Percentage of patients aged 18 years and older with a diagnosis of uncomplicated cataract who had cataract surgery and no significant ocular conditions impacting the visual outcome of surgery and had best-corrected visual acuity of 20/40 or better (distance or near) achieved within 90 days following the cataract surgery

**Note: This is an outcomes measure and can be calculated solely using registry data.**

- For patients who receive the cataract surgical procedures specified in the common denominator coding, it should be reported whether or not the patient had best-corrected visual acuity of 20/40 or better achieved within 90 days following cataract surgery.
- Patients who have any of the listed comorbid conditions in the exclusion criteria should be removed from the denominator; these patients have existing ocular conditions that could impact the outcome of surgery and are not included in the measure calculation for those patients who have best-corrected visual acuity of 20/40 or better (distance or near) achieved within 90 days following the cataract surgery.
- Include only procedures performed through September 30 of the reporting period. This will allow the post operative period to occur within the reporting year.

***Patients with documentation of any of the following comorbid conditions that impact the visual outcome of surgery prior to date of cataract surgery are excluded from the measure calculation.***

| <b>Comorbid Condition</b>                     | <b>Corresponding ICD-9-CM Codes</b>                            |
|---|--|
| Acute and subacute iridocyclitis              | 364.00, 364.01, 364.02, 364.03, 364.04, 364.05                 |
| Amblyopia                                     | 368.01, 368.02, 368.03   |
| Burn confined to eye and adnexa               | 940.0, 940.1, 940.2, 940.3, 940.4, 940.5, 940.9                |
| Cataract secondary to ocular disorders        | 366.32, 366.33   |
| Certain types of iridocyclitis                | 364.21, 364.22, 364.23, 364.24, 364.3                          |
| Choroidal degenerations                       | 363.43   |
| Choroidal detachment                          | 363.72   |
| Choroidal hemorrhage and rupture              | 363.61, 363.62, 363.63   |
| Chorioretinal scars                           | 363.30, 363.31, 363.32, 363.33, 363.35                         |
| Chronic iridocyclitis                         | 364.10, 364.11   |
| Cloudy cornea                                 | 371.01, 371.02, 371.03, 371.04                                 |
| Corneal opacity and other disorders of cornea | 371.00, 371.03, 371.04   |
| Corneal edema                                 | 371.20, 371.21, 371.22, 371.23, 371.43, 371.44                 |
| Degeneration of macula and posterior pole     | 362.50, 362.51, 362.52, 362.53, 362.54, 362.55, 362.56, 365.57 |
| Degenerative Disorders of Globe               | 360.20, 360.21, 360.23, 360.24, 360.29                         |

**SPECIFICATION FOR MEASURES GROUP REPORTING ONLY**

| <b>Comorbid Condition</b>  | <b>Corresponding ICD-9-CM Codes</b>  |
|--|--|
| Diabetic Macular Edema   | 362.07   |
| Diabetic Retinopathy   | 362.01, 362.02, 362.03, 362.04, 362.05, 362.06   |
| Disorders of optic chiasm  | 377.51, 377.52, 377.53, 377.54   |
| Disorders of visual cortex   | 377.75   |
| Disseminated chorioretinitis and disseminated retinochoroiditis                    | 363.10, 363.11, 363.12, 363.13, 363.14, 363.15   |
| Focal chorioretinitis and focal retinochoroiditis                                  | 363.00, 363.01, 363.03, 363.04, 363.05, 363.06, 363.07, 363.08   |
| Glaucoma   | 365.10, 365.11, 365.12, 365.13, 365.14, 365.15, 365.20, 365.21, 365.22, 365.23, 365.24, 365.31, 365.32, 365.51, 365.52, 365.59, 365.60, 365.61, 365.62, 365.63, 365.64, 365.65, 365.81, 365.82, 365.83, 365.89 |
| Glaucoma associated with congenital anomalies, dystrophies, and systemic syndromes | 365.41, 365.42, 365.43, 365.44, 365.60, 365.61, 365.62, 365.63, 365.64, 365.65, 365.81, 365.82, 365.83, 365.89, 365.9  |
| Hereditary corneal dystrophies   | 371.50, 371.51, 371.52, 371.53, 371.54, 371.55, 371.56, 371.57, 371.58   |
| Hereditary choroidal dystrophies   | 363.50, 363.51, 363.52, 363.53, 363.54, 363.55, 363.56, 363.57   |
| Hereditary retinal dystrophies   | 362.70, 362.71, 362.72, 362.73, 362.74, 362.75, 362.76   |
| High myopia  | 360.20, 360.21   |
| Injury to optic nerve and pathways   | 950.0, 950.1, 950.2, 950.3, 950.9  |
| Keratitis  | 370.03   |
| Moderate or severe impairment, better eye, profound impairment lesser eye          | 369.10, 369.11, 369.12, 369.13, 369.14, 369.15, 369.16, 369.17, 369.18   |
| Nystagmus and other irregular eye movements  | 379.51   |
| Open wound of eyeball  | 871.0, 871.1, 871.2, 871.3, 871.4, 871.5, 871.6, 871.7, 871.9, 921.3   |
| Optic Atrophy  | 377.10, 377.11, 377.12, 377.13, 377.14, 377.15, 377.16   |
| Optic neuritis   | 377.30, 377.31, 377.32, 377.33, 377.34, 377.39   |
| Other background retinopathy and retinal vascular changes                          | 362.12, 362.16, 362.18   |
| Other corneal deformities  | 371.70, 371.71, 371.72, 371.73   |
| Other disorders of optic nerve   | 377.41   |
| Other disorders of sclera  | 379.11, 379.12   |
| Other endophthalmitis  | 360.11, 360.12, 360.13, 360.14, 360.19   |
| Other retinal disorders  | 362.81, 362.82, 362.83, 362.84, 362.85, 362.89   |
| Other and unspecified forms of chorioretinitis and retinochoroiditis               | 363.20, 363.21, 363.22   |

**SPECIFICATION FOR MEASURES GROUP REPORTING ONLY**

| <b>Comorbid Condition</b>              | <b>Corresponding ICD-9-CM Codes</b>                                    |
|--|--|
| Prior penetrating keratoplasty         | 371.60, 371.61, 371.62   |
| Profound impairment, both eyes         | 369.00, 369.01, 369.02, 369.03, 369.04, 369.05, 369.06, 369.07, 369.08 |
| Purulent endophthalmitis               | 360.00, 360.01, 360.02, 360.03, 360.04                                 |
| Retinal detachment with retinal defect | 361.00, 361.01, 361.02, 361.03, 361.04, 361.05, 361.06, 361.07         |
| Retinal vascular occlusion             | 362.31, 362.32, 362.35, 362.36,  |
| Retinopathy of prematurity             | 362.20, 362.21, 362.22, 362.23, 362.24, 362.25, 362.26, 362.27         |
| Scleritis and episcleritis             | 379.04, 379.05, 379.06, 379.07, 379.09                                 |
| Separation of retinal layers           | 362.41, 362.42, 362.43   |
| Uveitis                                | 360.11, 360.12   |
| Visual field defects                   | 368.41   |

**NUMERATOR:**

Patients who had best-corrected visual acuity of 20/40 or better (distance or near) achieved within 90 days following cataract surgery

**Numerator Options:**

Best-corrected visual acuity of 20/40 or better (distance or near) achieved within 90 days following cataract surgery (4175F)

**OR**

Best-corrected visual acuity of 20/40 or better (distance or near) **not** achieved within 90 days following cataract surgery, reason not otherwise specified (4175F *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 "2012 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 #192: Cataracts: Complications within 30 Days Following Cataract Surgery Requiring Additional Surgical Procedures**

**DESCRIPTION:**

Percentage of patients aged 18 years and older with a diagnosis of uncomplicated cataract who had cataract surgery and had any of a specified list of surgical procedures in the 30 days following cataract surgery which would indicate the occurrence of any of the following major complications: retained nuclear fragments, endophthalmitis, dislocated or wrong power IOL, retinal detachment, or wound dehiscence

**Note: This is an outcomes measure and can be calculated solely using registry data.**

- For patients who receive the cataract surgical procedures specified in the denominator coding, claims should be reviewed to determine if any of the procedure codes listed in the numerator were performed within 30 days of the date of cataract surgery.
- Patients who have any of the listed comorbid conditions in the exclusion criteria should be removed from the denominator, and not considered as having a complication within 30 days following cataract surgery.

*Patients with documentation of one or more of the following comorbid conditions prior to date of cataract surgery are excluded from the measure calculation.*

| Comorbid Condition                                 | Corresponding ICD-9-CM Codes   |
|--|--|
| Acute and subacute iridocyclitis                   | 364.00, 364.01, 364.02, 364.03, 364.04, 364.05   |
| Adhesions and disruptions of iris and ciliary body | 364.70, 364.71, 364.72, 364.73, 364.74, 364.75, 364.76, 364.77, 364.81, 364.82, 364.89 |
| Anomalies of pupillary function                    | 379.42   |
| Aphakia and other disorders of lens                | 379.32, 379.33, 379.34   |
| Burn confined to eye and adnexa                    | 940.0, 940.1, 940.2, 940.3, 940.4, 940.5, 940.9  |
| Cataract secondary to ocular disorders             | 366.32, 366.33   |
| Cataract, congenital                               | 743.30   |
| Cataract, mature or hypermature                    | 366.9  |
| Cataract, posterior polar                          | 743.31   |
| Certain types of iridocyclitis                     | 364.21, 364.22, 364.23, 364.24, 364.3  |
| Chronic iridocyclitis                              | 364.10, 364.11   |
| Cloudy cornea                                      | 371.01, 371.02, 371.03, 371.04   |
| Corneal opacity and other disorders of cornea      | 371.00, 371.03, 371.04   |
| Corneal edema                                      | 371.20, 371.21, 371.22, 371.23, 371.43, 371.44   |



**SPECIFICATION FOR MEASURES GROUP REPORTING ONLY**

| <b>Comorbid Condition</b>   | <b>Corresponding ICD-9-CM Codes</b>  |
|---|--|
| Cysts of iris, ciliary body, and anterior chamber   | 364.60, 364.61, 364.62, 364.63, 364.64   |
| Enophthalmos  | 376.50, 376.51, 376.52   |
| Glaucoma  | 365.10, 365.11, 365.12, 365.13, 365.14, 365.15, 365.20, 365.21, 365.22, 365.23, 365.24, 365.31, 365.32, 365.51, 365.52, 365.59, 365.60, 365.61, 365.62, 365.63, 365.64, 365.65, 365.81, 365.82, 365.83, 365.89 |
| Hereditary corneal dystrophies  | 371.50, 371.51, 371.52, 371.53, 371.54, 371.55, 371.56, 371.57, 371.58   |
| High hyperopia  | 367.0  |
| High myopia   | 360.21   |
| Hypotony of eye   | 360.30, 360.31, 360.32, 360.33, 360.34   |
| Injury to optic nerve and pathways  | 950.0, 950.1, 950.2, 950.3, 950.9  |
| Keratitis   | 370.03   |
| Open wound of eyeball   | 871.0, 871.1, 871.2, 871.3, 871.4, 871.5, 871.6, 871.7, 871.9, 921.3   |
| Pathologic myopia   | 360.20, 360.21   |
| Posterior lenticonus  | 743.36   |
| Prior pars plana vitrectomy   | 67036, 67039, 67040, 67041, 67042, 67043 (patient with history of this procedure)  |
| Pseudoexfoliation syndrome  | 365.52   |
| Retinopathy of prematurity  | 362.21   |
| Senile cataract   | 366.11   |
| Traumatic cataract  | 366.21, 366.22, 366.23, 366.20   |
| Use of systemic sympathetic alpha-1a antagonist medication for treatment of prostatic hypertrophy | Patient taking tamsulosin hydrochloride  |
| Uveitis   | 360.11, 360.12   |
| Vascular disorders of iris and ciliary body   | 364.42   |

**NUMERATOR:**

Patients who had one or more specified operative procedures for any of the following major complications within 30 days following cataract surgery: retained nuclear fragments, endophthalmitis, dislocated or wrong power IOL, retinal detachment, or wound dehiscence

**SPECIFICATION FOR MEASURES GROUP REPORTING ONLY**

**Numerator Instructions:** Codes for major complications (e.g., retained nuclear fragments, endophthalmitis, dislocated or wrong power IOL, retinal detachment, or wound dehiscence): 65235, 65800, 65810, 65815, 65860, 65880, 65900, 65920, 65930, 66030, 66250, 66820, 66825, 66830, 66852, 66986, 67005, 67010, 67015, 67025, 67028, 67030, 67031, 67036, 67039, 67041, 67042, 67043, 67101, 67105, 67107, 67108, 67110, 67112, 67141, 67145, 67250, 67255

**NUMERATOR NOTE:** For performance, a lower rate indicates better performance.

**Numerator Options:**

Surgical procedure performed within 30 days following cataract surgery for major complications (e.g., retained nuclear fragments, endophthalmitis, dislocated or wrong power IOL, retinal detachment or wound dehiscence) (G8627)

**OR**

Surgical procedure **not** performed within 30 days following cataract surgery for major complications (e.g., retained nuclear fragments, endophthalmitis, dislocated or wrong power IOL, retinal detachment or wound dehiscence) (G8628)

*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 "2012 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 #303: Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery**

**DESCRIPTION:**

Percentage of patients aged 18 years and older in sample who had cataract surgery and had improvement in visual function achieved within 90 days following the cataract surgery, based on completing a pre-operative and post-operative visual function survey

**Note: This is an outcomes measure and will be calculated solely using registry data.**

- For patients who receive the cataract surgical procedures specified in the denominator coding in the sample, it should be reported whether or not the patient had improvement in visual function achieved within 90 days following the cataract surgery.
- Include only procedures performed through September 30 of the reporting period. This will allow the post-operative period to occur within the reporting year.

**NUMERATOR:**

Patients 18 years and older who had improvement in visual function achieved within 90 days following cataract surgery, based on completing a pre-operative and post-operative visual function survey

**Numerator Options:**

Improvement in visual function achieved within 90 days following cataract surgery (G0913)

**OR**

Patient care survey was not completed by patient (G0914)

**OR**

Improvement in visual function **not** achieved within 90 days following cataract surgery (G0915)

*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 "2012 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 #304: Patient Satisfaction within 90 Days Following Cataract Surgery

**DESCRIPTION:**

Percentage of patients aged 18 years and older in sample who had cataract surgery and were satisfied with their care within 90 days following the cataract surgery, based on completion of the Consumer Assessment of Healthcare Providers and Systems Surgical Care Survey

**Note: This is an outcomes measure and will be calculated solely using registry data.**

- For patients who receive the cataract surgical procedures specified in the denominator coding in the sample, it should be reported whether or not the patient was satisfied with their care within 90 days following the cataract surgery.
- Include only procedures performed through September 30 of the reporting period. This will allow the post-operative period to occur within the reporting year.

**NUMERATOR:**

Patients 18 years and older in the sample who were satisfied with their care within 90 days following cataract surgery, based on completion of the Consumer Assessment of Healthcare Providers and Systems Surgical Care Survey

**Numerator Options:**

Satisfaction with care achieved within 90 days following cataract surgery (G0916)

**OR**

Patient care survey was not completed by patient (G0917)

**OR**

Satisfaction with care **not** achieved within 90 days following cataract surgery (G0918)

*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 "2012 Physician Quality Reporting Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS Physician Quality Reporting website.*

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