2013 Physician Quality Reporting System (PQRS)

Claims/Registry Measure Specifications Manual

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2013 PQRS Measure Specifications Manual for Claims and Registry Reporting of Individual Measures

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PQRS Introduction

The measure specifications contained in this manual are intended for claims-based and registry-based reporting of individual measures for the 2013 Physician Quality Reporting System (PQRS). Each measure is assigned a unique number. Measure numbers for 2013 PQRS represents a continuation in numbering from the 2012 measures. For 2013 PQRS measures that are continuing forward in the 2013 PQRS, measure specifications have been updated. In addition to the measure specifications manual, please refer to the "2013 Physician Quality Reporting System Implementation Guide" for additional information essential in assisting eligible professionals' understanding and submission of measures. This document can be accessed at: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/MeasuresCodes.html. Measure specifications for measures groups reporting are included in a separate manual, "2013 Physician Quality Reporting System Measures Groups Specifications Manual," which can be accessed at: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/MeasuresCodes.html.

This specification manual applies to PQRS for incentive payment eligibility only. Those who report satisfactorily for the 2013 program year *may* avoid the 2015 payment adjustment. Additional information on how to avoid future PQRS payment adjustments can be found through supporting documentation available on the CMS website: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/.

Eligible Professionals

Eligible professionals submitting billable services on Part B claims for allowable Medicare Physician Fee Schedule (PFS) charges may report the quality action for selected PQRS quality measure(s). Providers not defined as eligible professionals in the Tax Relief and Health Care Act of 2006 or the Medicare Improvements for Patients and Providers Act of 2008 are not eligible to participate in PQRS. A list of eligible professionals can be found on the PQRS website at: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/How_To_Get_Started.html.

Frequency and Performance Timeframes

The measure instructions limit the frequency of reporting necessary in certain circumstances, such as for patients with chronic illness for whom a particular process of care is provided only periodically. Each individual eligible professional participating in 2013 PQRS should report according to the frequency and timeframe listed within each measure specification.

Denominator Codes (Eligible Cases) and Numerator Quality-Data Codes

Quality measures consist of a numerator and a denominator that permit the calculation of the percentage of a defined patient population that receive a particular process of care or achieve a particular outcome. The denominator population is defined by demographic information, certain International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) diagnosis, Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) codes specified in the measure that are submitted by individual eligible professionals as part of a claim for covered services under the PFS.

International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) diagnosis codes have been incorporated into the 2013 PQRS Measures Specifications. These codes are for REFERENCE ONLY and should not be used to determine eligible patients for the 2013 program year. Reporting ICD-10-CM codes will ***not*** count toward satisfactorily reporting the measures within the Physician Quality Reporting System for 2013.

If the specified denominator codes for a measure are not included on the patient's claim (for the same date of service) as submitted by the individual eligible professional, then the patient does not fall into the denominator population, and the PQRS measure does not apply to the patient. Some measure specifications are adapted as

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needed for implementation in PQRS in agreement with the measure developer. For example, CPT codes for non-covered services such as preventive visits are not included in the denominator. Also, the denominators for measures groups have been modified to provide common denominator codes for all measures within the group.

PQRS measure specifications include specific instructions regarding CPT Category I modifiers, place of service codes, and other detailed information. Each eligible professional should carefully review the measure's denominator coding to determine whether codes submitted on a given claim meet denominator inclusion criteria.

If the patient does fall into the denominator population, the applicable Quality Data Codes or QDCs (CPT Category II codes or G-codes) that define the numerator should be submitted to satisfactorily report quality data for a measure. When a patient falls into the denominator, but the measure specifications define circumstances in which a patient may be appropriately excluded, CPT Category II code modifiers such as 1P, 2P and 3P or G-codes are available to describe medical, patient, system, or other reasons for performance exclusion. When the performance exclusion does not apply, a measure-specific CPT Category II reporting modifier 8P or G-code may be used to indicate that the process of care was not provided for a reason not otherwise specified. Each measure specification provides detailed reporting information.

PQRS measures, including patient-level measure(s), may be reported for the same patient by multiple eligible professionals practicing under the same Tax Identification Number (TIN). If a patient sees multiple providers during the reporting period, that patient can be counted for each individual NPI reporting if the patient encounter(s) meet denominator inclusion. The following is an example of two provider NPIs (National Provider Identifiers), billing under the same TIN who are intending to report PQRS Measure #6: Coronary Artery Disease (CAD): Oral Antiplatelet Therapy Prescribed for Patients with CAD. Provider A sees a patient on February 2, 2013 and prescribes an aspirin and reports the appropriate quality-data code (QDC) for measure #6. Provider B sees the same patient at an encounter on July 16, 2013 and verifies that the patient has been prescribed and is currently taking an aspirin. Provider B must also report the appropriate QDCs for the patient at the July encounter to receive credit for reporting measure #6.

Measure Specification Format
Measure title
Reporting option available for each measure (claims-based and/or registry)
Measure description
Instructions on reporting including frequency, timeframes, and applicability
Denominator statement and coding
Numerator statement and coding options
Definition(s) of terms where applicable
Rationale statement for measure
Clinical recommendations or evidence forming the basis for supporting criteria for the measure

The Rationale and Clinical Recommendation Statements sections provide limited supporting information regarding the quality actions described in the measure. Please contact the measure owner for section references and further information regarding the clinical rational and recommendations for the described quality action. Measure owner contact information is located on the last page of the Measures List document, which can be accessed at: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/MeasuresCodes.html.

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List of 2013 PQRS Individual Measure Specifications for Claims and Registry Reporting			
Measure Number	Measure Title	Reporting Options	Page
1	Diabetes Mellitus: Hemoglobin A1c Poor Control	C, R	16
2	Diabetes Mellitus: Low Density Lipoprotein (LDL-C) Control	C, R	18
3	Diabetes Mellitus: High Blood Pressure Control	C, R	21
5	Heart Failure: Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD)	R	23
6	Coronary Artery Disease (CAD): Antiplatelet Therapy	C, R	26
7	Coronary Artery Disease (CAD): Beta-Blocker Therapy - Prior Myocardial Infarction (MI) or Left Ventricular Systolic Dysfunction (LVEF < 40%)	R	28
8	Heart Failure: Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)	R	32
9	Major Depressive Disorder (MDD): Antidepressant Medication During Acute Phase for Patients with MDD	C, R	35
12	Primary Open Angle Glaucoma (POAG): Optic Nerve Evaluation	C, R	38
14	Age-Related Macular Degeneration (AMD): Dilated Macular Examination	C, R	40
18	Diabetic Retinopathy: Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy	C, R	42
19	Diabetic Retinopathy: Communication with the Physician Managing On going Diabetes Care	C, R	45
20	Perioperative Care: Timing of Prophylactic Parenteral Antibiotic – Ordering Physician	C, R	48
21	Perioperative Care: Selection of Prophylactic Antibiotic – First OR Second Generation Cephalosporin	C, R	54
22	Perioperative Care: Discontinuation of Prophylactic Parenteral Antibiotics (Non-Cardiac Procedures)	C, R	59
23	Perioperative Care: Venous Thromboembolism (VTE) Prophylaxis (When Indicated in ALL Patients)	C, R	64
24	Osteoporosis: Communication with the Physician Managing On-going Care Post-Fracture of Hip, Spine or Distal Radius for Men and Women Aged 50 Years and Older	C, R	69
28	Aspirin at Arrival for Acute Myocardial Infarction (AMI)	C, R	86
30	Perioperative Care: Timely Administration of Prophylactic Parenteral Antibiotics	C, R	88
31	Stroke and Stroke Rehabilitation: Deep Vein Thrombosis (DVT) Prophylaxis for Ischemic Stroke or Intracranial Hemorrhage	C, R	91
32	Stroke and Stroke Rehabilitation: Discharged on Anithrombotic Therapy	C, R	94
33	Stroke and Stroke Rehabilitation: Anticoagulant Therapy Prescribed for Atrial Fibrillation (AF) at Discharge	R	98
35	Stroke and Stroke Rehabilitation: Screening for Dysphagia	C, R	101
36	Stroke and Stroke Rehabilitation: Rehabilitation Services Ordered	C, R	105
39	Screening or Therapy for Osteoporosis for Women Aged 65 Years and Older	C, R	107
40	Osteoporosis: Management Following Fracture of Hip, Spine or Distal Radius for Men and Women Aged 50 Years and Older	C, R	110
41	Osteoporosis: Pharmacologic Therapy for Men and Women Aged 50 Years and Older	C, R	127
43	Coronary Artery Bypass Graft (CABG): Use of Internal Mammary Artery (IMA) in Patients with Isolated CABG Surgery	C, R	130
44	Coronary Artery Bypass Graft (CABG): Preoperative Beta-Blocker in Patients with Isolated CABG Surgery	C, R	132

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List of 2013 PQRS Individual Measure Specifications for Claims and Registry Reporting			
Measure Number	Measure Title	Reporting Options	Page
45	Perioperative Care: Discontinuation of Prophylactic Parenteral Antibiotics (Cardiac Procedures)	C, R	134
46	Medication Reconciliation	C, R	137
47	Advance Care Plan	C, R	140
48	Urinary Incontinence: Assessment of Presence or Absence of Urinary Incontinence in Women Aged 65 Years and Older	C, R	143
49	Urinary Incontinence: Characterization of Urinary Incontinence in Women Aged 65 Years and Older	C, R	145
50	Urinary Incontinence: Plan of Care for Urinary Incontinence in Women Aged 65 Years and Older	C, R	147
51	Chronic Obstructive Pulmonary Disease (COPD): Spirometry Evaluation	C, R	149
52	Chronic Obstructive Pulmonary Disease (COPD): Bronchodilator Therapy	C, R	151
53	Asthma: Pharmacologic Therapy for Persistent Asthma – Ambulatory Care Setting	C, R	154
54	Emergency Medicine: 12-Lead Electrocardiogram (ECG) Performed for Non-Traumatic Chest Pain	C, R	157
55	Emergency Medicine: 12-Lead Electrocardiogram (ECG) Performed for Syncope	C, R	159
56	Emergency Medicine: Community-Acquired Pneumonia (CAP): Vital Signs	C, R	161
59	Emergency Medicine: Community-Acquired Pneumonia (CAP): Empiric Antibiotic	C, R	163
64	Asthma: Assessment of Asthma Control – Ambulatory Care Setting	C, R	166
65	Appropriate Treatment for Children with Upper Respiratory Infection (URI)	C, R	169
66	Appropriate Testing for Children with Pharyngitis	C, R	171
67	Hematology: Myelodysplastic Syndrome (MDS) and Acute Leukemias: Baseline Cytogenetic Testing Performed on Bone Marrow	C, R	173
68	Hematology: Myelodysplastic Syndrome (MDS): Documentation of Iron Stores in Patients Receiving Erythropoietin Therapy	C, R	176
69	Hematology: Multiple Myeloma: Treatment with Bisphosphonates	C, R	179
70	Hematology: Chronic Lymphocytic Leukemia (CLL): Baseline Flow Cytometry	C, R	181
71	Breast Cancer: Hormonal Therapy for Stage IC - IIIC Estrogen Receptor/ Progesterone Receptor (ER/PR) Positive Breast Cancer	C, R	183
72	Colon Cancer: Chemotherapy for AJCC Stage III Colon Cancer Patients	C, R	187
76	Prevention of Catheter-Related Bloodstream Infections (CRBSI): Central Venous Catheter (CVC) Insertion Protocol	C, R	190
81	Adult Kidney Disease: Hemodialysis Adequacy: Solute	R	192
82	Adult Kidney Disease: Peritoneal Dialysis Adequacy: Solute	R	194
83	Hepatitis C: Testing for Chronic Hepatitis C – Confirmation of Hepatitis C Viremia	R	196
84	Hepatitis C: Ribonucleic Acid (RNA) Testing Before Initiating Treatment	C, R	198
85	Hepatitis C: HCV Genotype Testing Prior to Treatment	C, R	201
86	Hepatitis C: Antiviral Treatment Prescribed	C, R	203
87	Hepatitis C: HCV Ribonucleic Acid (RNA) Testing at Week 12 of Treatment	C, R	206
89	Hepatitis C: Counseling Regarding Risk of Alcohol Consumption	C, R	209
90	Hepatitis C: Counseling Regarding Use of Contraception Prior to Antiviral Therapy	C, R	211
91	Acute Otitis Externa (AOE): Topical Therapy	C, R	214
93	Acute Otitis Externa (AOE): Systemic Antimicrobial Therapy – Avoidance of Inappropriate Use	C, R	216

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List of 2013 PQRS Individual Measure Specifications for Claims and Registry Reporting			
Measure Number	Measure Title	Reporting Options	Page
99	Breast Cancer Resection Pathology Reporting: pT Category (Primary Tumor) and pN Category (Regional Lymph Nodes) with Histologic Grade	C, R	218
100	Colorectal Cancer Resection Pathology Reporting: pT Category (Primary Tumor) and pN Category (Regional Lymph Nodes) with Histologic Grade	C, R	221
102	Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low Risk Prostate Cancer Patients	C, R	224
104	Prostate Cancer: Adjuvant Hormonal Therapy for High Risk Prostate Cancer Patients	C, R	227
106	Adult Major Depressive Disorder (MDD): Comprehensive Depression Evaluation: Diagnosis and Severity	C, R	230
107	Adult Major Depressive Disorder (MDD): Suicide Risk Assessment	C, R	234
108	Rheumatoid Arthritis (RA): Disease Modifying Anti-Rheumatic Drug (DMARD)Therapy	C, R	238
109	Osteoarthritis (OA): Function and Pain Assessment	C, R	241
110	Preventive Care and Screening: Influenza Immunization	C, R	243
111	Preventive Care and Screening: Pneumococcal Vaccination for Patients 65 Years and Older	C, R	245
112	Preventive Care and Screening: Breast Cancer Screening	C, R	247
113	Preventive Care and Screening: Colorectal Cancer Screening	C, R	249
116	Antibiotic Treatment for Adults with Acute Bronchitis: Avoidance of Inappropriate Use	C, R	252
117	Diabetes Mellitus: Dilated Eye Exam	C, R	255
118	Coronary Artery Disease (CAD): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy - Diabetes or Left Ventricular Systolic Dysfunction (LVEF < 40%)	R	258
119	Diabetes Mellitus: Medical Attention for Nephropathy	C, R	262
121	Adult Kidney Disease: Laboratory Testing (Lipid Profile)	C, R	265
122	Adult Kidney Disease: Blood Pressure Management	C, R	267
123	Adult Kidney Disease: Patients on Erythropoiesis-Stimulating Agent (ESA) - Hemoglobin Level > 12.0 g/dL	C, R	271
126	Diabetes Mellitus: Diabetic Foot and Ankle Care, Peripheral Neuropathy - Neurological Evaluation	C, R	274
127	Diabetes Mellitus: Diabetic Foot and Ankle Care, Ulcer Prevention – Evaluation of Footwear	C, R	277
128	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up	C, R	279
130	Documentation of Current Medications in the Medical Record	C, R	283
131	Pain Assessment and Follow-Up	C, R	287
134	Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan	C, R	291
137	Melanoma: Continuity of Care – Recall System	R	295
138	Melanoma: Coordination of Care	R	297
140	Age-Related Macular Degeneration (AMD): Counseling on Antioxidant Supplement	C, R	300
141	Primary Open-Angle Glaucoma (POAG): Reduction of Intraocular Pressure (IOP) by 15% OR Documentation of a Plan of Care	C, R	303
142	Osteoarthritis (OA): Assessment for Use of Anti-Inflammatory or Analgesic Over-the-Counter (OTC) Medications	C, R	306
143	Oncology: Medical and Radiation – Pain Intensity Quantified	R	308
144	Oncology: Medical and Radiation – Plan of Care for Pain	R	313

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146	Radiology: Inappropriate Use of "Probably Benign" Assessment Category in Mammography Screening	C, R	320
147	Nuclear Medicine: Correlation with Existing Imaging Studies for All Patients Undergoing Bone Scintigraphy	C, R	322
154	Falls: Risk Assessment	C, R	325
155	Falls: Plan of Care	C, R	329
156	Oncology: Radiation Dose Limits to Normal Tissues	C, R	331
157	Thoracic Surgery: Recording of Clinical Stage Prior to Lung Cancer or Esophageal Cancer Resection	C, R	334
159	HIV/AIDS: CD4+ Cell Count or CD4+ Percentage	R	336
160	HIV/AIDS: Pneumocystis Jiroveci Pneumonia (PCP) Prophylaxis	R	338
161	HIV/AIDS: Adolescent and Adult Patients with HIV/AIDS Who Are Prescribed Potent Antiretroviral Therapy	R	340
162	HIV/AIDS: HIV RNA Control After Six Months of Potent Antiretroviral Therapy	R	344
163	Diabetes Mellitus: Foot Exam	C, R	347
164	Coronary Artery Bypass Graft (CABG): Prolonged Intubation	R	350
165	Coronary Artery Bypass Graft (CABG): Deep Sternal Wound Infection Rate	R	352
166	Coronary Artery Bypass Graft (CABG): Stroke	R	354
167	Coronary Artery Bypass Graft (CABG): Postoperative Renal Failure	R	356
168	Coronary Artery Bypass Graft (CABG): Surgical Re-Exploration	R	358
169	Coronary Artery Bypass Graft (CABG): Antiplatelet Medications at Discharge	R	360
170	Coronary Artery Bypass Graft (CABG): Beta-Blockers Administered at Discharge	R	362
171	Coronary Artery Bypass Graft (CABG): Anti-Lipid Treatment at Discharge	R	364
172	Hemodialysis Vascular Access Decision-Making by Surgeon to Maximize Placement of Autogenous Arterial Venous (AV) Fistula	C, R	366
173	Preventive Care and Screening: Unhealthy Alcohol Use – Screening	C, R	368
176	Rheumatoid Arthritis (RA): Tuberculosis Screening	C, R	370
177	Rheumatoid Arthritis (RA): Periodic Assessment of Disease Activity	C, R	374
178	Rheumatoid Arthritis (RA): Functional Status Assessment	C, R	377
179	Rheumatoid Arthritis (RA): Assessment and Classification of Disease Prognosis	C, R	380
180	Rheumatoid Arthritis (RA): Glucocorticoid Management	C, R	383
181	Elder Maltreatment Screen and Follow-Up Plan	C, R	386
182	Functional Outcome Assessment	C, R	389
183	Hepatitis C: Hepatitis A Vaccination in Patients with HCV	C, R	392
184	Hepatitis C: Hepatitis B Vaccination in Patients with HCV	C, R	394
185	Endoscopy & Polyp Surveillance: Colonoscopy Interval for Patients with a History of Adenomatous Polyps – Avoidance of Inappropriate Use	C, R	396
187	Stroke and Stroke Rehabilitation: Thrombolytic Therapy	R	398
188	Referral for Otologic Evaluation for Patients with Congenital or Traumatic Deformity of the Ear	C, R	400
191	Cataracts: 20/40 or Better Visual Acuity within 90 Days Following Cataract Surgery	R	403
192	Cataracts: Complications within 30 days Following Cataract Surgery Requiring Additional Surgical Procedures	R	412

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195	Radiology: Stenosis Measurement in Carotid Imaging Reports	C, R	428
197	Coronary Artery Disease (CAD): Lipid Control	R	431
198	Heart Failure: Left Ventricular Ejection Fraction (LVEF) Assessment	R	434
201	Ischemic Vascular Disease (IVD): Blood Pressure Management	C, R	436
204	Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic	C, R	439
205	HIV/AIDS: Sexually Transmitted Disease Screening for Chlamydia and Gonorrhea	R	442
208	HIV/AIDS: Sexually Transmitted Disease Screening for Syphilis	R	444
209	Functional Communication Measure – Spoken Language Comprehension	R	446
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211	Functional Communication Measure – Memory	R	453
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213	Functional Communication Measure – Reading	R	460
214	Functional Communication Measure – Spoken Language Expression	R	464
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216	Functional Communication Measure – Swallowing	R	472
217	Functional Deficit: Change in Risk-Adjusted Functional Status for Patients with Knee Impairments	R	475
218	Functional Deficit: Change in Risk-Adjusted Functional Status for Patients with Hip Impairments	R	478
219	Functional Deficit: Change in Risk-Adjusted Functional Status for Patients with Lower Leg, Foot or Ankle Impairments	R	481
220	Functional Deficit: Change in Risk-Adjusted Functional Status for Patients with Lumbar Spine Impairments	R	485
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223	Functional Deficit: Change in Risk-Adjusted Functional Status for Patients with Neck, Cranium, Mandible, Thoracic Spine, Ribs, or Other General Orthopedic Impairments	R	495
224	Melanoma: Overutilization of Imaging Studies in Melanoma	R	499
225	Radiology: Reminder System for Mammograms	C, R	501
226	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	C, R	503
228	Heart Failure (HF): Left Ventricular Function (LVF) Testing	R	506
231	Asthma: Tobacco Use: Screening - Ambulatory Care Setting	C, R	508
232	Asthma: Tobacco Use Intervention - Ambulatory Care Setting	C, R	510
233	Thoracic Surgery: Recording of Performance Status Prior to Lung or Esophageal Cancer Resection	R	513
234	Thoracic Surgery: Pulmonary Function Tests Before Major Anatomic Lung Resection (Pneumonectomy, Lobectomy, or Formal Segmentectomy)	R	515
236	Hypertension (HTN): Controlling High Blood Pressure	C, R	517
241	Ischemic Vascular Disease (IVD): Complete Lipid Panel and Low Density Lipoprotein (LDL-C) Control	C, R	519

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243	Cardiac Rehabilitation Patient Referral From an Outpatient Setting	R	525
244	Hypertension: Blood Pressure Management	R	529
245	Chronic Wound Care: Use of Wound Surface Culture Technique in Patients with Chronic Skin Ulcers (Overuse Measure)	C, R	533
246	Chronic Wound Care: Use of Wet to Dry Dressings in Patients with Chronic Skin Ulcers (Overuse Measure)	C, R	537
247	Substance Use Disorders: Counseling Regarding Psychosocial and Pharmacologic Treatment Options for Alcohol Dependence	C, R	540
248	Substance Use Disorders: Screening for Depression Among Patients with Substance Abuse or Dependence	C, R	543
249	Barrett's Esophagus	C, R	546
250	Radical Prostatectomy Pathology Reporting	C, R	548
251	Immunohistochemical (IHC) Evaluation of Human Epidermal Growth Factor Receptor 2 Testing (HER2) for Breast Cancer Patients	C, R	551
252	Anticoagulation for Acute Pulmonary Embolus Patients	C, R	553
254	Ultrasound Determination of Pregnancy Location for Pregnant Patients with Abdominal Pain	C, R	555
255	Rh Immunoglobulin (Rhogam) for Rh-Negative Pregnant Women at Risk of Fetal Blood Exposure	C, R	558
256	Surveillance after Endovascular Abdominal Aortic Aneurysm Repair (EVAR)	R	560
257	Statin Therapy at Discharge after Lower Extremity Bypass (LEB)	R	563
258	Rate of Open Repair of Small or Moderate Non-Ruptured Abdominal Aortic Aneurysms (AAA) without Major Complications (Discharged to Home by Post-Operative Day #7)	R	566
259	Rate of Endovascular Aortic Repair (EVAR) of Small or Moderate Non-Ruptured Abdominal Aortic Aneurysms (AAA) without Major Complications (Discharged to Home by Post Operative Day #2)	R	568
260	Rate of Carotid Endarterectomy (CEA) for Asymptomatic Patients, without Major Complications (Discharged to Home by Post-Operative Day #2)	R	570
261	Referral for Otologic Evaluation for Patients with Acute or Chronic Dizziness	C,R	572
262	Image Confirmation of Successful Excision of Image-Localized Breast Lesion	C, R	575
263	Preoperative Diagnosis of Breast Cancer	C, R	577
264	Sentinel Lymph Node Biopsy for Invasive Breast Cancer	R	580
265	Biopsy Follow-Up	R	582
266	Epilepsy: Seizure Type(s) and Current Seizure Frequency(ies)	C, R	585
267	Epilepsy: Documentation of Etiology of Epilepsy or Epilepsy Syndrome	C, R	587
268	Epilepsy: Counseling for Women of Childbearing Potential with Epilepsy	C, R	589
303	Cataracts: Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery	R	592
304	Cataracts: Patient Satisfaction within 90 Days Following Cataract Surgery	R	597
317	Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented	C, R	601
320	Endoscopy/Polyp Surveillance: Appropriate Follow-Up Interval for Normal Colonoscopy	C, R	605

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List of 2013 PQRS Individual Measure Specifications for Claims and Registry Reporting			
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	in Average Risk Patients		
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322	Cardiac Stress Imaging Not Meeting Appropriate Use Criteria: Preoperative Evaluation in Low Risk Surgery Patients	R	609
323	Cardiac Stress Imaging Not Meeting Appropriate Use Criteria: Routine Testing After Percutaneous Coronary Intervention (PCI)	R	611
324	Cardiac Stress Imaging Not Meeting Appropriate Use Criteria: Testing in Asymptomatic, Low-Risk Patients	R	613
325	Adult Major Depressive Disorder (MDD): Coordination of Care of Patients with Specific Comorbid Conditions	R	615
326	Atrial Fibrillation and Atrial Flutter: Chronic Anticoagulation Therapy	C, R	619
327	Pediatric Kidney Disease: Adequacy of Volume Management	C, R	623
328	Pediatric Kidney Disease: ESRD Patients Receiving Dialysis: Hemoglobin Level < 10g/dL	C, R	625

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List of Retired Physician Quality Reporting Measure Specifications		
Measure #	Measure Title	Retirement Effective Date
4	Screening for Future Fall Risk	January 1, 2009
10	Stroke and Stroke Rehabilitation: Computed Tomography (CT) or Magnetic Resonance Imaging (MRI) Reports	January 1, 2013
11	Stroke and Stroke Rehabilitation: Carotid Imaging Reports	January 1, 2010
13	Age-Related Macular Degeneration: Age-Related Eye Disease Study (AREDS) Prescribed/Recommended	January 1, 2008
15	Cataracts: Assessment of Visual Functional Status	January 1, 2008
16	Cataracts: Documentation of Pre-Surgical Axial Length, Corneal Power Measurement and Method of Intraocular Lens Power Calculation	January 1, 2008
17	Cataracts: Pre-Surgical Dilated Fundus Evaluation	January 1, 2008
25	Melanoma: Patient Medical History	January 1, 2008
26	Melanoma: Complete Physical Skin Examination	January 1, 2008
27	Melanoma: Counseling on Self-Examination	January 1, 2008
29	Beta-Blocker at Time of Arrival for Acute Myocardial Infarction (AMI)	January 1, 2008
34	Stroke and Stroke Rehabilitation: Tissue Plasminogen Activator (t-PA) Considered	January 1, 2010
37	Dialysis Dose in End Stage Renal Disease (ESRD) Patients	January 1, 2008
38	Hematocrit Level in End Stage Renal Disease (ESRD) Patients	January 1, 2008
42	Osteoporosis: Counseling for Vitamin D, Calcium Intake, and Exercise	January 1, 2008
57	Emergency Medicine: Community-Acquired Pneumonia (CAP): Assessment of Oxygen Saturation	January 1, 2013
58	Emergency Medicine: Community-Acquired Pneumonia (CAP): Assessment of Mental Status	January 1, 2013
60	Gastroesophageal Reflux Disease (GERD): Assessment for Alarm Symptoms	January 1, 2008
61	Gastroesophageal Reflux Disease (GERD): Upper Endoscopy for Patients with Alarm Symptoms	January 1, 2008
62	Gastroesophageal Reflux Disease (GERD): Biopsy for Barrett's Esophagus	January 1, 2008
63	Gastroesophageal Reflux Disease (GERD): Barium Swallow-Inappropriate Use	January 1, 2008
73	Plan for Chemotherapy Documented Before Chemotherapy Administered	January 1, 2009
74	Radiation Therapy Recommended for Invasive Breast Cancer Patients Who Have Undergone Breast Conserving Surgery	January 1, 2009
75	Prevention of Ventilator-Associated Pneumonia – Head Elevation	January 1, 2009
77	Assessment of GERD Symptoms in Patients Receiving Chronic Medication for GERD	January 1, 2009

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List of Retired Physician Quality Reporting Measure Specifications		
Measure #	Measure Title	Retirement Effective Date
78	Vascular Access for Patients Undergoing Hemodialysis	January 1, 2009
79	End Stage Renal Disease (ESRD): Influenza Immunization in Patients with ESRD	January 1, 2012
80	End Stage Renal Disease (ESRD): Plan of Care for ESRD Patients with Anemia	January 1, 2009
88	Hepatitis C: Hepatitis A and B Vaccination in Patients with HCV	January 1, 2009
92	Acute Otitis Externa (AOE): Pain Assessment	January 1, 2013
94	Otitis Media with Effusion (OME): Diagnostic Evaluation – Assessment of Tympanic Membrane Mobility	January 1, 2012
95	Otitis Media with Effusion (OME): Hearing Testing	January 1, 2010
96	Otitis Media with Effusion (OME): Antihistamines or Decongestants – Avoidance of Inappropriate Use	January 1, 2009
97	Otitis Media with Effusion (OME): Systemic Antimicrobials – Avoidance of Inappropriate Use	January 1, 2009
98	Otitis Media with Effusion (OME): Systemic Corticosteroids – Avoidance of Inappropriate Use	January 1, 2009
101	Appropriate Initial Evaluation of Patients with Prostate Cancer	January 1, 2009
103	Prostate Cancer: Review of Treatment Options in Patients with Clinically Localized Prostate Cancer	January 1, 2009
105	Prostate Cancer: Three Dimensional (3D) Radiotherapy	January 1, 2013
114	Preventive Care and Screening: Inquiry Regarding Tobacco Use	January 1, 2011
115	Preventive Care and Screening: Advising Smokers and Tobacco Users to Quit	January 1, 2011
120	Chronic Kidney Disease (CKD): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy	January 1, 2009
124	Health Information Technology (HIT): Adoption/Use of Electronic Health Records (EHR)	January 1, 2013
125	Health Information Technology (HIT): Adoption/Use of Medication Electronic Prescribing (e-Rx) *Refer to new Electronic Prescribing (e-Rx) incentive program*	January 1, 2009
129	Universal Influenza Vaccine Screening and Counseling	January 1, 2009
132	Patient Co-Development of Treatment Plan/Plan of Care	January 1, 2009
133	Screening for Cognitive Impairment	January 1, 2009
135	Chronic Kidney Disease (CKD): Influenza Immunization	January 1, 2012
136	Melanoma: Follow-Up Aspects of Care	January 1, 2011
139	Cataracts: Comprehensive Preoperative Assessment for Cataract Surgery with Intraocular Lens (IOL) Placement	January 1, 2011

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List of Retired Physician Quality Reporting Measure Specifications		
Measure #	Measure Title	Retirement Effective Date
152	Coronary Artery Disease (CAD): Lipid Profile in Patients with CAD	January 1, 2010
153	Chronic Kidney Disease (CKD): Referral for Arteriovenous (AV) Fistula	January 1, 2012
158	Carotid Endarterectomy: Use of Patch During Conventional Carotid Endarterectomy	January 1, 2013
174	Pediatric End Stage Renal Disease (ESRD): Plan of Care for Inadequate Hemodialysis	January 1, 2011
175	Pediatric End Stage Renal Disease (ESRD): Influenza Immunization	January 1, 2012
186	Chronic Wound Care: Use of Compression System in Patients with Venous Ulcers	January 1, 2013
189	Referral for Otologic Evaluation for Patients with History of Active Drainage from the Ear Within the Previous 90 Days	January 1, 2013
190	Referral for Otologic Evaluation for Patients with a History of Sudden or Rapidly Progressive Hearing Loss	January 1, 2013
196	Coronary Artery Disease (CAD): Symptom and Activity Assessment	January 1, 2013
199	Heart Failure: Patient Education	January 1, 2012
200	Heart Failure: Warfarin Therapy for Patients with Atrial Fibrillation (AF)	January 1, 2012
202	Ischemic Vascular Disease (IVD): Complete Lipid Profile	January 1, 2012
203	Ischemic Vascular Disease (IVD): Low Density Lipoprotein (LDL-C) Control	January 1, 2012
206	HIV/AIDS: Screening for High Risk Sexual Behaviors	January 1, 2013
207	HIV/AIDS: Screening for Injection Drug Use	January 1, 2013
235	Hypertension (HTN): Plan of Care	January 1, 2013
253	Pregnancy Test for Female Abdominal Pain Patients	January 1, 2013

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♦Measure #1 (NQF 0059): Diabetes Mellitus: Hemoglobin A1c Poor Control

2013 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

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

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for patients with diabetes mellitus seen during the reporting period. The performance period for this measure is 12 months. The most recent quality-data code submitted will be used for performance calculation. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

Measure Reporting via Claims:
ICD-9-CM diagnosis codes, CPT or HCPCS codes, and patient demographics are used to identify patients who are included in the measure's denominator. CPT Category II codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed ICD-9-CM diagnosis codes, CPT or HCPCS codes, and the appropriate CPT Category II code OR the CPT Category II code with the modifier. The reporting modifier allowed for this measure is: 8P- reason not otherwise specified. There are no allowable performance exclusions for this measure. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT codes or HCPCS codes and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data. There are no allowable performance exclusions for this measure.

DENOMINATOR:
Patients aged 18 through 75 years with the diagnosis of diabetes

Denominator Criteria (Eligible Cases):
Patients aged 18 through 75 years on date of encounter
AND
Diagnosis for diabetes (ICD-9-CM): 250.00, 250.01, 250.02, 250.03, 250.10, 250.11, 250.12, 250.13, 250.20, 250.21, 250.22, 250.23, 250.30, 250.31, 250.32, 250.33, 250.40, 250.41, 250.42, 250.43, 250.50, 250.51, 250.52, 250.53, 250.60, 250.61, 250.62, 250.63, 250.70, 250.71, 250.72, 250.73, 250.80, 250.81, 250.82, 250.83, 250.90, 250.91, 250.92, 250.93, 357.2, 362.01, 362.02, 362.03, 362.04, 362.05, 362.06, 362.07, 366.41, 648.00, 648.01, 648.02, 648.03, 648.04
Diagnosis for diabetes (ICD-10-CM) [REFERENCE ONLY/Not Reportable]: E10.10, E10.11, E10.21, E10.22, E10.29, E10.311, E10.319, E10.321, E10.329, E10.331, E10.339, E10.341, E10.349, E10.351, E10.359, E10.36, E10.39, E10.40, E10.41, E10.42, E10.43, E10.44, E10.49, E10.51, E10.52, E10.59, E10.610, E10.618, E10.620, E10.621, E10.622, E10.628, E10.630, E10.638, E10.641, E10.649, E10.65, E10.69, E10.8, E10.9, E11.00, E11.01, E11.21, E11.22, E11.29, E11.311, E11.319, E11.321, E11.329,

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E11.331, E11.339, E11.341, E11.349, E11.351, E11.359, E11.36, E11.39, E11.40, E11.41, E11.42, E11.43, E11.44, E11.49, E11.51, E11.52, E11.59, E11.610, E11.618, E11.620, E11.621, E11.622, E11.628, E11.630, E11.638, E11.641, E11.65, E11.69, E11.8, E11.9, E11.649, O24.011, O24.012, O24.01
AND
Patient encounter during reporting period (CPT or HCPCS): 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, G0402

NUMERATOR:
Patients with most recent hemoglobin A1c level > 9.0%

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

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, Reason not Otherwise Specified
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%

RATIONALE:
Intensive management of hemoglobin (A1c) reduces the risk of microvascular complications.

CLINICAL RECOMMENDATION STATEMENTS:
The American Diabetes Association (ADA) and the European Association for the Study of Diabetes (EASD) released updated guidelines in 2012. Within this document, goals for treatment are specified in two strata, both are within HbA1c less than 9. The implication for measurement is that HbA1c of greater than 9 represents inadequate or poor control for persons 18 to 75 with diabetes.

Glycemic Targets
The ADA's "Standards of Medical Care in Diabetes" recommends lowering HbA1c to < 7.0% in most patients to reduce the incidence of microvascular disease. This can be achieved with a mean plasma glucose of ~8.3–8.9 mmol/L (~150–160 mg/dL); ideally, fasting and premeal glucose should be maintained at < 7.2 mmol/L (< 130 mg/dL) and the postprandial glucose at < 10 mmol/L (< 180 mg/dL). More stringent HbA1c targets (e.g., 6.0–6.5%) might be considered in selected patients (with short disease duration, long life expectancy, no significant CVD) if this can be achieved without significant hypoglycemia or other adverse effects of treatment. Conversely, less stringent HbA1c goals—e.g., 7.5–8.0% or even slightly higher—are appropriate for patients with a history of severe hypoglycemia, limited life expectancy, advanced complications, extensive comorbid conditions and those in whom the target is difficult to attain despite intensive self-management education, repeated counseling, and effective doses of multiple glucose-lowering agents, including insulin. [http://care.diabetesjournals.org/content/35/6/1364.full]

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♦Measure #2 (NQF 0064): Diabetes Mellitus: Low Density Lipoprotein (LDL-C) Control

2013 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

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)

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for patients with diabetes mellitus seen during the reporting period. *The performance period for this measure is 12 months. The* most recent quality code submitted will be used for performance calculation. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

Measure Reporting via Claims:
ICD-9-CM diagnosis codes, CPT or HCPCS codes, and patient demographics are used to identify patients who are included in the measure's denominator. CPT Category II codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed ICD-9-CM diagnosis codes, CPT or HCPCS codes and the appropriate CPT Category II code OR the CPT Category II code with the modifier. The reporting modifier allowed for this measure is: 8P- reason not otherwise specified. There are no allowable performance exclusions for this measure. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT or HCPCS codes and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data. There are no allowable performance exclusions for this measure.

DENOMINATOR:
Patients aged 18 through 75 years with the diagnosis of diabetes

> Denominator Criteria (Eligible Cases):
> Patients aged 18 through 75 years on date of encounter
> AND
> Diagnosis for diabetes (ICD-9-CM): 250.00, 250.01, 250.02, 250.03, 250.10, 250.11, 250.12, 250.13, 250.20, 250.21, 250.22, 250.23, 250.30, 250.31, 250.32, 250.33, 250.40, 250.41, 250.42, 250.43, 250.50, 250.51, 250.52, 250.53, 250.60, 250.61, 250.62, 250.63, 250.70, 250.71, 250.72, 250.73, 250.80, 250.81, 250.82, 250.83, 250.90, 250.91, 250.92, 250.93, 357.2, 362.01, 362.02, 362.03, 362.04, 362.05, 362.06, 362.07, 366.41, 648.00, 648.01, 648.02, 648.03, 648.04
> Diagnosis for diabetes (ICD-10-CM) [REFERENCE ONLY/Not Reportable]: E10.10, E10.11, E10.21, E10.22, E10.29, E10.311, E10.319, E10.321, E10.329, E10.331, E10.339, E10.341, E10.349, E10.351, E10.359, E10.36, E10.39, E10.40, E10.41, E10.42, E10.43, E10.44, E10.49, E10.51, E10.52, E10.59, E10.610, E10.618, E10.620, E10.621, E10.622, E10.628, E10.630, E10.638, E10.641, E10.649, E10.65,

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E10.69, E10.8, E10.9, E11.00, E11.01, E11.21, E11.22, E11.29, E11.311, E11.319, E11.321, E11.329, E11.331, E11.339, E11.341, E11.349, E11.351, E11.359, E11.36, E11.39, E11.40, E11.41, E11.42, E11.43, E11.44, E11.49, E11.51, E11.52, E11.59, E11.610, E11.618, E11.620, E11.621, E11.622, E11.628, E11.630, E11.638, E11.641, E11.65, E11.69, E11.8, E11.9, E11.649, O24.011, O24.012, O24.01
AND
Patient encounter during reporting period (CPT or HCPCS): 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, G0402

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 ≥ 100 mg/dL**
CPT II 3049F: Most recent LDL-C 100-129 mg/dL
OR
CPT II 3050F: Most recent LDL-C ≥ 130 mg/dL
OR
LDL-C Level not Performed, Reason not Otherwise 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)

RATIONALE:
Persons with diabetes are at increased risk for coronary heart disease (CHD). Lowering serum cholesterol levels can reduce the risk for CHD events.

CLINICAL RECOMMENDATION STATEMENTS:
A fasting lipid profile should be obtained during an initial assessment, each follow-up assessment, and annually as part of the cardiac-cerebrovascular-peripheral vascular module. (AACE/ACE, 2007)

Lifestyle modification focusing on the reduction of saturated fat, trans fat, and cholesterol intake; increase of n-3 fatty acids, viscous fiber and plant stanols/sterols; weight loss (if indicated); and increased physical activity should be recommended to improve the lipid profile in patients with diabetes. Statin therapy should be added to lifestyle therapy, regardless of baseline lipid levels, for diabetic patients:

- with overt CVD.
- without CVD who are over the age of 40 years and who have one or more other CVD risk factors.

In individuals without overt CVD, the primary goal is an LDL cholesterol < 100 mg/dL (2.6 mmol/L). (ADA, 2012)

Lipid-lowering therapy should be used for secondary prevention of cardiovascular mortality and morbidity for all patients with known coronary artery disease and type 2 diabetes.

Statins should be used for primary prevention against macrovascular complications in patients with type 2 diabetes and other cardiovascular risk factors. (ACP, 2004)

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When the older adult with diabetes mellitus has an LDL cholesterol level of 100 mg/dL or less, lipid status should be rechecked at least every 2 years. (AGS, 2004)

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♦Measure #3 (NQF 0061): Diabetes Mellitus: High Blood Pressure Control

2013 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

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)

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for patients with diabetes mellitus seen during the reporting period. The performance period for this measure is 12 months. The most recent quality code submitted will be used for performance calculation. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

Measure Reporting via Claims:
ICD-9-CM diagnosis codes, CPT or HCPCS codes and patient demographics are used to identify patients who are included in the measure's denominator. G-codes codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed ICD-9-CM diagnosis codes, CPT or HCPCS codes and the appropriate G-code(s) OR the CPT Category II code with modifier. The reporting modifier allowed for this measure is: 8P – reason not otherwise specified. There are no allowable performance exclusions for this measure. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT or HCPCS codes, and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data. There are no allowable performance exclusions for this measure.

DENOMINATOR:
Patients aged 18 through 75 years with the diagnosis of diabetes

Denominator Criteria (Eligible Cases):
Patients aged 18 through 75 years on date of encounter
AND
Diagnosis for diabetes (ICD-9-CM): 250.00, 250.01, 250.02, 250.03, 250.10, 250.11, 250.12, 250.13, 250.20, 250.21, 250.22, 250.23, 250.30, 250.31, 250.32, 250.33, 250.40, 250.41, 250.42, 250.43, 250.50, 250.51, 250.52, 250.53, 250.60, 250.61, 250.62, 250.63, 250.70, 250.71, 250.72, 250.73, 250.80, 250.81, 250.82, 250.83, 250.90, 250.91, 250.92, 250.93, 357.2, 362.01, 362.02, 362.03, 362.04, 362.05, 362.06, 362.07, 366.41, 648.00, 648.01, 648.02, 648.03, 648.04
Diagnosis for diabetes (ICD-10-CM) [REFERENCE ONLY/Not Reportable]: E10.10, E10.11, E10.21, E10.22, E10.29, E10.311, E10.319, E10.321, E10.329, E10.331, E10.339, E10.341, E10.349, E10.351, E10.359, E10.36, E10.39, E10.40, E10.41, E10.42, E10.43, E10.44, E10.49, E10.51, E10.52, E10.59, E10.610, E10.618, E10.620, E10.621, E10.622, E10.628, E10.630, E10.638, E10.641, E10.649, E10.65,

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E10.69, E10.8, E10.9, E11.00, E11.01, E11.21, E11.22, E11.29, E11.311, E11.319, E11.321, E11.329, E11.331, E11.339, E11.341, E11.349, E11.351, E11.359, E11.36, E11.39, E11.40, E11.41, E11.42, E11.43, E11.44, E11.49, E11.51, E11.52, E11.59, E11.610, E11.618, E11.620, E11.621, E11.622, E11.628, E11.630, E11.638, E11.641, E11.65, E11.69, E11.8, E11.9, E11.649, O24.011, O24.012, O24.01
AND
Patient encounter during reporting period (CPT or HCPCS): 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, G0402

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 Quality-Data Coding Options for Reporting Satisfactorily:
Most Recent Blood Pressure Measurement Performed
Systolic codes (Select one (1) code from this section):
G8919: Most recent systolic blood pressure < 140 mmHg
OR
G8920: Most recent systolic blood pressure ≥ 140 mmHg
AND
Diastolic pressure (Select one (1) code from this section):
G8921: Most recent diastolic blood pressure < 90 mmHg
OR
G8922: Most recent diastolic blood pressure ≥ 90 mmHg

OR

Blood Pressure Measurement not Performed, Reason not Otherwise 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

RATIONALE:
Intensive control of blood pressure in patients with diabetes reduces diabetes complications, diabetes-related deaths, strokes, heart failure, and microvascular complications.

CLINICAL RECOMMENDATION STATEMENTS:
Patients with more severe hypertension (SBP ≥ 140 or DBP ≥ 90 mmHg) at diagnosis or follow-up should receive pharmacologic therapy in addition to lifestyle therapy. Blood pressure should be measured at every routine diabetes visit. Patients found to have systolic blood pressure (SBP) ≥ 130mmHg or diastolic blood pressure (DBP) ≥ 80 mmHg should have blood pressure confirmed on a separate day. Repeat SBP ≥ 130 mmHg or DBP ≥ 80 mmHg confirms a diagnosis of hypertension. (ADA, 2012)

If an older adult has diabetes mellitus and requires medical therapy for hypertension, then the target blood pressure should be less than 140/80 if it is tolerated. (AGS, 2003)

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➤ Measure #5 (NQF 0081): Heart Failure: Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD)

2013 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

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

INSTRUCTIONS:
This measure is to be reported for all heart failure patients a minimum of once per reporting period when seen in the outpatient setting AND reported at each hospital discharge (99238* and 99239*) during the reporting period.

**NOTE: When reporting CPT code 99238 and 99239, it is recommended the measure be reported each time the code is submitted for hospital discharge.*

This measure is intended to reflect the quality of services provided for patients with HF and decreased left ventricular systolic function. 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. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT codes, CPT category II codes, and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All patients aged 18 years and older with a diagnosis of heart failure with a current or prior LVEF < 40%

> *DENOMINATOR NOTE: LVEF < 40% corresponds to qualitative documentation of moderate dysfunction or severe dysfunction.*
>
> Denominator Criteria (Eligible Cases):
> Patients aged ≥ 18 years on date of encounter
> AND
> Diagnosis for heart failure (ICD-9-CM): 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
> Diagnosis for heart failure (ICD-10-CM) [REFERENCE ONLY/Not Reportable]: I11.0, I13.0, I13.2, I50.1, I50.20, I50.21, I50.22, I50.23, I50.30, I50.31, I50.32, I50.33, I50.40, I50.41, I50.42, I50.43, I50.9
> AND

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Patient encounter during reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99238*, 99239*, 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

AND

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

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

Definitions:

Prescribed – Outpatient setting: 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.

Prescribed – Inpatient setting: May include prescription given to the patient for ACE inhibitor or ARB therapy at discharge OR ACE inhibitor or ARB therapy to be continued after discharge as documented in the discharge medication list.

Numerator Options

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

OR

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

OR

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

OR

Angiotensin converting enzyme (ACE) inhibitor or angiotensin receptor blocker (ARB) therapy was not prescribed, reason not otherwise specified (4010F *with* 8P)

RATIONALE:

In the absence of contraindications, ACE inhibitors or ARB's are recommended for all patients with symptoms of heart failure and reduced left ventricular systolic function. ACE inhibitors remain the first choice for inhibition of the renin-angiotensin system in chronic heart failure, but ARBs can now be considered a reasonable alternative. Both pharmacologic agents have been shown to decrease the risk of death and hospitalization. Additional benefits of ACE inhibitors include the alleviation of symptoms and the improvement of clinical status and overall sense of well-being of patients with heart failure.

CLINICAL RECOMMENDATION STATEMENTS:

The following evidence statements are quoted verbatim from the referenced clinical guidelines.

Angiotensin converting enzyme inhibitors are recommended for all patients with current or prior symptoms of [heart failure] and reduced LVEF, unless contraindicated. (Class I, Level of Evidence: A) (ACCF/AHA, 2009)

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Treatment with an [ACE inhibitor] should be initiated at low doses [see excerpt from guideline table below], followed by gradual increments in dose if lower doses have been well tolerated. Clinicians should attempt to use doses that have been shown to reduce the risk of cardiovascular events in clinical trials. If these target doses of an [ACE inhibitor] cannot be used or are poorly tolerated, intermediate doses should be used with the expectation that there are likely to be only small differences in efficacy between low and high doses. (ACCF/AHA, 2009)

Inhibitors of the Renin-Angiotensin-Aldosterone System…Commonly Used for the Treatment of Patients with [Heart Failure] with Low Ejection Fraction

Drug	Initial Daily Dose(s)	Maximum Doses(s)
ACE Inhibitors		
Captopril	6.25 mg 3 times	50 mg 3 times
Enalapril	2.5 mg twice	10 to 20 mg twice
Fosinopril	5 to 10 mg once	40 mg once
Lisinopril	2.5 to 5 mg once	20 to 40 mg once
Perindopril	2 mg once	8 to 16 mg once
Quinapril	5 mg twice	20 mg twice
Ramipril	1.25 to 2.5 mg once	10 mg once
Trandolapril	1 mg once	4 mg once
Angiotensin Receptor Blockers		
Candesartan	4 to 8 mg once	32 mg once
Losartan**	25 to 50 mg once	50 to 100 mg once
Valsartan	20 to 40 mg twice	160 mg twice

**[Note: *Among ARB's, losartan has the weakest* evidence supporting its value in heart failure patients.] Additionally, while the 2009 guidelines recommended a maximum dosage of 100mg, the maximum dosage recommendation for Losartan has been increased to 150mg based on the HEAAL trial.

An ARB should be administered to post - [myocardial infarction (MI)] patients without [heart failure] who are intolerant of [ACE inhibitors] and have a low LVEF. (Class I, Level of Evidence: B) (ACCF/AHA, 2009).
Angiotensin II receptor blockers are reasonable to use as alternatives to [ACE inhibitors] as first - line therapy for patients with mild to moderate [heart failure] and reduced LVEF, especially for patients already taking ARB's for other indications. (Class IIa, Level of Evidence: A) (ACCF/AHA, 2009)

For the hospitalized patient:
In patients with reduced ejection fraction experiencing a symptomatic exacerbation of [heart failure] requiring hospitalization during chronic maintenance treatment with oral therapies known to improve outcomes, particularly ACE inhibitors or ARBs and beta-blocker therapy, it is recommended that these therapies be continued in most patients in the absence of hemodynamic instability or contraindications. (Class I, Level of Evidence: C) (ACCF/AHA, 2009)

In patients hospitalized with [heart failure] with reduced ejection fraction not treated with oral therapies known to improve outcomes, particularly ACE inhibitors or ARBs and beta-blocker therapy, initiation of these therapies is recommended in stable patients prior to hospital discharge. Initiation of beta-blocker therapy is recommended after optimization of volume status and successful discontinuation of intravenous diuretics, vasodilators, and inotropic agents. Beta-blocker therapy should be initiated at a low dose and only in stable patients. Particular caution should be used when initiating beta-blockers in patients who have required inotropes during their hospital course. (Class I, Level of Evidence: B) (ACCF/AHA, 2009)

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Measure #6 (NQF 0067): Coronary Artery Disease (CAD): Antiplatelet Therapy

2013 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

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

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for patients with CAD seen during the reporting period. This measure may be reported by clinicians who perform the quality actions described in the measure for the primary management of patients with CAD based on the services provided and the measure-specific denominator coding.

Measure Reporting via Claims:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. CPT Category II codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed ICD-9-CM diagnosis codes, CPT codes, and the appropriate CPT Category II code OR the CPT Category II code with the modifier. The modifiers allowed for this measure are: 1P- medical reasons, 2P- patient reasons, 3P- system reasons, 8P- reason not otherwise specified. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All patients aged 18 years and older with a diagnosis of coronary artery disease seen within a 12 month period

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Diagnosis for coronary artery disease (ICD-9-CM): 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
Diagnosis for coronary artery disease (ICD-10-CM) [REFERENCE ONLY/Not Reportable]: I20.0, I20.1, I20.8, I20.9, I21.01, I21.02, I21.09, I21.11, I21.19, I21.21, I21.29, I21.3, I21.4, I22.0, I22.1, I22.2, I22.8, I22.9, I24.0, I24.1, I24.8, I24.9, I25.10, I25.110, I25.111, I25.118, I25.119, I25.2, I25.5, I25.6, I25.700, I25.701, I25.708, I25.709, I25.710, I25.711, I25.718, I25.719, I25.720, I25.721, I25.728, I25.729, I25.730, I25.731, I25.738, I25.739, I25.750, I25.751, I25.758, I25.759, I25.760, I25.761, I25.768, I25.769, I25.790, I25.791, I25.798, I25.799, I25.82, I25.83, I25.89, I25.9, Z95.1, Z95.5, Z98.61

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AND

Patient encounter during the reporting period (CPT): 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

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 (eg, 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 (eg, patient declined, other patient reasons)

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

OR

Aspirin or Clopidogrel was not Prescribed, Reason not Otherwise 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

RATIONALE:

Use of antiplatelet therapy has shown to reduce the occurrence of vascular events in patients with coronary artery disease, including myocardial infarction and death.

CLINICAL RECOMMENDATION STATEMENTS:

The following evidence statements are quoted verbatim from the referenced clinical guidelines.
Aspirin should be started at 75 to 162 mg per day and continued indefinitely in all patients unless contraindicated. (Class I Recommendation, Level A Evidence) (ACC/AHA, 2007)

Clopidogrel when aspirin is absolutely contraindicated. (Class IIa Recommendation; Level of Evidence B) (ACC/AHA, 2002)

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➤ Measure #7 (NQF 0070): Coronary Artery Disease (CAD): Beta-Blocker Therapy – Prior Myocardial Infarction (MI) or Left Ventricular Systolic Dysfunction (LVEF < 40%)

2013 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Percentage of patients aged 18 years and older with a diagnosis of coronary artery disease seen within a 12 month period who also have prior MI OR a current or prior left ventricular ejection fraction (LVEF) < 40% who were prescribed beta-blocker therapy

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for patients with a diagnosis of coronary artery disease (who also have a prior myocardial infarction (MI) or a current or prior LVEF < 40%) seen during the reporting period. This measure may be reported by clinicians who perform the quality actions described in the measure for the primary management of patients with CAD based on the services provided and the measure-specific denominator coding.

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

There are two reporting criteria for this measure:
(1) Patients who are 18 years and older with a diagnosis of CAD who have prior myocardial infarction

OR

(2) Patients who are 18 years and older with a diagnosis of CAD who have a current or prior LVEF < 40%

The eligible professional should submit data on one of the reporting criteria, depending on the clinical findings. If the patient has CAD (and who have prior MI), use Denominator Reporting Criteria 1. If the patient has CAD and a current or prior LVEF < 40%, use Denominator Reporting Criteria 2. If the patient has both prior MI and LVEF < 40%, the eligible professional may report quality data for Reporting Criteria 2 and this will count as appropriate reporting for this patient.

REPORTING CRITERIA 1: All patients with a diagnosis of CAD who have prior myocardial infarction

DENOMINATOR (REPORTING CRITERIA 1):
All patients aged 18 years and older with a diagnosis of coronary artery disease seen within a 12 month period who also have prior MI

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Diagnosis for coronary artery disease* (ICD-9-CM): 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*,

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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

Diagnosis for coronary artery disease* (ICD-10-CM) [REFERENCE ONLY/Not Reportable]: I20.0, I20.1, I20.8, I20.9, I21.01*, I21.02*, I21.09*, I21.11*, I21.19*, I21.21*, I21.29*, I21.3*, I21.4*, I22.0*, I22.1*, I22.2*, I22.8*, I22.9*, I24.0, I24.1*, I24.8, I24.9, I25.10, I25.110, I25.111, I25.118, I25.119, I25.2, I25.5, I25.6, I25.700, I25.701, I25.708, I25.709, I25.710, I25.711, I25.718, I25.719, I25.720, I25.721, I25.728, I25.729, I25.730, I25.731, I25.738, I25.739, I25.750, I25.751, I25.758, I25.759, I25.790, I25.791, I25.760, I25.761, I25.768, I25.769, I25.798, I25.799, I25.82, I25.83, I25.89, I25.9, Z95.1, Z95.5, Z98.61

AND

Diagnosis for myocardial infarction – includes patient that had a prior myocardial infarction at any time (ICD-9-CM): 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, 412

Diagnosis for myocardial infarction– includes patient that had a prior myocardial infarction at any time (ICD-10-CM) [REFERENCE ONLY/Not Reportable]: I21.01, I21.02, I21.09, I21.11, I21.19, I21.21, I21.29, I21.3, I21.4, I22.0, I22.1, I22.2, I22.8, I22.9, I24.1, I25.2

AND

Patient encounter during reporting period (CPT): 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

**DENOMINATOR NOTE: Inclusion for this reporting criteria requires the presence of a prior MI diagnosis AND at least one E/M code during the measurement period. Diagnosis codes for Coronary Artery Disease (which include MI diagnosis codes) may also accompany the MI diagnosis code, but are not required for inclusion in the measure.*

NUMERATOR (Reporting Criteria 1):

Patients who were prescribed beta-blocker therapy

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 – For patients with prior MI, no recommendations or evidence cited in current chronic stable angina guidelines for preferential use of specific agents.

Numerator Options:

Beta-blocker therapy prescribed or currently being taken (4008F)

OR

Documentation of medical reason(s) for not prescribing beta-blocker therapy (eg, allergy, intolerance, other medical reasons) (4008F *with* 1P)

OR

Documentation of patient reason(s) for not prescribing beta-blocker therapy (eg, patient declined, other patient reasons) (4008F *with* 2P)

OR

Documentation of system reason(s) for not prescribing beta-blocker therapy (eg, other reasons attributable to the health care system) (4008F *with* 3P)

OR

Beta-blocker therapy not prescribed, reason not otherwise specified (4008F *with* 8P)

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Reporting Criteria 2: All patients with a diagnosis of CAD who have a current or prior LVEF < 40%

DENOMINATOR (Reporting Criteria 2):
All patients aged 18 years and older with a diagnosis of coronary artery disease seen within a 12 month period who also have a current or prior LVEF < 40%

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Diagnosis for coronary artery disease (ICD-9-CM): 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
Diagnosis for coronary artery disease (ICD-10-CM) [REFERENCE ONLY/Not Reportable]: I20.0, I20.1, I20.8, I20.9, I21.01, I21.02, I21.09, I21.11, I21.19, I21.21, I21.29, I21.3, I21.4, I22.0, I22.1, I22.2, I22.8, I22.9, I24.0, I24.1, I24.8, I24.9, I25.10, I25.110, I25.111, I25.118, I25.119, I25.2, I25.5, 25.6, I25.700, I25.701, I25.708, I25.709, I25.710, I25.711, I25.718, I25.719, I25.720, I25.721, I25.728, I25.729, I25.730, I25.731, I25.738, I25.739, I25.750, I25.751, I25.758, I25.759, I25.790, I25.791, I25.760, I25.761, I25.768, I25.769, I25.798, I25.799, I25.82, I25.83, I25.89, I25.9, Z95.1, Z95.5, Z98.61
AND
Patient encounter during reporting period (CPT): 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
AND
Left ventricular ejection fraction (LVEF) < 40%: G8694

NUMERATOR (Reporting Criteria 2):
Patients who were prescribed beta-blocker therapy

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 – For patients with prior LVEF < 40%, beta-blocker therapy should include bisoprolol, carvedilol, or sustained release metoprolol succinate.

Numerator Options:
Beta-blocker therapy prescribed or currently being taken (4008F)
OR
Documentation of medical reason(s) for not prescribing beta-blocker therapy (eg, allergy, intolerance, other medical reasons) (4008F *with* 1P)
OR
Documentation of patient reason(s) for not prescribing beta-blocker therapy (eg, patient declined, other patient reasons) (4008F *with* 2P)
OR
Documentation of system reason(s) for not prescribing beta-blocker therapy (eg, other reasons attributable to the health care system) (4008F *with* 3P)
OR
Beta-blocker therapy not prescribed, reason not otherwise specified (4008F *with* 8P)

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RATIONALE:
Nonadherence to cardioprotective medications is prevalent among outpatients with coronary artery disease and can be associated with a broad range of adverse outcomes, including all-cause and cardiovascular mortality, cardiovascular hospitalizations, and the need for revascularization procedures.

A patient with a diagnosis of coronary artery disease seen within a 12 month period and LVEF < 40% should be taking either bisoprolol, carvedilol, or sustained release metoprolol succinate. While all beta-blockers appear to be of equal efficacy in patients with chronic stable coronary artery disease, these three medications have specifically shown to reduce mortality in patients with reduced LVEF.

CLINICAL RECOMMENDATION STATEMENTS:
The following evidence statements are quoted verbatim from the referenced clinical guidelines.

It is beneficial to start and continue beta-blocker therapy indefinitely in all patients who have had MI, acute coronary syndrome, or left ventricular dysfunction with or without heart failure symptoms, unless contraindicated. (Class I Recommendation, Level A Evidence) (ACC/AHA, 2007)

Beta-blockers (using 1 of the 3 proven to reduce mortality, i.e., bisoprolol, carvedilol, and sustained release metoprolol succinate) are recommended for all stable patients with current or prior symptoms of heart failure and reduced LVEF, unless contraindicated. (Class I, Level of Evidence: A) (ACC/AHA, 2009)

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➧ Measure #8 (NQF 0083): Heart Failure: Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)

2013 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

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

INSTRUCTIONS:
This measure is to be reported for all heart failure patients a minimum of once per reporting period when seen in the outpatient setting AND reported at each hospital discharge (99238* and 99239*) during the reporting period.

NOTE: When reporting CPT code 99238 and 99239, it is recommended the measure be reported each time the code is submitted for hospital discharge. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

This measure is intended to reflect the quality of services provided for patients with heart failure and decreased left ventricular systolic function. 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.

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT codes, a G-code, and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All patients aged 18 years and older with a diagnosis of heart failure with a current or prior LVEF < 40%

> *DENOMINATOR NOTE: LVEF < 40% corresponds to qualitative documentation of moderate dysfunction or severe left ventricular systolic function.*
>
> Denominator Criteria (Eligible Cases):
> Patients aged ≥ 18 years on date of encounter
> AND
> Diagnosis for heart failure (ICD-9-CM): 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
> Diagnosis for heart failure (ICD-10-CM) [REFERENCE ONLY/Not Reportable]: I11.0, I13.0, I13.2, I50.1, I50.20, I50.21, I50.22, I50.23, I50.23, I50.30, I50.31, I50.32, I50.33, I50.40, I50.41, I50.42, I50.43, I50.9
> AND

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Left ventricular ejection fraction (LVEF) < 40% or documentation of moderately or severely depressed left ventricular systolic function: G8923
AND
Patient encounter during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99238*, 99239*, 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

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

Definitions:
Prescribed – Outpatient Setting: 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.
Prescribed – Inpatient Setting: May include prescription given to the patient for beta-blocker therapy at discharge OR beta-blocker therapy to be continued after discharge as documented in the discharge medication list.
Beta-blocker Therapy for Patients with Prior LVEF < 40% – Should include bisoprolol, carvedilol, or sustained release metoprolol succinate.

Numerator Options:
Beta-blocker therapy prescribed (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 (e.g., low blood pressure, fluid overload, asthma, patients recently treated with an intravenous positive inotropic agent, allergy, intolerance, other medical reasons, patient declined, other patient reasons, or other reasons attributable to the healthcare system) (G8451)

OR

Beta-blocker therapy not prescribed (G8452)

RATIONALE:
Beta-blockers are recommended for all patients with stable heart failure and left ventricular systolic dysfunction, unless contraindicated. Treatment should be initiated as soon as a patient is diagnosed with left ventricular systolic dysfunction and does not have low blood pressure, fluid overload, or recent treatment with an intravenous positive inotropic agent. Beta-blockers have been shown to lessen the symptoms of heart failure, improve the clinical status of patients, reduce future clinical deterioration, and decrease the risk of mortality and the combined risk of mortality and hospitalization.

CLINICAL RECOMMENDATION STATEMENTS:
The following evidence statements are quoted verbatim from the referenced clinical guidelines.

Beta-blockers (using 1 of the 3 proven to reduce mortality, i.e., bisoprolol, carvedilol, and sustained release metoprolol succinate) are recommended for all stable patients with current or prior symptoms of [heart failure] and reduced LVEF, unless contraindicated. (Class I, Level of Evidence: A) (ACCF/AHA, 2009)

Treatment with a beta blocker should be initiated at very low doses [see excerpt from guideline table below], followed by gradual increments in dose if lower doses have been well tolerated… physicians, especially cardiologists and

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primary care physicians, should make every effort to achieve the target doses of the beta blockers shown to be effective in major clinical trials. (ACCF/AHA, 2009)

Beta Blockers Commonly Used for the Treatment of Patients with [Heart Failure] with Low Ejection Fraction

Drug	Initial Daily Dose(s)	Maximum Doses(s)
Beta Blockers		
Bisoprolol	1.25 mg once	10 mg once
Carvedilol	3.125 mg twice	25 mg twice 50 mg twice for patients > 85 kg
Metoprolol succinate extended release (metoprolol CR/XL)	12.5 to 25 mg once	200 mg once

For the hospitalized patient:

- In patients with reduced ejection fraction experiencing a symptomatic exacerbation of [heart failure] requiring hospitalization during chronic maintenance treatment with oral therapies known to improve outcomes, particularly [ACE inhibitors] or ARBs and beta-blocker therapy, it is recommended that these therapies be continued in most patients in the absence of hemodynamic instability or contraindications. (Class I, Level of Evidence: C) (ACCF/AHA, 2009)
- In patients hospitalized with [heart failure] with reduced ejection fraction not treated with oral therapies known to improve outcomes, particularly [ACE inhibitors] or ARBs and beta-blocker therapy, initiation of these therapies is recommended in stable patients prior to hospital discharge. (Class I, Level of Evidence: B) (ACCF/AHA, 2009)
- Initiation of beta-blocker therapy is recommended after optimization of volume status and successful discontinuation of intravenous diuretics, vasodilators, and inotropic agents. Beta-blocker therapy should be initiated at a low dose and only in stable patients. Particular caution should be used when initiating beta blockers in patients who have required inotropes during their hospital course. (Class I, Level of Evidence: B) (ACCF/AHA, 2009)

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♦Measure #9 (NQF 0105): Major Depressive Disorder (MDD): Antidepressant Medication During Acute Phase for Patients with MDD

2013 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of patients aged 18 years and older diagnosed with new episode of MDD and documented as treated with antidepressant medication during the entire 84-day (12-week) acute treatment phase

INSTRUCTIONS:
This measure is to be reported for each occurrence of MDD during the reporting period. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

Measure Reporting via Claims:
ICD-9-CM diagnosis codes, CPT or HCPCS codes, and patient demographics are used to identify patients who are included in the measure's denominator. G-codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed ICD-9-CM diagnosis codes, CPT or HCPCS codes, and the appropriate numerator G-code. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT or HCPCS codes, and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
Patients 18 years and older diagnosed with a new episode of MDD (major depression) and treated with antidepressant medication

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Diagnosis for MDD (ICD-9-CM): 296.20, 296.21, 296.22, 296.23, 296.24, 296.25, 296.30, 296.31, 296.32, 296.33, 296.34, 296.35, 298.0, 300.4, 309.0, 309.1, 311
Diagnosis for MDD (ICD-10-CM) [REFERENCE ONLY/Not Reportable]: F32.0, F32.1, F32.2, F32.3, F32.4, F32.9, F33.0, F33.1, F33.2, F33.3, F33.40, F33.41, F33.8, F33.9, F34.1
AND
Patient encounter during the reporting period (CPT or HCPCS): 90791, 90792, 90832, 90834, 90837, 90839, 90845, 90849, 90853, 90857, 99078, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, G0402

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NUMERATOR:
Patients with an 84-day (12-week) acute treatment of antidepressant medication

Numerator Instructions: Report G8126: 1) For all patients with a diagnosis of Major Depression, New Episode who were prescribed a full 12-week course of antidepressant medication OR 2) At the completion of a 12-week course of antidepressant medication.

Definition:
New Episode – Patient with major depression who has not been seen or treated for major depression by any practitioner in the prior 4 months. A new episode can either be a recurrence for a patient with prior major depression or a patient with a new onset of major depression.

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Acute Treatment with Antidepressant Medication
G8126: Patient with new episode of MDD documented as being treated with antidepressant medication during the entire 12 week acute treatment phase

OR

Acute Treatment with Antidepressant Medication not Completed for Documented Reasons
G8128: Clinician documented that patient with a new episode of MDD was not an eligible candidate for antidepressant medication treatment or patient did not have a new episode of MDD

OR

Acute Treatment with Antidepressant Medication not Completed, Reason not Given
G8127: Patient with new episode of MDD not documented as being treated with antidepressant medication during the entire 12 week acute treatment phase

RATIONALE:
Affecting more than 26 percent of the U.S. adult population, depression is the most common type of mental illness (Kessler, 2005) and can be debilitating. However, medication has been shown to bring depressive moods under control and prevent relapse once a patient's mood has been stabilized. Despite this, more than 50 percent of patients discontinue antidepressant medications during the maintenance phase (i.e. between one and six months after starting treatment). Premature discontinuation of treatment is associated with higher rates of depression relapse and major depressive episodes (Melartin, 2005). Continuation of treatment is important to curb health and economic strains on society.

Clinical guidelines for depression stress the importance of effective clinical management in increasing patients' medication compliance, monitoring treatment effectiveness, and identifying and managing side effects. If pharmacological treatment is initiated, appropriate dosing and continuation of therapy through the acute and continuation phases decrease recurrence of depression. Thus, evaluation of length of treatment serves as an important indicator of success in promoting patient compliance with the establishment and maintenance of an effective medication regimen.

CLINICAL RECOMMENDATION STATEMENTS:
Depression affects nearly 15 million adults in the U.S. (NAMI, 2009) and is estimated to affect nearly a quarter of adults in their lifetime. (Burcusa, 2007) Symptoms of depression include appetite and sleep disturbances, anxiety, irritability and decreased concentration. (Charbonneau, 2005) The American Psychiatric Association recommends use of antidepressant medication and behavioral therapies, such as psychotherapy, to treat depression. (APA, 2010)

For the past 50 years, antidepressant medication has proven to be effective—especially for patients with more severe symptoms. (Fournier, 2010) Among patients who initiate antidepressant treatment, one in three discontinues treatment within one month, before the effect of medication can be assessed, and nearly one in two discontinues treatment within three months. (Simon, 2002)

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Due to increased risky behaviors for chronic disease (e.g., physical inactivity, smoking, excessive drinking and insufficient sleep), evidence has shown that depressive disorders are strongly related to the occurrence of many chronic diseases including diabetes, cancer, cardiovascular disease and asthma. (CDC 2011)

Aligning depression quality improvement with methods used in managing other chronic illnesses has been an important step in depression care. Depression management systems have demonstrated improved short- and long-term outcomes of depression severity and persistence, employment retention, functional status and patient satisfaction. (Katon, 2002; Rost, 2001)

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*Measure #12 (NQF 0086): Primary Open Angle Glaucoma (POAG): Optic Nerve Evaluation

2013 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of patients aged 18 years and older with a diagnosis of primary open-angle glaucoma who have an optic nerve head evaluation during one or more office visits within 12 months

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for patients seen during the reporting period. It is anticipated that clinicians who provide the primary management of patients with primary open-angle glaucoma (in either one or both eyes) will submit this measure.

Measure Reporting via Claims:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. CPT Category II codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed ICD-9-CM diagnosis codes, CPT codes, and the appropriate CPT Category II code OR the CPT Category II code with the modifier. The modifiers allowed for this measure are: 1P- medical reasons, 8P- reason not otherwise specified. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All patients aged 18 years and older with a diagnosis of primary open-angle glaucoma

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Diagnosis for primary open-angle glaucoma (ICD-9-CM): 365.10, 365.11, 365.12, 365.15
Diagnosis for primary open-angle glaucoma (ICD-10-CM) [REFERENCE ONLY/Not Reportable]: H40.10X0, H40.10X1, H40.10X2, H40.10X3, H40.10X4, H40.11X0, H40.11X1, H40.11X2, H40.11X3, H40.11X4, H40.1210, H40.1211, H40.1212, H40.1213, H40.1214, H40.1220, H40.1221, H40.1222, H40.1223, H40.1224, H40.1230, H40.1231, H40.1232, H40.1233, H40.1234, H40.1290, H40.1291, H40.1292, H40.1293, H40.1294, H40.1510, H40.1511, H40.1512, H40.1513, H40.1514, H40.1520, H40.1521, H40.1522, H40.1523, H40.1524, H40.1530, H40.1531, H40.1532, H40.1533, H40.1534, H40.1590, H40.1591, H40.1592, H40.1593, H40.1594
AND
Patient encounter during the reporting period (CPT): 92002, 92004, 92012, 92014, 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

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NUMERATOR:
Patients who have an optic nerve head evaluation during one or more office visits within 12 months

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Optic Nerve Head Evaluation Performed
CPT II 2027F: Optic nerve head evaluation performed

OR

Optic Nerve Head Evaluation not Performed for Medical Reasons
Append a modifier (1P) to CPT Category II code 2027F to report documented circumstances that appropriately exclude patients from the denominator.
2027F *with* 1P: Documentation of medical reason(s) for not performing an optic nerve head evaluation

OR

Optic Nerve Head Evaluation not Performed, Reason not Otherwise Specified
Append a reporting modifier (8P) to CPT Category II code 2027F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.
2027F *with* 8P: Optic nerve head evaluation was not performed, reason not otherwise specified

RATIONALE:
Changes in the optic nerve are one of two characteristics which currently define progression and thus worsening of glaucoma disease status (the other characteristic is visual field). There is a significant gap in documentation patterns of the optic nerve for both initial and follow-up care (Fremont, 2003), even among specialists. (Lee, 2006) Examination of the optic nerve head and retinal nerve fiber layer provides valuable structural information about glaucomatous optic nerve damage. Visible structural alterations of the optic nerve head or retinal nerve fiber layer and development of peripapillary choroidal atrophy frequently occur before visual field defects can be detected. Careful study of the optic disc neural rim for small hemorrhages is important, since these hemorrhages can precede visual field loss and further optic nerve damage.

CLINICAL RECOMMENDATION STATEMENTS:
Ophthalmic Evaluation
In completing the elements in the comprehensive adult medical eye evaluation, the ophthalmic evaluation specifically focuses on the following elements:

- History [A:III]
- Visual acuity measurement [A:III]
- Pupil examination [B:II]
- Anterior segment examination [A:III]
- Intraocular pressure measurement [A:I]
- Gonioscopy [A:III]
- Optic nerve head and retinal nerve fiber layer examination [A:III]
- Fundus examination [A:III)

(AAO, 2010)

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*Measure #14 (NQF 0087): Age-Related Macular Degeneration (AMD): Dilated Macular Examination

2013 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of patients aged 50 years and older with a diagnosis of AMD who had a dilated macular examination performed which included documentation of the presence or absence of macular thickening or hemorrhage AND the level of macular degeneration severity during one or more office visits within 12 months

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for patients seen during the reporting period. It is anticipated that clinicians who provide the primary management of patients with age-related macular degeneration (in either one or both eyes) will submit this measure.

Measure Reporting via Claims:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. CPT Category II codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed ICD-9-CM diagnosis codes, CPT codes, and the appropriate CPT Category II code OR the CPT Category II code with the modifier. The modifiers allowed for this measure are: 1P- medical reasons, 2P- patient reasons, 8P- reason not otherwise specified. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All patients aged 50 years and older with a diagnosis of age-related macular degeneration

Denominator Criteria (Eligible Cases):
Patients aged ≥ 50 years on date of encounter
AND
Diagnosis for age-related macular degeneration (ICD-9-CM): 362.50, 362.51, 362.52
Diagnosis for age-related macular degeneration (ICD-10-CM) [REFERENCE ONLY/Not Reportable]: H35.30, H35.31, H35.32
AND
Patient encounter during the reporting period (CPT): 92002, 92004, 92012, 92014, 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

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NUMERATOR:
Patients who had a dilated macular examination performed which included documentation of the presence or absence of macular thickening or hemorrhage AND the level of macular degeneration severity during one or more office visits within 12 months

Definitions:
Macular Thickening – Acceptable synonyms for "macular thickening" include: intraretinal thickening, serous detachment of the retina, pigment epithelial detachment.
Severity of Macular Degeneration – Mild, moderate, or severe.

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Dilated Macular Examination Performed
CPT II 2019F: Dilated macular exam performed, including documentation of the presence or absence of macular thickening or hemorrhage AND the level of macular degeneration severity

OR

Dilated Macular Examination not Performed for Medical or Patient Reasons
Append a modifier (1P or 2P) to CPT Category II code 2019F to report documented circumstances that appropriately exclude patients from the denominator.
2019F *with* 1P: Documentation of medical reason(s) for not performing a dilated macular examination
2019F *with* 2P: Documentation of patient reason(s) for not performing a dilated macular examination

OR

Dilated Macular Examination not Performed, Reason not Otherwise Specified
Append a reporting modifier (8P) to CPT Category II code 2019F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.
2019F *with* 8P: Dilated macular exam was not performed, reason not otherwise specified

RATIONALE:
A documented complete macular examination is a necessary prerequisite to determine the presence and severity of AMD, so that a decision can be made as to the benefits of prescribing antioxidant vitamins. Further, periodic assessment is necessary to determine whether there is progression of the disease and to plan the on-going treatment of the disease, since several therapies exist that reduce vision loss once the advanced "wet" form of AMD occurs. While no data exist on the frequency or absence of regular examinations of the macula for patients with AMD, parallel data for key structural assessments for glaucoma, cataract and diabetic retinopathy suggest that significant gaps are likely.

CLINICAL RECOMMENDATION STATEMENTS:
According to the American Academy of Ophthalmology, a stereo biomicroscopic examination of the macula should be completed. Binocular slit-lamp biomicroscopy of the ocular fundus is often necessary to detect subtle clinical clues of CNV. These include small areas of hemorrhage, hard exudates, subretinal fluid, or pigment epithelial elevation. (Level A: III Recommendation) (AAO, 2005)

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*Measure #18 (NQF 0088): Diabetic Retinopathy: Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy

2013 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of patients aged 18 years and older with a diagnosis of diabetic retinopathy who had a dilated macular or fundus exam performed which included documentation of the level of severity of retinopathy and the presence or absence of macular edema during one or more office visits within 12 months

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for patients seen during the reporting period. It is anticipated that clinicians who provide the primary management of patients with diabetic retinopathy (in either one or both eyes) will submit this measure.

Measure Reporting via Claims:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. CPT Category II codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed ICD-9-CM diagnosis codes, CPT codes, and the appropriate CPT Category II code OR the CPT Category II code with the modifier. The modifiers allowed for this measure are: 1P- medical reasons, 2P- patient reasons, 8P- reason not otherwise specified. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All patients aged 18 years and older with a diagnosis of diabetic retinopathy

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Diagnosis for diabetic retinopathy (ICD-9-CM): 362.01, 362.02, 362.03, 362.04, 362.05, 362.06
Diagnosis for diabetic retinopathy (ICD-10-CM) [REFERENCE ONLY/Not Reportable]: E08.311, E08.319, E08.321, E08.329, E08.331, E08.339, E08.341, E08.349, E08.351, E08.359, E09.311, E09.319, E09.321, E09.329, E09.331, E09.339, E09.341, E09.349, E09.351, E09.359, E10.311, E10.319, E10.321, E10.329, E10.331, E10.339, E10.341, E10.349, E10.351, E10.359, E11.311, E11.319, E11.321, E11.329, E11.331, E11.339, E11.341, E11.349, E11.351, E11.359, E13.311, E13.319, E13.321, E13.329, E13.331, E13.339, E13.341, E13.349, E13.351, E13.359
AND

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Patient encounter during the reporting period (CPT): 92002, 92004, 92012, 92014, 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

NUMERATOR:
Patients who had a dilated macular or fundus exam performed which included documentation of the level of severity of retinopathy AND the presence or absence of macular edema during one or more office visits within 12 months

Definitions:
Documentation – The medical record must include: documentation of the level of severity of retinopathy (e.g., background diabetic retinopathy, proliferative diabetic retinopathy, non-proliferative diabetic retinopathy) AND documentation of whether macular edema was present or absent.
Macular Edema – Acceptable synonyms for macular edema include: intraretinal thickening, serous detachment of the retina, or pigment epithelial detachment.
Severity of Retinopathy – mild nonproliferative, preproliferative, very severe nonproliferative.

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Macular or Fundus Exam Performed
CPT II 2021F: Dilated macular or fundus exam performed, including documentation of the presence or absence of macular edema AND level of severity of retinopathy

OR

Macular or Fundus Exam not Performed for Medical or Patient Reasons
Append a modifier (1P or 2P) to CPT Category II code 2021F to report documented circumstances that appropriately exclude patients from the denominator.
2021F *with* 1P: Documentation of medical reason(s) for not performing a dilated macular or fundus examination
2021F *with* 2P: Documentation of patient reason(s) for not performing a dilated macular or fundus examination

OR

Macular or Fundus Exam not Performed, Reason not Otherwise Specified
Append a reporting modifier (8P) to CPT Category II code 2021F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.
2021F *with* 8P: Dilated macular or fundus exam was not performed, reason not otherwise specified

RATIONALE:
Several level 1 RCT studies demonstrate the ability of timely treatment to reduce the rate and severity of vision loss from diabetes (Diabetic Retinopathy Study – DRS, Early Treatment Diabetic Retinopathy Study – ETDRS). Necessary examination prerequisites to applying the study results are that the presence and severity of both peripheral diabetic retinopathy and macular edema be accurately documented. In the RAND chronic disease quality project, while administrative data indicated that roughly half of the patients had an eye exam in the recommended time period, chart review data indicated that only 19% had documented evidence of a dilated examination. (McGlynn, 2003). Thus, ensuring timely treatment that could prevent 95% of the blindness due to diabetes requires the performance and documentation of key examination parameters. The documented level of severity of retinopathy and the documented presence or absence of macular edema assists with the on-going plan of care for the patient with diabetic retinopathy.

CLINICAL RECOMMENDATION STATEMENTS:
Because treatment is effective in reducing the risk of visual loss, detailed examination is indicated to assess for the following features that often lead to visual impairment:

- Presence of macular edema
- Optic nerve head neovascularization and/or neovascularization elsewhere

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- Signs of severe NPDR (extensive retinal hemorrhages/microaneurysms, venous beading, and IRMA)
- Vitreous or preretinal hemorrhage

(Level A:III Recommendation) (AAO, 2008)

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*Measure #19 (NQF 0089): Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care

2013 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of patients aged 18 years and older with a diagnosis of diabetic retinopathy who had a dilated macular or fundus exam performed with documented communication to the physician who manages the ongoing care of the patient with diabetes mellitus regarding the findings of the macular or fundus exam at least once within 12 months

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for all patients with diabetic retinopathy seen during the reporting period. It is anticipated that clinicians who provide the primary management of patients with diabetic retinopathy (in either one or both eyes) will submit this measure.

Measure Reporting via Claims:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. CPT Category II and/or G-codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed ICD-9-CM diagnosis codes, CPT codes, and the appropriate CPT Category II code AND/OR G-code OR the CPT Category II code with the modifier AND G-code. The modifiers allowed for this measure are: 1P- medical reasons, 2P- patient reasons, 8P- reason not otherwise specified. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All patients aged 18 years and older with a diagnosis of diabetic retinopathy who had a dilated macular or fundus exam performed

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Diagnosis for diabetic retinopathy (ICD-9-CM): 362.01, 362.02, 362.03, 362.04, 362.05, 362.06
Diagnosis for diabetic retinopathy (ICD-10-CM) [REFERENCE ONLY/Not Reportable]: E08.311, E08.319, E08.321, E08.329, E08.331, E08.339, E08.341, E08.349, E08.351, E08.359, E09.311, E09.319, E09.321, E09.329, E09.331, E09.339, E09.341, E09.349, E09.351, E09.359, E10.311, E10.319, E10.321, E10.329, E10.331, E10.339, E10.341, E10.349, E10.351, E10.359, E11.311, E11.319, E11.321, E11.329, E11.331, E11.339, E11.341, E11.349, E11.351, E11.359, E13.311, E13.319, E13.321, E13.329, E13.331, E13.339, E13.341, E13.349, E13.351, E13.359
AND

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Patient encounter during the reporting period (CPT): 92002, 92004, 92012, 92014, 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

NUMERATOR:
Patients with documentation, at least once within 12 months, of the findings of the dilated macular or fundus exam via communication to the physician who manages the patient's diabetic care

Definitions:
Communication – May include documentation in the medical record indicating that the findings of the dilated macular or fundus exam were communicated (e.g., verbally, by letter) with the clinician managing the patient's diabetic care OR a copy of a letter in the medical record to the clinician managing the patient's diabetic care outlining the findings of the dilated macular or fundus exam.
Findings – Includes level of severity of retinopathy AND the presence or absence of macular edema.

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:
Dilated Macular or Fundus Exam Findings Communicated
(One CPT II code & one G-code [5010F & G8397] are required on the claim form to submit this numerator option)
CPT II 5010F: Findings of dilated macular or fundus exam communicated to the physician managing the diabetes care
AND
G8397: Dilated macular or fundus exam performed, including documentation of the presence or absence of macular edema AND level of severity of retinopathy

OR

Dilated Macular or Fundus Exam Findings not Communicated for Medical Reasons or Patient Reasons
(One CPT II code & one G-code [5010F-xP & G8397] are required on the claim form to submit this numerator option)
Append a modifier (1P or 2P) to CPT Category II code 5010F to report documented circumstances that appropriately exclude patients from the denominator.
5010F *with* 1P: Documentation of medical reason(s) for not communicating the findings of the dilated macular or fundus exam to the physician who manages the on going care of the patient with diabetes
5010F *with* 2P: Documentation of patient reason(s) for not communicating the findings of the dilated macular or fundus exam to the physician who manages the on going care of the patient with diabetes
AND
G8397: Dilated macular or fundus exam performed, including documentation of the presence or absence of macular edema AND level of severity of retinopathy

OR

If patient is not eligible for this measure because patient did not have dilated macular or fundus exam performed, report:
(One G-code [G8398] is required on the claim form to submit this numerator option)
G8398: Dilated macular or fundus exam not performed

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OR

Dilated Macular or Fundus Exam Findings not Communicated, Reason not Otherwise Specified
*(One CPT II code & one G-code [*5010F-8P & G8397*] are required on the claim form to submit this numerator option)*
Append a reporting modifier (8P) to CPT Category II code 5010F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.
5010F *with* 8P: Findings of dilated macular or fundus exam was not communicated to the physician managing the diabetes care, reason not otherwise specified

AND

G8397: Dilated macular or fundus exam performed, including documentation of the presence or absence of macular edema AND level of severity of retinopathy

RATIONALE:
The physician that manages the ongoing care of the patient with diabetes should be aware of the patient's dilated eye examination and severity of retinopathy to manage the ongoing diabetes care. Such communication is important in assisting the physician to better manage the diabetes. Several studies have shown that better management of diabetes is directly related to lower rates of development of diabetic eye disease. (Diabetes Control and Complications Trial – DCCT, UK Prospective Diabetes Study – UKPDS)

CLINICAL RECOMMENDATION STATEMENTS:
While it is clearly the responsibility of the ophthalmologist to manage eye disease, it is also the ophthalmologist's responsibility to ensure that patients with diabetes are referred for appropriate management of their systemic condition. It is the realm of the patient's family physician, internist or endocrinologist to manage the systemic diabetes. The ophthalmologist should communicate with the attending physician. (Level A: III Recommendation) (AAO, 2003)

Although the ophthalmologist will perform most of the examination and all surgery, certain aspects of data collection may be conducted by other trained individuals under the ophthalmologist's supervision and review. Because of the complexities of the diagnosis and surgery for PDR, the ophthalmologist caring for patients with this condition should be familiar with the specific recommendations of the DRS, ETDRS, UKPDS, and DCCT/EDIC (see Appendices 3 and 5). The ophthalmologist should also have training in and experience with the management of this particular condition. (AAO, 2008)

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*Measure #20 (NQF 0270): Perioperative Care: Timing of Prophylactic Parenteral Antibiotic – Ordering Physician

2013 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

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)

INSTRUCTIONS:
This measure is to be reported each time a procedure is performed during the reporting period for patients who undergo surgical procedures with the indications for prophylactic parenteral antibiotics. There is no diagnosis associated with this measure. It is anticipated that clinicians who perform the listed surgical procedures as specified in the denominator coding will submit this measure.

Measure Reporting via Claims:
CPT codes and patient demographics are used to identify patients who are included in the measure's denominator. G-codes are used to report the numerator of the measure. If multiple surgical procedures were performed on the same date of service and submitted on the same claim form, it is not necessary for the same clinician to submit the G-code with each procedure. However, if multiple NPIs are reporting this measure on the same claim, each NPI should report the quality-data code (G-code).

When reporting the measure via claims, submit the listed CPT codes, and the appropriate G-code. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
CPT codes and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All surgical patients aged 18 years and older undergoing procedures with the indications for prophylactic parenteral antibiotics

> Denominator Instructions: 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 the PQRS will be fully accountable for the clinical action described in the measure.
>
> Denominator Criteria (Eligible Cases):
> Patients aged ≥ 18 years on date of encounter
> AND
> Patient encounter during the reporting period (CPT): Listed below are surgical procedures for which prophylactic parenteral antibiotics are indicated

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SURGICAL PROCEDURE	CPT CODE
Integumentary	15732, 15734, 15736, 15738, 15830, 15832, 15833, 15834, 15835, 15836, 15837, 19260, 19271, 19272, 19300, 19301, 19302, 19303, 19304, 19305, 19306, 19307, 19316, 19318, 19324, 19325, 19328, 19330, 19340, 19342, 19350, 19355, 19357, 19361, 19364, 19366, 19367, 19368, 19369, 19370, 19371, 19380
Le Fort Fractures	21346, 21347, 21348, 21422, 21423, 21432, 21433, 21435, 21436
Mandibular Fracture	21454, 21461, 21462, 21465, 21470
Spine	22325, 22612, 22630, 22800, 22802, 22804, 63030, 63042
Hip Reconstruction	27125, 27130, 27132, 27134, 27137, 27138
Trauma (Fractures)	27235, 27236, 27244, 27245, 27269, 27758, 27759, 27766, 27769, 27792, 27814
Knee Reconstruction	27440, 27441, 27442, 27443, 27445, 27446, 27447
Laryngectomy	31360, 31365, 31367, 31368, 31370, 31375, 31380, 31382, 31390, 31395, 31400, 31420
Vascular	27880, 27881, 27882, 27884, 27886, 27888, 33877, 33880, 33881, 33883, 33886, 33889, 33891, 34800, 34802, 34803, 34804, 34805, 34812, 34820, 34825, 34830, 34831, 34832, 34833, 34834, 34900, 35011, 35013, 35081, 35082, 35091, 35092, 35102, 35103, 35131, 35141, 35142, 35151, 35152, 35206, 35266, 35301, 35363, 35371, 35372, 35460, 35512, 35521, 35522, 35523, 35525, 35533, 35537, 35538, 35539, 35540, 35556, 35558, 35565, 35566, 35570, 35571, 35572, 35583, 35585, 35587, 35601, 35606, 35612, 35616, 35621, 35623, 35626, 35631, 35632, 35633, 35634, 35636, 35637, 35638, 35642, 35645, 35646, 35647, 35650, 35651, 35654, 35656, 35661, 35663, 35665, 35666, 35671, 36830, 37224, 37225, 37226, 37227, 37228, 37229, 37230, 37231, 37617
Spleen and Lymph Nodes	38100, 38101, 38115, 38120, 38571, 38572, 38700, 38720, 38724, 38740, 38745, 38747, 38760, 38765, 38770, 38780
Glossectomy	41130, 41135, 41140, 41145, 41150, 41153, 41155
Esophagus	43020, 43030, 43045, 43100, 43101, 43107, 43108, 43112, 43113, 43116, 43117, 43118, 43121, 43122, 43123, 43124, 43130, 43135, 43279, 43280, 43281, 43282, 43300, 43305, 43310, 43312, 43313, 43314, 43320, 43325, 43327, 43328, 43330, 43331, 43332, 43333, 43334, 43335, 43336, 43337, 43340, 43341, 43350, 43351, 43352, 43360, 43361, 43400, 43401, 43405, 43410, 43415, 43420, 43425, 43496
Stomach	43500, 43501, 43502, 43510, 43520, 43605, 43610, 43611, 43620, 43621, 43622, 43631, 43632, 43633, 43634, 43640, 43641, 43644, 43645, 43651, 43652, 43653, 43800, 43810, 43820, 43825, 43830, 43832,

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SURGICAL PROCEDURE	CPT CODE
	43840, 43842, 43843, 43845, 43846, 43847, 43848, 43850, 43855, 43860, 43865, 43870, 43880
Small Intestine	44005, 44010, 44020, 44021, 44050, 44055, 44100, 44120, 44125, 44126, 44127, 44130, 44132, 44133, 44135, 44136
Colon	44140, 44141, 44143, 44144, 44145, 44146, 44147, 44150, 44151, 44155, 44156, 44157, 44158, 44160, 44180, 44186, 44187, 44188, 44202, 44204, 44205, 44206, 44207, 44208, 44210, 44211, 44212, 44227, 44300, 44310, 44312, 44314, 44316, 44320, 44322, 44340, 44345, 44346, 44602, 44603, 44604, 44605, 44615, 44620, 44625, 44626, 44640, 44650, 44660, 44661, 44680, 44700
Rectum	45000, 45020, 45110, 45111, 45112, 45113, 45114, 45116, 45119, 45120, 45121, 45123, 45126, 45130, 45135, 45136, 45150, 45160, 45171, 45172, 45395, 45397, 45400, 45402, 45540, 45541, 45550, 45560, 45562, 45563, 45800, 45805, 45820, 45825
Liver	47100, 47120, 47122, 47125, 47130, 47135, 47136, 47140, 47141, 47142, 47350, 47360
Biliary	47400, 47420, 47425, 47460, 47480, 47560, 47561, 47562, 47563, 47564, 47570, 47600, 47605, 47610, 47612, 47620, 47630, 47700, 47701, 47711, 47712, 47715, 47720, 47721, 47740, 47741, 47760, 47765, 47780, 47785, 47800, 47801, 47802, 47900
Pancreas	48000, 48001, 48020, 48100, 48102, 48105, 48120, 48140, 48145, 48146, 48148, 48150, 48152, 48153, 48154, 48155, 48160, 48500, 48510, 48511, 48520, 48540, 48545, 48547, 48548, 48554, 48556
Abdomen, Peritoneum, & Omentum	27080, 27158, 27202, 27215, 27216, 27217, 27218, 27280, 27282, 49000, 49002, 49010, 49020, 49021, 49040, 49041, 49060, 49203, 49204, 49205, 49215, 49220, 49250, 49320, 49321, 49322, 49323, 49505, 49507, 49568
Renal Transplant	50320, 50340, 50360, 50365, 50370, 50380
Gynecologic Surgery	57267, 58150, 58152, 58180, 58200, 58210, 58240, 58260, 58262, 58263, 58267, 58270, 58275, 58280, 58285, 58290, 58291, 58292, 58293, 58294, 58951, 58953, 58954, 58956
Acoustic Neuroma	61520, 61526, 61530, 61591, 61595, 61596, 61598, 61606, 61616, 61618, 61619, 69720, 69955, 69960, 69970
Cochlear Implants	69930
Neurological Surgery	22524, 22554, 22558, 22600, 22612, 22630, 61154, 61312, 61313, 61315, 61510, 61512, 61518, 61548, 61697, 61700, 61750, 61751, 61867, 62223, 62230, 63015, 63020, 63030, 63042, 63045, 63047, 63056, 63075, 63081, 63267, 63276
Cardiothoracic Surgery	33120, 33130, 33140, 33141, 33202, 33250, 33251,

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SURGICAL PROCEDURE	CPT CODE
	33256, 33261, 33305, 33315, 33321, 33322, 33332, 33335, 33400, 33401, 33403, 33404, 33405, 33406, 33410, 33411, 33413, 33416, 33422, 33425, 33426, 33427, 33430, 33460, 33463, 33464, 33465, 33475, 33496, 33510, 33511, 33512, 33513, 33514, 33516, 33517, 33518, 33519, 33521, 33522, 33523, 33530, 33533, 33534, 33535, 33536, 33542, 33545, 33548, 33572, 35211, 35241, 35271
Cardiothoracic (Pacemaker)	33203, 33206, 33207, 33208, 33212, 33213, 33214, 33215, 33216, 33217, 33218, 33220, 33222, 33223, 33224, 33225, 33226, 33233, 33234, 33235, 33236, 33237, 33238, 33240, 33241, 33243, 33244, 33249, 33254, 33255
Genitourinary Surgery	50020, 50234, 50236, 50548, 50727, 50728, 50760, 50770, 50780, 50782, 50783, 50785, 50800, 50810, 50815, 50820, 50947, 50948, 50951, 50953, 50955, 50957, 50961, 50970, 50972, 50974, 50976, 50980, 51550, 51555, 51565, 51570, 51575, 51580, 51585, 51590, 51595, 51596, 51597, 51800, 51820, 51900, 51920, 51925, 51960, 52007, 52204, 52214, 52224, 52234, 52235, 52240, 52250, 52260, 52265, 52281, 52300, 52301, 52310, 52315, 52325, 52327, 52330, 52332, 52341, 52342, 52343, 52344, 52345, 52346, 52352, 52354, 52400, 52402, 52450, 52601, 52630, 52640, 52647, 52648, 52649, 53445, 53850, 53852, 54400, 54401, 54405, 54406, 54408, 54410, 54411, 54415, 54416, 54417, 54700, 55700, 55705, 55706, 55801, 55810, 55812, 55815, 55821, 55831, 55840, 55842, 55845, 55866
General Thoracic Surgery	0236T, 21627, 21632, 21740, 21750, 21805, 21825, 31760, 31766, 31770, 31775, 31786, 31805, 32096, 32097, 32098, 32100, 32110, 32120, 32124, 32140, 32141, 32150, 32215, 32220, 32225, 32310, 32320, 32440, 32442, 32445, 32480, 32482, 32484, 32486, 32488, 32491, 32505, 32506, 32507, 32800, 32810, 32815, 32900, 32905, 32906, 32940, 33020, 33025, 33030, 33031, 33050, 33300, 33310, 33320, 34051, 35021, 35216, 35246, 35276, 35311, 35526, 37616, 38381, 38746, 39000, 39010, 39200, 39220, 39545, 39561, 64746
Foot & Ankle	27702, 27703, 27704, 28192, 28193, 28293, 28415, 28420, 28445, 28465, 28485, 28505, 28525, 28531, 28555, 28585, 28615, 28645, 28675, 28705, 28715, 28725, 28730, 28735, 28737
Mediastinum and Diaphragm	39501, 39540, 39541, 39545, 39560, 39561
Bariatric	43770, 43771, 43772, 43773, 43774, 43775, 43842, 43843, 43845, 43846, 43847, 43848, 43886, 43887, 43888
Meckel's Diverticulum and	44800, 44820, 44850, 44900, 44950, 44955, 44960,

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SURGICAL PROCEDURE	CPT CODE
Appendix	44970
General Surgery	23470, 23472, 23616, 24363, 60200, 60210, 60212, 60220, 60225, 60240, 60252, 60254, 60260, 60270, 60271, 60280, 60281, 60500, 60502, 60505, 60520, 60521, 60522, 60540, 60545, 60600, 60605, 60650

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).

NUMERATOR 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 • Aztreonam • Cefazolin • Cefmetazole • Cefotetan • Cefoxitin	• Cefuroxime • Ciprofloxacin • Clindamycin • Ertapenem • Erythromycin base • Gatifloxacin	• Gentamicin • Levofloxacin • Metronidazole • Moxifloxacin • Neomycin • 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 antibiotics 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

Order for Prophylactic Parenteral Antibiotic not Given for Documented 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

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Order for Administration of Prophylactic Parenteral Antibiotic not Given, Reason not Given
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 given

RATIONALE:
The appropriate timing of administration of prophylactic parenteral antibiotics has been demonstrated to reduce the incidence of surgical wound infections. Specifying the time of administration in the order is critical as available evidence suggests that the drug should be received within one hour before incision for maximum antimicrobial effect.

CLINICAL RECOMMENDATION STATEMENTS:
The anti-infective drug should ideally be given within 30 minutes to 1 hour before the initial incision to ensure its presence in an adequate concentration in the targeted tissues. For most procedures, scheduling administration at the time of induction of anesthesia ensures adequate concentrations during the period of potential contamination. Exceptions: cesarean procedures (after cross clamping of the umbilical cord); colonic procedures (starting 19 hours before the scheduled time of surgery). (ASHP)

Infusion of the first antimicrobial dose should begin within 60 minutes before incision. However, when a fluoroquinolone or vancomycin is indicated, the infusion should begin within 120 minutes before incision to prevent antibiotic-associated reactions. Although research has demonstrated that administration of the antimicrobial at the time of anesthesia induction is safe and results in adequate serum and tissue drug levels at the time of incision, there was no consensus that the infusion must be completed before incision. (SIPGWW)

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*Measure #21 (NQF 0268): Perioperative Care: Selection of Prophylactic Antibiotic – First OR Second Generation Cephalosporin

2013 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

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

INSTRUCTIONS:
This measure is to be reported each time a procedure is performed during the reporting period for patients who undergo surgical procedures with the indications for a first or second generation cephalosporin prophylactic antibiotic. There is no diagnosis associated with this measure. It is anticipated that clinicians who perform the listed surgical procedures as specified in the denominator coding will submit this measure.

Measure Reporting via Claims:
CPT codes and patient demographics are used to identify patients who are included in the measure's denominator. CPT Category II codes are used to report the numerator of the measure. If multiple surgical procedures were performed on the same date of service and submitted on the same claim form, it is not necessary for the same clinician to submit the CPT Category II code with each procedure. However, if multiple NPIs are reporting this measure on the same claim, each NPI should report the quality-data code (G-code).

When reporting the measure via claims, submit the listed CPT codes, and the appropriate CPT Category II code OR the CPT Category II code with the modifier. The modifiers allowed for this measure are: 1P- medical reasons, 8P-reason not otherwise specified. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
CPT codes and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All surgical patients aged 18 years and older undergoing procedures with the indications for a first OR second generation cephalosporin prophylactic antibiotic

> Denominator Instructions: 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 PQRS will be fully accountable for the clinical action described in the measure.
>
> Denominator Criteria (Eligible Cases):
> Patients aged ≥ 18 years on date of encounter
> AND

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Patient encounter during the reporting period (CPT): Listed below are surgical procedures with indications for first or second generation cephalosporin prophylactic antibiotic

SURGICAL PROCEDURE	CPT CODE
Integumentary	15732, 15734, 15736, 15738, 15830, 15832, 15833, 15834, 15835, 15836, 15837, 19260, 19271, 19272, 19300, 19301, 19302, 19303, 19304, 19305, 19306, 19307, 19316, 19318, 19324, 19325, 19328, 19330, 19340, 19342, 19350, 19355, 19357, 19361, 19364, 19366, 19367, 19368, 19369, 19370, 19371, 19380
Spine	22325, 22612, 22630, 22800, 22802, 22804, 63030, 63042
Hip Reconstruction	27125, 27130, 27132, 27134, 27137, 27138
Trauma (Fractures)	27235, 27236, 27244, 27245, 27269, 27758, 27759, 27766, 27769, 27792, 27814
Knee Reconstruction	27440, 27441, 27442, 27443, 27445, 27446, 27447
Vascular	27880, 27881, 27882, 27884, 27886, 27888, 33877, 33880, 33881, 33883, 33886, 33889, 33891, 34800, 34802, 34803, 34804, 34805, 34812, 34820, 34825, 34830, 34831, 34832, 34833, 34834, 34900, 35011, 35013, 35081, 35082, 35091, 35092, 35102, 35103, 35131, 35141, 35142, 35151, 35152, 35206, 35266, 35301, 35363, 35371, 35372, 35460, 35512, 35521, 35522, 35523, 35525, 35533, 35537, 35538, 35539, 35540, 35556, 35558, 35565, 35566, 35570, 35571, 35572, 35583, 35585, 35587, 35601, 35606, 35612, 35616, 35621, 35623, 35626, 35631, 35632, 35633, 35634, 35636, 35637, 35638, 35642, 35645, 35646, 35647, 35650, 35651, 35654, 35656, 35661, 35663, 35665, 35666, 35671, 36830, 37224, 37225, 37226, 37227, 37228, 37229, 37230, 37231, 37617
Spleen and Lymph Nodes	38100, 38101, 38115, 38120, 38571, 38572, 38700, 38720, 38724, 38740, 38745, 38747, 38760, 38765, 38770, 38780
Esophagus	43020, 43030, 43045, 43100, 43101, 43107, 43108, 43112, 43113, 43116, 43117, 43118, 43121, 43122, 43123, 43124, 43130, 43135, 43279, 43280, 43281, 43282, 43300, 43305, 43310, 43312, 43313, 43314, 43320, 43325, 43327, 43328, 43330, 43331, 43332, 43333, 43334, 43335, 43336, 43337, 43340, 43341, 43350, 43351, 43352, 43360, 43361, 43400, 43401, 43405, 43410, 43415, 43420, 43425, 43496
Stomach	43500, 43501, 43502, 43510, 43520, 43605, 43610, 43611, 43620, 43621, 43622, 43631, 43632, 43633, 43634, 43640, 43641, 43644, 43645, 43651, 43652, 43653, 43800, 43810, 43820, 43825, 43830, 43832, 43840, 43842, 43843, 43845, 43846, 43847, 43848, 43850, 43855, 43860, 43865, 43870, 43880
Small Intestine	44005, 44010, 44020, 44021, 44050, 44055, 44100, 44120, 44125, 44126, 44127, 44130, 44132, 44133, 44135, 44136
Colon	44140, 44141, 44143, 44144, 44145, 44146, 44147, 44150, 44151, 44155, 44156, 44157, 44158, 44160, 44180, 44186, 44187, 44188, 44202, 44204, 44205, 44206, 44207, 44208, 44210, 44211, 44212, 44227, 44300, 44310, 44312, 44314, 44316, 44320, 44322, 44340, 44345, 44346, 44602, 44603,

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SURGICAL PROCEDURE	CPT CODE
	44604, 44605, 44615, 44620, 44625, 44626, 44640, 44650, 44660, 44661, 44680, 44700
Rectum	45000, 45020, 45110, 45111, 45112, 45113, 45114, 45116, 45119, 45120, 45121, 45123, 45126, 45130, 45135, 45136, 45150, 45160, 45171, 45172, 45395, 45397, 45400, 45402, 45540, 45541, 45550, 45560, 45562, 45563, 45800, 45805, 45820, 45825
Biliary	47400, 47420, 47425, 47460, 47480, 47560, 47561, 47562, 47563, 47564, 47570, 47600, 47605, 47610, 47612, 47620, 47630, 47700, 47701, 47711, 47712, 47715, 47720, 47721, 47740, 47741, 47760, 47765, 47780, 47785, 47800, 47801, 47802, 47900
Pancreas	48000, 48001, 48020, 48100, 48102, 48105, 48120, 48140, 48145, 48146, 48148, 48150, 48152, 48153, 48154, 48155, 48160, 48500, 48510, 48511, 48520, 48540, 48545, 48547, 48548, 48554, 48556
Abdomen, Peritoneum & Omentum	27080, 27158, 27202, 27215, 27216, 27217, 27218, 27280, 27282, 49000, 49002, 49010, 49020, 49021, 49040, 49041, 49060, 49203, 49204, 49205, 49215, 49220, 49250, 49320, 49321, 49322, 49323, 49505, 49507, 49568
Renal Transplant	50320, 50340, 50360, 50365, 50370, 50380
Neurological Surgery	22524, 22554, 22558, 22600, 22612, 22630, 61154, 61312, 61313, 61315, 61510, 61512, 61518, 61548, 61697, 61700, 61750, 61751, 61867, 62223, 62230, 63015, 63020, 63030, 63042, 63045, 63047, 63056, 63075, 63081, 63267, 63276
Cardiothoracic Surgery	33120, 33130, 33140, 33141, 33202, 33250, 33251, 33256, 33261, 33305, 33315, 33321, 33322, 33332, 33335, 33400, 33401, 33403, 33404, 33405, 33406, 33410, 33411, 33413, 33416, 33422, 33425, 33426, 33427, 33430, 33460, 33463, 33464, 33465, 33475, 33496, 33510, 33511, 33512, 33513, 33514, 33516, 33517, 33518, 33519, 33521, 33522, 33523, 33530,33533, 33534, 33535, 33536, 33542, 33545, 33548, 33572, 35211, 35241, 35271
General Thoracic Surgery	0236T, 21627, 21632, 21740, 21750, 21805, 21825, 31760, 31766, 31770, 31775, 31786, 31805, 32096, 32097, 32098, 32100, 32110, 32120, 32124, 32140, 32141, 32150, 32215, 32220, 32225, 32310, 32320, 32440, 32442, 32445, 32480, 32482, 32484, 32486, 32488, 32491, 32505, 32506, 32507 32800, 32810, 32815, 32900, 32905, 32906, 32940, 33020, 33025, 33030, 33031, 33050, 33300, 33310, 33320, 34051, 35021, 35216, 35246, 35276, 35311, 35526, 37616, 38381, 38746, 39000, 39010, 39200, 39220, 39545, 39561, 64746
Foot & Ankle	27702, 27703, 27704, 28192, 28193, 28293, 28415, 28420, 28445, 28465, 28485, 28505, 28525, 28531, 28555, 28585, 28615, 28645, 28675, 28705, 28715, 28725, 28730, 28735, 28737
Laryngectomy	31400, 31420
Mediastinum and Diaphragm	39501, 39540, 39541, 39545, 39560, 39561
Bariatric	43770, 43771, 43772, 43773, 43774, 43775, 43842, 43843,

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SURGICAL PROCEDURE	CPT CODE
	43845, 43846, 43847, 43848, 43886, 43887, 43888
Meckel's Diverticulum and Appendix	44800, 44820, 44850, 44900, 44950, 44955, 44960, 44970
Liver	47100, 47120, 47122, 47125, 47130, 47140, 47141, 47142, 47350, 47370, 47371, 47380, 47381
Gynecologic Surgery	57267, 58150, 58152, 58180, 58200, 58210, 58240, 58260, 58262, 58263, 58267, 58270, 58275, 58280, 58285, 58290, 58291, 58292, 58293, 58294, 58951, 58953, 58954, 58956
General Surgery	23470, 23472, 23616, 24363, 60200, 60210, 60212, 60220, 60225, 60240, 60252, 60254, 60260, 60270, 60271, 60280, 60281, 60500, 60502, 60505, 60520, 60521, 60522, 60540, 60545, 60600, 60605, 60650

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***.

NUMERATOR 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 Otherwise 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

RATIONALE:
Current published evidence supports the use of either cefazolin, a first generation cephalosporin, or cefuroxime, a second generation cephalosporin, for many surgical procedures, in the absence of β-lactam allergy. An alternative

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antimicrobial regimen may be appropriate depending on the antimicrobial susceptibility pattern in an individual institution (potentially a medical reason for excluding patients treated at that institution from this measure).

CLINICAL RECOMMENDATION STATEMENTS:
For most procedures, cefazolin should be the agent of choice because of its relatively long duration of action, its effectiveness against the organisms most commonly encountered in surgery, and it's relatively low cost. (ASHP)

In operations for which cephalosporins represent appropriate prophylaxis, alternative antimicrobials should be provided to those with a high likelihood of serious adverse reaction or allergy on the basis of patient history or diagnostic tests such as skin testing.

The preferred antimicrobials for prophylaxis in patients undergoing hip or knee arthroplasty are cefazolin and cefuroxime. Vancomycin or clindamycin may be used in patients with serious allergy or adverse reactions to β-lactams.

The recommended antimicrobials for cardiothoracic and vascular operations include cefazolin or cefuroxime. For patients with serious allergy or adverse reaction to β-lactams, vancomycin is appropriate, and clindamycin may be an acceptable alternative. (SIPGWW)

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*Measure #22 (NQF 0271): Perioperative Care: Discontinuation of Prophylactic Parenteral Antibiotics (Non-Cardiac Procedures)

2013 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

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

INSTRUCTIONS:
This measure is to be reported each time a procedure is performed during the reporting period for patients who undergo non-cardiac surgical procedures with the indications for prophylactic parenteral antibiotics. There is no diagnosis associated with this measure. It is anticipated that clinicians who perform the listed surgical procedures as specified in the denominator coding will submit this measure.

Measure Reporting via Claims:
CPT codes and patient demographics are used to identify patients who are included in the denominator. CPT Category II codes are used to report the numerator of the measure. If multiple surgical procedures were performed on the same date of service and submitted on the same claim form, it is not necessary for the same clinician to submit the CPT Category II code with each procedure. However, if multiple NPIs are reporting this measure on the same claim, each NPI should report the quality-data code (G-code).

When reporting the measure via claims, submit the listed CPT codes, and the appropriate CPT Category II code(s) OR the CPT Category II code(s) with the modifier. The modifiers allowed for this measure are: 1P- medical reasons, 8P- reason not otherwise specified. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
CPT codes and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All 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

Denominator Instructions:
- 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 the PQRS will be fully accountable for the clinical action described in the measure.
- For the purpose of this measure of antibiotic discontinuation, patients may be counted as having "received a prophylactic parenteral antibiotic" if the antibiotic was received within 4 hours prior to the surgical incision (or start of procedure when no incision is required) or intraoperatively.

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Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Patient encounter during the reporting period (CPT): Listed below are non-cardiac surgical procedures for which prophylactic parenteral antibiotics are indicated

SURGICAL PROCEDURE	CPT CODE
Integumentary	15732, 15734, 15736, 15738, 15830, 15832, 15833, 15834, 15835, 15836, 15837, 19260, 19271, 19272, 19300, 19301, 19302, 19303, 19304, 19305, 19306, 19307, 19316, 19318, 19324, 19325, 19328, 19330, 19340, 19342, 19350, 19355, 19357, 19361, 19364, 19366, 19367, 19368, 19369, 19370, 19371, 19380
Le Fort Fractures	21346, 21347, 21348, 21422, 21423, 21432, 21433, 21435, 21436
Mandibular Fracture	21454, 21461, 21462, 21465, 21470
Spine	22325, 22612, 22630, 22800, 22802, 22804, 63030, 63042
Hip Reconstruction	27125, 27130, 27132, 27134, 27137, 27138
Trauma (Fractures)	27235, 27236, 27244, 27245, 27269, 27758, 27759, 27766, 27769, 27792, 27814
Knee Reconstruction	27440, 27441, 27442, 27443, 27445, 27446, 27447
Laryngectomy	31360, 31365, 31367, 31368, 31370, 31375, 31380, 31382, 31390, 31395, 31400, 31420
Vascular	27880, 27881, 27882, 27884, 27886, 27888, 33877, 33880, 33881, 33883, 33886, 33889, 33891, 34800, 34802, 34803, 34804, 34805, 34812, 34820, 34825, 34830, 34831, 34832, 34833, 34834, 34900, 35011, 35013, 35081, 35082, 35091, 35092, 35102, 35103, 35131, 35141, 35142, 35151, 35152, 35206, 35266, 35301, 35363, 35371, 35372, 35460, 35512, 35521, 35522, 35523, 35525, 35533, 35537, 35538, 35539, 35540, 35556, 35558, 35565, 35566, 35570, 35571, 35572, 35583, 35585, 35587, 35601, 35606, 35612, 35616, 35621, 35623, 35626, 35631, 35632, 35633, 35634, 35636, 35637, 35638, 35642, 35645, 35646, 35647, 35650, 35651, 35654, 35656, 35661, 35663, 35665, 35666, 35671, 36830, 37224, 37225, 37226, 37227, 37228, 37229, 37230, 37231, 37617
Glossectomy	41130, 41135, 41140, 41145, 41150, 41153, 41155
Esophagus	43020, 43030, 43045, 43100, 43101, 43107, 43108, 43112, 43113, 43116, 43117, 43118, 43121, 43122, 43123, 43124, 43130, 43135, 43279, 43280, 43281, 43282, 43300, 43305, 43310, 43312, 43313, 43314, 43320, 43325, 43327, 43328, 43330, 43331, 43332, 43333, 43334, 43335, 43336, 43337, 43340, 43341, 43350, 43351, 43352, 43360, 43361, 43400, 43401, 43405, 43410, 43415, 43420, 43425, 43496
Stomach	43500, 43501, 43502, 43510, 43520, 43605, 43610, 43611, 43620, 43621, 43622, 43631, 43632, 43633, 43634, 43640, 43641, 43644, 43645, 43651, 43652, 43653, 43800, 43810, 43820, 43825, 43830, 43832, 43840, 43842, 43843, 43845, 43846, 43847, 43848, 43850, 43855, 43860, 43865, 43870, 43880

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SURGICAL PROCEDURE	CPT CODE
Small Intestine	44005, 44010, 44020, 44021, 44050, 44055, 44100, 44120, 44125, 44126, 44127, 44130, 44132, 44133, 44135, 44136
Colon	44140, 44141, 44143, 44144, 44145, 44146, 44147, 44150, 44151, 44155, 44156, 44157, 44158, 44160, 44180, 44186, 44187, 44188, 44202, 44204, 44205, 44206, 44207, 44208, 44210, 44211, 44212, 44227, 44300, 44310, 44312, 44314, 44316, 44320, 44322, 44340, 44345, 44346, 44602, 44603, 44604, 44605, 44615, 44620, 44625, 44626, 44640, 44650, 44660, 44661, 44680, 44700
Rectum	45000, 45020, 45108, 45110, 45111, 45112, 45113, 45114, 45116, 45119, 45120, 45121, 45123, 45126, 45130, 45135, 45136, 45150, 45160, 45171, 45172, 45190, 45395, 45397, 45400, 45402, 45500, 45505, 45540, 45541, 45550, 45560, 45562, 45563, 45800, 45805, 45820, 45825
Biliary	47400, 47420, 47425, 47460, 47480, 47560, 47561, 47562, 47563, 47564, 47570, 47600, 47605, 47610, 47612, 47620, 47630, 47700, 47701, 47711, 47712, 47715, 47720, 47721, 47740, 47741, 47760, 47765, 47780, 47785, 47800, 47801, 47802, 47900
Pancreas	48000, 48001, 48020, 48100, 48102, 48105, 48120, 48140, 48145, 48146, 48148, 48150, 48152, 48153, 48154, 48155, 48160, 48500, 48510, 48511, 48520, 48540, 48545, 48547, 48548, 48554, 48556
Abdomen, Peritoneum, & Omentum	27080, 27158, 27202, 27215, 27216, 27217, 27218, 27280, 27282, 49000, 49002, 49010, 49020, 49021, 49040, 49041, 49060, 49203, 49204, 49205, 49215, 49220, 49250, 49320, 49321, 49322, 49323, 49505, 49507, 49568
Renal Transplant	50320, 50340, 50360, 50365, 50370, 50380
Gynecologic Surgery	57267, 58150, 58152, 58180, 58200, 58210, 58240, 58260, 58262, 58263, 58267, 58270, 58275, 58280, 58285, 58290, 58291, 58292, 58293, 58294, 58951, 58953, 58954, 58956
Acoustic Neuroma	61520, 61526, 61530, 61591, 61595, 61596, 61598, 61606, 61616, 61618, 61619, 69720, 69955, 69960, 69970
Cochlear Implants	69930
Neurological Surgery	22524, 22554, 22558, 22600, 22612, 22630, 61154, 61312, 61313, 61315, 61510, 61512, 61518, 61548, 61697, 61700, 61750, 61751, 61867, 62223, 62230, 63015, 63020, 63030, 63042, 63045, 63047, 63056, 63075, 63081, 63267, 63276
Cardiothoracic (Pacemaker)	33203, 33206, 33207, 33208, 33212, 33213, 33214, 33215, 33216, 33217, 33218, 33220, 33222, 33223, 33224, 33225, 33226, 33233, 33234, 33235, 33236, 33237, 33238, 33240, 33241, 33243, 33244, 33249, 33254, 33255
General Thoracic Surgery	0236T, 21627, 21632, 21740, 21750, 21805, 21825, 31760, 31766, 31770, 31775, 31786, 31805, 32096, 32097, 32098, 32100, 32110, 32120, 32124, 32140, 32141, 32150, 32215, 32220, 32225, 32310, 32320, 32440, 32442, 32445, 32480, 32482, 32484, 32486, 32488, 32491, 32505, 32506, 32507 32800, 32810, 32815, 32900, 32905, 32906, 32940, 33020, 33025, 33030, 33031, 33050, 33300, 33310, 33320, 34051,

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SURGICAL PROCEDURE	CPT CODE
	35021, 35211, 35216, 35241, 35246, 35271, 35276, 35311, 35526, 37616, 38381, 38746, 39000, 39010, 39200, 39220, 39545, 39561, 64746
Foot & Ankle	27702, 27703, 27704, 28192, 28193, 28293, 28415, 28420, 28445, 28465, 28485, 28505, 28525, 28531, 28555, 28585, 28615, 28645, 28675, 28705, 28715, 28725, 28730, 28735, 28737
Spleen and Lymphatic	38100, 38101, 38115, 38120, 38571, 38572, 38700, 38720, 38724, 38740, 38745, 38747, 38760, 38765, 38770, 38780
Mediastinum and Diaphragm	39501, 39540, 39541, 39545, 39560, 39561
Bariatric	43770, 43771, 43772, 43773, 43774, 43775, 43842, 43843, 43845, 43846, 43847, 43848, 43886, 43887, 43888
Meckel's Diverticulum and Appendix	44800, 44820, 44850, 44900, 44950, 44955, 44960, 44970
Liver	47100, 47120, 47122, 47125, 47130, 47140, 47141, 47142, 47350, 47370, 47371, 47380, 47381
General Surgery	23470, 23472, 23616, 24363, 60200, 60210, 60212, 60220, 60225, 60240, 60252, 60254, 60260, 60270, 60271, 60280, 60281, 60500, 60502, 60505, 60520, 60521, 60522, 60540, 60545, 60600, 60605, 60650

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 antibiotic ***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

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Prophylactic Parenteral Antibiotics not Discontinued for Medical Reasons
(Two CPT II codes [4049F-1P & 4046F] are required on the claim form to submit this numerator option)
Append a modifier (1P) to CPT Category II code 4049F to report documented circumstances that appropriately exclude patients from the denominator.
4049F *with* 1P: Documentation of medical reason(s) for not discontinuing prophylactic antibiotics within 24 hours of surgical end time

AND

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 Otherwise 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

RATIONALE:
There is no evidence there is added benefit of prolonged prophylactic parenteral antibiotic use. Prolonged use may increase antibiotic resistant organisms.

CLINICAL RECOMMENDATION STATEMENTS:
At a minimum, antimicrobial coverage must be provided from the time of incision to closure of the incision. For most procedures, the duration of antimicrobial prophylaxis should be 24 hours or less, with the exception of cardiothoracic procedures (up to 72 hours duration) and ophthalmic procedures (duration not clearly established). (ASHP)

Prophylactic antimicrobials should be discontinued within 24 hours after the operation. (SIPGWW)

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*Measure #23 (NQF 0239): Perioperative Care: Venous Thromboembolism (VTE) Prophylaxis (When Indicated in ALL Patients)

2013 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of surgical 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

INSTRUCTIONS:
This measure is to be reported each time a procedure is performed during the reporting period for all patients who undergo surgical procedures for which VTE prophylaxis is indicated. There is no diagnosis associated with this measure. It is anticipated that clinicians who perform the listed surgical procedures as specified in the denominator coding will submit this measure.

Measure Reporting via Claims:
CPT codes and patient demographics are used to identify patients who are included in the measure's denominator. CPT Category II codes are used to report the numerator of the measure. If multiple surgical procedures were performed on the same date of service and submitted on the same claim form, it is not necessary for the same clinician to submit the CPT Category II code with each procedure. However, if multiple NPIs are reporting this measure on the same claim, each NPI should report the quality-data code (G-code).

When reporting the measure via claims, submit the listed CPT codes, and the appropriate CPT Category II code OR the CPT Category II code with the modifier. The modifiers allowed for this measure are: 1P- medical reasons, 8P- reason not otherwise specified. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
CPT codes and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All surgical patients aged 18 years and older undergoing procedures for which VTE prophylaxis is indicated in all patients

> Denominator Instructions: 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 the PQRS will be fully accountable for the clinical action described in the measure.
>
> Denominator Criteria (Eligible Cases):
> Patients aged ≥ 18 years on date of encounter
> AND

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Patient encounter during the reporting period (CPT): Listed below are surgical procedures for which VTE prophylaxis is indicated

SURGICAL PROCEDURE	CPT CODE
Neurological Surgery	22558, 22600, 22612, 22630, 61312, 61313, 61315, 61510, 61512, 61518, 61548, 61697, 61700, 62230, 63015, 63020, 63047, 63056, 63081, 63267, 63276
Hip Reconstruction	27125, 27130, 27132, 27134, 27137, 27138
Knee Reconstruction	27440, 27441, 27442, 27443, 27445, 27446, 27447
Genitourinary Surgery	50020, 50220, 50225, 50230, 50234, 50236, 50240, 50543, 50545, 50546, 50547, 50548, 50715, 50722, 50725, 50727, 50728, 50760, 50770, 50780, 50782, 50783, 50785, 50800, 50810, 50815, 50820, 50947, 50948, 51550, 51555, 51565, 51570, 51575, 51580, 51585, 51590, 51595, 51596, 51597, 51800, 51820, 51900, 51920, 51925, 51960, 55810, 55812, 55815, 55821, 55831, 55840, 55842, 55845, 55866
Gynecologic Surgery	56630, 56631, 56632, 56633, 56634, 56637, 56640, 57267, 58150, 58152, 58180, 58200, 58210, 58240, 58260, 58262, 58263, 58267, 58270, 58275, 58280, 58285, 58290, 58291, 58292, 58293, 58294, 58951, 58953, 58954, 58956
Hip Fracture Surgery	27235, 27236, 27244, 27245, 27269
Le Fort Fractures	21346, 21347, 21348, 21422, 21423, 21432, 21433, 21435, 21436
Mandibular Fractures	21454, 21461, 21462, 21465, 21470
General Thoracic (Non-Cardiac)	0236T, 21627, 21632, 21740, 21750, 21805, 21825, 31760, 31766, 31770, 31775, 31786, 31805, 32096, 32097, 32098, 32100, 32110, 32120, 32124, 32140, 32141, 32150, 32215, 32220, 32225, 32310, 32320, 32440, 32442, 32445, 32480, 32482, 32484, 32486, 32488, 32491, 32505, 32506, 32507, 32800, 32810, 32815, 32900, 32905, 32906, 32940, 33020, 33025, 33030, 33031, 33050, 33300, 33310, 33320, 34051, 35021, 35211, 35216, 35241, 35246, 35271, 35276, 35311, 35526, 37616, 38381, 38746, 39000, 39010, 39200, 39220, 39545, 39561, 64746
Laryngectomy	31360, 31365, 31367, 31368, 31370, 31375, 31380, 31382, 31390, 31395
Vascular	27880, 27881, 27882, 27884, 27886, 27888, 33877, 33880, 33881, 33883, 33886, 33889, 33891, 34800, 34802, 34803, 34804, 34805, 34812, 34820, 34825, 34830, 34831, 34832, 34833, 34834, 34900, 35011, 35013, 35081, 35082, 35091, 35092, 35102, 35103, 35131, 35141, 35142, 35151, 35152, 35206, 35266, 35301, 35363, 35371, 35372, 35460, 35512, 35521, 35522, 35523, 35525, 35533, 35537, 35538, 35539, 35540, 35556, 35558, 35565, 35566, 35570, 35571, 35572, 35583, 35585, 35587, 35601, 35606, 35612, 35616, 35621, 35623, 35626, 35631, 35632, 35633, 35634, 35636, 35637, 35638, 35642, 35645, 35646, 35647, 35650, 35651, 35654, 35656, 35661, 35663, 35665, 35666, 35671, 36830, 37224, 37225, 37226, 37227, 37228, 37229, 37230, 37231, 37617
Glossectomy	41130, 41135, 41140, 41145, 41150, 41153, 41155

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Acoustic Neuroma	61520, 61526, 61530, 61591, 61595, 61596, 61598, 61606, 61616, 61618, 61619, 69720, 69955, 69960, 69970
General Surgery	15734, 15830, 15832, 15833, 15834, 15835, 15836, 15837, 19260, 19271, 19272, 19300, 19305, 19306, 19307, 19316, 19318, 19324, 19361, 19364, 19366, 19367, 19368, 19369, 19380, 27080, 27158, 27202, 27215, 27216, 27217, 27218, 27280, 27282, 38100, 38101, 38115, 38120, 38571, 38572, 38700, 38720, 38724, 38747, 38760, 38765, 38770, 38780, 39501, 39540, 39541, 39545, 39560, 39561, 43020, 43030, 43045, 43100, 43101, 43107, 43108, 43112, 43113, 43116, 43117, 43118, 43121, 43122, 43123, 43124, 43130, 43135, 43279, 43280, 43281, 43282, 43300, 43305, 43310, 43312, 43313, 43314, 43320, 43325, 43327, 43328, 43330, 43331, 43332, 43333, 43334, 43335, 43336, 43337, 43340, 43341, 43350, 43351, 43352, 43360, 43361, 43400, 43401, 43405, 43410, 43415, 43420, 43425, 43496, 43500, 43501, 43502, 43510, 43520, 43605, 43610, 43611, 43620, 43621, 43622, 43631, 43632, 43633, 43634, 43640, 43641, 43644, 43645, 43651, 43652, 43653, 43770, 43771, 43772, 43773, 43774, 43800, 43810, 43820, 43825, 43830, 43832, 43840, 43842, 43843, 43845, 43846, 43847, 43848, 43850, 43855, 43860, 43865, 43870, 43880, 43886, 43887, 43888, 44005, 44010, 44020, 44021, 44025, 44050, 44055, 44110, 44111, 44120, 44125, 44126, 44127, 44130, 44140, 44141, 44143, 44144, 44145, 44146, 44147, 44150, 44151, 44155, 44156, 44157, 44158, 44160, 44180, 44186, 44187, 44188, 44202, 44204, 44205, 44206, 44207, 44208, 44210, 44211, 44212, 44227, 44300, 44310, 44312, 44314, 44316, 44320, 44322, 44340, 44345, 44346, 44602, 44603, 44604, 44605, 44615, 44620, 44625, 44626, 44640, 44650, 44660, 44661, 44680, 44700, 44800, 44820, 44850, 44900, 44950, 44955, 44960, 44970, 45000, 45020, 45100, 45108, 45110, 45111, 45112, 45113, 45114, 45116, 45119, 45120, 45121, 45123, 45126, 45130, 45135, 45136, 45150, 45160, 45171, 45172, 45190, 45395, 45397, 45400, 45402, 45500, 45505, 45540, 45541, 45550, 45560, 45562, 45563, 45800, 45805, 45820, 45825, 46715, 46716, 46730, 46735, 46740, 46742, 46744, 46746, 46748, 46750, 46751, 46753, 46754, 46760, 46761, 46762, 47010, 47015, 47100, 47120, 47122, 47125, 47130, 47135, 47136, 47140, 47141, 47142, 47300, 47350, 47360, 47361, 47362, 47370, 47371, 47380, 47381, 47382, 47400, 47420, 47425, 47460, 47480, 47500, 47505, 47560, 47561, 47562, 47563, 47564, 47570, 47600, 47605, 47610, 47612, 47620, 47630, 47700, 47701, 47711, 47712, 47715, 47720, 47721, 47740, 47741, 47760, 47765, 47780, 47785, 47800, 47801, 47802, 47900, 48000, 48001, 48020, 48100, 48102, 48105, 48120, 48140, 48145, 48146, 48148, 48150, 48152, 48153, 48154, 48155, 48160, 48500, 48510, 48511, 48520, 48540, 48545, 48547, 48548, 48554, 48556, 49000, 49002, 49010, 49020, 49021, 49040, 49041, 49060, 49203, 49204, 49205, 49215, 49220, 49250, 49255, 49320, 49321, 49322, 49323, 49505, 49507, 49560, 49561, 49565, 49566, 49570, 50320, 50340, 50360, 50365, 50370, 50380, 60200, 60210, 60212, 60220, 60225, 60240, 60252, 60254, 60260, 60270, 60271, 60280, 60281, 60500, 60502, 60505, 60520, 60521, 60522, 60540, 60545, 60600, 60605, 60650

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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 Otherwise 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

RATIONALE:
This measure addresses VTE risk based on surgical procedure. VTE prophylaxis is appropriate for all patients undergoing these procedures regardless of individual patient thromboembolic risk factors.

Additional work is needed to determine if a physician-level measure for VTE prophylaxis can be developed to address individual patient thromboembolic risk factors, in addition to procedural risk, without creating data collection burden. Duration of VTE prophylaxis is not specified in the measure due to varying guideline recommendations for different patient populations.

CLINICAL RECOMMENDATION STATEMENTS:
Recommend that mechanical methods of prophylaxis be used primarily in patients who are at high risk of bleeding (Grade 1C+) or as an adjunct to anticoagulant-based prophylaxis (Grade 2A).

Recommend against the use of aspirin alone as prophylaxis against VTE for any patient group (Grade 1A).

Recommend consideration of renal impairment when deciding on doses of LMWH, fondaparinux, the direct thrombin inhibitors, and other antithrombotic drugs that are cleared by the kidneys, particularly in elderly patients and those who are at high risk for bleeding (Grade 1C+).

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Moderate-risk general surgery patients are those patients undergoing a non-major procedure and are between the ages of 40 and 60 years or have additional risk factors, or those patients who are undergoing major operations and are < 40 years of age with no additional risk factors. Recommend prophylaxis with LDUH, 5,000 U bid or LMWH ≤ 3,400 U once daily (both Grade 1A).

Higher-risk general surgery patients are those undergoing non-major surgery and are > 60 years of age or have additional risk factors, or patients undergoing major surgery who are > 40 years of age or have additional risk factors. Recommend thromboprophylaxis with LDUH, 5,000 U tid or LMWH, > 3,400 U daily (both Grade 1A).

Recommend that thromboprophylaxis be used in all major gynecologic surgery patients (Grade 1A).

For patients undergoing major, open urologic procedures, recommend routine prophylaxis with LDUH twice daily or three times daily (Grade 1A).

Patients undergoing major orthopedic surgery, which includes hip and knee arthroplasty and hip fracture repair, represent a group that is at particularly high risk for VTE, and routine thromboprophylaxis has been the standard of care for > 15 years. Elective total hip replacement: routine use of LMWH, fondaparinux, or adjusted-dose VKA (all Grade 1A). Elective total knee arthroplasty: routine thromboprophylaxis using LMWH, fondaparinux, or adjusted-dose VKA (all Grade 1A). Hip fracture surgery: routine use of fondaparinux (Grade 1A), LMWH (Grade 1C+), adjusted-dose VKA (Grade 2B), or LDUH (Grade 1B).

For major orthopedic surgical procedures, recommend that a decision about the timing of the initiation of pharmacologic prophylaxis be based on the efficacy-to-bleeding tradeoffs for that particular agent (Grade 1A). For LMWH, there are only small differences between starting preoperatively or postoperatively, both options acceptable (Grade 1A).

Recommend that thromboprophylaxis be routinely used in patients undergoing major neurosurgery (Grade 1A). (ACCP)

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*Measure #24 (NQF 0045): Osteoporosis: Communication with the Physician Managing On-going Care Post-Fracture of Hip, Spine or Distal Radius for Men and Women Aged 50 Years and Older

2013 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of patients aged 50 years and older treated for a hip, spine or distal radial fracture with documentation of communication with the physician managing the patient's on-going care that a fracture occurred and that the patient was or should be tested or treated for osteoporosis

INSTRUCTIONS:
This measure is to be reported after each occurrence of a fracture during the reporting period. It is anticipated that clinicians who treat the hip, spine, or distal radial fracture will submit this measure. Each occurrence of a fracture is identified by either an ICD-9-CM diagnosis code for fracture or osteoporosis and a CPT service code OR an ICD-9-CM diagnosis code for fracture or osteoporosis and a CPT procedure code for surgical treatment of a fracture.

Patients with a fracture of the hip, spine, or distal radius should have documentation in the medical record of communication from the clinician treating the fracture to the clinician managing the patient's on-going care that the fracture occurred and that the patient was or should be tested or treated for osteoporosis. If multiple fractures occurring on the same date of service are submitted on the same claim form, only one instance of reporting will be counted. Claims data will be analyzed to determine unique occurrences. Documentation must indicate that communication to the clinician managing the on-going care of the patient occurred within three months of treatment for the fracture. The CPT Category II code should be reported during the episode of care (e.g., treatment of the fracture). The reporting of the code and documentation of communication do not need to occur simultaneously.

Measure Reporting via Claims:
ICD-9-CM diagnosis codes, CPT or HCPCS codes, and patient demographics are used to identify patients who are included in the measure's denominator. CPT Category II codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed ICD-9-CM diagnosis codes, CPT or HCPCS codes, and the appropriate CPT Category II code OR the CPT Category II code with the modifier. The modifiers allowed for this measure are: 1P- medical reasons, 2P- patient reasons, 8P- reason not otherwise specified. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT or HCPCS codes, and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All patients aged 50 years and older treated for hip, spine, or distal radial fracture

Eligible cases are determined, and must be reported, if either of the following conditions are met:
Option 1 - Denominator Criteria (Eligible Cases):

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Patients aged ≥ 50 years on date of encounter
AND
Diagnosis for hip, spine or distal radial fracture (ICD-9-CM): 805.00, 805.01, 805.02, 805.03, 805.04, 805.05, 805.06, 805.07, 805.08, 805.2, 805.4, 805.6, 805.8, 813.40, 813.41, 813.42, 813.44, 813.45, 813.47, 813.50, 813.51, 813.52, 813.54, 820.00, 820.01, 820.02, 820.03, 820.09, 820.10, 820.11, 820.12, 820.13, 820.19, 820.20, 820.21, 820.22, 820.30, 820.31, 820.32, 820.8, 820.9
Diagnosis for hip, spine or distal radial fracture (ICD-10-CM) [REFERENCE ONLY/Not Reportable]: M81.0, M81.6, M81.8, S12.000A, S12.000B, S12.000D, S12.000G, S12.000K, S12.000S, S12.001A, S12.001B, S12.001D, S12.001G, S12.001K, S12.001S, S12.01XA, S12.01XB, S12.01XD, S12.01XG, S12.01XK, S12.01XS, S12.02XA, S12.02XB, S12.02XD, S12.02XG, S12.02XK, S12.02XS, S12.030A, S12.030B, S12.030D, S12.030G, S12.030K, S12.030S, S12.031A, S12.031B, S12.031D, S12.031G, S12.031K, S12.031S, S12.040A, S12.040B, S12.040D, S12.040G, S12.040K, S12.040S, S12.041A, S12.041B, S12.041D, S12.041G, S12.041K, S12.041S, S12.090A, S12.090B, S12.090D, S12.090G, S12.090K, S12.090S, S12.091A, S12.091B, S12.091D, S12.091G, S12.091K, S12.091S, S12.100A, S12.100B, S12.100D, S12.100G, S12.100K, S12.100S, S12.101A, S12.101B, S12.101D, S12.101G, S12.101K, S12.101S, S12.110A, S12.110B, S12.110D, S12.110G, S12.110K, S12.110S, S12.111A, S12.111B, S12.111D, S12.111G, S12.111K, S12.111S, S12.112A, S12.112B, S12.112D, S12.112G, S12.112K, S12.112S, S12.120A, S12.120B, S12.120D, S12.120G, S12.120K, S12.120S, S12.121A, S12.121B, S12.121D, S12.121G, S12.121K, S12.121S, S12.130A, S12.130B, S12.130D, S12.130G, S12.130K, S12.130S, S12.131A, S12.131B, S12.131D, S12.131G, S12.131K, S12.131S, S12.14XA, S12.14XB, S12.14XD, S12.14XG, S12.14XK, S12.14XS, S12.150A, S12.150B, S12.150D, S12.150G, S12.150K, S12.150S, S12.151A, S12.151B, S12.151D, S12.151G, S12.151K, S12.151S, S12.190A, S12.190B, S12.190D, S12.190G, S12.190K, S12.190S, S12.191A, S12.191B, S12.191D, S12.191G, S12.191K, S12.191S, S12.200A, S12.200B, S12.200D, S12.200G, S12.200K, S12.200S, S12.201A, S12.201B, S12.201D, S12.201G, S12.201K, S12.201S, S12.230A, S12.230B, S12.230D, S12.230G, S12.230K, S12.230S, S12.231A, S12.231B, S12.231D, S12.231G, S12.231K, S12.231S, S12.24XA, S12.24XB, S12.24XD, S12.24XG, S12.24XK, S12.24XS, S12.250A, S12.250B, S12.250D, S12.250G, S12.250K, S12.250S, S12.251A, S12.251B, S12.251D, S12.251G, S12.251K, S12.251S, S12.290A, S12.290B, S12.290D, S12.290G, S12.290K, S12.290S, S12.291A, S12.291B, S12.291D, S12.291G, S12.291K, S12.291S, S12.300A, S12.300B, S12.300D, S12.300G, S12.300K, S12.300S, S12.301A, S12.301B, S12.301D, S12.301G, S12.301K, S12.301S, S12.330A, S12.330B, S12.330D, S12.330G, S12.330K, S12.330S, S12.331A, S12.331B, S12.331D, S12.331G, S12.331K, S12.331S, S12.34XA, S12.34XB, S12.34XD, S12.34XG, S12.34XK, S12.34XS, S12.350A, S12.350B, S12.350D, S12.350G, S12.350K, S12.350S, S12.351A, S12.351B, S12.351D, S12.351G, S12.351K, S12.351S, S12.390A, S12.390B, S12.390D, S12.390G, S12.390K, S12.390S, S12.391A, S12.391B, S12.391D, S12.391G, S12.391K, S12.391S, S12.400A, S12.400B, S12.400D, S12.400G, S12.400K, S12.400S, S12.401A, S12.401B, S12.401D, S12.401G, S12.401K, S12.401S, S12.430A, S12.430B, S12.430D, S12.430G, S12.430K, S12.430S, S12.431A, S12.431B, S12.431D, S12.431G, S12.431K, S12.431S, S12.44XA, S12.44XB, S12.44XD, S12.44XG, S12.44XK, S12.44XS, S12.450A, S12.450B, S12.450D, S12.450G, S12.450K, S12.450S, S12.451A, S12.451B, S12.451D, S12.451G, S12.451K, S12.451S, S12.490A, S12.490B, S12.490D, S12.490G, S12.490K, S12.490S, S12.491A, S12.491B, S12.491D, S12.491G, S12.491K, S12.491S, S12.500A, S12.500B, S12.500D, S12.500G, S12.500K, S12.500S, S12.501A, S12.501B, S12.501D, S12.501G, S12.501K, S12.501S, S12.530A, S12.530B, S12.530D, S12.530G, S12.530K, S12.530S, S12.531A, S12.531B, S12.531D, S12.531G, S12.531K, S12.531S, S12.54XA, S12.54XB, S12.54XD, S12.54XG, S12.54XK, S12.54XS, S12.550A, S12.550B, S12.550D, S12.550G, S12.550K, S12.550S, S12.551A, S12.551B, S12.551D, S12.551G, S12.551K, S12.551S, S12.590A, S12.590B, S12.590D, S12.590G, S12.590K, S12.590S, S12.591A, S12.591B, S12.591D, S12.591G, S12.591K, S12.591S, S12.600A, S12.600B, S12.600D, S12.600G, S12.600K, S12.600S, S12.601A, S12.601B, S12.601D, S12.601G, S12.601K, S12.601S, S12.630A, S12.630B, S12.630D, S12.630G, S12.630K, S12.630S, S12.631A, S12.631B, S12.631D, S12.631G, S12.631K, S12.631S, S12.64XA, S12.64XB, S12.64XD, S12.64XG, S12.64XK, S12.64XS, S12.650A, S12.650B, S12.650D, S12.650G,

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S12.650K, S12.650S, S12.651A, S12.651B, S12.651D, S12.651G, S12.651K, S12.651S, S12.690A, S12.690B, S12.690D, S12.690G, S12.690K, S12.690S, S12.691A, S12.691B, S12.691D, S12.691G, S12.691K, S12.691S, S12.8XXA, S12.8XXD, S12.8XXS, S12.9XXA, S12.9XXD, S12.9XXS, S22.000A, S22.000B, S22.000D, S22.000G, S22.000K, S22.000S, S22.001B, S22.001D, S22.001G, S22.001K, S22.001S, S22.002A, S22.002B, S22.002D, S22.002G, S22.002K, S22.002S, S22.008A, S22.008B, S22.008D, S22.008G, S22.008K, S22.008S, S22.009A, S22.009B, S22.009D, S22.009G, S22.009K, S22.009S, S22.010A, S22.010B, S22.010D, S22.010G, S22.010K, S22.010S, S22.011A, S22.011B, S22.011D, S22.011G, S22.011K, S22.011S, S22.012A, S22.012B, S22.012D, S22.012G, S22.012K, S22.012S, S22.018A, S22.018B, S22.018D, S22.018G, S22.018K, S22.018S, S22.019A, S22.019B, S22.019D, S22.019G, S22.019K, S22.019S, S22.020A, S22.020B, S22.020D, S22.020G, S22.020K, S22.020S, S22.021A, S22.021B, S22.021D, S22.021G, S22.021K, S22.021S, S22.022A, S22.022B, S22.022D, S22.022G, S22.022K, S22.022S, S22.028A, S22.028B, S22.028D, S22.028G, S22.028K, S22.028S, S22.029A, S22.029B, S22.029D, S22.029G, S22.029K, S22.029S, S22.030A, S22.030B, S22.030D, S22.030G, S22.030K, S22.030S, S22.031A, S22.031B, S22.031D, S22.031G, S22.031K, S22.031S, S22.032A, S22.032B, S22.032D, S22.032G, S22.032K, S22.032S, S22.038A, S22.038B, S22.038D, S22.038G, S22.038K, S22.038S, S22.039A, S22.039B, S22.039D, S22.039G, S22.039K, S22.039S, S22.040A, S22.040B, S22.040D, S22.040G, S22.040K, S22.040S, S22.041A, S22.041B, S22.041D, S22.041G, S22.041K, S22.041S, S22.042A, S22.042B, S22.042D, S22.042G, S22.042K, S22.042S, S22.048A, S22.048B, S22.048D, S22.048G, S22.048K, S22.048S, S22.049A, S22.049B, S22.049D, S22.049G, S22.049K, S22.049S, S22.050A, S22.050B, S22.050D, S22.050G, S22.050K, S22.050S, S22.051A, S22.051B, S22.051D, S22.051G, S22.051K, S22.051S, S22.052A, S22.052B, S22.052D, S22.052G, S22.052K, S22.052S, S22.058A, S22.058B, S22.058D, S22.058G, S22.058K, S22.058S, S22.059A, S22.059B, S22.059D, S22.059G, S22.059K, S22.059S, S22.060A, S22.060B, S22.060D, S22.060G, S22.060K, S22.060S, S22.061A, S22.061B, S22.061D, S22.061G, S22.061K, S22.061S, S22.062A, S22.062B, S22.062D, S22.062G, S22.062K, S22.062S, S22.068A, S22.068B, S22.068D, S22.068G, S22.068K, S22.068S, S22.069A, S22.069B, S22.069D, S22.069G, S22.069K, S22.069S, S22.070A, S22.070B, S22.070D, S22.070G, S22.070K, S22.070S, S22.071A, S22.071B, S22.071D, S22.071G, S22.071K, S22.071S, S22.072A, S22.072B, S22.072D, S22.072G, S22.072K, S22.072S, S22.078A, S22.078B, S22.078D, S22.078G, S22.078K, S22.078S, S22.079A, S22.079B, S22.079D, S22.079G, S22.079K, S22.079S, S22.080A, S22.080B, S22.080D, S22.080G, S22.080K, S22.080S, S22.081A, S22.081B, S22.081D, S22.081G, S22.081K, S22.081S, S22.082A, S22.082B, S22.082D, S22.082G, S22.082K, S22.082S, S22.088A, S22.088B, S22.088D, S22.088G, S22.088K, S22.088S, S22.089A, S22.089B, S22.089D, S22.089G, S22.089K, S22.089S, S32.000A, S32.000B, S32.000D, S32.000G, S32.000K, S32.000S, S32.001A, S32.001B, S32.001D, S32.001G, S32.001K, S32.001S, S32.002A, S32.002B, S32.002D, S32.002G, S32.002K, S32.002S, S32.008A, S32.008B, S32.008D, S32.008G, S32.008K, S32.008S, S32.009A, S32.009B, S32.009D, S32.009G, S32.009K, S32.009S, S32.010A, S32.010B, S32.010D, S32.010G, S32.010K, S32.010S, S32.011A, S32.011B, S32.011D, S32.011G, S32.011K, S32.011S, S32.012A, S32.012B, S32.012D, S32.012G, S32.012K, S32.012S, S32.018A, S32.018B, S32.018D, S32.018G, S32.018K, S32.018S, S32.019A, S32.019B, S32.019D, S32.019G, S32.019K, S32.019S, S32.020A, S32.020B, S32.020D, S32.020G, S32.020K, S32.020S, S32.021A, S32.021B, S32.021D, S32.021G, S32.021K, S32.021S, S32.022A, S32.022B, S32.022D, S32.022G, S32.022K, S32.022S, S32.028A, S32.028B, S32.028D, S32.028G, S32.028K, S32.028S, S32.029A, S32.029B, S32.029D, S32.029G, S32.029K, S32.029S, S32.030A, S32.030B, S32.030D, S32.030G, S32.030K, S32.030S, S32.031A, S32.031B, S32.031D, S32.031G, S32.031K, S32.031S, S32.032A, S32.032B, S32.032D, S32.032G, S32.032K, S32.032S, S32.038A, S32.038B, S32.038D, S32.038G, S32.038K, S32.038S, S32.039A, S32.039B, S32.039D, S32.039G, S32.039K, S32.039S, S32.040A, S32.040B, S32.040D, S32.040G, S32.040K, S32.040S, S32.041A, S32.041B, S32.041D, S32.041G, S32.041K, S32.041S, S32.042A, S32.042B, S32.042D, S32.042G, S32.042K, S32.042S, S32.048A, S32.048B, S32.048D, S32.048G, S32.048K, S32.048S, S32.049A, S32.049B, S32.049D, S32.049G, S32.049K, S32.049S, S32.050A, S32.050B, S32.050D, S32.050G, S32.050K, S32.050S, S32.051A, S32.051B, S32.051D, S32.051G, S32.051K, S32.051S, S32.052A, S32.052B,

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AND

Patient encounter during the reporting period (CPT or HCPCS) – Service codes: 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, G0402

OR

Option 2 - Denominator Criteria (Eligible Cases):

Patients aged ≥ 50 years on the date of encounter

AND

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Diagnosis for hip, spine or distal radial fracture (ICD-9-CM): 805.00, 805.01, 805.02, 805.03, 805.04, 805.05, 805.06, 805.07, 805.08, 805.2, 805.4, 805.6, 805.8, 813.40, 813.41, 813.42, 813.44, 813.45, 813.47, 813.50, 813.51, 813.52, 813.54, 820.00, 820.01, 820.02, 820.03, 820.09, 820.10, 820.11, 820.12, 820.13, 820.19, 820.20, 820.21, 820.22, 820.30, 820.31, 820.32, 820.8, 820.9
Diagnosis for hip, spine or distal radial fracture (ICD-10-CM) [REFERENCE ONLY/Not Reportable]: M81.0, M81.6, M81.8, S12.000A, S12.000B, S12.000D, S12.000G, S12.000K, S12.000S, S12.001A, S12.001B, S12.001D, S12.001G, S12.001K, S12.001S, S12.01XA, S12.01XB, S12.01XD, S12.01XG, S12.01XK, S12.01XS, S12.02XA, S12.02XB, S12.02XD, S12.02XG, S12.02XK, S12.02XS, S12.030A, S12.030B, S12.030D, S12.030G, S12.030K, S12.030S, S12.031A, S12.031B, S12.031D, S12.031G, S12.031K, S12.031S, S12.040A, S12.040B, S12.040D, S12.040G, S12.040K, S12.040S, S12.041A, S12.041B, S12.041D, S12.041G, S12.041K, S12.041S, S12.090A, S12.090B, S12.090D, S12.090G, S12.090K, S12.090S, S12.091A, S12.091B, S12.091D, S12.091G, S12.091K, S12.091S, S12.100A, S12.100B, S12.100D, S12.100G, S12.100K, S12.100S, S12.101A, S12.101B, S12.101D, S12.101G, S12.101K, S12.101S, S12.110A, S12.110B, S12.110D, S12.110G, S12.110K, S12.110S, S12.111A, S12.111B, S12.111D, S12.111G, S12.111K, S12.111S, S12.112A, S12.112B, S12.112D, S12.112G, S12.112K, S12.112S, S12.120A, S12.120B, S12.120D, S12.120G, S12.120K, S12.120S, S12.121A, S12.121B, S12.121D, S12.121G, S12.121K, S12.121S, S12.130A, S12.130B, S12.130D, S12.130G, S12.130K, S12.130S, S12.131A, S12.131B, S12.131D, S12.131G, S12.131K, S12.131S, S12.14XA, S12.14XB, S12.14XD, S12.14XG, S12.14XK, S12.14XS, S12.150A, S12.150B, S12.150D, S12.150G, S12.150K, S12.150S, S12.151A, S12.151B, S12.151D, S12.151G, S12.151K, S12.151S, S12.190A, S12.190B, S12.190D, S12.190G, S12.190K, S12.190S, S12.191A, S12.191B, S12.191D, S12.191G, S12.191K, S12.191S, S12.200A, S12.200B, S12.200D, S12.200G, S12.200K, S12.200S, S12.201A, S12.201B, S12.201D, S12.201G, S12.201K, S12.201S, S12.230A, S12.230B, S12.230D, S12.230G, S12.230K, S12.230S, S12.231A, S12.231B, S12.231D, S12.231G, S12.231K, S12.231S, S12.24XA, S12.24XB, S12.24XD, S12.24XG, S12.24XK, S12.24XS, S12.250A, S12.250B, S12.250D, S12.250G, S12.250K, S12.250S, S12.251A, S12.251B, S12.251D, S12.251G, S12.251K, S12.251S, S12.290A, S12.290B, S12.290D, S12.290G, S12.290K, S12.290S, S12.291A, S12.291B, S12.291D, S12.291G, S12.291K, S12.291S, S12.300A, S12.300B, S12.300D, S12.300G, S12.300K, S12.300S, S12.301A, S12.301B, S12.301D, S12.301G, S12.301K, S12.301S, S12.330A, S12.330B, S12.330D, S12.330G, S12.330K, S12.330S, S12.331A, S12.331B, S12.331D, S12.331G, S12.331K, S12.331S, S12.34XA, S12.34XB, S12.34XD, S12.34XG, S12.34XK, S12.34XS, S12.350A, S12.350B, S12.350D, S12.350G, S12.350K, S12.350S, S12.351A, S12.351B, S12.351D, S12.351G, S12.351K, S12.351S, S12.390A, S12.390B, S12.390D, S12.390G, S12.390K, S12.390S, S12.391A, S12.391B, S12.391D, S12.391G, S12.391K, S12.391S, S12.400A, S12.400B, S12.400D, S12.400G, S12.400K, S12.400S, S12.401A, S12.401B, S12.401D, S12.401G, S12.401K, S12.401S, S12.430A, S12.430B, S12.430D, S12.430G, S12.430K, S12.430S, S12.431A, S12.431B, S12.431D, S12.431G, S12.431K, S12.431S, S12.44XA, S12.44XB, S12.44XD, S12.44XG, S12.44XK, S12.44XS, S12.450A, S12.450B, S12.450D, S12.450G, S12.450K, S12.450S, S12.451A, S12.451B, S12.451D, S12.451G, S12.451K, S12.451S, S12.490A, S12.490B, S12.490D, S12.490G, S12.490K, S12.490S, S12.491A, S12.491B, S12.491D, S12.491G, S12.491K, S12.491S, S12.500A, S12.500B, S12.500D, S12.500G, S12.500K, S12.500S, S12.501A, S12.501B, S12.501D, S12.501G, S12.501K, S12.501S, S12.530A, S12.530B, S12.530D, S12.530G, S12.530K, S12.530S, S12.531A, S12.531B, S12.531D, S12.531G, S12.531K, S12.531S, S12.54XA, S12.54XB, S12.54XD, S12.54XG, S12.54XK, S12.54XS, S12.550A, S12.550B, S12.550D, S12.550G, S12.550K, S12.550S, S12.551A, S12.551B, S12.551D, S12.551G, S12.551K, S12.551S, S12.590A, S12.590B, S12.590D, S12.590G, S12.590K, S12.590S, S12.591A, S12.591B, S12.591D, S12.591G, S12.591K, S12.591S, S12.600A, S12.600B, S12.600D, S12.600G, S12.600K, S12.600S, S12.601A, S12.601B, S12.601D, S12.601G, S12.601K, S12.601S, S12.630A, S12.630B, S12.630D, S12.630G, S12.630K, S12.630S, S12.631A, S12.631B, S12.631D, S12.631G, S12.631K, S12.631S, S12.64XA, S12.64XB, S12.64XD, S12.64XG, S12.64XK, S12.64XS, S12.650A, S12.650B, S12.650D, S12.650G, S12.650K, S12.650S, S12.651A, S12.651B, S12.651D, S12.651G, S12.651K, S12.651S, S12.690A, S12.690B, S12.690D, S12.690G, S12.690K, S12.690S, S12.691A, S12.691B, S12.691D, S12.691G,

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S12.691K, S12.691S, S12.8XXA, S12.8XXD, S12.8XXS, S12.9XXA, S12.9XXD, S12.9XXS, S22.000A, S22.000B, S22.000D, S22.000G, S22.000K, S22.000S, S22.001B, S22.001D, S22.001G, S22.001K, S22.001S, S22.002A, S22.002B, S22.002D, S22.002G, S22.002K, S22.002S, S22.008A, S22.008B, S22.008D, S22.008G, S22.008K, S22.008S, S22.009A, S22.009B, S22.009D, S22.009G, S22.009K, S22.009S, S22.010A, S22.010B, S22.010D, S22.010G, S22.010K, S22.010S, S22.011A, S22.011B, S22.011D, S22.011G, S22.011K, S22.011S, S22.012A, S22.012B, S22.012D, S22.012G, S22.012K, S22.012S, S22.018A, S22.018B, S22.018D, S22.018G, S22.018K, S22.018S, S22.019A, S22.019B, S22.019D, S22.019G, S22.019K, S22.019S, S22.020A, S22.020B, S22.020D, S22.020G, S22.020K, S22.020S, S22.021A, S22.021B, S22.021D, S22.021G, S22.021K, S22.021S, S22.022A, S22.022B, S22.022D, S22.022G, S22.022K, S22.022S, S22.028A, S22.028B, S22.028D, S22.028G, S22.028K, S22.028S, S22.029A, S22.029B, S22.029D, S22.029G, S22.029K, S22.029S, S22.030A, S22.030B, S22.030D, S22.030G, S22.030K, S22.030S, S22.031A, S22.031B, S22.031D, S22.031G, S22.031K, S22.031S, S22.032A, S22.032B, S22.032D, S22.032G, S22.032K, S22.032S, S22.038A, S22.038B, S22.038D, S22.038G, S22.038K, S22.038S, S22.039A, S22.039B, S22.039D, S22.039G, S22.039K, S22.039S, S22.040A, S22.040B, S22.040D, S22.040G, S22.040K, S22.040S, S22.041A, S22.041B, S22.041D, S22.041G, S22.041K, S22.041S, S22.042A, S22.042B, S22.042D, S22.042G, S22.042K, S22.042S, S22.048A, S22.048B, S22.048D, S22.048G, S22.048K, S22.048S, S22.049A, S22.049B, S22.049D, S22.049G, S22.049K, S22.049S, S22.050A, S22.050B, S22.050D, S22.050G, S22.050K, S22.050S, S22.051A, S22.051B, S22.051D, S22.051G, S22.051K, S22.051S, S22.052A, S22.052B, S22.052D, S22.052G, S22.052K, S22.052S, S22.058A, S22.058B, S22.058D, S22.058G, S22.058K, S22.058S, S22.059A, S22.059B, S22.059D, S22.059G, S22.059K, S22.059S, S22.060A, S22.060B, S22.060D, S22.060G, S22.060K, S22.060S, S22.061A, S22.061B, S22.061D, S22.061G, S22.061K, S22.061S, S22.062A, S22.062B, S22.062D, S22.062G, S22.062K, S22.062S, S22.068A, S22.068B, S22.068D, S22.068G, S22.068K, S22.068S, S22.069A, S22.069B, S22.069D, S22.069G, S22.069K, S22.069S, S22.070A, S22.070B, S22.070D, S22.070G, S22.070K, S22.070S, S22.071A, S22.071B, S22.071D, S22.071G, S22.071K, S22.071S, S22.072A, S22.072B, S22.072D, S22.072G, S22.072K, S22.072S, S22.078A, S22.078B, S22.078D, S22.078G, S22.078K, S22.078S, S22.079A, S22.079B, S22.079D, S22.079G, S22.079K, S22.079S, S22.080A, S22.080B, S22.080D, S22.080G, S22.080K, S22.080S, S22.081A, S22.081B, S22.081D, S22.081G, S22.081K, S22.081S, S22.082A, S22.082B, S22.082D, S22.082G, S22.082K, S22.082S, S22.088A, S22.088B, S22.088D, S22.088G, S22.088K, S22.088S, S22.089A, S22.089B, S22.089D, S22.089G, S22.089K, S22.089S, S32.000A, S32.000B, S32.000D, S32.000G, S32.000K, S32.000S, S32.001A, S32.001B, S32.001D, S32.001G, S32.001K, S32.001S, S32.002A, S32.002B, S32.002D, S32.002G, S32.002K, S32.002S, S32.008A, S32.008B, S32.008D, S32.008G, S32.008K, S32.008S, S32.009A, S32.009B, S32.009D, S32.009G, S32.009K, S32.009S, S32.010A, S32.010B, S32.010D, S32.010G, S32.010K, S32.010S, S32.011A, S32.011B, S32.011D, S32.011G, S32.011K, S32.011S, S32.012A, S32.012B, S32.012D, S32.012G, S32.012K, S32.012S, S32.018A, S32.018B, S32.018D, S32.018G, S32.018K, S32.018S, S32.019A, S32.019B, S32.019D, S32.019G, S32.019K, S32.019S, S32.020A, S32.020B, S32.020D, S32.020G, S32.020K, S32.020S, S32.021A, S32.021B, S32.021D, S32.021G, S32.021K, S32.021S, S32.022A, S32.022B, S32.022D, S32.022G, S32.022K, S32.022S, S32.028A, S32.028B, S32.028D, S32.028G, S32.028K, S32.028S, S32.029A, S32.029B, S32.029D, S32.029G, S32.029K, S32.029S, S32.030A, S32.030B, S32.030D, S32.030G, S32.030K, S32.030S, S32.031A, S32.031B, S32.031D, S32.031G, S32.031K, S32.031S, S32.032A, S32.032B, S32.032D, S32.032G, S32.032K, S32.032S, S32.038A, S32.038B, S32.038D, S32.038G, S32.038K, S32.038S, S32.039A, S32.039B, S32.039D, S32.039G, S32.039K, S32.039S, S32.040A, S32.040B, S32.040D, S32.040G, S32.040K, S32.040S, S32.041A, S32.041B, S32.041D, S32.041G, S32.041K, S32.041S, S32.042A, S32.042B, S32.042D, S32.042G, S32.042K, S32.042S, S32.048A, S32.048B, S32.048D, S32.048G, S32.048K, S32.048S, S32.049A, S32.049B, S32.049D, S32.049G, S32.049K, S32.049S, S32.050A, S32.050B, S32.050D, S32.050G, S32.050K, S32.050S, S32.051A, S32.051B, S32.051D, S32.051G, S32.051K, S32.051S, S32.052A, S32.052B, S32.052D, S32.052G, S32.052K, S32.052S, S32.058A, S32.058B, S32.058D, S32.058G, S32.058K, S32.058S, S32.059A, S32.059B, S32.059D, S32.059G, S32.059K, S32.059S, S32.10XA, S32.10XB,

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S72.114M, S72.114N, S72.114P, S72.114Q, S72.114R, S72.114S, S72.115A, S72.115B, S72.115C, S72.115D, S72.115E, S72.115F, S72.115G, S72.115H, S72.115J, S72.115K, S72.115M, S72.115N, S72.115P, S72.115Q, S72.115R, S72.115S, S72.116A, S72.116B, S72.116C, S72.116D, S72.116E, S72.116F, S72.116G, S72.116H, S72.116J, S72.116K, S72.116M, S72.116N, S72.116P, S72.116Q, S72.116R, S72.116S, S72.121A, S72.121B, S72.121C, S72.121D, S72.121E, S72.121F, S72.121G, S72.121H, S72.121J, S72.121K, S72.121M, S72.121N, S72.121P, S72.121Q, S72.121R, S72.121S, S72.122A, S72.122A, S72.122B, S72.122C, S72.122D, S72.122E, S72.122F, S72.122G, S72.122H, S72.122J, S72.122K, S72.122M, S72.122N, S72.122P, S72.122Q, S72.122R, S72.122S, S72.123A, S72.123B, S72.123C, S72.123D, S72.123E, S72.123F, S72.123G, S72.123H, S72.123J, S72.123K, S72.123M, S72.123N, S72.123P, S72.123Q, S72.123R, S72.123S, S72.124A, S72.124B, S72.124C, S72.124D, S72.124E, S72.124F, S72.124G, S72.124H, S72.124J, S72.124K, S72.124M, S72.124N, S72.124P, S72.124Q, S72.124R, S72.124S, S72.125A, S72.125B, S72.125C, S72.125D, S72.125E, S72.125F, S72.125G, S72.125H, S72.125J, S72.125K, S72.125M, S72.125N, S72.125P, S72.125Q, S72.125R, S72.125S, S72.126A, S72.126B, S72.126C, S72.126D, S72.126E, S72.126F, S72.126G, S72.126H, S72.126J, S72.126K, S72.126M, S72.126N, S72.126P, S72.126Q, S72.126R, S72.126S, S72.131A, S72.131B, S72.131C, S72.131D, S72.131E, S72.131F, S72.131G, S72.131H, S72.131J, S72.131K, S72.131M, S72.131N, S72.131P, S72.131Q, S72.131R, S72.131S, S72.132A, S72.132B, S72.132C, S72.132D, S72.132E, S72.132F, S72.132G, S72.132H, S72.132J, S72.132K, S72.132M, S72.132N, S72.132P, S72.132Q, S72.132R, S72.132S, S72.133A, S72.133B, S72.133C, S72.133D, S72.133E, S72.133F, S72.133G, S72.133H, S72.133J, S72.133K, S72.133M, S72.133N, S72.133P, S72.133Q, S72.133R, S72.133S, S72.134A, S72.134B, S72.134C, S72.134D, S72.134E, S72.134F, S72.134G, S72.134H, S72.134J, S72.134K, S72.134M, S72.134N, S72.134P, S72.134Q, S72.134R, S72.134S, S72.135A, S72.135B, S72.135C, S72.135D, S72.135E, S72.135F, S72.135G, S72.135H, S72.135J, S72.135K, S72.135M, S72.135N, S72.135P, S72.135Q, S72.135R, S72.135S, S72.136A, S72.136B, S72.136C, S72.136D, S72.136E, S72.136F, S72.136G, S72.136H, S72.136J, S72.136K, S72.136M, S72.136N, S72.136P, S72.136Q, S72.136R, S72.136S, S72.141A, S72.141B, S72.141C, S72.141D, S72.141E, S72.141F, S72.141G, S72.141H, S72.141J, S72.141K, S72.141M, S72.141N, S72.141P, S72.141Q, S72.141R, S72.141S, S72.142A, S72.142B, S72.142C, S72.142D, S72.142E, S72.142F, S72.142G, S72.142H, S72.142J, S72.142K, S72.142M, S72.142N, S72.142P, S72.142Q, S72.142R, S72.142S, S72.143A, S72.143B, S72.143C, S72.143D, S72.143E, S72.143F, S72.143G, S72.143H, S72.143J, S72.143K, S72.143M, S72.143N, S72.143P, S72.143Q, S72.143R, S72.143S, S72.144A, S72.144B, S72.144C, S72.144D, S72.144E, S72.144F, S72.144G, S72.144H, S72.144J, S72.144K, S72.144M, S72.144N, S72.144P, S72.144Q, S72.144R, S72.144S, S72.145A, S72.145B, S72.145C, S72.145D, S72.145E, S72.145F, S72.145G, S72.145H, S72.145J, S72.145K, S72.145M, S72.145N, S72.145P, S72.145Q, S72.145R, S72.145S, S72.146A, S72.146B, S72.146C, S72.146D, S72.146E, S72.146F, S72.146G, S72.146H, S72.146J, S72.146K, S72.146M, S72.146N, S72.146P, S72.146Q, S72.146R, S72.146S, S72.21XA, S72.21XB, S72.21XC, S72.21XD, S72.21XE, S72.21XF, S72.21XG, S72.21XH, S72.21XJ, S72.21XK, S72.21XM, S72.21XN, S72.21XP, S72.21XQ, S72.21XR, S72.21XS, S72.22XA, S72.22XB, S72.22XC, S72.22XD, S72.22XE, S72.22XF, S72.22XG, S72.22XH, S72.22XJ, S72.22XK, S72.22XM, S72.22XN, S72.22XP, S72.22XQ, S72.22XR, S72.22XS, S72.23XA, S72.23XB, S72.23XC, S72.23XD, S72.23XE, S72.23XF, S72.23XG, S72.23XH, S72.23XJ, S72.23XK, S72.23XM, S72.23XN, S72.23XP, S72.23XQ, S72.23XR, S72.23XS, S72.24XA, S72.24XB, S72.24XC, S72.24XD, S72.24XE, S72.24XF, S72.24XG, S72.24XH, S72.24XJ, S72.24XK, S72.24XM, S72.24XN, S72.24XP, S72.24XQ, S72.24XR, S72.24XS, S72.25XA, S72.25XB, S72.25XC, S72.25XD, S72.25XE, S72.25XF, S72.25XG, S72.25XH, S72.25XJ, S72.25XK, S72.25XM, S72.25XN, S72.25XP, S72.25XQ, S72.25XR, S72.25XS, S72.26XA, S72.26XB, S72.26XC, S72.26XD, S72.26XE, S72.26XF, S72.26XG, S72.26XH, S72.26XJ, S72.26XK, S72.26XM, S72.26XN, S72.26XP, S72.26XQ, S72.26XR, S72.26XS, S72.336J, S72.336K, S72.336M, S72.336N, S72.336P, S72.336Q, S72.336R, S72.336S, S52.549F, S52.549G, S52.549H, S52.549J, S52.549K, S52.549M, S52.549N, S52.549P, S52.549Q, S52.549R, S52.549S, S52.551B, S52.551C, S52.551D, S52.551E, S52.551F, S52.551G, S52.551H, S52.551J, S52.551K, S52.551M, S52.551N, S52.551P, S52.551Q, S52.551R, S52.551S, S52.552B, S52.552C,

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S52.552D, S52.552E, S52.552F, S52.552G, S52.552H, S52.552J, S52.552K, S52.552M, S52.552N, S52.552P, S52.552Q, S52.552R, S52.552S, S52.559B, S52.559C, S52.559D, S52.559E, S52.559F, S52.559G, S52.559H, S52.559J, S52.559K, S52.559M, S52.559N, S52.559P, S52.559Q, S52.559R, S52.559S, S52.561B, S52.561C, S52.561D, S52.561E, S52.561F, S52.561G, S52.561H, S52.561J, S52.561K, S52.561M, S52.561N, S52.561P, S52.561Q, S52.561R, S52.561S, S52.562B, S52.562C, S52.562D, S52.562E, S52.562F, S52.562G, S52.562H, S52.562J, S52.562K, S52.562M, S52.562N, S52.562P, S52.562Q, S52.562R, S52.562S, S52.569B, S52.569C, S52.569D, S52.569E, S52.569F, S52.569G, S52.569H, S52.569J, S52.569K, S52.569M, S52.569N, S52.569P, S52.569Q, S52.569R, S52.569S, S52.571B, S52.571C, S52.571D, S52.571E, S52.571F, S52.571G, S52.571H, S52.571J, S52.571K, S52.571M, S52.571N, S52.571P, S52.571Q, S52.571R, S52.571S, S52.572B, S52.572C, S52.572D, S52.572E, S52.572F, S52.572G, S52.572H, S52.572J, S52.572K, S52.572M, S52.572N, S52.572P, S52.572Q, S52.572R, S52.572S, S52.579B, S52.579C, S52.579D, S52.579E, S52.579F, S52.579G, S52.579H, S52.579J, S52.579K, S52.579M, S52.579N, S52.579P, S52.579Q, S52.579R, S52.579S, S52.591B, S52.591C, S52.591D, S52.591E, S52.591F, S52.591G, S52.591H, S52.591J, S52.591K, S52.591M, S52.591N, S52.591P, S52.591Q, S52.591R, S52.591S, S52.592B, S52.592C, S52.592D, S52.592E, S52.592F, S52.592G, S52.592H, S52.592J, S52.592K, S52.592M, S52.592N, S52.592P, S52.592Q, S52.592R, S52.592S, S52.599B, S52.599C, S52.599D, S52.599E, S52.599F, S52.599G, S52.599H, S52.599J, S52.599K, S52.599M, S52.599N, S52.599P, S52.599Q, S52.599R, S52.599S, S22.001A, S52.549F, S52.549G, S52.549H, S52.549J, S52.549K, S52.549M, S52.549N, S52.549P, S52.549Q, S52.549R, S52.549S, S52.551B, S52.551C, S52.551D, S52.551E, S52.551F, S52.551G, S52.551H, S52.551J, S52.551K, S52.551M, S52.551N, S52.551P, S52.551Q, S52.551R, S52.551S, S52.552B, S52.552C, S52.552D, S52.552E, S52.552F, S52.552G, S52.552H, S52.552J, S52.552K, S52.552M, S52.552N, S52.552P, S52.552Q, S52.552R, S52.552S, S52.559B, S52.559C, S52.559D, S52.559E, S52.559F, S52.559G, S52.559H, S52.559J, S52.559K, S52.559M, S52.559N, S52.559P, S52.559Q, S52.559R, S52.559S, S52.561B, S52.561C, S52.561D, S52.561E, S52.561F, S52.561G, S52.561H, S52.561J, S52.561K, S52.561M, S52.561N, S52.561P, S52.561Q, S52.561R, S52.561S, S52.562B, S52.562C, S52.562D, S52.562E, S52.562F, S52.562G, S52.562H, S52.562J, S52.562K, S52.562M, S52.562N, S52.562P, S52.562Q, S52.562R, S52.562S, S52.569B, S52.569C, S52.569D, S52.569E, S52.569F, S52.569G, S52.569H, S52.569J, S52.569K, S52.569M, S52.569N, S52.569P, S52.569Q, S52.569R, S52.569S, S52.571B, S52.571C, S52.571D, S52.571E, S52.571F, S52.571G, S52.571H, S52.571J, S52.571K, S52.571M, S52.571N, S52.571P, S52.571Q, S52.571R, S52.571S, S52.572B, S52.572C, S52.572D, S52.572E, S52.572F, S52.572G, S52.572H, S52.572J, S52.572K, S52.572M, S52.572N, S52.572P, S52.572Q, S52.572R, S52.572S, S52.579B, S52.579C, S52.579D, S52.579E, S52.579F, S52.579G, S52.579H, S52.579J, S52.579K, S52.579M, S52.579N, S52.579P, S52.579Q, S52.579R, S52.579S, S52.591B, S52.591C, S52.591D, S52.591E, S52.591F, S52.591G, S52.591H, S52.591J, S52.591K, S52.591M, S52.591N, S52.591P, S52.591Q, S52.591R, S52.591S, S52.592B, S52.592C, S52.592D, S52.592E, S52.592F, S52.592G, S52.592H, S52.592J, S52.592K, S52.592M, S52.592N, S52.592P, S52.592Q, S52.592R, S52.592S, S52.599B, S52.599C, S52.599D, S52.599E, S52.599F, S52.599G, S52.599H, S52.599J, S52.599K, S52.599M, S52.599N, S52.599P, S52.599Q, S52.599R, S52.599S, S22.001A

AND

Patient encounter during the reporting period (CPT) – Procedure codes: 22305, 22310, 22315, 22318, 22319, 22325, 22326, 22327, 22520, 22521, 22523, 22524, 25600, 25605, 25606, 25607, 25608, 25609, 27230, 27232, 27235, 27236, 27238, 27240, 27244, 27245, 27246, 27248

NUMERATOR:

Patients with documentation of communication with the physician managing the patient's on-going care that a fracture occurred and that the patient was or should be tested or treated for osteoporosis

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Definition:
Communication – May include documentation in the medical record indicating that the clinician treating the fracture communicated (e.g., verbally, by letter, DXA report was sent) with the clinician managing the patient's on-going care OR a copy of a letter in the medical record outlining whether the patient was or should be treated for osteoporosis.

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Post Fracture Care Communication Documented
CPT II 5015F: Documentation of communication that a fracture occurred and that the patient was or should be tested or treated for osteoporosis

OR

Post Fracture Care not Communicated for Medical or Patient Reasons
Append a modifier (1P or 2P) to CPT Category II code 5015F to report documented circumstances that appropriately exclude patients from the denominator.
5015F *with* 1P: Documentation of medical reason(s) for not communicating with physician managing on-going care of patient that a fracture occurred and that the patient was or should be tested or treated for osteoporosis
5015F *with* 2P: Documentation of patient reason(s) for not communicating with the physician managing on-going care of patient that a fracture occurred and that the patient was or should be tested or treated for osteoporosis

OR

Post Fracture Care not Communicated, Reason not Otherwise Specified
Append a reporting modifier (8P) to CPT Category II code 5015F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.
5015F *with* 8P: No documentation of communication that a fracture occurred and that the patient was or should be tested or treated for osteoporosis, reason not otherwise specified

RATIONALE:
Patients who experience fragility fractures should either be treated or screened for the presence of osteoporosis. Although the fracture may be treated by the orthopedic surgeon, the testing and/or treatment is likely to be under the responsibility of the physician providing on-going care. It is important the physician providing on-going care for the patient be made aware the patient has sustained a non-traumatic fracture. There is a high degree of variability and consensus by experts of what constitutes a fragility fracture and predictor of an underlying problem of osteoporosis. The work group determined that only those fractures, which have the strongest consensus and evidence that they are predictive of osteoporosis, should be included in the measure at this time. We anticipate that the list of fractures will expand as further evidence is published supporting the inclusion of other fractures.

CLINICAL RECOMMENDATION STATEMENTS:
The most important risk factors for osteoporosis-related fractures are a prior low-trauma fracture as an adult and a low BMD in patients with or without fractures. (AACE)

BMD measurement should be performed in all women 40 years old or older who have sustained a fracture. (AACE)

The decision to measure bone density should follow an individualized approach. It should be considered when it will help the patient decide whether to institute treatment to prevent osteoporotic fracture. It should also be considered in patients receiving glucocorticoid therapy for 2 months or more and patients with other conditions that place them at high risk for osteoporotic fracture. (NIH)

The most commonly used measurement to diagnose osteoporosis and predict fracture risk is based on assessment of BMD by dual-energy X-ray absorptiometry (DXA). (NIH) Measurements of BMD made at the hip predict hip

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fracture better than measurements made at other sites while BMD measurement at the spine predicts spine fracture better than measures at other sites. (NIH)

The single most powerful predictor of a future osteoporotic fracture is the presence of previous such fractures. (AGA)

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*Measure #28 (NQF 0092): Aspirin at Arrival for Acute Myocardial Infarction (AMI)

2013 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of patients, regardless of age, with an emergency department discharge diagnosis of AMI who had documentation of receiving aspirin within 24 hours before emergency department arrival or during emergency department stay

INSTRUCTIONS:
This measure is to be reported each time during the reporting period where a patient has been discharged from the emergency department with a diagnosis of AMI. Patients who are discharged from the emergency department with a diagnosis of AMI should have documentation in the medical record of having received aspirin 24 hours before emergency department arrival or during emergency department stay. It is anticipated that clinicians who provide care in the emergency department will submit this measure. The Part B claim form Place of Service field must indicate that the encounter has taken place in the emergency department.

Measure Reporting via Claims:
ICD-9-CM diagnosis codes and CPT codes, and Place of Service Indicator are used to identify patients who are included in the measure's denominator. CPT Category II codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed ICD-9-CM diagnosis codes, CPT codes, Place of Service Indicator, and the appropriate CPT Category II code OR the CPT Category II code with the modifier. The modifiers allowed for this measure are: 1P- medical reasons, 2P- patient reasons, 8P- reason not otherwise specified. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
ICD-9-CM diagnosis codes and CPT codes, and Place of Service Indicator are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All patients, regardless of age, with an emergency department discharge diagnosis of acute myocardial infarction

Denominator Criteria (Eligible Cases):
Diagnosis for acute myocardial infarction (ICD-9-CM): 410.00, 410.01, 410.10, 410.11, 410.20, 410.21, 410.30, 410.31, 410.40, 410.41, 410.50, 410.51, 410.60, 410.61, 410.70, 410.71, 410.80, 410.81, 410.90, 410.91
Diagnosis for acute myocardial infarction (ICD-10-CM) [REFERENCE ONLY/Not Reportable]: I21.01, I21.02, I21.09, I21.11, I21.19, I21.21, I21.29, I21.3, I21.4, I22.0, I22.1, I22.2, I22.8, I22.9
AND
Patient encounter during the reporting period (CPT): 99281, 99282, 99283, 99284, 99285, 99291
AND
Place of Service Indicator: 23
(The Part B claim form Place of Service field must indicate emergency department)

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NUMERATOR:
Patients who had documentation of receiving aspirin within 24 hours before emergency department arrival or during emergency department stay

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Aspirin Received or Taken 24 Hours Before Emergency Department Arrival or During Emergency Department Stay
CPT II 4084F: Aspirin received within 24 hours before emergency department arrival or during emergency department stay

OR

Aspirin not Received or Taken 24 Hours Before Emergency Department Arrival or During Emergency Department Stay for Medical or Patient Reasons
Append a modifier (1P or 2P) to CPT Category II code 4084F to report documented circumstances that appropriately exclude patients from the denominator.
4084F *with* 1P: Documentation of medical reason(s) for not receiving or taking aspirin within 24 hours before emergency department arrival or during emergency department stay
4084F *with* 2P: Documentation of patient reason(s) for not receiving or taking aspirin within 24 hours before emergency department arrival or during emergency department stay

OR

Aspirin not Received or Taken 24 Hours Before Emergency Department Arrival or During Emergency Department Stay, Reason not Otherwise Specified
Append a reporting modifier (8P) to CPT Category II code 4084F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.
4084F *with* 8P: Aspirin was not received within 24 hours before emergency department arrival or during emergency department stay, reason not otherwise specified

RATIONALE:
The emergency physician should document that the patient received aspirin no matter where or when the aspirin was taken.

CLINICAL RECOMMENDATION STATEMENTS:
Aspirin should be chewed by patients who have not taken aspirin before presentation with STEMI. The initial dose should be 162 mg (*Level A*) to 325 mg *(Level C).* Although some trials have used enteric-coated aspirin for initial dosing, more rapid buccal absorption occurs with non–enteric-coated aspirin formulations. (ACC/AHA)

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*Measure #30 (NQF 0269): Perioperative Care: Timely Administration of Prophylactic Parenteral Antibiotics

2013 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of surgical patients aged 18 years and older who receive an anesthetic when undergoing procedures with the indications for prophylactic parenteral antibiotics for whom administration of the prophylactic parenteral antibiotic ordered has been initiated within one hour (if fluoroquinolone or vancomycin, two hours) prior to the surgical incision (or start of procedure when no incision is required)

INSTRUCTIONS:
This measure is to be reported each time an anesthesia service in the denominator is provided for surgical patients during the reporting period. There is no diagnosis associated with this measure. It is anticipated that clinicians who provide anesthesia services, as specified in the denominator coding*, will submit this measure - reporting on the timeliness of parenteral antibiotic administration. The clinician providing anesthesia services does not need to be the clinician who ordered the prophylactic parenteral antibiotic.

* The anesthesia services included in the denominator are associated with some surgical procedures for which prophylactic parenteral antibiotics may not be indicated. As a result, clinicians should report 4047F-8P for those instances in which anesthesia services are provided but not associated with surgical procedures for which prophylactic parenteral antibiotics are indicated.

If the clinician providing anesthesia services orders AND administers the prophylactic parenteral antibiotic within the appropriate timeframe, report quality-data code CPT II 4048F. Report CPT II 4048F with the 1P modifier in circumstances where the prophylactic parenteral antibiotic was not given for medical reasons (e.g., contraindicated, patient already receiving antibiotics).

Measure Reporting via Claims:
CPT codes and patient demographics are used to identify patients who are included in the measure's denominator. CPT Category II codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed CPT codes, and the appropriate CPT Category II code OR the appropriate CPT Category II code with the modifier. The modifiers allowed for this measure are: 1P- medical reasons, 8P- reason not otherwise specified. All measure-specific coding should be reported on the claim(s) representing the eligible encounter as the denominator codes.

Measure Reporting via Registry:
CPT codes and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All surgical patients aged 18 years and older who receive an anesthetic when undergoing procedures* with the indications for prophylactic parenteral antibiotics

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*DENOMINATOR NOTE: Anesthesia services included in denominator are associated with some surgical procedures for which prophylactic parenteral antibiotics may not be indicated. Clinicians should report **4047F-8P** for those instances in which anesthesia services are provided but not associated with surgical procedures for which prophylactic parenteral antibiotics are indicated*

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Patient encounter during the reporting period (CPT): Anesthesia codes for which prophylactic parenteral antibiotics are commonly indicated for associated surgical procedure(s): 00100, 00102, 00103, 00120, 00140, 00145, 00147, 00160, 00162, 00164, 00170, 00172, 00174, 00176, 00190, 00192, 00210, 00211, 00212, 00214, 00215, 00216, 00218, 00220, 00222, 00300, 00320, 00322, 00350, 00352, 00400, 00402, 00404, 00406, 00450, 00452, 00454, 00470, 00472, 00474, 00500, 00528, 00529, 00530, 00532, 00534, 00537, 00539, 00540, 00541, 00542, 00546, 00548, 00550, 00560, 00561, 00562, 00563, 00566, 00567, 00580, 00600, 00604, 00620, 00622, 00625, 00626, 00630, 00632, 00634, 00670, 00700, 00730, 00750, 00752, 00754, 00756, 00770, 00790, 00792, 00794, 00796, 00797, 00800, 00802, 00820, 00830, 00832, 00840, 00844, 00846, 00848, 00851, 00860, 00862, 00864, 00865, 00866, 00868, 00870, 00880, 00882, 00902, 00904, 00906, 00908, 00910, 00912, 00914, 00916, 00918, 00920, 00921, 00922, 00924, 00926, 00928, 00930, 00932, 00934, 00936, 00938, 00940, 00942, 00944, 01120, 01140, 01150, 01170, 01173, 01180, 01190, 01202, 01210, 01212, 01214, 01215, 01230, 01232, 01234, 01250, 01260, 01270, 01272, 01274, 01320, 01360, 01382, 01392, 01400, 01402, 01404, 01430, 01432, 01440, 01442, 01444, 01464, 01470, 01472, 01474, 01480, 01482, 01484, 01486, 01500, 01502, 01520, 01522, 01610, 01622, 01630, 01634, 01636, 01638, 01650, 01652, 01654, 01656, 01670, 01710, 01712, 01714, 01716, 01732, 01740, 01742, 01744, 01756, 01758, 01760, 01770, 01772, 01780, 01782, 01810, 01829, 01830, 01832, 01840, 01842, 01844, 01850, 01852, 01924, 01925, 01926, 01951, 01952, 01953, 01961, 01962, 01963, 01965, 01966, 01968, 01969

NUMERATOR:
Surgical patients for whom administration of the prophylactic parenteral antibiotic ordered has been initiated 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: This measure seeks to identify the timely administration of prophylactic parenteral antibiotic. This administration should begin within one hour (if fluoroquinolone or vancomycin, two hours) prior to surgical incision.

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
The antimicrobial drugs listed below are considered prophylactic parenteral antibiotics for the purposes of this measure. ***4048F-8P** 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

NUMERATOR NOTE: "Ordered" includes instances in which the prophylactic parenteral antibiotic is ordered by the clinician performing the surgical procedure OR is ordered by the clinician providing the anesthesia services.

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Documentation that Prophylactic Parenteral Antibiotic was Administered Within Specified Timeframe

CPT II 4048F: 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

Prophylactic Parenteral Antibiotic not Administered for Medical Reasons (eg, contraindicated, patient already receiving antibiotics)

Append a modifier (1P) to CPT Category II code 4048F to report documented circumstances that appropriately exclude patients from the denominator.

4048F *with* 1P: Documentation of medical reason(s) for not initiating administration of prophylactic parenteral antibiotics as specified (eg, contraindicated, patient already receiving antibiotics).

OR

If patient is not eligible for this measure because prophylactic parenteral antibiotic not ordered, report:

Prophylactic Parenteral Antibiotic not Ordered

Append a reporting modifier (8P) to CPT Category II code 4047F to report circumstances when the patient is not eligible for the measure.

4047F *with* 8P: No 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

Prophylactic Parenteral Antibiotic Ordered but not Initiated Within One Hour, Reason not Otherwise Specified

Append a reporting modifier (8P) to CPT Category II code 4048F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

4048F *with* 8P: Administration of prophylactic parenteral antibiotic was not initiated 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.

RATIONALE:

The appropriate timing of administration of prophylactic parenteral antibiotics has been demonstrated to reduce the incidence of surgical wound infections. Available evidence suggests that although most surgical patients receive a prophylactic antibiotic, many do not receive the drug within one hour before incision as recommended.

CLINICAL RECOMMENDATION STATEMENTS:

The anti-infective drug should ideally be given within 30 minutes to 1 hour before the initial incision to ensure its presence in an adequate concentration in the targeted tissues. For most procedures, scheduling administration at the time of induction of anesthesia ensures adequate concentrations during the period of potential contamination. Exceptions: cesarean procedures (after cross clamping of the umbilical cord); colonic procedures (starting 19 hours before the scheduled time of surgery). (ASHP)

Infusion of the first antimicrobial dose should begin within 60 minutes before incision. However, when a fluoroquinolone or vancomycin is indicated, the infusion should begin within 120 minutes before incision to prevent antibiotic-associated reactions. Although research has demonstrated that administration of the antimicrobial at the time of anesthesia induction is safe and results in adequate serum and tissue drug levels at the time of incision, there was no consensus that the infusion must be completed before incision. (SIPGWW)

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*Measure #31 (NQF 0240): Stroke and Stroke Rehabilitation: Deep Vein Thrombosis (DVT) Prophylaxis for Ischemic Stroke or Intracranial Hemorrhage

2013 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of patients aged 18 years and older with a diagnosis of ischemic stroke or intracranial hemorrhage who were administered DVT prophylaxis by end of hospital day two

INSTRUCTIONS:
This measure is to be reported during each hospital stay when a patient is under active treatment for ischemic stroke or intracranial hemorrhage during the reporting period. Part B claims data will be analyzed to determine a hospital stay. If multiple qualifying diagnoses are submitted on the same claim form, only one instance of reporting will be counted. It is anticipated that clinicians who care for patients with a diagnosis of ischemic stroke or intracranial hemorrhage in the hospital setting will submit this measure.

Measure Reporting via Claims:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. CPT Category II codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed ICD-9-CM diagnosis codes, CPT codes, and the appropriate CPT Category II code OR the CPT Category II code with the modifier. The modifiers allowed for this measure are: 1P- medical reasons, 2P- patient reasons, 8P- reason not otherwise specified. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT codes and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All patients aged 18 years and older with a diagnosis of ischemic stroke or intracranial hemorrhage

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Diagnosis for ischemic stroke or intracranial hemorrhage (ICD-9-CM): 430, 431, 432.0, 432.1, 432.9, 433.01, 433.11, 433.21, 433.31, 433.81, 433.91, 434.01, 434.11, 434.91

Diagnosis for ischemic stroke or intracranial hemorrhage (ICD-10-CM) [REFERENCE ONLY/Not Reportable]: I60.00, I60.01, I60.02, I60.10, I60.11, I60.12, I60.20, I60.21, I60.22, I60.30, I60.31, I60.32, I60.4, I60.50, I60.51, I60.52, I60.6, I60.7, I60.8, I60.9, I61.0, I61.1, I61.2, I61.3, I61.4, I61.5, I61.6, I61.8, I61.9, I62.00, I62.01, I62.02, I62.03, I62.1, I62.9, I63.00, I63.011, I63.012, I63.019, I63.02, I63.031, I63.032, I63.039, I63.09, I63.10, I63.111, I63.112, I63.119, I63.12, I63.131, I63.132, I63.139, I63.19, I63.20, I63.211, I63.212, I63.219, I63.22, I63.231, I63.232, I63.239, I63.29, I63.30, I63.311, I63.312, I63.319, I63.321,

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I63.322, I63.329, I63.331, I63.332, I63.339, I63.341, I63.342, I63.349, I63.39, I63.40, I63.411, I63.412, I63.419, I63.421, I63.422, I63.429, I63.431, I63.432, I63.439, I63.441, I63.442, I63.449, I63.49, I63.50, I63.511, I63.512, I63.519, I63.521, I63.522, I63.529, I63.531, I63.532, I63.539, I63.541, I63.542, I63.549, I63.59, I63.6, I63.8, I63.9

AND

Patient encounter during the reporting period (CPT): 99221, 99222, 99223, 99231, 99232, 99233, 99291

NUMERATOR:

Patients who were administered Deep Vein Thrombosis (DVT) prophylaxis by the end of hospital day two

Definitions:

DVT Prophylaxis – Can include Low Molecular Weight Heparin (LMWH), Low-Dose Unfractionated Heparin (LDUH), low-dose subcutaneous heparin, or intermittent pneumatic compression devices.

Day Two – Ends at 11:59 pm on the second day of hospitalization; day one is day patient was admitted.

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

DVT Prophylaxis Received

CPT II 4070F: Deep Vein Thrombosis (DVT) prophylaxis received by end of hospital day 2

OR

DVT Prophylaxis not Received for Medical or Patient Reasons

Append a modifier (1P or 2P) to CPT Category II code 4070F to report documented circumstances that appropriately exclude patients from the denominator.

4070F *with* 1P: Documentation of medical reason(s) for not administering DVT Prophylaxis by end of hospital day 2 (eg, patient is ambulatory, patient expired during inpatient stay, patient already on warfarin or another anticoagulant, other medical reason(s))

4070F *with* 2P: Documentation of patient reason(s) for not administering DVT Prophylaxis by end of hospital day 2 (eg, patient left against medical advice, other patient reason(s))

OR

DVT Prophylaxis not Received, Reason not Otherwise Specified

Append a reporting modifier (8P) to CPT Category II code 4070F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

4070F *with* 8P: Deep Vein Thrombosis (DVT) prophylaxis was not received by end of hospital day 2, reason not otherwise specified

RATIONALE:

Patients on bed rest are at high risk for deep vein thrombosis. DVT prevention is important for all patients who have suffered a stroke or an intracranial hemorrhage and may have decreased mobility. The intent of this measure is to assure that adequate DVT prophylaxis is received for either diagnosis. As noted in the clinical recommendation statements, the appropriate *type* of prophylaxis differs by diagnosis. Anticoagulants are generally contraindicated in patients with intracranial hemorrhage. These patients are still at risk for DVT so they should receive prophylaxis with mechanical devices. Low-dose subcutaneous heparin may be initiated on the second day after onset of the hemorrhage.

CLINICAL RECOMMENDATION STATEMENTS:

The following evidence statements are quoted verbatim from the referenced clinical guidelines.

Subcutaneous unfractionated heparin, LMW heparins, and heparinoids may be considered for DVT prophylaxis in at-risk patients with acute ischemic stroke, recognizing that nonpharmacologic treatments for DVT prevention also exist. (Grade A) (AAN/ASA, Reaffirmed 2008)

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Aspirin is a potential intervention to prevent deep vein thrombosis but is less effective than anticoagulants. (Class IIa, Level of Evidence A) (ASA, 2007)

The use of intermittent external compression devices is recommended for treatment of patients who cannot receive anticoagulants. (Class IIa, Level of Evidence B) (ASA, 2007)

Subcutaneous administration of anticoagulants is recommended for treatment of immobilized patients to prevent deep vein thrombosis. (Class I, Level of Evidence A) The ideal timing for starting these medications is not known. (ASA, 2007)

For acute stroke patients with restricted mobility, we recommend prophylactic low-dose SC heparin or low-molecular-weight heparins. (Grade 1A) (ACCP, 2008)

For patients who have contraindications to anticoagulants, we recommend intermittent pneumatic compression (IPC devices or elastic stockings. (Grade 1B) (ACCP, 2008)

In patients with an acute intracerebral hematoma (ICH), we recommend the initial use of IPC devices. (Grade 1B) (ACCP, 2008)

In stable patients, we suggest low-dose SC heparin as soon as the second day after the onset of the hemorrhage. (Grade 2C) (ACCP, 2008)

Early implementation of anticoagulant therapy or physical compression modalities should be considered for all stroke patients who cannot ambulate at 2 days and who are at risk for DVT or pulmonary embolus (Class I, Level of Evidence A). Early mobility should always be attempted if safe for the patient. (Class I, Level of Evidence B) (ASA, 2009)

After documentation of cessation of bleeding, low-dose subcutaneous low-molecular-weight heparin or unfractionated heparin may be considered for prevention of venous thromboembolism in patients with lack of mobility after 1 to 4 days from onset. (Class IIb, Level of Evidence B) (ASA, 2010)

Patients with ICH should have intermittent pneumatic compression for prevention of venous thromboembolism in addition to elastic stockings. (Class I, Level of Evidence B) (ASA, 2010)

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*Measure #32 (NQF 0325): Stroke and Stroke Rehabilitation: Discharged on Antithrombotic Therapy

2013 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of patients aged 18 years and older with a diagnosis of ischemic stroke or transient ischemic attack (TIA) who were prescribed antithrombotic therapy at discharge

INSTRUCTIONS:
This measure is to be reported for patients under active treatment for ischemic stroke or TIA at discharge from a hospital during the reporting period. Part B claims data will be analyzed to determine the hospital discharge. If multiple qualifying diagnoses are submitted on the same claim form, only one instance of reporting will be counted. It is anticipated that clinicians who care for patients with a diagnosis of ischemic stroke or TIA in the hospital setting will submit this measure.

Measure Reporting via Claims:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. G-codes are used to report the numerator of the measure.

When reporting the measures via claims, submit the listed ICD-9-CM diagnosis codes, CPT codes, and appropriate numerator G-code. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT codes and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All patients aged 18 years and older with a diagnosis of ischemic stroke or transient ischemic attack (TIA)

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Diagnosis for ischemic stroke or transient ischemic attack (ICD-9-CM): 433.01, 433.11, 433.21, 433.31, 433.81, 433.91, 434.01, 434.11, 434.91, 435.0, 435.1, 435.2, 435.3, 435.8, 435.9
Diagnosis for ischemic stroke or transient ischemic attack (ICD-10-CM) [REFERENCE ONLY/Not Reportable]: G45.0, G45.1, G45.2, G45.8, G45.9, G46.0, G46.1, G46.2, I63.00, I63.011, I63.012, I63.019, I63.02, I63.031, I63.032, I63.039, I63.09, I63.10, I63.111, I63.112, I63.119, I63.12, I63.131, I63.132, I63.139, I63.19, I63.20, I63.211, I63.212, I63.219, I63.22, I63.231, I63.232, I63.239, I63.29, I63.30, I63.311, I63.312, I63.319, I63.321, I63.322, I63.329, I63.331, I63.332, I63.339, I63.341, I63.342, I63.349, I63.39, I63.40, I63.411, I63.412, I63.419, I63.421, I63.422, I63.429, I63.431, I63.432, I63.439, I63.441, I63.442, I63.449, I63.49, I63.50, I63.511, I63.512, I63.519, I63.521, I63.531, I63.532, I63.539, I63.541, I63.542, I63.549, I63.59, I63.6, I63.8, I63.9
AND

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Patient encounter during the reporting period (CPT): 99221, 99222, 99223, 99231, 99232, 99233, 99234, 99235, 99236, 99238, 99239

NUMERATOR:
Patients who were prescribed antithrombotic therapy at discharge

Numerator Instructions: If the consulting physician orders or agrees with a prior antithrombotic therapy order (from current or previous episodes of care during the reporting period) and there is supporting documentation, report G8696.

Definitions:
Antithrombotic Therapy – Aspirin, combination of aspirin and extended-release dipyridamole, clopidogrel, ticlopidine, warfarin, low molecular weight heparin, dabigatran, rivaroxaban.
Prescribed – May include prescription given to the patient for antithrombotic therapy at discharge or therapy to be continued after discharge as documented in the discharge medication list.

NUMERATOR NOTE: In order to meet the measure, antithrombotic therapy is to be prescribed at the time of discharge. If a physician other than the discharging physician (e.g., consulting physician) is reporting on this measure, it should be clear from the documentation that the prescription is being ordered for the patient at the time of discharge, and included in the "medications prescribed at discharge."

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Antithrombotic Therapy Prescribed
G8696: Antithrombotic therapy prescribed at discharge

OR

Antithrombotic Therapy not Prescribed for Documented Reasons
G8697: Antithrombotic therapy not prescribed for documented reasons (e.g., patient admitted for performance of elective carotid intervention, patient had stroke during hospital stay, patient expired during inpatient stay, other medical reason(s)); (e.g., patient left against medical advice, other patient reason(s))

OR

Antithrombotic Therapy Prescription not Prescribed, Reason not Given
G8698: Antithrombotic therapy was not prescribed at discharge, reason not given

RATIONALE:
The focus on stroke as an outcome is important because patients who experience a stroke or TIA are most likely to have a stroke as their next serious vascular outcome. Platelet antiaggregation drugs prevent strokes. The selection of individual drugs is primarily based on interpretation of their relative efficacy, safety, and cost. Therefore, following a stroke, patients should be prescribed antithrombotic therapy to decrease the risk of additional strokes.

CLINICAL RECOMMENDATION STATEMENTS:
The following evidence statements are quoted verbatim from the referenced clinical guidelines.

In patients who have experienced a non-cardioembolic stroke or TIA (i.e., atherothrombotic, lacunar, or cryptogenic), we recommend treatment with an antiplatelet drug. (Grade 1A) (ACCP, 2008)

Aspirin, the combination of aspirin, 25 mg and extended-release dipyridamole, 200 mg twice a day, and clopidogrel (75 mg daily) are all acceptable options for initial therapy. We recommend an aspirin dose of 50-100 mg/daily over higher aspirin doses. (Grade 1B) (ACCP, 2008)

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In patients who have experienced a non-cardioembolic stroke or TIA, we recommend using the combination of aspirin and extended-release dipyridamole (25/200 mg twice a day) over aspirin (Grade 1A) and suggest clopidogrel over aspirin. (Grade 2B) (ACCP, 2008)

In most patients with a non-cardioembolic stroke or TIA, we recommend avoiding long-term use of the combination of aspirin and clopidogrel (Grade 1B). In those with a recent acute myocardial infarction, other acute coronary syndrome, or a recently placed coronary stent, we recommend clopidogrel plus aspirin (75-100 mg). (Grade 1A) (ACCP, 2008)

For patients who are allergic to aspirin, we recommend clopidogrel. (Grade 1A) (ACCP, 2008)

For patients with non-cardioembolic stroke or TIA, we recommend antiplatelet agents over oral anticoagulation. (Grade 1A) (ACCP, 2008)

In patients with atrial fibrillation who have suffered a recent stroke or TIA, we recommend long-term oral anticoagulation (target INR, 2.5; range, 2.0-3.0). (Grade 1A) (ACCP, 2008)

For patients with cardioemboloic stroke who have contraindications to anticoagulant therapy, we recommend aspirin at a dose of 75-325 mg/daily. (Grade 1B) (ACCP, 2008)

In patients with stroke associated with aortic atherosclerotic lesions, we recommend antiplatelet therapy over no therapy. (Grade 1A) (ACCP, 2008)

For patients with cryptogenic stroke associated with mobile aortic arch thrombi, we suggest either oral anticoagulation or antiplatelet agents. (Grade 2C) (ACCP, 2008)

In patients with cryptogenic ischemic stroke and a patent foramen ovale, we recommend antiplatelet therapy over no therapy (Grade 1A) and suggest antiplatelet agents over anticoagulation. (Grade 2A) (ACCP, 2008)

In patient with mitral valve strands or prolapse, who have a history of TIA or stroke, we recommend antiplatelet therapy. (Grade 1A) (ACCP, 2008)

For patients with non-cardioembolic ischemic stroke or TIA, the use of antiplatelet agents rather than oral anticoagulation is recommended to reduce the risk of recurrent stroke and other cardiovascular events. (Class I, Level of Evidence A) (ASA, 2010)

Aspirin (50 mg/daily to 325 mg/daily) monotherapy (Class I, Level of Evidence A), the combination of aspirin 25 mg and extended-release dipyridamole 200 mg twice daily (Class I, Level of Evidence B), and clopidogrel 75 mg monotherapy (Class IIa, Level of Evidence B) are all acceptable options for initial therapy. The selection of an antiplatelet agent should be individualized on the basis of patient risk factor profiles, cost, tolerance, and other clinical characteristics. (ASA, 2010)

For patients allergic to aspirin, clopidogrel is reasonable. (Class IIa, Level of Evidence C) (ASA, 2010)

The addition of aspirin to clopidogrel increases the risk of hemorrhage and is not recommended for routine secondary prevention after ischemic stroke or TIA. (Class III, Level of Evidence A) (ASA, 2010)

For patients who have an ischemic stroke while taking aspirin, there is no evidence that increasing the dose of aspirin provides additional benefit. Although alternative antiplatelet agents are often considered, no single agent or combination has been studied in patients who have had an event while receiving aspirin. (Class IIb Level of Evidence C) (ASA, 2010)

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Dabigatran is useful as an alternative to warfarin for the prevention of stroke and systemic thromboembolism in patients with paroxysmal to permanent Atrial Fibrillation and risk factors for stroke or systemic embolization who do not have a prosthetic heart valve or hemodynamically significant valve disease, severe renal failure (creatinine clearance < 15 mL/min) or advanced liver disease (impaired baseline clotting function). (Class I Level of Evidence: B) (ACCF/AHA/HRS, 2011)

For patients with ischemic stroke or TIA with paroxysmal (intermittent) or permanent AF, anticoagulation with a vitamin K antagonist (target INR 2.5;range, 2.0 to 3.0) is recommended. (ASA, 2011)

Patients with ischemic stroke or TIA in the setting of acute MI complicated by LV mural thrombus formation identified by echocardiography or another cardiac imaging technique should be treated with oral anticoagulation (target INR 2.5, range 2.0 to 3.0) for at least 3 months. (ASA, 2011)

Warfarin (INR 2.0 to 3.0), aspirin (81 mg daily), clopidogrel (75 mg daily), or the combination of aspirin (25 mg twice daily) plus extended-release dipyramidamole (200 mg twice daily) may be considered to prevent recurrent ischemic events in patients with previous ischemic stroke or TIA and cardiomyopathy. (ASA, 2011)

For patients with ischemic stroke or TIA who have rheumatic mitral valve disease, whether or not AF is present, long-term warfarin therapy is reasonable with an INR target range of 2.5 (range, 2.0 to 3.0). (ASA, 2011)

For patients with ischemic stroke or TIA who have mechanical prosthetic heart valves, warfarin is recommended with an INR target of 3.0 (range, 2.5 to 3.5). (ASA, 2011)

For patients with non-cardioembolic ischemic stroke or TIA, the use of antiplatelet agents rather than oral anticoagulation is recommended to reduce the risk of recurrent stroke and other cardiovascular events. (ASA, 2011)

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*Measure #33 (NQF 0241): Stroke and Stroke Rehabilitation: Anticoagulant Therapy Prescribed for Atrial Fibrillation (AF) at Discharge

2013 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Percentage of patients aged 18 years and older with a diagnosis of ischemic stroke or transient ischemic attack (TIA) with documented permanent, persistent, or paroxysmal atrial fibrillation who were prescribed an anticoagulant at discharge

INSTRUCTIONS:
This measure is to be reported for patients under active treatment for ischemic stroke or TIA with documented atrial fibrillation at discharge from a hospital during the reporting period. It is anticipated that clinicians who care for patients with a diagnosis of ischemic stroke or TIA in the hospital setting will submit this measure.

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All patients aged 18 years and older with a diagnosis of ischemic stroke or transient ischemic attack (TIA) with documented permanent, persistent, or paroxysmal atrial fibrillation

Definitions:
First Detected – Only one diagnosed episode.
Persistent Atrial Fibrillation – Recurrent episodes that last more than 7 days.
Paroxysmal Atrial Fibrillation – Recurrent episodes that self terminate in less than 7 days.
Permanent Atrial Fibrillation – An ongoing long term episode.

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Diagnosis for ischemic stroke or transient ischemic attack (TIA) (ICD-9-CM): 433.01, 433.11, 433.21, 433.31, 433.81, 433.91, 434.01, 434.11, 434.91, 435.0, 435.1, 435.2, 435.3, 435.8, 435.9
Diagnosis for ischemic stroke or transient ischemic attack (TIA) (ICD-10-CM) [REFERENCE ONLY/Not Reportable]: G45.0, G45.1, G45.2, G45.8, G45.9, G46.0, G46.1, G46.2, I63.00, I63.011, I63.012, I63.019, I63.02, I63.031, I63.032, I63.039, I63.09, I63.10, I63.111, I63.112, I63.119, I63.12, I63.131, I63.132, I63.139, I63.19, I63.20, I63.211, I63.212, I63.219, I63.22, I63.231, I63.232, I63.239, I63.29, I63.30, I63.311, I63.312, I63.319, I63.321, I63.322, I63.329, I63.331, I63.332, I63.339, I63.341, I63.342, I63.349, I63.39, I63.40, I63.411, I63.412, I63.419, I63.421, I63.422, I63.429, I63.431, I63.432, I63.439, I63.441, 163.442, I63.449, I63.49, I63.50, I63.511, I63.512, I63.519, I63.521, I63.522, I63.529, I63.531, I63.532, I63.539, I63.541, I63.542, I63.549, I63.59, I63.6, I63.8, I63.9
AND
Diagnosis for atrial fibrillation (ICD-9-CM): 427.31
Diagnosis for atrial fibrillation (ICD-10-CM) [REFERENCE ONLY/Not Reportable]: I48.0, I48.1, I48.2

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AND
Patient encounter during the reporting period (CPT): 99221, 99222, 99223, 99231, 99232, 99233, 99238, 99239

NUMERATOR:
Patients who were prescribed an anticoagulant at discharge

Definitions:
Anticoagulants – warfarin, low molecular weight heparin, dabigatran, rivaroxaban
Prescribed – May include prescription given to the patient for anticoagulant therapy at discharge OR anticoagulant to be continued after discharge as documented in the discharge medication list.

NUMERATOR NOTE: In order to meet the measure, anticoagulant therapy is to be prescribed at the time of discharge. If a physician other than the discharging physician (e.g., consulting physician) is reporting on this measure, it should be clear from the documentation that the prescription is being ordered for the patient at the time of discharge, and included in the "medications prescribed at discharge."

Numerator Options:
Anticoagulant therapy prescribed at discharge (4075F)

OR

Anticoagulant therapy not prescribed at discharge for medical reason (eg, patient expired during inpatient stay, other medical reason(s)) (4075F *with* 1P)
OR
Anticoagulant therapy not prescribed at discharge for patient reason (eg, patient left against medical advice, other patient reason(s)) (4075F *with* 2P)

OR

Anticoagulant therapy not prescribed at discharge, reason not otherwise specified (4075F *with* 8P)

RATIONALE:
In patients with nonvalvular AF, prior stroke or TIA is the strongest independent predictor of stroke, significantly associated with stroke in all 6 studies in which it was evaluated with incremental relative risk between 1.9 and 3.7 (averaging approximately 3.0). The pathogenic constructs of stroke in AF are incomplete, but available data indicate that all patients with prior stroke or TIA are at high risk of recurrent thromboembolism and require anticoagulation unless there are firm contraindications in a given patient. Patients with atrial fibrillation (permanent, persistent, or paroxysmal) and stroke should be prescribed an anticoagulant to prevent recurrent strokes.

CLINICAL RECOMMENDATION STATEMENTS:
The following evidence statements are quoted verbatim from the referenced clinical guidelines.

Antithrombotic therapy to prevent thromboembolism is recommended for all patients with AF, except those with lone AF or contraindications. (Class I, Level of Evidence A) (ACC/AHA/ESC, 2006)

The selection of the antithrombotic agent should be based upon the absolute risks of stroke and bleeding and the relative risk and benefit for a given patient. (Class I, Level of Evidence A) (ACC/AHA/ESC, 2006)

In patients with atrial fibrillation who have suffered a recent stroke or TIA, we recommend long-term oral anticoagulation (target INR, 2.5; range, 2.0-3.0). (Grade 1A) (ACCP, 2008)

For patients with cardioembolic stroke who have contraindications to anticoagulant therapy, we recommend aspirin at a dose of 75-325 mg/daily. (Grade 1B) (ACCP, 2008)

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For patients with ischemic stroke or TIA with persistent or paroxysmal (intermittent) or permanent AF, anticoagulation with vitamin K antagonist (target INR, 2.5; range, 2.0 to 3.0) is recommended. (Class I, Level of Evidence A) (ASA, 2010)

For patients unable to take oral anticoagulants, aspirin alone (Class I; Level of Evidence A) is recommended. The combination of clopidogrel plus aspirin carries a risk of bleeding similar to that of warfarin and therefore is not recommended for patients with a hemorrhagic contraindication to warfarin. (Class III; Level of Evidence B) (ASA, 2010)

For patients with AF at high risk for stroke (stroke or TIA within 3 months, $CHADS_2$ score of 5 or 6, mechanical or rheumatic valve disease) who require temporary interruption of oral anticoagulation, bridging therapy with an LMWH administered subcutaneously is reasonable. (Class IIa; Level of Evidence C) (ASA, 2010)

Dabigatran is useful as an alternative to warfarin for the prevention of stroke and systemic thromboembolism in patients with paroxysmal to permanent AF and risk factors for stroke or systemic embolization who do not have a prosthetic heart valve or hemodynamically significant valve disease, severe renal failure (creatinine clearance < 15 mL/min) or advanced liver disease (impaired baseline clotting function). (Class I Level of Evidence: B) (ACCF/AHA/HRS, 2011)

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* Measure #35 (NQF 0243) : Stroke and Stroke Rehabilitation: Screening for Dysphagia

2013 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of patients aged 18 years and older with a diagnosis of ischemic stroke or intracranial hemorrhage who receive any food, fluids or medication by mouth (PO) for whom a dysphagia screening was performed prior to PO intake in accordance with a dysphagia screening tool approved by the institution in which the patient is receiving care

INSTRUCTIONS:
This measure is to be reported during each hospital stay for all patients under active treatment for ischemic stroke or intracranial hemorrhage during the reporting period. Part B claims data will be analyzed to determine a hospital stay. If multiple qualifying diagnoses are submitted on the same claim form, only one instance of reporting will be counted. It is anticipated that clinicians who care for patients with a diagnosis of ischemic stroke or intracranial hemorrhage in the hospital setting will submit this measure.

Measure Reporting via Claims:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. CPT Category II codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed ICD-9-CM diagnosis codes, CPT codes, and the appropriate CPT Category II code(s) OR the CPT Category II code(s) with the modifier. The modifiers allowed for this measure are: 1P- medical reasons, 2P- patient reasons, 8P- reason not otherwise specified. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT codes and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All patients aged 18 years and older with a diagnosis of ischemic stroke or intracranial hemorrhage who receive any food, fluids or medication by mouth (PO)

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Diagnosis for ischemic stroke or intracranial hemorrhage (ICD-9-CM): 430, 431, 432.0, 432.1, 432.9, 433.01, 433.11, 433.21, 433.31, 433.81, 433.91, 434.01, 434.11, 434.91

Diagnosis for ischemic stroke or intracranial hemorrhage (ICD-10-CM) [REFERENCE ONLY/Not Reportable]: I60.00, I60.01, I60.02, I60.10, I60.11, I60.12, I60.20, I60.21, I60.22, I60.30, I60.31, I60.32, I60.4, I60.50, I60.51, I60.52, I60.6, I60.7, I60.8, I60.9, I61.0, I61.1, I61.2, I61.3, I61.4, I61.5, I61.6, I61.8, I61.9, I62.00, I62.01, I62.02, I62.03, I62.1, I62.9, I63.00, I63.011, I63.012, I63.019, I63.02, I63.031, I63.032, I63.039, I63.09, I63.10, I63.111, I63.112, I63.119, I63.12, I63.131, I63.132, I63.139, I63.19, I63.20, I63.211, I63.212, I63.219, I63.22, I63.231, I63.232, I63.239, I63.29, I63.30, I63.311, I63.312, I63.319, I63.321,

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I63.322, I63.329, I63.331, I63.332, I63.339, I63.341, I63.342, I63.349, I63.39, I63.40, I63.411, I63.412, I63.419, I63.421, I63.422, I63.429, I63.431, I63.432, I63.439, I63.441, I63.442, I63.449, I63.49, I63.50, I63.511, I63.512, I63.519, I63.521, I63.522, I63.529, I63.531, I63.532, I63.539, I63.541, I63.542, I63.549, I63.59, I63.6, I63.8, I63.9

AND

Patient encounter during the reporting period (CPT): 99218, 99219, 99220, 99221, 99222, 99223, 99234, 99235, 99236, 99281, 99282, 99283, 99284, 99285, 99291

NUMERATOR:

Patients for whom a dysphagia screening was performed prior to PO intake in accordance with a dysphagia screening tool approved by the institution in which the patient is receiving care

Numerator Instructions: Patients "who receive any food, fluids or medication by mouth" may be identified by the absence of an NPO (nothing by mouth) order.

Definition:

Dysphagia Screening – May include, but is not limited to videofluoroscopic swallow evaluation (VSE), fiberoptic endoscopic evaluation of swallowing (FEES), modified barium swallow, structured bedside swallowing assessment.

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:

Dysphagia Screening Conducted

(Two CPT II codes [6010F & 6015F] are required on the claim form to submit this numerator option)

CPT II 6010F: Dysphagia screening conducted prior to order for or receipt of any foods, fluids or medication by mouth

AND

CPT II 6015F: Patient receiving or eligible to receive foods, fluids or medication by mouth

OR

Dysphagia Screening not Conducted for Medical or Patient Reasons

(Two CPT II codes [6010F-xP & 6015F] are required on the claim form to submit this numerator option)

Append a modifier (1P or 2P) to CPT Category II code 6010F to report documented circumstances that appropriately exclude patients from the denominator.

6010F *with* 1P: Documentation of medical reason(s) for not conducting dysphagia screening prior to taking any foods, fluids or medication by mouth (eg, patient expired during inpatient stay, patient without any focal findings and not thought to be having a stroke when initially evaluated, other medical reason(s)).

6010F *with* 2P: Documentation of patient reason(s) for not performing a dysphagia screening prior to taking any foods, fluids or medication by mouth (eg, patient left against medical advice, other patient reason(s)).

AND

CPT II 6015F: Patient receiving or eligible to receive foods, fluids or medication by mouth

OR

If patient is not eligible for this measure because patient is NPO, report:

(One CPT II code [6020F] is required on the claim form to submit this numerator option)

CPT II 6020F: NPO (nothing by mouth) ordered

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OR

Dysphagia Screening not Conducted, Reason not Otherwise Specified
*(Two CPT II codes [*6010F-8P & 6015F*] are required on the claim form to submit this numerator option)*
Append a reporting modifier (8P) to CPT Category II code 6010F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.
6010F *with* 8P: Dysphagia screening was not conducted prior to order for or receipt of any foods, fluids or medication by mouth, reason not otherwise specified

AND

CPT II 6015F: Patient receiving or eligible to receive foods, fluids or medication by mouth

RATIONALE:

Impairments of swallowing are associated with a high risk of pneumonia. Some patients cannot receive food or fluids because of impairments in swallowing or mental status. Patients with infarctions of the brain stem, multiple strokes, major hemispheric lesions, or depressed consciousness are at the greatest risk for aspiration. Swallowing impairments are associated with an increased risk of death. An abnormal gag reflex, impaired voluntary cough, dysphonia, incomplete oral-labial closure, a high NIHSS score, or cranial nerve palsies should alert the physician to the risk. A preserved gag reflex may not indicate safety with swallowing. An assessment of the ability to swallow is important before the patient is allowed to eat or drink.

CLINICAL RECOMMENDATION STATEMENTS:

The following evidence statements are quoted verbatim from the referenced clinical guidelines.

Assessment of swallowing before starting eating or drinking is recommended. (Class I, Level of Evidence B) (ASA, 2007)

At the time of the stroke or during the acute stages of a stroke, patients may not be able to clear secretions and could be at high risk for aspiration. Aspiration can result in respiratory compromises due to infection or pulmonary edema. Nurses must frequently auscultate lungs, evaluate for signs of respiratory compromise, and evaluate for signs of dysphagia to prevent the occurrence of aspiration pneumonia. Initial interventions may include elevating the head of the bed (HOB) or turning the patient on his or her side, monitoring the patient during oral intake, and obtaining a formal swallowing evaluation if symptoms of choking are noted. Nurses must do or obtain a bedside swallowing assessment prior to the institution of any oral intake, including medications. (Level 1) (AANN, 2009)

A swallow assessment should be performed as soon as possible after admission to the hospital, no later than 48 hours after admission. Patients suspected of having swallowing problems should be given nothing by mouth until after a structured bedside swallowing assessment is performed that includes a water challenge. (Level 2) (AANN, 2009)

Nurses must monitor patients for clinically observable signs of dysphagia that include coughing or choking on saliva or food, pocketing of food in the mouth, garbled speech, facial muscle weakness, delayed or absent swallow reflex, drooling, watery eyes after any intake, or gurgling voice. Clinically observable signs of aspiration are not always evident because stroke patients can be “silent aspirators.” Patients at highest risk include those with infarctions in the brainstem, large hemispheric lesions, multiple strokes, or decreased LOC. Clinical interventions after the initial nursing swallow screen include consulting the speech and language pathologist (SLP) for formal evaluation and further recommendations on diet or techniques for decreasing the risk of aspiration. Also, nurses should perform aggressive oral care. Minimizing the bacterial count in the mouth can decrease the risk of developing aspiration pneumonia if the patient aspirates. (Level 2) (AANN, 2009)

In patients with cough, a medical history particularly directed at identifying conditions increasing the likelihood of oral pharyngeal dysphagia and aspiration, as indicated in the table above entitled "Medical Diagnoses and Conditions Associated With Aspiration and Silent Aspiration on Videofluoroscopic Swallow Evaluation (VSE)", should be

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obtained. Patients with high-risk conditions should be referred for an oral-pharyngeal swallowing evaluation. (Level of evidence, low; benefit, substantial; grade of recommendation, B) (ACCP, 2006)

Patients with cough and their caregivers should be questioned regarding perceived swallowing problems, including an association of cough while eating or drinking and a fear of choking while eating and drinking. If a patient with cough reports swallowing problems, further evaluation for oral-pharyngeal dysphagia is indicated. (Level of evidence, low; benefit, substantial; grade of recommendation, B) (ACCP, 2006)

Further evaluation, including a chest radiograph and a nutritional assessment, should be considered in patients with cough or conditions associated with aspiration. (Level of evidence, low; benefit, substantial; grade of recommendation, B) (ACCP, 2006)

Patients with oral-pharyngeal dysphagia and cough should be referred, ideally to a speech-language pathologist (SLP), for an oral-pharyngeal swallow evaluation. (Level of evidence, low; benefit, substantial; grade of recommendation, B) (ACCP, 2006)

In acute stroke patients, the expulsive phase rise time of VC may predict aspiration. The use of this test has not been validated in other patient groups, and further studies comparing the accuracy of objective measures of VC to the clinical swallow evaluation to identify aspiration risk are needed. (Level of evidence, low; benefit, small; grade of recommendation, C) (ACCP, 2006)

Patients with dysphagia should undergo VSE or fiber optic endoscopic evaluation of swallowing (FEES) evaluation of swallow to identify appropriate treatment. (Level of evidence, low; benefit, substantial; grade of recommendation, B) (ACCP, 2006)

Patients with dysphagia should be managed by organized multidisciplinary teams that may include a physician, a nurse, an SLP, a dietitian, and physical and occupational therapists. (Level of evidence, low; benefit, substantial; grade of recommendation, B) (ACCP, 2006)

In patients with dysphagia, VSE or FEES can be useful for determining compensatory strategies enabling patients with dysphagia to safely swallow. (Level of evidence, low; benefit, substantial; grade of recommendation, B) (ACCP, 2006)

In patients with dysphagia, dietary recommendations should be prescribed when indicated, and can be refined by testing with foods and liquids simulating those in a normal diet during the VSE or FEES. (Level of evidence, low; benefit, substantial; grade of recommendation, B) (ACCP, 2006)

A swallow screen should be performed in the first 24 hours after stroke, preferably by the speech language pathologist (Class I, Level of Evidence B). Nurses should be familiar with bedside swallow assessment if a formal evaluation cannot be done within the specified period. Stroke patients should be kept NPA until the screen has been performed (Class I, Level of Evidence B). Further studies of dysphagia in the setting of acute stroke should be performed. (ASA, 2009)

Nurses should be familiar with bedside swallow assessment if a formal evaluation cannot be done within the specified period. Stroke patients should be kept NPA until the screen has been performed. (AHA, 2009)

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*Measure #36 (NQF 0244): Stroke and Stroke Rehabilitation: Rehabilitation Services Ordered

2013 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of patients aged 18 years and older with a diagnosis of ischemic stroke or intracranial hemorrhage for whom occupational, physical, or speech rehabilitation services were ordered at or prior to inpatient discharge OR documentation that no rehabilitation services are indicated at or prior to inpatient discharge

INSTRUCTIONS:
This measure is to be reported for patients under active treatment for ischemic stroke or intracranial hemorrhage a minimum of once during each hospital stay occurring during the reporting period. Part B claims data will be analyzed to determine the hospital stay. If multiple qualifying diagnoses are submitted on the same claim form, only one instance of reporting will be counted. It is anticipated that clinicians who care for patients with a diagnosis of ischemic stroke or intracranial hemorrhage in the hospital setting will submit this measure.

Measure Reporting via Claims:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. G-codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed ICD-9-CM diagnosis codes, CPT codes, and the appropriate G-code. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT codes and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All patients aged 18 years and older with a diagnosis of ischemic stroke or intracranial hemorrhage

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Diagnosis for ischemic stroke or intracranial hemorrhage (ICD-9-CM): 430, 431, 432.0, 432.1, 432.9, 433.01, 433.11, 433.21, 433.31, 433.81, 433.91, 434.01, 434.11, 434.91
Diagnosis for ischemic stroke or intracranial hemorrhage (ICD-9-CM) [REFERENCE ONLY/Not Reportable]: I60.00, I60.01, I60.02, I60.10, I60.11, I60.12, I60.20, I60.21, I60.22, I60.30, I60.31, I60.32, I60.4, I60.50, I60.51, I60.52, I60.6, I60.7, I60.8, I60.9, I61.0, I61.1, I61.2, I61.3, I61.4, I61.5, I61.6, I61.8, I61.9, I62.00, I62.01, I62.02, I62.03, I62.1, I62.9, I63.00, I63.011, I63.012, I63.019, I63.02, I63.031, I63.032, I63.039, I63.09, I63.10, I63.111, I63.112, I63.119, I63.12, I63.131, I63.132, I63.139, I63.19, I63.20, I63.211, I63.212, I63.219, I63.22, I63.231, I63.232, I63.239, I63.29, I63.30, I63.311, I63.312, I63.319, I63.321, I63.322, I63.329, I63.331, I63.332, I63.339, I63.341, I63.342, I63.349, I63.39, I63.40, I63.411, I63.412, I63.419, I63.421, I63.422, I63.429, I63.431, I63.432, I63.439, I63.441, I63.442, I63.449, I63.49, I63.50,

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I63.511, I63.512, I63.519, I63.521, I63.522, I63.529, I63.531, I63.532, I63.539, I63.541, I63.542, I63.549, I63.59, I63.6, I63.8, I63.9
AND
Patient encounter during the reporting period (CPT): 99221, 99222, 99223, 99231, 99232, 99233, 99234, 99235, 99236, 99238, 99239

NUMERATOR:
Patients for whom occupational, physical, or speech rehabilitation services were ordered at or prior to inpatient discharge OR documentation that no rehabilitation services are indicated at or prior to inpatient discharge

Definition:
Rehabilitation Services – Includes services required in order to improve physical, cognitive (including neuropsychological), behavioral, and speech functions.

NUMERATOR NOTE: Rehabilitation order can include one or more of the services listed.

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Rehabilitation Services Ordered
G8699: Rehabilitation services (occupational, physical, or speech) ordered at or prior to discharge
OR
Documentation of Rehabilitation Services not Indicated at or Prior to Discharge
G8700: Rehabilitation services (occupational, physical, or speech) not indicated at or prior to discharge
OR
Rehabilitation Services not Ordered, Reason not Given
G8701: Rehabilitation services were not ordered, reason not given

RATIONALE:
Specifically, stroke rehabilitation programs are provided to optimize neurological recovery, teach compensatory strategies for residual deficits, teach activities of daily living (ADLs) and skills required for community living, and provide psychosocial and medical interventions to manage depression.

CLINICAL RECOMMENDATION STATEMENTS:
The following evidence statements are quoted verbatim from the referenced clinical guidelines.

The use of comprehensive specialized stroke care (stroke units) incorporating rehabilitation is recommended. (Class I, Level of Evidence A) (ASA, 2007)

The use of standardized stroke care order sets is recommended to improve general management. (Class I, Level of Evidence B) (ASA, 2007)

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*Measure #39 (NQF 0046): Screening or Therapy for Osteoporosis for Women Aged 65 Years and Older

2013 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

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

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for patients seen during the reporting period. Female patients aged 65 years and older should have a central DXA measurement ordered or performed at least once since the time they turned 60 years or have pharmacologic therapy prescribed to prevent or treat osteoporosis. There is no diagnosis associated with this measure. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

Measure Reporting via Claims:
CPT codes and patient demographics are used to identify patients who are included in the measure's denominator. G-codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed CPT codes, and the appropriate numerator G-code. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
CPT codes and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All female patients aged 65 years and older

> Denominator Criteria (Eligible Cases):
> Patients aged ≥ 65 years on date of encounter
> AND
> Patient encounter during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215

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

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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

OR

Central DXA Measurement not Ordered or Performed or Pharmacologic Therapy not Prescribed, Reason not Given
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, reason not given

RATIONALE:
Patients with elevated risk for osteoporosis should have the diagnosis of osteoporosis excluded or be on treatment of osteoporosis.

CLINICAL RECOMMENDATION STATEMENTS:
The U.S. Preventive Services Task Force (USPSTF) recommends that women aged 65 and older be screened routinely for osteoporosis. (B Recommendation) (USPSTF)

The USPSTF recommends that routine screening begin at age 60 for women at increased risk for osteoporotic fractures. Use of risk factors, particularly increasing age, low weight, and non-use of estrogen replacement, to screen younger women may identify high-risk women. (B Recommendation) (USPSTF)

BMD measurement should be performed in all women beyond 65 years of age. Dual x-ray absorptiometry of the lumbar spine and proximal femur provides reproducible values at important sites of osteoporosis-associated fracture. These sites are preferred for baseline and serial measurements. (AACE)

The most important risk factors for osteoporosis-related fractures are a prior low-trauma fracture as an adult and a low BMD in patients with or without fractures. (AACE)
BMD testing should be performed on:

- All women aged 65 and older regardless of risk factors
- Younger postmenopausal women with one or more risk factors (other than being white, postmenopausal, and female)
- Postmenopausal women who present with fractures (NQF)

The decision to test for BMD should be based on an individual's risk profile. Testing is never indicated unless the results could influence a treatment decision. (NQF)

Markers of greater osteoporosis and fracture risk include older age, hypogonadism, corticosteroid therapy, and established cirrhosis. (Level B Evidence) (NQF)

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The single most powerful predictor of a future osteoporotic fracture is the presence of previous such fractures. (NQF)

Pharmacologic therapy should be initiated to reduce fracture risk in women with:

- BMD T-scores below - 2.0 by central dual x-ray absorptiometry (DXA) with no risk factors
- BMD T-scores below - 1.5 by central dual x-ray absorptiometry (DXA) with one or more risk factors
- A prior vertebral or hip fracture (NQF)

The decision to measure bone density should follow an individualized approach. It should be considered when it will help the patient decide whether to institute treatment to prevent osteoporotic fracture. It should also be considered in patients receiving glucocorticoid therapy for 2 months or more and patients with other conditions that place them at high risk for osteoporotic fracture. (NIH)

The most commonly used measurement to diagnose osteoporosis and predict fracture risk is based on assessment of BMD by dual-energy X-ray absorptiometry (DXA). (NIH)

Measurements of BMD made at the hip predict hip fracture better than measurements made at other sites while BMD measurement at the spine predicts spine fracture better than measures at other sites. (NIH)

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* Measure #40 (NQF 0048): Osteoporosis: Management Following Fracture of Hip, Spine or Distal Radius for Men and Women Aged 50 Years and Older

2013 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of patients aged 50 years and older with fracture of the hip, spine, or distal radius who had a central dual-energy X-ray absorptiometry (DXA) measurement ordered or performed or pharmacologic therapy prescribed

INSTRUCTIONS:
This measure is to be reported after each occurrence of a fracture during the reporting period. It is anticipated that clinicians who treat hip, spine or distal radial fractures will submit this measure. Each occurrence of a fracture is identified by either an ICD-9-CM diagnosis code for fracture or osteoporosis and a CPT service code OR an ICD-9-CM diagnosis code for a fracture or osteoporosis and a CPT procedure code for surgical treatment of fractures.

Patients with a fracture of the hip, spine, or distal radius should have a central DXA measurement ordered or performed or pharmacologic therapy prescribed. The management (DXA ordered or performed or pharmacologic therapy prescribed) should occur within three months of the initial visit with the reporting clinician following the fracture. If multiple fractures occurring on the same date of service are submitted on the same claim form, only one instance of reporting will be counted. Claims data will be analyzed to determine unique occurrences. Patients with documentation of prior central DXA measurement or already receiving pharmacologic therapy would automatically meet the intent of this measure.

Measure Reporting via Claims:
ICD-9-CM diagnosis codes, CPT or HCPCS codes, and patient demographics are used to identify patients who are included in the measure's denominator. CPT Category II codes and/or G-codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed ICD-9-CM diagnosis codes, CPT or HCPCS codes, and the appropriate CPT Category II code OR G-code OR the CPT Category II code with the modifier. The modifiers allowed for this measure are: 1P- medical reasons, 2P- patient reasons, 3P- system reasons, 8P- reason not otherwise specified. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT codes and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All patients aged 50 years and older with a fracture of the hip, spine, or distal radius

Eligible cases are determined, and must be reported, if either of the following conditions are met:

Option 1 - Denominator Criteria (Eligible Cases):
Patients aged ≥ 50 years on date of encounter
AND

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Diagnosis for hip, spine, or distal radial fracture (ICD-9-CM): 805.00, 805.01, 805.02, 805.03, 805.04, 805.05, 805.06, 805.07, 805.08, 805.2, 805.4, 805.6, 805.8, 813.40, 813.41, 813.42, 813.44, 813.45, 813.47, 813.50, 813.51, 813.52, 813.54, 820.00, 820.01, 820.02, 820.03, 820.09, 820.10, 820.11, 820.12, 820.13, 820.19, 820.20, 820.21, 820.22, 820.30, 820.31, 820.32, 820.8, 820.9
Diagnosis for hip, spine, or distal radial fracture (ICD-10-CM) [REFERENCE ONLY/Not Reportable]: M81.0, M81.6, M81.8, S12.000A, S12.000B, S12.000D, S12.000G, S12.000K, S12.000S, S12.001A, S12.001B, S12.001D, S12.001G, S12.001K, S12.001S, S12.01XA, S12.01XB, S12.01XD, S12.01XG, S12.01XK, S12.01XS, S12.02XA, S12.02XB, S12.02XD, S12.02XG, S12.02XK, S12.02XS, S12.030A, S12.030B, S12.030D, S12.030G, S12.030K, S12.030S, S12.031A, S12.031B, S12.031D, S12.031G, S12.031K, S12.031S, S12.040A, S12.040B, S12.040D, S12.040G, S12.040K, S12.040S, S12.041A, S12.041B, S12.041D, S12.041G, S12.041K, S12.041S, S12.090A, S12.090B, S12.090D, S12.090G, S12.090K, S12.090S, S12.091A, S12.091B, S12.091D, S12.091G, S12.091K, S12.091S, S12.100A, S12.100B, S12.100D, S12.100G, S12.100K, S12.100S, S12.101A, S12.101B, S12.101D, S12.101G, S12.101K, S12.101S, S12.110A, S12.110B, S12.110D, S12.110G, S12.110K, S12.110S, S12.111A, S12.111B, S12.111D, S12.111G, S12.111K, S12.111S, S12.112A, S12.112B, S12.112D, S12.112G, S12.112K, S12.112S, S12.120A, S12.120B, S12.120D, S12.120G, S12.120K, S12.120S, S12.121A, S12.121B, S12.121D, S12.121G, S12.121K, S12.121S, S12.130A, S12.130B, S12.130D, S12.130G, S12.130K, S12.130S, S12.131A, S12.131B, S12.131D, S12.131G, S12.131K, S12.131S, S12.14XA, S12.14XB, S12.14XD, S12.14XG, S12.14XK, S12.14XS, S12.150A, S12.150B, S12.150D, S12.150G, S12.150K, S12.150S, S12.151A, S12.151B, S12.151D, S12.151G, S12.151K, S12.151S, S12.190A, S12.190B, S12.190D, S12.190G, S12.190K, S12.190S, S12.191A, S12.191B, S12.191D, S12.191G, S12.191K, S12.191S, S12.200A, S12.200B, S12.200D, S12.200G, S12.200K, S12.200S, S12.201A, S12.201B, S12.201D, S12.201G, S12.201K, S12.201S, S12.230A, S12.230B, S12.230D, S12.230G, S12.230K, S12.230S, S12.231A, S12.231B, S12.231D, S12.231G, S12.231K, S12.231S, S12.24XA, S12.24XB, S12.24XD, S12.24XG, S12.24XK, S12.24XS, S12.250A, S12.250B, S12.250D, S12.250G, S12.250K, S12.250S, S12.251A, S12.251B, S12.251D, S12.251G, S12.251K, S12.251S, S12.290A, S12.290B, S12.290D, S12.290G, S12.290K, S12.290S, S12.291A, S12.291B, S12.291D, S12.291G, S12.291K, S12.291S, S12.300A, S12.300B, S12.300D, S12.300G, S12.300K, S12.300S, S12.301A, S12.301B, S12.301D, S12.301G, S12.301K, S12.301S, S12.330A, S12.330B, S12.330D, S12.330G, S12.330K, S12.330S, S12.331A, S12.331B, S12.331D, S12.331G, S12.331K, S12.331S, S12.34XA, S12.34XB, S12.34XD, S12.34XG, S12.34XK, S12.34XS, S12.350A, S12.350B, S12.350D, S12.350G, S12.350K, S12.350S, S12.351A, S12.351B, S12.351D, S12.351G, S12.351K, S12.351S, S12.390A, S12.390B, S12.390D, S12.390G, S12.390K, S12.390S, S12.391A, S12.391B, S12.391D, S12.391G, S12.391K, S12.391S, S12.400A, S12.400B, S12.400D, S12.400G, S12.400K, S12.400S, S12.401A, S12.401B, S12.401D, S12.401G, S12.401K, S12.401S, S12.430A, S12.430B, S12.430D, S12.430G, S12.430K, S12.430S, S12.431A, S12.431B, S12.431D, S12.431G, S12.431K, S12.431S, S12.44XA, S12.44XB, S12.44XD, S12.44XG, S12.44XK, S12.44XS, S12.450A, S12.450B, S12.450D, S12.450G, S12.450K, S12.450S, S12.451A, S12.451B, S12.451D, S12.451G, S12.451K, S12.451S, S12.490A, S12.490B, S12.490D, S12.490G, S12.490K, S12.490S, S12.491A, S12.491B, S12.491D, S12.491G, S12.491K, S12.491S, S12.500A, S12.500B, S12.500D, S12.500G, S12.500K, S12.500S, S12.501A, S12.501B, S12.501D, S12.501G, S12.501K, S12.501S, S12.530A, S12.530B, S12.530D, S12.530G, S12.530K, S12.530S, S12.531A, S12.531B, S12.531D, S12.531G, S12.531K, S12.531S, S12.54XA, S12.54XB, S12.54XD, S12.54XG, S12.54XK, S12.54XS, S12.550A, S12.550B, S12.550D, S12.550G, S12.550K, S12.550S, S12.551A, S12.551B, S12.551D, S12.551G, S12.551K, S12.551S, S12.590A, S12.590B, S12.590D, S12.590G, S12.590K, S12.590S, S12.591A, S12.591B, S12.591D, S12.591G, S12.591K, S12.591S, S12.600A, S12.600B, S12.600D, S12.600G, S12.600K, S12.600S, S12.601A, S12.601B, S12.601D, S12.601G, S12.601K, S12.601S, S12.630A, S12.630B, S12.630D, S12.630G, S12.630K, S12.630S, S12.631A, S12.631B, S12.631D, S12.631G, S12.631K, S12.631S, S12.64XA, S12.64XB, S12.64XD, S12.64XG, S12.64XK, S12.64XS, S12.650A, S12.650B, S12.650D, S12.650G, S12.650K, S12.650S, S12.651A, S12.651B, S12.651D, S12.651G, S12.651K, S12.651S, S12.690A, S12.690B, S12.690D, S12.690G, S12.690K, S12.690S, S12.691A, S12.691B, S12.691D, S12.691G,

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S12.691K, S12.691S, S12.8XXA, S12.8XXD, S12.8XXS, S12.9XXA, S12.9XXD, S12.9XXS, S22.000A, S22.000B, S22.000D, S22.000G, S22.000K, S22.000S, S22.001B, S22.001D, S22.001G, S22.001K, S22.001S, S22.002A, S22.002B, S22.002D, S22.002G, S22.002K, S22.002S, S22.008A, S22.008B, S22.008D, S22.008G, S22.008K, S22.008S, S22.009A, S22.009B, S22.009D, S22.009G, S22.009K, S22.009S, S22.010A, S22.010B, S22.010D, S22.010G, S22.010K, S22.010S, S22.011A, S22.011B, S22.011D, S22.011G, S22.011K, S22.011S, S22.012A, S22.012B, S22.012D, S22.012G, S22.012K, S22.012S, S22.018A, S22.018B, S22.018D, S22.018G, S22.018K, S22.018S, S22.019A, S22.019B, S22.019D, S22.019G, S22.019K, S22.019S, S22.020A, S22.020B, S22.020D, S22.020G, S22.020K, S22.020S, S22.021A, S22.021B, S22.021D, S22.021G, S22.021K, S22.021S, S22.022A, S22.022B, S22.022D, S22.022G, S22.022K, S22.022S, S22.028A, S22.028B, S22.028D, S22.028G, S22.028K, S22.028S, S22.029A, S22.029B, S22.029D, S22.029G, S22.029K, S22.029S, S22.030A, S22.030B, S22.030D, S22.030G, S22.030K, S22.030S, S22.031A, S22.031B, S22.031D, S22.031G, S22.031K, S22.031S, S22.032A, S22.032B, S22.032D, S22.032G, S22.032K, S22.032S, S22.038A, S22.038B, S22.038D, S22.038G, S22.038K, S22.038S, S22.039A, S22.039B, S22.039D, S22.039G, S22.039K, S22.039S, S22.040A, S22.040B, S22.040D, S22.040G, S22.040K, S22.040S, S22.041A, S22.041B, S22.041D, S22.041G, S22.041K, S22.041S, S22.042A, S22.042B, S22.042D, S22.042G, S22.042K, S22.042S, S22.048A, S22.048B, S22.048D, S22.048G, S22.048K, S22.048S, S22.049A, S22.049B, S22.049D, S22.049G, S22.049K, S22.049S, S22.050A, S22.050B, S22.050D, S22.050G, S22.050K, S22.050S, S22.051A, S22.051B, S22.051D, S22.051G, S22.051K, S22.051S, S22.052A, S22.052B, S22.052D, S22.052G, S22.052K, S22.052S, S22.058A, S22.058B, S22.058D, S22.058G, S22.058K, S22.058S, S22.059A, S22.059B, S22.059D, S22.059G, S22.059K, S22.059S, S22.060A, S22.060B, S22.060D, S22.060G, S22.060K, S22.060S, S22.061A, S22.061B, S22.061D, S22.061G, S22.061K, S22.061S, S22.062A, S22.062B, S22.062D, S22.062G, S22.062K, S22.062S, S22.068A, S22.068B, S22.068D, S22.068G, S22.068K, S22.068S, S22.069A, S22.069B, S22.069D, S22.069G, S22.069K, S22.069S, S22.070A, S22.070B, S22.070D, S22.070G, S22.070K, S22.070S, S22.071A, S22.071B, S22.071D, S22.071G, S22.071K, S22.071S, S22.072A, S22.072B, S22.072D, S22.072G, S22.072K, S22.072S, S22.078A, S22.078B, S22.078D, S22.078G, S22.078K, S22.078S, S22.079A, S22.079B, S22.079D, S22.079G, S22.079K, S22.079S, S22.080A, S22.080B, S22.080D, S22.080G, S22.080K, S22.080S, S22.081A, S22.081B, S22.081D, S22.081G, S22.081K, S22.081S, S22.082A, S22.082B, S22.082D, S22.082G, S22.082K, S22.082S, S22.088A, S22.088B, S22.088D, S22.088G, S22.088K, S22.088S, S22.089A, S22.089B, S22.089D, S22.089G, S22.089K, S22.089S, S32.000A, S32.000B, S32.000D, S32.000G, S32.000K, S32.000S, S32.001A, S32.001B, S32.001D, S32.001G, S32.001K, S32.001S, S32.002A, S32.002B, S32.002D, S32.002G, S32.002K, S32.002S, S32.008A, S32.008B, S32.008D, S32.008G, S32.008K, S32.008S, S32.009A, S32.009B, S32.009D, S32.009G, S32.009K, S32.009S, S32.010A, S32.010B, S32.010D, S32.010G, S32.010K, S32.010S, S32.011A, S32.011B, S32.011D, S32.011G, S32.011K, S32.011S, S32.012A, S32.012B, S32.012D, S32.012G, S32.012K, S32.012S, S32.018A, S32.018B, S32.018D, S32.018G, S32.018K, S32.018S, S32.019A, S32.019B, S32.019D, S32.019G, S32.019K, S32.019S, S32.020A, S32.020B, S32.020D, S32.020G, S32.020K, S32.020S, S32.021A, S32.021B, S32.021D, S32.021G, S32.021K, S32.021S, S32.022A, S32.022B, S32.022D, S32.022G, S32.022K, S32.022S, S32.028A, S32.028B, S32.028D, S32.028G, S32.028K, S32.028S, S32.029A, S32.029B, S32.029D, S32.029G, S32.029K, S32.029S, S32.030A, S32.030B, S32.030D, S32.030G, S32.030K, S32.030S, S32.031A, S32.031B, S32.031D, S32.031G, S32.031K, S32.031S, S32.032A, S32.032B, S32.032D, S32.032G, S32.032K, S32.032S, S32.038A, S32.038B, S32.038D, S32.038G, S32.038K, S32.038S, S32.039A, S32.039B, S32.039D, S32.039G, S32.039K, S32.039S, S32.040A, S32.040B, S32.040D, S32.040G, S32.040K, S32.040S, S32.041A, S32.041B, S32.041D, S32.041G, S32.041K, S32.041S, S32.042A, S32.042B, S32.042D, S32.042G, S32.042K, S32.042S, S32.048A, S32.048B, S32.048D, S32.048G, S32.048K, S32.048S, S32.049A, S32.049B, S32.049D, S32.049G, S32.049K, S32.049S, S32.050A, S32.050B, S32.050D, S32.050G, S32.050K, S32.050S, S32.051A, S32.051B, S32.051D, S32.051G, S32.051K, S32.051S, S32.052A, S32.052B, S32.052D, S32.052G, S32.052K, S32.052S, S32.058A, S32.058B, S32.058D, S32.058G, S32.058K, S32.058S, S32.059A, S32.059B, S32.059D, S32.059G, S32.059K, S32.059S, S32.10XA, S32.10XB,

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S72.114M, S72.114N, S72.114P, S72.114Q, S72.114R, S72.114S, S72.115A, S72.115B, S72.115C, S72.115D, S72.115E, S72.115F, S72.115G, S72.115H, S72.115J, S72.115K, S72.115M, S72.115N, S72.115P, S72.115Q, S72.115R, S72.115S, S72.116A, S72.116B, S72.116C, S72.116D, S72.116E, S72.116F, S72.116G, S72.116H, S72.116J, S72.116K, S72.116M, S72.116N, S72.116P, S72.116Q, S72.116R, S72.116S, S72.121A, S72.121B, S72.121C, S72.121D, S72.121E, S72.121F, S72.121G, S72.121H, S72.121J, S72.121K, S72.121M, S72.121N, S72.121P, S72.121Q, S72.121R, S72.121S, S72.122A, S72.122A, S72.122B, S72.122C, S72.122D, S72.122E, S72.122F, S72.122G, S72.122H, S72.122J, S72.122K, S72.122M, S72.122N, S72.122P, S72.122Q, S72.122R, S72.122S, S72.123A, S72.123B, S72.123C, S72.123D, S72.123E, S72.123F, S72.123G, S72.123H, S72.123J, S72.123K, S72.123M, S72.123N, S72.123P, S72.123Q, S72.123R, S72.123S, S72.124A, S72.124B, S72.124C, S72.124D, S72.124E, S72.124F, S72.124G, S72.124H, S72.124J, S72.124K, S72.124M, S72.124N, S72.124P, S72.124Q, S72.124R, S72.124S, S72.125A, S72.125B, S72.125C, S72.125D, S72.125E, S72.125F, S72.125G, S72.125H, S72.125J, S72.125K, S72.125M, S72.125N, S72.125P, S72.125Q, S72.125R, S72.125S, S72.126A, S72.126B, S72.126C, S72.126D, S72.126E, S72.126F, S72.126G, S72.126H, S72.126J, S72.126K, S72.126M, S72.126N, S72.126P, S72.126Q, S72.126R, S72.126S, S72.131A, S72.131B, S72.131C, S72.131D, S72.131E, S72.131F, S72.131G, S72.131H, S72.131J, S72.131K, S72.131M, S72.131N, S72.131P, S72.131Q, S72.131R, S72.131S, S72.132A, S72.132B, S72.132C, S72.132D, S72.132E, S72.132F, S72.132G, S72.132H, S72.132J, S72.132K, S72.132M, S72.132N, S72.132P, S72.132Q, S72.132R, S72.132S, S72.133A, S72.133B, S72.133C, S72.133D, S72.133E, S72.133F, S72.133G, S72.133H, S72.133J, S72.133K, S72.133M, S72.133N, S72.133P, S72.133Q, S72.133R, S72.133S, S72.134A, S72.134B, S72.134C, S72.134D, S72.134E, S72.134F, S72.134G, S72.134H, S72.134J, S72.134K, S72.134M, S72.134N, S72.134P, S72.134Q, S72.134R, S72.134S, S72.135A, S72.135B, S72.135C, S72.135D, S72.135E, S72.135F, S72.135G, S72.135H, S72.135J, S72.135K, S72.135M, S72.135N, S72.135P, S72.135Q, S72.135R, S72.135S, S72.136A, S72.136B, S72.136C, S72.136D, S72.136E, S72.136F, S72.136G, S72.136H, S72.136J, S72.136K, S72.136M, S72.136N, S72.136P, S72.136Q, S72.136R, S72.136S, S72.141A, S72.141B, S72.141C, S72.141D, S72.141E, S72.141F, S72.141G, S72.141H, S72.141J, S72.141K, S72.141M, S72.141N, S72.141P, S72.141Q, S72.141R, S72.141S, S72.142A, S72.142B, S72.142C, S72.142D, S72.142E, S72.142F, S72.142G, S72.142H, S72.142J, S72.142K, S72.142M, S72.142N, S72.142P, S72.142Q, S72.142R, S72.142S, S72.143A, S72.143B, S72.143C, S72.143D, S72.143E, S72.143F, S72.143G, S72.143H, S72.143J, S72.143K, S72.143M, S72.143N, S72.143P, S72.143Q, S72.143R, S72.143S, S72.144A, S72.144B, S72.144C, S72.144D, S72.144E, S72.144F, S72.144G, S72.144H, S72.144J, S72.144K, S72.144M, S72.144N, S72.144P, S72.144Q, S72.144R, S72.144S, S72.145A, S72.145B, S72.145C, S72.145D, S72.145E, S72.145F, S72.145G, S72.145H, S72.145J, S72.145K, S72.145M, S72.145N, S72.145P, S72.145Q, S72.145R, S72.145S, S72.146A, S72.146B, S72.146C, S72.146D, S72.146E, S72.146F, S72.146G, S72.146H, S72.146J, S72.146K, S72.146M, S72.146N, S72.146P, S72.146Q, S72.146R, S72.146S, S72.21XA, S72.21XB, S72.21XC, S72.21XD, S72.21XE, S72.21XF, S72.21XG, S72.21XH, S72.21XJ, S72.21XK, S72.21XM, S72.21XN, S72.21XP, S72.21XQ, S72.21XR, S72.21XS, S72.22XA, S72.22XB, S72.22XC, S72.22XD, S72.22XE, S72.22XF, S72.22XG, S72.22XH, S72.22XJ, S72.22XK, S72.22XM, S72.22XN, S72.22XP, S72.22XQ, S72.22XR, S72.22XS, S72.23XA, S72.23XB, S72.23XC, S72.23XD, S72.23XE, S72.23XF, S72.23XG, S72.23XH, S72.23XJ, S72.23XK, S72.23XM, S72.23XN, S72.23XP, S72.23XQ, S72.23XR, S72.23XS, S72.24XA, S72.24XB, S72.24XC, S72.24XD, S72.24XE, S72.24XF, S72.24XG, S72.24XH, S72.24XJ, S72.24XK, S72.24XM, S72.24XN, S72.24XP, S72.24XQ, S72.24XR, S72.24XS, S72.25XA, S72.25XB, S72.25XC, S72.25XD, S72.25XE, S72.25XF, S72.25XG, S72.25XH, S72.25XJ, S72.25XK, S72.25XM, S72.25XN, S72.25XP, S72.25XQ, S72.25XR, S72.25XS, S72.26XA, S72.26XB, S72.26XC, S72.26XD, S72.26XE, S72.26XF, S72.26XG, S72.26XH, S72.26XJ, S72.26XK, S72.26XM, S72.26XN, S72.26XP, S72.26XQ, S72.26XR, S72.26XS, S72.336J, S72.336K, S72.336M, S72.336N, S72.336P, S72.336Q, S72.336R, S72.336S, S52.549F, S52.549G, S52.549H, S52.549J, S52.549K, S52.549M, S52.549N, S52.549P, S52.549Q, S52.549R, S52.549S, S52.551B, S52.551C, S52.551D, S52.551E, S52.551F, S52.551G, S52.551H, S52.551J, S52.551K, S52.551M, S52.551N, S52.551P, S52.551Q, S52.551R, S52.551S, S52.552B, S52.552C,

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S52.552D, S52.552E, S52.552F, S52.552G, S52.552H, S52.552J, S52.552K, S52.552M, S52.552N, S52.552P, S52.552Q, S52.552R, S52.552S, S52.559B, S52.559C, S52.559D, S52.559E, S52.559F, S52.559G, S52.559H, S52.559J, S52.559K, S52.559M, S52.559N, S52.559P, S52.559Q, S52.559R, S52.559S, S52.561B, S52.561C, S52.561D, S52.561E, S52.561F, S52.561G, S52.561H, S52.561J, S52.561K, S52.561M, S52.561N, S52.561P, S52.561Q, S52.561R, S52.561S, S52.562B, S52.562C, S52.562D, S52.562E, S52.562F, S52.562G, S52.562H, S52.562J, S52.562K, S52.562M, S52.562N, S52.562P, S52.562Q, S52.562R, S52.562S, S52.569B, S52.569C, S52.569D, S52.569E, S52.569F, S52.569G, S52.569H, S52.569J, S52.569K, S52.569M, S52.569N, S52.569P, S52.569Q, S52.569R, S52.569S, S52.571B, S52.571C, S52.571D, S52.571E, S52.571F, S52.571G, S52.571H, S52.571J, S52.571K, S52.571M, S52.571N, S52.571P, S52.571Q, S52.571R, S52.571S, S52.572B, S52.572C, S52.572D, S52.572E, S52.572F, S52.572G, S52.572H, S52.572J, S52.572K, S52.572M, S52.572N, S52.572P, S52.572Q, S52.572R, S52.572S, S52.579B, S52.579C, S52.579D, S52.579E, S52.579F, S52.579G, S52.579H, S52.579J, S52.579K, S52.579M, S52.579N, S52.579P, S52.579Q, S52.579R, S52.579S, S52.591B, S52.591C, S52.591D, S52.591E, S52.591F, S52.591G, S52.591H, S52.591J, S52.591K, S52.591M, S52.591N, S52.591P, S52.591Q, S52.591R, S52.591S, S52.592B, S52.592C, S52.592D, S52.592E, S52.592F, S52.592G, S52.592H, S52.592J, S52.592K, S52.592M, S52.592N, S52.592P, S52.592Q, S52.592R, S52.592S, S52.599B, S52.599C, S52.599D, S52.599E, S52.599F, S52.599G, S52.599H, S52.599J, S52.599K, S52.599M, S52.599N, S52.599P, S52.599Q, S52.599R, S52.599S, S22.001A, S52.549F, S52.549G, S52.549H, S52.549J, S52.549K, S52.549M, S52.549N, S52.549P, S52.549Q, S52.549R, S52.549S, S52.551B, S52.551C, S52.551D, S52.551E, S52.551F, S52.551G, S52.551H, S52.551J, S52.551K, S52.551M, S52.551N, S52.551P, S52.551Q, S52.551R, S52.551S, S52.552B, S52.552C, S52.552D, S52.552E, S52.552F, S52.552G, S52.552H, S52.552J, S52.552K, S52.552M, S52.552N, S52.552P, S52.552Q, S52.552R, S52.552S, S52.559B, S52.559C, S52.559D, S52.559E, S52.559F, S52.559G, S52.559H, S52.559J, S52.559K, S52.559M, S52.559N, S52.559P, S52.559Q, S52.559R, S52.559S, S52.561B, S52.561C, S52.561D, S52.561E, S52.561F, S52.561G, S52.561H, S52.561J, S52.561K, S52.561M, S52.561N, S52.561P, S52.561Q, S52.561R, S52.561S, S52.562B, S52.562C, S52.562D, S52.562E, S52.562F, S52.562G, S52.562H, S52.562J, S52.562K, S52.562M, S52.562N, S52.562P, S52.562Q, S52.562R, S52.562S, S52.569B, S52.569C, S52.569D, S52.569E, S52.569F, S52.569G, S52.569H, S52.569J, S52.569K, S52.569M, S52.569N, S52.569P, S52.569Q, S52.569R, S52.569S, S52.571B, S52.571C, S52.571D, S52.571E, S52.571F, S52.571G, S52.571H, S52.571J, S52.571K, S52.571M, S52.571N, S52.571P, S52.571Q, S52.571R, S52.571S, S52.572B, S52.572C, S52.572D, S52.572E, S52.572F, S52.572G, S52.572H, S52.572J, S52.572K, S52.572M, S52.572N, S52.572P, S52.572Q, S52.572R, S52.572S, S52.579B, S52.579C, S52.579D, S52.579E, S52.579F, S52.579G, S52.579H, S52.579J, S52.579K, S52.579M, S52.579N, S52.579P, S52.579Q, S52.579R, S52.579S, S52.591B, S52.591C, S52.591D, S52.591E, S52.591F, S52.591G, S52.591H, S52.591J, S52.591K, S52.591M, S52.591N, S52.591P, S52.591Q, S52.591R, S52.591S, S52.592B, S52.592C, S52.592D, S52.592E, S52.592F, S52.592G, S52.592H, S52.592J, S52.592K, S52.592M, S52.592N, S52.592P, S52.592Q, S52.592R, S52.592S, S52.599B, S52.599C, S52.599D, S52.599E, S52.599F, S52.599G, S52.599H, S52.599J, S52.599K, S52.599M, S52.599N, S52.599P, S52.599Q, S52.599R, S52.599S, S22.001A

AND

Patient encounter during the reporting period (CPT or HCPCS) - Service codes: 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, G0402

OR

Option 2 - Denominator Criteria (Eligible Cases):

Patients aged ≥ 50 years on date of encounter

AND

Diagnosis for hip, spine, or distal radial fracture (ICD-9-CM): 805.00, 805.01, 805.02, 805.03, 805.04, 805.05, 805.06, 805.07, 805.08, 805.2, 805.4, 805.6, 805.8, 813.40, 813.41, 813.42, 813.44, 813.45,

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813.47, 813.50, 813.51, 813.52, 813.54, 820.00, 820.01, 820.02, 820.03, 820.09, 820.10, 820.11, 820.12, 820.13, 820.19, 820.20, 820.21, 820.22, 820.30, 820.31, 820.32, 820.8, 820.9

Diagnosis for hip, spine, or distal radial fracture (ICD-10-CM) [REFERENCE ONLY/Not Reportable]: M81.0, M81.6, M81.8, S12.000A, S12.000B, S12.000D, S12.000G, S12.000K, S12.000S, S12.001A, S12.001B, S12.001D, S12.001G, S12.001K, S12.001S, S12.01XA, S12.01XB, S12.01XD, S12.01XG, S12.01XK, S12.01XS, S12.02XA, S12.02XB, S12.02XD, S12.02XG, S12.02XK, S12.02XS, S12.030A, S12.030B, S12.030D, S12.030G, S12.030K, S12.030S, S12.031A, S12.031B, S12.031D, S12.031G, S12.031K, S12.031S, S12.040A, S12.040B, S12.040D, S12.040G, S12.040K, S12.040S, S12.041A, S12.041B, S12.041D, S12.041G, S12.041K, S12.041S, S12.090A, S12.090B, S12.090D, S12.090G, S12.090K, S12.090S, S12.091A, S12.091B, S12.091D, S12.091G, S12.091K, S12.091S, S12.100A, S12.100B, S12.100D, S12.100G, S12.100K, S12.100S, S12.101A, S12.101B, S12.101D, S12.101G, S12.101K, S12.101S, S12.110A, S12.110B, S12.110D, S12.110G, S12.110K, S12.110S, S12.111A, S12.111B, S12.111D, S12.111G, S12.111K, S12.111S, S12.112A, S12.112B, S12.112D, S12.112G, S12.112K, S12.112S, S12.120A, S12.120B, S12.120D, S12.120G, S12.120K, S12.120S, S12.121A, S12.121B, S12.121D, S12.121G, S12.121K, S12.121S, S12.130A, S12.130B, S12.130D, S12.130G, S12.130K, S12.130S, S12.131A, S12.131B, S12.131D, S12.131G, S12.131K, S12.131S, S12.14XA, S12.14XB, S12.14XD, S12.14XG, S12.14XK, S12.14XS, S12.150A, S12.150B, S12.150D, S12.150G, S12.150K, S12.150S, S12.151A, S12.151B, S12.151D, S12.151G, S12.151K, S12.151S, S12.190A, S12.190B, S12.190D, S12.190G, S12.190K, S12.190S, S12.191A, S12.191B, S12.191D, S12.191G, S12.191K, S12.191S, S12.200A, S12.200B, S12.200D, S12.200G, S12.200K, S12.200S, S12.201A, S12.201B, S12.201D, S12.201G, S12.201K, S12.201S, S12.230A, S12.230B, S12.230D, S12.230G, S12.230K, S12.230S, S12.231A, S12.231B, S12.231D, S12.231G, S12.231K, S12.231S, S12.24XA, S12.24XB, S12.24XD, S12.24XG, S12.24XK, S12.24XS, S12.250A, S12.250B, S12.250D, S12.250G, S12.250K, S12.250S, S12.251A, S12.251B, S12.251D, S12.251G, S12.251K, S12.251S, S12.290A, S12.290B, S12.290D, S12.290G, S12.290K, S12.290S, S12.291A, S12.291B, S12.291D, S12.291G, S12.291K, S12.291S, S12.300A, S12.300B, S12.300D, S12.300G, S12.300K, S12.300S, S12.301A, S12.301B, S12.301D, S12.301G, S12.301K, S12.301S, S12.330A, S12.330B, S12.330D, S12.330G, S12.330K, S12.330S, S12.331A, S12.331B, S12.331D, S12.331G, S12.331K, S12.331S, S12.34XA, S12.34XB, S12.34XD, S12.34XG, S12.34XK, S12.34XS, S12.350A, S12.350B, S12.350D, S12.350G, S12.350K, S12.350S, S12.351A, S12.351B, S12.351D, S12.351G, S12.351K, S12.351S, S12.390A, S12.390B, S12.390D, S12.390G, S12.390K, S12.390S, S12.391A, S12.391B, S12.391D, S12.391G, S12.391K, S12.391S, S12.400A, S12.400B, S12.400D, S12.400G, S12.400K, S12.400S, S12.401A, S12.401B, S12.401D, S12.401G, S12.401K, S12.401S, S12.430A, S12.430B, S12.430D, S12.430G, S12.430K, S12.430S, S12.431A, S12.431B, S12.431D, S12.431G, S12.431K, S12.431S, S12.44XA, S12.44XB, S12.44XD, S12.44XG, S12.44XK, S12.44XS, S12.450A, S12.450B, S12.450D, S12.450G, S12.450K, S12.450S, S12.451A, S12.451B, S12.451D, S12.451G, S12.451K, S12.451S, S12.490A, S12.490B, S12.490D, S12.490G, S12.490K, S12.490S, S12.491A, S12.491B, S12.491D, S12.491G, S12.491K, S12.491S, S12.500A, S12.500B, S12.500D, S12.500G, S12.500K, S12.500S, S12.501A, S12.501B, S12.501D, S12.501G, S12.501K, S12.501S, S12.530A, S12.530B, S12.530D, S12.530G, S12.530K, S12.530S, S12.531A, S12.531B, S12.531D, S12.531G, S12.531K, S12.531S, S12.54XA, S12.54XB, S12.54XD, S12.54XG, S12.54XK, S12.54XS, S12.550A, S12.550B, S12.550D, S12.550G, S12.550K, S12.550S, S12.551A, S12.551B, S12.551D, S12.551G, S12.551K, S12.551S, S12.590A, S12.590B, S12.590D, S12.590G, S12.590K, S12.590S, S12.591A, S12.591B, S12.591D, S12.591G, S12.591K, S12.591S, S12.600A, S12.600B, S12.600D, S12.600G, S12.600K, S12.600S, S12.601A, S12.601B, S12.601D, S12.601G, S12.601K, S12.601S, S12.630A, S12.630B, S12.630D, S12.630G, S12.630K, S12.630S, S12.631A, S12.631B, S12.631D, S12.631G, S12.631K, S12.631S, S12.64XA, S12.64XB, S12.64XD, S12.64XG, S12.64XK, S12.64XS, S12.650A, S12.650B, S12.650D, S12.650G, S12.650K, S12.650S, S12.651A, S12.651B, S12.651D, S12.651G, S12.651K, S12.651S, S12.690A, S12.690B, S12.690D, S12.690G, S12.690K, S12.690S, S12.691A, S12.691B, S12.691D, S12.691G, S12.691K, S12.691S, S12.8XXA, S12.8XXD, S12.8XXS, S12.9XXA, S12.9XXD, S12.9XXS, S22.000A, S22.000B, S22.000D, S22.000G, S22.000K, S22.000S, S22.001B, S22.001D, S22.001G, S22.001K,

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AND

Patient encounter during the reporting period (CPT) - Procedure codes: 22305, 22310, 22315, 22318, 22319, 22325, 22326, 22327, 22520, 22521, 22523, 22524, 25600, 25605, 25606, 25607, 25608, 25609, 27230, 27232, 27235, 27236, 27238, 27240, 27244, 27245, 27246, 27248

NUMERATOR:

Patients who had a central DXA measurement ordered or performed or pharmacologic therapy prescribed

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

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hormone therapy), parathyroid hormone [PTH (1-34), teriparatide], and selective estrogen receptor modules or SERMs (raloxifene).
Prescribed – May include prescription given to the patient for treatment of osteoporosis (as listed above) at one or more encounters during the reporting period, or documentation that patient is already taking pharmacologic therapy for osteoporosis, as documented in the current medical list.

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Central DXA Measurement Ordered or Results Documented or Pharmacologic Therapy Prescribed
CPT II 3096F: Central Dual-energy X-Ray Absorptiometry (DXA) ordered
OR
CPT II 3095F: Central Dual-energy X-Ray Absorptiometry (DXA) results documented
OR
G8633: Pharmacologic therapy (other than minerals/vitamins) for osteoporosis prescribed

OR

Central DXA Measurement not Ordered or Results not Documented for Medical, Patient, or System Reasons
Append a modifier (1P, 2P or 3P) to CPT Category II codes 3096F or 3095F to report documented circumstances that appropriately exclude patients from the denominator.
3096F or 3095F *with* 1P: Documentation of medical reason(s) for not ordering or performing a central dual energy X-ray absorptiometry (DXA) measurement
3096F or 3095F *with* 2P: Documentation of patient reason(s) for not ordering or performing a central dual energy X-ray absorptiometry (DXA) measurement
3096F or 3095F *with* 3P: Documentation of system reason(s) for not ordering or performing a central dual energy X-ray absorptiometry (DXA) measurement
OR
Pharmacologic Therapy not Prescribed for Documented Reasons
G8634: Clinician documented patient not an eligible candidate to receive pharmacologic therapy for osteoporosis

OR

Central DXA Measurement not Ordered or Results not Documented, Reason not Otherwise Specified
Append a reporting modifier (8P) to CPT Category II code 3096F or 3095F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.
3096F or 3095F *with* 8P: Central dual energy X-ray absorptiometry (DXA) measurement was not ordered or performed, reason not otherwise specified
OR
Pharmacologic Therapy not Prescribed, Reason not Given
G8635: Pharmacologic therapy for osteoporosis was not prescribed, reason not given

RATIONALE:
Patients with a history of fracture should have a baseline bone mass measurement and/or receive treatment for osteoporosis. Given that the majority of osteoporotic fractures occur in patients with a diagnosis of osteoporosis by bone mass measurement, exclusion of osteoporosis by bone mass testing does not preclude treatment of osteoporosis in a patient with a history of fracture. There is a high degree of variability and consensus by experts of what constitutes a fragility fracture and predictor of an underlying problem of osteoporosis. The work group determined that only those fractures, which have the strongest consensus and evidence that they are predictive of osteoporosis, should be included in the measure at this time. We anticipate that the list of fractures will expand as further evidence is published supporting the inclusion of other fractures.

CLINICAL RECOMMENDATION STATEMENTS:
The most important risk factors for osteoporosis-related fractures are a prior low-trauma fracture as an adult and a low BMD in patients with or without fractures. (AACE)

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BMD measurement should be performed in all women 40 years old or older who have sustained a fracture. (AACE)

The single most powerful predictor of a future osteoporotic fracture is the presence of previous such fractures. (AACE)

The decision to measure bone density should follow an individualized approach. It should be considered when it will help the patient decide whether to institute treatment to prevent osteoporotic fracture. It should also be considered in patients receiving glucocorticoid therapy for 2 months or more and patients with other conditions that place them at high risk for osteoporotic fracture. (NIH)

The most commonly used measurement to diagnose osteoporosis and predict fracture risk is based on assessment of BMD by dual-energy X-ray absorptiometry (DXA). (NIH)

Measurements of BMD made at the hip predict hip fracture better than measurements made at other sites while BMD measurement at the spine predicts spine fracture better than measures at other sites. (NIH)

Pharmacologic therapy should be initiated to reduce fracture risk in women with:

- BMD T-scores below -2.0 by central dual x-ray absorptiometry (DXA) with no risk factors
- BMD T-scores below -1.5 by central dual x-ray absorptiometry (DXA) with one or more risk factors
- A prior vertebral or hip fracture (NOF)

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*Measure #41 (NQF 0049): Osteoporosis: Pharmacologic Therapy for Men and Women Aged 50 Years and Older

2013 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of patients aged 50 years and older with a diagnosis of osteoporosis who were prescribed pharmacologic therapy within 12 months

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for patients seen during the reporting period. Patients with a diagnosis of osteoporosis should be prescribed pharmacologic therapy to treat osteoporosis. It is anticipated that clinicians who provide services for patients with the diagnosis of osteoporosis will submit this measure.

Measure Reporting via Claims:
ICD-9-CM diagnosis codes, CPT or HCPCS codes, and patient demographics are used to identify patients who are included in the measure's denominator. CPT Category II codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed ICD-9-CM diagnosis codes, CPT or HCPCS codes, and the appropriate CPT Category II code OR the CPT Category II code with the modifier. The modifiers allowed for this measure are: 1P- medical reasons, 2P- patient reasons, 3P- system reasons, 8P- reason not otherwise specified. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT or HCPCS codes, and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All patients aged 50 years and older with the diagnosis of osteoporosis

Denominator Criteria (Eligible Cases):
Patients aged ≥ 50 years on date of encounter
AND
Diagnosis for osteoporosis (ICD-9-CM): 733.00, 733.01, 733.02, 733.03, 733.09
Diagnosis for osteoporosis (ICD-10-CM) [REFERENCE ONLY/Not Reportable]: M80.00XA, M80.00XD, M80.00XG, M80.00XK, M80.00XP, M80.00XS, M80.011A, M80.011D, M80.011G, M80.011K, M80.011P, M80.011S, M80.012A, M80.012D, M80.012G, M80.012K, M80.012P, M80.012S, M80.019A, M80.019D, M80.019G, M80.019K, M80.019P, M80.019S, M80.021A, M80.021D, M80.021G, M80.021K, M80.021P, M80.021S, M80.022A, M80.022D, M80.022G, M80.022K, M80.022P, M80.022S, M80.029A, M80.029D, M80.029G, M80.029K, M80.029P, M80.029S, M80.031A, M80.031D, M80.031G, M80.031K, M80.031P, M80.031S, M80.032A, M80.032D, M80.032G, M80.032K, M80.032P, M80.032S, M80.039A, M80.039D, M80.039G, M80.039K, M80.039P, M80.039S, M80.041A, M80.041D, M80.041G, M80.041K, M80.041P, M80.041S, M80.042A, M80.042D, M80.042G, M80.042K, M80.042P, M80.042S, M80.049A, M80.049D,

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M80.049G, M80.049K, M80.049P, M80.049S, M80.051A, M80.051D, M80.051G, M80.051K, M80.051P, M80.051S, M80.052A, M80.052D, M80.052G, M80.052K, M80.052P, M80.052S, M80.059A, M80.059D, M80.059G, M80.059K, M80.059P, M80.059S, M80.061A, M80.061D, M80.061G, M80.061K, M80.061P, M80.061S, M80.062A, M80.062D, M80.062G, M80.062K, M80.062P, M80.062S, M80.069A, M80.069D, M80.069G, M80.069K, M80.069P, M80.069S, M80.071A, M80.071D, M80.071G, M80.071K, M80.071P, M80.071S, M80.072A, M80.072D, M80.072G, M80.072K, M80.072P, M80.072S, M80.079A, M80.079D, M80.079G, M80.079K, M80.079P, M80.079S, M80.08XA, M80.08XD, M80.08XG, M80.08XK, M80.08XP, M80.08XS, M80.80XA, M80.80XD, M80.80XG, M80.80XK, M80.80XP, M80.80XS, M80.811A, M80.811D, M80.811G, M80.811K, M80.811P, M80.811S, M80.812A, M80.812D, M80.812G, M80.812K, M80.812P, M80.812S, M80.819A, M80.819D, M80.819G, M80.819K, M80.819P, M80.819S, M80.821A, M80.821D, M80.821G, M80.821K, M80.821P, M80.821S, M80.822A, M80.822D, M80.822G, M80.822K, M80.822P, M80.822S, M80.829A, M80.829D, M80.829G, M80.829K, M80.829P, M80.829S, M80.831A, M80.831D, M80.831G, M80.831K, M80.831P, M80.831S, M80.832A, M80.832D, M80.832G, M80.832K, M80.832P, M80.832S, M80.839A, M80.839D, M80.839G, M80.839K, M80.839P, M80.839S, M80.841A, M80.841D, M80.841G, M80.841K, M80.841P, M80.841S, M80.842A, M80.842D, M80.842G, M80.842K, M80.842P, M80.842S, M80.849A, M80.849D, M80.849G, M80.849K, M80.849P, M80.849S, M80.851A, M80.851D, M80.851G, M80.851K, M80.851P, M80.851S, M80.852A, M80.852D, M80.852G, M80.852K, M80.852P, M80.852S, M80.859A, M80.859D, M80.859G, M80.859K, M80.859P, M80.859S, M80.861A, M80.861D, M80.861G, M80.861K, M80.861P, M80.861S, M80.862A, M80.862D, M80.862G, M80.862K, M80.862P, M80.862S, M80.869A, M80.869D, M80.869G, M80.869K, M80.869P, M80.869S, M80.871A, M80.871D, M80.871G, M80.871K, M80.871P, M80.871S, M80.872A, M80.872D, M80.872G, M80.872K, M80.872P, M80.872S, M80.879A, M80.879D, M80.879G, M80.879K, M80.879P, M80.879S, M80.88XA, M80.88XD, M80.88XG, M80.88XK, M80.88XP, M80.88XS, M81.0, M81.6, M81.8, M81.0, M81.6, M81.8

AND

Patient encounter during the reporting period (CPT or HCPCS): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, G0402

NUMERATOR:

Patients who were prescribed pharmacologic therapy for osteoporosis 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 – May include prescription given to the patient for treatment of osteoporosis (as listed above) at one or more encounters during the reporting period, OR documentation that patient is already taking pharmacologic therapy for osteoporosis, as documented in the current medication list.

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Pharmacologic Therapy Prescribed

CPT II 4005F: Pharmacologic therapy (other than minerals/vitamins) for osteoporosis prescribed

OR

Pharmacologic Therapy not Prescribed for Medical, Patient, or System Reasons

Append a modifier (1P, 2P or 3P) to CPT Category II code 4005F to report documented circumstances that appropriately exclude patients from the denominator.

4005F *with* 1P: Documentation of medical reason(s) for not prescribing pharmacologic therapy for osteoporosis

4005F *with* 2P: Documentation of patient reason(s) for not prescribing pharmacologic therapy for osteoporosis

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4005F *with* 3P: Documentation of system reason(s) for not prescribing pharmacologic therapy for osteoporosis

OR

Pharmacologic Therapy not Prescribed, Reason not Otherwise Specified
Append a reporting modifier (8P) to CPT Category II code 4005F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.
4005F *with* 8P: Pharmacologic therapy for osteoporosis was not prescribed, reason not otherwise specified

RATIONALE:
Pharmacologic therapy is an evidence-based recommendation for the treatment of osteoporosis.

CLINICAL RECOMMENDATION STATEMENTS:
Agents approved by the FDA for osteoporosis prevention and/or treatment include (in alphabetical order) bisphosphonates (alendronate, ibandronate, risedronate), salmon calcitonin, estrogen, raloxifene, and teriparatide. All act by reducing bone resorption, except for teriparatide, which has anabolic effects on bone.

Although estrogen is not approved for treatment of osteoporosis, there is level 1 evidence for its efficacy in reducing vertebral fractures, nonvertebral fractures, and hip fractures.

Level 1 evidence of efficacy in reducing the risk of vertebral fractures is available for all the agents approved for treatment of osteoporosis (bisphosphonates, calcitonin, raloxifene, and teriparatide). Prospective trials have demonstrated the effectiveness of bisphosphonates and teriparatide in reducing the risk of nonvertebral fractures (level 1), but only bisphosphonates have been shown to reduce the risk of hip fractures in prospective controlled trials (level 1). (AACE)

US Food and Drug Administration-approved pharmacologic options for osteoporosis prevention and/or treatment of postmenopausal osteoporosis include, in alphabetical order: bisphosphonates (alendronate, alendronate plus D, ibandronate, and risedronate, risedronate with 500 mg of calcium as the carbonate), calcitonin, estrogens (estrogens and/or hormone therapy), parathyroid hormone [PTH (1-34), teriparatide], and selective estrogen receptor modulators or SERMS (raloxifene). (NOF)

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Ω Measure #43 (NQF 0134): Coronary Artery Bypass Graft (CABG): Use of Internal Mammary Artery (IMA) in Patients with Isolated CABG Surgery

2013 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of patients aged 18 years and older undergoing isolated CABG surgery who received an IMA graft

INSTRUCTIONS:
This measure is to be reported each time an isolated CABG procedure is performed during the reporting period. It is anticipated that clinicians who provide services for isolated CABG will submit this measure. This measure is intended to reflect the quality of the surgical services provided for isolated CABG patients. Isolated CABG refers to CABG using arterial and/or venous grafts only. Part B claims data will be analyzed to determine "isolated" CABG. This measure does not include patients undergoing repeat CABG surgery.

Measure Reporting via Claims:
CPT codes and patient demographics are used to identify patients who are included in the measure's denominator. CPT Category II codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed CPT codes, and the appropriate CPT Category II code OR the CPT Category II code with the modifier. The modifiers allowed for this measure are: 1P- medical reasons, 8P- reason not otherwise specified. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
CPT codes and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All patients undergoing isolated CABG

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Patient encounter during the reporting period (CPT): 33510, 33511, 33512, 33513, 33514, 33516, 33517, 33518, 33519, 33521, 33522, 33523, 33533, 33534, 33535, 33536

NUMERATOR:
Patients undergoing isolated CABG who received an IMA graft

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

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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. Acceptable medical reasons include: subclavian stenosis, previous cardiac or thoracic surgery, previous mediastinal radiation, emergent or salvage procedure, no left anterior descending artery disease.

OR

IMA Graft not Performed, Reason not Otherwise 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

RATIONALE:

A major innovation has been the introduction of off-bypass CABG, which has reduced the post-procedure length of stay in some centers to between 2 and 3 days. In some centers, this has led to a total 3-month cost for single-vessel coronary bypass that is not significantly different from the total 3-month cost for angioplasty of single-vessel disease. Considering the favorable long-term patency of an internal mammary artery (IMA) graft to the LAD, the cost reductions possible with off-bypass CABG may improve the relative cost-effectiveness of coronary bypass compared with either medical therapy or percutaneous techniques, particularly for symptomatic, proximal LAD disease.

CLINICAL RECOMMENDATION STATEMENTS:

Class I

In every patient undergoing CABG, the left internal mammary artery (IMA) should be given primary consideration for revascularization of the left anterior descending (LAD) artery.
(*Level of Evidence: B*)

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♠ Measure #44 (NQF 0236): Coronary Artery Bypass Graft (CABG): Preoperative Beta-Blocker in Patients with Isolated CABG Surgery

2013 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of isolated Coronary Artery Bypass Graft (CABG) surgeries for patients aged 18 years and older who received a beta-blocker within 24 hours prior to surgical incision

INSTRUCTIONS:
This measure is to be reported each time an isolated CABG procedure is performed during the reporting period. It is anticipated that clinicians who provide services for isolated CABG will submit this measure. Isolated CABG refers to CABG using arterial and/or venous grafts only. Part B claims data will be analyzed to determine "isolated" CABG. The timeframe for this measure includes the entire 24 hour period prior to the surgical incision time.

Measure Reporting via Claims:
CPT codes and patient demographics are used to identify patients who are included in the measure's denominator. CPT Category II codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed CPT codes, and the appropriate CPT Category II code OR the CPT Category II code with the modifier. The modifiers allowed for this measure are: 1P- medical reasons, 8P- reason not otherwise specified. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
CPT codes and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
Isolated CABG surgeries for patients aged 18 years and older

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Patient encounter during the reporting period (CPT): 33510, 33511, 33512, 33513, 33514, 33516, 33517, 33518, 33519, 33521, 33522, 33523, 33533, 33534, 33535, 33536

NUMERATOR:
Isolated CABG surgeries for patients who received a beta-blocker within 24 hours prior to surgical incision.

Definition:
Medical Reason - Eligible professional must document specific reason(s) for not administering beta-blockers

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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 Otherwise 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

RATIONALE:
Postoperative atrial fibrillation (POAF) is a common complication following cardiac surgery, occurring in 25-40% of patients (Crystal, 2004, Burgess, 2006). POAF has been associated with increased rates of post-operative morbidity and mortality and consequently, increased costs (Mariscalco, 2008, Crystal, 2004, Bramer, 2010). Prophylactic administration of beta-blockers have been shown to reduce the risk of POAF and mortality following isolated coronary artery bypass graft surgery (Connolly, 2003, Mariscalco, 2008, Ferguson, 2002).

CLINICAL RECOMMENDATION STATEMENTS:
Preoperative Beta-blockers
Class I

1. Beta-blockers should be administered for at least 24 hours before CABG to all patients without contraindications to reduce the incidence or clinical sequelae of postoperative AF. *(Level of Evidence: B)*

Class IIa

1. Preoperative use of beta-blockers in patients without contraindications, particularly in those with an LV ejection fraction (LVEF) greater than 30%, can be effective in reducing the risk of in-hospital mortality. *(Level of Evidence: B)*
2. Beta-blockers can be effective in reducing the incidence of perioperative myocardial ischemia. *(Level of Evidence: B)*

Class IIb

1. The effectiveness of preoperative beta-blockers in reducing in-hospital mortality rate in patients with LVEF less than 30% is uncertain. *(Level of Evidence: B)*

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*Measure #45 (NQF 0637): Perioperative Care: Discontinuation of Prophylactic Parenteral Antibiotics (Cardiac Procedures)

2013 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of 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 48 hours of surgical end time

INSTRUCTIONS:
This measure is to be reported each time a procedure is performed during the reporting period for patients who undergo cardiac procedures with the indications for prophylactic parenteral antibiotics. There is no diagnosis associated with this measure. It is anticipated that clinicians who perform the listed surgical procedures as specified in the denominator coding will submit this measure.

Measure Reporting via Claims:
CPT codes and patient demographics are used to identify patients who are included in the measure's denominator. CPT Category II codes and/or G-codes are used to report the numerator of the measure. If multiple surgical procedures were performed on the same date of service and submitted on the same claim form, it is not necessary to submit the CPT Category II code(s) or G-code code(s) with each procedure.

When reporting the measure via claims, submit the listed CPT codes, and the appropriate CPT Category II code AND/OR G-code OR the CPT Category II code with the modifier AND G-code. The modifiers allowed for this measure are: 1P- medical reasons, 8P- reason not otherwise specified. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
CPT codes and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All cardiac surgical patients aged 18 years and older undergoing procedures with the indications for prophylactic parenteral antibiotics AND who received a prophylactic parenteral antibiotic

Denominator Instructions:

- 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 PQRS will be fully accountable for the clinical action described in the measure.
- For the purpose of this measure of antibiotic discontinuation, patients may be counted as having "received a prophylactic parenteral antibiotic" if the antibiotic was received within 4 hours prior to the surgical incision (or start of procedure when no incision is required) or intraoperatively.

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Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Patient encounter during the reporting period (CPT): Listed below are cardiac surgical procedures for which prophylactic parenteral antibiotics are indicated

SURGICAL PROCEDURE	CPT CODE
Cardiothoracic Surgery	33120, 33130, 33140, 33141, 33250, 33251, 33256, 33261, 33305, 33315, 33332, 33335, 33400, 33401, 33403, 33404, 33405, 33406, 33410, 33411, 33413, 33416, 33422, 33425, 33426, 33427, 33430, 33460, 33463, 33464, 33465, 33475, 33496, 33510, 33511, 33512, 33513, 33514, 33516, 33517, 33518, 33519, 33521, 33522, 33523, 33530, 33533, 33534, 33535, 33536, 33542, 33545, 33548, 33572

NUMERATOR:
Cardiac surgical patients who have an order for discontinuation of prophylactic parenteral antibiotics within 48 hours of surgical end time

Numerator Instructions: There must be documentation of order (written order, verbal order, or standing order/protocol) specifying that the prophylactic parenteral antibiotic is to be discontinued within 48 hours of surgical end time OR specifying a course of antibiotic administration limited to that 48-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 antibiotic ***was*** discontinued within 48 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 48 hours of surgical end time
*(One CPT II code and one G-code [*4043F & G8702*] are required on the claim form to submit this numerator option)*
CPT II 4043F: Documentation that an order was given to discontinue prophylactic antibiotics within 48 hours of surgical end time, cardiac procedures
*Note: CPT Category II code **4043F** may be provided for documentation that antibiotic discontinuation within 48 hours was **ordered** or that antibiotic discontinuation was **accomplished**.*
AND
G8702: Documentation that prophylactic antibiotics were given within 4 hours prior to surgical incision or intraoperatively

OR

Prophylactic Parenteral Antibiotics not Discontinued for Medical Reasons
*(One CPT II code and one G-code [*4043F-1P & G8702*] are required on the claim form to submit this numerator option)*
Append a modifier (1P) to CPT Category II code 4043F to report documented circumstances that appropriately exclude patients from the denominator.
4043F *with* 1P: Documentation of medical reason(s) for not discontinuing prophylactic antibiotics within 48 hours of surgical end time, cardiac procedures
AND

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G8702: Documentation that prophylactic antibiotics were given within 4 hours prior to surgical incision or intraoperatively

OR

If patient is not eligible for this measure because patient was not documented to have prophylactic parenteral antibiotics given within 4 hours prior to surgical incision, report:
(One G-code [G8703] is required on the claim form to submit this numerator option)
G8703: Documentation that prophylactic antibiotics were neither given within 4 hours prior to surgical incision nor intraoperatively

OR

Prophylactic Parenteral Antibiotics not Discontinued, Reason not Otherwise Specified
(One CPT II code and G-code [4043F-8P & G8702] are required on the claim form to submit this numerator option)
Append a reporting modifier (8P) to CPT Category II code 4043F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.
4043F *with* 8P: Order was not given to discontinue prophylactic antibiotics within 48 hours of surgical end time, cardiac procedures, reason not otherwise specified

AND

G8702: Documentation that prophylactic antibiotics were given within 4 hours prior to surgical incision or intraoperatively

RATIONALE:
There is no evidence there is added benefit of prolonged prophylactic antibiotic use. Prolonged use may increase antibiotic resistant organisms.

CLINICAL RECOMMENDATION STATEMENTS:
At a minimum, antimicrobial coverage must be provided from the time of incision to closure of the incision. For most procedures, the duration of antimicrobial prophylaxis should be 24 hours or less, with the exception of cardiothoracic procedures (up to 72 hours' duration) and ophthalmic procedures (duration not clearly established). (ASHP) There is evidence indicating that antibiotic prophylaxis of 48 hours duration is effective. There is some evidence that single-dose prophylaxis or 24-hour prophylaxis may be as effective as 48-hour prophylaxis, but additional studies are necessary before confirming the effectiveness of prophylaxis lasting less than 48 hours. There is no evidence that prophylaxis administered for longer than 48 hours is more effective than a 48-hour regimen. Optimal practice: Antibiotic prophylaxis is not continued for more than 48 hours postoperatively. (STS) (Class IIa, Level B)

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*Measure #46 (NQF 0097): Medication Reconciliation

2013 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of patients aged 65 years and older discharged from any inpatient facility (e.g., hospital, skilled nursing facility, or rehabilitation facility) and seen within 30 days following discharge in the office by the physician providing on-going care who had a reconciliation of the discharge medications with the current medication list in the outpatient medical record documented

INSTRUCTIONS:
This measure is to be reported at an outpatient visit occurring within 30 days of each inpatient facility discharge date during the reporting period. This measure is appropriate for use in the ambulatory setting only. There is no diagnosis associated with this measure. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding. This measure is not to be reported unless a patient has been discharged from an inpatient facility within 30 days prior to the outpatient visit.

Measure Reporting via Claims:
CPT or HCPCS codes and patient demographics are used to identify patients who are included in the measure's denominator. CPT Category II codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed CPT or HCPCS codes, and the appropriate CPT Category II code(s) OR the CPT Category II code(s) with the modifier. The reporting modifier allowed for this is: 8P- reason not otherwise specified. There are no allowable performance exclusions for this measure. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
CPT or HCPCS codes and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data. There are no allowable performance exclusions for this measure.

DENOMINATOR:
All patients aged 65 years and older discharged from any inpatient facility (e.g., hospital, skilled nursing facility, or rehabilitation facility) and seen within 30 days following discharge in the office by the physician providing on-going care

> Denominator Criteria (Eligible Cases):
> Patients aged ≥ 65 years on date of encounter
> AND
> Patient encounter during the reporting period (CPT or HCPCS): 90791, 90792, 90832, 90834, 90837, 90839, 90845, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, G0402, G0438, G0439

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NUMERATOR:
Patients who had a reconciliation of the discharge medications with the current medication list in the outpatient medical record documented

Definition:
Medical Record – Must indicate: The clinician is aware of the inpatient facility discharge medications and will either keep the inpatient facility discharge medications or change the inpatient facility discharge medications or the dosage of an inpatient facility discharge medication.

NUMERATOR NOTE: Medication reconciliation should be completed and documented within 30 days of discharge. If the patient has an eligible discharge but medication reconciliation is not performed and documented within 30 days, report 1111F with 8P.

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Documentation of Reconciliation of Discharge Medication with Current Medication List in the Medical Record
CPT II 1111F: Discharge medications reconciled with the current medication list in outpatient medical record

OR

If patient is not eligible for this measure because patient was not discharged from an inpatient facility within the last 30 days, there are no reporting requirements in this case.

OR

Discharge Medication not Reconciled with Current Medication List in the Medical Record, Reason Not Otherwise Specified
Append a reporting modifier (8P) to CPT Category II code 1111F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.
1111F *with* 8P: Discharge medications not reconciled with the current medication list in outpatient medical record, reason not otherwise specified

RATIONALE:
Medications are often changed while a patient is hospitalized. Continuity between inpatient and on-going care is essential.

CLINICAL RECOMMENDATION STATEMENTS:
No trials of the effects of physician acknowledgment of medications post-discharge were found. However, patients are likely to have their medications changed during a hospitalization. One observational study showed that 1.5 new medications were initiated per patient during hospitalization, and 28% of chronic medications were canceled by the time of hospital discharge. Another observational study showed that at one week post-discharge, 72% of elderly patients were taking incorrectly at least one medication started in the inpatient setting, and 32% of medications were not being taken at all. One survey study faulted the quality of discharge communication as contributing to early hospital readmission, although this study did not implicate medication discontinuity as the cause. (ACOVE)

First, a medication list must be collected. It is important to know what medications the patient has been taking or receiving prior to the outpatient visit in order to provide quality care. This applies regardless of the setting from which the patient came — home, long-term care, assisted living, etc. The medication list should include all medications (prescriptions, over-the-counter, herbals, supplements, etc.) with dose, frequency, route, and reason for taking it. It is also important to verify whether the patient is actually taking the medication as prescribed or instructed, as sometimes this is not the case.

At the end of the outpatient visit, a clinician needs to verify three questions:
1. Based on what occurred in the visit, should any medication that the patient was taking or receiving prior to the visit be discontinued or altered?

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2. Based on what occurred in the visit, should any prior medication be suspended pending consultation with the prescriber?
3. Have any new prescriptions been added today?

These questions should be reviewed by the physician who completed the procedure, or the physician who evaluated and treated the patient.

- If the answer to *all three questions* is "no," the process is complete.
- If the answer to *any question* is "yes," the patient needs to receive clear instructions about what to do — all changes, holds, and discontinuations of medications should be specifically noted. Include any follow-up required, such as calling or making appointments with other practitioners and a timeframe for doing so. (IHI)

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*Measure #47 (NQF 0326): Advance Care Plan

2013 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of patients aged 65 years and older who have an advance care plan or surrogate decision maker documented in the medical record or documentation in the medical record that an advance care plan was discussed but the patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for patients seen during the reporting period. There is no diagnosis associated with this measure. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

This measure is appropriate for use in all healthcare settings (e.g., inpatient, nursing home, ambulatory) except the emergency department. For each of these settings, there should be documentation in the medical record(s) that advance care planning was discussed or documented.

Measure Reporting via Claims:
CPT or HCPCS codes and patient demographics are used to identify patients who are included in the measure's denominator. CPT Category II codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed CPT or HCPCS codes, and the appropriate CPT Category II codes OR the CPT Category II code(s) with the modifier. The reporting modifier allowed for this measure is: 8P-reason not otherwise specified. There are no allowable performance exclusions for this measure. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
CPT or HCPCS codes and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data. There are no allowable performance exclusions for this measure.

DENOMINATOR:
All patients aged 65 years and older

*DENOMINATOR NOTE: *Clinicians indicating the Place of Service as the emergency department will not be included in this measure.*

Denominator Criteria (Eligible Cases):
Patients aged ≥ 65 years on date of encounter
AND
Patient encounter during the reporting period (CPT or HCPCS): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99218, 99219, 99220, 99221, 99222, 99223, 99231, 99232, 99233, 99234,

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99235, 99236, 99291*, 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, G0402

NUMERATOR:
Patients who have an advance care plan or surrogate decision maker documented in the medical record or documentation in the medical record that an advance care plan was discussed but patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan

Numerator Instructions: If patient's cultural and/or spiritual beliefs preclude a discussion of advance care planning, report 1124F.

Definition:
Documentation that Patient did not Wish or was not able to Name a Surrogate Decision Maker or Provide an Advance Care Plan – May also include, as appropriate, the following:

- That the patient's cultural and/or spiritual beliefs preclude a discussion of advance care planning, as it would be viewed as harmful to the patient's beliefs and thus harmful to the physician-patient relationship.

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Advance Care Planning Discussed and Documented
CPT II 1123F: Advance Care Planning discussed and documented; advance care plan or surrogate decision maker documented in the medical record
OR
CPT II 1124F: Advance Care Planning discussed and documented in the medical record; patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan

OR

Advance Care Planning not Documented, Reason not Otherwise Specified
Append a reporting modifier (8P) to CPT Category II code 1123F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.
1123F *with* 8P: Advance care planning not documented, reason not otherwise specified

RATIONALE:
It is essential that the patient's wishes regarding medical treatment be established as much as possible prior to incapacity. The Work Group has determined that the measure should remain as specified with no required timeframe based on a review of the literature. Studies have shown that people do change their preferences often with regard to advanced care planning, but it primarily occurs after a major medical event or other health status change. In the stable patient, it would be very difficult to define the correct interval. It was felt by the Work Group that the error rate in simply not having addressed the issue at all is so much more substantial (Teno 1997) than the risk that an established plan has become outdated that we should not define a specific timeframe at this time. As this measure is tested and reviewed, we will continue to evaluate if and when a specific timeframe should be included.

CLINICAL RECOMMENDATION STATEMENTS:
Advance directives are designed to respect patient's autonomy and determine his/her wishes about future life-sustaining medical treatment if unable to indicate wishes. Key interventions and treatment decisions to include in advance directives are: resuscitation procedures, mechanical respiration, chemotherapy, radiation therapy, dialysis, simple diagnostic tests, pain control, blood products, transfusions, and intentional deep sedation.
Oral statements

- Conversations with relatives, friends, and clinicians are most common form; should be thoroughly documented in medical record for later reference.
- Properly verified oral statements carry same ethical and legal weight as those recorded in writing.

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Instructional advance directives (DNR orders, living wills)

- Written instructions regarding the initiation, continuation, withholding, or withdrawal of particular forms of life-sustaining medical treatment.
- May be revoked or altered at any time by the patient.
- Clinicians who comply with such directives are provided legal immunity for such actions.

Durable power of attorney for health care or health care proxy

- A written document that enables a capable person to appoint someone else to make future medical treatment choices for him or her in the event of decisional incapacity. (AGS)

The National Hospice and Palliative Care Organization provides the Caring Connection web site, which provides resources and information on end-of-life care, including a national repository of state-by-state advance directives.

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*Measure #48 (NQF 0098): Urinary Incontinence: Assessment of Presence or Absence of Urinary Incontinence in Women Aged 65 Years and Older

2013 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

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

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for patients seen during the reporting period. This measure is appropriate for use in the ambulatory setting only and is considered a general screening measure. There is no diagnosis associated with this measure. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

Measure Reporting via Claims:
CPT or HCPCS codes and patient demographics are used to identify patients who are included in the measure's denominator. CPT Category II codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed CPT or HCPCS codes, and the appropriate CPT Category II code OR the CPT Category II code with the modifier. The modifiers allowed for this measure are: 1P- medical reasons, 8P- reason not otherwise specified. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
CPT or HCPCS codes and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All female patients aged 65 years and older

Denominator Criteria (Eligible Cases):
All female patients aged ≥ 65 years on date of encounter
AND
Patient encounter during the reporting period (CPT or HCPCS): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, G0402

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

Definition:
Urinary Incontinence – Any involuntary leakage of urine.

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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 Otherwise 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

RATIONALE:
Female patients may not volunteer information regarding incontinence so they should be asked by their physician.

CLINICAL RECOMMENDATION STATEMENTS:
Strategies to increase recognition and reporting of UI are required and especially the perception that it is an inevitable consequence of aging for which little or nothing can be done. (ICI)

Patients with urinary incontinence should undergo a basic evaluation that includes a history, physical examination, measurement of post-void residual volume, and urinalysis. (ACOG) (Level C)

Health care providers should be able to initiate evaluation and treatment of UI basing their judgment on the results of history, physical examination, post-voiding residual and urinalysis. (ICI) (Grade B for women)

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*Measure #49 (NQF 0099): Urinary Incontinence: Characterization of Urinary Incontinence in Women Aged 65 Years and Older

2013 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of female patients aged 65 years and older with a diagnosis of urinary incontinence whose urinary incontinence was characterized at least once within 12 months

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for patients seen during the reporting period. This measure is appropriate for use in the ambulatory setting only. It is anticipated that clinicians who provide services for patients with the diagnosis of urinary incontinence will submit this measure.

Measure Reporting via Claims:
ICD-9-CM diagnosis codes, CPT or HCPCS codes, and patient demographics are used to identify patients who are included in the measure's denominator. CPT Category II codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed ICD-9-CM diagnosis codes, CPT or HCPCS codes, and the appropriate CPT Category II code OR the CPT Category II code with the modifier. The reporting modifier allowed for this measure is: 8P- reason not otherwise specified. There are no allowable performance exclusions for this measure. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT or HCPCS codes, and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data. There are no allowable performance exclusions for this measure.

DENOMINATOR:
All female patients aged 65 years and older with a diagnosis of urinary incontinence

Denominator Criteria (Eligible Cases):
All female patients aged ≥ 65 years on date of encounter
AND
Diagnosis for urinary incontinence (ICD-9-CM): 307.6, 625.6, 788.30, 788.31, 788.33, 788.34, 788.35, 788.36, 788.37, 788.38, 788.39
Diagnosis for urinary incontinence (ICD-10-CM) [REFERENCE ONLY/Not Reportable]: F98.0, N39.3, N39.41, N39.42, N39.43, N39.44, N39.45, N39.46, N39.490, N39.498, R32
AND
Patient encounter during the reporting period (CPT or HCPCS): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, G0402

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NUMERATOR:
Patients whose urinary incontinence was characterized (may include one or more of the following: frequency, volume, timing, type of symptoms or how bothersome to the patient) at least once within 12 months

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Urinary Incontinence Characterized
CPT II 1091F: Urinary incontinence characterized (eg, frequency, volume, timing, type of symptoms, how bothersome)

OR

Urinary Incontinence not Characterized, Reason not Otherwise Specified
Append a reporting modifier (8P) to CPT Category II code 1091F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.
1091F *with* 8P: Urinary incontinence not characterized (eg, frequency, volume, timing, type of symptoms, how bothersome), reason not otherwise specified

RATIONALE:
Treatment indications are dependent on the severity and impact on the patient.

CLINICAL RECOMMENDATION STATEMENTS:
Patients with urinary incontinence should undergo a basic evaluation that includes a history, physical examination, measurement of post-void residual volume, and urinalysis. (ACOG) (Level C)

Health care providers should be able to initiate evaluation and treatment of UI basing their judgment on the results of history, physical examination, post-voiding residual and urinalysis. (ICI) (Grade B for women)

Bladder diaries provide valuable information on severity and bladder capacity in older persons without disability in the community. (ICI) (Grade B)

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Measure #50 (NQF 0100): Urinary Incontinence: Plan of Care for Urinary Incontinence in Women Aged 65 Years and Older

2013 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of female patients aged 65 years and older with a diagnosis of urinary incontinence with a documented plan of care for urinary incontinence at least once within 12 months

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for patients seen during the reporting period. This measure is appropriate for use in the ambulatory setting only. It is anticipated that clinicians who provide services for patients with the diagnosis of urinary incontinence will submit this measure.

Measure Reporting via Claims:
ICD-9-CM diagnosis codes, CPT or HCPCS codes, and patient demographics are used to identify patients who are included in the measure's denominator. CPT Category II codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed ICD-9-CM diagnosis codes, CPT or HCPCS codes, and the appropriate CPT Category II code OR the CPT Category II code with the modifier. The reporting modifier allowed for this measure is: 8P- reason not otherwise specified. There are no allowable performance exclusions for this measure. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT or HCPCS codes, and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data. There are no allowable performance exclusions for this measure.

DENOMINATOR:
All female patients aged 65 years and older with a diagnosis of urinary incontinence

Denominator Criteria (Eligible Cases):
All female patients aged ≥ 65 years on date of encounter
AND
Diagnosis for urinary incontinence (ICD-9-CM): 307.6, 625.6, 788.30, 788.31, 788.33, 788.34, 788.35, 788.36, 788.37, 788.38, 788.39
Diagnosis for urinary incontinence (ICD-10-CM) [REFERENCE ONLY/Not Reportable]: F98.0, N39.3, N39.41, N39.42, N39.43, N39.44, N39.45, N39.46, N39.490, N39.498, R32
AND
Patient encounter during the reporting period (CPT or HCPCS): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, G0402

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NUMERATOR:
Patients with a documented plan of care for urinary incontinence at least once within 12 months

Definition:
Plan of Care – May include behavioral interventions (e.g., bladder training, pelvic floor muscle training, prompted voiding), referral to specialist, surgical treatment, reassess at follow-up visit, lifestyle interventions, addressing co-morbid factors, modification or discontinuation of medications contributing to urinary incontinence, or pharmacologic therapy.

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Plan of Care for Urinary Incontinence Documented
CPT II 0509F: Urinary incontinence plan of care documented

OR

Plan of Care for Urinary Incontinence not Documented, Reason not Otherwise Specified
Append a reporting modifier (8P) to CPT Category II code 0509F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.
0509F *with* 8P: Urinary incontinence plan of care not documented, reason not otherwise specified

RATIONALE:
A treatment option should be documented for the patient with incontinence.

CLINICAL RECOMMENDATION STATEMENTS:
All conservative management options used in younger adults can be used in selected frail, older, motivated people. This includes:

- Bladder retraining
- Pelvic muscle exercises including biofeedback and/or electro-stimulation (ICI) (Grade B)

Pharmacologic agents, especially oxybutynin and tolterodine, may have a small beneficial effect on improving symptoms of detrusor overactivity in women. (ACOG) (Level A)

Oxybutynin and potentially other bladder relaxants can improve the effectiveness of behavioral therapies in frail older persons. (ICI) (Grade B)

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▲Measure #51 (NQF 0091): Chronic Obstructive Pulmonary Disease (COPD): Spirometry Evaluation

2013 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

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

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period using the most recent spirometry results in the patient record for patients seen during the reporting period. Do not limit the search for spirometry results to the reporting period. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

Measure Reporting via Claims:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. CPT Category II codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed ICD-9-CM diagnosis code, CPT codes, and the appropriate CPT Category II code OR the CPT Category II code with the modifier. The modifiers allowed for this measure are: 1P- medical reasons, 2P- patient reasons, 3P- system reasons, 8P- reason not otherwise specified. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All patients aged 18 and older with a diagnosis of COPD

> Denominator Criteria (Eligible Cases):
> Patients aged ≥ 18 years on date of encounter
> AND
> Diagnosis for COPD (ICD-9-CM): 491.0, 491.1, 491.20, 491.21, 491.22, 491.8, 491.9, 492.0, 492.8, 493.20, 493.21, 493.22, 496
> Diagnosis for COPD (ICD-10-CM) [REFERENCE ONLY/Not Reportable]: J41.0, J41.1, J41.8, J42, J43.0, J43.1, J43.2, J43.8, J43.9, J44.0, J44.1, J44.9
> AND
> Patient encounter during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215

NUMERATOR:
Patients with documented spirometry results in the medical record (FEV_1 and FEV_1/FVC)

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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 Otherwise 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

RATIONALE:
Evaluation of lung function for a patient with COPD is vital to determine what treatments are needed and whether those treatments are effective. COPD is often underdiagnosed and misdiagnosed in the primary care setting (Tinkelman, 2006). Marked underutilization of spirometry testing has been well documented and is thought to be a contributing factor (Foster et al, 2007; Yawn et al, 2008; Lee et al, 2006; Damarla et al, 2006). A recent study found that only 32% of patients with a new diagnosis of COPD had undergone spirometry within the previous 2 years to 6 months following diagnosis (Han et al., 2007). This measure is for patients already diagnosed with COPD, in order to confirm diagnosis.

CLINICAL RECOMMENDATION STATEMENTS:
A clinical diagnosis of COPD should be considered in any patient who has dyspnea, chronic cough or sputum production, and/or a history of exposure to risk factors for the disease. Spirometry is required to make the diagnosis in this clinical context; the presence of a post-bronchodilator FEV1/FVC < 0.70 confirms the presence of persistent airflow limitation and thus of COPD. Spirometry is the most reproducible and objective measurement of airflow available. (GOLD, 2011)

For the diagnosis and assessment of COPD, spirometry is the gold standard as it is the most reproducible, standardized, and objective way of measuring airflow limitation. $FEV_1/FVC < 70\%$ and a post bronchodilator $FEV_1 <$ 80% predicted confirms the presence of airflow limitation that is not fully reversible. (NHLBI/WHO)

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▲Measure #52 (NQF 0102): Chronic Obstructive Pulmonary Disease (COPD): Bronchodilator Therapy

2013 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of patients aged 18 years and older with a diagnosis of COPD and who have an FEV_1/FVC less than 60% and have symptoms who were prescribed an inhaled bronchodilator

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for all COPD patients seen during the reporting period. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

Measure Reporting via Claims:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. CPT Category II codes and/or G-codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed ICD-9-CM diagnosis codes, CPT codes, and the appropriate CPT Category II code(s) AND/OR G-code OR the CPT Category II code(s) with the modifier AND G-code. The modifiers allowed for this measure are: 1P- medical reasons, 2P- patient reasons, 3P- system reasons, 8P- reason not otherwise specified. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All patients aged 18 years and older with a diagnosis of COPD, who have an FEV_1/FVC < 60% and have symptoms (e.g., dyspnea, cough/sputum, wheezing)

> Denominator Criteria (Eligible Cases):
> Patients aged ≥ 18 years on date of encounter
> AND
> Diagnosis for COPD (ICD-9-CM): 491.0, 491.1, 491.20, 491.21, 491.22, 491.8, 491.9, 492.0, 492.8, 493.20, 493.21, 493.22, 496
> Diagnosis for COPD (ICD-10-CM) [REFERENCE ONLY/Not Reportable]: J41.0, J41.1, J41.8, J42, J43.0, J43.1, J43.2, J43.8, J43.9, J44.0, J44.1, J44.9
> AND
> Patient encounter during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215

NUMERATOR:
Patients who were prescribed an inhaled bronchodilator

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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
(One CPT II code & one G-code [4025F & G8924] are required on the claim form to submit this numerator option)
CPT II 4025F: Inhaled bronchodilator prescribed
AND
G8924: Spirometry test results demonstrate $FEV_1/FVC < 60\%$ with COPD symptoms (e.g., dyspnea, cough/sputum, wheezing)

OR

Patient not Documented to have Inhaled Bronchodilator Prescribed for Medical, Patient, or System Reasons
(One CPT II code & one G-code [4025F-xP & G8924] 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
G8924: Spirometry test results demonstrate $FEV_1/FVC < 60\%$ with COPD symptoms (e.g., dyspnea, cough/sputum, wheezing)

OR

If patient is not eligible for this measure because spirometry results demonstrate FEV_1**/FVC ≥ 60% or** patient does not have COPD symptoms, report:
Spirometry Results Demonstrate FEV_1**/FVC ≥ 60% or Patient does** not have COPD symptoms
(One G-code [G8925 or G8926] is required on the claim form to submit this numerator option)
G8925: Spirometry test results demonstrate $FEV_1/FVC \geq 60\%$ or patient does not have COPD symptoms
OR
Spirometry Test not Performed or Documented
G8926: Spirometry test not performed or documented, reason not given

OR

Patient not Documented to have Inhaled Bronchodilator Prescribed, Reason not Otherwise Specified
(One CPT II code & one G-code [4025F-8P & G8924] 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

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G8924: Spirometry test results demonstrate $FEV_1/FVC < 60\%$ with COPD symptoms (e.g., dyspnea, cough/sputum, wheezing)

RATIONALE:
Inhaled bronchodilator therapy is effective in treating and managing the symptoms of COPD, particularly, for those patients with moderate to very severe COPD, and improving a patient's quality of life. The Global Initiative for Chronic Obstructive Lung Disease (GOLD) guidelines recommend inhaled bronchodilators as a cornerstone of COPD symptom management; however, PCPs often turn to other agents as first-line COPD therapy (Barr et al, 2005; Foster et al, 2007). In a recent study of general medicine practices, 154 clinicians completed a survey to identify barriers to implementing seven recommendations from the GOLD guidelines. Adherence was only 54% to prescribing long-acting bronchodilators when FEV(1) < 80% predicted (Perez, et al, 2011).

CLINICAL RECOMMENDATION STATEMENTS:
For stable COPD patients with respiratory symptoms and FEV1 < 60% predicted, ACP, ACCP, ATS, and ERS recommend treatment with inhaled bronchodilators (Grade: strong recommendation, moderate-quality evidence). (ACP, ACCP, ATS and ERS)

Bronchodilator medications are given on either an as-needed basis or a regular basis to reduce or prevent symptoms (Evidence A). Bronchodilator medications are central to symptom management in COPD. Inhaled therapy is preferred. Long-acting inhaled bronchodilators are convenient and more effective at producing maintained symptom relief than short-acting bronchodilators. (GOLD, 2011)

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❑ Measure #53 (NQF 0047): Asthma: Pharmacologic Therapy for Persistent Asthma - Ambulatory Care Setting

2013 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

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

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for all patients with a diagnosis of persistent asthma seen during the reporting period. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

Measure Reporting via Claims:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. CPT Category II codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed ICD-9-CM diagnosis codes, CPT codes, and the appropriate CPT Category II code(s) AND/OR the CPT Category II code(s) with the modifier. The modifiers allowed for this measure are: 2P- patient reasons, 8P- reason not otherwise specified. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All patients aged 5 through 50 years with a diagnosis of persistent asthma during the one-year measurement period

Denominator Criteria (Eligible Cases):
Patients aged 5 through 50 years on date of encounter
AND
Diagnosis for asthma (ICD-9-CM): 493.00, 493.01, 493.02, 493.10, 493.11, 493.12, 493.20, 493.21, 493.22, 493.81, 493.82, 493.90, 493.91, 493.92
Diagnosis for asthma (ICD-10-CM) [REFERENCE ONLY/Not Reportable]: J45.20, J45.21, J45.22, J45.30, J45.31, J45.32, J45.40, J45.41, J45.42, J45.50, J45.51, J45.52, J45.901, J45.902, J45.909, J45.990, J45.991, J45.998
AND
Patient encounter during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350

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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).
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 [1038F & 414xF] are required on the claim form to submit this numerator option)
CPT II 1038F: Persistent asthma (mild, moderate or severe)
AND

CPT II 4140F: Inhaled corticosteroids prescribed
OR
CPT II 4144F: Alternative long-term control medication prescribed
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.
4140F *with* 2P: Documentation of patient reason(s) for not prescribing inhaled corticosteroids (eg, patient declined, other patient reason)
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 Otherwise Specified
(Two CPT II codes [4140F-8P & 1038F] are required on the claim form to submit this numerator option)

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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)

RATIONALE:
The following statement is quoted verbatim from the NHLBI/NAEPP guideline (NHLBI August 2007):

"The broad action of ICS on the inflammatory process may account for their efficacy as preventive therapy. Their clinical effects include reduction in severity of symptoms; improvement in asthma control and quality of life; improvement in PEF and spirometry; diminished airway hyper-responsiveness; prevention of exacerbations; reduction in systemic corticosteroid courses; emergency department (ED) care; hospitalizations, and deaths due to asthma; and possibly the attenuation of loss of lung function in adults" (Rafferty P 1985; Haahtela T 1991; Jeffery PK 1992; Van Essesn-Zandvliet EE 1992; Barnes NC 1993; Fabbri L 1993; Gustafsson P 1993; Kamada AK 1996; Suissa S 2000; Pauwels RA 2003; Barnes PJ October 1992)

CLINICAL RECOMMENDATION STATEMENTS:
The following evidence statements are quoted verbatim from the referenced clinical guidelines:

The Expert Panel recommends that long-term control medications be taken daily on a long-term basis to achieve and maintain control of persistent asthma. The most effective long-term control medications are those that attenuate the underlying inflammation characteristic of asthma. (Evidence A) (NHLBI, 2007)

The Expert Panel concludes that ICS is the most potent and clinically effective long-term control medication for asthma. (Evidence A) (NHLBI, 2007)

The Expert Panel concludes that ICS is the most effective long-term therapy available for patients who have persistent asthma, and, in general, ICS is well tolerated and safe at the recommended dosages. (Evidence A) (NHLBI, 2007)

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*Measure #54 (NQF 0090): Emergency Medicine: 12-Lead Electrocardiogram (ECG) Performed for Non-Traumatic Chest Pain

2013 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of patients aged 40 years and older with an emergency department discharge diagnosis of non-traumatic chest pain who had a 12-lead ECG performed

INSTRUCTIONS:
This measure is to be reported each time a patient has been discharged from the emergency department with a discharge diagnosis of non-traumatic chest pain during the reporting period. Claims data will be analyzed to determine the emergency department discharge. Patients who were discharged from an emergency department with a diagnosis of non-traumatic chest pain should have documentation in the medical record of having a 12-lead ECG performed. It is anticipated that clinicians who provide care in the emergency department will submit this measure. The Part B claim form Place of Service field must indicate that the encounter has taken place in the emergency department.

Measure Reporting via Claims:
ICD-9-CM diagnosis codes, CPT codes, Place of Service Indicator, and patient demographics are used to identify patients who are included in the measure's denominator. CPT Category II codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed ICD-9-CM diagnosis codes, CPT codes, Place of Service Indicator, and the appropriate CPT Category II code OR the CPT Category II code with the modifier. The modifiers allowed for this measure are: 1P- medical reasons, 2P- patient reasons, 8P- reason not otherwise specified. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT codes, Place of Service Indicator, and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All patients aged 40 years and older with an emergency department discharge diagnosis of non-traumatic chest pain

Denominator Criteria (Eligible Cases):
Patients aged ≥ 40 years on date of encounter
AND
Diagnosis for non-traumatic chest pain (ICD-9-CM): 413.0, 413.1, 413.9, 786.50, 786.51, 786.52, 786.59
Diagnosis for non-traumatic chest pain (ICD-10-CM) [REFERENCE ONLY/Not Reportable]: I20.1, I20.8, I20.9, I25.111, I25.118, I25.119, I25.701, I25.708, I25.709, I25.711, I25.718, I25.719, I25.721, I25.728, I25.729, I25.731, I25.738, I25.739, I25.751, I25.758, I25.759, I25.761, I25.768, I25.769, I25.791, I25.798, I25.799, R07.1, R07.2, R07.81, R07.82, R07.89, R07.9
AND

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Patient encounter during the reporting period (CPT): 99281, 99282, 99283, 99284, 99285, 99291
AND
Place of Service Indicator: 23
(The Part B claim form place of service field must indicate emergency department)

NUMERATOR:
Patients who had a 12-lead ECG performed

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
12-Lead ECG Performed
CPT II 3120F: 12-Lead ECG Performed

OR

12-Lead ECG not Performed for Medical or Patient Reasons
Append a modifier (1P or 2P) to CPT Category II code 3120F to report documented circumstances that appropriately exclude patients from the denominator.
3120F *with* 1P: Documentation of medical reason(s) for not performing a 12-Lead ECG
OR
3120F *with* 2P: Documentation of patient reason(s) for not performing a 12-Lead ECG

OR

12-Lead ECG not Performed, Reason not Otherwise Specified
Append a reporting modifier (8P) to CPT Category II code 3120F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.
3120F *with* 8P: 12-Lead ECG not performed, reason not otherwise specified

RATIONALE:
All patients in the age group for which CAD/ACS is part of the differential diagnosis, should have a 12-lead ECG performed.

CLINICAL RECOMMENDATION STATEMENTS:
A 12-lead ECG should be performed and shown to an experienced emergency physician within 10 minutes of ED arrival for all patients with chest discomfort (or anginal equivalent) or other symptoms of STEMI. (ACC/AHA)(Class I, Level C)

If pain is severe or pressure or substernal or exertional or radiating to jaw, neck, shoulder or arm, then the following are recommended:

- 12-lead ECG (Rule)
- IV access, supplemental oxygen, cardiac monitor, serum cardiac markers (e.g., CKMB), CXR, nitrates, management of on-going pain, admit (ACEP)

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*Measure #55 (NQF 0093): Emergency Medicine: 12-Lead Electrocardiogram (ECG) Performed for Syncope

2013 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of patients aged 60 years and older with an emergency department discharge diagnosis of syncope who had a 12-lead ECG performed

INSTRUCTIONS:
This measure is to be reported each time a patient has been discharged from the emergency department with a discharge diagnosis of syncope during the reporting period. Claims data will be analyzed to determine the emergency department discharge. Patients who experienced syncope should have documentation in the medical record of having a 12-lead ECG performed. It is anticipated that clinicians who provide care in the emergency department will submit this measure. The Part B claim form Place of Service field must indicate that the encounter has taken place in the emergency department.

Measure Reporting via Claims:
ICD-9-CM codes, CPT codes, Place of Service Indicator, and patient demographics are used to identify patients who are included in the measure's denominator. G-codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed ICD-9-CM diagnosis codes, CPT codes, Place of Service Indicator, and the appropriate G-code. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT codes, Place of Service Indicator, and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All patients aged 60 years and older with an emergency department discharge diagnosis of syncope

Denominator Criteria (Eligible Cases):
Patients aged ≥ 60 years on date of encounter
AND
Diagnosis for syncope (ICD-9-CM): 780.2
Diagnosis for syncope (ICD-10-CM) [REFERENCE ONLY/Not Reportable]: R55
AND
Patient encounter during the reporting period (CPT): 99281, 99282, 99283, 99284, 99285, 99291
AND

Place of Service Indicator: 23
(The Part B claim form Place of Service field must indicate emergency department)

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NUMERATOR:
Patients who had a 12-lead ECG performed

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
12-Lead ECG Performed
G8704: 12-Lead Electrocardiogram (ECG) Performed
OR
12-Lead ECG not Performed for Medical or Patient Reasons
G8705: Documentation of medical reason(s) for not performing a 12-lead electrocardiogram (ECG)
OR
G8706: Documentation of patient reason(s) for not performing a 12-lead electrocardiogram (ECG)
OR
12-Lead ECG not Performed, Reason not Given
G8707: 12-Lead Electrocardiogram (ECG) not performed, reason not given

RATIONALE:
12-lead ECG can occasionally pick up potentially life-threatening conditions such as pre-excitation syndromes, prolonged QT syndromes, or Brugada's syndrome in otherwise healthy appearing young adults. 12-lead ECG testing is performed inconsistently, even in high risk patients; the largest study to date of 12-lead ECG testing variation in ED syncope visits using a 9 year national sample illustrated that 12-lead ECG testing was documented in only 59% of ED syncope visits.

CLINICAL RECOMMENDATION STATEMENTS:
Obtain a standard 12-lead ECG in patients with syncope. (ACEP) (Level A)

- A patient with normal 12-lead ECG has a low likelihood of dysrhythmias as a cause of syncope.
- Abnormal 12-lead ECG has been associated as being the most important predictor of serious outcomes and a multivariate predictor for arrhythmia or death within 1 year after the syncopal episode.

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*Measure #56 (NQF 0232): Emergency Medicine: Community-Acquired Pneumonia (CAP): Vital Signs

2013 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of patients aged 18 years and older with a diagnosis of community-acquired bacterial pneumonia with vital signs documented and reviewed

INSTRUCTIONS:
This measure is to be reported once for each occurrence of community-acquired bacterial pneumonia during the reporting period. Each unique occurrence is defined as a 45-day period from onset of community-acquired bacterial pneumonia. Claims data will be analyzed to determine unique occurrences. All patients 18 years and older with a diagnosis of community-acquired bacterial pneumonia should have documentation in the medical record of having vital signs recorded and reviewed. It is anticipated that clinicians who provide care in the emergency department or office setting will submit this measure. Clinicians utilizing the critical care code must indicate the emergency department Place of Service code in order to be counted in the measure's denominator.

Measure Reporting via Claims:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. CPT Category II codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed ICD-9-CM diagnosis codes, CPT codes, and the appropriate CPT Category II code OR the CPT Category II code with the modifier. The reporting modifier allowed for this measure is: 8P- reason not otherwise specified. There are no allowable performance exclusions for this measure. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data. There are no allowable performance exclusions for this measure.

DENOMINATOR:
All patients aged 18 years and older with a diagnosis of community-acquired bacterial pneumonia

> Denominator Criteria (Eligible Cases):
> Patients aged ≥ 18 years on date of encounter
> AND
> Diagnosis for community-acquired bacterial pneumonia (ICD-9-CM): 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
> Diagnosis for community-acquired bacterial pneumonia (ICD-10-CM) [REFERENCE ONLY/Not Reportable]: A48.1, J13, J14, J15.0, J15.1, J15.20, J15.211, J15.212, J15.29, J15.3, J15.4, J15.5, J15.6, J15.7, J15.8, J15.9, J16.0, J16.8, J18.0, J18.1, J18.8, J18.9, Z16
> AND

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Patient encounter during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99281, 99282, 99283, 99284, 99285, 99291*, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350

** Clinicians utilizing the critical care code (99291) must indicate the emergency department Place of Service (23) on the Part B claim form in order to report this measure.*

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 Otherwise 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

RATIONALE:
Each of the vital signs should be recorded in the emergency department. While vital signs may be routinely recorded, there likely is a gap in care on acting on those values that warrant further evaluation. Moreover, it is important for physicians to review the vital signs to ensure continuous quality improvement and consistent patient care.

CLINICAL RECOMMENDATION STATEMENTS:
It is necessary to assess the severity of illness. This includes the radiographic findings (multilobar pneumonia or pleural effusion) and physical findings (respiratory rate, systolic and diastolic blood pressure, signs of dehydration and mental status). (ATS) (Level II Evidence)

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*Measure #59 (NQF 0096): Emergency Medicine: Community-Acquired Pneumonia (CAP): Empiric Antibiotic

2013 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of patients aged 18 years and older with a diagnosis of community-acquired bacterial pneumonia with an appropriate empiric antibiotic prescribed

INSTRUCTIONS:
This measure is to be reported once for each occurrence of community-acquired bacterial pneumonia during the reporting period. Each unique occurrence is defined as a 45-day period from onset of community-acquired bacterial pneumonia. Claims data will be analyzed to determine unique occurrences. All patients 18 years and older with a diagnosis of community-acquired bacterial pneumonia should have documentation in the medical record of having an appropriate empiric antibiotic prescribed. It is anticipated that clinicians who provide care in the emergency department or office setting will submit this measure. Clinicians utilizing the critical care code must indicate the emergency department Place of Service code in order to be counted in the measure's denominator.

Measure Reporting via Claims:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. CPT Category II codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed ICD-9-CM diagnosis codes, CPT codes, and the appropriate CPT Category II code OR the CPT Category II code with the modifier. The modifiers allowed for this measure are: 1P- medical reasons, 2P- patient reasons, 3P- system reasons, 8P- reason not otherwise specified. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All patients aged 18 years and older with the diagnosis of community-acquired bacterial pneumonia

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Diagnosis for community-acquired bacterial pneumonia (ICD-9-CM): 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
Diagnosis for community-acquired bacterial pneumonia (ICD-10-CM) [REFERENCE ONLY/Not Reportable]: A48.1, J13, J14, J15.0, J15.1, J15.20, J15.211, J15.212, J15.29, J15.3, J15.4, J15.5, J15.6, J15.7, J15.8, J15.9, J16.0, J16.8, J18.0, J18.1, J18.8, J18.9, Z16
AND

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Patient encounter during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99281, 99282, 99283, 99284, 99285, 99291*, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350

** Clinicians utilizing the critical care code (99291) must indicate the emergency department Place of Service (23) on the Part B claim form in order to report this measure.*

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 Otherwise 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

RATIONALE:
All patients need to be treated empirically according to the guideline recommendations.

CLINICAL RECOMMENDATION STATEMENTS:
All patients should be treated empirically. Patients treated as outpatients with no cardiopulmonary disease and no modifying factors should be treated with advanced generation macrolide: azithromycin or clarithromycin or doxycycline. Patients treated as an outpatient with cardiopulmonary disease and/or risk factors should be treated with beta lactam plus macrolide or doxycycline or fluoroquinolone alone. Empiric therapy based on the ATS guidelines lead to better outcomes than if the guidelines are not followed. (ATS) (Level II Evidence)

Fluoroquinolones (gatifloxacin, gemifloxacin, levofloxacin, and moxifloxacin) are recommended for initial empiric therapy of selected outpatients with CAP. (Level A Recommendation, Level I Evidence)

Other options (macrolides and doxycycline) are generally preferred for uncomplicated infections in outpatients. (IDSA) (Level A Recommendation, Level I Evidence)

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A macrolide is recommended as monotherapy for selected outpatients, such as those who were previously well and not recently treated with antibiotics. (Level A Recommendation, Level l Evidence)

A macrolide plus a beta lactam is recommended for initial empiric treatment of outpatients in whom resistance is an issue. (IDSA) (Level A Recommendation, Level I Evidence)

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❑ Measure #64 (NQF 0001): Asthma: Assessment of Asthma Control - Ambulatory Care Setting

2013 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

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)

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for patients with asthma seen during the reporting period. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

Measure Reporting via Claims:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. CPT Category II codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed ICD-9-CM diagnosis codes, CPT codes, and the appropriate CPT Category II code OR the CPT Category II code with the modifier. The reporting modifier allowed for this measure is: 8P- reason not otherwise specified. There are no allowable performance exclusions for this measure. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data. There are no allowable performance exclusions for this measure.

DENOMINATOR:
All patients aged 5 through 50 years with a diagnosis of asthma

Denominator Criteria (Eligible Cases):
Patients aged 5 through 50 years on date of encounter
AND
Diagnosis for asthma (ICD-9-CM): 493.00, 493.01, 493.02, 493.10, 493.11, 493.12, 493.20, 493.21, 493.22, 493.81, 493.82, 493.90, 493.91, 493.92
Diagnosis for asthma (ICD-10-CM) [REFERENCE ONLY/Not Reportable]: J45.20, J45.21, J45.22, J45.30, J45.31, J45.32, J45.40, J45.41, J45.42, J45.50, J45.51, J45.52, J45.901, J45.902, J45.909, J45.990, J45.991, J45.998
AND
Patient encounter during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350

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NUMERATOR:
Patients who were evaluated at least once during the measurement period for asthma control

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]

The specifications of this numerator enable documentation for the impairment and risk components separately to facilitate quality improvement. Evaluation of asthma impairment and asthma risk must occur during the same medical encounter.

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 $beta_2$-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 Quality-Data Coding Options for Reporting Satisfactorily:
Asthma Control Evaluated
*(Two CPT II codes [*2015F & 2016F*] are required on the claim form to submit this numerator option)*
CPT II 2015F: Asthma impairment assessed
AND
CPT II 2016F: Asthma risk assessed

OR

Asthma Control not Evaluated, Reason not Otherwise Specified
*(One CPT II code [*2015F-8P or 2016F-8P*] is required on the claim form to submit this numerator option)*
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

RATIONALE:
The goal of asthma therapy is to achieve asthma control. The level of asthma control serves as a basis for treatment modification (i.e., whether or not a patient needs a step up or step down in therapy). Patients with poorly controlled asthma can experience significant asthma burden (Fuhlbrigge AL 2002), decreased quality of life (Schatz M 2005a), and increased health utilization. (Vollmer WM 2002; Schatz M 2005b) A large international study found that guideline-defined asthma control can be achieved. In their trial, 30% of the patients achieved total control (defined as absence of asthma symptoms) and 60% achieve well-controlled asthma (defined as low-level of symptoms or rescue medication use. (Bateman ED 2004) A follow-up to this study found that this control can be maintained, which can lead to a decrease in the use of unscheduled health care visits. (Bateman ED, 2008)

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CLINICAL RECOMMENDATION STATEMENTS:
The following evidence statements are quoted verbatim from the referenced clinical guidelines.

The Expert Panel recommends that asthma control be defined as follows: (Evidence A) (NHLBI August 2007)

- Reduce Impairment
- Prevent chronic and troublesome symptoms (e.g., coughing or breathlessness in the daytime, night, or after exertion)
- Require infrequent use (≤ 2 days a week) of SABA for quick relief of symptoms
- Maintain (near) "normal" pulmonary function
- Maintain normal activity levels (including exercise and other physical activity and attendance at work or school)
- Meet patients' and families' expectations of satisfaction with asthma care
- Reduce risk
- Prevent recurrent exacerbations of asthma and minimize the need for ED visits or hospitalizations
- Prevent progressive loss of lung function; for children, prevent reduced lung growth
- Provide optimal pharmacotherapy with minimal or no adverse effects

The Expert Panel recommends that ongoing monitoring of asthma control be performed to determine whether all the goals of therapy are met—that is reducing both impairment and risk. (Evidence B) (NHLBI, 2007)

The Expert Panel recommends that the frequency of visits to a clinician for a review of asthma control is a matter of clinical judgment; in general, patients who have intermittent or mild persistent asthma that has been under control for at least 3 months should be seen by a physician about every 6 months, and patients who have uncontrolled and/or severe persistent asthma and those who need additional supervision to help them follow their treatment plan need to be seen more often. (NHLBI August 2007)

The Expert Panel recommends that symptoms and clinical signs of asthma should be assessed at each health care visit through physical examination and appropriate questions. (EPR-2, 1997) (NHLBI/NAEPP, 2007)

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♦ Measure #65 (NQF 0069): Appropriate Treatment for Children with Upper Respiratory Infection (URI)

2013 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of children aged 3 months through 18 years with a diagnosis of URI who were not prescribed or dispensed an antibiotic prescription on or within 3 days of the initial date of service

INSTRUCTIONS:
This measure is to be reported once for each occurrence of upper respiratory infection during the reporting period. Claims data will be analyzed to determine unique occurrences. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

Measure Reporting via Claims:
ICD-9-CM diagnosis codes, CPT or HCPCS codes, and patient demographics are used to identify patients who are included in the measure's denominator. G-codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed ICD-9-CM diagnosis codes, CPT or HCPCS codes, and the appropriate G-code. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT or HCPCS codes, and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All patients aged 3 months through 18 years with a diagnosis of upper respiratory infection

> Denominator Criteria (Eligible Cases):
> Patients aged 3 months through 18 years on date of encounter
> AND
> Diagnosis for URI (ICD-9-CM): 460, 465.0, 465.8, 465.9
> Diagnosis for URI (ICD-10-CM) [REFERENCE ONLY/Not Reportable]: J00, J06.0, J06.9
> AND
> Patient encounter during the reporting period (CPT or HCPCS): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99217, 99218, 99219, 99220, G0402

NUMERATOR:
Patients who were not dispensed an antibiotic prescription on or within 3 days of the initial date of service

> Numerator Instructions: For performance, the measure will be calculated as the number of patients for whom antibiotics were neither prescribed nor dispensed over the number of patients in the denominator

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(patients aged 3 months through 18 years with URI). A higher score indicates appropriate treatment of patients with URI (e.g., the proportion for whom antibiotics were not prescribed or dispensed).

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Antibiotic not Prescribed or Dispensed
G8708: Patient not prescribed or dispensed antibiotic

OR

Antibiotic Prescribed or Dispensed for Medical Reasons
G8709: Patient prescribed or dispensed antibiotic for documented medical reason(s)

OR

Antibiotic Prescribed or Dispensed
G8710: Patient prescribed or dispensed antibiotic

RATIONALE:
Existing clinical guidelines do not support the use of antibiotics for the common cold/upper respiratory infection.

CLINICAL RECOMMENDATION STATEMENTS:
Recent clinical practice guidelines set out the evidence supporting the recommendations for treating a host of upper respiratory tract infections in pediatrics. The guidelines do not recommend antibiotics for a majority of upper respiratory tract infections, except for conditions with bacterial etiology such as acute otitis media, bacterial sinusitis, mucopurulent rhinitis with prolonged symptoms, i.e., at least 10 days of continual symptoms, and group A streptococcal pharyngitis (but only cases with a confirmatory test for group A strep). The guidelines support targeting treatment of non-specific URI (the common cold) or viral rhinosinusitis with antibiotics as an indicator of inappropriate antibiotic prescribing.

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♦Measure #66 (NQF 0002): Appropriate Testing for Children with Pharyngitis

2013 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of children aged 2 through 18 years with a diagnosis of pharyngitis, who were prescribed an antibiotic and who received a group A streptococcus (strep) test for the episode. A higher rate represents better performance (i.e. appropriate testing).

INSTRUCTIONS:
This measure is to be reported once for each occurrence of pharyngitis during the reporting period. Claims data will be analyzed to determine unique occurrences. This measure is intended to reflect the quality of services provided for the primary management of patients with pharyngitis who were dispensed an antibiotic. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

Measure Reporting via Claims:
ICD-9-CM diagnosis codes, CPT or HCPCS codes, and patient demographics are used to identify patients who are included in the measure's denominator. CPT Category II codes and/or G-codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed ICD-9-CM diagnosis codes, CPT or HCPCS codes, and the appropriate CPT Category II code AND/OR G-code OR the CPT Category II code(s) with the modifier AND G-code. The modifiers allowed for this measure are: 1P- medical reasons, 8P- reason not otherwise specified. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT or HCPCS codes, and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All patients aged 2 through 18 years with a diagnosis of pharyngitis

> Denominator Criteria (Eligible Cases):
> Patients aged 2 through 18 years on date of encounter
> AND
> Diagnosis for pharyngitis (ICD-9-CM): 034.0, 462, 463
> Diagnosis for pharyngitis (ICD-10-CM) [REFERENCE ONLY/Not Reportable]: J02.8, J02.9, J03.80, J03.81, J03.90, J03.91
> AND
> Patient encounter during the reporting period (CPT or HCPCS): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99217, 99218, 99219, 99220, G0402

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NUMERATOR:
Patients who were dispensed an antibiotic and who received a group A streptococcus (strep) test for the episode

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:
Group A Streptococcus Test Performed and Antibiotic Prescribed
*(One CPT II code & G-code [*3210F & G8711*] are required on the claim form to submit this numerator option)*
CPT II 3210F: Group A Strep Test Performed
AND
G8711: Prescribed or dispensed antibiotic

OR

Group A Streptococcus Test not Performed for Medical Reasons
*(One CPT II code & one G-code [*3210F-1P & G8711*] are required on the claim form to submit this numerator option*)
Append a modifier (1P) to CPT Category II codes 3210F to report documented circumstances that appropriately exclude patients from the denominator.
3210F *with* 1P: Documentation of medical reason(s) for not Performing Group A Strep Test
AND
G8711: Prescribed or dispensed antibiotic

OR

If patient is not eligible for this measure because patient was not prescribed antibiotics, report:
*(One G-code [*G8712*] is required on the claim form to submit this numerator option)*
G8712: Antibiotic not prescribed or dispensed

OR

Group A Streptococcus Test not Performed, Reason not Otherwise Specified
*(One CPT II code & one G-code [*3210F-8P & G8711*] are required on the claim form to submit this numerator option)*
Append a reporting modifier (8P) to CPT Category II code 3210F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.
3210F *with* 8P: Group A Strep Test not Performed, reason not otherwise specified
AND
G8711: Prescribed or dispensed antibiotic

RATIONALE:
Clinical practice guidelines recommend group A streptococcus pharyngitis be treated with antibiotics (Schwartz et al, 1998)

CLINICAL RECOMMENDATION STATEMENTS:
The group A strep test (rapid assay or throat culture) is the definitive test of group A strep pharyngitis. Pharyngitis is the only respiratory tract infection with an objective diagnostic test that can be validated with administrative data, and not medical records. A process measure that requires the performance of a group A strep test for children given antibiotics for pharyngitis is supported by the guidelines. (Ibid)

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♣ Measure #67 (NQF 0377): Hematology: Myelodysplastic Syndrome (MDS) and Acute Leukemias: Baseline Cytogenetic Testing Performed on Bone Marrow

2013 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of patients aged 18 years and older with a diagnosis of MDS or an acute leukemia who had baseline cytogenetic testing performed on bone marrow

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for patients seen during the reporting period, regardless of when the baseline testing is performed. It is anticipated that clinicians who provide services for patients with the diagnosis of myelodysplastic syndromes or an acute leukemia (not in remission) will submit this measure.

Measure Reporting via Claims:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. CPT Category II codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed ICD-9-CM diagnosis codes, CPT codes, and the appropriate CPT Category II code OR the CPT Category II code with the modifier. The modifiers allowed for this measure are: 1P- medical reasons, 2P- patient reasons, 3P- system reasons, and 8P- reason not otherwise specified. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All patients aged 18 years and older with a diagnosis of MDS or an acute leukemia

> Denominator Criteria (Eligible Cases):
> Patients aged ≥ 18 years on date of encounter
> AND
> Diagnosis for MDS or acute leukemia – not in remission (ICD-9-CM): 204.00, 204.02, 205.00, 205.02, 206.00, 206.02, 207.00, 207.02, 207.20, 207.22, 208.00, 208.02, 238.72, 238.73, 238.74, 238.75
> Diagnosis for MDS or acute leukemia – not in remission (ICD-10-CM) [REFERENCE ONLY/Not Reportable]: C91.00, C91.02, C92.00, C92.02, C92.40, C92.42, C92.50, C92.52, C92.60, C92.62, C92.A0, C92.A2, C93.00, C93.02, C94.00, C94.02, C94.20, C92.22, C95.00, C95.02, D46.0, D46.1, D46.20, D46.21, D46.22, D46.4, D46.9, D46.A, D46.B, D46.C, D46.Z
> AND
> Patient encounter during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215

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NUMERATOR:
Patients who had baseline cytogenetic testing performed on bone marrow

Definition:
Baseline Cytogenetic Testing – Testing that is performed at time of diagnosis or prior to initiating treatment (transfusion, growth factors, or antineoplastic therapy) for that diagnosis

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Baseline Cytogenetic Testing Performed
CPT II 3155F: Cytogenetic testing performed on bone marrow at time of diagnosis or prior to initiating treatment

OR

Baseline Cytogenetic Testing not Performed for Medical, Patient, or System Reasons
Append a modifier (1P, 2P or 3P) to CPT Category II code 3155F to report documented circumstances that appropriately exclude patients from the denominator.
3155F *with* 1P: Documentation of medical reason(s) for not performing baseline cytogenetic testing on bone marrow (eg, no liquid bone marrow or fibrotic marrow)
3155F *with* 2P: Documentation of patient reason(s) for not performing baseline cytogenetic testing on bone marrow (eg, at time of diagnosis receiving palliative care or not receiving treatment as defined above)
3155F *with* 3P: Documentation of system reason(s) for not performing baseline cytogenetic testing on bone marrow (eg, patient previously treated by another physician at the time cytogenetic testing performed)

OR

Baseline Cytogenetic Testing not Performed, Reason not Otherwise Specified
Append a reporting modifier (8P) to CPT Category II code 3155F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.
3155F *with* 8P: Cytogenetic testing not performed on bone marrow at time of diagnosis or prior to initiating treatment, reason not otherwise specified

RATIONALE:
For MDS:
Cytogenetic testing is an integral component in calculating the International Prognostic Scoring System (IPSS) score. Cytogenetic testing should be performed on the bone marrow of patients with MDS in order to guide treatment options, determine prognosis, and predict the likelihood of disease evolution to leukemia.

For acute leukemias:
In addition to establishing the type of acute leukemia, cytogenetic testing is essential to detect chromosomal abnormalities that have diagnostic, prognostic, and therapeutic significance.

CLINICAL RECOMMENDATION STATEMENTS:
For MDS:
Bone marrow aspiration with Prussian blue stain for iron and biopsy are needed to evaluate the degree of hematopoietic cell maturation abnormalities and relative proportions, percentage of marrow blasts, marrow cellularity, presence or absence of ringed sideroblasts (and presence of iron per se), and fibrosis. Cytogenetics for bone marrow samples (by standard karyotypingmethods) should be obtained because they are of major importance for prognosis (Category 2A).

Significant independent variables for determining outcome for both survival and AML evolution were found to be marrow blast percentage, number of cytopenias, and cytogenetic subgroup (good, intermediate, poor). The

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percentage of marrow blasts was divisible into four categories: 1) less than 5%, 2) 5% to 10%, 3) 11% to 20%, and 4) 21% to 30% (Category 2A).

A chromosome abnormality confirms the presence of a clonal disorder aiding the distinction between MDS and reactive causes of dysplasia, and in addition has major prognostic value. Cytogenetic analysis should therefore be performed for all patients in whom a bone marrow examination is indicated (BCSH).

For Acute Leukemias:
Although cytogenetic information is usually unknown when treatment is initiated in patients with de novo AML, karyotype represents the single most important prognostic factor for predicting remission rate, relapse, and overall survival. Therefore, the importance of obtaining sufficient samples of marrow or peripheral blood blasts at diagnosis for this analysis cannot be overemphasized (Category 2A Recommendation).

The importance of obtaining adequate samples on marrow or peripheral blood at diagnosis to do full karyotyping as well as FISH probes for the most common abnormalities cannot be overemphasized. In addition to basic cytogentic analysis, new molecular markers are helping to refine prognostics groups particularly in patients with a normal karyotype (Category 2A Recommendation).

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♣ Measure #68 (NQF 0378): Hematology: Myelodysplastic Syndrome (MDS): Documentation of Iron Stores in Patients Receiving Erythropoietin Therapy

2013 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of patients aged 18 years and older with a diagnosis of MDS who are receiving erythropoietin therapy with documentation of iron stores within 60 days prior to initiating erythropoietin therapy

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for all MDS patients seen during the reporting period, regardless of when the documentation of iron stores occurs. It is anticipated that clinicians who provide services for patients with the diagnosis of myelodysplastic syndromes will submit this measure.

Measure Reporting via Claims:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. CPT Category II codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed ICD-9-CM diagnosis codes, CPT codes, and the appropriate CPT Category II code(s) OR the CPT Category II code(s) with the modifier. The modifiers allowed for this measure are: 3P- system reasons, 8P- reason not otherwise specified. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All patients aged 18 years and older with a diagnosis of MDS who are receiving erythropoietin therapy

> Denominator Criteria (Eligible Cases):
> Patients aged ≥ 18 years on date of encounter
> AND
> Diagnosis for MDS (ICD-9-CM): 238.72, 238.73, 238.74, 238.75
> Diagnosis for MDS (ICD-10-CM) [REFERENCE ONLY/Not Reportable]: D46.0, D46.1, D46.20, D46.21, D46.22, D46.4, D46.9, D46.A, D46.B, D46.C, D46.Z
> AND
> Patient encounter during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215

NUMERATOR:
Patients with documentation of iron stores within 60 days prior to initiating erythropoietin therapy

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Definitions:
Documentation of Iron Stores – Includes either: 1) bone marrow examination including iron stain OR 2) serum iron measurement including ferritin, serum iron and TIBC.
Erythropoietin Therapy – Includes the following medications: epoetin and darbepoetin for the purpose of this measure.

NUMERATOR NOTE: The correct combination of numerator code(s) must be reported on the claim form in order to properly report this measure. The "correct combination" of codes may require the submission of multiple numerator codes.

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Documentation of Iron Stores within 60 Days Prior to Initiating Erythropoietin Therapy Performed
*(Two CPT II codes [*3160F & 4090F*] are required on the claim form to submit this numerator option)*
CPT II 3160F: Documentation of iron stores prior to initiating erythropoietin therapy
AND
CPT II 4090F: Patient receiving erythropoietin therapy

OR

Documentation of Iron Stores within 60 Days Prior to Initiating Erythropoietin Therapy not Performed for System Reasons
*(Two CPT II codes [*3160F-3P & 4090F*] are required on the claim form to submit this numerator option)*
Append a modifier (3P) to CPT Category II code 3160F to report documented circumstances that appropriately exclude patients from the denominator.
3160F *with* 3P: Documentation of system reason(s) for not documenting iron stores prior to initiating erythropoietin therapy
AND
CPT II 4090F: Patient receiving erythropoietin therapy

OR

If patient is not eligible for this measure because patient is not receiving erythropoietin therapy, report:
*(One CPT II code [*4095F*] is required on the claim form to submit this numerator option)*
CPT II 4095F: Patient not receiving erythropoietin therapy

OR

Documentation of Iron Stores within 60 Days Prior to Initiating Erythropoietin Therapy not Performed, Reason not Otherwise Specified
*(Two CPT II codes [*3160F-8P & 4090F*] are required on the claim form to submit this numerator option)*
Append a reporting modifier (8P) to CPT Category II code 3160F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.
3160F *with* 8P: Iron stores prior to initiating erythropoietin therapy not documented, reason not otherwise specified
AND
CPT II 4090F: Patient receiving erythropoietin therapy

RATIONALE:
To be effective erythropoietin requires that adequate iron stores be present due to iron's importance in red-blood-cell synthesis. Iron deficiency presents a major limitation to the efficacy of erythropoietin therapy.

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CLINICAL RECOMMENDATION STATEMENTS:

Anemia related to MDS generally presents as a hypoproductive macrocytic anemia, often associated with suboptimal elevation of serum Epo levels. To determine FAB subtype, iron status, and the level of ring sideroblasts, bone marrow aspiration with iron stain, biopsy, and cytogenetics should be examined. Patients should also be considered for HLA-DR15 typing as indicated above. Iron repletion needs to be verified before instituting Epo or darbepoetintherapy.

2010 recommendation by American Society of Hematology: This recommendation remains the same as in 2007. Baseline and periodic monitoring of iron, total iron-binding capacity, transferrin saturation, or ferritin levels and instituting iron repletion when indicated may help to reduce the need for ESAs, maximize symptomatic improvement for patients, and determine the reason for failure to respond adequately to ESA therapy.

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♣ Measure #69 (NQF 0380): Hematology: Multiple Myeloma: Treatment with Bisphosphonates

2013 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of patients aged 18 years and older with a diagnosis of multiple myeloma, not in remission, who were prescribed or received intravenous bisphosphonate therapy within the 12-month reporting period

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for patients seen during the reporting period. It is anticipated that clinicians who provide services for the patients with the diagnosis of multiple myeloma, not in remission, will submit this measure.

Measure Reporting via Claims:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. CPT Category II codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed ICD-9-CM diagnosis codes, CPT codes, and the appropriate CPT Category II code OR the CPT Category II code with the modifier. The modifiers allowed for this measure are: 1P- medical reasons, 2P- patient reasons, 8P- reason not otherwise specified. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All patients aged 18 years and older with a diagnosis of multiple myeloma, not in remission

> Denominator Criteria (Eligible Cases):
> Patients aged ≥ 18 years on date of encounter
> AND
> Diagnosis for multiple myeloma – not in remission (ICD-9-CM): 203.00, 203.02
> Diagnosis for multiple myeloma – not in remission (ICD-10-CM) [REFERENCE ONLY/Not Reportable]: C90.00, C90.02
> AND
> Patient encounter during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215

NUMERATOR:
Patients who were prescribed or received intravenous bisphosphonate therapy within the 12 month reporting period

> Definitions:
> Bisphosphonate Therapy – Includes the following medications: pamidronate and zoledronate.

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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:
Intravenous Bisphosphonate Therapy Prescribed or Received
CPT II 4100F: Bisphosphonate therapy, intravenous, ordered or received

OR

Intravenous Bisphosphonate Therapy not Prescribed or Received for Medical or Patient Reasons
Append a modifier (1P or 2P) to CPT Category II code 4100F to report documented circumstances that appropriately exclude patients from the denominator.
4100F *with* 1P: Documentation of medical reason(s) for not prescribing bisphosphonates (eg, patients who do not have bone disease, patients with dental disease, patients with renal insufficiency)
4100F *with* 2P: Documentation of patient reason(s) for not prescribing bisphosphonates

OR

Intravenous Bisphosphonate Therapy not Prescribed, Reason not Otherwise Specified
Append a reporting modifier (8P) to CPT Category II code 4100F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.
4100F *with* 8P: Bisphosphonate therapy, intravenous, not ordered or received, reason not otherwise specified

RATIONALE:
Multiple myeloma is a disease characterized by bone destruction, in the form of diffuse osteopenia and/or osteolytic lesions, which develop in 85% of patients. Bisphosphonates can inhibit bone resorption by reducing the number and activity of osteoclasts and therefore could "reduce pain and bone fractures in people with multiple myeloma".

Bisphosphonates have played an important palliative role in the care of patients with MM. Use of these agents has demonstrated benefit in reducing painful bone complications. (Mayo Clin Proc. 2006;81(8):1047-1053)

CLINICAL RECOMMENDATION STATEMENTS:
Based on published data and clinical experience, the guidelines recommend the use of bisphosphonates for all patients with multiple Myeloma who have bone disease, including osteopenia (Category I Recommendation) (NCCN).

Intravenous bisphosphonates should be administered monthly for patients with MM and lytic disease evident on plain radiographs (Grade A, Level II). It is reasonable to start intravenous bisphosphonates in patients with MM who do not have lytic bone disease if there is evidence of osteopenia or osteoporosis on bone mineral density studies (Consensus Recommendation, Level N/A).

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♣ Measure #70 (NQF 0379): Hematology: Chronic Lymphocytic Leukemia (CLL): Baseline Flow Cytometry

2013 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of patients aged 18 years and older seen within a 12 month reporting period with a diagnosis of chronic lymphocytic leukemia (CLL) made at any time during or prior to the reporting period who had baseline flow cytometry studies performed and documented in the chart

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for patients seen during the reporting period, regardless of when the baseline flow cytometry studies are performed. It is anticipated that clinicians who provide services for patients with the diagnosis of chronic lymphocytic leukemia, not in remission, will submit this measure.

Measure Reporting via Claims:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. CPT Category II codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed ICD-9-CM diagnosis codes, CPT codes, and the appropriate CPT Category II code OR the CPT Category II code with the modifier. The modifiers allowed for this measure are: 1P- medical reasons, 2P- patient reasons, 3P- system reasons, 8P- reason not otherwise specified. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All patients aged 18 years and older seen within a 12 month reporting period, with a diagnosis of chronic lymphocytic leukemia (CLL) made at any time during or prior to the reporting period

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Diagnosis for CLL – not in remission (ICD-9-CM): 204.10, 204.12
Diagnosis for CLL – not in remission (ICD-10-CM) [REFERENCE ONLY/Not Reportable]: C91.10, C91.12
AND
Patient encounter during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215

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NUMERATOR:
Patients who had baseline flow cytometry studies performed and documented in the chart

Definition:
Baseline Flow Cytometry Studies – Refer to testing that is performed at time of diagnosis or prior to initiating treatment for that diagnosis. Treatment may include anti-neoplastic therapy.

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Baseline Flow Cytometry Studies Performed and Documented in the Chart
CPT II 3170F: Flow cytometry studies performed at time of diagnosis or prior to initiating treatment

OR

Baseline Flow Cytometry Studies not Performed or Documented in the Chart for Medical, Patient, or System Reasons
Append a modifier (1P, 2P or 3P) to CPT Category II code 3170F to report documented circumstances that appropriately exclude patients from the denominator.
3170F *with* 1P: Documentation of medical reason(s) for not performing baseline flow cytometry studies
3170F *with* 2P: Documentation of patient reason(s) for not performing baseline flow cytometry studies (eg, receiving palliative care or not receiving treatment as defined above)
3170F *with* 3P: Documentation of system reason(s) for not performing baseline flow cytometry studies (eg, patient previously treated by another physician at the time baseline flow cytometry studies were performed)

OR

Baseline Flow Cytometry Studies not Performed or Documented in the Chart, Reason not Otherwise Specified
Append a reporting modifier (8P) to CPT Category II code 3170F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.
3170F *with* 8P: Flow cytometry studies not performed at time of diagnosis or prior to initiating treatment, reason not otherwise specified

RATIONALE:
Due to the distinct pattern of protein antigens expressed in CLL, flow cytometry should be performed in order to confirm the diagnosis, correctly characterize the pathological cells, and determine prognosis. In some instances, flow cytometry may also offer additional therapeutically relevant information.

CLINICAL RECOMMENDATION STATEMENTS:
Adequate immunophenotyping using flow cytometry of peripheral blood or paraffin-section immunohistochemistry is required to confirm the diagnosis of CLL/SLL. These can be useful, particularly for diagnosing CLL/SLL type without circulating cells (Category 2A Recommendation).

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¥ Measure #71 (NQF 0387): Breast Cancer: Hormonal Therapy for Stage IC - IIIC Estrogen Receptor/ Progesterone Receptor (ER/PR) Positive Breast Cancer

2013 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of female patients aged 18 years and older with Stage IC through IIIC, ER or PR positive breast cancer who were prescribed tamoxifen or aromatase inhibitor (AI) during the 12-month reporting period

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for all female patients with breast cancer seen during the reporting period. Review estrogen receptor (ER) or progesterone receptor (PR) AND breast cancer stage status AND tumor size to determine which quality-data codes should be submitted. It is anticipated that clinicians who treat female breast cancer patients will submit this measure.

Measure Reporting via Claims:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. CPT Category II codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed ICD-9-CM diagnosis codes, CPT codes, and the appropriate CPT Category II codes OR the CPT Category II code(s) with the modifier. The modifiers allowed for this measure are: 1P- medical reasons, 2P- patient reasons, 3P- system reasons, 8P- reason not otherwise specified. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All female patients aged 18 years and older with Stage IC through IIIC, estrogen receptor (ER) or progesterone receptor (PR) positive breast cancer

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Diagnosis for breast cancer (ICD-9-CM): 174.0, 174.1, 174.2, 174.3, 174.4, 174.5, 174.6, 174.8, 174.9
Diagnosis for breast cancer (ICD-10-CM) [REFERENCE ONLY/Not Reportable]: C50.011, C50.012, C50.019, C50.111, C50.112, C50.119, C50.211, C50.212, C50.219, C50.311, C50.312, C50.319, C50.411, C50.412, C50.419, C50.511, C50.512, C50.519, C50.611, C50.612, C50.619, C50.811, C50.812, C50.819, C50.911, C50.912, C50.919
AND
Patient encounter during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215

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NUMERATOR:
Patients who were prescribed tamoxifen or aromatase inhibitor (AI) during the12-month reporting period

Definition:
Prescribed – Prescribed may include prescription given to the patient for tamoxifen or aromatase inhibitor (AI) at one or more visits in the 12-month period OR patient already taking tamoxifen or aromatase inhibitor (AI) as documented in the 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:
Tamoxifen or Aromatase Inhibitor Prescribed
(Three CPT II codes [4179F & 337xF & 3315F] are required on the claim form to submit this numerator option)
CPT II 4179F: Tamoxifen or aromatase inhibitor (AI) prescribed
AND

CPT II 3374F: AJCC Breast Cancer Stage I: TIC (tumor size > 1 cm to 2 cm), documented
OR
CPT II 3376F: AJCC Breast Cancer Stage II, documented
OR
CPT II 3378F: AJCC Breast Cancer Stage III, documented

AND
CPT II 3315F: Estrogen receptor (ER) or progesterone receptor (PR) positive breast cancer

OR

Tamoxifen or Aromatase Inhibitor not Prescribed for Medical, Patient, or System Reasons
(Three CPT II codes [4179F-xP & 337xF & 3315F] are required on the claim form to submit this numerator option)
Append a modifier (1P, 2P or 3P) to CPT Category II code 4179F to report documented circumstances that appropriately exclude patients from the denominator.
4179F *with* 1P: Documentation of medical reason(s) for not prescribing tamoxifen or aromatase inhibitor (eg, patient's disease has progressed to metastatic; patient is receiving a gonadotropin-releasing hormone analogue, patient has received oophorectomy, patient is receiving radiation or chemotherapy, patient's diagnosis date was ≥ 5 years from reporting date, other medical reasons)
4179F *with* 2P: Documentation of patient reason(s) for not prescribing tamoxifen or aromatase inhibitor (eg, patient refusal, other patient reasons)
4179F *with* 3P: Documentation of system reason(s) for not prescribing tamoxifen or aromatase inhibitor (eg, patient is currently enrolled in a clinical trial, other system reasons)
AND

CPT II 3374F: AJCC Breast Cancer Stage I: T1C (tumor size > 1 cm to 2 cm), documented
OR
CPT II 3376F: AJCC Breast Cancer Stage II, documented
OR
CPT II 3378F: AJCC Breast Cancer Stage III, documented

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AND
CPT II 3315F: Estrogen receptor (ER) or progesterone receptor (PR) positive breast cancer

OR

If patient is not eligible for this measure because patient is not stage IC through IIIC breast cancer, report:
Patient not Stage IC through IIIC Breast Cancer
(One CPT II code [3xxF] is required on the claim form to submit this numerator option)
Note: If reporting a code from the category below (3370F or 3372F or 3380F), it is not necessary to report the patient's ER/PR status.

CPT II 3370F: AJCC Breast Cancer Stage 0, documented
OR
CPT II 3372F: AJCC Breast Cancer Stage I: T1 mic, T1a or T1b (tumor size ≤ 1 cm), documented
OR
CPT II 3380F: AJCC Breast Cancer Stage IV, documented

OR

If patient is not eligible for this measure because patient is estrogen receptor (ER) and progesterone receptor (PR) negative, report:
Patient is Estrogen Receptor (ER) and Progesterone Receptor (PR) Negative
(One CPT II code [3316F] is required on the claim form to submit this numerator option)
Note: If reporting code 3316F, it is not necessary to report the patient's AJCC Cancer Stage.

CPT II 3316F: Estrogen receptor (ER) and progesterone receptor (PR) negative breast cancer

OR

If patient is not eligible for this measure because the cancer stage is not documented OR the ER/PR is not documented, report:
Cancer Stage not Documented OR ER/PR not Documented
(One CPT II code [3xxF-8P] is required on the claim form to submit this numerator option)
Append a reporting modifier (8P) to CPT Category II codes 3370F or 3316F to report circumstances when the patient is not eligible for the measure.
3370F *with* 8P: No documentation of cancer stage
OR
3316F *with* 8P: No documentation of estrogen receptor (ER) and progesterone receptor (PR) status
OR

Tamoxifen or Aromatase Inhibitor not Prescribed, Reason not Otherwise Specified
(Three CPT II codes [4179F-8P & 337xF & 3315F] are required on the claim form to submit this numerator option)
Append a reporting modifier (8P) to CPT Category II code 4179F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.
4179F *with* 8P: Tamoxifen or aromatase inhibitor not prescribed, reason not otherwise specified
AND

CPT II 3374F: AJCC Breast Cancer Stage I: TIC (tumor size > 1 cm to 2 cm), documented

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OR
CPT II 3376F: AJCC Breast Cancer Stage II, documented
OR
CPT II 3378F: AJCC Breast Cancer Stage III, documented

AND
CPT II 3315F: Estrogen receptor (ER) or progesterone receptor (PR) positive breast cancer

RATIONALE:
Despite evidence suggesting the role of adjuvant endocrine therapy in lowering the risk of tumor recurrence, many female patients who should be receiving this therapy are not. This measure assesses whether patients with a certain stage of breast cancer (IC through IIIC) and ER/PR+ are currently receiving the therapy. There are allowable medical, patient, and system reasons to document instances in which a woman with stage IC through IIIC, ER/PR+ may not be a candidate for the therapy.

Note: The reporting/managing physician does not need to have actually written the prescription; however, the reporting/managing physician must verify that the patient already has been prescribed the hormonal therapy by another physician.

CLINICAL RECOMMENDATION STATEMENTS:
Patients with lymph node involvement or with tumors greater than 1 cm in diameter are appropriate candidates for adjuvant systemic therapy. (Category 1) For those with lymph node-negative, hormone receptor-positive breast cancer tumors greater than 1 cm, endocrine therapy with chemotherapy is recommended. (Category 1) (NCCN, 2011)

Patients with invasive breast cancers that are estrogen or progesterone receptor positive should be considered for adjuvant endocrine therapy regardless of patient age, lymph node status, or whether or not adjuvant chemotherapy is to be administered. (Category 2A) (NCCN, 2011)

Postmenopausal women should consider taking an AI during the course of adjuvant treatment to lower recurrence risk, either as primary therapy or after 2 to 3 years of tamoxifen. Duration of AI therapy should not exceed 5 years. (ASCO, 2009)

Women who are pre- or perimenopausal at diagnosis should be treated with 5 years of tamoxifen. (ASCO, 2009)

The most firmly established adjuvant endocrine therapy is tamoxifen for both premenopausal and postmenopausal women...Prospective, randomized trials demonstrate that the optimal duration of tamoxifen appears to be five years. In patients receiving both tamoxifen and chemotherapy, chemotherapy should be given first, followed by sequential tamoxifen. A number of studies have evaluated aromatase inhibitors in the treatment of postmenopausal women with early-stage breast cancer. (Category 2A) (NCCN, 2011)

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¥ Measure #72 (NQF 0385): Colon Cancer: Chemotherapy for AJCC Stage III Colon Cancer Patient

2013 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of patients aged 18 through 80 years with AJCC Stage III colon cancer who are referred for adjuvant chemotherapy, prescribed adjuvant chemotherapy, or have previously received adjuvant chemotherapy within the 12-month reporting period

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for all patients with colon cancer seen during the reporting period. It is anticipated that clinicians who treat patients with colon cancer will submit this measure.

Measure Reporting via Claims:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. CPT Category II codes and G-codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed ICD-9-CM diagnosis codes, CPT codes, and the appropriate G-code AND/OR CPT Category II code OR the CPT Category II code with the modifier. The modifiers allowed for this measure are: 8P- reason not otherwise specified. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All patients aged 18 through 80 years with AJCC Stage III colon cancer

> Denominator Criteria (Eligible Cases):
> Patients aged 18 through 80 years on date of encounter
> AND
> Diagnosis for colon cancer (ICD-9-CM): 153.0, 153.1, 153.2, 153.3, 153.4, 153.6, 153.7, 153.8, 153.9
> Diagnosis for colon cancer (ICD-10-CM) [REFERENCE ONLY/Not Reportable]: C18.0, C18.2, C18.3, C18.4, C18.5, C18.6, C18.7, C18.8, C18.9
> AND
> Patient encounter during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215

NUMERATOR:
Patients who are referred for adjuvant chemotherapy, prescribed adjuvant chemotherapy, or who have previously received adjuvant chemotherapy within the 12-month reporting period

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Definitions:
Adjuvant Chemotherapy – According to current NCCN guidelines, the following therapies are recommended: 5-FU/LV/oxaliplatin (mFOLFOX6) as the standard of care (category 1); bolus 5-FU/LV/oxaliplatin (FLOX, category 1); capecitabine/oxaliplatin (CapeOx, category 1); or single agent capecitabine (category 2A) or 5-FU/LV (category 2A) in patients felt to be inappropriate for oxaliplatin therapy (NCCN). See clinical recommendation statement for cases where leucovorin is not available.
Prescribed – May include prescription ordered for the patient for adjuvant chemotherapy at one or more visits in the 12-month period OR patient already receiving adjuvant chemotherapy as documented in the 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:
Adjuvant Chemotherapy Referred, Prescribed or Previously Received
*(One G-code & one CPT II code [*G8927 & 3388F*] are required on the claim form to submit this numerator option)*
G8927: Adjuvant chemotherapy referred, prescribed or previously received for AJCC Stage III colon cancer
AND
CPT II 3388F: AJCC Colon Cancer Stage III, documented

OR

Adjuvant Chemotherapy not Referred, Prescribed or Previously Received for Documented Reasons
*(One G-code & one CPT II code [*G8928 & 3388F*] are required on the claim form to submit this numerator option)*
G8928: Adjuvant chemotherapy not prescribed or previously received, reason given
AND
CPT II 3388F: AJCC Colon Cancer Stage III, documented

OR

If patient is not eligible for this measure because patient is not stage III colon cancer, report:
Patient not Stage III Colon Cancer
*(One CPT II code [*33xxF*] is required on the claim form to submit this numerator option)*
CPT II 3382F: AJCC Colon Cancer Stage 0, documented
OR
CPT II 3384F: AJCC Colon Cancer Stage I, documented
OR
CPT II 3386F: AJCC Colon Cancer Stage II, documented
OR
CPT II 3390F: AJCC Colon Cancer Stage IV, documented

OR

If patient is not eligible for this measure because cancer stage is not documented, report:
Cancer Stage not Documented
*(One CPT II code [*3382F-8P*] is required on the claim form to submit this category)*
Append a reporting modifier (8P) to CPT Category II code 3382F to report circumstances when the patient is not eligible for the measure.
3382F *with* 8P: No documentation of cancer stage

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OR

Adjuvant Chemotherapy not Referred, Prescribed or Previously Received, Reason not Given
(One G-code & one CPT II code [G8929 & 3388F] are required on the claim form to submit this numerator option)
Report G8929 in circumstances when the action described in the numerator is not performed and the reason is not given.
G8929: Adjuvant chemotherapy not prescribed or previously received, reason not given.
AND
CPT II 3388F: AJCC Colon Cancer Stage III, documented

RATIONALE:
The receipt of adjuvant chemotherapy in Stage III colon cancer patients following primary surgical treatment is associated with a significant survival benefit.

CLINICAL RECOMMENDATION STATEMENTS:
For stage III patients (T1-4, N1-2, M0), the panel recommends 6 months of adjuvant chemotherapy following primary surgical treatment. The treatment options are: 5-FU/LV/oxaliplatin (mFOLFOX6) as the standard of care (Category 1); bolus 5-FU/LV/oxaliplatin (FLOX, Category 1), capecitabine/oxaliplatin (CapeOx, Category 1); or single agent capecitabine (Category 2A) or 5-FU/LV (Category 2A) in patients felt to be inappropriate for oxaliplatin therapy. (NCCN, 2012)

There is currently a shortage of leucovorin in the United States. There are no specific data to guide management under these circumstances, and all proposed strategies are empiric. The panel recommends several possible options to help alleviate the problems associated with this shortage. One is the use of levo-leucovorin, which is commonly used in Europe. A dose of 200 mg/m^2 of levo–leucovorin is equivalent to 400 mg/m^2 of standard leucovorin. Another option is for practices or institutions to use lower doses of leucovorin for all doses in all patients, since the panel feels that lower doses are likely to be as efficacious as higher doses, based on several studies...Finally, if none of the above options are available, treatment without leucovorin would be reasonable. (NCCN)

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▲Measure #76 (NQF 0464): Prevention of Catheter-Related Bloodstream Infections (CRBSI): Central Venous Catheter (CVC) Insertion Protocol

2013 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of patients, regardless of age, who undergo CVC insertion for whom CVC was inserted with all elements of maximal sterile barrier technique [cap AND mask AND sterile gown AND sterile gloves AND a large sterile sheet AND hand hygiene AND 2% chlorhexidine for cutaneous antisepsis (or acceptable alternative antiseptics per current guideline)] followed

INSTRUCTIONS:
This measure is to be reported each time a CVC insertion is performed during the reporting period. There is no diagnosis associated with this measure. It is anticipated that clinicians who perform CVC insertion will submit this measure.

Measure Reporting via Claims:
CPT procedure codes are used to identify patients who are included in the measure's denominator. CPT Category II codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed CPT codes, and the appropriate CPT Category II code OR the CPT Category II code with the modifier. The modifiers allowed for this measure are: 1P- medical reasons, 8P- reason not otherwise specified. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
CPT codes are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All patients, regardless of age, who undergo CVC insertion

> Denominator Criteria (Eligible Cases):
> Patient encounter during the reporting period (CPT): 36555, 36556, 36557, 36558, 36560, 36561, 36563, 36565, 36566, 36568, 36569, 36570, 36571, 36578, 36580, 36581, 36582, 36583, 36584, 36585, 93503

NUMERATOR:
Patients for whom central venous catheter (CVC) was inserted with all elements of maximal sterile barrier technique [cap AND mask AND sterile gown AND sterile gloves AND a large sterile sheet AND hand hygiene AND 2% chlorhexidine for cutaneous antisepsis (or acceptable alternative antiseptics, per current guideline)] followed

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Definition:
Maximal Sterile Barrier Technique during CVC Insertion – Includes use of all of the following: Cap AND mask AND sterile gown AND sterile gloves AND a large sterile sheet AND hand hygiene AND 2% chlorhexidine for cutaneous antisepsis (or acceptable alternative antiseptics, per current guideline).

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
All Elements of Maximal Sterile Barrier Technique Followed
CPT II 6030F: All elements of maximal sterile barrier technique followed including: cap AND mask AND sterile gown AND sterile gloves AND a large sterile sheet AND hand hygiene AND 2% chlorhexidine for cutaneous antisepsis (or acceptable alternative antiseptics, per current guideline)

OR

All Elements of Maximal Sterile Barrier Technique not Followed for Medical Reasons
Append a modifier (1P) to CPT Category II code 6030F to report documented circumstances that appropriately exclude patients from the denominator.
6030F *with* 1P: Documentation of medical reason(s) for not following all elements of maximal sterile barrier technique during CVC insertion (including CVC insertion performed on emergency basis)

OR

All Elements of Maximal Sterile Barrier Technique not Followed, Reason not Otherwise Specified
Append a reporting modifier (8P) to CPT Category II code 6030F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.
6030F *with* 8P: All elements of maximal sterile barrier technique not followed including: cap AND mask AND sterile gown AND sterile gloves AND a large sterile sheet AND hand hygiene AND 2% chlorhexidine for cutaneous antisepsis (or acceptable alternative antiseptics, per current guideline), reason not otherwise specified

RATIONALE:
Catheter-related bloodstream infection is a costly complication of central venous catheter insertion, but may be avoided with routine use of aseptic technique during catheter insertion. This measure is constructed to require that *all* of the listed elements of aseptic technique are followed and documented.

Existing hospital-level measures for this topic were consulted and, to the extent feasible, harmonization between physician- and hospital- level measurement was achieved.

CLINICAL RECOMMENDATION STATEMENTS:
Maximal sterile barrier precautions during catheter insertion: Use aseptic technique including the use of a cap, mask, sterile gown, sterile gloves, and a large sterile sheet, for the insertion of CVCs (including PICCS) or guidewire exchange. (CDC/MMWR) (Category IA)

Hand hygiene: Observe proper hand-hygiene procedures either by washing hands with conventional antiseptic-containing soap and water or with waterless alcohol-based gels or foams. Observe hand hygiene before and after palpating catheter insertion sites, as well as before and after inserting, replacing, accessing, repairing, or dressing an intravascular catheter. Palpation of the insertion site should not be performed after the application of antiseptic, unless aseptic technique is maintained. Use of gloves does not obviate the need for hand hygiene. (CDC/MMWR) (Category IA)

Cutaneous antisepsis: Disinfect clean skin with an appropriate antiseptic before catheter insertion and during dressing changes. Although a 2% chlorhexidine-based preparation is preferred, tincture of iodine, an iodophor, or 70% alcohol can be used. (CDC/MMWR) (Category IA)

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▲Measure #81 (NQF 0323): Adult Kidney Disease: Hemodialysis Adequacy: Solute

2013 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Percentage of calendar months within a 12-month period during which patients aged 18 years and older with a diagnosis of ESRD receiving hemodialysis three times a week for ≥ 90 days who have a spKt/V ≥ 1.2

INSTRUCTIONS:
This measure is to be reported each calendar month the patient meets denominator criteria for End-Stage Renal Disease (ESRD) patients seen during the reporting period. It is anticipated that clinicians providing care for patients with ESRD will submit this measure.

Measure Reporting via Registry:
ICD-9-CM diagnosis codes CPT codes, HCPCS codes and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data. There are no allowable performance exclusions for this measure.

DENOMINATOR:
All calendar months during which patients aged 18 years and older with a diagnosis of ESRD are receiving hemodialysis three times a week for ≥ 90 days

DENOMINATOR NOTE: There should be documentation in the patient's chart that he/she is receiving hemodialysis three times per week for ***≥ 90 days****.*

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Diagnosis for ESRD (ICD-9-CM): 585.6
Diagnosis for ESRD (ICD-10-CM) [REFERENCE ONLY/Not Reportable]: N18.6
AND
Encounter for Dialysis and Dialysis Catheter Care (ICD-9-CM): V56.0, V56.1, V56.32
Encounter for Dialysis and Dialysis Catheter Care (ICD-10-CM) [REFERENCE ONLY/Not Reportable]: Z49.01, Z49.31, Z49.32
AND
Hemodialysis treatment performed exactly three times per week **for ≥ 90 days:** G8714
AND
Patient encounter during the reporting period (CPT): 90957, 90958, 90959, 90960, 90961, 90962, 90965, 90966, 90969, 90970

NUMERATOR:
Calendar months during which patients have a spKt/V ≥ 1.2

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NUMERATOR NOTE: *Urea kinetic modeling (UKM) or the second generation Daugirdas formula (simplified multivariable equation) are the most appropriate ways to calculate spKt/V, and the two accepted methods for calculating spKt/V per the KDOQI guidelines. For more information on these methods, please refer to National Kidney Foundation's KDOQI Clinical Practice Guidelines and Clinical Practice Recommendations for 2006 Updates: Hemodialysis Adequacy, Peritoneal Dialysis Adequacy and Vascular Access. Am J Kidney Dis 48:S1-S322, 2006 (suppl 1).*

Numerator Options:
spKt/V greater than or equal to 1.2 (single-pool clearance of urea [Kt] / volume [V]) (G8713)

OR

spKt/V less than 1.2 (single-pool clearance of urea [Kt] / volume [V]), reason not given (G8717)

RATIONALE:
Adequate dialysis dose (Kt/V ≥ 1.2), is strongly associated with better outcomes, including decreased mortality, fewer hospitalizations, decreased length of hospitalizations, and decreased hospital costs. (Plantinga et al, 2007 and Sehgal et al, 2001)

CLINICAL RECOMMENDATION STATEMENTS:
The following evidence statements are quoted verbatim from the referenced clinical guidelines. Only selected portions of the clinical guidelines are quoted here; for more details, please refer to the full guideline.

The minimally adequate dose of HD given 3 times per week to patients with Kr less than 2 mL/min/1.73m2 should be an spKt/V (excluding RKF) of 1.2 per dialysis. For treatment times less than 5 hours, an alternative minimum dose is a URR of 65% (A). The target dose for HD given 3 times per week with Kr less than 2mL/min/1.73m2 should be an spKt/V of 1.4 per dialysis not including RKF, or URR of 70% (A). (KDOQI, 2006)

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▲Measure #82 (NQF 0321): Adult Kidney Disease: Peritoneal Dialysis Adequacy: Solute

2013 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Percentage of patients aged 18 years and older with a diagnosis of ESRD receiving peritoneal dialysis who have a total Kt/V ≥ 1.7 per week measured once every 4 months

INSTRUCTIONS:
This measure is to be reported up to three times per reporting year for End-Staged Renal Disease (ESRD) patients receiving peritoneal dialysis during the entire reporting period and seen during the reporting period. This measure should be reported according to the following frequency depending on the number of months during the reporting period a patient is receiving peritoneal dialysis:

- 1 to 4 consecutive months of treatment – report once during the reporting year
- 5 to 8 consecutive months of treatment – report twice during the reporting year
- 9 to 12 consecutive months of treatment – report three times during the reporting year

It is anticipated that clinicians providing care for patients with ESRD will submit this measure.

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data. There are no allowable performance exclusions for this measure.

DENOMINATOR:
All patients aged 18 years and older with a diagnosis of ESRD receiving peritoneal dialysis

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Diagnosis for ESRD (ICD-9-CM): 585.6
Diagnosis for ESRD (ICD-10-CM) [REFERENCE ONLY/Not Reportable]: N18.6
AND
Encounter for Dialysis and Dialysis Catheter Care (ICD-9-CM): V56.2, V56.32, V56.8
Encounter for Dialysis and Dialysis Catheter Care (ICD-10-CM) [REFERENCE ONLY/Not Reportable]: Z49.02, Z49.32
AND
Patient encounter during the reporting period (CPT): 90945, 90947, 90957, 90958, 90959, 90960, 90961, 90962, 90965, 90966, 90969, 90970

NUMERATOR:
Patients who have a total Kt/V ≥ 1.7 per week measured once every 4 months

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Definition:
Total Kt/V - Total Kt/V includes residual kidney function and equals peritoneal dialysate Kt/V plus renal Kt/V.

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Total Kt/V greater than or equal to 1.7 per week (Total clearance of urea [Kt]/volume [V]) (G8718)

OR

Total Kt/V less than 1.7 per week (Total clearance of urea [Kt]/volume [V]), reason not given (G8720)

RATIONALE:
Adequate dialysis dose is strongly associated with better outcomes, including decreased mortality, fewer hospitalizations, fewer days in the hospital, and decreased hospital costs. (Plantinga et al, 2007)

CLINICAL RECOMMENDATION STATEMENTS:
The following evidence statements are quoted verbatim from the referenced clinical guidelines. Only selected portions of the clinical guidelines are quoted here; for more details, please refer to the full guideline.

Total solute clearance (residual kidney and peritoneal, in terms of Kt/V urea) should be measured within the first month after initiating dialysis therapy and at least once every 4 months thereafter (B). (KDOQI, 2006)

For patients with residual kidney function (considered to be significant when urine volume is > 100 mL/d): The minimal "delivered" dose of total small-solute clearance should be a total (peritoneal and kidney) Kt/V urea of at least 1.7 per week (B). For patients without RKF (considered insignificant when urine volume is ≤ 100 mol/d): The minimal "delivered" dose of total small-solute clearance should be a peritoneal Kt/V urea of at least 1.7 per week measured within the first month after starting dialysis therapy and at least once every 4 months thereafter (B). (KDOQI, 2006)

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▲ Measure #83 (NQF 0393): Hepatitis C: Testing for Chronic Hepatitis C – Confirmation of Hepatitis C Viremia

2013 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Percentage of patients aged 18 years and older with a diagnosis of hepatitis C seen for an initial evaluation who had HCV RNA testing ordered or previously performed

INSTRUCTIONS:
This measure should be reported on the first visit occurring during the reporting period for all patients with a diagnosis of hepatitis C seen during the reporting period. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT codes, CPT Category II codes and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All patients aged 18 years and older with a diagnosis of hepatitis C seen for initial evaluation

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Diagnosis for Hepatitis C (ICD-9-CM): 070.51, 070.54, 070.70
Diagnosis for Hepatitis C (ICD-10-CM) [REFERENCE ONLY/Not Reportable]: B17.10, B18.2, B19.20
AND
Initial evaluation for condition (CPT II): 1119F
AND
Patient encounter during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215

NUMERATOR:
Patients for whom HCV RNA testing was ordered or previously performed

Numerator Options:
Ribonucleic acid (RNA) testing for Hepatitis C viremia ordered or results documented (3265F)
OR
Documentation of medical reason(s) for not ordering or performing RNA testing for HCV (3265F *with* 1P)
OR
Documentation of patient reason(s) for not ordering or performing RNA testing for HCV (3265F *with* 2P)
OR

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RNA testing for HCV was not ordered or results not documented, reason not otherwise specified (3265F *with* 8P)

RATIONALE:
HCV RNA testing is needed to establish and confirm diagnosis of chronic hepatitis C. HCV is an RNA virus of the Flaviviridae family. HCV replicates preferentially in hepatocytes but is not directly cytopathic, leading to persistent infection. (NIH) After initial exposure, HCV RNA can be detected in blood within 1 to 3 weeks and is present at the onset of symptoms. Antibodies to HCV are detected by enzyme immunoassay (EIA) in only 50 to 70 percent of patients at the onset of symptoms, increasing to more than 90 percent after 3 months. Establishment of the baseline viral RNA level is very important in interpreting the response to therapy.

CLINICAL RECOMMENDATION STATEMENTS:
HCV ribonucleic acid (RNA) testing should be performed in:

a. patients with a positive anti-HCV test
b. patients for whom antiviral treatment is being considered, using a sensitive quantitative assay
c. patients with unexplained liver disease whose anti-HCV test is negative and who are immunocompromised or suspected of having acute HCV infection (AASLD, 2009)

For the diagnosis of acute hepatitis C, HCV RNA testing is required since HCV RNA appears before anti-HCV antibodies may be detectable. (EASL, 2011)

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▲Measure #84 (NQF 0395): Hepatitis C: Ribonucleic Acid (RNA) Testing Before Initiating Treatment

2013 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

If reporting Measure #84: Hepatitis C: RNA Testing Before Initiating Treatment, also report 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 quantitative HCV RNA testing was performed within 6 months prior to initiation of antiviral treatment

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for all patients with a diagnosis of chronic hepatitis C seen during the reporting period. This measure is intended to reflect the quality of services provided for patients with chronic hepatitis C who are receiving antiviral treatment. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

Measure Reporting via Claims:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. CPT Category II codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed ICD-9-CM diagnosis codes, CPT codes, and the appropriate CPT Category II code(s) OR the CPT Category II code(s) with the modifier. The modifiers allowed for this measure are: 1P- medical reasons, 8P- reason not otherwise specified. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All patients aged 18 years and older with a diagnosis of chronic hepatitis C who are receiving antiviral treatment

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Diagnosis for chronic hepatitis C (ICD-9-CM): 070.54
Diagnosis for chronic hepatitis C (ICD-10-CM) [REFERENCE ONLY/Not Reportable]: B18.2
AND
Patient encounter during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215

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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 6 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 6 months prior to initiation of antiviral treatment for Hepatitis C (eg, if patient is first seen by physician after initiation of treatment)
AND
CPT II 4150F: Patient receiving antiviral treatment for Hepatitis C

OR

If patient is not eligible for this measure because patient is not receiving antiviral treatment, report:
*(One CPT II code [*4151F*] is required on the claim form to submit this numerator option)*
CPT II 4151F: Patient not receiving antiviral treatment for Hepatitis C

OR

RNA Testing not Performed within Six Months, Reason not Otherwise Specified
*(Two CPT II codes [*3218F-8P & 4150F*] are required on the claim form to submit this numerator option)*
Append a reporting modifier (8P) to CPT Category II code 3218F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.
3218F *with* 8P: RNA testing for Hepatitis C was not documented as performed within 6 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

RATIONALE:
The diagnosis of acute or chronic HCV infection generally requires testing of serum for both antibody to HCV (anti-HCV) and for HCV RNA. A sensitive quantitative HCV RNA assay is recommended for diagnosis because it also provides information on the level of virus which is helpful in management. The differentiation of acute from chronic HCV infection depends on the clinical presentation: namely the presence of symptoms or jaundice, and whether or not there was a prior history of ALT elevation and its duration. After acute exposure, HCV RNA is usually detected in serum before antibody; HCV RNA can be identified as early as 2 weeks following exposure whereas anti-HCV is generally not detectable before 8-12 weeks. These two markers of HCV infection may be present in varying permutations, requiring careful analysis for interpretation. (AASLD, 2009)

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CLINICAL RECOMMENDATION STATEMENTS:

HCV RNA testing should be performed in:
a) Patients with a positive anti-HCV test
b) Patients for whom antiviral treatment is being considered, using a sensitive quantitative assay
c) Patients with unexplained liver disease whose anti-HCV test is negative and who are immunocompromised or suspected of having acute HCV infection (AASLD, 2009)

HCV RNA should be tested by a highly sensitive quantitative assay at the initiation of or shortly before treatment and at week 12 of therapy. (AASLD, 2009)

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▲Measure #85 (NQF 0396): Hepatitis C: HCV Genotype Testing Prior to Treatment

2013 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

If reporting Measure #85: Hepatitis C HCV Genotype Testing Prior to Treatment, also report Measure #84: Hepatitis C: 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 HCV genotype testing was performed prior to initiation of antiviral treatment

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for all patients with a diagnosis of chronic hepatitis C seen during the reporting period. This measure is intended to reflect the quality of services provided for patients with chronic hepatitis C who are receiving antiviral treatment. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

Measure Reporting via Claims:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. CPT Category II codes and/or G-codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed ICD-9-CM diagnosis codes, CPT codes, and the appropriate CPT Category II code AND/OR G-code OR the CPT Category II code with the modifier AND G-code. The reporting modifier allowed for this measure is: 8P- reason not otherwise specified. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All patients aged 18 years and older with a diagnosis of chronic hepatitis C who are receiving antiviral treatment

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Diagnosis for chronic hepatitis C (ICD-9-CM): 070.54
Diagnosis for chronic hepatitis C (ICD-10-CM) [REFERENCE ONLY/Not Reportable]: B18.2
AND
Patient encounter during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215

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NUMERATOR:
Patients for whom HCV genotype testing was performed 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 Otherwise 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

RATIONALE:
To guide treatment decisions regarding duration of therapy and likelihood of response. There are 6 HCV genotypes and more than 50 subtypes. These genotypes differ by as much as 31 to 34 percent in their nucleotide sequences, whereas subtypes differ by 20 to 23 percent based on full-length genomic sequence comparisons. Genotype determinations influence treatment decisions. Patients with genotypes 2 or 3 have better response rates to re-treatment than those with genotype 1. (NIH) More recently, treatment of genotype 1b has shown the most favorable outcomes leading to differences in the licensure and use of new therapies by sub-genotype.

CLINICAL RECOMMENDATION STATEMENTS:
HCV genotyping should be performed in all HCV-infected persons prior to interferon-based treatment in order to plan for the dose and duration of therapy and to estimate the likelihood of response. (AASLD, 2009)

The HCV genotype must be assessed prior to antiviral treatment initiation and will determine the dose of ribavirin and treatment decision. (EASL, 2011)

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▲Measure #86 (NQF 0397): Hepatitis C: Antiviral Treatment Prescribed

2013 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

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

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for patients with a diagnosis of chronic hepatitis C seen during the reporting period. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

Measure Reporting via Claims:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. CPT Category II codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed ICD-9-CM diagnosis codes, CPT codes, and the appropriate CPT Category II code OR the CPT Category II code with the modifier. The modifiers allowed for this measure are: 1P- medical reasons, 2P- patient reasons, 3P- system reasons, 8P- reason not otherwise specified. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All patients aged 18 years and older with a diagnosis of chronic hepatitis C

> Denominator Criteria (Eligible Cases):
> Patients aged ≥ 18 years on date of encounter
> AND
> Diagnosis for chronic hepatitis C (ICD-9-CM): 070.54
> Diagnosis for chronic hepatitis C (ICD-10-CM) [REFERENCE ONLY/Not Reportable]: B18.2
> AND
> Patient encounter during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215

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

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and ribavirin therapy as documented in current medication list (i.e., may include additional antiviral therapy, as appropriate).

NUMERATOR NOTE: The language of "at a minimum" in this measure is an acknowledgement that the recommended treatment for hepatitis C genotype 1 has changed to include directly-acting antiviral medications, in addition to peginterferon and ribavirin. However, the recommended treatment for genotypes 2-6 remains the same: only peginterferon and ribavirin. Further treatment changes are anticipated in the near future; therefore, in an effort to keep this measure feasible and to accommodate changing treatments, the base requirement for this measure is to prescribe peginterferon and ribavirin. Further measure modifications are expected in the coming years.

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 ribavarin therapy within 12 month reporting period (eg, patient was not a candidate for therapy, could not tolerate)
4153F *with* 2P: Documentation of patient reason(s) for not prescribing peginterferon and ribavirin therapy within 12 month reporting period (eg, patient declined)
4153F *with* 3P: Documentation of system reason(s) for not prescribing peginterferon and ribavirin therapy within 12 month reporting period (eg, patient has no insurance coverage, therapy not covered)

OR

Peginterferon and Ribavirin Therapy not Prescribed, Reason not Otherwise 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

RATIONALE:
Assure that antiviral therapy is prescribed for all patients with confirmed Hepatitis C.

The standard of care (SOC) therapy for patients with chronic hepatitis C virus (HCV) infection has been the use of both peginterferon (PegIFN) and ribavirin (RBV). These drugs are administered for either 48 weeks (HCV genotypes 1, 4, 5, and 6) or for 24 weeks (HCV genotypes 2 and 3), inducing sustained virologic response (SVR) rates of 40%-50% in those with genotype 1 and of 80% or more in those with genotypes 2 and 3 infections. (AASLD, 2011)

Two major advances have occurred since the last update of treatment guidelines for chronic hepatitis C (CHC) that have changed the optimal treatment regimen of genotype 1 chronic HCV infection: the development of direct-acting antiviral (DAA) agents and the identification of several single-nucleotide polymorphisms associated with spontaneous and treatment-induced clearance of HCV infection. Although PegIFN and RBV remain vital components of therapy, the emergence of DAAs has led to a substantial improvement in SVR rates and the option of abbreviated therapy in many patients with genotype 1 chronic HCV infection. A revision of the prior treatment guidelines is therefore necessary, but is based on data that are presently limited. Accordingly, there may be need to reconsider some of the recommendations as additional data become available. (AASLD, 2011)

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The issue of treatment of chronic HCV infection is in constant flux. There is highly active clinical research in this area, and new information appears with increasing frequency. (AASLD, 2009)

CLINICAL RECOMMENDATION STATEMENTS:
The optimal therapy for chronic HCV infection is the combination of peginterferon alfa and ribavirin. (AASLD, 2009)

The optimal therapy for genotype 1, chronic HCV infection is the use of boceprevir or telaprevir in combination with peginterferon alfa and ribavirin. (AASLD, 2011)

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▲Measure #87 (NQF 0398): Hepatitis C: HCV Ribonucleic Acid (RNA) Testing at Week 12 of Treatment

2013 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

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

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for all patients with a diagnosis of chronic hepatitis C seen during the reporting period. This measure is intended to reflect the quality of services provided for patients with chronic hepatitis C who are receiving antiviral treatment. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

Measure Reporting via Claims:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. CPT Category II codes and/or G-codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed ICD-9-CM diagnosis codes, CPT codes, and the appropriate CPT Category II code AND/OR G-code OR the CPT Category II code with the modifier AND G-code. The modifiers allowed for this measure are: 1P- medical reasons, 2P- patient reasons, 8P- reason not otherwise specified. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All patients aged 18 years and older with a diagnosis of chronic hepatitis C who are receiving antiviral treatment

> Denominator Criteria (Eligible Cases):
> Patients aged ≥ 18 years on date of encounter
> AND
> Diagnosis for chronic hepatitis C (ICD-9-CM): 070.54
> Diagnosis for chronic hepatitis C (ICD-10-CM) [REFERENCE ONLY/Not Reportable]: B18.2
> AND
> Patient encounter during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215

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

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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

OR

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

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RATIONALE:
Monitor effectiveness of antiviral therapy. An early virologic response (EVR), during the first 12 weeks of therapy, is a valuable clinical milestone.

Patients should be monitored during therapy to assess the response to treatment and for the occurrence of side effects. A reasonable schedule would be monthly visits during the first 12 weeks of treatment followed by visits at 8 to 12 week intervals thereafter until the end of therapy. At each visit the patient should be questioned regarding the presence of side effects and depression. They should also be queried about adherence to treatment. Laboratory monitoring should include measurement of the complete blood count, serum creatinine and ALT levels, and HCV RNA by a sensitive assay at weeks 4, 12, 24, 4 to 12 week intervals thereafter, the end of treatment, and 24 weeks after stopping treatment. (AASLD,2009)

CLINICAL RECOMMENDATION STATEMENTS:
HCV RNA should be tested by a highly sensitive quantitative assay at the initiation of or shortly before treatment and at week 12 of therapy. (AASLD, 2009)

Patients [with genotype 1] without cirrhosis treated with boceprevir, peginterferon, and ribavirin, preceded by 4 weeks of lead-in peginterferon and ribavirin, whose HCV RNA level at weeks 8 and 24 is undetectable, may be considered for a shortened duration of treatment of 28 weeks in total (4 weeks lead-in with peginterferon and ribavirin followed by 24 weeks of triple therapy). (AASLD, 2011)

Patients [with genotype 1] without cirrhosis treated with telaprevir, peginterferon, and ribavirin, whose HCV RNA level at weeks 4 and 12 is undetectable should be considered for a shortened duration of therapy of 24 weeks. (AASLD, 2011)

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▲Measure #89 (NQF 0401): Hepatitis C: Counseling Regarding Risk of Alcohol Consumption

2013 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

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

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for patients with a diagnosis of hepatitis C seen during the reporting period. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

Measure Reporting via Claims:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. CPT Category II codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed ICD-9-CM diagnosis codes, CPT codes, and the appropriate CPT Category II code OR the CPT Category II code with the modifier. The reporting modifier allowed for this measure is: 8P- reason not otherwise specified. There are no allowable performance exclusions for this measure. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data. There are no allowable performance exclusions for this measure.

DENOMINATOR:
All patients aged 18 years and older with a diagnosis of hepatitis C

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Diagnosis for hepatitis C (ICD-9-CM): 070.51, 070.54, 070.70
Diagnosis for hepatitis C (ICD-10-CM) [REFERENCE ONLY/Not Reportable]: B17.10, B18.2, B19.20
AND
Patient encounter during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215

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

Definition:

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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 Otherwise 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

RATIONALE:
There are numerous studies that have reported a strong association between the use of excess alcohol and the development or progression of liver fibrosis and even the development of HCC. Moreover, excess alcohol intake may increase HCV RNA replication and interfere with response to treatment. Controversy exists, however, about the level of alcohol intake that is clearly harmful to the HCV-infected person. It is widely believed that the daily consumption of more than 50 grams of alcohol has a high likelihood of worsening the fibrosis, but there are reports of levels of alcohol intake of less than that amount having a deleterious effect on the liver disease. (AASLD, 2009)

CLINICAL RECOMMENDATION STATEMENTS:
Persons with chronic HCV infection should be advised to abstain from alcohol consumption. (AASLD, 2009)

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▲Measure #90 (NQF 0394): Hepatitis C: Counseling Regarding Use of Contraception Prior to Antiviral Therapy

2013 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

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

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for all patients with a diagnosis of chronic hepatitis C seen during the reporting period. This measure is intended to reflect the quality of services provided for patients with chronic hepatitis C who are receiving antiviral treatment. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

Measure Reporting via Claims:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. CPT Category II codes and/or G-codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed ICD-9-CM diagnosis codes, CPT codes, and the appropriate CPT Category II code AND/OR G-code OR the CPT Category II code with the modifier AND G-code. The modifiers allowed for this measure are: 1P- medical reasons, 8P- reason not otherwise specified. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All women 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

Denominator Criteria (Eligible Cases):
Patients (females aged 18 through 44 years or males aged ≥ 18 years) on date of encounter
AND
Diagnosis for chronic hepatitis C (ICD-9-CM): 070.54
Diagnosis for chronic hepatitis C (ICD-10-CM) [REFERENCE ONLY/Not Reportable]: B18.2
AND
Patient encounter during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215

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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

Counseling Regarding Contraception not Received, Reason not Otherwise 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

RATIONALE:
Ribavirin is contraindicated in pregnancy. Therefore, counseling regarding strict precautions and contraception in women of childbearing age and their sexual partners and in HCV-infected men with female partners of childbearing age needs to be provided to those receiving treatment for chronic hepatitis C prior to the initiation of treatment. Although this measure only captures data related to counseling prior to therapy it should be subsequently re-enforced during treatment and for a period of 6 months after treatment.

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CLINICAL RECOMMENDATION STATEMENTS:

Ribavirin is reported to cause fetal death and fetal abnormalities in animals and thus it is imperative for persons who receive the drug to use strict contraceptive methods both during treatment and for a period of 6 months thereafter. (AASLD, 2009)

Ribavirin is contraindicated in pregnancy, necessitating strict precautions and contraception in women of childbearing age and their sexual partners and in HCV-infected men with female partners of childbearing age. (AGA)

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▲Measure #91 (NQF 0653): Acute Otitis Externa (AOE): Topical Therapy

2013 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of patients aged 2 years and older with a diagnosis of AOE who were prescribed topical preparations

INSTRUCTIONS:
This measure is to be reported once for each occurrence of AOE during the reporting period. Each unique occurrence is defined as a 30-day period from onset of AOE. Claims data will be analyzed to determine unique occurrences. If multiple claims are submitted within that 30-day period, only one instance of reporting will be counted. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

Measure Reporting via Claims:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. CPT Category II codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the appropriate ICD-9-CM diagnosis codes, CPT codes, and the appropriate CPT Category II code OR the CPT Category II code with the modifier. The modifiers allowed for this measure are: 1P- medical reasons, 2P- patient reasons, 8P- reason not otherwise specified. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All patients aged 2 years and older with a diagnosis of AOE

> Denominator Criteria (Eligible Cases):
> Patients aged ≥ 2 years on date of encounter
> AND
> Diagnosis for AOE (ICD-9-CM): 380.10, 380.11, 380.12, 380.13, 380.22
> Diagnosis for AOE (ICD-10-CM) [REFERENCE ONLY/Not Reportable]: H60.00, H60.01, H60.02, H60.03, H60.10, H60.11, H60.12, H60.13, H60.311, H60.312, H60.313, H60.319, H60.321, H60.322, H60.323, H60.329, H60.331, H60.332, H60.333, H60.339, H60.391, H60.392, H60.393, H60.399, H60.501, H60.502, H60.503, H60.509, H60.511, H60.512, H60.513, H60.519, H60.521, H60.522, H60.523, H60.529, H60.531, H60.532, H60.533, H60.539, H60.541, H60.542, H60.543, H60.549, H60.551, H60.552, H60.553, H60.559, H60.591, H60.592, H60.593, H60.599, H61.90, H61.91, H61.92, H61.93, H62.40, H62.41, H62.42, H62.43, H62.8X1, H62.8X2, H62.8X3, H62.8X9
> AND
> Patient encounter during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99281, 99282, 99283, 99284, 99285

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NUMERATOR:
Patients who were prescribed topical preparations

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 Quality-Data Coding Options for Reporting Satisfactorily:
Topical Preparations Prescribed
CPT II 4130F: Topical preparations (including OTC) prescribed for acute otitis externa

OR

Topical Preparations not Prescribed for Medical or Patient Reasons
Append a modifier (1P or 2P) to CPT Category II code 4130F to report documented circumstances that appropriately exclude patients from the denominator.
4130F *with* 1P: Documentation of medical reason(s) for not prescribing topical preparations (including OTC) for acute otitis externa (eg, coexisting acute otitis media, tympanic membrane perforation)
4130F *with* 2P: Documentation of patient reason(s) for not prescribing topical preparations (including OTC) for acute otitis externa

OR

Topical Preparations not Prescribed, Reason not Otherwise Specified
Append a reporting modifier (8P) to CPT Category II code 4130F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.
4130F *with* 8P: Topical preparations (including OTC) for acute otitis externa (AOE) not prescribed, reason not otherwise specified

RATIONALE:
Topical preparations should be used to treat AOE as they are active against the most common bacterial pathogens in AOE, Pseudomonas aeruginosa and Staphylococcus aureus. Topical preparations have demonstrated efficacy in the treatment of AOE with resolution in about 65-90% of patients.

CLINICAL RECOMMENDATION STATEMENTS:
Clinicians should use topical preparations for initial therapy of diffuse, uncomplicated AOE. (Recommendation based on randomized controlled trials with minor limitations and a preponderance of benefit over harm. [Aggregate evidence quality – Grade B]) (AAO-HNSF)

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▲Measure #93 (NQF 0654): Acute Otitis Externa (AOE): Systemic Antimicrobial Therapy – Avoidance of Inappropriate Use

2013 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of patients aged 2 years and older with a diagnosis of AOE who were not prescribed systemic antimicrobial therapy

INSTRUCTIONS:
This measure is to be reported once for each occurrence of AOE during the reporting period. Each unique occurrence is defined as a 30-day period from onset of AOE. Claims data will be analyzed to determine unique occurrences. If multiple claims are submitted within that 30-day period, only one instance of reporting will be counted. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

Measure Reporting via Claims:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. CPT Category II codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the appropriate ICD-9-CM diagnosis codes, CPT codes, and the appropriate CPT Category II code OR the CPT Category II code with the modifier. The modifier allowed for this measure is: 1P- medical reasons. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All patients aged 2 years and older with a diagnosis of AOE

Denominator Criteria (Eligible Cases):
Patients aged ≥ 2 years on date of encounter
AND
Diagnosis for AOE (ICD-9-CM): 380.10, 380.11, 380.12, 380.13, 380.22
Diagnosis for AOE (ICD-10-CM) [REFERENCE ONLY/Not Reportable]: H60.00, H60.01, H60.02, H60.03, H60.10, H60.11, H60.12, H60.13, H60.311, H60.312, H60.313, H60.319, H60.321, H60.322, H60.323, H60.329, H60.331, H60.332, H60.333, H60.339, H60.391, H60.392, H60.393, H60.399, H60.501, H60.502, H60.503, H60.509, H60.511, H60.512, H60.513, H60.519, H60.521, H60.522, H60.523, H60.529, H60.531, H60.532, H60.533, H60.539, H60.541, H60.542, H60.543, H60.549, H60.551, H60.552, H60.553, H60.559, H60.591, H60.592, H60.593, H60.599, H61.90, H61.91, H61.92, H61.93, H62.40, H62.41, H62.42, H62.43, H62.8X1, H62.8X2, H62.8X3, H62.8X9
AND

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Patient encounter during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99281, 99282, 99283, 99284, 99285

NUMERATOR:
Patients who were not prescribed systemic antimicrobial therapy

Numerator Instructions: For performance, the measure will be calculated as the number of patients for whom systemic antimicrobial therapy was not prescribed over the number of patients in the denominator (patients aged 2 years and older with acute otitis externa). A higher score indicates appropriate treatment of patients with AOE (e.g., the proportion for whom systemic antimicrobials were not prescribed).

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Systemic Antimicrobial Therapy not Prescribed
CPT II 4132F: Systemic antimicrobial therapy not prescribed

OR

Systemic Antimicrobial Therapy Prescribed for Medical Reasons
Append a modifier (1P) to CPT Category II code 4131F to report documented circumstances that appropriately exclude patients from the denominator
4131F *with* 1P: Documentation of medical reason(s) for prescribing systemic antimicrobial therapy (eg, coexisting diabetes, immune deficiency)

OR

Systemic Antimicrobial Therapy Prescribed
CPT II 4131F: Systemic antimicrobial therapy prescribed

RATIONALE:
Despite their limited utility, many patients with AOE receive systemic antimicrobial therapy, often in addition to topical therapy. “There are no data on the efficacy of systemic therapy with the use of appropriate antibacterials and stratified by severity of the infection. Moreover, orally administered antibiotics have significant adverse effects that include rashes, vomiting, diarrhea, allergic reactions, altered nasopharyngeal flora, and development of bacterial resistance.” The use of systemic antimicrobial therapy to treat AOE should be limited only to those clinical situations in which it is indicated.

CLINICAL RECOMMENDATION STATEMENTS:
Systemic antimicrobial therapy should not be used unless there is extension outside the ear canal or the presence of specific host factors that would indicate a need for systemic therapy. (Recommendation based on randomized controlled trials with minor limitations and a preponderance of benefit over harm. [Aggregate evidence quality – Grade B]) (AAO-HNSF)

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€ Measure #99 (NQF 0391): Breast Cancer Resection Pathology Reporting: pT Category (Primary Tumor) and pN Category (Regional Lymph Nodes) with Histologic Grade

2013 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of breast cancer resection pathology reports that include the pT category (primary tumor), the pN category (regional lymph nodes), and the histologic grade

INSTRUCTIONS:
This measure is to be reported each time a breast cancer resection surgical pathology examination is performed during the reporting period for breast cancer patients. Each unique CPT Category I code submitted on the claim will be counted for denominator inclusion. It is anticipated that clinicians who examine breast tissue specimens following resection in a laboratory or institution will submit this measure. Independent laboratories (ILs) and independent diagnostic testing facilities (IDTFs), using indicator Place of Service 81, are not included in PQRS. If the specimen is not primary breast tissue (e.g., liver, lung), report only CPT II code 3250F.

Measure Reporting via Claims:
ICD-9-CM diagnosis codes and CPT codes are used to identify patients who are included in the measure's denominator. CPT Category II codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the appropriate ICD-9-CM diagnosis codes, CPT codes, and the appropriate CPT Category II code OR the CPT Category II code with the modifier. The modifiers allowed for this measure are: 1P- medical reasons, 8P- reason not otherwise specified. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
ICD-9-CM diagnosis codes and CPT codes are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All breast cancer resection pathology reports (excluding biopsies)

Denominator Criteria (Eligible Cases):
Diagnosis for breast cancer (ICD-9-CM): 174.0, 174.1, 174.2, 174.3, 174.4, 174.5, 174.6, 174.8, 174.9, 175.0, 175.9
Diagnosis for breast cancer (ICD-10-CM) [REFERENCE ONLY/Not Reportable]: C50.011, C50.012, C50.019, C50.021, C50.022, C50.029, C50.111, C50.112, C50.119, C50.121, C50.122, C50.129, C50.211, C50.212, C50.219, C50.221, C50.222, C50.229, C50.311, C50.312, C50.319, C50.321, C50.322, C50.329, C50.411, C50.412, C50.419, C50.421, C50.422, C50.429, C50.511, C50.512, C50.519, C50.521, C50.522, C50.529, C50.611, C50.612, C50.619, C50.621, C50.622, C50.629, C50.811, C50.812, C50.819, C50.821, C50.822, C50.829, C50.911, C50.912, C50.919, C50.921, C50.922, C50.929
AND
Patient encounter during the reporting period (CPT): 88307, 88309

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NUMERATOR:
Reports that include the pT category, the pN category and the histologic grade

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
pT Category, pN Category and Histologic Grade Documented
CPT II 3260F: pT category (primary tumor), pN category (regional lymph nodes), and histologic grade documented in pathology report

OR

pT Category, pN Category and Histologic Grade not Documented for Medical Reasons
Append a modifier (1P) to CPT Category II code 3260F to report documented circumstances that appropriately exclude patients from the denominator.
3260F *with* 1P: Documentation of medical reason(s) for not including pT category, pN category, and histologic grade in the pathology report (eg, re-excision without residual tumor)

OR

If patient is not eligible for this measure because the specimen is not primary breast tissue (e.g., liver, lung) report:
CPT II 3250F: Specimen site other than anatomic location of primary tumor

OR

pT Category, pN Category and Histologic Grade not Documented, Reason not Otherwise Specified
Append a reporting modifier (8P) to CPT Category II code 3260F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.
3260F *with* 8P: pT category, pN category, and histologic grade were not documented in pathology report, reason not otherwise specified

RATIONALE:
Therapeutic decisions for breast cancer management are stage driven and cannot be made without a complete set of pathology descriptors. Incomplete cancer resection pathology reports may result in misclassification of patients, rework and delays, and suboptimal management. The College of American Pathologists (CAP) has produced evidence-based checklists of essential pathologic parameters that are recommended to be included in cancer resection pathology reports. These checklists have been endorsed as a voluntary standard by National Quality Forum (NQF) and are considered the reporting standard by the Commission on Cancer (CoC) of the American College of Surgeons (ACS).

The CAP recently conducted a structured audit of breast cancer pathology report adequacy at 86 institutions. Overall, 35% of eligible reports were missing at least one of the ten CAP-recommended breast cancer elements. Cancer Care Ontario (CCO) conducted a similar study in 2005 and found that 25% of breast cancer pathology reports did not include all of the information required by the CAP standards. While the exact percentage of breast cancer resection pathology reports that are missing the pT category, the pN category and the histologic grade is unknown, these are essential elements in breast cancer treatment decisions and should be included in every pathology report when possible.

A complete set of pathology descriptors is necessary for breast cancer management. This is so that the doctor can track the stages of the cancer. If a cancer resection pathology report is not complete this can lead to incorrect classification as well as delays in the treatment process. The evidence based checklist produced by The College of American Pathologists (CAP) contains essential pathologic parameters that are recommended to be included in cancer resection pathology reports.

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CLINICAL RECOMMENDATION STATEMENTS:

All invasive breast carcinomas, with the exception of medullary carcinoma should be graded. The grading system used must be specified in the report; the Nottingham combined histologic grade (Elston-Ellis modification of Scarff-Bloom-Richardson grading system) is recommended. Within each stage grouping there is a relation between histologic grade and outcome (CAP).

All patients with breast cancer should be assigned a clinical stage of disease, and if appropriate evaluation is available, a pathologic stage of disease. The routine use of staging allows for efficient identification of local treatment options, assists in identifying systemic treatment options, allows the comparison of outcomes results across institutions and clinical trials, and provides baseline prognostic information (NCCN).

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€ Measure #100 (NQF 0392): Colorectal Cancer Resection Pathology Reporting: pT Category (Primary Tumor) and pN Category (Regional Lymph Nodes) with Histologic Grade

2013 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of colon and rectum cancer resection pathology reports that include the pT category (primary tumor), the pN category (regional lymph nodes) and the histologic grade

INSTRUCTIONS:
This measure is to be reported each time a colorectal cancer resection surgical pathology examination is performed during the reporting period for colorectal cancer patients. Each unique CPT Category I code submitted on the claim will be counted for denominator inclusion. It is anticipated that clinicians who examine colorectal tissue specimens following resection in a laboratory or institution will submit this measure. Independent Laboratories (ILs) and Independent Diagnostic Testing Facilities (IDTFs), using indicator Place of Service 81, are not included in PQRS. If the specimen is not primary colorectal tissue (e.g., liver, lung), report only G8723.

Measure Reporting via Claims:
ICD-9-CM diagnosis codes and CPT codes are used to identify patients who are included in the measure's denominator. G-codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the appropriate ICD-9-CM diagnosis codes, CPT codes, and the appropriate G-code. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
ICD-9-CM diagnosis codes and CPT codes are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All colon and rectum cancer resection pathology reports

Denominator Criteria (Eligible Cases):
Diagnosis for colon or rectum cancer (ICD-9-CM): 153.0, 153.1, 153.2, 153.3, 153.4, 153.5, 153.6, 153.7, 153.8, 153.9, 154.0, 154.1, 154.8
Diagnosis for colon or rectum cancer (ICD-9-CM) [REFERENCE ONLY/Not Reportable]: C18.0, C18.1, C18.2, C18.3, C18.4, C18.5, C18.6, C18.7, C18.8, C18.9, C19, C20, C21.2, C21.8
AND
Patient encounter during the reporting period (CPT): 88309

NUMERATOR:
Reports that include the pT category, the pN category and the histologic grade

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Numerator Quality-Data Coding Options for Reporting Satisfactorily:
pT Category, pN Category and Histologic Grade Documented
G8721: pT category (primary tumor), pN category (regional lymph nodes), and histologic grade were documented in pathology report

OR

pT Category, pN Category and Histologic Grade not Documented for Medical Reasons
G8722: Medical reason(s) documented for not including pT category, pN category and histologic grade in the pathology report (e.g., anal canal)

OR

If patient is not eligible for this measure because the specimen is not primary colorectal tissue (e.g., liver, lung) report:
G8723: Specimen site is other than anatomic location of primary tumor

OR

pT Category, pN Category and Histologic Grade not Documented, Reason not Given
G8724: pT category, pN category and histologic grade were not documented in the pathology report, reason not given

RATIONALE:
Therapeutic decisions for colorectal cancer management are stage driven and cannot be made without a complete set of pathology descriptors. Incomplete cancer resection pathology reports may result in misclassification of patients, rework and delays, and suboptimal management. The College of American Pathologists (CAP) has produced evidence-based checklists of essential pathologic parameters that are recommended to be included in cancer resection pathology reports. These checklists have been endorsed as a voluntary standard by National Quality Forum (NQF) and are considered the reporting standard by the Commission on Cancer (CoC) of the American College of Surgeons (ACS).

The CAP recently conducted a structured audit of colorectal cancer pathology report adequacy at 86 institutions. Overall, 34% of eligible reports were missing at least one of the ten CAP-recommended colorectal cancer elements. Cancer Care Ontario (CCO) conducted a similar study in 2005 and found that 31% of colorectal cancer pathology reports did not include all of the information required by the CAP standards.

While the exact percentage of colorectal cancer resection pathology reports that are missing the pT category, the pN category and the histologic grade is unknown, these are essential elements in colorectal cancer treatment decisions and should be included in every pathology report when possible.

CLINICAL RECOMMENDATION STATEMENTS:
Surgical resection remains the most effective therapy for colorectal carcinoma, and the best estimation of prognosis is derived from the pathologic findings on the resection specimen. The anatomic extent of disease is by far the most important prognostic factor in colorectal cancer. The protocol recommends the TNM staging system of the American Joint Committee on Cancer (AJCC) and the International Union Against Cancer (UICC)1 but does not preclude the use of other staging systems. By AJCC/UICC convention, the designation “T” refers to a primary tumor that has not been previously treated. The symbol “p” refers to the pathologic classification of the TNM, as opposed to the clinical classification, and is based on gross and microscopic examination. pT entails a resection of the primary tumor or biopsy adequate to evaluate the highest pT category, pN entails removal or biopsy of nodes adequate to validate lymph node metastasis, and pM implies microscopic examination of distant lesions.

Colorectal cancers are usually staged after surgical exploration of the abdomen and pathologic examination of the surgical specimen. Some of the criteria that should be included in the report of the pathologic evaluation include the

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following: grade of the cancer; depth of penetration and extension to adjacent structures (T); number of regional lymph nodes evaluated; number of positive regional lymph nodes (N); an assessment of the presence of distant metastasis to other organs, the peritoneum of an abdominal structure, or in non-regional lymph nodes (M); the status of proximal, distal and radial margins; lymphovascular invasion, perineurial invasion and extra-nodal tumor deposits (NCCN).

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▲Measure #102 (NQF 0389): Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low Risk Prostate Cancer Patients

2013 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of patients, regardless of age, with a diagnosis of prostate cancer at low risk of recurrence receiving interstitial prostate brachytherapy, OR external beam radiotherapy to the prostate, OR radical prostatectomy, OR cryotherapy who did not have a bone scan performed at any time since diagnosis of prostate cancer

INSTRUCTIONS:
This measure is to be reported once per episode of treatment (i.e., interstitial prostate brachytherapy, OR external beam radiotherapy to the prostate, OR radical prostatectomy, OR cryotherapy) for all patients with prostate cancer who receive interstitial prostate brachytherapy, external beam radiotherapy to the prostate, radical prostatectomy, or cryotherapy during the reporting period. Claims data will be analyzed to determine unique episodes of radiation therapy. Each episode of radiation therapy in an eligible patient receiving external beam radiotherapy to the prostate occurring during the reporting period will be counted when calculating the reporting and performance rates. The PQRS quality-data code needs to be submitted only once during the episode of radiation therapy (e.g., 8 weeks of therapy). It is anticipated that clinicians who perform the listed procedures as specified in the denominator coding will submit this measure.

Measure Reporting via Claims:
ICD-9-CM diagnosis codes and CPT codes are used to identify patients who are included in the measure's denominator. CPT Category II codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the appropriate ICD-9-CM diagnosis code, CPT codes, and the appropriate CPT Category II code(s) OR the CPT Category II code(s) with the modifier. The modifiers allowed for this measure are: 1P- medical reasons, 3P- system reasons. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
ICD-9-CM diagnosis codes and CPT codes are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All patients, regardless of age, with a diagnosis of prostate cancer at low risk of recurrence receiving interstitial prostate brachytherapy, OR external beam radiotherapy to the prostate, OR radical prostatectomy, OR cryotherapy

DENOMINATOR NOTE: Only patients with prostate cancer with low risk of recurrence will be counted in the performance denominator of this measure.

Denominator Criteria (Eligible Cases):
Diagnosis for prostate cancer (ICD-9-CM): 185
Diagnosis for prostate cancer (ICD-10-CM) [REFERENCE ONLY/Not Reportable]: C61

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AND
Patient encounter during the reporting period (CPT): 55810, 55812, 55815, 55840, 55842, 55845, 55866, 55873, 55875, 55876, 77427, 77776, 77777, 77778, 77787

NUMERATOR:
Patients who did *not* have a bone scan performed at any time since diagnosis of prostate cancer

Numerator Instructions: A higher score indicates appropriate treatment of patients with prostate cancer at low risk of recurrence.

Definitions:
Risk Strata: Low, Intermediate, or High –
Low Risk – PSA ≤ 10 ng/ml; AND Gleason score 6 or less; AND clinical stage T1c or T2a.
Intermediate Risk – PSA > 10 to 20 ng/ml; OR Gleason score 7; OR clinical stage T2b, and not qualifying for high risk.
High Risk – PSA > 20 ng/ml; OR Gleason score 8 to 10; OR clinically localized stage T3a.

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:
Bone Scan not Performed
(Two CPT II codes [3270F & 3271F] are required on the claim form to submit this numerator option)
CPT II 3270F: Bone scan not performed prior to initiation of treatment nor at any time since diagnosis of prostate cancer
AND
CPT II 3271F: Low risk of recurrence, prostate cancer
OR
Bone Scan Performed for Medical or System Reasons
(Two CPT II codes [3269F-xP & 3271F] are required on the claim form to submit this numerator option)
Append a modifier (1P or 3P) to CPT Category II code 3269F to report documented circumstances that appropriately exclude patients from the denominator.
3269F *with* 1P: Documentation of medical reason(s) for performing a bone scan (including documented pain, salvage therapy, other medical reasons)
3269F *with* 3P: Documentation of system reason(s) for performing a bone scan (including bone scan ordered by someone other than reporting physician)
AND
CPT II 3271F: Low risk of recurrence, prostate cancer

OR

If patient is not eligible for this measure because the risk of recurrence is intermediate, high or not determined, report:
(One CPT II code [327xF] is required on the claim form to submit this numerator option)
Intermediate Risk of Recurrence
CPT II 3272F: Intermediate risk of recurrence, prostate cancer
OR
High Risk of Recurrence
CPT II 3273F: High risk of recurrence, prostate cancer

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OR

Risk of Recurrence not Determined

CPT II 3274F: Prostate cancer risk of recurrence not determined or neither low, intermediate nor high

OR

Bone Scan Performed

(Two CPT II codes [3269F & 3271F] are required on the claim form to submit this numerator option)

CPT II 3269F: Bone scan performed prior to initiation of treatment or at any time since diagnosis of prostate cancer

AND

CPT II 3271F: Low risk of recurrence, prostate cancer

RATIONALE:

A bone scan is generally not required for staging prostate cancer in men with a low risk of recurrence and receiving primary therapy. This measure is written as a negative measure so that the performance goal is 100%, consistent with the other measures for this condition.

CLINICAL RECOMMENDATION STATEMENTS:

Routine use of a bone scan is not required for staging asymptomatic men with clinically localized prostate cancer when their PSA is equal to or less than 20.0 ng/mL. (AUA)

For symptomatic patients and/or those with a life expectancy of greater than 5 years, a bone scan is appropriate for patients with any of the following: 1) T1 disease with PSA over 20 ng/mL or T2 disease with PSA over 10 ng/mL; 2) a Gleason score of 8 or higher; 3) T3 to T4 tumors or symptomatic disease. (NCCN) (Category 2A)

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▲Measure #104 (NQF 0390): Prostate Cancer: Adjuvant Hormonal Therapy for High Risk Prostate Cancer Patients

2013 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of patients, regardless of age, with a diagnosis of prostate cancer at high risk of recurrence receiving external beam radiotherapy to the prostate who were prescribed adjuvant hormonal therapy (GnRH agonist or antagonist)

INSTRUCTIONS:
This measure is to be reported once per episode of radiation therapy for all patients with prostate cancer who receive external beam radiotherapy to the prostate during the reporting period. Claims data will be analyzed to determine unique episodes of radiation therapy. Each episode of radiation therapy in an eligible patient receiving external beam radiotherapy to the prostate occurring during the reporting period will be counted when calculating the reporting and performance rates. The PQRS quality-data code needs to be submitted only once during the episode of radiation therapy (e.g., 8 weeks of therapy). It is anticipated that clinicians who perform external beam radiotherapy to the prostate will submit this measure.

Measure Reporting via Claims:
ICD-9-CM diagnosis codes and CPT codes are used to identify patients who are included in the measure's denominator. CPT Category II codes and/or G-codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed ICD-9-CM diagnosis code, CPT code, and the appropriate CPT Category II code AND/OR G-code OR the CPT Category II code with the modifier AND G-code. The modifiers allowed for this measure are: 1P- medical reasons, 2P- patient reasons, 8P- reason not otherwise specified. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
The ICD-9-CM diagnosis code and CPT codes are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All patients, regardless of age, with a diagnosis of prostate cancer at high risk of recurrence receiving external beam radiotherapy to the prostate

> *DENOMINATOR NOTE: Only patients with prostate cancer with high risk of recurrence will be counted in the performance denominator of this measure.*
>
> Denominator Criteria (Eligible Cases):
> Diagnosis for prostate cancer (ICD-9-CM): 185
> Diagnosis for prostate cancer (ICD-10-CM) [REFERENCE ONLY/Not Reportable]: C61
> AND
> Patient encounter during the reporting period (CPT): 77427

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NUMERATOR:
Patients who were prescribed adjuvant hormonal therapy (GnRH [gonadotropin-releasing hormone] agonist or antagonist)

Definitions:
Risk Strata: Low, Intermediate, or High –
Low Risk – PSA ≤ 10 ng/ml; AND Gleason score 6 or less; AND clinical stage T1c or T2a.
Intermediate Risk – PSA > 10 to 20 ng/ml; OR Gleason score 7; OR clinical stage T2b, and not qualifying for high risk.
High Risk – PSA > 20 ng/ml; OR Gleason score 8 to 10; OR clinically localized stage T3a.
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:
Adjuvant Hormonal Therapy Prescribed/Administered
*(One CPT II code & one G-code [*4164F & G8465*] are required on the claim form to submit this numerator option)*
CPT II 4164F: Adjuvant (ie, in combination with external beam radiotherapy to the prostate for prostate cancer) hormonal therapy (GnRH [gonadotropin-releasing hormone] agonist or antagonist) prescribed/administered
AND
G8465: High risk of recurrence of prostate cancer

OR

Adjuvant Hormonal Therapy not Prescribed/Administered for Medical or Patient Reasons
*(One CPT II code & one G-code [*4164F-xP & G8465*] are required on the claim form to submit this numerator option)*
Append a modifier (1P or 2P) to CPT Category II code 4164F to report documented circumstances that appropriately exclude patients from the denominator.
4164F *with* 1P: Documentation of medical reason(s) for not prescribing/administering adjuvant hormonal therapy (eg, salvage therapy)
4164F *with* 2P: Documentation of patient reason(s) for not prescribing/administering adjuvant hormonal therapy
AND
G8465: High risk of recurrence of prostate cancer

OR

If patient is not eligible for this measure because the risk of recurrence is low, intermediate or not determined, report:
*(One G-code [*G8464*] is required on the claim form to submit this numerator option)*
G8464: Clinician documented that prostate cancer patient is not an eligible candidate for adjuvant hormonal therapy; Low or intermediate risk of recurrence OR risk of recurrence not determined

OR

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Adjuvant Hormonal Therapy not Prescribed/Administered, Reason not Otherwise Specified
*(One CPT II code & one G-code [*4164F-8P & G8465*] are required on the claim form to submit this numerator option)*
Append a reporting modifier (8P) to CPT Category II code 4164F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.
4164F *with* 8P: Patients who were not prescribed/administered adjuvant hormonal therapy, reason not otherwise specified
AND
G8465: High risk of recurrence of prostate cancer

RATIONALE:
If receiving external beam radiotherapy as primary therapy, prostate cancer patients with a high risk of recurrence should also be prescribed hormonal therapy, which has been shown to increase the effectiveness of the radiotherapy.

CLINICAL RECOMMENDATION STATEMENTS:
High risk patients who are considering specific treatment options should be informed of findings of recent high quality clinical trials, including those considering external beam radiotherapy, use of hormonal therapy combined with conventional radiotherapy may prolong survival. (AUA) (Standard)

There are several treatment options for patients with high-risk disease. The preferred treatment is 3D-CRT/IMRT with daily IGRT in conjunction with long-term ADT; ADT alone is insufficient. In particular, patients with low volume, high grade tumors warrant aggressive local radiation combined with typically 2-3 years of ADT. (NCCN, Category 1)

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▲Measure #106 (NQF 0103): Adult Major Depressive Disorder (MDD): Comprehensive Depression Evaluation: Diagnosis and Severity

2013 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of patients aged 18 years and older with a diagnosis of major depressive disorder (MDD) with evidence that they met the DSM-IV-TR criteria for MDD AND for whom there is an assessment of depression severity during the visit in which a new diagnosis or recurrent episode was identified

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for all patients with an active diagnosis of major depressive disorder seen during the reporting period, including episodes of MDD that began prior to the reporting period. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

Measure Reporting via Claims:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. CPT Category II codes and/or G-codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed ICD-9-CM diagnosis codes, CPT codes, and the appropriate CPT Category II code AND/OR G-code OR the CPT Category II code with the modifier. The reporting modifier allowed for this measure is: 8P- reason not otherwise specified. There are no allowable performance exclusions for this measure. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data. There are no allowable performance exclusions for this measure.

DENOMINATOR:
All patients aged 18 years and older with a diagnosis of major depressive disorder (MDD)

> Denominator Criteria (Eligible Cases):
> Patients aged ≥ 18 years on date of encounter
> AND
> Diagnosis for MDD (ICD-9-CM): 296.20, 296.21, 296.22, 296.23, 296.24, 296.30, 296.31, 296.32, 296.33, 296.34
> Diagnosis for MDD (ICD-10-CM) [REFERENCE ONLY/Not Reportable]: F32.0, F32.1, F32.2, F32.3, F32.9, F33.0, F33.1, F33.2, F33.3, F33.9
> AND
> Patient encounter during the reporting period (CPT): 90791, 90792, 90832, 90834, 90837, 90839, 90845, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215

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NUMERATOR:
Patients with evidence that they met the DSM-IV-TR criteria for Major Depressive Disorder AND for whom there is an assessment of depression severity during the visit in which a new diagnosis or recurrent episode was identified

Definitions:
MDD diagnosis (DSM-IV-TR) - For a diagnosis of MDD a patient must endorse five of nine symptoms, with one of those five being either 1) depressed mood or 2) loss of interest or pleasure. The other symptoms include significant weight loss or gain, or decrease or increase in appetite nearly every day; insomnia or hypersomnia nearly every day; psychomotor agitation or retardation nearly every day; feelings of worthlessness or guilt nearly every day; diminished ability to think or concentrate, or indecisiveness, nearly every day; and recurrent thoughts of death or suicidal ideation.

These symptoms must be present for a duration of 2 weeks or longer and cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

These symptoms must:

- Not meet criteria for a mixed episode,
- Not be due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., hypothyroidism), OR
- Not be better accounted for by bereavement, i.e., after the loss of a loved one, the symptoms persist for longer than 2 months or are characterized by marked functional impairment, morbid preoccupation with worthlessness, suicidal ideation, psychotic symptoms, or psychomotor retardation.

Severity – According to DSM-IV-TR (2000), severity is judged to be mild, moderate, or severe based on the number of criteria symptoms, the severity of the symptoms, and the degree of functional disability and distress. See the Rationale and Clinical Recommendation Statements Sections for Supporting Guidelines and Other References for additional information on defining severity levels.

NUMERATOR NOTES:
For clinicians who use the term relapse, generally that refers to an episode of MDD that occurs within 6 months after either response or remission, which may be a variation on the initial episode. This measure is intended to capture either an initial or recurrent episode.

It can be helpful to use screening tools such as the PHQ-9 in order to substantiate the need for further evaluation and accurate diagnosis of MDD; however, simply using a tool alone would not constitute making a successful MDD diagnosis. A validated depression screening tool may include the PHQ-9, which is based on the DSM-IV-TR criteria for MDD. Other validated tools based on the DSM-IV-TR criteria may be available; this list is not intended to be all-inclusive.

Please refer to the most recent version of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM) (version IV-TR as of 2012) for more information regarding diagnosing Major Depressive Disorder.

It is expected that an initial evaluation will occur during the visit in which a new diagnosis or recurrent episode was identified.

FOR PATIENTS WHOSE EPISODE OF MDD BEGAN PRIOR TO THE CURRENT REPORTING PERIOD: The clinician should report that DSM-IV-TR criteria and depression severity was assessed during the visit in which the new diagnosis or recurrent episode was identified.

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Numerator Quality-Data Coding Options for Reporting Satisfactorily:
DSM-IV-TR Criteria for Major Depressive Disorder Documented
(One CPT II code & one G-code [1040F & G8930] are required on the claim form to submit this numerator option)
CPT II 1040F: DSM-IV™ criteria for major depressive disorder documented at the initial evaluation
AND
G8930: Assessment of depression severity at the initial evaluation

OR

DSM-IV-TR Criteria for Major Depressive Disorder not Documented, Reason not Otherwise Specified
(One CPT II code [1040-8P] or one G-code [G8931] are required on the claim form to submit this numerator option)
Append a reporting modifier (8P) to CPT Category II code 1040F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.
1040F *with* 8P: DSM-IV-TR criteria for major depressive disorder not documented at the initial evaluation, reason not otherwise specified
OR
G8931: Assessment of depression severity not documented, reason not given

RATIONALE:
Chronic depression often goes unrecognized and untreated. The recognition and appropriate treatment of MDD is dependent on a thorough diagnostic assessment and an evaluation of the degree of severity of the disorder. A diagnostic assessment can help clinicians tailor a patient's treatment to their needs. It can help clinicians rule-out general medical conditions or other psychiatric conditions which may be contributing to depressive symptomology. An assessment of severity can also help clinicians tailor a patient's treatment. As noted in clinical guidelines, treatment methods should vary by the severity of depression. A diagnostic evaluation should be instituted for all patients with major depressive disorder to determine whether a diagnosis of depression is warranted and to reveal the presence of other conditions that may have an impact on treatment.

CLINICAL RECOMMENDATION STATEMENTS:
The following evidence statements are quoted verbatim from the referenced clinical guidelines. Only selected portions of the clinical guidelines are quoted here; for more details, please refer to the full guideline.

Patients should receive a thorough diagnostic assessment in order to establish the diagnosis of major depressive disorder, identify other psychiatric or general medical conditions that may require attention, and develop a comprehensive plan for treatment [I]. (APA 2010)

Criteria for Major Depressive Episode
A. At least five of the following symptoms have been present during the same 2-week period and represent a change from previous functioning; at least one of the symptoms is either 1) depressed mood or 2) loss of interest or pleasure (do not include symptoms that are clearly due to general medical condition or mood-incongruent delusions or hallucinations).
    1. Depressed mood most of the day, nearly every day as indicated by either subjective report (eg, feels sad or empty) or observation made by others (eg, appears tearful)
    2. Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation made by others)
    3. Significant weight loss when not dieting or weight gain (eg, a change of more than 5% body weight in a month), or decrease in appetite nearly every day
    4. Insomnia or hypersomnia nearly every day

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5. Psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down)
6. Fatigue or loss of energy nearly every day
7. Feelings of worthlessness or excessive inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick)
8. Diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or observed by others)
9. Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or specific plan for committing suicide

B. The symptoms do not meet criteria for a mixed episode
C. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning
D. The symptoms are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., hypothyroidism)
E. The symptoms are not better accounted for by bereavement, ie, after the loss of a loved one, the symptoms persist for longer than 2 months or are characterized by marked functional impairment, morbid preoccupation with worthlessness, suicidal ideation, psychotic symptoms, or psychomotor retardation. (DSM-IV-TR 2000)

Major depressive disorder can alter functioning in numerous spheres of life including work, school, family, social relationships, leisure activities, or maintenance of health and hygiene. The psychiatrist (clinician) should evaluate the patient's activity in each of these domains and determine the presence, type, severity, and chronicity of any dysfunction [I]. (APA, 2010)

In developing a treatment plan, interventions should be aimed at maximizing the patient's level of functioning as well as helping the patient to set specific goals appropriate to his or her functional impairments and symptom severity [I]. (APA, 2010)

If criteria are currently met for the major depressive episode, it can be classified as Mild, Moderate, Severe Without Psychotic Features, or Severe with Psychotic Features. [The fifth digit (in the diagnostic codes for Major Depressive Disorder) indicates the severity as follows: 1 for mild severity, 2 for moderate severity, 3 for severe without psychotic features, and 4 for severe with psychotic features.] (DSM-IV-TR 2000)

Severity is judged to be mild, moderate, or severe based on the number of criteria symptoms, the severity of the symptoms, and the degree of functional disability and distress. (DSM-IV-TR 2000)

- Mild episodes are characterized by the presence of only five or six depressive symptoms and either mild disability or the capacity to function normally but with substantial and unusual effort.
- Episodes that are Severe Without Psychotic Features are characterized by the presence of most of the criteria symptoms and clear-cut, observable disability (e.g., inability to work or care for children).
- Moderate episodes have a severity that is intermediate between mild and severe.
- [Severe With Psychotic Features] indicates the presence of either delusions or hallucinations (typically auditory). The clinician can indicate the nature of the psychotic features by specifying With Mood-Congruent Features [ie, content of the delusions or hallucinations are consistent with the depressive themes] or With Mood-Incongruent Features (i.e., content of the delusions or hallucinations has no apparent relationship to depressive themes).

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▲ Measure #107 (NQF 0104): Adult Major Depressive Disorder (MDD): Suicide Risk Assessment

2013 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of patients aged 18 years and older with a diagnosis of major depressive disorder (MDD) with a suicide risk assessment completed during the visit in which a new diagnosis or recurrent episode was identified

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for all patients with an active diagnosis of major depressive disorder seen individually during the reporting period, including episodes of MDD that began prior to the reporting period. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

Measure Reporting via Claims:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. CPT Category II code(s) are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed ICD-9-CM diagnosis codes, CPT codes, and the appropriate CPT Category II code OR G-code. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All patients aged 18 years and older with a diagnosis of major depressive disorder (MDD)

> Denominator Criteria (Eligible Cases):
> Patients aged ≥ 18 years on date of encounter
> AND
> Diagnosis for MDD (ICD-9-CM): 296.20, 296.21, 296.22, 296.23, 296.24, 296.30, 296.31, 296.32, 296.33, 296.34
> Diagnosis for MDD (ICD-10-CM) [REFERENCE ONLY/Not Reportable]: F32.0, F32.1, F32.2, F32.3, F32.9, F33.0, F33.1, F33.2, F33.3, F33.9
> AND
> Patient encounter during the reporting period (CPT): 90791, 90792, 90832, 90834, 90837, 90839, 90845, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215

NUMERATOR:
Patients with a suicide risk assessment completed during the visit in which a new diagnosis or recurrent episode was identified

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Definition:
Suicide risk assessment - Must include questions about the following:
1) Suicidal ideation
2) Patient's intent of initiating a suicide attempt AND, if either is present,
3) Patient plans for a suicide attempt
4) Whether the patient has means for completing suicide

NUMERATOR NOTE: It is expected that an initial evaluation will occur during the visit in which a new diagnosis or recurrent episode was identified.

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Suicide Risk Assessed
G8932: Suicide risk assessed at the initial evaluation

OR

If patient is not eligible for this measure because MDD is in remission, report:
CPT II 3092F: Major depressive disorder, in remission

OR

Suicide Risk not Assessed, Reason not Given
G8933: Suicide risk not assessed at the initial evaluation, reason not given

RATIONALE:
Research has shown that more than 90% of people who kill themselves have depression or another diagnosable mental or substance abuse disorder. Depression is the cause of over two-thirds of the reported suicides in the U.S. each year. The intent of this measure is for a clinician to assess suicide risk at initial intake or at visit in which depression was diagnosed. As the guidelines state, it is important to assess for additional factors which may increase or decrease suicide risk, such as presence of additional symptoms (e.g., psychosis, severe anxiety, hopelessness, severe chronic pain); presence of substance abuse, history and seriousness of previous attempts, particularly, recent suicidal behavior, current stressors and potential protective factors (e.g., positive reasons for living, strong social support),family history of suicide or mental illness or recent exposure to suicide, impulsivity and potential for risk to others, including history of violence or violent or homicidal ideas, plans, or intentions, and putting one's affairs in order (e.g., giving away possessions, writing a will). In addition, although the measure focuses on the initial visit, it is critical that suicide risk be monitored especially for the 90 days following the initial visit and throughout MDD treatment.

CLINICAL RECOMMENDATION STATEMENTS:
The following evidence statements are quoted verbatim from the referenced clinical guidelines. Only selected portions of the clinical guidelines are quoted here; for more details, please refer to the full guideline.

A careful and ongoing evaluation of suicide risk is necessary for all patients with major depressive disorder [I]. (APA, 2010)

Such an assessment includes specific inquiry about suicidal thoughts, intent, plans, means, and behaviors; identification of specific psychiatric symptoms (e.g., psychosis, severe anxiety, substance use) or general medical conditions that may increase the likelihood of acting on suicidal ideas; assessment of past and, particularly, recent suicidal behavior; delineation of current stressors and potential protective factors (e.g., positive reasons for living, strong social support); and identification of any family history of suicide or mental illness [I]. (APA, 2010)
As part of the assessment process, impulsivity and potential for risk to others should also be evaluated, including any history of violence or violent or homicidal ideas, plans, or intentions [I]. (APA, 2010)

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The patient's risk of harm to him- or herself and to others should also be monitored as treatment proceeds [I]. (APA, 2010)
Guidelines for Selecting a Treatment Setting for Patients at Risk for Suicide or Suicidal Behaviors (from APA's Practice Guideline for Assessment and Treatment of Patients With Suicidal Behaviors-2010, Downloaded from http://psychiatryonline.org/ on 6/25/12):

Admission generally indicated

After a suicide attempt or aborted suicide attempt if:

- Patient is psychotic
- Attempt was violent, near-lethal, or premeditated
- Precautions were taken to avoid rescue or discovery
- Persistent plan and/or intent is present
- Distress is increased or patient regrets surviving
- Patient is male, older than age 45 years, especially with new onset of psychiatric illness or suicidal thinking
- Patient has limited family and/or social support, including lack of stable living situation
- Current impulsive behavior, severe agitation, poor judgment, or refusal of help is evident
- Patient has change in mental status with a metabolic, toxic, infectious, or other etiology requiring further workup in a structured setting

In the presence of suicidal ideation with:

- Specific plan with high lethality
- High suicidal intent

Admission may be necessary

[In addition to the list above, these additional circumstances may warrant admission]
After a suicide attempt or aborted suicide attempt

In the presence of suicidal ideation with:

- Psychosis
- Major psychiatric disorder
- Past attempts, particularly if medically serious
- Possibly contributing medical condition (e.g., acute neurological disorder, cancer, infection)
- Lack of response to or inability to cooperate with partial hospital or outpatient treatment
- Need for supervised setting for medication trial or ECT
- Need for skilled observation, clinical tests, or diagnostic assessments that require a structured setting
- Limited family and/or social support, including lack of stable living situation
- Lack of an ongoing clinician-patient relationship or lack of access to timely outpatient follow-up
- Evidence of putting one's affairs in order (e.g., giving away possessions, writing a will)

In the absence of suicide attempts or reported suicidal ideation/plan/intent but evidence from the psychiatric evaluation and/or history from others suggests a high level of suicide risk and a recent acute increase in risk.

Release from emergency department with follow-up recommendations may be possible

After a suicide attempt or in the presence of suicidal ideation/plan when:

- Suicidality is a reaction to precipitating events (e.g., exam failure, relationship difficulties), particularly if the patient's view of situation has changed since coming to emergency department
- Plan/method and intent have low lethality
- Patient has stable and supportive living situation
- Patient is able to cooperate with recommendations for follow-up, with treater contacted, if possible, if patient is currently in treatment

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Outpatient treatment may be more beneficial than hospitalization

Patient has chronic suicidal ideation and/or self-injury without prior medically serious attempts, if a safe and supportive living situation is available and outpatient psychiatric care is ongoing.

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♦Measure #108 (NQF 0054): Rheumatoid Arthritis (RA): Disease Modifying Anti-Rheumatic Drug (DMARD) Therapy

2013 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

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

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for RA patients seen during the reporting period. It is anticipated that clinicians who provide care for patients with a diagnosis of RA will submit this measure.

Measure Reporting via Claims:
ICD-9-CM diagnosis codes, CPT or HCPCS codes, and patient demographics are used to identify patients who are included in the measure's denominator. CPT Category II codes can be used to report the numerator of the measure.

When reporting the measure via claims, submit the listed ICD-9-CM diagnosis codes, CPT or HCPCS codes, and the appropriate CPT Category II code OR the CPT Category II code with the modifier. The modifier codes allowed for this measure are: 1P- medical reasons, 8P- reason not otherwise specified. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT or HCPCS codes, and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All patients aged 18 years and older with a diagnosis of rheumatoid arthritis (RA)

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Diagnosis for rheumatoid arthritis (RA) (ICD-9-CM): 714.0, 714.1, 714.2, 714.81
Diagnosis for rheumatoid arthritis (RA) (ICD-10-CM) [REFERENCE ONLY/Not Reportable]: M05.00, M05.011, M05.012, M05.019, M05.021, M05.022, M05.029, M05.031, M05.032, M05.039, M05.041, M05.042, M05.049, M05.051, M05.052, M05.059, M05.061, M05.062, M05.069, M05.071, M05.072, M05.079, M05.09, M05.111, M05.112, M05.119, M05.121, M05.122, M05.129, M05.131, M05.132, M05.139, M05.141, M05.142, M05.149, M05.151, M05.152, M05.159, M05.161, M05.162, M05.169, M05.171, M05.172, M05.179, M05.19, M05.20, M05.211, M05.212, M05.219, M05.221, M05.222, M05.229, M05.231, M05.232, M05.239, M05.241, M05.242, M05.249, M05.251, M05.252, M05.259, M05.261, M05.262, M05.269, M05.271, M05.272, M05.279, M05.29, M05.30, M05.311, M05.312, M05.319, M05.321, M05.322, M05.329, M05.331, M05.332, M05.339, M05.341, M05.342, M05.349, M05.351, M05.352, M05.359, M05.361, M05.362, M05.369, M05.371, M05.372, M05.379, M05.39, M05.40, M05.411, M05.412,

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M05.419, M05.421, M05.422, M05.429, M05.431, M05.432, M05.439, M05.441, M05.442, M05.449, M05.451, M05.452, M05.459, M05.461, M05.462, M05.469, M05.471, M05.472, M05.479, M05.49, M05.50, M05.511, M05.512, M05.519, M05.521, M05.522, M05.529, M05.531, M05.532, M05.539, M05.541, M05.542, M05.549, M05.551, M05.552, M05.559, M05.561, M05.562, M05.569, M05.571, M05.572, M05.579, M05.59, M05.60, M05.611, M05.612, M05.619, M05.621, M05.622, M05.629, M05.631, M05.632, M05.639, M05.641, M05.642, M05.649, M05.651, M05.652, M05.659, M05.661, M05.662, M05.669, M05.671, M05.672, M05.679, M05.69, M05.70, M05.711, M05.712, M05.719, M05.721, M05.722, M05.729, M05.731, M05.732, M05.739, M05.741, M05.742, M05.749, M05.751, M05.752, M05.759, M05.761, M05.762, M05.769, M05.771, M05.772, M05.779, M05.79, M05.80, M05.811, M05.812, M05.819, M05.821, M05.822, M05.829, M05.831, M05.832, M05.839, M05.841, M05.842, M05.849, M05.851, M05.852, M05.859, M05.861, M05.862, M05.869, M05.871, M05.872, M05.879, M05.89, M05.9, M06.00, M06.011, M06.012, M06.019, M06.021, M06.022, M06.029, M06.031, M06.032, M06.039, M06.041, M06.042, M06.049, M06.051, M06.052, M06.059, M06.061, M06.062, M06.069, M06.071, M06.072, M06.079, M06.08, M06.09, M06.1, M06.30, M06.311, M06.312, M06.319, M06.321, M06.322, M06.329, M06.331, M06.332, M06.339, M06.341, M06.342, M06.349, M06.351, M06.352, M06.359, M06.361, M06.362, M06.369, M06.371, M06.372, M06.379, M06.38, M06.39

AND

Patient encounter during the reporting period (CPT or HCPCS): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, G0402

NUMERATOR:

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

Definition:

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.

The DMARDs listed below are considered DMARDs for the purposes of this measure:

Description	Prescription			J Codes
5-Aminosalicylates	• Sulfasalazine			N/A
Alkylating agents	• Cyclophosphamide			N/A
Aminoquinolines	• Hydroxychloroquine			N/A
Anti-rheumatics	• Auranofin • Gold sodium thiomalate	• Leflunomide • Methotrexate	• Penicillamine	J1600, J9250, J9260
Immunomodulators	• Abatacept • Adalimumab • Anakinra • Certolizumab	• Certolizumab pegol • Etanercept • Golimumab	• Infliximab • Rituximab • Tocilizumab	J0129, J0135, J0718, J1438, J1745, J3262, J9310
Immunosuppressive agents	• Azathioprine	• Cyclosporine	• Mycophenolate	J7502, J7515, J7516, J7517, J7518
Tetracyclines	• Minocycline			N/A

Note: J codes should only be used to identify if the appropriate DMARD therapy was prescribed to the patient. CPT II codes are used when reporting this measure.

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

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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 Otherwise 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

RATIONALE:
Early diagnosis and management of RA presents an important opportunity to alter the course of this progressive disease. Treatment in the first few months after disease onset takes advantage of a window of opportunity to effectively limit structural damage to joints and improves health outcomes. American College of Rheumatology (ACR) guidelines underscore early DMARD therapy.

CLINICAL RECOMMENDATION STATEMENTS:
The American College of Rheumatology (ACR) recommends targeting either low disease activity or remission in all patients with early RA (level of evidence C) and established RA (level of evidence C) receiving any DMARD or biologic agent.

In patients with early RA, the ACR recommends the use of DMARD monotherapy both for low disease activity and for moderate or high disease activity with the absence of poor prognostic features (level of evidence A–C). In patients with early RA, the ACR recommends the use of DMARD combination therapy (including double and triple therapy) in patients with moderate or high disease activity plus poor prognostic features (level of evidence A–C). In patients with early RA, the ACR also recommends the use of an anti-TNF biologic with or without methotrexate in patients who have high disease activity with poor prognostic features (level of evidence A and B). Infliximab is the only exception and the recommendation is to use it in combination with methotrexate, but not as monotherapy.

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▲Measure #109 (NQF 0050): Osteoarthritis (OA): Function and Pain Assessment

2013 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of patient visits for patients aged 21 years and older with a diagnosis of OA with assessment for function and pain

INSTRUCTIONS:
This measure is to be reported at each visit occurring during the reporting period for patients with osteoarthritis seen during the reporting period. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

Measure Reporting via Claims:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. CPT Category II codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed ICD-9-CM diagnosis codes, CPT codes, and the appropriate CPT Category II code OR the CPT Category II code with the modifier. The reporting modifier allowed for this measure is: 8P- reason not otherwise specified. There are no allowable performance exclusions for this measure. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data. There are no allowable performance exclusions for this measure.

DENOMINATOR:
All patient visits for patients aged 21 years and older with a diagnosis of OA

> Denominator Criteria (Eligible Cases):
> Patients aged ≥ 21 years on date of encounter
> AND
> Diagnosis for osteoarthritis (OA) (ICD-9-CM): 715.00, 715.04, 715.09, 715.10, 715.11, 715.12, 715.13, 715.14, 715.15, 715.16, 715.17, 715.18, 715.20, 715.21, 715.22, 715.23, 715.24, 715.25, 715.26, 715.27, 715.28, 715.30, 715.31, 715.32, 715.33, 715.34, 715.35, 715.36, 715.37, 715.38, 715.80, 715.89, 715.90, 715.91, 715.92, 715.93, 715.94, 715.95, 715.96, 715.97, 715.98
> Diagnosis for osteoarthritis (OA) (ICD-10-CM) [REFERENCE ONLY/Not Reportable]: M15.0, M15.1, M15.2, M15.3, M15.4, M15.8, M15.9, M16.0, M16.10, M16.11, M16.12, M16.2, M16.30, M16.31, M16.32, M16.4, M16.50, M16.51, M16.52, M16.6, M16.7, M16.9, M17.0, M17.10, M17.11, M17.12, M17.2, M17.30, M17.31, M17.32, M17.4, M17.5, M17.9, M18.0, M18.10, M18.11, M18.12, M18.2, M18.30, M18.31, M18.32, M18.4, M18.50, M18.51, M18.52, M18.9, M19.011, M19.012, M19.019, M19.021, M19.022, M19.029, M19.031, M19.032, M19.039, M19.041, M19.042, M19.049, M19.071, M19.072, M19.079, M19.111, M19.112, M19.119, M19.121, M19.122, M19.129, M19.131, M19.132, M19.139, M19.141, M19.142,

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M19.149, M19.171, M19.172, M19.179, M19.211, M19.212, M19.219, M19.221, M19.222, M19.229, M19.231, M19.232, M19.239, M19.241, M19.242, M19.249, M19.271, M19.272, M19.279, M19.90, M19.91, M19.92, M19.93

AND

Patient encounter during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215

NUMERATOR:

Patient visits with assessment for level of function and pain documented

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Osteoarthritis Symptoms and Functional Status Assessed

CPT II 1006F: Osteoarthritis symptoms and functional status assessed (may include the use of a standardized scale or the completion of an assessment questionnaire, such as the SF-36, AAOS Hip & Knee Questionnaire)

OR

Osteoarthritis Symptoms and Functional Status not Assessed, Reason not Otherwise Specified

Append a reporting modifier (8P) to CPT Category II code 1006F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

1006F *with* 8P: Osteoarthritis symptoms and functional status not assessed, reason not otherwise specified

RATIONALE:

Osteoarthritis can be a debilitating condition. An assessment of patient symptoms and functional status is important as it serves as the basis for making treatment modifications, which in turn, assists in improving the patient's quality of life.

CLINICAL RECOMMENDATION STATEMENTS:

Any persistent pain that has an impact on physical function, psychosocial function, or other aspects of quality of life should be recognized as a significant problem. (AGA; IIA Recommendation)

Control of pain and maintenance of activity correlate well with satisfactory quality of life. If the patient is not satisfied with the outcome due to continued pain and limitation of activity, more aggressive intervention may be warranted. (AAOS, 2003)

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▲Measure #110 (NQF 0041): Preventive Care and Screening: Influenza Immunization

2013 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of patients aged 6 months and older seen for a visit between October 1 and March 31 who received an influenza immunization OR who reported previous receipt of an influenza immunization

INSTRUCTIONS:
This measure is to be reported a minimum of once for visits for patients seen between January and March for the 2012-2013 influenza season AND a minimum of once for visits for patients seen between October and December for the 2013-2014 influenza season. This measure is intended to determine whether or not all patients aged 6 months and older received (either from the reporting physician or from an alternate care provider) or had an order for influenza immunization during the flu season. There is no diagnosis associated with this measure. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

- If reporting this measure between January 1, 2013 and March 31, 2013, G-code G8482 should be reported when the influenza immunization is ordered or administered to the patient during the months of August, September, October, November, and December of 2012 or January, February, and March of 2013 for the flu season ending March 31, 2013.
- If reporting this measure between October 1, 2013 and December 31, 2013, G-code G8482 should be reported when the influenza immunization is ordered or administered to the patient during the months of August, September, October, November, and December of 2013 for the flu season ending March 31, 2014.
- Influenza immunizations administered during the month of August or September of a given flu season (either 2012-2013 flu season OR 2013-2014 flu season) can be reported when a visit occurs during the flu season (October1 - March 31). In these cases, G8482 should be reported.

Measure Reporting via Claims:
CPT or HCPCS codes and patient demographics are used to identify patients who are included in the measure's denominator. G-codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed CPT or HCPCS codes, and the appropriate numerator G-code. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
CPT or HCPCS codes and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All patients aged 6 months and older seen for a visit between October 1 and March 31

Denominator Criteria (Eligible Cases):
All patients aged 6 months and older seen for a visit between October 1 and March 31
AND

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Patient encounter during the reporting period (CPT or HCPCS): 90653, 90655, 90656, 90657, 90660, 90661, 90662, 90664, 90666, 90667, 90668, 90672, 90945, 90947, 90951, 90952, 90953, 90954, 90955, 90956, 90957, 90958, 90959, 90960, 90961, 90962, 90963, 90964, 90965, 90966, 90967, 90968, 90969, 90970, 90989, 90993, 90997, 90999, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99315, 99316, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, G0438, G0439, Q2035, Q2036, Q2037, Q2038, Q2039

NUMERATOR:
Patients who received an influenza immunization OR who reported previous receipt of influenza immunization

Definition:
Previous Receipt – Receipt of the current season's influenza immunization from another provider OR from same provider prior to the visit to which the measure is applied (typically, prior vaccination would include influenza vaccine given since August 1st).

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 (e.g., patient allergy or other medical reason, patient declined or other patient reasons, or other system reasons)
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 Given
G8484: Influenza immunization was not ordered or administered, reason not given

RATIONALE:
Annual influenza vaccination is the most effective method for preventing influenza virus infection and its complications. Influenza vaccine is recommended for all persons aged ≥ 6 months who do not have contraindications to vaccination.

CLINICAL RECOMMENDATION STATEMENTS:
The following evidence statements are quoted verbatim from the referenced clinical guidelines.

Routine annual influenza vaccination is recommended for all persons aged ≥ 6 months. (CDC/ACIP, 2011)

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♦Measure #111 (NQF 0043): Preventive Care and Screening: Pneumococcal Vaccination for Patients 65 Years and Older

2013 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

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

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for patients seen during the reporting period. There is no diagnosis associated with this measure. Performance for this measure is not limited to the reporting period. This measure may be reported by clinicians who perform the quality actions described in the measure based on services provided and the measure-specific denominator coding.

Measure Reporting via Claims:
CPT or HCPCS codes and patient demographics are used to identify patients who are included in the measure's denominator. CPT Category II codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed CPT or HCPCS codes, and the appropriate CPT Category II code OR the CPT Category II code with the modifier. The modifiers allowed for this measure are: 1P- medical reasons, 8P- reason not otherwise specified. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
CPT or HCPCS codes and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All patients 65 years and older

Denominator Criteria (Eligible Cases):
Patients aged ≥ 65 years on date of encounter
AND
Patient encounter during the reporting period (CPT or HCPCS): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99218, 99219, 99220, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, 99356, 99357, G0402

NUMERATOR:
Patients who have ever received a pneumococcal vaccination

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Pneumococcal Vaccination Administered or Previously Received
CPT II 4040F: Pneumococcal vaccine administered or previously received

OR

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Pneumococcal 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

Pneumococcal Vaccination not Administered or Previously Received, Reason not Otherwise 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

RATIONALE:
Pneumonia is a common cause of illness and death in the elderly and persons with certain underlying conditions such as heart failure, diabetes, cystic fibrosis, asthma, sickle cell anemia, or chronic obstructive pulmonary disease (NHLBI, 2011). In 1998, an estimated 3,400 adults aged > 65 years died as a result of invasive pneumococcal disease (IPD) (CDC, 2003). Pneumococcal infection accounts for more deaths than any other vaccine-preventable bacterial disease.

Among the 91.5 million US adults aged > 50 years, 29,500 cases of IPD, 502,600 cases of nonbacteremic pneumococcal pneumonia and 25,400 pneumococcal-related deaths are estimated to occur yearly; annual direct and indirect costs are estimated to total $3.7 billion and $1.8 billion, respectively. Pneumococcal disease remains a substantial burden among older US adults, despite increased coverage with 23-valent pneumococcal polysaccharide vaccine, (PPV23) and indirect benefits afforded by PCV7 vaccination of young children (Weycker, et al., 2011).

The Centers for Disease Control and Prevention (CDC) also analyzed cost-effectiveness of a measure for pneumococcal immunization. Using conservative health impact figures, the study's principal conclusions indicate that a 10 percent absolute increase in immunization among Medicare HMO enrollees would result in cost savings of $8,471 for an average HMO with 17,000 enrollees, and that deaths due to pneumococcal disease would be reduced. The study only considers the prevention of pneumococcal bacteria; actual savings may be greater, as vaccination is also likely to confer protection against pneumococcal pneumonia (nonbacteremic pneumococcal). Vaccination has been found to be effective against bacteremic cases (OR: 0.34; 95% CI: 0.27–0.66) as well as nonbacteremic cases (OR: 0.58; 95% CI: 0.39–0.86). Vaccine effectiveness was highest against bacteremic infections caused by vaccine types (OR: 0.24; 95% CI: 0.09–0.66) (Vila-Corcoles, et al., 2009).

The disease burden is large for older adults and the potential for prevention is high. Pneumococcal infections result in significant health care expenditures each year, and vaccination is safe and effective. Modest cash outlays for vaccination have been shown to result in substantial cost savings and significantly lower morbidity.

CLINICAL RECOMMENDATION STATEMENTS:
The Advisory Committee on Immunization Practices' (ACIP) Updated Recommendations for Prevention of Invasive Pneumococcal Disease Among Adults Using the 23-Valent Pneumococcal Polysaccharide Vaccine recommends pneumococcal vaccine for all immunocompetent individuals who are 65 and older or otherwise at increased risk for pneumococcal disease. Routine revaccination is not recommended, but a second dose is appropriate for those who received PPV23 before age 65 years for any indication if at least 5 years have passed since their previous dose (USPSTF, 1989; ACIP, 2010). Both primary vaccination and revaccination with PPV23 induce antibody responses that persist during 5 years of observation (Musher, et al., 2010). Subsequently, Medicare Part B fully covers the cost of the vaccine and its administration every five years.

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♦Measure #112 (NQF 0031): Preventive Care and Screening: Breast Cancer Screening

2013 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

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

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for female patients seen during the reporting period. There is no diagnosis associated with this measure. The patient should either be screened for breast cancer on the date of service OR there should be documentation that the patient was screened for breast cancer at least once within 24 months prior to the date of service. Performance for this measure is not limited to the reporting period. This measure may be reported by clinicians who perform the quality actions described in the measure based on services provided and the measure-specific denominator coding.

Measure Reporting via Claims:
CPT or HCPCS codes and patient demographics are used to identify patients who are included in the measure's denominator. CPT Category II codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed CPT or HCPCS codes, and the appropriate CPT Category II code OR the CPT Category II code with the modifier. The modifiers allowed for this measure are: 1P- medical reasons, 8P- reason not otherwise specified. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
CPT or HCPCS codes and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All female patients aged 40 through 69 years

> Denominator Criteria (Eligible Cases):
> Patients aged 40 through 69 years on date of encounter
> AND
> Patient encounter during the reporting period (CPT or HCPCS): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, G0402

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

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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 Otherwise 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

RATIONALE:

Breast cancer ranks as the second leading cause of death in women. For women 40 to 49 years of age mammography can reduce mortality by 17 percent. (American Medical Association AMA, 2003)

CLINICAL RECOMMENDATION STATEMENTS:

The U.S. Preventive Services Task Force (USPSTF) recommends biennial screening mammography for women aged 50-74 years (B recommendation). The decision to start regular, biennial screening mammography before the age of 50 years should an individual one and take patient context into account, including the patient's values regarding specific benefits and harms (C recommendation). (USPSTF, 2009) The Task Force concludes the evidence is insufficient to assess the additional benefits and harms of screening mammography in women 75 years and older (I statement).

The American Cancer Society recommends yearly Mammograms starting at age 40 and continuing for as long as a woman is in good health. Clinical Breast Exam (CBE) about every 3 years for women in the 20s and 30s and every year for women 40 and over. (Smith, 2003)

Based on the incidence of breast cancer, the sojourn time for breast cancer growth, and the potential reduction in breast cancer mortality, the American College of Obstetricians and Gynecologists recommends that women aged 40 years and older be offered screening mammography annually. Clinical breast examination should be performed annually for women aged 40 years and older. For women aged 20–39 years, clinical breast examinations are recommended every 1–3 years. (ACOG, 2011)

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♦Measure #113 (NQF 0034): Preventive Care and Screening: Colorectal Cancer Screening

2013 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

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

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for patients seen during the reporting period. There is no diagnosis associated with this measure. Performance for this measure is not limited to the reporting period. This measure may be reported by clinicians who perform the quality actions described in the measure based on services provided and the measure-specific denominator coding.

Measure Reporting via Claims:
CPT or HCPCS codes and patient demographics are used to identify patients who are included in the measure's denominator. CPT Category II codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed CPT or HCPCS codes, and the appropriate CPT Category II code OR the CPT Category II code with the modifier. The modifiers allowed for this measure are: 1P- medical reasons, 8P- reason not otherwise specified. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
CPT or HCPCS codes and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All patients aged 50 through 75 years

> Denominator Criteria (Eligible Cases):
> Patients aged 50 through 75 years on date of encounter
> AND
> Patient encounter during the reporting period (CPT or HCPCS): 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, G0402

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

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NUMERATOR NOTE: Documentation in the medical record must include a note indicating the date when the colorectal cancer screening was performed. A result is not required if the documentation is clearly part of the "medical history" section of the record. If it is unclear whether the documentation is part of the medical history, then the result or finding must be present (this ensures that the screening was performed and not merely ordered).

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 Otherwise 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

RATIONALE:
Colorectal cancer is the second leading cause of cancer-related death in the United States. There were an estimated 135,400 new cases and 56,700 deaths from the disease during 2001. Colorectal cancer (CRC) places significant economic burden on the society as well with treatment costs over $6.5 billion per year and, among malignancies, is second only to breast cancer at $6.6 billion per year. (Schrag, 1999)

Colorectal cancer screening can detect pre-malignant polyps and early stage cancers. Unlike other screening tests that only detect disease, colorectal cancer screening can guide removal of pre-malignant polyps, which in theory can prevent development of colon cancer. Three tests are currently recommended for screening: fecal occult blood testing (FOBT), flexible sigmoidoscopy, and colonoscopy.

CLINICAL RECOMMENDATION STATEMENTS:
During the past FOBT screening to biennial FOBT screening, and found that annual screening resulted in greater reduction in colorectal cancer mortality. Two case control studies have provided evidence that sigmoidoscopy reduces colorectal cancer mortality (Selby et al., 1992; Newcomb et al., 1992). Approximately 75% of all colorectal cancers arise sporadically (Stephenson et al., 1991). Part of the effectiveness of colorectal cancer screening is mediated by the removal of the precursor lesion—an adenomatous polyp (Vogtelstein et al., 1988). It has been shown that removal of polyps in a population can reduce the incidence of colorectal cancer (Winawer, 1993). Colorectal screening may also lower mortality by decade, compelling evidence has accumulated that systematic screening of the population can reduce mortality from colorectal cancer. Three randomized, controlled trials demonstrated that fecal occult blood testing (FOBT), followed by complete diagnostic evaluation of the colon for a positive test, reduced colorectal cancer mortality (Hardcastle et al., 1996; Mandel & Oken, 1998; Kronborg; 1996). One of these randomized trials (Mandel et al., 1993) compared annual allowing detection of cancer at earlier stages, when treatment is more effective (Kavanaugh, 1998).

The U.S. Preventive Services Task Force (USPSTF) published an updated recommendation for colorectal cancer screening in 2008. The guideline strongly recommends that clinicians screen men and women ages 50 to 75 years of age for colorectal cancer (A recommendation). The USPSTF recommends not screening adults age 85 and older due

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to possible harms (D recommendation). The appropriateness of colorectal cancer screening for men and women aged 76 to 85 years old should be considered on an individual basis (C recommendation). While the approved modalities vary for patients 50 to 75 years old, the USPSTF found there is insufficient evidence to assess the benefits and harms of computed tomographic colonography (CTC) and fecal DNA (fDNA) testing as screening modalities for colorectal cancer for all patients. (I statement)

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♦Measure #116 (NQF 0058): Antibiotic Treatment for Adults with Acute Bronchitis: Avoidance of Inappropriate Use

2013 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of adults aged 18 through 64 years with a diagnosis of acute bronchitis who were not prescribed or dispensed an antibiotic prescription on or within 3 days of the initial date of service

INSTRUCTIONS:
This measure is to be reported at each visit for acute bronchitis during the reporting period. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

Measure Reporting via Claims:
ICD-9-CM diagnosis codes, CPT or HCPCS codes, and patient demographics are used to identify patients who are included in the measure's denominator. CPT Category II codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed ICD-9-CM diagnosis code, CPT or HCPCS codes, and the appropriate CPT Category II code OR the CPT Category II code with the modifier. The modifier allowed for this measure is: 1P- medical reasons. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT or HCPCS codes, and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All patients aged 18 through 64 years with a diagnosis of acute bronchitis

> Denominator Criteria (Eligible Cases):
> Patients aged 18 through 64 years on date of encounter
> AND
> Diagnosis for acute bronchitis (ICD-9-CM): 466.0
> Diagnosis for acute bronchitis (ICD-10-CM) [REFERENCE ONLY/Not Reportable]: J20.0, J20.1, J20.2, J20.3, J20.4, J20.5, J20.6, J20.7, J20.8, J20.9
> AND
> Patient encounter during the reporting period (CPT or HCPCS): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99217, 99218, 99219, 99220, G0402

NUMERATOR:
Patients who were not prescribed or dispensed antibiotics on or within 3 days of the initial date of service

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Numerator Instructions: For performance, the measure will be calculated as the number of patients for whom antibiotics were neither prescribed nor dispensed on or within 3 days of the initial date of service over the number of patients in the denominator (patients aged 18 through 64 years with acute bronchitis). A higher score indicates appropriate treatment of patients with acute bronchitis (e.g., the proportion for whom antibiotics *were not* prescribed or dispensed on or three days after the initial date of service).

The antibiotics listed below are considered antibiotics for the purposes of this measure:

DESCRIPTION	PRESCRIPTION		
Aminoglycosides	• amikacin • gentamicin	• kanamycin • neomycin	• tobramycin
Aminopenicillins	• amoxicillin	• ampicillin	
Antipseudomonal penicillins	• piperacillin	• ticarcillin	
Beta-lactamase inhibitors	• amoxicillin-clavulanate • ampicillin-sulbactam	• piperacillin-tazobactam	• ticarcillin-clavulanate
First generation cephalosporins	• cefadroxil • cefazolin	• cephalexin • cephradine	
Fourth generation cephalosporins	• cefepime		
Ketolides	• telithromycin		
Lincomycin derivatives	• clindamycin	• lincomycin	
Macrolides	• azithromycin • clarithromycin	• erythromycin • erythromycin ethylsuccinate	• erythromycin lactobionate • erythromycin stearate
Miscellaneous antibiotics	• aztreonam • chloramphenicol • dalfopristin-quinupristin	• daptomycin • erythromycin-sulfisoxazole • linezolid	• metronidazole • vancomycin
Sulfamethoxazole-trimethoprim DS	• sulfamethoxazole-trimethoprim		
Natural penicillins	• penicillin G benzathine-procaine • penicillin G potassium	• penicillin G procaine • penicillin G sodium	• penicillin V potassium
Penicillinase resistant penicillins	• dicloxacillin	• nafcillin	• oxacillin
Quinolones	• ciprofloxacin • gatifloxacin • gemifloxacin	• levofloxacin • lomefloxacin • moxifloxacin	• Norfloxacin • ofloxacin • sparfloxacin
Rifamycin derivatives	• rifampin		
Second generation cephalosporin	• cefaclor • cefotetan	• cefoxitin • cefprozil	• cefuroxime • loracarbef
Sulfonamides	• sulfadiazine • sulfamethoxazole-trimethoprim		• sulfisoxazole
Tetracyclines	• doxycycline	• minocycline	• tetracycline

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DESCRIPTION	PRESCRIPTION		
Third generation cephalosporins	• cefdinir • cefditoren • cefixime	• cefotaxime • cefpodoxime • ceftazidime	• ceftibuten • ceftizoxime • ceftriaxone
Urinary anti-infectives	• fosfomycin • nitrofurantoin • nitrofurantoin macrocrystals	• nitrofurantoin macrocrystals-monohydrate • trimethoprim	

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Antibiotic not Prescribed or Dispensed

CPT II 4124F: Antibiotic neither prescribed nor dispensed

OR

Antibiotic Prescribed or Dispensed for Medical Reasons

Append a modifier (1P) to CPT Category II code 4120F to report documented circumstances that appropriately exclude patients from the denominator.

4120F *with* 1P: Documentation of medical reason(s) for prescribing or dispensing antibiotic

OR

Antibiotic Prescribed or Dispensed

CPT II 4120F: Antibiotic prescribed or dispensed

RATIONALE:

Antibiotics are commonly misused and overused for a number of viral respiratory conditions where antibiotic treatment is not clinically indicated. (Scott J.G., D. Cohen, B. Dicicco-Bloom, 2001) About 80 percent of antibiotics prescribed for acute respiratory infections in adults are unnecessary, according to CDC prevention guidelines. In adults, antibiotics are most often (65–80 percent) prescribed for acute bronchitis, despite its viral origin. The misuse and overuse of antibiotics contributes to antibiotic drug resistance, which is of public health concern due to the diminished efficacy of antibiotics against bacterial infections, particularly in sick patients and the elderly. (Austin D.J., K.G. Kristinsson, R.M. Anderson, 1999, Patterson, JE, 2001, Cohen ML, 1992, Lipsitch M, 2001)

A HEDIS measure that highlights inappropriate antibiotic prescribing in adults for a common respiratory condition will help to raise awareness among clinicians and patients about inappropriate antibiotic use. Antibiotics are most often inappropriately prescribed in adults with acute bronchitis. This measure builds on an existing HEDIS measure targeting inappropriate antibiotic prescribing for children with upper respiratory infection (common cold), where antibiotics are also most often inappropriately prescribed. (Chandran R., 2001, Gonzales R., J.F. Steiner, et al, 1999)

CLINICAL RECOMMENDATION STATEMENTS:

Clinical guidelines do not support antibiotic treatment of otherwise healthy adults with acute bronchitis due to the viral origin of acute bronchitis. Patients with chronic bronchitis, COPD or other chronic comorbidity may be treated with antibiotics and are therefore excluded from the measure denominator. (Gonzales R., D.C. Malone, J.H. Maselli, et al, 2001)

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♦Measure #117 (NQF 0055): Diabetes Mellitus: Dilated Eye Exam

2013 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

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

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for patients with diabetes mellitus seen during the reporting period. This measure may be reported by clinicians who perform the quality actions described in the measure based on services provided and the measure-specific denominator coding.

Measure Reporting via Claims:
ICD-9-CM diagnosis codes, CPT or HCPCS codes, and patient demographics are used to identify patients who are included in the measure's denominator. CPT Category II codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed ICD-9-CM diagnosis codes, CPT or HCPCS codes, and the appropriate CPT Category II code OR the CPT Category II code with the modifier. The reporting modifier allowed for this measure is: 8P- reason not otherwise specified. There are no allowable performance exclusions for this measure. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT or HCPCS codes, and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data. There are no allowable performance exclusions for this measure.

DENOMINATOR:
All patients aged 18 through 75 years with a diagnosis of diabetes

Denominator Criteria (Eligible Cases):
Patients aged 18 through 75 years on date of encounter
AND
Diagnosis for diabetes (ICD-9-CM): 250.00, 250.01, 250.02, 250.03, 250.10, 250.11, 250.12, 250.13, 250.20, 250.21, 250.22, 250.23, 250.30, 250.31, 250.32, 250.33, 250.40, 250.41, 250.42, 250.43, 250.50, 250.51, 250.52, 250.53, 250.60, 250.61, 250.62, 250.63, 250.70, 250.71, 250.72, 250.73, 250.80, 250.81, 250.82, 250.83, 250.90, 250.91, 250.92, 250.93, 357.2, 362.01, 362.02, 362.03, 362.04, 362.05, 362.06, 362.07, 366.41, 648.00, 648.01, 648.02, 648.03, 648.04

Diagnosis for diabetes (ICD-10-CM) [REFERENCE ONLY/Not Reportable]: E10.10, E10.11, E10.21, E10.22, E10.29, E10.311, E10.319, E10.321, E10.329, E10.331, E10.339, E10.341, E10.349, E10.351, E10.359, E10.36, E10.39, E10.40, E10.41, E10.42, E10.43, E10.44, E10.49, E10.51, E10.52, E10.59, E10.610, E10.618, E10.620, E10.621, E10.622, E10.628, E10.630, E10.638, E10.641, E10.649, E10.65, E10.69, E10.8, E10.9, E11.00, E11.01, E11.21, E11.22, E11.29, E11.311, E11.319, E11.321, E11.329,

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E11.331, E11.339, E11.341, E11.349, E11.351, E11.359, E11.36, E11.39, E11.40, E11.41, E11.42, E11.43, E11.44, E11.49, E11.51, E11.52, E11.59, E11.610, E11.618, E11.620, E11.621, E11.622, E11.628, E11.630, E11.638, E11.641, E11.65, E11.69, E11.8, E11.9, E11.649, O24.011, O24.012, O24.013, O24.019, O24.02, O24.03, O24.111, O24.112, O24.113, O24.119, O24.12, O24.13

AND

Patient encounter during the reporting period (CPT or HCPCS): 92002, 92004, 92012, 92014, 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, G0402

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 Otherwise 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.

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

RATIONALE:

Examination of the eyes is the first step in the treatment of any existing or developing conditions related to retinopathy and the first step in the prevention of blindness.

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CLINICAL RECOMMENDATION STATEMENTS:

American Diabetes Association (ADA): Patients with type 1 diabetes should have an initial dilated and comprehensive eye examination by an ophthalmologist or optometrist within 3-5 years after the onset of diabetes. In general evaluation for diabetic eye disease is not necessary before 10 years of age. However, some evidence suggests that the prepubertal duration of diabetes may be important in the development of microvascular complications; therefore, clinical judgment should be used when applying these recommendations to individual patients. (Level of Evidence: B)

Patients with type 2 diabetes should have an initial dilated and comprehensive eye examination by an ophthalmologist or optometrist shortly after diabetes diagnosis. (Level of Evidence: B)

Subsequent examinations for type 1 and type 2 diabetic patients should be repeated annually by an ophthalmologist or optometrist who is knowledgeable and experienced in diagnosing the presence of diabetic retinopathy and is aware of its management. Examination will be required more frequently if retinopathy is progressing. This follow-up interval is recommended recognizing that there are limited data addressing this issue. (Level of Evidence: B)

The older adult who has new-onset diabetes mellitus should have an initial screening dilated-eye examination performed by an eye-care specialist with funduscopy training (AGS, 2003).

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➧ Measure #118 (NQF 0066): Coronary Artery Disease (CAD): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy - Diabetes or Left Ventricular Systolic Dysfunction (LVEF < 40%)

2013 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Percentage of patients aged 18 years and older with a diagnosis of coronary artery disease seen within a 12 month period who also have diabetes OR a current or prior Left Ventricular Ejection Fraction (LVEF) < 40% who were prescribed ACE inhibitor or ARB therapy

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for all patients with CAD seen during the reporting period. This measure may be reported by clinicians who perform the quality actions described in the measure for the primary management of patients with CAD based on the services provided and the measure-specific denominator coding.

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT codes, HCPCS codes, and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

There are two reporting criteria for this measure:
(1) Patients who are 18 years and older with a diagnosis of CAD

OR

(2) Patients who are 18 years and older with a diagnosis of CAD who are also diabetic

> The eligible professional should submit data on one of the reporting criteria, depending on the clinical findings. If the patient has CAD (without a diagnosis of Diabetes), use Denominator Reporting Criteria 1. If the patient has CAD and Diabetes, use Denominator Reporting Criteria 2. If the patient has both diabetes and LVSD, the eligible professional may report quality data for Reporting Criteria 2 and this will count as appropriate reporting for this patient.

REPORTING CRITERIA 1: All patients with CAD (without a diagnosis of diabetes)

DENOMINATOR (REPORTING CRITERIA 1):
All patients aged 18 years and older with a diagnosis of coronary artery disease seen within a 12 month period who also have a current or prior LVEF < 40%

> Denominator Instructions: It is necessary to determine the LVEF for the patient, either through quantitative or qualitative assessment. 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 function.

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Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Diagnosis for CAD (ICD-9-CM): 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
Diagnosis for CAD (ICD-10-CM) [REFERENCE ONLY/Not Reportable]: I20.0, I20.1, I20.8, I20.9, I21.01, I21.02, I21.09, I21.11, I21.19, I21.21, I21.3, I21.4, I22.0, I22.1, I22.2, I21.29, I22.8, I22.9, I24.0, I24.1, I24.8, I24.9, I25.10, I25.110, I25.111, I25.118, I25.119, I25.2, I25.5, I25.6, I25.700, I25.701, I25.708, I25.709, I25.710, I25.711, I25.718, I25.719, I25.720, I25.721, I25.728, I25.729, I25.730, I25.731, I25.738, I25.739, I25.750, I25.751, I25.758, I25.759, I25.760, I25.761, I25.768, I25.769, I25.790, I25.791, I25.798, I25.799, I25.82, I25.83, I25.89, I25.9, Z95.1, Z95.5, Z98.61
AND
Patient encounter during the reporting period (CPT): 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
AND
Left Ventricular Ejection Fraction (LVEF) < 40% or documentation of moderately or severely depressed left ventricular systolic function: G8934

NUMERATOR:
Patients who were prescribed ACE inhibitor or ARB therapy

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:
Clinician prescribed angiotensin converting enzyme (ACE) inhibitor or angiotensin receptor blocker (ARB) therapy (G8935)

OR

Clinician documented that patient was not an eligible candidate for angiotensin converting enzyme (ACE) inhibitor or angiotensin receptor blocker (ARB) therapy (G8936)

OR

Clinician did not prescribe angiotensin converting enzyme (ACE) inhibitor or angiotensin receptor blocker (ARB) therapy, reason not given (G8937)

OR

REPORTING CRITERIA 2: Patients with CAD and diabetes

DENOMINATOR (REPORTING CRITERIA 2):
All patients aged 18 years and older with a diagnosis of coronary artery disease seen within a 12 month period who also have a diagnosis of diabetes

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DENOMINATOR NOTE: If a patient has both diabetes and LVSD, reporting criteria #2 will count as appropriate reporting for this patient.

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Diagnosis for CAD (ICD-9-CM): 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
Diagnosis for CAD (ICD-10-CM) [REFERENCE ONLY/Not Reportable]: I20.0, I20.1, I20.8, I20.9, I21.01, I21.02, I21.09, I21.11, I21.19, I21.21, I21.3, I21.4, I22.0, I22.1, I22.2, I21.29, I22.8, I22.9, I24.0, I24.1, I24.8, I24.9, I25.10, I25.110, I25.111, I25.118, I25.119, I25.2, I25.5, I25.6, I25.700, I25.701, I25.708, I25.709, I25.710, I25.711, I25.718, I25.719, I25.720, I25.721, I25.728, I25.729, I25.730, I25.731, I25.738, I25.739, I25.750, I25.751, I25.758, I25.759, I25.760, I25.761, I25.768, I25.769, I25.790, I25.791, I25.798, I25.799, I25.82, I25.83, I25.89, I25.9, Z95.1, Z95.5, Z98.61
AND
Diagnosis for diabetes (ICD-9-CM): 250.00, 250.01, 250.02, 250.03, 250.10, 250.11, 250.12, 250.13, 250.20, 250.21, 250.22, 250.23, 250.30, 250.31, 250.32, 250.33, 250.40, 250.41, 250.42, 250.43, 250.50, 250.51, 250.52, 250.53, 250.60, 250.61, 250.62, 250.63, 250.70, 250.71, 250.72, 250.73, 250.80, 250.81, 250.82, 250.83, 250.90, 250.91, 250.92, 250.93
Diagnosis for diabetes (ICD-10-CM) [REFERENCE ONLY/Not Reportable]: E10.10, E10.11, E10.21, E10.22, E10.29, E10.311, E10.319, E10.321, E10.329, E10.331, E10.339, E10.341, E10.349, E10.351, E10.359, E10.36, E10.39, E10.40, E10.41, E10.42, E10.43, E10.44, E10.49, E10.51, E10.52, E10.59, E10.610, E10.618, E10.620, E10.621, E10.622, E10.628, E10.630, E10.638, E10.641, E10.649, E10.65, E10.69, E10.8, E10.9, E11.00, E11.01, E11.21, E11.22, E11.29, E11.311, E11.319, E11.321, E11.329, E11.331, E11.339, E11.341, E11.349, E11.351, E11.359, E11.36, E11.39, E11.40, E11.41, E11.42, E11.43, E11.44, E11.49, E11.51, E11.52, E11.59, E11.610, E11.618, E11.620, E11.621, E11.622, E11.628, E11.630, E11.638, E11.641, E11.649, E11.65, E11.69, E11.8, E11.9, E13.00, E13.01, E13.10, E13.11, E13.21, E13.22, E13.29, E13.311, E13.319, E13.321, E13.329, E13.331, E13.339, E13.341, E13.349, E13.351, E13.359, E13.36, E13.39, E13.40, E13.41, E13.42, E13.43, E13.44, E13.49, E13.51, E13.52, E13.59, E13.610, E13.618, E13.620, E13.621, E13.622, E13.628, E13.630, E13.638, E13.641, E13.649, E13.65, E13.69, E13.8, E13.9
AND
Patient encounter during the reporting period (CPT): 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

NUMERATOR:
Patients who were prescribed ACE inhibitor or ARB therapy

Numerator Options:
Angiotensin converting enzyme (ACE) inhibitor or angiotensin receptor blocker (ARB) therapy prescribed (G8473)

OR

Angiotensin converting enzyme (ACE) inhibitor or angiotensin receptor blocker (ARB) therapy not prescribed for reasons documented by the clinician (G8474)

OR

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Angiotensin converting enzyme (ACE) inhibitor or angiotensin receptor blocker (ARB) therapy not prescribed, reason not given (G8475)

RATIONALE:
Nonadherence to cardioprotective medications is prevalent among outpatients with coronary artery disease and can be associated with a broad range of adverse outcomes, including all-cause and cardiovascular mortality, cardiovascular hospitalizations, and the need for revascularization procedures.

In the absence of contraindications, ACE inhibitors or ARBs are recommended for all patients with a diagnosis of coronary artery disease and diabetes or reduced left ventricular systolic function. ACE inhibitors remain the first choice, but ARBs can now be considered a reasonable alternative. Both pharmacologic agents have been shown to decrease the risk of death, myocardial infarction, and stroke. Additional benefits of ACE inhibitors include the reduction of diabetic symptoms and complications for patients with diabetes.

CLINICAL RECOMMENDATION STATEMENTS:
The following evidence statements are quoted verbatim from the referenced clinical guidelines.

ACE inhibitors should be started and continued indefinitely in all patients with left ventricular ejection fraction less than or equal to 40% and in those with hypertension, diabetes, or chronic kidney disease, unless contraindicated. (Class I Recommendation, Level A Evidence). (ACC/AHA, 2007)

Angiotensin receptor blockers are recommended for patients who have hypertension, have indicators for but are intolerant of ACE inhibitors, have heart failure, or have had a myocardial infarction with left ventricular ejection fraction less than or equal to 40% (Class I Recommendation, Level A Evidence). (ACC/AHA, 2007)

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♦Measure #119 (NQF 0062): Diabetes Mellitus: Medical Attention for Nephropathy

2013 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

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

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for all patients with diabetes mellitus seen during the reporting period. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

Measure Reporting via Claims:
ICD-9-CM diagnosis codes, CPT or HCPCS codes, and patient demographics are used to identify patients who are included in the measure's denominator. CPT Category II codes or G-codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed ICD-9-CM diagnosis codes, CPT or HCPCS codes, and the appropriate CPT Category II code OR G-code OR the CPT Category II code with the modifier. The reporting modifier allowed for this measure is: 8P- reason not otherwise specified. There are no allowable performance exclusions for this measure. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT or HCPCS -codes, and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data. There are no allowable performance exclusions for this measure.

DENOMINATOR:
All patients aged 18 through 75 years with the diagnosis of diabetes

Denominator Criteria (Eligible Cases):
Patients aged 18 years through 75 years on date of encounter
AND
Diagnosis for diabetes (ICD-9-CM): 250.00, 250.01, 250.02, 250.03, 250.10, 250.11, 250.12, 250.13, 250.20, 250.21, 250.22, 250.23, 250.30, 250.31, 250.32, 250.33, 250.40, 250.41, 250.42, 250.43, 250.50, 250.51, 250.52, 250.53, 250.60, 250.61, 250.62, 250.63, 250.70, 250.71, 250.72, 250.73, 250.80, 250.81, 250.82, 250.83, 250.90, 250.91, 250.92, 250.93, 357.2, 362.01, 362.02, 362.03, 362.04, 362.05, 362.06, 362.07, 366.41, 648.00, 648.01, 648.02, 648.03, 648.04
Diagnosis for diabetes (ICD-10-CM) [REFERENCE ONLY/Not Reportable]: E10.10, E10.11, E10.21, E10.22, E10.29, E10.311, E10.319, E10.321, E10.329, E10.331, E10.339, E10.341, E10.349, E10.351, E10.359, E10.36, E10.39, E10.40, E10.41, E10.42, E10.43, E10.44, E10.49, E10.51, E10.52, E10.59, E10.610, E10.618, E10.620, E10.621, E10.622, E10.628, E10.630, E10.638, E10.641, E10.649, E10.65, E10.69, E10.8, E10.9, E11.00, E11.01, E11.21, E11.22, E11.29, E11.311, E11.319, E11.321, E11.329,

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E11.331, E11.339, E11.341, E11.349, E11.351, E11.359, E11.36, E11.39, E11.40, E11.41, E11.42, E11.43, E11.44, E11.49, E11.51, E11.52, E11.59, E11.610, E11.618, E11.620, E11.621, E11.622, E11.628, E11.630, E11.638, E11.641, E11.65, E11.69, E11.8, E11.9, E11.649, O24.011, O24.012, O24.013, O24.019, O24.02, O24.03, O24.111, O24.112, O24.113, O24.119, O24.12, O24.13
AND
Patient encounter during the reporting period (CPT or HCPCS): 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, G0402

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 Otherwise 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

RATIONALE:
Nephropathy is a frequent complication of renal disease for both type 1 and type 2 diabetes and often ends in end-stage renal disease (ESRD) (ADA, 2002). Of all people with diabetes, 10-21% have nephropathy (ADA 2002).

CLINICAL RECOMMENDATION STATEMENTS:
American Association of Clinical Endocrinologists and American College of Endocrinology (AACE/ACE):
Screen all patients with diabetes mellitus for chronic kidney disease annually; screening should begin 5 years after diagnosis in patients with type 1 diabetes and at the time of diagnosis in patients with type 2 diabetes. Testing includes:

- Measurement of albumin-to-creatinine ratio in a spot urine specimen and measurement of the estimated glomerular filtration rate derived from serum creatinine
- The following are diagnostic criteria for chronic kidney disease:

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- Estimated glomerular filtration rate < 60 mL/min/1.73 m2 or albumin-to-creatinine ratio > 30 mg albumin/g creatinine
- Microalbuminuria > 30 mg albumin/g creatinine
- Macroalbuminuria > 300 mg albumin/g creatinine

Prescribe ACE inhibitor or ARB in the antihypertensive regimen in the absence of contraindications (ACE/AACE, 2007).

American Diabetes Association (ADA): Perform an annual test to assess urine albumin excretion in type 1 diabetic patients with diabetes duration of ≥ 5 years and in all type 2 diabetic patients starting at diagnosis. Measure serum creatinine at least annually in all adults with diabetes regardless of the degree of urine albumin excretion. The serum creatinine should be used to estimate GFR and stage the level of chronic kidney disease (CKD), if present. In the treatment of the nonpregnant patient with micro- or macroalbuminuria, either ACE inhibitors or ARBs should be used (ADA,2012).

A test for the presence of microalbumin should be performed at diagnosis in patients with type 2 diabetes. After the initial screening and in the absence of previously demonstrated macro-or microalbuminuria, a test for the presence of microalbumin should be performed annually (AGS, 2003).

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▲Measure #121: Adult Kidney Disease: Laboratory Testing (Lipid Profile)

2013 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

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

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for patients with a diagnosis of chronic kidney disease (CKD) (stage 3, 4, or 5, not receiving RRT) seen during the reporting period. It is anticipated that clinicians providing care for patients with CKD will submit this measure.

Measure Reporting via Claims:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. G-codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed ICD-9-CM diagnosis codes, CPT codes, and the appropriate G-code. There are no allowable performance exclusions for this measure. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data. There are no allowable performance exclusions for this measure.

DENOMINATOR:
All patients aged 18 years and older with a diagnosis of CKD (stage 3, 4, or 5, not receiving RRT)

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

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Diagnosis for stage 3, 4, or 5 CKD (ICD-9-CM): 585.3, 585.4, 585.5
Diagnosis for stage 3, 4, or 5 CKD (ICD-10-CM) [REFERENCE ONLY/Not Reportable]: N18.3, N18.4, N18.5
AND
Patient encounter during the reporting period (CPT): 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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NUMERATOR:
Patients who had a fasting lipid profile performed at least once within a 12-month period

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 Given
G8728: Fasting lipid profile not performed, reason not given

RATIONALE:
The principal reason to evaluate dyslipidemias in patients with CKD is to detect abnormalities that may be treated to reduce the incidence of ACVD. A number of observational studies have reported that various dyslipidemias are associated with decreased kidney function in the general population and in patients with CKD. (KDOQI)

Many factors influence the prevalence of dyslipidemias in CKD. Changes in proteinuria, GFR, and treatment of CKD may alter lipoprotein levels. Therefore, it is prudent to evaluate dyslipidemias more often than is recommended in the general population. (KDOQI)

CLINICAL RECOMMENDATION STATEMENTS:
The following evidence statements are quoted verbatim from the referenced clinical guidelines.
Only selected portions of the clinical guidelines are quoted here; for more details, please refer to the full guideline.

All adults and adolescents with CKD should be evaluated for dyslipidemias. (Grade B) (KDOQI, 2003)

For adults and adolescents with CKD, the assessment of dyslipidemias should include a complete fasting lipid profile with total cholesterol, LDL, HDL, and triglycerides. (Grade B) (KDOQI, 2003)
If a patient has GFR ≤ 30 ml/min/1.73m2, then s/he should be monitored for dyslipidemias; measurements should include triglycerides, LDL, HDL, and total cholesterol. (B) (RPA, 2002)

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▲Measure #122: Adult Kidney Disease: Blood Pressure Management

2013 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

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 ≥ 130/80 mmHg with a documented plan of care

INSTRUCTIONS:
This measure is to be reported at each visit for patients with a diagnosis of chronic kidney disease (CKD) (stage 3, 4, or 5, not receiving RRT) seen during the reporting period. It is anticipated that clinicians providing care for patients with CKD will submit this measure.

Measure Reporting via Claims:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. G-codes and/or CPT Category II codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed ICD-9-CM diagnosis codes, CPT codes, and the appropriate G-code AND/OR CPT Category II code OR the CPT Category II code with the modifier AND G-code. The reporting modifier allowed for this measure is: 8P- reason not otherwise specified. There are no allowable performance exclusions for this measure.

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data. There are no allowable performance exclusions for this measure.

DENOMINATOR:
All patient visits for those patients aged 18 years and older with a diagnosis of CKD (stage 3, 4, or 5, not receiving RRT) and proteinuria

Definitions:
Proteinuria - > 300mg 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.
RRT (Renal Replacement Therapy) - For the purposes of this measure, RRT includes hemodialysis, peritoneal dialysis, and kidney transplantation.

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Diagnosis for stage 3, 4, or 5 CKD (ICD-9-CM): 585.3, 585.4, 585.5
Diagnosis for stage 3, 4, or 5 CKD (ICD-10-CM) [REFERENCE ONLY/Not Reportable]: N18.3, N18.4, N18.5

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AND
Diagnosis for Proteinuria (ICD-9-CM): 791.0
Diagnosis for Proteinuria (ICD-10-CM) [REFERENCE ONLY/Not Reportable]: R80.1, R80.8, R80.9
AND
Patient encounter during the reporting period (CPT): 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

NUMERATOR:
Patient visits with blood pressure < 130/80 mmHg OR ≥ 130/80 mmHg and with a documented plan of care

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

Definition:
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.

NUMERATOR NOTE: The correct combination of numerator code(s) must be reported on the claim form in order to properly report this measure. The "correct combination" of codes may require the submission of multiple numerator codes.

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Patient Visits with Blood Pressure < 130/80 mmHg
(One G-code [G8476] is required on the claim form to submit this numerator option)
G8476: Most recent blood pressure has a systolic measurement of <130 mmHg and a diastolic measurement of < 80 mmHg

OR

Blood Pressure Plan of Care Documented for Patient Visits with Systolic Blood Pressure ≥ 130 mmHg and/or Diastolic Blood Pressure ≥ 80 mmHg (If either systolic blood pressure is ≥ 130 mmHg OR diastolic blood pressure is ≥ 80 mmHg, patient requires a plan of care):
(One G-code & one CPT II code [G8477 & 0513F] are required on the claim form to submit this numerator option)
G8477: Most recent blood pressure has a systolic measurement of ≥ 130 mmHg and/or a diastolic measurement of ≥ 80 mmHg
AND
CPT II 0513F: Elevated blood pressure plan of care documented

OR

Blood Pressure Measurement not Performed, Reason not Given
(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 given

OR

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Elevated Blood Pressure Plan of Care not Documented for Patient Visits with Systolic Blood **Pressure ≥ 130 mmHg and/or Diastolic Blood Pressure ≥ 80 mmHg, Reason not Otherwise 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 ≥130 mmHg and/or a diastolic measurement of ≥ 80 mmHg

RATIONALE:
Accurate measurement in CKD is especially important, because hypertension is more common in CKD, and because JNC 7 identifies CKD as a "compelling indication" for more aggressive antihypertensive therapy because of the higher risk of CVD in CKD than in the general population. (KDOQI)
Target blood pressure in nondiabetic kidney disease should be < 130 < 80 mmHg. (KDOQI)
The requirement for proteinuria in the denominator for these measures is based on growing controversy regarding the appropriateness of prior recommendations for a BP < 130/80 and for the use of ACE inhibition/angiotensin receptor blockade in non-proteinuric kidney disease. (Chang et al; 2010 and Agarwal, 2011)

CLINICAL RECOMMENDATION STATEMENTS:
The following evidence statements are quoted verbatim from the referenced clinical guidelines.

Only selected portions of the clinical guidelines are quoted here; for more details, please refer to the full guideline.

Blood pressure should be measured at each health encounter (Grade A). (KDOQI™ 2004)

If a patient has GFR ≤ 30 ml/min/1.73m2, then his/her blood pressure should be checked with every clinic visit (Grade A). (RPA, 2002)

If a patient has a GFR ≤ 30 ml/min/1.73m², and if blood pressure is determined to be elevated (systolic > 130 mmHg OR diastolic > 80 mmHg), then s/he should receive intensified antihypertensive therapy (Grade B). (RPA, 2002)

Patients with CKD should be considered in the “highest-risk” group for CVD for implementing recommendations for pharmacological therapy, irrespective of cause of CKD (Grade A). (KDOQI, 2004)

Target blood pressure for CVD risk reduction in CKD and diabetic/nondiabetic kidney disease should be < 130/80 mmHg (Grade B). (KDOQI, 2004)
All antihypertensive agents can be used to lower blood pressure in CKD. Multidrug regimens will be necessary in most patients with CKD to achieve therapeutic goals. Patients with specific causes of kidney disease and CVD will benefit from specific classes of agents. (KDOQI, 2004)
All classes of antihypertensive agents are effective in lowering blood pressure in CKD. Antihypertensive agents should be prescribed as follows, when possible: Preferred agents for CKD should be used first (Grade A); Diuretics should be included in the antihypertensive regimen in most patients (Grade A); Choose additional agents based on cardiovascular disease-specific indications to achieve therapeutic and preventive targets and to avoid side-effects and interactions (Grade B). (KDOQI, 2004)

Lifestyle modifications recommended for CVD risk reduction should be recommended as part of the treatment regimen (Grade B). (KDOQI, 2004)

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Elevated blood pressure must be confirmed on repeated visits before characterizing an individual as having hypertension. Blood pressure can be determined by resting blood pressure measurement in the health-care provider's office (casual blood pressure [CBP]), self-measured blood pressure (SMBP), or ambulatory blood pressure monitoring (ABPM). Blood pressure should be measured according to the recommendations for indirect measurement of arterial blood pressure of the American Heart Association and Seventh Report of the Joint National Committee on the Prevention, Detection, Evaluation and Treatment of High Blood Pressure (JNC 7) (Grade A); Patients should be taught to measure and record their blood pressure, whenever possible (Grade C). (KDOQI, 2004)

High blood pressure is both a cause and a complication of chronic kidney disease. As a complication, high blood pressure may develop early during the course of chronic kidney disease and is associated with adverse outcomes—in particular, faster loss of kidney function and development of cardiovascular disease.

- Blood pressure should be closely monitored in all patients with chronic kidney disease.
- Treatment of high blood pressure in chronic kidney disease should include specification of target blood pressure levels, nonpharmacologic therapy, and specific antihypertensive agents for the prevention of progression of kidney disease (Guideline 13) and development of cardiovascular disease (Guideline 15). (KDOQI, 2002)
- Interventions to slow the progression of kidney disease should be considered in all patients with chronic kidney disease.
- Interventions that have been proven to be effective include:
    (1) Strict glucose control in diabetes;
    (2) Strict blood pressure control;
    (3) Angiotensin-converting enzyme inhibition or angiotensin-2 receptor blockade. (KDOQI, 2002)

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▲Measure #123: Adult Kidney Disease: Patients On Erythropoiesis-Stimulating Agent (ESA) - Hemoglobin Level > 12.0 g/dL

2013 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

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 [Renal Replacement Therapy]) or End Stage Renal Disease (ESRD) (who are on hemodialysis or peritoneal dialysis) who are also receiving ESA therapy AND have a Hemoglobin level > 12.0 g/dL

INSTRUCTIONS:
This measure is to be reported each calendar month patients are seen with a diagnosis of advanced CKD (stage 4 or 5, not receiving RRT) or ESRD (who are on hemodialysis or peritoneal dialysis) during the reporting period. The most recent quality code submitted will be used for performance calculation. It is anticipated that clinicians providing care for patients with advanced CKD or ESRD will submit this measure.

Measure Reporting via Claims:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. CPT Category II codes and/or G-codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed ICD-9-CM diagnosis codes, CPT codes, and the appropriate CPT Category II code AND/OR G-code. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All calendar months 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

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

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND

Diagnosis for stage 4 or 5 CKD (ICD-9-CM): 585.4, 585.5
Diagnosis for stage 4 or 5 CKD (ICD-10-CM) [REFERENCE ONLY/Not Reportable]: N18.4, N18.5

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OR
Diagnosis for ESRD (ICD-9-CM): 585.6
Diagnosis for ESRD (ICD-10-CM) [REFERENCE ONLY/Not Reportable]: N18.6

AND
Patient encounter during the reporting period (CPT): 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

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.

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 G-code & one CPT II code [*G0908 & 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 Given
*(One G-code & one CPT II code [*G0909 & 4171F*] are required on the claim form to submit this numerator option)*
G0909: Hemoglobin level measurement not documented, reason not given
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

Most Recent Hemoglobin Level ≤ 12.0 g/dL
*(One G-code & one CPT II code [*G0910 & 4171F*] are required on the claim form to submit this numerator option)*
G0910: Most Recent Hemoglobin Level ≤ 12.0 g/dL
AND
CPT II 4171F: Patient receiving Erythropoiesis-Stimulating Agents (ESA) therapy

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RATIONALE:
Anemia is a common complication of chronic kidney disease (CKD). The prevalence of anemia varies with the degree of renal impairment in predialysis patients with CKD, but once end-stage kidney failure occurs, all patients are eventually affected. Anemia develops once renal function decreases to < 50% because of a deficiency in endogenous erythropoietin (EPO) production by the kidney, decreased red cell survival, blood losses, and increased red blood cell destruction once the patient begins dialysis treatment, particularly hemodialysis. Anemia reduces physical capacity, well-being, neurocognitive function, and energy level and worsens quality of life both in predialysis and dialysis patients. Anemia also induces adaptive cardiovascular mechanisms to maintain tissue oxygen supply. This leads to left ventricular hypertrophy, left ventricular dilation, and myocardial ischemia, which are risk factors for cardiovascular disease and death. It is plausible that reversing anemia may reduce this risk. (Strippoli et al, 2004)

In clinical practice for CKD patients, determination of the frequency and size of sequential ESA dose adjustments in relationship to a threshold Hgb or target Hgb level; and an interpretation of previous therapeutic trends and responsiveness to ESA therapy is critical. (KDOQI, 2007)

Improvement in quality of life and avoidance of transfusion are treatment benefits from determining the appropriate hemoglobin level, and there is potential for harm when aiming for high Hgb targets. The potential harms are based on evidence from RCTs suggesting that assignment to Hgb targets greater than 13.0 g/dL may increase the risk of life threatening adverse events. (KDOQI, 2007)

CLINICAL RECOMMENDATION STATEMENTS:
The following evidence statements are quoted verbatim from the referenced clinical guidelines.

Only selected portions of the clinical guidelines are quoted here; for more details, please refer to the full guideline.

In the opinion of the [KDOQI] Work Group, in dialysis and nondialysis patients with CKD receiving ESA therapy, the selected Hgb target should generally be in the range of 11.0 to 12.0 g/dL. (Clinical Practice RECOMMENDATION) (KDOQI, 2007)

In dialysis and nondialysis patient with CKD receiving ESA therapy, the Hgb target should not be greater than 13.0 g/dL. (Clinical Practice GUIDELINE—MODERATELY STRONG EVIDENCE) (KDOQI, 2007)

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♪ Measure #126 (NQF 0417): Diabetes Mellitus: Diabetic Foot and Ankle Care, Peripheral Neuropathy – Neurological Evaluation

2013 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of patients aged 18 years and older with a diagnosis of diabetes mellitus who had a neurological examination of their lower extremities within 12 months

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for patients with diabetes mellitus seen during the reporting period. Evaluation of neurological status in patients with diabetes to assign risk category and therefore have appropriate foot and ankle care to prevent ulcerations and infections ultimately reduces the number and severity of amputations that occur. Risk catagorization and follow up treatment plan should be done according to the following table:

Risk Categorization System:

Category	Risk Profile	Evaluation Frequency
0	Normal	Annual
1	Peripheral Neuropathy (LOPS)	Semi-annual
2	Neuropathy, deformity, and/or PAD	Quarterly
3	Previous ulcer or amputation	Monthly to quarterly

This measure may be reported by non-MD/DO clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

Measure Reporting via Claims:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. G-codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed ICD-9-CM diagnosis codes, CPT codes, and the appropriate numerator G-code. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All patients aged 18 years and older with a diagnosis of diabetes mellitus

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter

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AND

Diagnosis for diabetes (ICD-9-CM): 250.00, 250.01, 250.02, 250.03, 250.10, 250.11, 250.12, 250.13, 250.20, 250.21, 250.22, 250.23, 250.30, 250.31, 250.32, 250.33, 250.40, 250.41, 250.42, 250.43, 250.50, 250.51, 250.52, 250.53, 250.60, 250.61, 250.62, 250.63, 250.70, 250.71, 250.72, 250.73, 250.80, 250.81, 250.82, 250.83, 250.90, 250.91, 250.92, 250.93

Diagnosis for diabetes (ICD-10-CM) [REFERENCE ONLY/Not Reportable]: E10.10, E10.11, E10.21, E10.22, E10.29, E10.311, E10.319, E10.321, E10.329, E10.331, E10.339, E10.341, E10.349, E10.351, E10.359, E10.36, E10.39, E10.40, E10.41, E10.42, E10.43, E10.44, E10.49, E10.51, E10.52, E10.59, E10.610, E10.618, E10.620, E10.621, E10.622, E10.628, E10.630, E10.638, E10.641, E10.649, E10.65, E10.69, E10.8, E10.9, E11.00, E11.01, E11.21, E11.22, E11.29, E11.311, E11.319, E11.321, E11.329, E11.331, E11.339, E11.341, E11.349, E11.351, E11.359, E11.36, E11.39, E11.40, E11.41, E11.42, E11.43, E11.44, E11.49, E11.51, E11.52, E11.59, E11.610, E11.618, E11.620, E11.621, E11.622, E11.628, E11.630, E11.638, E11.641, E11.649, E11.65, E11.69, E11.8, E11.9, E13.00, E13.01, E13.10, E13.11, E13.21, E13.22, E13.29, E13.311, E13.319, E13.321, E13.329, E13.331, E13.339, E13.341, E13.349, E13.351, E13.359, E13.36, E13.39, E13.40, E13.41, E13.42, E13.43, E13.44, E13.49, E13.51, E13.52, E13.59, E13.610, E13.618, E13.620, E13.621, E13.622, E13.628, E13.630, E13.638, E13.641, E13.649, E13.65, E13.69, E13.8, E13.9

AND

Patient encounter during the reporting period (CPT): 11042, 11043, 11044, 11055, 11056, 11057, 11719, 11720, 11721, 11730, 11740, 97001, 97002, 97597, 97598, 97802, 97803, 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

NUMERATOR:

Patients who had a lower extremity neurological exam performed at least once within 12 months

Definition:

Lower Extremity Neurological Exam – Consists of a documented evaluation of motor and sensory abilities and may include: reflexes, vibratory, proprioception, sharp/dull and 5.07 filament detection. The components listed are consistent with the neurological assessment recommended by the Task Force of the Foot Care Interest Group of the American Diabetes Association. They generally recommend at least two of the listed tests be performed when evaluating for loss of protective sensation; however the clinician should perform all necessary tests to make the proper evaluation.

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Lower Extremity Neurological Exam Performed

G8404: Lower extremity neurological exam performed and documented

OR

Lower Extremity Neurological Exam not Performed for Documented Reasons

G8406: Clinician documented that patient was not an eligible candidate for lower extremity neurological exam measure

OR

Lower Extremity Neurological Exam not Performed

G8405: Lower extremity neurological exam not performed

RATIONALE:

Foot ulceration is the most common single precursor to lower extremity amputations among persons with diabetes. Treatment of infected foot wounds accounts for up to one-quarter of all inpatient hospital admissions for people with diabetes in the United States. Peripheral sensory neuropathy in the absence of perceived trauma is the primary

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factor leading to diabetic foot ulcerations. Approximately 45-60% of all diabetic ulcerations are purely neuropathic. Other forms of neuropathy may also play a role in foot ulcerations. Motor neuropathy resulting in anterior crural muscle atrophy or intrinsic muscle wasting can lead to foot deformities such as foot drop, equinus, and hammertoes. In people with diabetes, 22.8% have foot problems – such as amputations and numbness – compared with 10% of nondiabetics. Over the age of 40 years old, 30% of people with diabetes have loss of sensation in their feet.

CLINICAL RECOMMENDATION STATEMENTS:

Recognizing important risk factors and making a logical, treatment-oriented assessment of the diabetic foot requires a consistent and thorough diagnostic approach using a common language. Without such a method, the practitioner is more likely to overlook vital information and to pay inordinate attention to less critical points in the evaluation. A useful examination will involve identification of key risk factors and assignment into appropriate risk category. Only then can an effective treatment plan be designed and implemented. (ACFAS/ACFAOM Clinical Practice Guidelines)

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♪ Measure #127 (NQF 0416): Diabetes Mellitus: Diabetic Foot and Ankle Care, Ulcer Prevention – Evaluation of Footwear

2013PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of patients aged 18 years and older with a diagnosis of diabetes mellitus who were evaluated for proper footwear and sizing

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for patients with diabetes mellitus seen during the reporting period. This measure may be reported by non-MD/DO clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

Measure Reporting via Claims:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. G-codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed ICD-9-CM diagnosis codes, CPT codes, and the appropriate numerator G-code. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All patients aged 18 years and older with a diagnosis of diabetes mellitus

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Diagnosis for diabetes (ICD-9-CM): 250.00, 250.01, 250.02, 250.03, 250.10, 250.11, 250.12, 250.13, 250.20, 250.21, 250.22, 250.23, 250.30, 250.31, 250.32, 250.33, 250.40, 250.41, 250.42, 250.43, 250.50, 250.51, 250.52, 250.53, 250.60, 250.61, 250.62, 250.63, 250.70, 250.71, 250.72, 250.73, 250.80, 250.81, 250.82, 250.83, 250.90, 250.91, 250.92, 250.93
Diagnosis for diabetes (ICD-10-CM) [REFERENCE ONLY/Not Reportable]: E10.10, E10.11, E10.21, E10.22, E10.29, E10.311, E10.319, E10.321, E10.329, E10.331, E10.339, E10.341, E10.349, E10.351, E10.359, E10.36, E10.39, E10.40, E10.41, E10.42, E10.43, E10.44, E10.49, E10.51, E10.52, E10.59, E10.610, E10.618, E10.620, E10.621, E10.622, E10.628, E10.630, E10.638, E10.641, E10.649, E10.65, E10.69, E10.8, E10.9, E11.00, E11.01, E11.21, E11.22, E11.29, E11.311, E11.319, E11.321, E11.329, E11.331, E11.339, E11.341, E11.349, E11.351, E11.359, E11.36, E11.39, E11.40, E11.41, E11.42, E11.43, E11.44, E11.49, E11.51, E11.52, E11.59, E11.610, E11.618, E11.620, E11.621, E11.622, E11.628, E11.630, E11.638, E11.641, E11.649, E11.65, E11.69, E11.8, E11.9, E13.00, E13.01, E13.10, E13.11,

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E13.21, E13.22, E13.29, E13.311, E13.319, E13.321, E13.329, E13.331, E13.339, E13.341, E13.349, E13.351, E13.359, E13.36, E13.39, E13.40, E13.41, E13.42, E13.43, E13.44, E13.49, E13.51, E13.52, E13.59, E13.610, E13.618, E13.620, E13.621, E13.622, E13.628, E13.630, E13.638, E13.641, E13.649, E13.65, E13.69, E13.8, E13.9

AND

Patient encounter during the reporting period (CPT): 11042, 11043, 11044, 11055, 11056, 11057, 11719, 11720, 11721, 11730, 11740, 97001, 97002, 97597, 97598, 97802, 97803, 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

NUMERATOR:

Patients who were evaluated for proper footwear and sizing at least once within 12 months

Definition:

Evaluation for Proper Footwear – Includes a foot examination documenting the vascular, neurological, dermatological, and structural/biomechanical findings. The foot should be measured using a standard measuring device, and counseling on appropriate footwear should be based on risk categorization.

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Footwear Evaluation Performed

G8410: Footwear evaluation performed and documented

OR

Footwear Evaluation not Performed for Documented Reasons

G8416: Clinician documented that patient was not an eligible candidate for footwear evaluation measure

OR

Footwear Evaluation not Performed

G8415: Footwear evaluation was not performed

RATIONALE:

Foot ulceration is the most common single precursor to lower extremity amputations among persons with diabetes. Shoe trauma, in concert with loss of protective sensation and concomitant foot deformity, is the leading event precipitating foot ulceration in persons with diabetes. Treatment of infected foot wounds accounts for up to one-quarter of all inpatient hospital admissions for people with diabetes in the United States. Peripheral sensory neuropathy in the absence of perceived trauma is the primary factor leading to diabetic foot ulcerations. Approximately 45-60% of all diabetic ulcerations are purely neuropathic. In people with diabetes, 22.8% have foot problems – such as amputations and numbness – compared with 10% of non-diabetics. Over the age of 40 years old, 30% of people with diabetes have loss of sensation in their feet.

CLINICAL RECOMMENDATION STATEMENTS:

The multifactorial etiology of diabetic foot ulcers is evidenced by the numerous pathophysiologic pathways that can potentially lead to this disorder. Among these are two common mechanisms by which foot deformity and neuropathy may induce skin breakdown in persons with diabetes. The first mechanism of injury refers to prolonged low pressure over a bony prominence (i.e., bunion or hammertoe deformity). This generally causes wounds over the medial, lateral, and dorsal aspects of the forefoot and is associated with tight or ill-fitting shoes. (ACFAS/ACFAOM Clinical Practice Guidelines)

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♠ Measure #128 (NQF 0421): Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up

2013 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

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 within the past six months or during the current visit

Normal Parameters: Age 65 years and older BMI ≥ 23 and < 30
Age 18 – 64 years BMI ≥ 18.5 and < 25

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for patients seen during the reporting period. *The most recent quality code submitted will be used for performance calculation.* There is no diagnosis associated with this measure. This measure may be reported by eligible professionals who perform the quality actions described in the measure based on the services provided at the time of the qualifying visit and the measure-specific denominator coding. Calculated BMI or follow-up plan for BMI outside of normal parameters that is documented in the medical record may be reported if done in the provider's office/facility, or if obtained by the provider, from outside medical records within the past six months. The documented follow-up interventions must be related to the BMI outside of normal parameters, example: "Patient referred to nutrition counseling for BMI above normal parameters".

Measure Reporting via Claims:
CPT codes or HCPCS codes, and patient demographics are used to identify patients who are included in the measure's denominator. G-codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed CPT or HCPCS codes, and the appropriate numerator G-code. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
CPT or HCPCS codes, and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All patients aged 18 years and older

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Patient encounter during the reporting period (CPT or HCPCS): 90791, 90792, 90832, 90834, 90837, 90839, 97001, 97003, 97802, 97803, 98960, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, D7140, D7210, G0101, G0108, G0270, G0271, G0402, G0438, G0439, G0447, G0449

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

Definitions:
BMI – Body mass index (BMI), is expressed as weight/height (kg/m^2) and is commonly used to classify weight categories.
Calculated BMI – Requires an eligible professional or their staff to measure both the height and weight. Self-reported values cannot be used. 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.
Follow-Up Plan – Proposed outline of treatment to be conducted as a result of a BMI out of normal parameters. Such follow-up may include but is not limited to: documentation of a future appointment, education, referral (such as, a registered dietician, nutritionist, occupational therapist, physical therapist, primary care provider, exercise physiologist, mental health professional, or surgeon), pharmacological interventions, dietary supplements, exercise counseling, or nutrition counseling.
Not Eligible/Not Appropriate for BMI Measurement or Follow-Up Plan – A patient is not eligible if one or more of the following reasons exists:

- Patient is receiving palliative care
- Patient is pregnant
- Patient refuses BMI measurement
- If there is any other reason documented in the medical record by the provider explaining why BMI measurement or follow-up plan was not appropriate
- Patient is in an urgent or emergent medical situation where time is of the essence, and to delay treatment would jeopardize the patient's health status.

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
BMI Calculated as Normal, No Follow-Up Plan Required
(One G-code [G84xx] is required on the claim form to submit this numerator option)
G8420: Calculated BMI within normal parameters and documented
OR
BMI Calculated Above Normal Parameters, Follow-Up Documented
G8417: Calculated BMI above normal parameters and a follow-up plan was documented
OR
BMI Calculated Below Normal Parameters, Follow-Up Documented
G8418: Calculated BMI below normal parameters and a follow-up plan was documented
OR
BMI not Calculated, Patient not Eligible/not Appropriate
(One G-code [G8422 or G8938] is required on the claim form to submit this numerator option)
G8422: Patient not eligible for BMI calculation
OR
BMI Calculated, Patient not Eligible/not Appropriate for Follow-up Plan
G8938: BMI is calculated, but patient not eligible for follow-up plan
OR
BMI not Calculated, Reason not Given
(One G-code [G84xx] is required on the claim form to submit this numerator option)
G8421: BMI not calculated
OR
BMI Calculated Outside Normal Parameters, Follow-Up Plan not Documented, Reason not Given
G8419: Calculated BMI outside normal parameters, no follow-up plan documented

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RATIONALE:

BMI Above Upper Parameters

"In 2009, no state met the healthy people 2012 obesity target of 15 percent, and the self reported overall prevalence of obesity among U.S. adults had increased 1.1 percentage points from 2007. Overall self-reported obesity prevalence in the U.S. was 26.7 percent" (CDC, 2010).

Obesity continues to be a public health concern in the United States and throughout the world. In the United States, obesity prevalence doubled among adults between 1980 and 2004 (Flegal et al., 2002; Ogden et al., 2006). Obesity is associated with increased risk of a number of conditions, including diabetes mellitus, cardiovascular disease, hypertension, and certain cancers, as well as with increased risk of disability and a modestly elevated risk of all-cause mortality. "Obesity is associated with an increased risk of death, particularly in adults younger than age 65 years. Obesity has been shown to reduce life expectancy by 6 to 20 years depending on age and race. Ischemic heart disease, diabetes, cancer (especially liver, kidney, breast, endometrial, prostate and colon), and respiratory diseases are the leading causes of death in persons who are obese" (AHRQ, 2011).

Results from the 2009-2010 National Health and Nutrition Examination Survey (NHANES) indicate that an estimated 35.7 percent of adults are obese (NCHS, CDC, 2012). Although the prevalence of adults in the U.S. who are obese is still high with about one-third of adults obese in 2007-2008, data suggest that the rate of increase for obesity in the U.S. in recent decades may be slowing (Flegal et al., 2010).

Finkelstein et al. (2009) found that across all payers, per capita medical spending for the obese is $1,429 higher per year, or roughly 42 percent higher than for someone of normal weight. In aggregate, the annual medical burden of obesity has increased from 6.5 percent to 9.1 percent of annual medical spending and could be as high as $147 billion per year (in 2008 dollars). A study by Tsai et al. (2010) estimated cost for obesity to be even higher. A recent study by Cawley et al. (2012) reported findings that indicate that the effect of obesity of medical care cost is much greater than previously appreciated.

Ma et al. (2009) performed a retrospective, cross-sectional analysis of ambulatory visits in the National Ambulatory Medical Care Survey from 2005 and 2006. The study findings on obesity and office-based quality of care concluded the evidence is compelling and that obesity is underappreciated in office-based physician practices across the United States. Many opportunities are missed for obesity screening and diagnosis, as well as for the prevention and treatment of obesity and related health risks, regardless of patient and provider characteristics.

BMI Below Normal Parameters

Poor nutrition or underlying health conditions can result in underweight. Results from the 2007-2008 National Health and Nutrition Examination Survey (CDC, 2010), using measured heights and weights, indicate an estimated 1.6% of U.S. adults are underweight with women more likely to be underweight than men.

Huffman (2002) states elderly patients with unintentional weight loss are at higher risk for infection, depression and death. The leading causes of involuntary weight loss are depression (especially in residents of long-term care facilities), cancer (lung and gastrointestinal malignancies), cardiac disorders and benign gastrointestinal diseases. Medications that may cause nausea and vomiting, dysphagia, dysgeusia and anorexia have been implicated. Polypharmacy can cause unintended weight loss, as can psychotropic medication reduction (e.g., by unmasking problems such as anxiety). In an observational study, Ranhoff et al. (2005) recommended using BMI < 23 for the elderly to identify positive results with malnutrition screens and poor nutritional status.

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CLINICAL RECOMMENDATION STATEMENTS:

Although multiple clinical recommendations addressing obesity have been developed by professional organizations, societies and associations, two recommendations have been identified which exemplify the intent of the measure and address the numerator and denominator.

The US Preventive Health Services Task Force (USPSTF) *The Guide to Clinical Preventive Services*, 2010-2011 recommends that clinicians screen all adult patients for obesity and offer intensive counseling and behavioral interventions to promote sustained weight loss for obese adults (Level Evidence B).

Institute for Clinical Systems Improvement (ICSI, 2011) Prevention and Management of Obesity (Mature Adolescents and Adults) provides the following guidance:

- Calculate the body mass index; classify the individual based on the body mass index categories. Educate patients about their body mass index and their associated risks.
- Weight management requires a team approach. Be aware of clinical and community resources. The patient needs to have an ongoing therapeutic relationship and follow-up with a health care team.
- Weight control is a lifelong commitment, and the health care team can assist with setting specific goals with the patient.

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♠ Measure #130 (NQF 0419): Documentation of Current Medications in the Medical Record

2013PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of specified visits for patients aged 18 years and older for which the eligible professional attests to documenting a list of current medications to the best of his/her knowledge and ability. This list ***must*** include ALL prescriptions, over-the-counters, herbals, and vitamin/mineral/dietary (nutritional) supplements AND ***must*** contain the medications' name, dosage, frequency and route of administration

INSTRUCTIONS:
This measure is to be reported at each visit during the 12 month reporting period. Eligible professionals meet the intent of this measure by making a best effort to document a current, complete and accurate medication list during each encounter. There is no diagnosis associated with this measure. This measure may be reported by eligible professionals who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

Measure Reporting via Claims:
CPT or HCPCS codes, and patient demographics are used to identify visits that are included in the measure's denominator. G-codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the CPT or HCPCS codes, and the appropriate numerator G-code. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
CPT or HCPCS codes, and patient demographics are used to identify visits that are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All visits occurring during the 12 month reporting period for patients aged 18 years and older on the date of the encounter where one or more CPT or HCPCS codes listed below are reported on the claims submission for that encounter.

> Denominator Criteria (Eligible Cases):
> Patients aged ≥ 18 years on date of encounter
> AND
> Patient encounter during the reporting period (CPT or HCPCS): 90791, 90792, 90832, 90834, 90837, 90839, 90957, 90958, 90959, 90960, 90962, 90965, 90966, 92002, 92004, 92012, 92014, 92507, 92508, 92526, 92541, 92542, 92543, 92544, 92545, 92547, 92548, 92557, 92567, 92568, 92570, 92585, 92588, 92626, 96116, 96150, 96152, 97001, 97002, 97003, 97004, 97532, 97802, 97803, 97804, 98960, 98961, 98962, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, G0101, G0108, G0270, G0402, G0438, G0439

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NUMERATOR:
Eligible professional attests to documenting a list of current medications to the best of his/her knowledge and ability. This list ***must*** include ALL prescriptions, over-the counters, herbals, and vitamin/mineral/dietary (nutritional) supplements AND ***must*** contain the medications' name, dosages, frequency and route of administration

Definitions:
Current Medications – Medications the patient is presently taking including all prescriptions, over-the-counters, herbals and vitamin/mineral/dietary (nutritional) supplements with each medication's name, dosage, frequency and administered route.
Not Eligible – A patient is not eligible if the following reason exist:

- 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.

NUMERATOR NOTE: By reporting G8427, the eligible professional is attesting the documented medication information is current, accurate and complete to the best of his/her knowledge and ability at the time of the patient encounter. This code should also be reported if the eligible professional documented that the patient is not currently taking any medications. Eligible professionals reporting this measure may document medication information received from the patient, authorized representative(s), caregiver(s) or other available healthcare resources.

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Current Medications Documented
G8427: Eligible professional attests to documenting the patient's current medications to the best of his/her knowledge and ability

OR

Current Medications not Documented, Patient not Eligible
G8430: Eligible professional attests the patient is not eligible for medication documentation

OR

Current Medications with Name, Dosage, Frequency, Route not Documented, Reason not Given
G8428: Current medications not documented by the eligible professional, reason not given

RATIONALE:
In the American Medical Association's (AMA) *Physician's Role in Medication Reconciliation* (2007), critical patient information, including medical and medication histories, current medications the patient is receiving and taking, and sources of medications, is essential to the delivery of safe medical care. However, interruptions in the continuity of care and information gaps in patient health records are common and significantly affect patient outcomes. Consequently, clinical judgments may be based on incomplete, inaccurate, poorly documented or unavailable information about the patient and his or her medication.

Medication safety efforts have primarily focused on hospitals; however, the majority of health care services are provided in the outpatient setting where two-thirds of physician visits result in writing at least one prescription (Stock et al., 2009). Chronically ill patients are increasingly being treated as outpatients, many of whom take multiple medications requiring close monitoring (Nassaralla et al., 2007).

Adverse drug events (ADEs) prove to be more fatal in outpatient settings (1 of 131 outpatient deaths) than in hospitals (1 of 854 inpatient deaths) (Nassaralla et al., 2007). According to The Commonwealth Fund report (2010) about 11 to 15 of every 1,000 Americans visit a health care provider because of ADEs in a given year, representing about three to four of every 1,000 patient visits during 1995 to 2001. The total number of visits to treat ADEs increased from 2.9 million in 1995 to 4.3 million visits in 2001.

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ADEs in the ambulatory setting substantially increased the healthcare costs of elderly persons and estimated costs of $1,983 per case. Further findings of The Commonwealth Fund studies additionally identified 11% to 28% of the 4.3 million VADEs in 2001 might have been prevented with improved systems of care and better patient education, yielding an estimate of 473,000 to 1.2 million potentially preventable VADEs annually and potential cost-savings of $946 million to $2.4 billion.

In the Institute for Safe Medication Practices *The White Paper on Medication Safety in the U.S. and the Roles of Community Pharmacists* (2007), the American Pharmaceutical Association identified that Americans spend more than $75 billion per year on prescription and nonprescription drugs. Unnecessary costs include: improper use of prescription medicines due to lack of knowledge costs the economy an estimated $20-100 billion per year; American businesses lose an estimated 20 million workdays per year due to incorrect use of medicines prescribed for heart and circulatory diseases alone; failure to have prescriptions dispensed and/or renewed has resulted in an estimated cost of $8.5 billion for increased hospital admissions and physician visits, nearly one percent of the country's total health care expenditures.

In 2005, the rate of medication errors during hospitalization was estimated to be 52 per 100 admissions, or 70 per 1,000 patient days. Emerging research suggests the scope of medication-related errors in ambulatory settings is as extensive as or more extensive than during hospitalization. Ambulatory visits result in a prescription for medication 50 to 70% of the time. One study estimated the rate of ADEs in the ambulatory setting to be 27 per 100 patients. It is estimated that between 2004 and 2005 in the United States, 701,547 patients were treated for ADEs in emergency departments, and 117,318 patients were hospitalized for injuries caused by an ADE. Individuals aged 65 years and older are more likely than any other population group to require treatment in the emergency department for ADEs (AMA, 2007).

The Agency for Healthcare Quality's (AHRQ) The National Healthcare Disparities Report (2008) identified the rate of adverse drug events (ADE) among Medicare beneficiaries in ambulatory settings as 50 per 1,000 person-years. In 2005, AHRQ reported data on adults age 65 and over who received potentially inappropriate prescription medicines in the calendar year, by race, ethnicity, income, education, insurance status, and gender. The disparities were identified as follows: older Asians were more likely than older whites to have inappropriate drug use (20.3% compared with 17.3%); older Hispanics were less likely than older non-Hispanic Whites to have inappropriate drug use (13.5% compared with 17.6%); older women were more likely than older men to have inappropriate drug use (20.2% compared with 14.3%); there were no statistically significant differences by income or education.

Weeks et al. (2010) noted that fragmented medication records across the health care continuum, inaccurate reporting of medication regimens by patients, and provider failure to acquire all of the all the necessary elements of medication information from the patient or record, present significant obstacles to obtaining an accurate medication list in the ambulatory care setting. Because these obstacles require solutions demonstrating improvements in access to information and communication, the Institute of Medicine and others have encouraged the incorporation of IT solutions in the medication reconciliation process. In a survey administered to office-based physicians with high rates of EMR use, Weeks, et al found there is an opportunity for universal medication lists utilizing health IT.

CLINICAL RECOMMENDATION STATEMENTS:

The Joint Commission's 2011 National Patient Safety Goals guides providers to maintain and communicate accurate patient medication information guiding elements of performance to obtain and/or update information on the medications the patient is currently taking. The National Quality Forum's 2010 update of the *Safe Practices for Better Healthcare*, states healthcare organizations must develop, reconcile, and communicate an accurate patient medication list throughout the continuum of care. Improving the safety of healthcare delivery saves lives, helps avoid unnecessary complications, and increases the confidence that receiving medical care actually makes patients better, not worse. Every healthcare stakeholder group should insist that provider organizations demonstrate their commitment to reducing healthcare error and improving safety by putting into place evidence-based safe practices.

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The AMA's published report, *The Physician's Role in Medication Reconciliation*, identified the best practice medication reconciliation team as one that is multidisciplinary and--in all settings of care--will include physicians, pharmacists, nurses, ancillary health care professionals and clerical staff. The team's variable requisite knowledge, skills, experiences, and perspectives are needed to make medication reconciliation work as safely and smoothly as possible. Team members may have access to vital information or data needed to optimize medication safety. Because physicians are ultimately responsible for the medication reconciliation process and subsequently accountable for medication management, physician leadership and involvement in all phases of developing and initiating a medication reconciliation process or model is important to its success.

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♠ Measure #131 (NQF 0420): Pain Assessment and Follow-Up

2013 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of visits for patients aged 18 years and older with documentation of a pain assessment through discussion with the patient including the use of a standardized tool(s) on each visit AND documentation of a follow-up plan when pain is present

INSTRUCTIONS:
This measure is to be reported for each visit occurring during the reporting period for patients seen during the reporting period. There is no diagnosis associated with this measure. This measure may be reported by eligible professionals who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding. The documented follow up plan must be related to the presence of pain, example: "Patient referred to pain management specialist for back pain".

Measure Reporting via Claims:
CPT or HCPCS codes and patient demographics are used to identify visits included in the measure's denominator. G-codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed CPT or HCPCS codes, and the appropriate numerator G-code. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
CPT or HCPCS codes and patient demographics are used to identify visits included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All visits for patients aged 18 years and older

> Denominator Criteria (Eligible Cases):
> Patients aged ≥ 18 years on date of encounter
> AND
> Patient encounter during the reporting period (CPT or HCPCS): 90791, 90792, 92507, 92508, 92526, 96116, 96150, 97001, 97003, 97532, 98940, 98941, 98942, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, G0101, G0402, G0438, G0439

NUMERATOR:
Patient's pain assessment is documented through discussion with the patient including the use of a standardized tool(s) AND a follow-up plan is documented when pain is present

> Definitions:
> Pain Assessment - A clinical assessment of pain using a standardized tool for the presence and characteristics of pain; characteristics may include location, intensity, quality, and onset/duration.

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Standardized Tool – An assessment tool that has been appropriately normalized and validated for the population in which it is used. Examples of tools for pain assessment, include, but are not limited to: Brief Pain Inventory (BPI), Faces Pain Scale (FPS), McGill Pain Questionnaire (MPQ), Multidimensional Pain Inventory (MPI), Neuropathic Pain Scale (NPS), Numeric Rating Scale (NRS), Oswestry Disability Index (ODI), Roland Morris Disability Questionnaire (RMDQ), Verbal Descriptor Scale (VDS), Verbal Numeric Rating Scale (VNRS), and Visual Analog Scale (VAS).
Follow-Up Plan – Proposed outline of treatment to be conducted as a result of pain assessment. Follow-up ***must*** include a planned reassessment of pain and may include documentation of future appointments, education, referrals, pharmacological intervention, or notification of other care providers as applicable.
Not Eligible – A patient is not eligible if one or more of the following reasons exist:

- Severe mental and/or physical incapacity where the person is unable to express himself/herself in a manner understood by others. For example, cases where pain cannot be accurately assessed through use of nationally recognized standardized pain assessment tools.
- 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:
Pain Assessment Documented as Positive AND Follow-Up Plan Documented
(One G-code [G873x] is required on the claim form to submit this numerator option)
G8730: Pain assessment documented as positive utilizing a standardized tool AND a follow-up plan is documented
OR
Pain Assessment Documented as Negative, No Follow-Up Plan Required
G8731: Pain assessment documented as negative, no follow-up plan required
OR
Patient not Eligible for Pain Assessment for Documented Reasons
(One G-code [G8442 or G8939] is required on the claim form to submit this numerator option)
G8442: Documentation that patient is not eligible for a pain assessment
OR
Pain Assessment Documented, Follow-Up Plan not Documented, Patient not Eligible/Appropriate
G8939: Pain assessment documented, follow-up plan not documented, patient not eligible/appropriate
OR
Pain Assessment not Documented, Reason not Given
(One G-code [G87xx] is required on the claim form to submit this numerator option)
G8732: No documentation of pain assessment, reason not given
OR
Pain Assessment Documented as Positive, Follow-Up Plan not Documented, Reason not Given
G8509: Documentation of positive pain assessment; no documentation of a follow-up plan, reason not given

RATIONALE:
Several provisions from the National Pain Care Policy Act (H.R. 756/S. 660) have been included in the Affordable Care Act (ACA) of 2010 to improve pain care. The legislation includes:

- Mandating an Institute of Medicine (IOM) conference on pain to address key medical and policy issues affecting the delivery of quality pain care
- Establishing a training program to improve the skills of health care professionals to assess and treat pain
- Enhancing the pain research agenda for the National Institute of Health (NIH)

The American Pain Foundation (2009) identified pertinent facts related to the impact of pain as follows:

- 76.5 million Americans suffering from pain.

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- Pain affects more Americans than diabetes, heart disease and cancer combined. It is the number one reason people seek medical care.
- Uncontrolled pain is a leading cause of disability and diminishes quality of life for patients, survivors, and their loved ones. It interferes with all aspects of daily activity, including sleep, work, social and sexual relations.
- Under-treated pain drives up costs – estimated at $100 billion annually in healthcare expenses, lost income, and lost productivity – extending length of hospital stays, as well as increasing emergency room trips and unplanned clinic visits.
- Medically underserved populations endure a disproportionate pain burden in all health care settings. Disparities exist among racial and ethnic minorities in pain perception, assessment, and treatment for all types of pain, whether chronic or acute.

The Institute Of Medicine's (IOM) *Relieving Pain in America: A Blueprint for Transforming Prevention, Care, Education and Research* (2011) report suggests that chronic pain rates will continue to increase as a result of:

- More Americans will experience a disease in which chronic pain is associated (diabetes, cardiovascular disease, etc)
- Increase in obesity which is associated with chronic conditions that have painful symptoms
- Progress in lifesaving techniques for catastrophic injuries for people who would have previously died leads to a group of young people at risk for lifelong chronic pain
- Surgical patients are at risk for acute and chronic pain
- The public has a better understanding of chronic pain syndromes and new treatments and therefore may seek help when they may not have sought help in the past.

The prevalence of pain has a tremendous impact on business, with an estimated annual cost of $61.2 billion in lost productive time. Studies show that most of the pain-related lost productive time occurs while employees are at work, and is in the form of reduced performance. The cost of pain is an enormous burden on today's society, particularly to employers (American Academy of Pain Medicine, 2010). Stewart et al. (2003) identified almost thirteen percent of the total workforce experienced a loss in productive time during a two-week period due to a common pain condition: 5.4% for headache; 3.2% for back pain; 2.0% for arthritis pain; 2.0% for other musculoskeletal pain.

There are no current estimates of the total cost of poorly controlled pain in today's dollars. Viewed from the perspective of health care inflation at levels of more than 40% during the past decade (President's Council of Economic Advisors, 2009), the cost of health care due to pain is estimated to be between $261 to $300 billion. The value of lost productivity based on estimates of days of work missed is $11.6 to 12.7 billion, hours of work lost is $95.2 to $96.5 billion and lower wages is $190.6 to $226.3 billion. Total financial cost of pain to society, combining healthcare cost estimates and productivity estimates, ranges from $560 to $635 billion in 2010 dollars (Relieving Pain in America: A Blueprint for Transforming Prevention, Care, Education and Research, Appendix C, 2011).

Chronic pain—commonly defined as pain persisting longer than six months—affects an estimated 70 million Americans and is a tragically overlooked public health problem (USDHHS, 2006). It is clear the enormous pain-related costs represent both a great challenge and an opportunity in terms of improving the quality and cost-effectiveness of care (The Mayday Fund, 2009).

Research also shows gender differences in the experience and treatment of pain. Most chronic pain conditions are more prevalent among women; however, women's pain complaints tend to be poorly assessed and undertreated (Green, 2003 , Chronic Pain Research Alliance 2011).

A growing body of research reveals even more extensive gaps in pain assessment and treatment among racial and ethnic populations, with minorities receiving less care for pain than non-Hispanic whites (Green, 2003; Green, 2007; Green et al., 2011; Todd et al., 2004; Todd et al., 2007). Differences in pain care occur across all types of pain (e.g.,

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acute, chronic, cancer-related) and medical settings (e.g., emergency departments and primary care) (Green, 2003; Green, 2007; Todd et al., 2007). Even when income, insurance status and access to health care are accounted for, minorities are still less likely than whites to receive necessary pain treatments (Green, 2003; Green, 2007; Paulson et al., 2007).

CLINICAL RECOMMENDATION STATEMENTS:
Chronic pain assessment should include determining the mechanisms of pain through documentation of pain location, intensity, quality and onset/duration; functional ability and goals; and psychological/social factors such as depression or substance abuse.

A patient-centered, multifactorial, comprehensive care plan is necessary, one that includes addressing biopsychosocial factors, spiritual and cultural issues are also important. It is important to have a multidisciplinary team approach coordinated by the primary care physician to lead a team including specialty areas of psychology and physical rehabilitation.

The Institute for Clinical Systems Improvement (ICSI, 2009) *Assessment and Management of Chronic Pain Guideline, Fourth Edition* was chosen because it addresses the key factors of the plan of care, pain assessment, and outcomes. In addition, it is based on a very broad foundation of evidence, and addresses a wide range of clinical conditions.

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♠ Measure #134 (NQF 0418): Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan

2013 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of patients aged 12 years and older screened for clinical depression on the date of encounter using an age appropriate standardized depression screening tool AND, if positive, a follow-up plan is documented on the date of the positive screen

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for patients seen during the reporting period. This measure may be reported by eligible professionals who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding. The documented follow up plan must be related to positive depression screening, example: "Patient referred for psychiatric evaluation due to positive depression screening."

Measure Reporting via Claims:
CPT or HCPCS codes and patient demographics are used to identify patients who are included in the measure's denominator. G-codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed CPT or HCPCS codes and the appropriate numerator G-code. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
CPT or HCPCS codes and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All patients aged 12 years and older

Denominator Criteria (Eligible Cases):
Patients aged ≥ 12 years on date of encounter
AND
Patient encounter during the reporting period (CPT or HCPCS): 90791, 90792, 90832, 90834, 90837, 90839, 92557, 92567, 92568, 92625, 92626, 96150, 96151, 97003, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, G0101, G0402, G0438, G0439, G0444

NUMERATOR:
Patients screened for clinical depression on the date of the encounter using an age appropriate standardized tool AND, if positive, a follow-up plan is documented on the date of the positive screen

Definitions:

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Screening – Completion of a clinical or diagnostic tool used to identify people at risk of developing or having a certain disease or condition, even in the absence of symptoms.
Standardized Depression Screening Tool – A normalized and validated depression screening tool developed for the patient population in which it is being utilized. Examples of depression screening tools include but are not limited to:

- Adolescent Screening Tools (12-17 years)
  Patient Health Questionnaire for Adolescents (PHQ-A), Beck Depression Inventory-Primary Care Version (BDI-PC), Mood Feeling Questionnaire (MFQ), Center for Epidemiologic Studies Depression Scale (CES-D), and PRIME MD-PHQ2
- Adult Screening Tools (18 years and older)
  Patient Health Questionnaire (PHQ-9), Beck Depression Inventory (BDI or BDI-II), Center for Epidemiologic Studies Depression Scale (CES-D), Depression Scale (DEPS), Duke Anxiety-Depression Scale (DADS), Geriatric Depression Scale (GDS), Cornell Scale Screening, and PRIME MD-PHQ2

Follow-Up Plan – Proposed outline of treatment to be conducted as a result of positive clinical depression screening. Follow-up for a positive depression screening ***must*** include one (1) or more of the following:

- Additional evaluation
- Suicide Risk Assessment
- Referral to a practitioner who is qualified to diagnose and treat depression
- Pharmacological interventions
- Other interventions or follow-up for the diagnosis or treatment of depression

Not Eligible/Not Appropriate – A patient is not eligible if one or more of the following conditions exist:

- Patient refuses to participate
- 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
- Situations where the patient's functional capacity or motivation to improve may impact the accuracy of results of standardized depression assessment tools. For example: certain court appointed cases or cases of delirium
- Patient has an active diagnosis of Depression or Bipolar Disorder

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Positive Screen for Clinical Depression Documented, Follow-Up Plan Documented
*(One G-code [*G8431or G8510*] is required on the claim form to submit this numerator option)*
G8431: Positive screen for clinical depression with a documented follow-up plan
OR
Negative Screen for Clinical Depression Documented, Follow-Up Plan not Required
G8510: Negative screen for clinical depression, follow-up not required

OR

Screening for Clinical Depression not Documented, Patient not Eligible/Appropriate
*(One G-code [*G8433 or G8940*] is required on the claim form to submit this numerator option)*
G8433: Screening for clinical depression not documented, patient not eligible/appropriate
OR
Screening for Clinical Depression Documented, Follow-Up Plan not Documented, Patient not Eligible/Appropriate
G8940: Screening for clinical depression documented, follow-up plan not documented, patient not eligible/appropriate

OR

Screening for Clinical Depression not Documented, Reason not Given
*(One G-code [*G8432 or G8511*] is required on the claim form to submit this numerator option)*
G8432: Clinical depression screening not documented, reason not given

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OR

Screening for Clinical Depression Documented, Follow-Up Plan not Documented, Reason not Given

G8511: Positive Screen for clinical depression documented, follow-up plan not documented, reason not given

RATIONALE:

The World Health Organization (WHO), as seen in Pratt & Brody (2008), found that major depression was the leading cause of disability worldwide. Depression causes suffering, decreases quality of life, and causes impairment in social and occupational functioning. It is associated with increased health care costs as well as with higher rates of many chronic medical conditions. Studies have shown that a higher number of depression symptoms are associated with poor health and impaired functioning, whether or not the criteria for a diagnosis of major depression are met. Persons 40-59 years of age had higher rates of depression than any other age group. Persons 12-17, 18-39 and 60 years of age and older had similar rates of depression. Depression was more common in females than in males. Non-Hispanic black persons had higher rates of depression than non-Hispanic white persons. In the 18-39 and 40-59 age groups, those with income below the federal poverty level had higher rates of depression than those with higher income. Among persons 12-17 and 60 years of age and older, raters of depression did not vary significantly by poverty status. Overall, approximately 80% of persons with depression reported some level of difficulty in functioning because of their depressive symptoms. In addition, 35% of males and 22% of females with depression reported that their depressive symptoms make it very or extremely difficult for them to work, get things done at home, or get along with other people. More than one-half of all persons with mild depressive symptoms also reported some difficulty in daily functioning attributable to their symptoms.

The negative outcomes associated with early onset depression, make it crucial to identify and treat depression in its early stages. As reported in Borner (2010), a study conducted by the World Health Organization (WHO) concluded that in North America, primary care and family physicians are likely to provide the first line of treatment for depressive disorders. Others consistently report a 10% prevalence rate of depression in primary care patients. But studies have shown that primary care physicians fail to recognize up to 50% of depressed patients, purportedly because of time constraints and a lack of brief, sensitive, easy-to administer psychiatric screening instruments. Coyle et al. (2003), suggested that the picture is more grim for adolescents, and that more than 70% of children and adolescents suffering from serious mood disorders go unrecognized or inadequately treated. In 2000, Healthy People 2010 recommended routine screening for mental health problems as a part of primary care for both children and adults.

Major depressive disorder (MDD) is a debilitating condition that has been increasingly recognized among youth, particularly adolescents. The prevalence of current or recent depression among children is 3% and among adolescents is 6%. The lifetime prevalence of MDD among adolescents may be as high as 20%. Adolescent-onset MDD is associated with an increased risk of death by suicide, suicide attempts, and recurrence of major depression by young adulthood. MDD is also associated with early pregnancy, decreased school performance, and impaired work, social, and family functioning during young adulthood (Williams et al., 2009). Every fifth adolescent may have a history of depression by age 18. The increase in the onset of depression occurs around puberty. According to Gil Zalsman et al., (2006) as reported in Borner et al. (2010), depression ranks among the most commonly reported mental health problems in adolescent girls.

The economic burden of depression is substantial for individuals as well as society. Costs to an individual may include suffering, possible side effects from treatment, fees for mental health and medical visits and medications, time away from work and lost wages, transportation, and reduced quality of personal relationships. Costs to society may include loss of life, reduced productivity (because of both diminished capacity while at work and absenteeism from work), and increased costs of mental health and medical care. In 2000, the United States spent an estimated $83.1 billion in direct and indirect costs of depression (USPSTF, 2009).

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CLINICAL RECOMMENDATION STATEMENTS:

Adolescent Recommendation (12-18 years)

The USPSTF recommends screening of adolescents (12-18 years of age) for major depressive disorder (MDD) when systems are in place to ensure accurate diagnosis, psychotherapy (cognitive-behavioral or interpersonal), and follow-up (2009).

Level II Child Preventive Services should be assessed and offered to each patient; as such services have been shown to be effective. Such Level II services include: Screening adolescents ages 12-18 for major depressive disorder when systems are in place for accurate diagnosis, treatment, and follow-up (ICSI, 2010).

Adult Recommendation (18 years and older)

The USPSTF recommends screening adults for depression when staff-assisted depression care supports are in place to assure accurate diagnosis, effective treatment, and follow-up (2009).

Routine depression screening should be performed for adult patients (including older adults) but only if the practice has staff-assisted "systems in place to ensure that positive results are followed by accurate diagnosis, effective treatment, and careful follow-up" (ICSI, 2010).

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*Measure #137 (NQF 0650): Melanoma: Continuity of Care – Recall System

2013 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Percentage of patients, regardless of age, with a current diagnosis of melanoma or a history of melanoma whose information was entered, at least once within a 12 month period, into a recall system that includes:

- A target date for the next complete physical skin exam, AND
- A process to follow up with patients who either did not make an appointment within the specified timeframe or who missed a scheduled appointment

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for melanoma patients seen during the reporting period. It is anticipated that clinicians providing care for patients with melanoma or a history of melanoma will submit this measure.

Measure Reporting via Registry:
ICD-9-CM diagnosis codes and CPT codes are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All patients, regardless of age, with a current diagnosis of melanoma or a history of melanoma

Denominator Criteria (Eligible Cases):
Diagnosis for melanoma or history of melanoma (ICD-9-CM): 172.0, 172.1, 172.2, 172.3, 172.4, 172.5, 172.6, 172.7, 172.8, 172.9, V10.82
Diagnosis for melanoma or history of melanoma (ICD-10-CM) [REFERENCE ONLY/Not Reportable]: C43.0, C43.10, C43.11, C43.12, C43.20, C43.21, C43.22, C43.30, C43.31, C43.39, C43.4, C43.51, C43.52, C43.59, C43.60, C43.61, C43.62, C43.70, C43.71, C43.72, C43.8, C43.9, D03.0, D03.10, D03.11, D03.12, D03.20, D03.21, D03.22, D03.30, D03.39, D03.4, D03.51, D03.52, D03.59, D03.60, D03.61, D03.62, D03.70, D03.71, D03.72, D03.8, D03.9, Z85.820
AND
Patient encounter during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215

NUMERATOR:
Patients whose information is entered, at least once within a 12 month period, into a recall system that includes:

- A target date for the next complete physical exam AND
- A process to follow up with patients who either did not make an appointment within the specified timeframe or who missed a scheduled appointment

Numerator Instructions: To satisfy this measure, the recall system must be linked to a process to notify patients when their next physical exam is due, and to follow up with patients who either did not make an appointment within the specified timeframe or who missed a scheduled appointment and must include the

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following elements at a minimum: patient identifier, patient contact information, cancer diagnosis(es), date(s) of initial cancer diagnosis (if known), and the target date for the next complete physical exam.

Numerator Options:

Patient information entered into a recall system that includes: target date for the next exam specified AND a process to follow up with patients regarding missed or unscheduled appointments (7010F)

OR

Documentation of system reason(s) for not entering patient's information into a recall system (eg, melanoma being monitored by another physician provider) (7010F *with* 3P)

OR

Recall system not utilized, reason not otherwise specified (7010F *with* 8P)

RATIONALE:

Lack of follow-up with providers noted in the Institute of Medicine (IOM) report on patient errors. Follow-up for skin examination and surveillance is an important aspect in the management of patients with a current diagnosis or a history of melanoma. The presence of a recall system, whether it is electronic or paper based, enables providers to ensure that patients receive follow-up appointments in accordance with their individual needs.

CLINICAL RECOMMENDATION STATEMENTS:

Skin examination and surveillance at least once a year for life is recommended for all melanoma patients, including those with stage 0, in situ melanoma. Clinicians should educate all patients about post-treatment monthly self-exam of their skin and of their lymph nodes if they had stage 1A to IV melanoma. Specific signs or symptoms are indications for additional radiologic imaging. (NCCN, Category 2A)

No clear data regarding follow-up interval exists, but at least annual history and physical examination with attention to the skin and lymph nodes is recommended. (AAD)

Regular clinical follow-up and interval patient self exam of skin and regional lymph nodes are the most important means of detecting recurrent disease or new primary melanoma; findings from history and physical exam should direct the need for further studies to detect local, regional, and distant metastasis. (AAD)

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*Measure #138 (NQF 0561): Melanoma: Coordination of Care

2013 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Percentage of patient visits, regardless of age, with a new occurrence of melanoma who have a treatment plan documented in the chart that was communicated to the physician(s) providing continuing care within one month of diagnosis

INSTRUCTIONS:
This measure is to be reported at each visit occurring during the reporting period for melanoma patients seen during the reporting period. It is anticipated that clinicians providing care for patients with melanoma will submit this measure.

Measure Reporting via Registry:
ICD-9-CM diagnosis codes and CPT codes are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All visits for patients, regardless of age, diagnosed with a new occurrence of melanoma

Eligible cases are determined, and must be reported, if either of the following conditions are met:

Option 1 - Denominator Criteria (Eligible Cases):
Diagnosis for melanoma (ICD-9-CM): 172.0, 172.1, 172.2, 172.3, 172.4, 172.5, 172.6, 172.7, 172.8, 172.9
Diagnosis for melanoma (ICD-10-CM) [REFERENCE ONLY/Not Reportable]: C43.0, C43.10, C43.11, C43.12, C43.20, C43.21, C43.22, C43.30, C43.31, C43.39, C43.4, C43.51, C43.52, C43.59, C43.60, C43.61, C43.62, C43.70, C43.71, C43.72, C43.8, C43.9, D03.0, D03.10, D03.11, D03.12, D03.20, D03.21, D03.22, D03.30, D03.39, D03.4, D03.51, D03.52, D03.59, D03.60, D03.61, D03.62, D03.70, D03.71, D03.72, D03.8, D03.9
AND
Patient encounter for excision of malignant melanoma (CPT): 11600, 11601, 11602, 11603, 11604, 11606, 11620, 11621, 11622, 11623, 11624, 11626, 11640, 11641, 11642, 11643, 11644, 11646, 14000, 14001, 14020, 14021, 14040, 14041, 14060, 14061, 14301, 17311, 17313

OR

Option 2 - Denominator Criteria (Eligible Cases):
Diagnosis for melanoma (ICD-9-CM): 172.0, 172.1, 172.2, 172.3, 172.4, 172.5, 172.6, 172.7, 172.8, 172.9
Diagnosis for melanoma (ICD-10-CM) [REFERENCE ONLY/Not Reportable]: C43.0, C43.10, C43.11, C43.12, C43.20, C43.21, C43.22, C43.30, C43.31, C43.39, C43.4, C43.51, C43.52, C43.59, C43.60, C43.61, C43.62, C43.70, C43.71, C43.72, C43.8, C43.9, D03.0, D03.10, D03.11, D03.12, D03.20, D03.21, D03.22, D03.30, D03.39, D03.4, D03.51, D03.52, D03.59, D03.60, D03.61, D03.62, D03.70, D03.71, D03.72, D03.8, D03.9
AND

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Patient encounter during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215

NUMERATOR:
Patient visits with a treatment plan documented in the chart that was communicated to the physician(s) providing continuing care within one month of diagnosis

Numerator Instructions: A treatment plan should include the following elements: diagnosis, tumor thickness, and plan for surgery or alternate care.

Definition:
Communication – Communication may include: documentation in the medical record that the physician(s) treating the melanoma communicated (e.g., verbally, by letter, copy of treatment plan sent) with the physician(s) providing the continuing care OR a copy of a letter in the medical record outlining whether the patient was or should be treated for melanoma.

Numerator Options:
Treatment plan communicated to provider(s) managing continuing care within 1 month of diagnosis (5050F)
OR
Documentation of patient reason(s) for not communicating treatment plan to the Primary Care Physician(s) (PCP)(s) (eg, patient asks that treatment plan not be communicated to the physician(s) providing continuing care) (5050F *with* 2P)
OR
Documentation of system reason(s) for not communicating treatment plan to the PCP(s) (eg, patient does not have a primary care physician or referring physician) (5050F *with* 3P)
OR
Treatment plan not communicated, reason not otherwise specified (5050F *with* 8P)

RATIONALE:
Perceived lack of follow-up with primary care providers which is reinforced in the Institute of Medicine (IOM) report on patient errors. The intention of this measure is to enable the primary care provider to support, facilitate, and coordinate the care of the patient.

CLINICAL RECOMMENDATION STATEMENTS:
Each local skin cancer multi-disciplinary team (LSMDT) and specialist skin cancer multi-disciplinary team (SSMDT) should have at least one skin cancer clinical nurse specialist (CNS) who will play a leading role in supporting patients and caregivers. There should be equity of access to information and support regardless of where the care is delivered. A checklist may be used by healthcare professionals to remind them to give patients and caregivers the information they need in an appropriate format for pre-diagnosis, diagnosis, treatment, follow-up, and palliative care. This may also include a copy of the letter confirming the diagnosis and treatment plan sent by the consultant to the general practitioner (GP).

- Provide a rapid referral service for patients who require specialist management through the LSMDT/SSMDT.
- Be responsible for the provision of information, advice, and support for patients managed in primary care and their care givers.
- Maintain a register of all patients treated, whose care should be part of a regular audit presented to the LSMDT/SSMDT.
- Liaise and communicate with all members of the skin cancer site-specific network group.
- Ensure that referring GPs are given prompt and full information about their patients' diagnosis or treatment in line with national standards on communication to GPs of cancer diagnoses.

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- Collect data for network-wide audit. (NICE)

Communication and information exchange between the medical home and the receiving provider should occur in an amount of time that will allow the receiving provider to effectively treat the patient. This communication and information exchange should ideally occur whenever patients are at a transition of care; e.g., at discharge from the inpatient setting. The timeliness of this communication should be consistent with the patient´s clinical presentation and, in the case of a patient being discharged, the urgency of the follow-up required.
Communication and information exchange between the MD and other physicians may be in the forma of a call, voicemail, fax or other secure, private, and accessible means including mutual access to an EHR.

The TOCCC proposed a minimal set of data elements that should always be part of the transition record and be part of any initial implementation of this standard. That list includes the following:

- Principle diagnosis and problem list
- Medication list (reconciliation) including over the counter/ herbals, allergies and drug interactions
- Clearly identifies the medical home/transferring coordinating physician/institution and their contact information
- Patient's cognitive status
- Test results/pending results

The TOCCC recommended the following additional elements that should be included in an "ideal transition record" in addition to the above:

- Emergency plan and contact number and person
- Treatment and diagnostic plan
- Prognosis and goals of care
- Advance directives, power of attorney, consent
- Planned interventions, durable medical equipment, wound care etc
- Assessment of caregiver status
- Patients and/or their family/caregivers must receive, understand and be encouraged to participate in the development of their transition record which should take into consideration the patient's health literacy, insurance status and be culturally sensitive. (ACP, SGIMSHM, AGS, ACEP, SAEM) (Consensus Policy Statement)

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*Measure #140 (NQF 0566): Age-Related Macular Degeneration (AMD): Counseling on Antioxidant Supplement

2013 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of patients aged 50 years and older with a diagnosis of age-related macular degeneration or their caregiver(s) who were counseled within 12 months on the benefits and/or risks of the Age-Related Eye Disease Study (AREDS) formulation for preventing progression of AMD

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for AMD patients seen during the reporting period. It is anticipated that clinicians who provide the primary management of patients with AMD will submit this measure.

Measure Reporting via Claims:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. CPT Category II codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the appropriate ICD-9-CM diagnosis code, CPT codes, and the appropriate CPT Category II code OR the CPT Category II code with the modifier. The reporting modifier allowed for this measure is: 8P- reason not otherwise specified. There are no allowable performance exclusions for this measure. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data. There are no allowable performance exclusions for this measure.

DENOMINATOR:
All patients aged 50 years and older with a diagnosis of age-related macular degeneration

Denominator Criteria (Eligible Cases):
Patients aged ≥ 50 years on date of encounter
AND
Diagnosis for AMD (ICD-9-CM): 362.50, 362.51, 362.52
Diagnosis for AMD (ICD-10-CM) [REFERENCE ONLY/Not Reportable]: H35.30, H35.31, H35.32
AND
Patient encounter during the reporting period (CPT): 92002, 92004, 92012, 92014, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337

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NUMERATOR:
Patients with AMD or their caregiver(s) who were counseled within 12 months on the benefits and/or risks of the AREDS formulation for preventing progression of AMD

Definition:
Counseling – Documentation in the medical record should include a discussion of risk or benefits of the AREDS formulation. Counseling can be discussed with all patients with AMD, even those who do not meet the criteria for the AREDS formulation, patients who are smokers (beta-carotene can increase the risk for cancer in these patients) or other reasons why the patient would not meet criteria for AREDS formulation as outlined in the AREDS. The ophthalmologist or optometrist can explain why these supplements are not appropriate for their particular situation. Also, given the purported risks associated with antioxidant use, patients would be informed of the risks and benefits and make their choice based on valuation of vision loss vs. other risks. As such, the measure seeks to educate patients about overuse as well as appropriate use.

NUMERATOR NOTE: If patient is already receiving AREDS formulation, the assumption is that counseling about AREDS has already been performed.

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
AREDS Counseling Performed
CPT II 4177F: Counseling about the benefits and/or risks of the Age-Related Eye Disease Study (AREDS) formulation for preventing progression of age-related macular degeneration (AMD) provided to patient and/or caregiver(s)

OR

AREDS Counseling not Performed, Reason not Otherwise Specified
Append a reporting modifier (8P) to CPT Category II code 4177F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.
4177F *with* 8P: AREDS counseling not performed, reason not otherwise specified

RATIONALE:
1. Scientific basis for counseling regarding use of AREDS formulation for patients with AMD

Antioxidant vitamins and mineral supplements help to reduce the rate of progression to advanced AMD for those patients with intermediate or advanced AMD in one eye. From the same AREDS study, there is no evidence that the use of antioxidant vitamin and mineral supplements for patients with mild AMD alters the natural history of mild AMD.

At the same time, published meta-analyses have raised an issue as to the presence of an elevated mortality risk among patients taking elements similar to parts of the AREDS formulation (and elevated risk among smokers). As such, patients need to know of their individualized risk profile for taking the AREDS formula AND the potential benefits, so that they can make their OWN individual decision as to whether or not to take the AREDS formulation.

This indicator thus seeks to directly enhance the provider-patient relationship to apply the results of level 1 randomized controlled trials (RCTs) in a manner that accommodates the needs of each individual patient in a patient-centered manner, rather than a paternalistic approach of either recommending or withholding treatment.

2. Evidence of gap in care.

Antioxidant vitamins and mineral supplements help to reduce the rate of progression to advanced AMD for those patients with intermediate or advanced AMD in one eye. From the same AREDS study, there is no evidence that the use of antioxidant vitamin and mineral supplements for patients with mild AMD alters the natural history of mild AMD.

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CLINICAL RECOMMENDATION STATEMENTS:

Patients with intermediate AMD or advanced AMD in one eye should be counseled on the use of antioxidant vitamin and mineral supplements as recommended in the Age-related Eye Disease Study (AREDS) reports. (Level A:I Recommendation) (AAO)

TABLE 1
Antioxidant Vitamin and Mineral Supplements Used in the AREDS

Supplement	Daily Dose (See note below)
Vitamin C	500 mg
Vitamin E	400 IU
Beta-carotene	15 mg (25,000 IU)
Zinc oxide	80 mg
Cupric oxide	2 mg

Note: These doses are not those listed on the commercially available vitamin/mineral supplements because of a change in labeling rules by the U.S. Food and Drug Administration that specifies that the doses must reflect the amounts available at the end of the shelf life.

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*Measure #141 (NQF 0563): Primary Open-Angle Glaucoma (POAG): Reduction of Intraocular Pressure (IOP) by 15% OR Documentation of a Plan of Care

2013 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of patients aged 18 years and older with a diagnosis of primary open-angle glaucoma whose glaucoma treatment has not failed (the most recent IOP was reduced by at least 15% from the pre-intervention level) OR if the most recent IOP was not reduced by at least 15% from the pre-intervention level, a plan of care was documented within 12 months

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for glaucoma patients seen during the reporting period. It is anticipated that clinicians who provide the primary management of patients with POAG will submit this measure.

Measure Reporting via Claims:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. CPT Category II codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the appropriate ICD-9-CM diagnosis code, CPT codes, and the appropriate CPT Category II code(s) OR the CPT Category II code(s) with the modifier. The reporting modifier allowed for this measure is: 8P- reason not otherwise specified. There are no allowable performance exclusions for this measure. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data. There are no allowable performance exclusions for this measure.

DENOMINATOR:
All patients aged 18 years and older with a diagnosis of primary open-angle glaucoma

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Diagnosis for primary open-angle glaucoma (ICD-9-CM): 365.10, 365.11, 365.12, 365.15
Diagnosis for primary open-angle glaucoma (ICD-10-CM) [REFERENCE ONLY/Not Reportable]: H40.10X0, H40.10X1, H40.10X2, H40.10X3, H40.10X4, H40.11X0, H40.11X1, H40.11X2, H40.11X3, H40.11X4, H40.1210, H40.1211, H40.1212, H40.1213, H40.1214, H40.1220, H40.1221, H40.1222, H40.1223, H40.1224, H40.1230, H40.1231, H40.1232, H40.1233, H40.1234, H40.1290, H40.1291, H40.1292, H40.1293, H40.1294, H40.1510, H40.1511, H40.1512, H40.1513, H40.1514, H40.1520, H40.1521, H40.1522, H40.1523, H40.1524, H40.1530, H40.1531, H40.1532, H40.1533, H40.1534, H40.1590, H40.1591, H40.1592, H40.1593, H40.1594

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AND

Patient encounter during the reporting period (CPT): 92002, 92004, 92012, 92014, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337

NUMERATOR:

Patients whose glaucoma treatment has not failed (the most recent IOP was reduced by at least 15% from the pre-intervention level) OR if the most recent IOP was not reduced by at least 15% from the pre-intervention level a plan of care was documented within 12 months

Definitions:

Plan of Care – May include: recheck of IOP at specified time, change in therapy, perform additional diagnostic evaluations, monitoring per patient decisions or health system reasons, and/or referral to a specialist.

Plan to Recheck – In the event certain factors do not allow for the IOP to be measured (e.g., patient has an eye infection) but the physician has a plan to measure the IOP at the next visit; the plan of care code should be reported.

Glaucoma Treatment Not Failed – The most recent IOP was reduced by at least 15% in the affected eye or if both eyes were affected, the reduction of at least 15% occurred in both eyes.

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:

Intraocular Pressure (IOP) Reduced Greater than or Equal to 15% Pre-Intervention Level

*(One CPT II code [*3284F*] is required on the claim form to submit this numerator option)*

CPT II 3284F: Intraocular pressure (IOP) reduced by a value of greater than or equal to 15% from the pre-intervention level

OR

Intraocular Pressure (IOP) Reduced Less than 15% Pre-Intervention Level with Plan of Care

*(Two CPT II codes [*0517F & 3285F*] are required on the claim form to submit this numerator option)*

CPT II 0517F: Glaucoma plan of care documented

AND

CPT II 3285F: Intraocular pressure (IOP) reduced by a value less than 15% from the pre-intervention level

OR

Glaucoma Plan of Care not Documented, Reason not Otherwise Specified

*(Two CPT II codes [*0517F-8P & 3285F*] are required on the claim form to submit this numerator option)*

Append a reporting modifier (8P) to CPT Category II code 0517F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

0517F *with* 8P: Glaucoma plan of care not documented, reason not otherwise specified

AND

CPT II 3285F: Intraocular pressure (IOP) reduced by a value less than 15% from the pre-intervention level

OR

Intraocular Pressure (IOP) Measurement not Documented, Reason not Otherwise Specified

*(One CPT II code [*3284F-8P*] is required on the claim form to submit this numerator option)*

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Append a reporting modifier (8P) to CPT Category II code 3284F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.
3284F *with* 8P: IOP measurement not documented, reason not otherwise specified

RATIONALE:
1. Scientific basis for intraocular pressure (IOP) control as outcomes measure (intermediate)
Analyses of results of several randomized clinical trials all demonstrate that reduction of IOP of at least 18% (EMGT, CIGTS, AGIS, CNTGS) reduces the rate of worsening of visual fields by at least 40%. The various studies, however, achieved different levels of mean IOP lowering in realizing their benefit in patient outcomes, ranging from 18% in the "normal pressure" subpopulation of EMGT to 42% in the CIGTS study. (Level I studies) As such, an appropriate "failure" indicator is to NOT achieve at least a 15% IOP reduction. The rationales for a failure indicator are that 1) the results of different studies can lead experienced clinicians to believe that different levels of IOP reduction are appropriate; 2) to minimize the impact of adverse selection for those patients whose IOPs are more difficult to control; and 3) because each patient's clinical course may require IOP reduction that may vary from 18 to 40+%.

In addition, "…[s]several population based studies have demonstrated that the prevalence of POAG as well as the incidence of POAG, increases as the level of IOP increases. These studies provide strong evidence that IOP plays an important role in the neuropathy of POAG. Furthermore, studies have demonstrated that reduction in the level of IOP lessens the risk of visual field progression in open-angle glaucoma. In addition, treated eyes that have a greater IOP fluctuation are at increased risk of progression.

Intraocular pressure is the intermediate outcome of therapy used by the FDA for approval of new drugs and devices and, as noted above, has been shown to be directly related to ultimate patient outcomes of vision loss. As such, failure to achieve minimal pressure lowering, absent an appropriate plan of care to address the situation, would constitute performance whose improvement would directly benefit patients with POAG.

2. Evidence for gap in care
Based on studies in the literature reviewing documentation of IOP achieved under care, the gap could be as great as 50% or more in the community of ophthalmologists and optometrists treating patients with primary open-angle glaucoma. Based on loose criteria for control, IOP was controlled in 66% of follow-up visits for patients with mild glaucoma and 52% of visits for patients with moderate to severe glaucoma. Another study of a single comprehensive insurance plan suggested that a large proportion of individuals felt to require treatment for glaucoma or suspect glaucoma are falling out of care and are being monitored at rates lower than expected from recommendations of published guidelines.

CLINICAL RECOMMENDATION STATEMENTS:
The initial target pressure selected should be at least 20% lower than the pretreatment IOP, depending upon the clinical findings. Further reduction of the target IOP is often also justified by the severity of existing optic nerve damage, the level of the measured pretreatment IOP, the rapidity with which the damage occurred, and other risk factors. In general, the more advanced the damage, the lower the initial pressure should be (Level A: III Recommendation).

Please note that the American Optometric Association's (AOA) 2002 guideline on Open-angle Glaucoma was not reviewed during the development of this measure prior to the public comment period and therefore is not presented here verbatim. Review of the AOA guideline subsequent to initial measure development indicates that the recommendations in the AOA guideline are consistent with the intent of the measure. This also applies to the 2010 guidelines. As such, the intent of this measure is to have this indicator apply to both optometrists and ophthalmologists (and any other physician who provides glaucoma care); the use of "ophthalmologists" only in the preceding verbatim section reflects the wording in the American Academy of Ophthalmology Preferred Practice pattern.

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▲Measure #142 (NQF 0051): Osteoarthritis (OA): Assessment for Use of Anti-Inflammatory or Analgesic Over-the-Counter (OTC) Medications

2013 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of patient visits for patients aged 21 years and older with a diagnosis of OA with an assessment for use of anti-inflammatory or analgesic OTC medications

INSTRUCTIONS:
This measure is to be reported at each visit occurring during the reporting period for OA patients seen during the reporting period. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

Measure Reporting via Claims:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. CPT Category II codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed ICD-9-CM diagnosis code, CPT codes, and the appropriate CPT Category II code OR the CPT Category II code with the modifier. The reporting modifier allowed for this measure is: 8P- reason not otherwise specified. There are no allowable performance exclusions for this measure. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data. There are no allowable performance exclusions for this measure.

DENOMINATOR:
All patient visits for patients aged 21 years and older with a diagnosis of OA

Denominator Criteria (Eligible Cases):
Patients aged ≥ 21 years on date of encounter
AND
Diagnosis for osteoarthritis (OA) (ICD-9-CM): 715.00, 715.04, 715.09, 715.10, 715.11, 715.12, 715.13, 715.14, 715.15, 715.16, 715.17, 715.18, 715.20, 715.21, 715.22, 715.23, 715.24, 715.25, 715.26, 715.27, 715.28, 715.30, 715.31, 715.32, 715.33, 715.34, 715.35, 715.36, 715.37, 715.38, 715.80, 715.89, 715.90, 715.91, 715.92, 715.93, 715.94, 715.95, 715.96, 715.97, 715.98
Diagnosis for osteoarthritis (OA) (ICD-10-CM) [REFERENCE ONLY/Not Reportable]: M15.0, M15.1, M15.2, M15.3, M15.4, M15.8, M15.9, M16.0, M16.10, M16.11, M16.12, M16.2, M16.30, M16.31, M16.32, M16.4, M16.50, M16.51, M16.52, M16.6, M16.7, M16.9, M17.0, M17.10, M17.11, M17.12, M17.2, M17.30, M17.31, M17.32, M17.4, M17.5, M17.9, M18.0, M18.10, M18.11, M18.12, M18.2, M18.30, M18.31, M18.32, M18.4, M18.50, M18.51, M18.52, M18.9, M19.011, M19.012, M19.019, M19.021, M19.022, M19.029, M19.031, M19.032, M19.039, M19.041, M19.042, M19.049, M19.071, M19.072, M19.079, M19.111,

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M19.112, M19.119, M19.121, M19.122, M19.129, M19.131, M19.132, M19.139, M19.141, M19.142, M19.149, M19.171, M19.172, M19.179, M19.211, M19.212, M19.219, M19.221, M19.222, M19.229, M19.231, M19.232, M19.239, M19.241, M19.242, M19.249, M19.271, M19.272, M19.279, M19.90, M19.91, M19.92, M19.93

AND

Patient encounter during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215

NUMERATOR:

Patient visits with assessment for use of anti-inflammatory or analgesic OTC medications documented

Definition:

Assessment - May include: documentation of current medications, continue same medications, change in medication dose, documentation indicating that the patient was asked about OTC medication use.

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Assessment for Anti-Inflammatory or Analgesic OTC Medications Performed

CPT II 1007F: Use of anti-inflammatory or analgesic over-the-counter (OTC) medications for symptom relief assessed

OR

Assessment for Anti-Inflammatory or Analgesic OTC Medications not Performed, Reason not Otherwise Specified

Append a reporting modifier (8P) to CPT Category II code 1007F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

1007F *with* 8P: Use of anti-inflammatory or analgesic OTC medications not assessed, reason not otherwise specified

RATIONALE:

Treatment goals for OA are to reduce pain, maintain or improve joint mobility, and limit functional impairment. Use of anti-inflammatory and analgesics has a documented role in these goals. Assessment of current medication use is a precursor to appropriate pharmacologic therapy.

CLINICAL RECOMMENDATION STATEMENTS:

Initial treatment should include activity modification and trial of analgesic or non-steroidal anti-inflammatory medication (NSAID). (AAOS; A Recommendation)

Acetaminophen has been shown to be as effective a pain reliever as NSAIDs in patients with OA of the knee. (AAOS, A Recommendation)

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▲Measure #143 (NQF 0384): Oncology: Medical and Radiation – Pain Intensity Quantified

2013 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

This is a two-part measure which is paired with Measure #144: Oncology: Medical and Radiation: Plan of Care for Pain. If pain is present, Measure #144 *should* also be reported.

DESCRIPTION:
Percentage of patient visits, regardless of patient age, with a diagnosis of cancer currently receiving chemotherapy or radiation therapy in which pain intensity is quantified

INSTRUCTIONS:
This measure is to be reported at each visit occurring during the reporting period for patients with a diagnosis of cancer who are seen during the reporting period. It is anticipated that clinicians providing care for patients with cancer will submit this measure.

Measure Reporting via Registry:
ICD-9-CM diagnosis codes and CPT codes are used to identify patients who are included in the measure's denominator. There are no allowable performance exclusions for this measure. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data. There are no allowable performance exclusions for this measure.

DENOMINATOR:
All patient visits, regardless of patient age, with a diagnosis of cancer currently receiving chemotherapy or radiation therapy

Denominator Criteria (Eligible Cases):
Diagnosis for cancer (ICD-9-CM): 140.0, 140.1, 140.3, 140.4, 140.5, 140.6, 140.8, 140.9, 141.0, 141.1, 141.2, 141.3, 141.4, 141.5, 141.6, 141.8, 141.9, 142.0, 142.1, 142.2, 142.8, 142.9, 143.0, 143.1, 143.8, 143.9, 144.0, 144.1, 144.8, 144.9, 145.0, 145.1, 145.2, 145.3, 145.4, 145.5, 145.6, 145.8, 145.9, 146.0, 146.1, 146.2, 146.3, 146.4, 146.5, 146.6, 146.7, 146.8, 146.9, 147.0, 147.1, 147.2, 147.3, 147.8, 147.9, 148.0, 148.1, 148.2, 148.3, 148.8, 148.9, 149.0, 149.1, 149.8, 149.9, 150.0, 150.1, 150.2, 150.3, 150.4, 150.5, 150.8, 150.9, 151.0, 151.1, 151.2, 151.3, 151.4, 151.5, 151.6, 151.8, 151.9, 152.0, 152.1, 152.2, 152.3, 152.8, 152.9, 153.0, 153.1, 153.2, 153.3, 153.4, 153.5, 153.6, 153.7, 153.8, 153.9, 154.0, 154.1, 154.2, 154.3, 154.8, 155.0, 155.1, 155.2, 156.0, 156.1, 156.2, 156.8, 156.9, 157.0, 157.1, 157.2, 157.3, 157.4, 157.8, 157.9, 158.0, 158.8, 158.9, 159.0, 159.1, 159.8, 159.9, 160.0, 160.1, 160.2, 160.3, 160.4, 160.5, 160.8, 160.9, 161.0, 161.1, 161.2, 161.3, 161.8, 161.9, 162.0, 162.2, 162.3, 162.4, 162.5, 162.8, 162.9, 163.0, 163.1, 163.8, 163.9, 164.0, 164.1, 164.2, 164.3, 164.8, 164.9, 165.0, 165.8, 165.9, 170.0, 170.1, 170.2, 170.3, 170.4, 170.5, 170.6, 170.7, 170.8, 170.9, 171.0, 171.2, 171.3, 171.4, 171.5, 171.6, 171.7, 171.8, 171.9, 172.0, 172.1, 172.2, 172.3, 172.4, 172.5, 172.6, 172.7, 172.8, 172.9, 173.00, 173.01, 173.02, 173.09, 173.10, 173.11, 173.12, 173.19, 173.20, 173.21, 173.22, 173.29, 173.30, 173.31, 173.32, 173.39, 173.40, 173.41, 173.42, 173.49, 173.50, 173.51, 173.52, 173.59, 173.60, 173.61, 173.62, 173.69, 173.70, 173.71, 173.72, 173.79, 173.80, 173.81, 173.82, 173.89, 173.90, 173.91, 173.92, 173.99, 174.0, 174.1, 174.2, 174.3, 174.4, 174.5, 174.6, 174.8, 174.9, 175.0, 175.9, 176.0, 176.1, 176.2, 176.3, 176.4, 176.5, 176.8, 176.9, 179, 180.0, 180.1, 180.8, 180.9, 181, 182.0, 182.1, 182.8, 183.0, 183.2, 183.3, 183.4,

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183.5, 183.8, 183.9, 184.0, 184.1, 184.2, 184.3, 184.4, 184.8, 184.9, 185, 186.0, 186.9, 187.1, 187.2, 187.3, 187.4, 187.5, 187.6, 187.7, 187.8, 187.9, 188.0, 188.1, 188.2, 188.3, 188.4, 188.5, 188.6, 188.7, 188.8, 188.9, 189.0, 189.1, 189.2, 189.3, 189.4, 189.8, 189.9, 190.0, 190.1, 190.2, 190.3, 190.4, 190.5, 190.6, 190.7, 190.8, 190.9, 191.0, 191.1, 191.2, 191.3, 191.4, 191.5, 191.6, 191.7, 191.8, 191.9, 192.0, 192.1, 192.2, 192.3, 192.8, 192.9, 193, 194.0, 194.1, 194.3, 194.4, 194.5, 194.6, 194.8, 194.9, 195.0, 195.1, 195.2, 195.3, 195.4, 195.5, 195.8, 196.0, 196.1, 196.2, 196.3, 196.5, 196.6, 196.8, 196.9, 197.0, 197.1, 197.2, 197.3, 197.4, 197.5, 197.6, 197.7, 197.8, 198.0, 198.1, 198.2, 198.3, 198.4, 198.5, 198.6, 198.7, 198.81, 198.82, 198.89, 199.0, 199.1, 199.2, 200.00, 200.01, 200.02, 200.03, 200.04, 200.05, 200.06, 200.07, 200.08, 200.10, 200.11, 200.12, 200.13, 200.14, 200.15, 200.16, 200.17, 200.18, 200.20, 200.21, 200.22, 200.23, 200.24, 200.25, 200.26, 200.27, 200.28, 200.30, 200.31, 200.32, 200.33, 200.34, 200.35, 200.36, 200.37, 200.38, 200.40, 200.41, 200.42, 200.43, 200.44, 200.45, 200.46, 200.47, 200.48; 200.50, 200.51, 200.52, 200.53, 200.54, 200.55, 200.56, 200.57, 200.58, 200.60, 200.61, 200.62, 200.63, 200.64, 200.65, 200.66, 200.67, 200.68, 200.70, 200.71, 200.72, 200.73, 200.74, 200.75, 200.76, 200.77, 200.78, 200.80, 200.81, 200.82, 200.83, 200.84, 200.85, 200.86, 200.87, 200.88, 201.00, 201.01, 201.02, 201.03, 201.04, 201.05, 201.06, 201.07, 201.08, 201.10, 201.11, 201.12, 201.13, 201.14, 201.15, 201.16, 201.17, 201.18, 201.20, 201.21, 201.22, 201.23, 201.24, 201.25, 201.26, 201.27, 201.28, 201.40, 201.41, 201.42, 201.43, 201.44, 201.45, 201.46, 201.47, 201.48, 201.50, 201.51, 201.52, 201.53, 201.54, 201.55, 201.56, 201.57, 201.58, 201.60, 201.61, 201.62, 201.63, 201.64, 201.65, 201.66, 201.67, 201.68, 201.70, 201.71, 201.72, 201.73, 201.74, 201.75, 201.76, 201.77, 201.78, 201.90, 201.91, 201.92, 201.93, 201.94, 201.95, 201.96, 201.97, 201.98, 202.00, 202.01, 202.02, 202.03, 202.04, 202.05, 202.06, 202.07, 202.08, 202.10, 202.11, 202.12, 202.13, 202.14, 202.15, 202.16, 202.17, 202.18, 202.20, 202.21, 202.22, 202.23, 202.24, 202.25, 202.26, 202.27, 202.28, 202.30, 202.31, 202.32, 202.33, 202.34, 202.35, 202.36, 202.37, 202.38, 202.40, 202.41, 202.42, 202.43, 202.44, 202.45, 202.46, 202.47, 202.48, 202.50, 202.51, 202.52, 202.53, 202.54, 202.55, 202.56, 202.57, 202.58, 202.60, 202.61, 202.62, 202.63, 202.64, 202.65, 202.66, 202.67, 202.68, 202.70, 202.71, 202.72, 202.73, 202.74, 202.75, 202.76, 202.77, 202.78, 202.80, 202.81, 202.82, 202.83, 202.84, 202.85, 202.86, 202.87, 202.88, 202.90, 202.91, 202.92, 202.93, 202.94, 202.95, 202.96, 202.97, 202.98, 203.00, 203.01, 203.02, 203.10, 203.11, 203.12, 203.80, 203.81, 203.82, 204.00, 204.01, 204.02, 204.10, 204.11, 204.12, 204.20, 204.21, 204.22, 204.80, 204.81, 204.82, 204.90, 204.91, 204.92, 205.00, 205.01, 205.02, 205.10, 205.11, 205.12, 205.20, 205.21, 205.22, 205.30, 205.31, 205.32, 205.80, 205.81, 205.82, 205.90, 205.91, 205.92, 206.00, 206.01, 206.02, 206.10, 206.11, 206.12, 206.20, 206.21, 206.22, 206.80, 206.81, 206.82, 206.90, 206.91, 206.92, 207.00, 207.01, 207.02, 207.10, 207.11, 207.12, 207.20, 207.21, 207.22, 207.80, 207.81, 207.82, 208.00, 208.01, 208.02, 208.10, 208.11, 208.12, 208.20, 208.21, 208.22, 208.80, 208.81, 208.82, 208.90, 208.91, 208.92, 209.00, 209.01, 209.02, 209.03, 209.10, 209.11, 209.12, 209.13, 209.14, 209.15, 209.16, 209.17, 209.20, 209.21, 209.22, 209.23, 209.24, 209.25, 209.26, 209.27, 209.29, 209.30, 209.31, 209.32, 209.33, 209.34, 209.35, 209.36, 209.70, 209.71, 209.72, 209.73, 209.74, 209.75, 209.79, 235.0, 235.1, 235.2, 235.3, 235.4, 235.5, 235.6, 235.7, 235.8, 235.9, 236.0, 236.1, 236.2, 236.3, 236.4, 236.5, 236.6, 236.7, 236.90, 236.91, 236.99, 237.0, 237.1, 237.2, 237.3, 237.4, 237.5, 237.6, 237.70, 237.71, 237.72, 237.73, 237.79, 237.9, 238.0, 238.1, 238.2, 238.3, 238.4, 238.5, 238.6, 238.71, 238.72, 238.73, 238.74, 238.75, 238.76, 238.77, 238.79, 238.8, 238.9, 239.0, 239.1, 239.2, 239.3, 239.4, 239.5, 239.6, 239.7, 239.81, 239.89, 239.9

Diagnosis for cancer (ICD-10-CM) [REFERENCE ONLY/Not Reportable]: C00.0, C00.1, C00.2, C00.3, C00.4, C00.5, C00.6, C00.8, C00.9, C01, C02.0, C02.1, C02.2, C02.3, C02.4, C02.8, C02.9, C03.0, C03.1, C03.9, C04.0, C04.1, C04.8, C04.9, C05.0, C05.1, C05.2, C05.8, C05.9, C06.0, C06.1, C06.2, C06.80, C06.89, C06.9, C07, C08.0, C08.1, C08.9, C09.0, C09.1, C09.8, C09.9, C10.0, C10.1, C10.2, C10.3, C10.4, C10.8, C10.9, C11.0, C11.1, C11.2, C11.3, C11.8, C11.9, C12, C13.0, C13.1, C13.2, C13.8, C13.9, C14.0, C14.2, C14.8, C15.3, C15.4, C15.5, C15.8, C15.9, C16.0, C16.1, C16.2, C16.3, C16.4, C16.5, C16.6, C16.8, C16.9, C17.0, C17.1, C17.2, C17.3, C17.8, C17.9, C18.0, C18.1, C18.2, C18.3, C18.4, C18.5, C18.6, C18.7, C18.8, C18.9, C19, C20, C21.0, C21.1, C21.2, C21.8, C22.0, C22.1, C22.2, C22.3, C22.4, C22.7, C22.8, C22.9, C23, C24.0, C24.1, C24.8, C24.9, C25.0, C25.1, C25.2, C25.3, C25.4, C25.7, C25.8, C25.9,C26.0, C26.1, C26.9, C30.0, C30.1, C31.0, C31.1, C31.2, C31.3, C31.8, C31.9, C32.0, C32.1, C32.2,

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C32.3, C32.8, C32.9, C33, C34.00, C34.01, C34.02, C34.10, C34.11, C34.12, C34.2, C34.30, C34.31, C34.32, C34.80, C34.81, C34.82, C34.90, C34.91, C34.92, C37, C38.0, C38.1, C38.2, C38.3, C38.4, C38.8, C39.0, C39.9, C40.00, C40.01, C40.02, C40.10, C40.11, C40.12, C40.20, C40.21, C40.22, C40.30, C40.31, C40.32, C40.80, C40.81, C40.82, C40.90, C40.91, C40.92, C41.0, C41.1, C41.2, C41.3, C41.4, C41.9, C43.0, C43.10, C43.11, C43.12, C43.20, C43.21, C43.22, C43.30, C43.31, C43.39, C43.4, C43.51, C43.52, C43.59, C43.60, C43.61, C43.62, C43.70, C43.71, C43.72, C43.8, C43.9, C44.00, C44.01, C44.02, C44.09, C44.101, C44.102, C44.109, C44.111, C44.112, C44.119, C44.121, C44.122, C44.129, C44.191, C44.192, C44.199, C44.201, C44.202, C44.209, C44.211, C44.212, C44.219, C44.221, C44.222, C44.229, C44.291, C44.292, C44.299,C44.300, C44.301, C44.309, C44.310, C44.311, C44.319, C44.320, C44.321, C44.329, C44.390, C44.391, C44.399, C44.40, C44.41, C44.42, C44.49, C44.500, C44.501, C44.509, C44.510, C44.511, C44.519, C44.520, C44.521, C44.529, C44.590, C44.591, C44.599, C44.601, C44.602, C44.609, C44.611, C44.612, C44.619, C44.621, C44.622, C44.629, C44.691, C44.692, C44.699, C44.701, C44.702, C44.709, C44.711, C44.712, C44.719, C44.721, C44.722, C44.729, C44.791, C44.792, C44.799, C44.80, C44.81, C44.82, C44.89, C44.90, C44.91, C44.92, C44.99, C45.0, C45.1, C45.2, C45.7, C45.9, C46.0, C46.1, C46.2, C46.3, C46.4, C46.50, C46.51, C46.52, C46.7, C46.9, C47.0, C47.10, C47.11, C44.30, C47.12, C47.20, C47.21, C47.22, C47.3, C47.4, C47.5, C47.6, C47.8, C47.9, C48.0, C48.1, C48.2, C48.8, C49.0, C49.10, C49.11, C49.12, C49.20, C49.21, C49.22, C49.3, C49.4, C49.5, C49.6, C49.8, C49.9, C4A.0, C4A.10, C4A.11, C4A.12, C4A.20, C4A.21, C4A.22, C4A.30, C4A.31, C4A.39, C4A.4, C4A.51, C4A.52, C4A.59, C4A.60, C4A.61, C4A.62, C4A.70, C4A.71, C4A.72, C4A.8, C4A.9, C50.011, C50.012, C50.019, C50.021, C50.022, C50.029, C50.111, C50.112, C50.119, C50.121, C50.122, C50.129, C50.211, C50.212, C50.219, C50.221, C50.222, C50.229, C50.311, C50.312, C50.319, C50.321, C50.322, C50.329, C50.411, C50.412, C50.419, C50.421, C50.422, C50.429, C50.511, C50.512, C50.519, C50.521, C50.522, C50.529, C50.611, C50.612, C50.619, C50.621, C50.622, C50.629, C50.811, C50.812, C50.819, C50.821, C50.822, C50.829, C50.911, C50.912, C50.919, C50.921, C50.922, C50.929, C51.0, C51.1, C51.2, C51.8, C51.9, C52, C53.0, C53.1, C53.8, C53.9, C54.0, C54.1, C54.2, C54.3, C54.8, C54.9, C55, C56.1, C56.2, C56.9, C57.00, C57.01, C57.02, C57.10, C57.11, C57.12, C57.20, C57.21, C57.22, C57.3, C57.4, C57.7, C57.8, C57.9, C58, C60.0, C60.1, C60.2, C60.8, C60.9, C61, C62.00, C62.01, C62.02, C62.10, C62.11, C62.12, C62.90, C62.91, C62.92, C63.00, C63.01, C63.02, C63.10, C63.11, C63.12, C63.2, C63.7, C63.8, C63.9, C64.1, C64.2, C64.9, C65.1, C65.2, C65.9, C66.1, C66.2, C66.9, C67.0, C67.1, C67.2, C67.3, C67.4, C67.5, C67.6, C67.7, C67.8, C67.9, C68.0, C68.1, C68.8, C68.9, C69.00, C69.01, C69.02, C69.10, C69.11, C69.12, C69.20, C69.21, C69.22, C69.30, C69.31, C69.32, C69.40, C69.41, C69.42, C69.50, C69.51, C69.52, C69.60, C69.61, C69.62, C69.80, C69.81, C69.82, C69.90, C69.91, C69.92, C70.0, C70.1, C70.9, C71.0, C71.1, C71.2, C71.3, C71.4, C71.5, C71.6, C71.7, C71.8, C71.9, C72.0, C72.1, C72.20, C72.21, C72.22, C72.30, C72.31, C72.32, C72.40, C72.41, C72.42, C72.50, C72.59, C72.9, C73, C74.00, C74.01, C74.02, C74.10, C74.11, C74.12, C74.90, C74.91, C74.92, C75.0, C75.1, C75.2, C75.3, C75.4, C75.5, C75.8, C75.9, C76.0, C76.1, C76.2, C76.3, C76.40, C76.41, C76.42, C76.50, C76.51, C76.52, C76.8 C77.0, C77.1, C77.2, C77.3, C77.4, C77.5, C77.8, C77.9, C78.00, C78.01, C78.02, C78.1, C78.2, C78.30, C78.39, C78.4, C78.5, C78.6, C78.7, C78.80, C78.89, C79.00, C79.01, C79.02, C79.10, C79.11, C79.19, C79.2, C79.31, C79.32, C79.40, C79.49, C79.51, C79.52, C79.60, C79.61, C79.62, C79.70, C79.71, C79.72, C79.81, C79.82, C79.89, C79.9, C7A.00, C7A.010, C7A.011, C7A.012, C7A.019, C7A.020, C7A.021, C7A.022, C7A.023, C7A.024, C7A.025, C7A.026, C7A.029, C7A.090, C7A.091, C7A.092, C7A.093, C7A.094, C7A.095, C7A.096, C7A.098, C7A.1, C7A.8, C7B.00, C7B.01, C7B.02, C7B.03, C7B.04, C7B.09, C7B.1, C7B.8, C80.0, C80.1, C80.2, C81.00, C81.01, C81.02, C81.03, C81.04, C81.05, C81.06, C81.07, C81.08, C81.09, C81.10, C81.11, C81.12, C81.13, C81.14, C81.15, C81.16, C81.17, C81.18, C81.19, C81.20, C81.21, C81.22, C81.23, C81.24, C81.25, C81.26, C81.27, C81.28, C81.29, C81.30, C81.31, C81.32, C81.33, C81.34, C81.35, C81.36, C81.37, C81.38, C81.39, C81.40, C81.41, C81.42, C81.43, C81.44, C81.45, C81.46, C81.47, C81.48, C81.49, C81.70, C81.71, C81.72, C81.73, C81.74, C81.75, C81.76, C81.77, C81.78, C81.79, C81.90, C81.91, C81.92, C81.93, C81.94, C81.95, C81.96, C81.97, C81.98, C81.99, C82.00, C82.01, C82.02, C82.03, C82.04, C82.05, C82.06, C82.07, C82.08, C82.09, C82.10, C82.11, C82.12, C82.13, C82.14, C82.15, C82.16,

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C82.17, C82.18, C82.19, C82.20, C82.21, C82.22, C82.23, C82.24, C82.25, C82.26, C82.27, C82.28, C82.29, C82.30, C82.31, C82.32, C82.33, C82.34, C82.35, C82.36, C82.37, C82.38, C82.39, C82.40, C82.41, C82.42, C82.43, C82.44, C82.45, C82.46, C82.47, C82.48, C82.49, C82.50, C82.51, C82.52, C82.53, C82.54, C82.55, C82.56, C82.57, C82.58, C82.59, C82.60, C82.61, C82.62, C82.63, C82.64, C82.65, C82.66, C82.67, C82.68, C82.69, C82.80, C82.81, C82.82, C82.83, C82.84, C82.85, C82.86, C82.87, C82.88, C82.89, C82.90, C82.91, C82.92, C82.93, C82.94, C82.95, C82.96, C82.97, C82.98, C82.99, C83.00, C83.01, C83.02, C83.03, C83.04, C83.05, C83.06, C83.07, C83.08, C83.09, C83.10, C83.11, C83.12, C83.13, C83.14, C83.15, C83.16, C83.17, C83.18, C83.19, C83.30, C83.31, C83.32, C83.33, C83.34, C83.35, C83.36, C83.37, C83.38, C83.39, C83.50, C83.51, C83.52, C83.53, C83.54, C83.55, C83.56, C83.57, C83.58, C83.59, C83.70, C83.71, C83.72, C83.73, C83.74, C83.75, C83.76, C83.77, C83.78, C83.79, C83.80, C83.81, C83.82, C83.83, C83.84, C83.85, C83.86, C83.87, C83.88, C83.89, C83.90, C83.91, C83.92, C83.93, C83.94, C83.95, C83.96, C83.97, C83.98, C83.99, C84.00, C84.01, C84.02, C84.03, C84.04, C84.05, C84.06, C84.07, C84.08, C84.09, C84.10, C84.11, C84.12, C84.13, C84.14, C84.15, C84.16, C84.17, C84.18, C84.19, C84.40, C84.41, C84.42, C84.43, C84.44, C84.45, C84.46, C84.47, C84.48, C84.49, C84.60, C84.61, C84.62, C84.63, C84.64, C84.65, C84.66, C84.67, C84.68, C84.69, C84.70, C84.71, C84.72, C84.73, C84.74, C84.75, C84.76, C84.77, C84.78, C84.79, C84.90, C84.91, C84.92, C84.93, C84.94, C84.95, C84.96, C84.97, C84.98, C84.99, C84.A0, C84.A1, C84.A2, C84.A3, C84.A4, C84.A5, C84.A6, C84.A7, C84.A8, C84.A9, C84.Z0, C84.Z1, C84.Z2, C84.Z3, C84.Z4, C84.Z5, C84.Z6, C84.Z7, C84.Z8, C84.Z9, C85.10, C85.11, C85.12, C85.13, C85.14, C85.15, C85.16, C85.17, C85.18, C85.19, C85.20, C85.21, C85.22, C85.23, C85.24, C85.25, C85.26, C85.27, C85.28, C85.29, C85.80, C85.81, C85.82, C85.83, C85.84, C85.85, C85.86, C85.87, C85.88, C85.89, C85.90, C85.91, C85.92, C85.93, C85.94, C85.95, C85.96, C85.97, C85.98, C85.99, C86.0, C86.1, C86.2, C86.3, C86.4, C86.5, C86.6, C88.0, C88.2, C88.3, C88.4, C88.8, C88.9, C90.00, C90.01, C90.02, C90.10, C90.11, C90.12, C90.20, C90.21, C90.22, C90.30, C90.31, C90.32, C91.00, C91.01, C91.02, C91.10, C91.11, C91.12, C91.30, C91.31, C91.32, C91.40, C91.41, C91.42, C91.50, C91.51, C91.52, C91.60, C91.61, C91.62, C91.90, C91.91, C91.92, C91.A0, C91.A1, C91.A2, C91.Z0, C91.Z1, C91.Z2, C92.00, C92.01, C92.02, C92.10, C92.11, C92.12, C92.20, C92.21, C92.22, C92.30, C92.31, C92.32, C92.40, C92.41, C92.42, C92.50, C92.51, C92.52, C92.60, C92.61, C92.62, C92.90, C92.91, C92.92, C92.A0, C92.A1, C92.A2, C92.Z0, C92.Z1, C92.Z2, C93.00, C93.01, C93.02, C93.10, C93.11, C93.12, C93.30, C93.31, C93.32, C93.90, C93.91, C93.92, C93.Z0, C93.Z1, C93.Z2, C94.00, C94.01, C94.02, C94.20, C94.21, C94.22, C94.30, C94.31, C94.32, C94.40, C94.41, C94.42, C94.6, C94.80, C94.81, C94.82, C95.00, C95.01, C95.02, C95.10, C95.11, C95.12, C95.90, C95.91, C95.92, C96.0, C96.2, C96.4, C96.5, C96.6, C96.9, C96.A, C96.Z, D37.01, D37.02, D37.030, D37.031, D37.032, D37.039, D37.04, D37.05, D37.09, D37.1, D37.2, D37.3, D37.4, D37.5, D37.6, D37.8 D37.9, D38.0, D38.1, D38.2, D38.3, D38.4, D38.5, D38.6, D39.0, D39.10, D39.11, D39.12, D39.2, D39.8, D39.9, D40.0, D40.10, D40.11, D40.12, D40.8, D40.9, D41.00, D41.01, D41.02, D41.10, D41.11, D41.12, D41.20, D41.21, D41.22, D41.3, D41.4, D41.8, D41.9, D42.0, D42.1, D42.9, D43.0, D43.1, D43.2, D43.3, D43.4, D43.8, D43.9, D44.0, D44.10, D44.11, D44.12, D44.2, D44.3, D44.4, D44.5, D44.6, D44.7, D44.9, D45, D46.0, D46.1, D46.20, D46.21, D46.22, D46.4, D46.9, D46.A, D46.B, D46.C, D46.Z, D47.0, D47.1, D47.2, D47.3, D47.4, D47.9, D47.Z1, D47.Z9, D48.0, D48.1, D48.2, D48.3, D48.4, D48.5, D48.60, D48.61, D48.62, D48.7, D48.9, D49.0, D49.1, D49.2, D49.3, D49.4, D49.5, D49.6, D49.7, D49.81, D49.89, D49.9, Q85.00, Q85.01, Q85.02, Q85.03, Q85.09

AND:

Patient encounter during the reporting period (CPT) - Procedure codes: 77427, 77431, 77432, 77435, 77470

OR

Patient encounter during the reporting period (CPT) - Service codes: 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215

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AND

Patient encounter during the reporting period (CPT) - Procedure codes: 51720, 96401, 96402, 96405, 96406, 96409, 96411, 96413, 96415, 96416, 96417, 96420, 96422, 96423, 96425, 96440, 96446, 96450, 96521, 96522, 96523, 96542, 96549

NUMERATOR:
Patient visits in which pain intensity is quantified

Numerator Instructions: Pain intensity should be quantified using a standard instrument, such as a 0-10 numeric rating scale, a categorical scale, or the pictorial scale.

Numerator Options:
Pain severity quantified; pain present (1125F)
OR
Pain severity quantified; no pain present (1126F)
OR
Pain severity not documented, reason not otherwise specified (1125F *with* 8P)

RATIONALE:
Inadequate cancer pain management is widely prevalent, harmful to the patient, and costly.

CLINICAL RECOMMENDATION STATEMENTS:
This algorithm begins with the premise that all patients with cancer should be screened for pain during the initial evaluation, at regular intervals, and whenever new therapy is initiated. If pain is present on a screening evaluation, the pain intensity must be quantified by the patient (whenever possible). Since pain is inherently subjective, patient's self report to pain is the current standard of care for assessment. Intensity of pain should be quantified using a 0-10 numerical rating scale, a categorical scale, or a pictorial scale (e.g., The Faces Pain Rating Scale). The Faces Pain Rating Scale may be successful with patients who have difficulty with other scales, for example, children, the elderly, and patients with language or cultural differences or other communication barriers. (NCCN, 2011)

All patients should be routinely screened for pain, and when it is present, pain intensity should be recorded in highly visible ways that facilitate regular review by health care providers. A standard for pain assessment and documentation should be established in each setting to ensure that pain is recognized, documented, and treated promptly. (APS, 2005)

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▲Measure #144 (NQF 0383): Oncology: Medical and Radiation – Plan of Care for Pain

2013 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

This is a two-part measure which is paired with Measure #143: Oncology: Medical and Radiation: Pain Intensity Quantified. This measure *should* be reported if patient reports pain for Measure #143.

DESCRIPTION:
Percentage of visits for patients, regardless of age, with a diagnosis of cancer currently receiving chemotherapy or radiation therapy who report having pain with a documented plan of care to address pain

INSTRUCTIONS:
This measure is to be reported at each visit occurring during the reporting period for patients with a diagnosis of cancer and in which pain is present who are seen during the reporting period. It is anticipated that clinicians providing care for patients with cancer will submit this measure.

Measure Reporting via Registry:
All eligible instances when patient reports pain for Measure #143 make up the denominator for this measure. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data. There are no allowable performance exclusions for this measure.

DENOMINATOR:
All visits for patients, regardless of age, with a diagnosis of cancer currently receiving chemotherapy or radiation therapy who report having pain

Denominator Criteria (Eligible Cases):
All eligible instances when pain severity quantified; pain present (1125F) is reported in the numerator for Measure #143
AND
Diagnosis for cancer (ICD-9-CM): 140.0, 140.1, 140.3, 140.4, 140.5, 140.6, 140.8, 140.9, 141.0, 141.1, 141.2, 141.3, 141.4, 141.5, 141.6, 141.8, 141.9, 142.0, 142.1, 142.2, 142.8, 142.9, 143.0, 143.1, 143.8, 143.9, 144.0, 144.1, 144.8, 144.9, 145.0, 145.1, 145.2, 145.3, 145.4, 145.5, 145.6, 145.8, 145.9, 146.0, 146.1, 146.2, 146.3, 146.4, 146.5, 146.6, 146.7, 146.8, 146.9, 147.0, 147.1, 147.2, 147.3, 147.8, 147.9, 148.0, 148.1, 148.2, 148.3, 148.8, 148.9, 149.0, 149.1, 149.8, 149.9, 150.0, 150.1, 150.2, 150.3, 150.4, 150.5, 150.8, 150.9, 151.0, 151.1, 151.2, 151.3, 151.4, 151.5, 151.6, 151.8, 151.9, 152.0, 152.1, 152.2, 152.3, 152.8, 152.9, 153.0, 153.1, 153.2, 153.3, 153.4, 153.5, 153.6, 153.7, 153.8, 153.9, 154.0, 154.1, 154.2, 154.3, 154.8, 155.0, 155.1, 155.2, 156.0, 156.1, 156.2, 156.8, 156.9, 157.0, 157.1, 157.2, 157.3, 157.4, 157.8, 157.9, 158.0, 158.8, 158.9, 159.0, 159.1, 159.8, 159.9, 160.0, 160.1, 160.2, 160.3, 160.4, 160.5, 160.8, 160.9, 161.0, 161.1, 161.2, 161.3, 161.8, 161.9, 162.0, 162.2, 162.3, 162.4, 162.5, 162.8, 162.9, 163.0, 163.1, 163.8, 163.9, 164.0, 164.1, 164.2, 164.3, 164.8, 164.9, 165.0, 165.8, 165.9, 170.0, 170.1, 170.2, 170.3, 170.4, 170.5, 170.6, 170.7, 170.8, 170.9, 171.0, 171.2, 171.3, 171.4, 171.5, 171.6, 171.7, 171.8, 171.9, 172.0, 172.1, 172.2, 172.3, 172.4, 172.5, 172.6, 172.7, 172.8, 172.9, 173.00, 173.01, 173.02, 173.09, 173.10, 173.11, 173.12, 173.19, 173.20, 173.21, 173.22, 173.29, 173.30, 173.31, 173.32, 173.39, 173.40, 173.41, 173.42, 173.49, 173.50, 173.51, 173.52, 173.59, 173.60, 173.61, 173.62, 173.69, 173.70, 173.71, 173.72, 173.79, 173.80, 173.81, 173.82, 173.89, 173.90, 173.91, 173.92, 173.99, 174.0,

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174.1, 174.2, 174.3, 174.4, 174.5, 174.6, 174.8, 174.9, 175.0, 175.9, 176.0, 176.1, 176.2, 176.3, 176.4, 176.5, 176.8, 176.9, 179, 180.0, 180.1, 180.8, 180.9, 181, 182.0, 182.1, 182.8, 183.0, 183.2, 183.3, 183.4, 183.5, 183.8, 183.9, 184.0, 184.1, 184.2, 184.3, 184.4, 184.8, 184.9, 185, 186.0, 186.9, 187.1, 187.2, 187.3, 187.4, 187.5, 187.6, 187.7, 187.8, 187.9, 188.0, 188.1, 188.2, 188.3, 188.4, 188.5, 188.6, 188.7, 188.8, 188.9, 189.0, 189.1, 189.2, 189.3, 189.4, 189.8, 189.9, 190.0, 190.1, 190.2, 190.3, 190.4, 190.5, 190.6, 190.7, 190.8, 190.9, 191.0, 191.1, 191.2, 191.3, 191.4, 191.5, 191.6, 191.7, 191.8, 191.9, 192.0, 192.1, 192.2, 192.3, 192.8, 192.9, 193, 194.0, 194.1, 194.3, 194.4, 194.5, 194.6, 194.8, 194.9, 195.0, 195.1, 195.2, 195.3, 195.4, 195.5, 195.8, 196.0, 196.1, 196.2, 196.3, 196.5, 196.6, 196.8, 196.9, 197.0, 197.1, 197.2, 197.3, 197.4, 197.5, 197.6, 197.7, 197.8, 198.0, 198.1, 198.2, 198.3, 198.4, 198.5, 198.6, 198.7, 198.81, 198.82, 198.89, 199.0, 199.1, 199.2, 200.00, 200.01, 200.02, 200.03, 200.04, 200.05, 200.06, 200.07, 200.08, 200.10, 200.11, 200.12, 200.13, 200.14, 200.15, 200.16, 200.17, 200.18, 200.20, 200.21, 200.22, 200.23, 200.24, 200.25, 200.26, 200.27, 200.28, 200.30, 200.31, 200.32, 200.33, 200.34, 200.35, 200.36, 200.37, 200.38, 200.40, 200.41, 200.42, 200.43, 200.44, 200.45, 200.46, 200.47, 200.48; 200.50, 200.51, 200.52, 200.53, 200.54, 200.55, 200.56, 200.57, 200.58, 200.60, 200.61, 200.62, 200.63, 200.64, 200.65, 200.66, 200.67, 200.68, 200.70, 200.71, 200.72, 200.73, 200.74, 200.75, 200.76, 200.77, 200.78, 200.80, 200.81, 200.82, 200.83, 200.84, 200.85, 200.86, 200.87, 200.88, 201.00, 201.01, 201.02, 201.03, 201.04, 201.05, 201.06, 201.07, 201.08, 201.10, 201.11, 201.12, 201.13, 201.14, 201.15, 201.16, 201.17, 201.18, 201.20, 201.21, 201.22, 201.23, 201.24, 201.25, 201.26, 201.27, 201.28, 201.40, 201.41, 201.42, 201.43, 201.44, 201.45, 201.46, 201.47, 201.48, 201.50, 201.51, 201.52, 201.53, 201.54, 201.55, 201.56, 201.57, 201.58, 201.60, 201.61, 201.62, 201.63, 201.64, 201.65, 201.66, 201.67, 201.68, 201.70, 201.71, 201.72, 201.73, 201.74, 201.75, 201.76, 201.77, 201.78, 201.90, 201.91, 201.92, 201.93, 201.94, 201.95, 201.96, 201.97, 201.98, 202.00, 202.01, 202.02, 202.03, 202.04, 202.05, 202.06, 202.07, 202.08, 202.10, 202.11, 202.12, 202.13, 202.14, 202.15, 202.16, 202.17, 202.18, 202.20, 202.21, 202.22, 202.23, 202.24, 202.25, 202.26, 202.27, 202.28, 202.30, 202.31, 202.32, 202.33, 202.34, 202.35, 202.36, 202.37, 202.38, 202.40, 202.41, 202.42, 202.43, 202.44, 202.45, 202.46, 202.47, 202.48, 202.50, 202.51, 202.52, 202.53, 202.54, 202.55, 202.56, 202.57, 202.58, 202.60, 202.61, 202.62, 202.63, 202.64, 202.65, 202.66, 202.67, 202.68, 202.70, 202.71, 202.72, 202.73, 202.74, 202.75, 202.76, 202.77, 202.78, 202.80, 202.81, 202.82, 202.83, 202.84, 202.85, 202.86, 202.87, 202.88, 202.90, 202.91, 202.92, 202.93, 202.94, 202.95, 202.96, 202.97, 202.98, 203.00, 203.01, 203.02, 203.10, 203.11, 203.12, 203.80, 203.81, 203.82, 204.00, 204.01, 204.02, 204.10, 204.11, 204.12, 204.20, 204.21, 204.22, 204.80, 204.81, 204.82, 204.90, 204.91, 204.92, 205.00, 205.01, 205.02, 205.10, 205.11, 205.12, 205.20, 205.21, 205.22, 205.30, 205.31, 205.32, 205.80, 205.81, 205.82, 205.90, 205.91, 205.92, 206.00, 206.01, 206.02, 206.10, 206.11, 206.12, 206.20, 206.21, 206.22, 206.80, 206.81, 206.82, 206.90, 206.91, 206.92, 207.00, 207.01, 207.02, 207.10, 207.11, 207.12, 207.20, 207.21, 207.22, 207.80, 207.81, 207.82, 208.00, 208.01, 208.02, 208.10, 208.11, 208.12, 208.20, 208.21, 208.22, 208.80, 208.81, 208.82, 208.90, 208.91, 208.92, 209.00, 209.01, 209.02, 209.03, 209.10, 209.11, 209.12, 209.13, 209.14, 209.15, 209.16, 209.17, 209.20, 209.21, 209.22, 209.23, 209.24, 209.25, 209.26, 209.27, 209.29, 209.30, 209.31, 209.32, 209.33, 209.34, 209.35, 209.36, 209.70, 209.71, 209.72, 209.73, 209.74, 209.75, 209.79, 235.0, 235.1, 235.2, 235.3, 235.4, 235.5, 235.6, 235.7, 235.8, 235.9, 236.0, 236.1, 236.2, 236.3, 236.4, 236.5, 236.6, 236.7, 236.90, 236.91, 236.99, 237.0, 237.1, 237.2, 237.3, 237.4, 237.5, 237.6, 237.70, 237.71, 237.72, 237.73, 237.79, 237.9, 238.0, 238.1, 238.2, 238.3, 238.4, 238.5, 238.6, 238.71, 238.72, 238.73, 238.74, 238.75, 238.76, 238.77, 238.79, 238.8, 238.9, 239.0, 239.1, 239.2, 239.3, 239.4, 239.5, 239.6, 239.7, 239.81, 239.89, 239.9

Diagnosis for cancer (ICD-10-CM) [REFERENCE ONLY/Not Reportable]: C00.0, C00.1, C00.2, C00.3, C00.4, C00.5, C00.6, C00.8, C00.9, C01, C02.0, C02.1, C02.2, C02.3, C02.4, C02.8, C02.9, C03.0, C03.1, C03.9, C04.0, C04.1, C04.8, C04.9, C05.0, C05.1, C05.2, C05.8, C05.9, C06.0, C06.1, C06.2, C06.80, C06.89, C06.9, C07, C08.0, C08.1, C08.9, C09.0, C09.1, C09.8, C09.9, C10.0, C10.1, C10.2, C10.3, C10.4, C10.8, C10.9, C11.0, C11.1, C11.2, C11.3, C11.8, C11.9, C12, C13.0, C13.1, C13.2, C13.8, C13.9, C14.0, C14.2, C14.8, C15.3, C15.4, C15.5, C15.8, C15.9, C16.0, C16.1, C16.2, C16.3, C16.4, C16.5, C16.6, C16.8, C16.9, C17.0, C17.1, C17.2, C17.3, C17.8, C17.9, C18.0, C18.1, C18.2, C18.3, C18.4, C18.5, C18.6, C18.7, C18.8, C18.9, C19, C20, C21.0, C21.1, C21.2, C21.8, C22.0, C22.1, C22.2, C22.3, C22.4,

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C22.7, C22.8, C22.9, C23, C24.0, C24.1, C24.8, C24.9, C25.0, C25.1, C25.2, C25.3, C25.4, C25.7, C25.8, C25.9,C26.0, C26.1, C26.9, C30.0, C30.1, C31.0, C31.1, C31.2, C31.3, C31.8, C31.9, C32.0, C32.1, C32.2, C32.3, C32.8, C32.9, C33, C34.00, C34.01, C34.02, C34.10, C34.11, C34.12, C34.2, C34.30, C34.31, C34.32, C34.80, C34.81, C34.82, C34.90, C34.91, C34.92, C37, C38.0, C38.1, C38.2, C38.3, C38.4, C38.8, C39.0, C39.9, C40.00, C40.01, C40.02, C40.10, C40.11, C40.12, C40.20, C40.21, C40.22, C40.30, C40.31, C40.32, C40.80, C40.81, C40.82, C40.90, C40.91, C40.92, C41.0, C41.1, C41.2, C41.3, C41.4, C41.9, C43.0, C43.10, C43.11, C43.12, C43.20, C43.21, C43.22, C43.30, C43.31, C43.39, C43.4, C43.51, C43.52, C43.59, C43.60, C43.61, C43.62, C43.70, C43.71, C43.72, C43.8, C43.9, C44.00, C44.01, C44.02, C44.09, C44.101, C44.102, C44.109, C44.111, C44.112, C44.119, C44.121, C44.122, C44.129, C44.191, C44.192, C44.199, C44.201, C44.202, C44.209, C44.211, C44.212, C44.219, C44.221, C44.222, C44.229, C44.291, C44.292, C44.299,C44.300, C44.301, C44.309, C44.310, C44.311, C44.319, C44.320, C44.321, C44.329, C44.390, C44.391, C44.399, C44.40, C44.41, C44.42, C44.49, C44.500, C44.501, C44.509, C44.510, C44.511, C44.519, C44.520, C44.521, C44.529, C44.590, C44.591, C44.599, C44.601, C44.602, C44.609, C44.611, C44.612, C44.619, C44.621, C44.622, C44.629, C44.691, C44.692, C44.699, C44.701, C44.702, C44.709, C44.711, C44.712, C44.719, C44.721, C44.722, C44.729, C44.791, C44.792, C44.799, C44.80, C44.81, C44.82,C44.89, C44.90, C44.91, C44.92, C44.99, C45.0, C45.1, C45.2, C45.7, C45.9, C46.0, C46.1, C46.2, C46.3, C46.4, C46.50, C46.51, C46.52, C46.7, C46.9, C47.0, C47.10, C47.11, C44.30, C47.12, C47.20, C47.21, C47.22, C47.3, C47.4, C47.5, C47.6, C47.8, C47.9, C48.0, C48.1, C48.2, C48.8, C49.0, C49.10, C49.11, C49.12, C49.20, C49.21, C49.22, C49.3, C49.4, C49.5, C49.6, C49.8, C49.9, C4A.0, C4A.10, C4A.11, C4A.12, C4A.20, C4A.21, C4A.22, C4A.30, C4A.31, C4A.39, C4A.4, C4A.51, C4A.52, C4A.59, C4A.60, C4A.61, C4A.62, C4A.70, C4A.71, C4A.72, C4A.8, C4A.9, C50.011, C50.012, C50.019, C50.021, C50.022, C50.029, C50.111, C50.112, C50.119, C50.121, C50.122, C50.129, C50.211, C50.212, C50.219, C50.221, C50.222, C50.229, C50.311, C50.312, C50.319, C50.321, C50.322, C50.329, C50.411, C50.412, C50.419, C50.421, C50.422, C50.429, C50.511, C50.512, C50.519, C50.521, C50.522, C50.529, C50.611, C50.612, C50.619, C50.621, C50.622, C50.629, C50.811, C50.812, C50.819, C50.821, C50.822, C50.829, C50.911, C50.912, C50.919, C50.921, C50.922, C50.929, C51.0, C51.1, C51.2, C51.8, C51.9, C52, C53.0, C53.1, C53.8, C53.9, C54.0, C54.1, C54.2, C54.3, C54.8, C54.9, C55, C56.1, C56.2, C56.9, C57.00, C57.01, C57.02, C57.10, C57.11, C57.12, C57.20, C57.21, C57.22, C57.3, C57.4, C57.7, C57.8, C57.9, C58, C60.0, C60.1, C60.2, C60.8, C60.9, C61, C62.00, C62.01, C62.02, C62.10, C62.11, C62.12, C62.90, C62.91, C62.92, C63.00, C63.01, C63.02, C63.10, C63.11, C63.12, C63.2, C63.7, C63.8, C63.9, C64.1, C64.2, C64.9, C65.1, C65.2, C65.9, C66.1, C66.2, C66.9, C67.0, C67.1, C67.2, C67.3, C67.4, C67.5, C67.6, C67.7, C67.8, C67.9, C68.0, C68.1, C68.8, C68.9, C69.00, C69.01, C69.02, C69.10, C69.11, C69.12, C69.20, C69.21, C69.22, C69.30, C69.31, C69.32, C69.40, C69.41, C69.42, C69.50, C69.51, C69.52, C69.60, C69.61, C69.62, C69.80, C69.81, C69.82, C69.90, C69.91, C69.92, C70.0, C70.1, C70.9, C71.0, C71.1, C71.2, C71.3, C71.4, C71.5, C71.6, C71.7, C71.8, C71.9, C72.0, C72.1, C72.20, C72.21, C72.22, C72.30, C72.31, C72.32, C72.40, C72.41, C72.42, C72.50, C72.59, C72.9, C73, C74.00, C74.01, C74.02, C74.10, C74.11, C74.12, C74.90, C74.91, C74.92, C75.0, C75.1, C75.2, C75.3, C75.4, C75.5, C75.8, C75.9, C76.0, C76.1, C76.2, C76.3, C76.40, C76.41, C76.42, C76.50, C76.51, C76.52, C76.8, C77.0, C77.1, C77.2, C77.3, C77.4, C77.5, C77.8, C77.9, C78.00, C78.01, C78.02, C78.1, C78.2, C78.30, C78.39, C78.4, C78.5, C78.6, C78.7, C78.80, C78.89, C79.00, C79.01, C79.02, C79.10, C79.11, C79.19, C79.2, C79.31, C79.32, C79.40, C79.49, C79.51, C79.52, C79.60, C79.61, C79.62, C79.70, C79.71, C79.72, C79.81, C79.82, C79.89, C79.9, C7A.00, C7A.010, C7A.011, C7A.012, C7A.019, C7A.020, C7A.021, C7A.022, C7A.023, C7A.024, C7A.025, C7A.026, C7A.029, C7A.090, C7A.091, C7A.092, C7A.093, C7A.094, C7A.095, C7A.096, C7A.098, C7A.1, C7A.8, C7B.00, C7B.01, C7B.02, C7B.03, C7B.04, C7B.09, C7B.1, C7B.8, C80.0, C80.1, C80.2, C81.00, C81.01, C81.02, C81.03, C81.04, C81.05, C81.06, C81.07, C81.08, C81.09, C81.10, C81.11, C81.12, C81.13, C81.14, C81.15, C81.16, C81.17, C81.18, C81.19, C81.20, C81.21, C81.22, C81.23, C81.24, C81.25, C81.26, C81.27, C81.28, C81.29, C81.30, C81.31, C81.32, C81.33, C81.34, C81.35, C81.36, C81.37, C81.38, C81.39, C81.40, C81.41, C81.42, C81.43, C81.44, C81.45, C81.46, C81.47, C81.48, C81.49, C81.70, C81.71, C81.72, C81.73, C81.74, C81.75, C81.76, C81.77, C81.78, C81.79, C81.90, C81.91, C81.92,

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C81.93, C81.94, C81.95, C81.96, C81.97, C81.98, C81.99, C82.00, C82.01, C82.02, C82.03, C82.04, C82.05, C82.06, C82.07, C82.08, C82.09, C82.10, C82.11, C82.12, C82.13, C82.14, C82.15, C82.16, C82.17, C82.18, C82.19, C82.20, C82.21, C82.22, C82.23, C82.24, C82.25, C82.26, C82.27, C82.28, C82.29, C82.30, C82.31, C82.32, C82.33, C82.34, C82.35, C82.36, C82.37, C82.38, C82.39, C82.40, C82.41, C82.42, C82.43, C82.44, C82.45, C82.46, C82.47, C82.48, C82.49, C82.50, C82.51, C82.52, C82.53, C82.54, C82.55, C82.56, C82.57, C82.58, C82.59, C82.60, C82.61, C82.62, C82.63, C82.64, C82.65, C82.66, C82.67, C82.68, C82.69, C82.80, C82.81, C82.82, C82.83, C82.84, C82.85, C82.86, C82.87, C82.88, C82.89, C82.90, C82.91, C82.92, C82.93, C82.94, C82.95, C82.96, C82.97, C82.98, C82.99, C83.00, C83.01, C83.02, C83.03, C83.04, C83.05, C83.06, C83.07, C83.08, C83.09, C83.10, C83.11, C83.12, C83.13, C83.14, C83.15, C83.16, C83.17, C83.18, C83.19, C83.30, C83.31, C83.32, C83.33, C83.34, C83.35, C83.36, C83.37, C83.38, C83.39, C83.50, C83.51, C83.52, C83.53, C83.54, C83.55, C83.56, C83.57, C83.58, C83.59, C83.70, C83.71, C83.72, C83.73, C83.74, C83.75, C83.76, C83.77, C83.78, C83.79, C83.80, C83.81, C83.82, C83.83, C83.84, C83.85, C83.86, C83.87, C83.88, C83.89, C83.90, C83.91, C83.92, C83.93, C83.94, C83.95, C83.96, C83.97, C83.98, C83.99, C84.00, C84.01, C84.02, C84.03, C84.04, C84.05, C84.06, C84.07, C84.08, C84.09, C84.10, C84.11, C84.12, C84.13, C84.14, C84.15, C84.16, C84.17, C84.18, C84.19, C84.40, C84.41, C84.42, C84.43, C84.44, C84.45, C84.46, C84.47, C84.48, C84.49, C84.60, C84.61, C84.62, C84.63, C84.64, C84.65, C84.66, C84.67, C84.68, C84.69, C84.70, C84.71, C84.72, C84.73, C84.74, C84.75, C84.76, C84.77, C84.78, C84.79, C84.90, C84.91, C84.92, C84.93, C84.94, C84.95, C84.96, C84.97, C84.98, C84.99, C84.A0, C84.A1, C84.A2, C84.A3, C84.A4, C84.A5, C84.A6, C84.A7, C84.A8, C84.A9, C84.Z0, C84.Z1, C84.Z2, C84.Z3, C84.Z4, C84.Z5, C84.Z6, C84.Z7, C84.Z8, C84.Z9, C85.10, C85.11, C85.12, C85.13, C85.14, C85.15, C85.16, C85.17, C85.18, C85.19, C85.20, C85.21, C85.22, C85.23, C85.24, C85.25, C85.26, C85.27, C85.28, C85.29, C85.80, C85.81, C85.82, C85.83, C85.84, C85.85, C85.86, C85.87, C85.88, C85.89, C85.90, C85.91, C85.92, C85.93, C85.94, C85.95, C85.96, C85.97, C85.98, C85.99, C86.0, C86.1, C86.2, C86.3, C86.4, C86.5, C86.6, C88.0, C88.2, C88.3, C88.4, C88.8, C88.9, C90.00, C90.01, C90.02, C90.10, C90.11, C90.12, C90.20, C90.21, C90.22, C90.30, C90.31, C90.32, C91.00, C91.01, C91.02, C91.10, C91.11, C91.12, C91.30, C91.31, C91.32, C91.40, C91.41, C91.42, C91.50, C91.51, C91.52, C91.60, C91.61, C91.62, C91.90, C91.91, C91.92, C91.A0, C91.A1, C91.A2, C91.Z0, C91.Z1, C91.Z2, C92.00, C92.01, C92.02, C92.10, C92.11, C92.12, C92.20, C92.21, C92.22, C92.30, C92.31, C92.32, C92.40, C92.41, C92.42, C92.50, C92.51, C92.52, C92.60, C92.61, C92.62, C92.90, C92.91, C92.92, C92.A0, C92.A1, C92.A2, C92.Z0, C92.Z1, C92.Z2, C93.00, C93.01, C93.02, C93.10, C93.11, C93.12, C93.30, C93.31, C93.32, C93.90, C93.91, C93.92, C93.Z0, C93.Z1, C93.Z2, C94.00, C94.01, C94.02, C94.20, C94.21, C94.22, C94.30, C94.31, C94.32, C94.40, C94.41, C94.42, C94.6, C94.80, C94.81, C94.82, C95.00, C95.01, C95.02, C95.10, C95.11, C95.12, C95.90, C95.91, C95.92, C96.0, C96.2, C96.4, C96.5, C96.6, C96.9, C96.A, C96.Z, D37.01, D37.02, D37.030, D37.031, D37.032, D37.039, D37.04, D37.05, D37.09, D37.1, D37.2, D37.3, D37.4, D37.5, D37.6, D37.8, D37.9, D38.0, D38.1, D38.2, D38.3, D38.4, D38.5, D38.6, D39.0, D39.10, D39.11, D39.12, D39.2, D39.8, D39.9, D40.0, D40.10, D40.11, D40.12, D40.8, D40.9, D41.00, D41.01, D41.02, D41.10, D41.11, D41.12, D41.20, D41.21, D41.22, D41.3, D41.4, D41.8, D41.9, D42.0, D42.1, D42.9, D43.0, D43.1, D43.2, D43.3, D43.4, D43.8, D43.9, D44.0, D44.10, D44.11, D44.12, D44.2, D44.3, D44.4, D44.5, D44.6, D44.7, D44.9, D45, D46.0, D46.1, D46.20, D46.21, D46.22, D46.4, D46.9, D46.A, D46.B, D46.C, D46.Z, D47.0, D47.1, D47.2, D47.3, D47.4, D47.9, D47.Z1, D47.Z9, D48.0, D48.1, D48.2, D48.3, D48.4, D48.5, D48.60, D48.61, D48.62, D48.7, D48.9, D49.0, D49.1, D49.2, D49.3, D49.4, D49.5, D49.6, D49.7, D49.81, D49.89, D49.9, Q85.00, Q85.01, Q85.02, Q85.03, Q85.09

AND:

Patient encounter during the reporting period (CPT) - Procedure codes: 77427, 77431, 77432, 77435, 77470

OR

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Patient encounter during the reporting period (CPT) - Service codes: 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215
AND
Patient encounter during the reporting period (CPT) - Procedure codes: 51720, 96401, 96402, 96405, 96406, 96409, 96411, 96413, 96415, 96416, 96417, 96420, 96422, 96423, 96425, 96440, 96446, 96450, 96521, 96522, 96523, 96542, 96549

NUMERATOR:
Patient visits that included a documented plan of care to address pain

Numerator Instructions: A documented plan of care may include: use of opioids, non-opioid analgesics, psychological support, patient and/or family education, referral to a pain clinic, or reassessment of pain at an appropriate time interval.

Numerator Options:
Plan of care to address pain documented (0521F)
OR
Plan of care for pain not documented, reason not otherwise specified (0521F *with* 8P)

RATIONALE:
Inadequate cancer pain management is widely prevalent, harmful to the patient, and costly.

CLINICAL RECOMMENDATION STATEMENTS:
If the Pain Rating Scale score is above 0, a comprehensive pain assessment is initiated. (NCCN, 2011)

For management of cancer related pain in adults, the algorithm distinguishes three levels of pain intensity, based on a 0-10 numerical value obtained using numerical or the pictorial rating scale (with 0 being no pain to 10 being the worst pain). The three levels of pain intensity listed in the algorithm are mild pain (1-3); moderate pain (4-6); and severe pain (7-10). (NCCN, 2011)

The [NCCN] guidelines acknowledge the range of complex decisions faced in caring for these patients. As a result, they provide dosing guidelines for opioids, non-opioid analgesics, and adjuvant analgesics. They also provide specific suggestions for titrating and rotating opioids, escalation of opioid dosage, management of opioid adverse effects, and when and how to proceed to other techniques/interventions for the management of cancer pain.(1) Treatment must be individualized based on clinical circumstances and patient wishes, with the goal of maximizing function and quality of life. (NCCN, 2011)

Clinicians must respond to pain reports in a manner appropriate to the type of pain (eg, acute vs chronic) and setting (eg, inpatient vs outpatient)… Appropriate responses may not always include more opioids but rather more detailed assessments, use of nonopioid analgesics or techniques, or nonpharmacologic interventions (eg, education, relaxation, and use of heat or cold). (APS, 2005)

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❑ Measure #145 (NQF 0510): Radiology: Exposure Time Reported for Procedures Using Fluoroscopy

2013 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of final reports for procedures using fluoroscopy that include documentation of radiation exposure or exposure time

INSTRUCTIONS:
This measure is to be reported each time fluoroscopy is performed in a hospital or outpatient setting during the reporting period. There is no diagnosis associated with this measure. It is anticipated that clinicians providing the services for procedures using fluoroscopy will submit this measure.

Measure Reporting via Claims:
CPT or HCPCS codes are used to identify patients who are included in the measure's denominator. CPT Category II codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed CPT or HCPCS codes, and the appropriate CPT Category II code OR the CPT Category II code with the modifier. The reporting modifier allowed for this measure is: 8P-reason not otherwise specified. There are no allowable performance exclusions for this measure. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
CPT or HCPCS codes are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data. There are no allowable performance exclusions for this measure.

DENOMINATOR:
All final reports for procedures using fluoroscopy

Denominator Criteria (Eligible Cases):
Patient encounter during the reporting period (CPT or HCPCS): 0234T, 0235T, 0238T, 0075T, 0080T, 25606, 25651, 26608, 26650, 26676, 26706, 26727, 27096, 27235, 27244, 27245, 27509, 27756, 27759, 28406, 28436, 28456, 28476, 36147, 36221, 36222, 36223, 36224, 36225, 36226, 36251, 36252, 36253, 36254, 36598, 37182, 37183, 37184, 37187, 37188, 37210, 37220, 37221, 37222, 37223, 37224, 37225, 37226, 37227, 37228, 37229, 37230, 37231, 37232, 37234, 37235, 43260, 43261, 43262, 43263, 43264, 43265, 43267, 43268, 43269, 43271, 43272, 43752, 44500, 49440, 49441, 49442, 49446, 49450, 49451, 49452, 49460, 49465, 50382, 50384, 50385, 50386, 50387, 50389, 50590, 61623, 62263, 62264, 62280, 62281, 62282, 63610, 64610, 64620, 70010, 70015, 70170, 70332, 70370, 70371, 70373, 70390, 71023, 71034, 72240, 72255, 72265, 72270, 72275, 72285, 72291, 72295, 73040, 73085, 73115, 73525, 73580, 73615, 74190, 74210, 74220, 74230, 74235, 74240, 74241, 74245, 74246, 74247, 74249, 74250, 74251, 74260, 74270, 74280, 74283, 74290, 74291, 74300, 74305, 74320, 74327, 74328, 74329, 74330, 74340, 74355, 74360, 74363, 74425, 74430, 74440, 74445, 74450, 74455, 74470, 74475, 74480, 74485, 74740, 74742, 75600, 75605, 75625, 75630, 75658, 75705, 75710, 75716, 75726, 75731, 75733, 75736, 75741, 75743, 75746, 75756, 75791, 75801, 75803, 75805, 75807, 75809, 75810, 75825, 75827, 75831, 75833,

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75840, 75842, 75860, 75870, 75872, 75880, 75885, 75887, 75889, 75891, 75893, 75894, 75896, 75898, 75901, 75902, 75952, 75953, 75954, 75956, 75957, 75958, 75959, 75960, 75962, 75966, 75970, 75978, 75980, 75982, 75984, 76000, 76001, 76080, 76120, 76496, 76499, 77001, 77002, 77003, 92611, 93565, 93566, 93567, 93568, G0106, G0120, G0275, G0278

NUMERATOR:
Final reports for procedures using fluoroscopy that include documentation of radiation exposure or exposure time

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Radiation Exposure or Exposure Time Documented in Fluoroscopy Report
CPT II 6045F: Radiation exposure or exposure time in final report for procedure using fluoroscopy, documented

OR

Radiation Exposure or Exposure Time not Documented in Fluoroscopy Report, Reason not Otherwise Specified
Append a reporting modifier (8P) to CPT Category II code 6045F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.
6045F *with* 8P: Final fluoroscopy report does not include documentation of radiation exposure or exposure time, reason not otherwise specified

RATIONALE:
Data suggests that the lifetime risk for cancer can be increased, albeit by a small amount, with frequent or repeated exposure to ionizing radiation, including procedures using fluoroscopy. (NCI, 2002) The BEIR report concluded that "the linear no-threshold model (LNT) provided the most reasonable description of the relation between low-dose exposure to ionizing radiation and the incidence of solid cancers that are induced by ionizing radiation." (NRC, 2006) In order to monitor these long-term effects, the exposure time or radiation dose that a patient receives as a result of the procedure should be measured and recorded in the patient's record.

CLINICAL RECOMMENDATION STATEMENTS:
Radiation dose related information provided by automated dosimetry systems should be recorded in the patient's permanent record for procedures involving more than 10 minutes of fluoroscopic exposure. If automated dosimetry data is not available, fluoroscopic exposure times should be recorded in the patient's medical record for such procedures. (ACR, 2003)

[ACR] should now encourage practices to record actual fluoroscopy time for all fluoroscopic procedures. The fluoroscopy time for various procedures (e.g., upper gastrointestinal, pediatric voiding cystourethrography, diagnostic angiography) should then be compared with benchmark figures. More complete patient radiation dose data should be recorded for all high-dose interventional procedures, such as embolizations, transjugular intrahepatic portosystemic shunts, and arterial angioplasty or stent placement anywhere in the abdomen and pelvis. (Amis et al., ACR, 2007)
Measure & record patient radiation dose:

- Record fluoroscopy time
- Record available measures – DAP (dose area product), cumulative dose, skin dose (NCI, 2005)

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❑ Measure #146 (NQF 0508): Radiology: Inappropriate Use of "Probably Benign" Assessment Category in Mammography Screening

2013 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of final reports for screening mammograms that are classified as "probably benign"

INSTRUCTIONS:
This measure is to be reported each time a screening mammogram is performed during the reporting period. It is anticipated that clinicians who provide the physician component of diagnostic imaging studies for screening mammograms will submit this measure.

Measure Reporting via Claims:
ICD-9-CM codes, CPT or HCPCS codes are used to identify patients who are included in the measure's denominator. CPT Category II codes are used to report the numerator of the measure.
When reporting the measure via claims, submit the listed ICD-9-CM diagnosis codes, CPT or HCPCS codes, and the appropriate CPT Category II codes. There are no allowable performance exclusions for this measure. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT or HCPCS codes, are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data. There are no allowable performance exclusions for this measure.

DENOMINATOR:
All final reports for screening mammograms

Denominator Criteria (Eligible Cases):
Diagnosis for screening mammogram (ICD-9-CM): V76.11, V76.12
Diagnosis for screening mammogram (ICD-10-CM) [REFERENCE ONLY/Not Reportable]: Z12.31
AND
Patient encounter during the reporting period (CPT or HCPCS): 77057, G0202

NUMERATOR:
Final reports classified as "probably benign"

Numerator Instructions: For performance, a lower percentage, with a definitional target approaching 0%, indicates appropriate assessment of screening mammograms (e.g., the proportion of screening mammograms that are classified as "probably benign").

The mammogram assessment category (corresponding CPT Category II 33xxF code for "Other than Probably Benign") to be reported is the single overall final assessment for the mammographic study. Separate breast assessment categories should not be reported for this measure.

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Definition:
"Probably Benign" Classification – Mammography Quality Standards Act (MQSA) assessment category of "probably benign"; BI-RADS® category 3; or Food and Drug Administration (FDA)-approved equivalent assessment category

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Mammogram Assessment Category of "Probably Benign" Documented
CPT II 3343F: Mammogram assessment category of "probably benign", documented
OR
Mammogram Assessment Category Other than "Probably Benign" Documented
(One CPT II code [33xxF] is required on the claim form to submit this numerator option)
CPT II 3340F: Mammogram assessment category of "incomplete: need additional imaging evaluation," documented
OR
CPT II 3341F: Mammogram assessment category of "negative", documented
OR
CPT II 3342F: Mammogram assessment category of "benign", documented
OR
CPT II 3344F: Mammogram assessment category of "suspicious", documented
OR
CPT II 3345F: Mammogram assessment category "highly suggestive of malignancy", documented
OR
CPT II 3350F: Mammogram assessment category of "known biopsy proven malignancy", documented

RATIONALE:
Although a mammogram assessment category of "probably benign" is not recommended for use in interpreting screening mammograms, it is associated with up to 11% of screening mammograms and accounts for over 40%–50% of abnormal screening mammograms. (Yasmeen et al., 2003A) Mammogram assessment category of "probably benign" is coupled with a recommendation for short-interval follow-up (typically 6 months), resulting in economic and emotional consequences for the women that receive them.

CLINICAL RECOMMENDATION STATEMENTS:
Do not use Category 3 in interpreting screening examinations. (ACR, 2003)

All the published studies emphasize the need to conduct a complete diagnostic imaging evaluation before making a probably benign (Category 3) assessment; hence it is inadvisable to render such an assessment when interpreting a screening examination. (ACR, 2003)

The use of Category 3, probably benign, is reserved for findings that are almost certainly benign. It must be emphasized that this is NOT an indeterminate category for malignancy, but one that, for mammography, has a less than 2% chance of malignancy (i.e. is almost certainly benign). (ACR, 2003)

Such findings are generally identified on baseline screening or on screening for which previous examinations are unavailable for comparison. Immediate evaluation with additional mammographic views and/or ultrasound is required to render a Category 3, probably benign assessment. (ACR, 2003)

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▲Measure #147 (NQF 0511): Nuclear Medicine: Correlation with Existing Imaging Studies for All Patients Undergoing Bone Scintigraphy

2013 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of final reports for all patients, regardless of age, undergoing bone scintigraphy that include physician documentation of correlation with existing relevant imaging studies (e.g., x-ray, MRI, CT, etc.) that were performed

INSTRUCTIONS:
This measure is to be reported each time bone scintigraphy is performed during the reporting period. There is no diagnosis associated with this measure. It is anticipated clinicians performing the bone scintigraphy study will report on this measure.

Measure Reporting via Claims:
CPT codes are used to identify patients who are included in the measure's denominator. CPT Category II codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed CPT codes, and the appropriate CPT Category II code OR the CPT Category II code with the modifier. The modifiers allowed for this measure are: 3P- system reasons, 8P- reason not otherwise specified. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
CPT codes are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure. The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All final reports for patients, regardless of age, undergoing bone scintigraphy

Denominator Criteria (Eligible Cases):
Patient encounter during the reporting period (CPT): 78300, 78305, 78306, 78315, 78320

NUMERATOR:
Final reports that include physician documentation of correlation with existing relevant imaging studies (e.g., x-ray, MRI, CT, etc.)

Definition:
Relevant Imaging Studies – Relevant imaging studies are defined as studies that correspond to the same anatomical region in question.

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Bone Scintigraphy Report Correlated with Existing Studies
CPT II 3570F: Final report for bone scintigraphy study includes correlation with existing relevant imaging studies (eg, x-ray, MRI, CT) corresponding to the same anatomical region in question

OR

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Bone Scintigraphy Report not Correlated for System Reasons
Append a modifier (3P) to CPT Category II code 3570F to report documented circumstances that appropriately exclude patients from the denominator.
3570F *with* 3P: Documentation of system reason(s) for not documenting correlation with existing relevant imaging studies in final report (eg, no existing relevant imaging study available, patient did not have a previous relevant imaging study)
Note: Correlative studies are considered to be unavailable if relevant studies (reports and/or actual examination material) from other imaging modalities exist but could not be obtained after reasonable efforts to retrieve the studies are made by the interpreting physician prior to the finalization of the bone scintigraphy report.

OR

Bone Scintigraphy Report not Correlated, Reason not Otherwise Specified
Append a reporting modifier (8P) to CPT Category II code 3570F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.
3570F *with* 8P: Bone scintigraphy report not correlated, reason not otherwise specified

RATIONALE:
Radionuclide bone imaging plays an integral part in tumor staging and management; the majority of bone scans are performed in patients with a diagnosis of malignancy, especially carcinoma of the breast, prostate gland, and lung. This modality is extremely sensitive for detecting skeletal abnormalities, and numerous studies have confirmed that it is considerably more sensitive than conventional radiography for this purpose. However, the specificity of bone scan abnormalities can be low since many other conditions may mimic tumor; therefore, it is important that radionuclide bone scans are correlated with available, relevant imaging studies. Existing imaging studies that are available can help inform the diagnosis and treatment for the patient. Furthermore, correlation with existing radiographs is considered essential to insure that benign conditions are not interpreted as tumor. While there are no formal studies on variations in care in how often correlation with existing studies is not performed, there is significant anecdotal information from physicians practicing in the field that there is a gap in care and that correlation is not occurring frequently when images are available.

Literature suggests that as many as 30% of Radiology reports contain errors, regardless of the imaging modality, Radiologists experience, or time spent in interpretation. Evidence has also suggested that Radiology reports are largely non-standardized and commonly incomplete, vague, untimely, and error-prone and may not serve the needs of referring physicians. Therefore, it is imperative that existing imaging reports be correlated with the Nuclear Medicine bone scintigraphy procedure to ensure proper diagnosis and appropriate patient treatment.

CLINICAL RECOMMENDATION STATEMENTS:
Bone scintigraphic abnormalities should be correlated with appropriate physical examination and imaging studies to ascertain that osseous or soft-tissue abnormalities, which might cause cord or other nerve compression or pathologic fracture in an extremity, are not present. (SNM, 2003)

Relevant radiographs and/or MR imaging of painful sites to exclude cord compression or severe lytic lesions which carry an increased risk of pathologic fracture should be examined by the physician. (SNM, 2003)

Interpretation criteria
Bone scans are very sensitive for disease, but specificity of findings is low and must be interpreted in light of other information
a. History
b. Physical exam
c. Other test results
d. Comparison with previous studies

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(Procedure guideline for bone scintigraphy, Society of Nuclear Medicine, 2003)
Reporting
1. Description of technique
2. Description of abnormal tracer uptake
3. Correlation with other studies
4. Comparison with previous studies
5. Interpretation
(Procedure guideline for bone scintigraphy, Society of Nuclear Medicine, 2003)

Comparisons with previous examinations and reports, when possible, should be a part of the imaging consultation and report. Integrated PET/CT studies are more valuable when correlated with previous diagnostic CT, previous PET, previous PET/CT, previous MRI, and all appropriate imaging studies and clinical data that are relevant. (The SNM Practice Guideline for Sodium 18F-Fluoride PET/CT Bone Scans 1.1, Society of Nuclear Medicine, 2010)

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*Measure #154 (NQF: 0101): Falls: Risk Assessment

2013 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

This is a two-part measure which is paired with Measure #155: Falls: Plan of Care. If the falls risk assessment indicates the patient has documentation of two or more falls in the past year or any fall with injury in the past year (CPT II code 1100F is submitted), #155 *should* also be reported.

DESCRIPTION:
Percentage of patients aged 65 years and older with a history of falls who had a risk assessment for falls completed within 12 months

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for patients seen during the reporting period. There is no diagnosis associated with this measure. This measure is appropriate for use in all non-acute settings (excludes emergency departments and acute care hospitals). This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

Measure Reporting via Claims:
CPT or HCPCS codes and patient demographics are used to identify patients who are included in the measure's denominator. CPT Category II codes are used to report the numerator of the measure.
When reporting the measure via claims, submit the listed CPT or HCPCS codes, and the appropriate CPT Category II codes OR the CPT Category II code(s) with the modifier. The modifiers allowed for this measure are: 1P- medical reasons, 8P- reason not otherwise specified. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
CPT or HCPCS codes and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All patients aged 65 years and older who have a history of falls (history of falls is defined as 2 or more falls in the past year or any fall with injury in the past year)

> Denominator Criteria (Eligible Cases):
> Patients aged ≥ 65 years on date of encounter
> AND
> Patient encounter during the reporting period (CPT or HCPCS): 97001, 97002, 97003, 97004, 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, G0402, G0438, G0439

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NUMERATOR:
Patients who had a risk assessment for falls completed within 12 months

Numerator Instructions: All components do not need to be completed during one patient visit, but should be documented in the medical record as having been performed within the past 12 months.

Definitions:
Fall – A sudden, unintentional change in position causing an individual to land at a lower level, on an object, the floor, or the ground, other than as a consequence of sudden onset of paralysis, epileptic seizure, or overwhelming external force.
Risk Assessment – Comprised of balance/gait AND one or more of the following: postural blood pressure, vision, home fall hazards, and documentation on whether medications are a contributing factor or not to falls within the past 12 months.

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:
Risk Assessment for Falls Completed
(Two CPT II codes [3288F & 1100F] are required on the claim form to submit this numerator option)
CPT II 3288F: Falls risk assessment documented
AND
CPT II 1100F: Patient screened for future fall risk; documentation of two or more falls in the past year or any fall with injury in the past year

OR

Risk Assessment for Falls not Completed for Medical Reasons
(Two CPT II codes [3288F-1P & 1100F] are required on the claim form to submit this numerator option)
Append a modifier (1P) to CPT Category II code 3288F to report documented circumstances that appropriately exclude patients from the denominator.
3288F *with* 1P: Documentation of medical reason(s) for not completing a risk assessment for falls (i.e., reduced mobility, bed ridden, immobile, confined to chair, wheelchair bound, dependent on helper pushing wheelchair, independent in wheelchair or minimal help in wheelchair)
AND
CPT II 1100F: Patient screened for future fall risk; documentation of two or more falls in the past year or any fall with injury in the past year

OR

If patient is not eligible for this measure because patient has documentation of no falls or only one fall without injury the past year, report:
Patient not at Risk for Falls
(One CPT II code [1101F] is required on the claim form to submit this numerator option)
CPT II 1101F: Patient screened for future fall risk; documentation of no falls in the past year or only one fall without injury in the past year

OR

If patient is not eligible for this measure because falls status is not documented, report:
Falls Status not Documented
(One CPT II code [1101F-8P] is required on the claim form to submit this numerator option)

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Append a reporting modifier (8P) to CPT Category II code 1101F to report circumstances when the patient is not eligible for the measure.
1101F *with* 8P: No documentation of falls status

OR

Risk Assessment for Falls not Completed, Reason not Otherwise Specified
*(Two CPT II codes [*3288F-8P & 1100F*] are required on the claim form to submit this numerator option)*
Append a reporting modifier (8P) to CPT Category II code 3288F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.
3288F *with* 8P: Falls risk assessment not completed, reason not otherwise specified
AND
CPT II 1100F: Patient screened for future fall risk; documentation of two or more falls in the past year or any fall with injury in the past year

RATIONALE:
Screening for specific medical conditions may direct the therapy. Although the clinical guidelines and supporting evidence calls for an evaluation of many factors, it was felt that for the purposes of measuring performance and facilitating implementation this initial measure must be limited in scope. For this reason, the work group defined an evaluation of balance and gait as a core component that must be completed on all patients with a history of falls as well as four additional evaluations – at least one of which must be completed within the 12 month period. Data elements required for the measure can be captured and the measure is actionable by the physician.

CLINICAL RECOMMENDATION STATEMENTS:
Older people who present for medical attention because of a fall, or report recurrent falls in the past year, or demonstrate abnormalities of gait and/or balance should be offered a multifactorial falls risk assessment. This assessment should be performed by a health care professional with appropriate skills and experience, normally in the setting of a specialist falls service. This assessment should be part of an individualized, multifactorial intervention. (NICE) (Grade C)
Multifactorial assessment may include the following:

- identification of falls history
- assessment of gait, balance and mobility, and muscle weakness
- assessment of osteoporosis risk
- assessment of the older person's perceived functional ability and fear relating to falling
- assessment of visual impairment
- assessment of cognitive impairment and neurological examination
- assessment of urinary incontinence
- assessment of home hazards
- cardiovascular examination and medication review (NICE) (Grade C)

A falls risk assessment should be performed for older persons who present for medical attention because of a fall, report recurrent falls in the past year, report difficulties in walking or balance or fear of falling, or demonstrate unsteadiness or difficulty performing a gait and balance test.

The falls risk evaluation should be performed by a clinician with appropriate skills and experience. [C]

A falls risk assessment is a clinical evaluation that should include the following, but are not limited to:

- a history of fall circumstances
- review of all medications and doses
- evaluation of gait and balance, mobility levels and lower extremity joint function
- examination of vision

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- examination of neurological function, muscle strength, proprioception, reflexes, and tests of cortical, extrapyramidal, and cerebellar function
- cognitive evaluation
- screening for depression
- assessment of postural blood pressure
- assessment of heart rate and rhythm
- assessment of heart rate and rhythm, and blood pressure responses to carotid sinus stimulation if appropriate
- assessment of home environment

The falls risks assessment should be followed by direct intervention on the identified risk. [A] (AGS)

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*Measure #155 (NQF: 0101): Falls: Plan of Care

2013 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

This is a two-part measure which is paired with Measure #154: Falls: Risk Assessment.
This measure *should* be reported if CPT II code 1100F "Patient screened for future falls risk; documentation of two or more falls in the past year or any fall with injury in the past year" is submitted for Measure #154.

DESCRIPTION:
Percentage of patients aged 65 years and older with a history of falls who had a plan of care for falls documented within 12 months

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for patients seen during the reporting period. There is no diagnosis associated with this measure. This measure is appropriate for use in all non-acute settings (excludes emergency departments and acute care hospitals). This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

Measure Reporting via Claims:
All eligible instances when CPT II code 1100F (patient screened for future falls risk; documentation of two or more falls in the past year or any fall with injury in the past year) is reported in the numerator for Measure #154 make up the denominator for this measure. CPT Category II codes are used to report the numerator of the measure.

When CPT II code 1100F is reported with Measure #154, add the appropriate CPT Category II codes OR the CPT Category II code(s) with the modifier. The modifiers allowed for this measure are: 1P- medical reasons, 8P- reason not otherwise specified. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
All eligible instances when patient is reported in the numerator for Measure #154 as screened for future falls risk; documentation of two or more falls in the past year or any fall with injury in the past year are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All patients aged 65 years and older with a history of falls (history of falls is defined as 2 or more falls in the past year or any fall with injury in the past year)

> Denominator Criteria (Eligible Cases):
> Patients aged ≥ 65 years on date of encounter
> AND
> All eligible instances when CPT II code 1100F (Patient screened for future fall risk; documentation of two or more falls in the past year or any fall with injury in the past year) is reported in the numerator for Measure #154.

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AND

Patient encounter during the reporting period (CPT or HCPCS): 97001, 97002, 97003, 97004, 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, G0402, G0438, G0439

NUMERATOR:

Patients with a plan of care for falls documented within 12 months

Numerator Instructions: All components do not need to be completed during one patient visit, but should be documented in the medical record as having been performed within the past 12 months.

Definitions:

Plan of Care – Must include: 1) consideration of appropriate assistance device AND 2) balance, strength, and gait training.

Consideration of Appropriate Assistance Device – Medical record must include: documentation that an assistive device was provided or considered OR referral for evaluation for an appropriate assistance device.

Balance, Strength, and Gait Training – Medical record must include: documentation that balance, strength, and gait training/instructions were provided OR referral to an exercise program, which includes at least one of the three components: balance, strength or gait.

Fall – A sudden, unintentional change in position causing an individual to land at a lower level, on an object, the floor, or the ground, other than as a consequence of sudden onset of paralysis, epileptic seizure, or overwhelming external force.

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Plan of Care Documented

CPT II 0518F: Falls plan of care documented

OR

Plan of Care not Documented for Medical Reasons

Append a modifier (1P) to CPT Category II code 0518F to report documented circumstances that appropriately exclude patients from the denominator.

0518F *with* 1P: Documentation of medical reason(s) for no plan of care for falls

OR

Plan of Care not Documented, Reason not Otherwise Specified

Append a reporting modifier (8P) to CPT Category II code 0518F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

0518F *with* 8P: Plan of care not documented, reason not otherwise specified

RATIONALE:

Interventions to prevent future falls should be documented for the patient with 2 or more falls or injurious falls.

CLINICAL RECOMMENDATION STATEMENTS:

Among community-dwelling older persons (i.e., those living in their own homes), multifactorial interventions should include:

- gait training and advice on the appropriate use of assistive devices (Grade B)
- review and modification of medication, especially psychotropic medication (Grade B)
- exercise programs, with balance training as one of the components (Grade B)
- treatment of postural hypotension (Grade B)
- modification of environmental hazards (Grade C)
- treatment for cardiovascular disorders (Grade D) (AGS/BGS/AAOS)

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▲Measure #156 (NQF 0382): Oncology: Radiation Dose Limits to Normal Tissues

2013 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of patients, regardless of age, with a diagnosis of pancreatic or lung cancer receiving 3D conformal radiation therapy with documentation in medical record that radiation dose limits to normal tissues were established prior to the initiation of a course of 3D conformal radiation for a minimum of two tissues

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for patients with a diagnosis of cancer receiving 3D conformal radiation therapy seen during the reporting period. It is anticipated that clinicians providing radiation therapy for patients with cancer will submit this measure.

Measure Reporting via Claims:
ICD-9-CM diagnosis codes and a CPT codes are used to identify patients who are included in the measure's denominator. CPT Category II code(s) are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed ICD-9-CM diagnosis codes, CPT codes, and the appropriate CPT Category II code OR the CPT Category II code with the modifier. The reporting modifier allowed for this measure is: 8P- reason not otherwise specified. There are no allowable performance exclusions for this measure. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
ICD-9-CM diagnosis codes and CPT codes are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data. There are no allowable performance exclusions for this measure.

DENOMINATOR:
All patients, regardless of age, with a diagnosis of pancreatic or lung cancer who receive 3D conformal radiation therapy

Denominator Criteria (Eligible Cases):
Diagnosis for pancreatic or lung cancer (ICD-9-CM): 157.0, 157.1, 157.2, 157.3, 157.4, 157.8, 157.9, 162.0, 162.2, 162.3, 162.4, 162.5, 162.8, 162.9
Diagnosis for pancreatic or lung cancer (ICD-10-CM) [REFERENCE ONLY/Not Reportable]: C25.0, C25.1, C25.2, C25.3, C25.4, C25.7, C25.8, C25.9, C33, C34.00, C34.01, C34.02, C34.10, C34.11, C34.12, C34.2, C34.30, C34.31, C34.32, C34.80, C34.81, C34.82, C34.90, C34.91, C34.92
AND NOT
Diagnosis for metastatic cancer (ICD-9-CM): 196.0, 196.1, 196.2, 196.3, 196.5, 196.6, 196.8, 196.9, 197.0, 197.1, 197.2, 197.3, 197.4, 197.5, 197.6, 197.7, 197.8, 198.0, 198.1, 198.2, 198.3, 198.4, 198.5, 198.6, 198.7, 198.81, 198.82, 198.89
Diagnosis for metastatic cancer (ICD-10-CM) [REFERENCE ONLY/Not Reportable]:

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C77.0, C77.1, C77.2, C77.3, C77.4, C77.5, C77.8, C77.9, C78.00, C78.01, C78.02, C78.1, C78.2, C78.30, C78.39, C78.4, C78.5, C78.6, C78.7, C78.80, C78.89, C79.00, C79.01, C79.02, C79.10, C79.11, C79.19, C79.2, C79.31, C79.32, C79.40, C79.49, C79.51, C79.52, C79.60, C79.61, C79.62, C79.70, C79.71, C79.72, C79.81, C79.82, C79.89, C79.9

AND

Patient encounter during the reporting period (CPT): 77295

NUMERATOR:

Patients who had documentation in medical record that radiation dose limits to normal tissues were established prior to the initiation of a course of 3D conformal radiation for a minimum of two tissues

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Radiation Dose Limits to Normal Tissues Established

CPT II 0520F: Radiation dose limits to normal tissues established prior to the initiation of a course of 3D conformal radiation for a minimum of two tissues/organs

OR

Radiation Dose Limits to Normal Tissues not Established, Reason not Otherwise Specified

Append a reporting modifier (8P) to CPT Category II code 0520F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

0520F *with* 8P: Radiation dose limits to normal tissues not established prior to the initiation of a course of 3D conformal radiation for a minimum of two tissues/organs, reason not otherwise specified

RATIONALE:

Identifying radiation dose limits to normal tissues is an important step in the process of care for patients receiving radiation therapy treatments. Although no specific data is available, in its practice accreditation reviews, the American College of Radiation Oncology has found that radiation dose limits to normal tissues are included in the patient chart less frequently than reviewers expected. While dose constraint specification is an integral part of IMRT, it is not required for 3D conformal radiation therapy. Patients treated with 3D conformal radiation therapy are often subjected to dose levels that exceed normal tissue tolerance, and precise specification of maximum doses to be received by normal tissues represent both an intellectual process for the physician during radiation treatment planning, and a fail-safe point for the treating therapists. In most circumstances where facilities require specification of radiation dose limits to normal tissues prior to initiation of therapy, policies and procedures exist that prohibit exceeding those limits in the absence of written physician approval.

CLINICAL RECOMMENDATION STATEMENTS:

"The cognitive process of treatment planning requires the radiation oncologist to have knowledge of the natural history of the tumor to be treated and to determine the tumor site, its extent, and its relationship with adjacent normal tissues. This process is based on consideration of the history, physician examination, endoscopy, diagnostic imaging, findings at surgery, and histology. When ionizing radiation is to be used, the radiation oncologist must select beam characteristics and/or radionuclide sources, method of delivery, doses, and sequencing with other treatments. The sequencing with other treatments should be coordinated in collaboration with medical and surgical oncologists. The radiation oncologist determines the dose to be delivered to the tumor, limiting doses to critical structures (emphasis added), and the fractionation desired." (ACR, 2004)

Pancreatic Adenocarcinoma

It is imperative to evaluate the DVH [dose volume histogram] of the PTV [planning target volume] and critical normal structures such as liver, kidneys, spinal cord, liver and bowel. While these limits are empirical they differ based on dose per fraction, total dose delivered, and disease status (adjuvant vs. unresectable). Studies have shown that the

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tolerability of radiation is largely dependent on PTV size/elective nodal irradiation, types of concurrent systemic/ targeted therapy, and whether conformal (3-D, IMRT, SBRT) vs. conventional radiation is used. (NCCN, 2012)

Non-Small Cell Lung Cancer
It is essential to evaluate the dose volume histogram (DVH) of critical structures and to limit the doses to the spinal cord, lungs, heart, esophagus, and brachial plexus to minimize normal tissue toxicity. These limits are mainly empirical. For patients receiving postoperative RT, more strict DVH parameters should be considered for lung. (NCCN, 2012)

Small Cell Lung Cancer
Normal tissue doses will be dependent on tumor size and location. (NCCN, 2012)

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Ω Measure #157 (NQF 0455): Thoracic Surgery: Recording of Clinical Stage Prior to Lung Cancer or Esophageal Cancer Resection

2013 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of surgical patients aged 18 years and older undergoing resection for lung or esophageal cancer who had clinical staging provided prior to surgery

INSTRUCTIONS:
This measure is to be reported each time a major cancer resection of the lung or esophagus is performed. This measure is intended to reflect the quality of services provided for patients undergoing resection for lung or esophageal cancer. The clinical staging of lung and esophageal cancer patients guides the decision-making process when choosing optimal treatment modality which may or may not include surgery. It is anticipated that clinicians who perform the listed surgical procedures with a diagnosis of lung or esophageal cancer will submit this measure.

Measure Reporting via Claims:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. CPT Category II code(s) are used to report the numerator of the measure.

When reporting the measure via claims submit the listed ICD-9-CM diagnosis codes, CPT codes and the appropriate CPT Category II code OR the CPT Category II code with the modifier. The modifier allowed for this measure is: 8P-reason not otherwise specified. There are no allowable performance exclusions for this measure. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data. There are no allowable performance exclusions for this measure.

DENOMINATOR:
All patients undergoing resection for lung or esophageal cancer

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Diagnosis for lung or esophageal cancer (ICD-9-CM): 150.3, 150.4, 150.5, 150.8, 151.0, 162.2, 162.3, 162.4, 162.5, 162.9
Diagnosis for lung or esophageal cancer (ICD-10-CM) [REFERENCE ONLY/Not Reportable]: C15.3, C15.4, C15.5, C15.8, C16.0, C34.00, C34.01, C34.02, C34.10, C34.11, C34.12, C34.2, C34.30, C34.31, C34.32, C34.90, C34.91, C34.92
AND

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Patient encounter during the reporting period (CPT): 32440, 32442, 32445, 32480, 32482, 32484, 32486, 32488, 32503, 32504, 32505, 32506, 32507, 32663, 32666, 32667, 32668, 32669, 32670, 32671, 43107, 43108, 43112, 43113, 43116, 43117, 43118, 43121, 43122, 43123, 43124

NUMERATOR:
Patients undergoing resection for lung or esophageal cancer who had clinical staging provided prior to surgery

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Clinical Staging Provided
CPTII 3323F: Clinical tumor, node and metastases (TNM) staging documented and reviewed prior to surgery

OR

Clinical Staging not Provided, Reason not Otherwise Specified
Append a reporting modifier (8P) to CPT Category II code 3323F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.
3323F *with* 8P: Clinical tumor, node and metastases (TNM) staging not documented and reviewed prior to surgery, reason not otherwise specified

RATIONALE:
Evaluation of patients with suspected lung cancer and esophageal cancer includes both diagnosis of the primary tumor and evaluation of the extent of disease. The current system for staging lung and esophageal cancer is based on the AJCC TNM classification. The clinical staging of lung and esophageal cancer patients guides the decision-making process when choosing optimal treatment modality which may or may not include surgery. Review of the 8,133 patients who underwent surgery and met the inclusion criteria for the measures recorded in the current STS General Thoracic Database identified a significant gap with respect to recording of clinical stage; it was reported in 89% of patients undergoing resection for lung or esophageal cancer. Remediation of this process gap should improve quality by reducing inappropriate selection of treatment modalities including surgery.

CLINICAL RECOMMENDATION STATEMENTS:
BTS Guidelines on the selection of patients with lung cancer for surgery, Thorax 2001;56,89-108(February), and National Cancer Institute Web site: Non-Small Cell Lung Cancer PDQ®: Treatment. Available for download at the following address: http://www.cancer.gov page 3, and Surgical treatment of esophageal cancer. Manchester (MA): Society for Surgery of the Alimentary Tract (SSAT); 2002. 3 p.ASSESSMENT OF OPERABILITY (Clinical Staging Importance in Lung Cancer)

"Assuming satisfactory performance status, operability in patients with lung cancer depends on the clinical assessment of tumor stage. Preoperative clinical staging (cTNM), as accurately as possible given the limitations of the investigations available, is therefore crucial.
Recommendations:

1. All patients being considered for surgery should have a plain chest radiograph and a computed tomographic (CT) scan of the thorax including the liver and adrenal glands. [B]
2. Confirmatory diagnostic percutaneous needle biopsy in patients presenting with peripheral lesions is not mandatory in patients who are otherwise fit, particularly if there are previous chest radiographs showing no evidence of a lesion. [B]
3. Patients with mediastinal nodes greater than 1 cm in short axis diameter on the CT scan should undergo biopsy by staging mediastinoscopy, anterior mediastinotomy, or needle biopsy as appropriate. [B]

On the basis of these investigations, cTNM staging should be possible and appropriate surgery undertaken in the light of current knowledge of results."

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❑ Measure #159 (NQF 0404): HIV/AIDS: CD4+ Cell Count or CD4+ Percentage

2013 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

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

INSTRUCTIONS:
This measure is to be reported either once or twice per reporting period for patients with HIV/AIDS. If the patient is seen during both the first and second halves of the year, we would expect 2 QDCs: one during the first half of the year and one in the second half of the year. However, if the two visits both occurred in either the first or second half of the year, only 1 QDC needs to be reported. This measure is intended to reflect the quality of services provided for the primary management of patients with HIV/AIDS.

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT or HCPCS codes, and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data. There are no allowable performance exclusions for this measure.

DENOMINATOR:
Patients aged 6 months and older with a diagnosis of HIV/AIDS who had at least two medical visits during the measurement year, with at least 60 days between each visit

Denominator Criteria (Eligible Cases):
Patients aged ≥ 6 months on date of encounter
AND
Diagnosis for HIV/AIDS (ICD-9-CM): 042, V08
Diagnosis for HIV/AIDS (ICD-10-CM) [REFERENCE ONLY/Not Reportable]: B20, Z21
AND
Patient encounters during the reporting period (CPT or HCPCS): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, G0402

NUMERATOR:
Patients with CD4+ cell count or CD4+ cell percentage performed at least once every 6 months

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 otherwise specified (3500F *with* 8P)

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RATIONALE:
CD4+ cell counts help to establish monitoring frequency, and are taken into account when establishing a patient's disease stage.

CLINICAL RECOMMENDATION STATEMENTS:
Asymptomatic patients with normal CD4 cell counts and low virus loads can be monitored infrequently, repeating virus load measurements every 3-4 months and CD4 cell counts every 3-6 months. (Level of Evidence: B) (IDSA)

CD4 percentage or count should be measured at the time of diagnosis of HIV infection and at least every 3-4 months thereafter. (DHHS)

Clinicians should measure CD4 cell counts at the time of diagnosis of HIV infection and every 3 to 4 months thereafter. (NYSDOH)

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❑ Measure #160 (NQF 0405): HIV/AIDS: Pneumocystis Jiroveci Pneumonia (PCP) Prophylaxis

2013 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Percentage of patients aged 6 years and older with a diagnosis of HIV/AIDS and CD4+ cell count < 200 cells/mm^3 who were prescribed PCP prophylaxis within 3 months of low CD4+ cell count

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for patients with HIV/AIDS seen during the reporting period. Only patients who had at least two visits during the reporting period, with at least 60 days between each visit will be counted in the denominator for this measure. This measure is intended to reflect the quality of services provided for the primary management of patients with HIV/AIDS.

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT or HCPCS codes, and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
Patients aged 6 years and older with a diagnosis of HIV/AIDS whose CD4+ cell count < 200 cells/mm^3, and who had at least two medical visits during the measurement year, with at least 60 days between each visit

Denominator Criteria (Eligible Cases):
Patients aged ≥ 6 years on date of encounter
AND
Diagnosis for HIV/AIDS (ICD-9-CM): 042, V08
Diagnosis for HIV/AIDS (ICD-10-CM) [REFERENCE ONLY/Not Reportable]: B20, Z21
AND
Patient encounters during the reporting period (CPT or HCPCS): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, G0402
AND
CD4+ cell count < 200 cells/mm^3: 3494F

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)

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OR

Pneumocystis jiroveci pneumonia prophylaxis not prescribed within 3 months of low CD4+ cell count or percentage for medical reason (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) (4280F *with* 1P)

OR

PCP prophylaxis was not prescribed within 3 months of low CD4+ cell count, reason not otherwise specified (4280F *with* 8P)

RATIONALE:

Although advances in the management of HIV and AIDS diseases have been made, Pneumocystis carinii pneumonia (PCP) remains an important complication and cause of morbidity. Without PCP prophylaxis, patients with HIV/AIDS are at increased risk of developing PCP, especially when CD4 cell counts fall 200 cells/mm^3 to 250 cells/mm^3. (Kaplan, 1998; Phair, 1990) PCP prophylaxis is very effective and has been demonstrated to prolong life.

CLINICAL RECOMMENDATION STATEMENTS:

HIV-infected adults and adolescents, including pregnant women and those on HAART, should receive chemoprophylaxis against PCP if they have a CD4+T lymphocyte count of < 200/mL or a history of oropharyngeal candidiasis. (USPH/IDSA, 2002)

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❑ Measure #161 (NQF 0406): HIV/AIDS: Adolescent and Adult Patients with HIV/AIDS Who Are Prescribed Potent Antiretroviral Therapy

2013 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

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^3 or who have a history of an AIDS-defining condition, regardless of CD4+ cell count; or who are pregnant, regardless of CD4+ cell count or age, who were prescribed potent antiretroviral therapy

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for patients with HIV/AIDS seen during the reporting period. Only patients who had at least two visits during the reporting period, with at least 60 days between each visit will be counted in the denominator for this measure. This measure is intended to reflect the quality of services provided for the primary management of patients with HIV/AIDS.

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT or HCPCS codes, and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

There are two reporting criteria for this measure:
(1) Patients who are aged 13 years and older with a diagnosis of HIV/AIDS who have a history of a nadir CD4+ cell count below 350/mm^3 or who have a history of an AIDS-defining condition, regardless of CD4+ cell count

OR

(2) Patients with a diagnosis of HIV/AIDS and who are pregnant, regardless of CD4+ cell count or age

> Eligible professionals should submit data on one set of reporting criteria, depending on the clinical findings. If patient has HIV/AIDS (without a diagnosis of pregnancy) and a history of a nadir CD4+ cell count below 350/mm^3 or a history of AIDS-defining condition, use Denominator Reporting Criteria 1. If the patient has HIV/AIDS and pregnant, use Denominator Reporting Criteria 2. If the patient can be included in both criteria, the eligible professional may report quality data for either reporting criteria and this will count as appropriate reporting for this patient.

REPORTING CRITERIA 1: For all patients with HIV/AIDS (without a diagnosis of pregnancy)

DENOMINATOR (REPORTING CRITERIA 1):
Patients aged 13 years or older with a diagnosis of HIV/AIDS who have a history of nadir CD4+ cell count below 350/mm^3 or who have a history of an AIDS-defining condition, regardless of CD4+ cell count who had at least two medical visits during the measurement year, with at least 60 days between each visit

> Denominator Instructions: Nadir (lowest ever) CD4+ cell count may be the present count.

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Definition:
AIDS-defining Condition – Conditions included in the 1993 AIDS surveillance case definition (NYSDOH, 2007)

- Candidiasis of bronchi, trachea, or lungs
- Candidiasis, esophageal
- Cervical cancer, invasive
- Coccidiodomycosis, 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
- Toxoplasmosis of brain
- Wasting syndrome due to HIV

Denominator Criteria (Eligible Cases):
Patients aged ≥ 13 years on date of encounter
AND
Diagnosis for HIV/AIDS (ICD-9-CM): 042, V08
Diagnosis for HIV/AIDS (ICD-10-CM) [REFERENCE ONLY/Not Reportable]: B20, Z21
AND
Patient encounters during the reporting period (CPT or HCPCS): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, G0402
AND
History of nadir CD4+ cell count < 350 cells/mm^3: 3492F
OR
History of AIDS-defining condition: 3490F

NUMERATOR:
Patients who were prescribed potent antiretroviral therapy

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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 on Aids.gov.
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)

OR

Potent antiretroviral therapy not prescribed, reason not otherwise specified (4276F *with* 8P)

OR

REPORTING CRITERIA 2: For patients with HIV/AIDS who are pregnant

DENOMINATOR (REPORTING CRITERIA 2):
Patients with a diagnosis of HIV/AIDS who are pregnant, regardless of CD4+ cell count or age who had at least two medical visits during the measurement year, with at least 60 days between each visit

Denominator Criteria (Eligible Cases):
Diagnosis for HIV/AIDS (ICD-9-CM): 042, V08
Diagnosis for HIV/AIDS (ICD-10-CM) [REFERENCE ONLY/Not Reportable]: B20, Z21
AND
Diagnosis for pregnancy (ICD-9-CM): V22.0, V22.1, V22.2, V23.0, V23.1, V23.2, V23.3, V23.41, V23.42, V23.49, V23.5, V23.7, V23.81, V23.82, V23.83, V23.84, V23.87, V23.89, V23.9
Diagnosis for pregnancy (ICD-10-CM) [REFERENCE ONLY/Not Reportable]: O09.00, O09.01, O09.02, O09.03, O09.10, O09.11, O09.12, O09.13, O09.211, O09.212, O09.213, O09.219, O09.291, O09.292, O09.293, O09.299, O09.30, O09.31, O09.32, O09.33, O09.40, O09.41, O09.42, O09.43, O09.511, O09.512, O09.513, O09.519, O09.521, O09.522, O09.523, O09.529, O09.611, O09.612, O09.613, O09.619, O09.621, O09.622, O09.623, O09.629, O09.70, O09.71, O09.72, O09.73, O09.811, O09.812, O09.813, O09.819, O09.821, O09.822, O09.823, O09.829, O09.891, O09.892, O09.893, O09.899, O09.90, O09.91, O09.92, O09.93, Z33.1, Z34.00, Z34.01, Z34.02, Z34.03, Z34.80, Z34.81, Z34.82, Z34.83, Z34.90, Z34.91, Z34.92, Z34.93, Z36
AND
Patient encounter during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, G0402

NUMERATOR:
Patients who were prescribed potent antiretroviral therapy

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.

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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)

OR

Potent antiretroviral therapy not prescribed, reason not otherwise specified (4276F *with* 8P)

RATIONALE:
Potent antiretroviral therapy slows disease progression, extends survival, and results in maintained quality of life by suppressing HIV RNA viral load.

CLINICAL RECOMMENDATION STATEMENTS:
Antiretroviral therapy should be initiated in patients with a history of an AIDS-defining illness (AI) or with a CD4 T-cell count < 350 cells/mm^3. The data supporting this recommendation are stronger for those with a CD4 T-cell count < 200 cells/mm^3 and with a history of AIDS (AI) than for those with CD4 T-cell counts between 200 and 350 cells/mm^3 (AII). Antiretroviral therapy should also be initiated in the following groups of patients regardless of CD4 T-cell count: a) pregnant women (AI); b) patients with HIV-associated nephropathy (AI); and c) patients co-infected with HBV when treatment for HBV infection is indicated (BIII). (DHHS)

Clinicians should prescribe a HAART regimen that is best able to delay disease progression, prolong survival, and maintain quality of life through maximal viral suppression. (NYSDOH)

Initiation of HAART is recommended for patients who: are symptomatic* from HIV, OR
have an AIDS-defining condition,** including those with CD4 counts < 200 cells/mm^3, *or*
are asymptomatic with two successive measurements of CD4 counts < 350 cells/mm^3 *and*
patient-related barriers to adherence are minimized.

*Signs and symptoms include but are not limited to oropharyngeal candidiasis (thrush); vulvovaginal candidiasis that is frequent or responds poorly to therapy; cervical dysplasia (moderate or severe)/cervical carcinoma *in situ*; HIV nephropathy in the setting of worsening serum creatinine; severe seborrheic dermatitis, constitutional symptoms, such as fever or diarrhea lasting > 1 month; oral hairy leukoplakia; herpes zoster (shingles) involving at least two distinct episodes or more than one dermatome; thrombocytopenia; listeriosis; pelvic inflammatory disease, particularly if complicated by tubo-ovarian abscess; peripheral neuropathy; bacillary angiomatosis; or any conditions included in the CDC-defined AIDS definition.

**All HIV-infected persons with CD4+ T-lymphocyte counts of less than 200 cells/uL or a CD4+ percentage of less than 14. Conditions included in the 1993 AIDS surveillance case definition: Candidiasis of bronchi, trachea, or lungs; candidiasis, esophageal; cervical cancer, invasive; coccidiodomycosis, disseminated or extrapulmonary; cryptococcosis, extrapulmonary; crytosporidiosis, 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); or 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; toxoplasmosis of brain; wasting syndrome due to HIV. (NYSDOH)

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❑ Measure #162 (NQF 0407): HIV/AIDS: HIV RNA Control After Six Months of Potent Antiretroviral Therapy

2013 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

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

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for patients with HIV/AIDS who are receiving potent antiretroviral therapy during the reporting period. Only patients who had at least two visits during the reporting period, with at least 60 days between each visit will be counted in the denominator for this measure. This measure is intended to reflect the quality of services provided for the primary management of patients with HIV/AIDS.

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT or HCPCS codes, and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All patients aged 13 years and older with a diagnosis of HIV/AIDS who had at least two medical visits during the measurement year, with at least 60 days between each visit, who have received potent antiretroviral therapy for at least 6 months

Definition:
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.

Denominator Criteria (Eligible Cases):
Patients aged ≥ 13 years on date of encounter
AND
Diagnosis for HIV/AIDS (ICD-9-CM): 042, V08
Diagnosis for HIV/AIDS (ICD-10-CM) [REFERENCE ONLY/Not Reportable]: B20, Z21
AND
Patient encounters during the reporting period (CPT or HCPCS): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, G0402
AND
Patient receiving potent antiretroviral therapy for 6 months or longer: 4270F

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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.

Definition:
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)

OR

HIV RNA viral load not below limits of quantification (3503F)
AND
HIV RNA control plan of care, documented (0575F)

OR

Viral load not performed or documented, reason not otherwise specified (3502F *with* 8P)

OR

Plan of care for viral load not below limits of quantification was not documented, reason not otherwise specified (0575F *with* 8P)
AND
HIV RNA viral load not below limits of quantification (3503F)

RATIONALE:
The goal of potent antiretroviral therapy is to establish HIV RNA viral load below limits of quantification.

CLINICAL RECOMMENDATION STATEMENTS:
The goal of treatment for patients with prior drug exposure and drug resistance is to re-establish maximal virologic suppression, HIV RNA < 50 copies/ml (AI). (DHHS) Clinicians should prescribe a HAART regimen that is best able to delay disease progression, prolong survival, and maintain quality of life through maximal viral suppression. (NYSDOH)

Initiation of HAART is recommended for patients who:
are symptomatic* from HIV, OR
have an AIDS-defining condition,** including those with CD4 counts < 200 cells/mm^3, *or*
are asymptomatic with two successive measurements of CD4 counts < 350 cells/mm^3 *and*
patient-related barriers to adherence are minimized.

*Signs and symptoms include but are not limited to oropharyngeal candidiasis (thrush); vulvovaginal candidiasis that is frequent or responds poorly to therapy; cervical dysplasia (moderate or severe)/cervical carcinoma *in situ*; HIV nephropathy in the setting of worsening serum creatinine; severe seborrheic dermatitis, constitutional symptoms, such as fever or diarrhea lasting > 1 month; oral hairy leukoplakia; herpes zoster (shingles) involving at least two distinct episodes or more than one dermatome; thrombocytopenia; listeriosis; pelvic inflammatory disease,

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particularly if complicated by tubo-ovarian abscess; peripheral neuropathy; bacillary angiomatosis; or any conditions included in the CDC-defined AIDS definition.

**All HIV-infected persons with CD4+ T-lymphocyte counts of less than 200 cells/uL or a CD4+ percentage of less than 14. Conditions included in the 1993 AIDS surveillance case definition: Candidiasis of bronchi, trachea, or lungs; candidiasis, esophageal; cervical cancer, invasive; coccidiodomycosis, disseminated or extrapulmonary; cryptococcosis, extrapulmonary; crytosporidiosis, 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); or 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; toxoplasmosis of brain; wasting syndrome due to HIV. (NYSDOH)

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♦Measure #163 (NQF 0056): Diabetes Mellitus: Foot Exam

2013 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

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

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for patients with diabetes mellitus seen during the reporting period. The performance period for this measure is 12 months. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

Measure Reporting via Claims:
ICD-9-CM diagnosis codes, CPT or HCPCS codes, and patient demographics are used to identify patients who are included in the measure's denominator. CPT Category II codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed ICD-9-CM diagnosis codes, CPT or HCPCS codes, and the appropriate CPT Category II code OR the CPT Category II code with the modifier. The modifiers allowed for this measure are: 1P- medical reasons, 8P- reason not otherwise specified. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT or HCPCS codes, and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
Patients aged 18 through 75 years with a diagnosis of diabetes

Denominator Criteria (Eligible Cases):
Patients aged 18 through 75 years on date of encounter
AND
Diagnosis for diabetes (ICD-9-CM): 250.00, 250.01, 250.02, 250.03, 250.10, 250.11, 250.12, 250.13, 250.20, 250.21, 250.22, 250.23, 250.30, 250.31, 250.32, 250.33, 250.40, 250.41, 250.42, 250.43, 250.50, 250.51, 250.52, 250.53, 250.60, 250.61, 250.62, 250.63, 250.70, 250.71, 250.72, 250.73, 250.80, 250.81, 250.82, 250.83, 250.90, 250.91, 250.92, 250.93, 357.2, 362.01, 362.02, 362.03, 362.04, 362.05, 362.06, 362.07, 366.41, 648.00, 648.01, 648.02, 648.03, 648.04
Diagnosis for diabetes (ICD-10-CM) [REFERENCE ONLY/Not Reportable]: E10.8, E10.9, E10.10, E10.11, E10.21, E10.22, E10.29, E10.311, E10.319, E10.321, E10.329, E10.331, E10.339, E10.341, E10.349, E10.351, E10.359, E10.36, E10.39, E10.40, E10.41, E10.42, E10.43, E10.44, E10.49, E10.51, E10.52, E10.59, E10.610, E10.618, E10.620, E10.621, E10.622, E10.628, E10.630, E10.638, E10.641, E10.649, E10.65, E10.69, E11.00, E11.01, E11.21, E11.22, E11.29, E11.311, E11.319, E11.321, E11.329, E11.331, E11.339, E11.341, E11.349, E11.351, E11.359, E11.36, E11.39, E11.40, E11.41, E11.42, E11.43, E11.44, E11.49, E11.51, E11.52, E11.59, E11.65, E11.69, E11.610, E11.618, E11.620, E11.621, E11.622,

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E11.628, E11.630, E11.638, E11.641, E11.649, E11.8, E11.9, O24.011, O24.012, O24.013, O24.019, O24.02, O24.03, O24.111, O24.112, O24.113, O24.119, O24.12, O24.13
AND
Patient encounter during the reporting period (CPT or HCPCS): 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, G0402

NUMERATOR:
Patients who received a foot exam (visual inspection, sensory exam with monofilament AND pulse exam)

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 3 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 Otherwise 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

RATIONALE:
The most common consequences of diabetic neuropathy are amputation and foot ulceration (ADA, 2006). In developed countries, up to five percent of diabetic patients have foot ulcers (IDF, 2005). One in every six diabetics will have an ulcer during their lifetime (IDF, 2005). Amputation and foot ulceration are also major causes of morbidity and mortality. One half to 80% of all amputations are diabetes-related (Mayfield, 1998; Reiber, 1995; ADA, 2001; Unwin, 2000).The risk of ulcers or amputations increases the longer someone has diabetes. Early recognition and management of risk factors can prevent or delay adverse outcomes. (ADA, 2006)

CLINICAL RECOMMENDATION STATEMENTS:
American Association of Clinical Endocrinologists/American College of Endocrinology (AACE/ACE) and American Diabetes Association (ADA) recommend that a foot examination (visual inspection, sensory exam, and pulse exam) be performed during an initial assessment.

AACE/ACE (2007) recommends to inspect the patient's feet at every visit; evaluate skin, nails, pulses, temperature, evidence of pressure, and hygiene. Perform an annual comprehensive foot examination; assess sensory function by pinprick, temperature and vibration sensation using a tuning fork, or pressure using a monofilament.

ADA (2012) recommends that for all patients with diabetes, perform an annual comprehensive foot examination to identify risk factors predictive of ulcers and amputations. The foot examination should include inspection, assessment of foot pulses, and testing for loss of protective sensation (10-g monofilament plus testing any one of the following: vibration using 128-Hz tuning fork, pinprick sensation, ankle reflexes, or vibration perception threshold). Provide general foot self-care education to all patients with diabetes. A multidisciplinary approach is recommended for individuals with foot ulcers and high-risk feet, especially those with a history of prior ulcer or amputation.

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The American College of Foot and Ankle Surgeons (ACFAS) recommends that all patients with diabetes require a pedal inspection whenever they present to any health care practitioner, and they should receive a thorough lower extremity examination at least once annually. (ACFAS, 2006)

The older adult who has diabetes mellitus should have a careful foot examination at least annually to check skin integrity and to determine whether there is bony deformity, loss of sensation, or decreased perfusion and more frequently if there is evidence of any of these findings. (AGS, 2003)

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Ω Measure #164 (NQF 0129): Coronary Artery Bypass Graft (CABG): Prolonged Intubation

2013 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

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

INSTRUCTIONS:
This measure is to be reported each time an isolated CABG procedure is performed during the reporting period. It is anticipated that clinicians who provide services for isolated CABG will submit this measure. This measure is intended to reflect the quality of the surgical services provided for isolated CABG patients. Isolated CABG refers to CABG using arterial and/or venous grafts only.

Measure Reporting via Registry:
CPT codes and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data. There are no allowable performance exclusions for this measure.

DENOMINATOR:
All patients undergoing isolated CABG surgery

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Patient encounter during the reporting period (CPT): 33510, 33511, 33512, 33513, 33514, 33516, 33517, 33518, 33519, 33521, 33522, 33523, 33533, 33534, 33535, 33536

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)

RATIONALE:
Based on the STS coronary artery bypass graft (CABG) study population, the morbidity rate associated with prolonged intubation following CABG is 5.96%. Also, prolonged ventilation (defined as > 24 hours) was an independent predictor for readmission to the ICU following CABG surgery (OR=10.53; CI: 6.18 to 17.91). Shorter ventilation times are linked to high quality of care (i.e., reduced in-hospital and operative mortality, as well as better long-term outcomes as compared to prolonged ventilation).

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CLINICAL RECOMMENDATION STATEMENTS:

Extubation greater than (>) 24 hours is considered a “pulmonary complication.” Patients who were extubated after 24 hours had a longer duration of hospital stay and a greater incidence of postoperative complications.

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Ω Measure #165 (NQF 0130): Coronary Artery Bypass Graft (CABG): Deep Sternal Wound Infection Rate

2013 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

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

INSTRUCTIONS:
This measure is to be reported each time an isolated CABG procedure is performed during the reporting period. It is anticipated that clinicians who provide services for isolated CABG will submit this measure. This measure is intended to reflect the quality of the surgical services provided for isolated CABG patients. Isolated CABG refers to CABG using arterial and/or venous grafts only.

Measure Reporting via Registry:
CPT codes and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data. There are no allowable performance exclusions for this measure.

DENOMINATOR:
All patients undergoing isolated CABG surgery

Denominator Criteria (Eligible Cases):
All patients aged ≥ 18 years on date of encounter
AND
Patient encounter during the reporting period (CPT): 33510, 33511, 33512, 33513, 33514, 33516, 33517, 33518, 33519, 33521, 33522, 33523, 33533, 33534, 33535, 33536

NUMERATOR:
Patients who, within 30 days post operatively, develop deep sternal wound infection involving muscle, bone, and/or mediastinum requiring operative intervention. 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)

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RATIONALE:
The most serious hospital-acquired infection associated with coronary artery bypass graft (CABG) surgery is deep sternal wound or deep surgical site infection. The most common bacteria involved are *S. aureus* including increasingly more common methicillin resistant *Staph* (MRS). For CABG only outcomes 1997-1999 the STS dataset reported 0.63% deep sternal wound infection rate in 503,478 records. A report from an academic hospital reported 1.9% deep surgical site infections (Centers for Disease Control and Prevention National Nosocomial Infection Surveillance [CDC NNIS] criteria) in 1,980 patients undergoing isolated CABG or CABG+ procedures from 1996-1999. The Northern New England Cardiovascular Disease Study Group reported an incidence rate for mediastinitis of 1.25% and noted a marked increase in mortality during the first year post-CABG and a threefold increase during a 4-year follow-up period.

CLINICAL RECOMMENDATION STATEMENTS:
Several risk factors for sternal wound infection have been identified that can be optimized with good care practices: prophylactic antibiotics within 1 hour before incision time (odds ratio 5.3) [see antibiotic timing process measure] and avoiding elevated blood glucose levels (odds ratio 10.2). Surveillance for surgical site infections is a critical hospital function to monitor infection control practices and direct improvement activity.

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Ω Measure #166 (NQF 0131): Coronary Artery Bypass Graft (CABG): Stroke

2013 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

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

INSTRUCTIONS:
This measure is to be reported each time an isolated CABG procedure is performed during the reporting period. It is anticipated that clinicians who provide services for isolated CABG will submit this measure. This measure is intended to reflect the quality of the surgical services provided for isolated CABG patients. Isolated CABG refers to CABG using arterial and/or venous grafts only.

Measure Reporting via Registry:
CPT codes and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data. There are no allowable performance exclusions for this measure.

DENOMINATOR:
All patients undergoing isolated CABG surgery

Denominator Criteria (Eligible Cases):
All patients aged ≥ 18 years on date of encounter
AND
Patient encounter during the reporting period (CPT): 33510, 33511, 33512, 33513, 33514, 33516, 33517, 33518, 33519, 33521, 33522, 33523, 33533, 33534, 33535, 33536

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)

RATIONALE:
Stroke is a devastating complication after coronary bypass surgery. The 1999 American College of Cardiology/American Heart Association (ACC/AHA) guidelines indicate that adverse cerebral outcomes are observed in ~6% of patients after bypass surgery equally divided between 2 types:

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1) associated with major, focal neurological defects, stupor or coma and 2) evidence of deterioration in intellectual function. Type 1 deficits occur in ~3% of patients and are responsible for 21% mortality.

Reports in the literature on postoperative stroke incidence are difficult to compare because the conditions included in the term “stroke” vary. A standardized definition of stoke will provide common language to compare stroke incidence and evaluate management strategies for reducing this devastating complication.

Reported rates of postoperative cerebral dysfunction range from 0.4% to 13.8% following coronary operations. Complications for patients undergoing emergent CABG or valve surgery were greater than the complication rate for patients undergoing elective CABG or valve surgery. As bypass times increased, so did the incidence of stroke. When bypass time was 90 to 113 minutes, OR =1.59, p=0.022 and when bypass time was > 114 minutes, the OR =2.59, p < 0.001. Outcomes are better when patient age is younger and with beating-heart surgery rather than on-pump surgery.

CLINICAL RECOMMENDATION STATEMENTS:

The 1999 ACC/AHA guidelines describe strategies for reducing the risk of postoperative stroke such as an aggressive approach to the management of patients with severely diseased ascending aortas identified by intraoperative echocardiographic imaging, prevention or aggressive management of postoperative atrial fibrillation, delay of bypass surgery in the case of a left ventricular mural thrombus or a recent, preoperative CVA and preoperative carotid screening. Patients should carefully be screened for cerebrovascular disease to help prevent stroke and its associated morbidities.

Use of beta-adrenergic antagonists was associated with a lower incidence of stroke in patients undergoing elective CABG (OR=0.45; 95% CI 0.23 to 0.83; p=0.016). Use of antiplatelet agents within 48 hours of surgery is associated with a decreased risk of stroke (OR=0.51, p=0.01). Increased use of beating-heart surgery without cardiopulmonary bypass may lead to a lower prevalence of stroke following cardiac surgery and thus improve patient outcomes.

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Ω Measure #167 (NQF 0114): Coronary Artery Bypass Graft (CABG): Postoperative Renal Failure

2013 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

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

INSTRUCTIONS:
This measure is to be reported each time an isolated CABG procedure is performed during the reporting period. It is anticipated that clinicians who provide services for isolated CABG will submit this measure. This measure is intended to reflect the quality of the surgical services provided for isolated CABG patients. Isolated CABG refers to CABG using arterial and/or venous grafts only.

Measure Reporting via Registry:
CPT codes and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data. There are no allowable performance exclusions for this measure.

DENOMINATOR:
All patients undergoing isolated CABG surgery

Denominator Criteria (Eligible Cases):
All patients aged ≥ 18 years on date of encounter
AND
Patient encounter during the reporting period (CPT): 33510, 33511, 33512, 33513, 33514, 33516, 33517, 33518, 33519, 33521, 33522, 33523, 33533, 33534, 33535, 33536
WITHOUT
History of renal failure or baseline serum creatinine ≥ 4.0 mg/dL

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 ≥ 4.0 mg/dL or 3x most recent preoperative creatinine level, or 2) 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)

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RATIONALE:
In 2000, coronary artery bypass graft (CABG) surgery was performed on more than 350,000 patients at a cost of close to $20 billion. Some degree of Acute Renal Dysfunction (ARD) occurs in about 8% of patients following CABG, and dialysis-dependent renal failure occurs in 0.7% to 3.5% of patients receiving CABG. The latter is associated with substantial increases in morbidity, length of stay, and mortality (odds ratios for mortality range from 15 to 27). ARD is associated with increased morbidity, mortality and length of stay in an ICU following surgery. In addition, Acute Renal Failure occurs in 1.5% of patients undergoing any type of cardiac surgery. There has been a substantial increase in postoperative morbidity, mortality, and cost associated with this relatively common complication, regardless of whether or not this incidence varies much between providers, and there are implications of even a modest decrease in its incidence.

CLINICAL RECOMMENDATION STATEMENTS:
Acute renal failure following CABG is an intermediate outcome measure for mortality since this complication is independently associated (OR=27) with early mortality following cardiac surgery, even after adjustment for co-morbidity and postoperative complications.

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Ω Measure #168 (NQF 0115): Coronary Artery Bypass Graft (CABG): Surgical Re-Exploration

2013 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

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

INSTRUCTIONS:
This measure is to be reported each time an isolated CABG procedure is performed during the reporting period. It is anticipated that clinicians who provide services for isolated CABG will submit this measure. This measure is intended to reflect the quality of the surgical services provided for isolated CABG patients. Isolated CABG refers to CABG using arterial and/or venous grafts only.

Measure Reporting via Registry:
CPT codes and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data. There are no allowable performance exclusions for this measure.

DENOMINATOR:
All patients undergoing isolated CABG surgery

Denominator Criteria (Eligible Cases):
All patients aged ≥ 18 years on date of encounter
AND
Patient encounter during the reporting period (CPT): 33510, 33511, 33512, 33513, 33514, 33516, 33517, 33518, 33519, 33521, 33522, 33523, 33533, 33534, 33535, 33536

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

OR

Re-exploration not required due to mediastinal bleeding with or without tamponade, graft occlusion, valve dysfunction, or other cardiac reason (G8578)

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RATIONALE:
In 2000, coronary artery bypass graft (CABG) surgery was performed on more than 350,000 patients at a cost of close to $20 billion. Re-exploration after surgery is a serious complication that impacts length of stay, efficient use of resources, and increases risk for additional complications and death. As one of several major complications of cardiac surgery, repeat surgery is particularly worrisome for consumers and is an inefficient use of resources.

CLINICAL RECOMMENDATION STATEMENTS:
Re-exploration after surgery is a serious complication that impacts length of stay, efficient use of resources, and increases risk for additional complications and death. This measure is currently in use by approximately 65% of providers in the United States who perform cardiac surgery and report data to the STS National Database.

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Ω Measure #169 (NQF 0116): Coronary Artery Bypass Graft (CABG): Antiplatelet Medications at Discharge

2013 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Percentage of patients aged 18 years and older undergoing isolated CABG surgery who were discharged on antiplatelet medication

INSTRUCTIONS:
This measure is to be reported each time an isolated CABG procedure is performed during the reporting period. It is anticipated that clinicians who provide services for isolated CABG will submit this measure. This measure is intended to reflect the quality of the surgical services provided for isolated CABG patients. Isolated CABG refers to CABG using arterial and/or venous grafts only.

Measure Reporting via Registry:
CPT codes and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All patients undergoing isolated CABG surgery

Denominator Criteria (Eligible Cases):
All patients aged ≥ 18 years on date of encounter
AND
Patient encounter during the reporting period (CPT): 33510, 33511, 33512, 33513, 33514, 33516, 33517, 33518, 33519, 33521, 33522, 33523, 33533, 33534, 33535, 33536
AND
Patient not deceased prior to discharge

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)

RATIONALE:
Use of aspirin soon after coronary artery bypass graft (CABG) is associated with reduced risk of death and ischemic complications involving the heart, brain, kidneys, and gastrointestinal tract. High-risk patients now represent the majority of patients who undergo bypass surgery, giving rise to rates of 15% or higher for complications affecting heart, brain, kidneys, and intestines.

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Guidelines from the American College of Chest Physicians recommend the administration of aspirin soon after CABG, specifically 325 mg per day starting six hours after surgery.

CLINICAL RECOMMENDATION STATEMENTS:

Evidence-based discharge therapies are underutilized in older patients who underwent CABG during hospitalization for acute myocardial infarction.

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Ω Measure #170 (NQF 0117): Coronary Artery Bypass Graft (CABG): Beta-Blockers Administered at Discharge

2013 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

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

INSTRUCTIONS:
This measure is to be reported each time an isolated CABG procedure is performed during the reporting period. It is anticipated that clinicians who provide services for isolated CABG will submit this measure. This measure is intended to reflect the quality of the surgical services provided for isolated CABG patients. Isolated CABG refers to CABG using arterial and/or venous grafts only.

Measure Reporting via Registry:
CPT codes and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All patients undergoing isolated CABG surgery

Denominator Criteria (Eligible Cases):
All patients aged ≥ 18 years on date of encounter
AND
Patient encounter during the reporting period (CPT): 33510, 33511, 33512, 33513, 33514, 33516, 33517, 33518, 33519, 33521, 33522, 33523, 33533, 33534, 33535, 33536
AND
Patient not deceased prior to discharge

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)

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RATIONALE:
Upwards of 70% of patients who undergo revascularization procedures have had a myocardial infarction (MI). Cumulative evidence and randomized trials indicate that patients with a previous MI live longer if they are on beta blockers. For many years, patients were taken off beta-blocker medications in preparation for surgery. Evidence from the STS National Database demonstrated that beta blocker use is safe and effective in many CABG patients previously thought to be at high risk for adverse events of beta blocker therapy (women, elderly, diabetes, congestive heart failure). In addition, the use of post-operative b-blockers is now known to protect patients both at one year and long term (greater than 5 years) from death following cardiac surgery. This effect is associated with a 46 % risk reduction in death at one year and 35% risk reduction in mortality during long-term follow-up (Chan et al., 2012).

CLINICAL RECOMMENDATION STATEMENTS:
Beta blockade reduces atrial fibrillation complications following CABG. At four to five years, survival was approximately 13% worse in patients who developed postoperative atrial fibrillation ($p < 0.001$).

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Ω Measure #171 (NQF 0118): Coronary Artery Bypass Graft (CABG): Anti-Lipid Treatment at Discharge

2013 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

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

INSTRUCTIONS:
This measure is to be reported each time an isolated CABG procedure is performed during the reporting period. It is anticipated that clinicians who provide services for isolated CABG will submit this measure. This measure is intended to reflect the quality of the surgical services provided for isolated CABG patients. Isolated CABG refers to CABG using arterial and/or venous grafts only.

Measure Reporting via Registry:
CPT codes and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All patients undergoing isolated CABG surgery

Denominator Criteria (Eligible Cases):
All patients aged ≥ 18 years on date of encounter
AND
Patient encounter during the reporting period (CPT): 33510, 33511, 33512, 33513, 33514, 33516, 33517, 33518, 33519, 33521, 33522, 33523, 33533, 33534, 33535, 33536
AND
Patient not deceased prior to discharge

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)

RATIONALE:
Atherosclerosis is a chronic disease. Events such as acute myocardial infarction (AMI) and coronary artery bypass graft (CABG) surgery identify patients with the disease, but acute therapy is not sufficient for optimal long-term outcomes. In post-bypass patients, atherosclerosis continues to progress in the native circulation and develops at an accelerated rate in saphenous vein bypass grafts. Management of the chronic disease is critically important in patients with atherosclerosis, such as those undergoing CABG.

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The advantages of adherence to the American College of Cardiology/American Heart Association "Get with the Guidelines" program are discussed in a recent article, which also demonstrates both variation in quality and opportunity for improvement (38% compliance with guidelines before program implementation, 98.4% compliance thereafter). The article also discusses educational and process measures used by a major medical center to achieve compliance.

CLINICAL RECOMMENDATION STATEMENTS:

Compliance rates for patients receiving personalized follow-up for lipid management over two years were significantly better than in the control group. Lipid lowering in coronary heart disease has been demonstrated distinctively through three trials (CLAS, post-CABG, and CARE) to delay the progression of atherosclerosis and/or reduce deaths, and non- fatal MI following bypass surgery. Aggressive (low-density lipoprotein [LDL]) cholesterol-lowering treatment (target < 85 mg/dL) was correlated to a slower rate of disease progression (31%) after 4-5 years in comparison to the control group, which was comprised of patients receiving moderate lipid- lowering treatment (target < 130 to 140 mg/dL).

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✦ Measure #172 (NQF 0259): Hemodialysis Vascular Access Decision-Making by Surgeon to Maximize Placement of Autogenous Arterial Venous (AV) Fistula

2013 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of patients aged 18 years and older with a diagnosis of advanced Chronic Kidney Disease (CKD) (stage 4 or 5) or End Stage Renal Disease (ESRD) requiring hemodialysis vascular access documented by surgeon to have received autogenous AV fistula

INSTRUCTIONS:
This measure is to be reported each time a procedure for hemodialysis access is performed during the reporting period. It is anticipated that clinicians who perform the listed surgical procedures as specified in the denominator coding will submit this measure.

Measure Reporting via Claims:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. G-codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed ICD-9-CM diagnosis codes, CPT code, and the appropriate numerator G-code. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All patients with advanced CKD or ESRD who undergo open surgical placement of permanent hemodialysis access

> Denominator Criteria (Eligible Cases):
> Patients aged ≥ 18 years on date of encounter
> AND
> Diagnosis for stage 4 or 5 CKD or ESRD (ICD-9-CM): 585.3, 585.4, 585.5, 585.6, 996.73
> Diagnosis for stage 4 or 5 CKD or ESRD (ICD-10-CM) [REFERENCE ONLY/Not Reportable]: N18.3, N18.4, N18.5, N18.6, T82.818A, T82.828A, T82.838A, T82.848A, T82.858A, T82.868A, T82.898A
> AND
> Patient encounter during the reporting period (CPT): 36818, 36819, 36820, 36821, 36825, 36830

NUMERATOR:
Patients diagnosed with advanced CKD or ESRD requiring hemodialysis vascular access as documented by the surgeon

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Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Autogenous AV Fistula Performed
G8530: Autogenous AV fistula received

OR

Autogenous AV Fistula not Performed for Documented Reasons
G8531: Clinician documented that patient was not an eligible candidate for autogenous AV fistula

OR

Autogenous AV Fistula not Performed, Reason not Given
G8532: Clinician documented that patient received vascular access other than autogenous AV fistula, reason not given

RATIONALE:
AV access complications account for more than 15% of hospital admissions among hemodialysis patients. As the number of patients in need of chronic hemodialysis increases—estimated at 10% per year starting at a base population of 345,000 in 2000 – the cost to the health care system of dialysis access-related complications will increase proportionally.

CLINICAL RECOMMENDATION STATEMENTS:
For the surgeon, the most directly measurable performance parameter is the percentage of autogenous accesses placed as a proportion of the total number of accesses, (autogenous and prosthetic) placed by the particular surgeon.

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

2013 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

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

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for patients seen during the reporting period. This measure is intended to determine whether or not all patients aged 18 years and older were screened for unhealthy alcohol use during the reporting period. There is no diagnosis associated with this measure. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

Measure Reporting via Claims:
CPT or HCPCS codes, and patient demographics are used to identify patients who are included in the measure's denominator. CPT Category II codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed CPT or HCPCS codes and the appropriate CPT Category II code OR the CPT Category II code(s) with the modifier. The modifiers allowed for this measure are: 1P- medical reason, 8P- reason not otherwise specified. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
CPT or HCPCS codes, and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All patients aged 18 years and older

> Denominator Criteria (Eligible Cases):
> Patients aged ≥ 18 years on date of encounter
> AND
> Patient encounter during the reporting period (CPT or HCPCS): 90791, 90792, 90832, 90834, 90837, 90839, 90845, 96150, 96152, 97003, 97004, 97802, 97803, 97804, 98960, 98961, 98962, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, G0270, G0271, G0438, G0439

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

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

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Unhealthy Alcohol Use Screening Performed
CPT II 3016F: Patient screened for unhealthy alcohol use using a systematic screening method

OR

Unhealthy Alcohol Use Screening not Performed, for Medical Reasons
Append a modifier (1P) to CPT Category II code 3016F to report documented circumstances that appropriately exclude patients from the denominator.
3016F *with* 1P: Documentation of medical reason(s) for not screening for unhealthy alcohol use (eg, limited life expectancy, other medical reasons)

OR

Unhealthy Alcohol Use Screening not Performed, Reason not Otherwise 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

RATIONALE:
Screening for unhealthy alcohol use can identify patients whose habits may put them at risk for adverse health outcomes due to their alcohol use. While this measure does not require counseling for those patients to be found at risk, brief counseling interventions for unhealthy alcohol use have shown to be effective in reducing alcohol use. It would be expected that if a provider found their patient to be at risk after screening that intervention would be provided.

A systematic method of assessing for unhealthy alcohol use should be utilized. Please refer to the National Institute on Alcohol Abuse and Alcoholism publication: *Helping Patients Who Drink Too Much: A Clinician's Guide* for additional information regarding systematic screening methods.

CLINICAL RECOMMENDATION STATEMENTS:
The USPSTF strongly recommends screening and behavioral counseling interventions to reduce alcohol misuse by adults, including pregnant women, in primary care settings. (B Recommendation) (USPSTF, 2004)

During new patient encounters and at least annually, patients in general and mental healthcare settings should be screened for at-risk drinking, alcohol use problems and illnesses, and any tobacco use. (NQF, 2007)

All patients identified with alcohol use in excess of National Institute on Alcohol Abuse and Alcoholism guidelines and/or any tobacco use should receive brief motivational counseling intervention by a healthcare worker trained in this technique. (NQF, 2007)

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

2013 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

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)

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for all RA patients who are being considered or prescribed a first course of biologic disease-modifying anti-rheumatic drug therapy. It is anticipated that clinicians who provide care for patients with a diagnosis of RA will submit this measure.

Measure Reporting via Claims:
ICD-9-CM diagnosis codes, CPT or HCPCS codes, and patient demographics are used to identify patients who are included in the measure's denominator. CPT Category II codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed ICD-9-CM diagnosis codes, CPT or HCPCS codes, and the appropriate CPT Category II codes OR the CPT Category II code(s) with the modifier. The modifiers allowed for this measure are: 1P- medical reasons, 8P- reason not otherwise specified. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT or HCPCS codes, and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All patients aged 18 years and older with a diagnosis of rheumatoid arthritis (RA) who are receiving a first course of therapy using a biologic DMARD

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Diagnosis for rheumatoid arthritis (RA) (ICD-9-CM): 714.0, 714.1, 714.2, 714.81
Diagnosis for rheumatoid arthritis (RA) (ICD-10-CM) [REFERENCE ONLY/Not Reportable]: M05.00, M05.011, M05.012, M05.019, M05.021, M05.022, M05.029, M05.031, M05.032, M05.039, M05.041, M05.042, M05.049, M05.051, M05.052, M05.059, M05.061, M05.062, M05.069, M05.071, M05.072, M05.079, M05.09, M05.111, M05.112, M05.119, M05.121, M05.122, M05.129, M05.131, M05.132, M05.139, M05.141, M05.142, M05.149, M05.151, M05.152, M05.159, M05.161, M05.162, M05.169, M05.171, M05.172, M05.179, M05.19, M05.20, M05.211, M05.212, M05.219, M05.221, M05.222, M05.229, M05.231, M05.232, M05.239, M05.241, M05.242, M05.249, M05.251, M05.252, M05.259, M05.261, M05.262, M05.269, M05.271, M05.272, M05.279, M05.29, M05.30, M05.311, M05.312, M05.319, M05.321, M05.322, M05.329, M05.331, M05.332, M05.339, M05.341, M05.342, M05.349, M05.351, M05.352,

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M05.359, M05.361, M05.362, M05.369, M05.371, M05.372, M05.379, M05.39, M05.40, M05.411, M05.412, M05.419, M05.421, M05.422, M05.429, M05.431, M05.432, M05.439, M05.441, M05.442, M05.449, M05.451, M05.452, M05.459, M05.461, M05.462, M05.469, M05.471, M05.472, M05.479, M05.49, M05.50, M05.511, M05.512, M05.519, M05.521, M05.522, M05.529, M05.531, M05.532, M05.539, M05.541, M05.542, M05.549, M05.551, M05.552, M05.559, M05.561, M05.562, M05.569, M05.571, M05.572, M05.579, M05.59, M05.60, M05.611, M05.612, M05.619, M05.621, M05.622, M05.629, M05.631, M05.632, M05.639, M05.641, M05.642, M05.649, M05.651, M05.652, M05.659, M05.661, M05.662, M05.669, M05.671, M05.672, M05.679, M05.69, M05.70, M05.711, M05.712, M05.719, M05.721, M05.722, M05.729, M05.731, M05.732, M05.739, M05.741, M05.742, M05.749, M05.751, M05.752, M05.759, M05.761, M05.762, M05.769, M05.771, M05.772, M05.779, M05.79, M05.80, M05.811, M05.812, M05.819, M05.821, M05.822, M05.829, M05.831, M05.832, M05.839, M05.841, M05.842, M05.849, M05.851, M05.852, M05.859, M05.861, M05.862, M05.869, M05.871, M05.872, M05.879, M05.89, M05.9, M06.00, M06.011, M06.012, M06.019, M06.021, M06.022, M06.029, M06.031, M06.032, M06.039, M06.041, M06.042, M06.049, M06.051, M06.052, M06.059, M06.061, M06.062, M06.069, M06.071, M06.072, M06.079, M06.08, M06.09, M06.1, M06.30, M06.311, M06.312, M06.319, M06.321, M06.322, M06.329, M06.331, M06.332, M06.339, M06.341, M06.342, M06.349, M06.351, M06.352, M06.359, M06.361, M06.362, M06.369, M06.371, M06.372, M06.379, M06.38, M06.39

AND

Patient encounter during the reporting period (CPT or HCPCS): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, G0402

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 Adalimunab, 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

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TB Screening not Performed or Results not Interpreted for Medical Reasons
(Two CPT II codes [3455F-1P & 4195F] are required on the claim form to submit this numerator option)
Append a modifier (1P) to CPT Category II code 3455F to report documented circumstances that appropriately exclude patients from the denominator.
3455F *with* 1P: Documentation of medical reason for not screening for TB or interpreting results (i.e., patient positive for TB and documentation of past treatment; patient has recently completed a course of anti-TB therapy)
AND
CPT II 4195F: Patient receiving first-time biologic disease modifying anti-rheumatic drug therapy for rheumatoid arthritis

OR

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 Otherwise 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

RATIONALE:
Before initiating biologic DMARDs for a patient with RA, it is essential to screen the patient for tuberculosis, as research has documented a higher incidence of TB after anti-TNFα therapy. All patients being considered for biologic DMARD should receive a tuberculin skin test, even if the patient has previously received the BCG vaccination. Test results, in addition to patient risk for TB and other tests, should be used to assess the patient's risk for latent TB infection. This is a patient safety measure.

CLINICAL RECOMMENDATION STATEMENTS:
The American College of Rheumatology's updated Recommendations for the use of nonbiologic and biologic therapies in RA recommend routine tuberculosis screening to identify latent TB infection (LTBI) in patients being considered for therapy with biologics. The evidence for TB testing is based on a documented higher incidence of TB following ant-TNFα therapy. To begin, clinicians should ask all RA patients being considered for biologic DMARDs about their potential risk factors for TB infection (see below) and, irrespective of prior Bacillus-Calmette-Guérin (BCG) vaccination, use a Tuberculin Skin Test (TST) as a diagnostic aid to assess their patient's probability of latent TB infection.

In addition to the ACR recommendations, guidelines from the British Society for Rheumatology have consistent recommendations. There have been a large number of cases of tuberculosis (TB) reported in association with the use of infliximab, and studies that demonstrate a significantly higher rate of TB in patients on this treatment compared with controls. Cases of TB have also been reported in association with etanercept and adalimumab. Reactivation of latent TB is highest in the first 12 months of treatment, so particular vigilance is required during this time. With infliximab, the majority of cases occurred within three cycles of treatment, with a median of 12 weeks after

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starting treatment, suggesting reactivation of latent TB as the main factor predisposing to TB in these cases. The following are the British Society for Rheumatology's recommended guidelines for patients with RA: Prior to commencing treatment with anti-TNF, all patients should be screened for TB in accordance with the British Thoracic Society (BTS) guidelines. Active TB needs to be adequately treated before anti-TNF therapy can be started; prior to commencing anti-TNF therapy, consideration of prophylactic anti-TB therapy (as directed by the BTS guidelines) should be given to patients with evidence of potential latent disease (past history of TB treatment or abnormal chest X-ray raising the possibility of TB) after consultation with a local TB specialist; all patients commenced on anti-TNF therapies need to be closely monitored for TB.

This needs to continue for 6 months after discontinuing infliximab treatment due to the prolonged elimination phase of infliximab; patients on anti-TNF therapy who develop symptoms suggestive of TB should receive full anti-TB chemotherapy, but may continue with their anti-TNF therapy if it is clinically indicated; anti-TNF therapy should only be resumed in accordance with the BTS guidelines and after agreement in collaboration with a TB specialist. (Level of Evidence C)

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

2013 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

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

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for patients with RA seen during the reporting period. While there are disease activity assessment tools and instruments used as examples in this measure, they are not required. The intent of this measure is to promote physician assessment of the level of RA disease activity to inform treatment decisions. It is anticipated that clinicians who provide care for patients with a diagnosis of RA will submit this measure.

Measure Reporting via Claims:
ICD-9-CM diagnosis codes, CPT or HCPCS codes, and patient demographics are used to identify patients who are included in the measure's denominator. CPT Category II codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed ICD-9-CM diagnosis codes, CPT or HCPCS codes, and the appropriate CPT Category II codes OR the CPT Category II code(s) with the modifier. The reporting modifier allowed for this measure is: 8P- reason not otherwise specified. There are no allowable performance exclusions for this measure. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT or HCPCS codes, and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data. There are no allowable performance exclusions for this measure.

DENOMINATOR:
All patients aged 18 years and older with a diagnosis of rheumatoid arthritis (RA)

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Diagnosis for rheumatoid arthritis (RA) (ICD-9-CM): 714.0, 714.1, 714.2, 714.81
Diagnosis for rheumatoid arthritis (RA) (ICD-10-CM) [REFERENCE ONLY/Not Reportable]: M05.00, M05.011, M05.012, M05.019, M05.021, M05.022, M05.029, M05.031, M05.032, M05.039, M05.041, M05.042, M05.049, M05.051, M05.052, M05.059, M05.061, M05.062, M05.069, M05.071, M05.072, M05.079, M05.09, M05.111, M05.112, M05.119, M05.121, M05.122, M05.129, M05.131, M05.132, M05.139, M05.141, M05.142, M05.149, M05.151, M05.152, M05.159, M05.161, M05.162, M05.169, M05.171, M05.172, M05.179, M05.19, M05.20, M05.211, M05.212, M05.219, M05.221, M05.222, M05.229, M05.231, M05.232, M05.239, M05.241, M05.242, M05.249, M05.251, M05.252, M05.259, M05.261, M05.262, M05.269, M05.271, M05.272, M05.279, M05.29, M05.30, M05.311, M05.312, M05.319, M05.321,

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M05.322, M05.329, M05.331, M05.332, M05.339, M05.341, M05.342, M05.349, M05.351, M05.352, M05.359, M05.361, M05.362, M05.369, M05.371, M05.372, M05.379, M05.39, M05.40, M05.411, M05.412, M05.419, M05.421, M05.422, M05.429, M05.431, M05.432, M05.439, M05.441, M05.442, M05.449, M05.451, M05.452, M05.459, M05.461, M05.462, M05.469, M05.471, M05.472, M05.479, M05.49, M05.50, M05.511, M05.512, M05.519, M05.521, M05.522, M05.529, M05.531, M05.532, M05.539, M05.541, M05.542, M05.549, M05.551, M05.552, M05.559, M05.561, M05.562, M05.569, M05.571, M05.572, M05.579, M05.59, M05.60, M05.611, M05.612, M05.619, M05.621, M05.622, M05.629, M05.631, M05.632, M05.639, M05.641, M05.642, M05.649, M05.651, M05.652, M05.659, M05.661, M05.662, M05.669, M05.671, M05.672, M05.679, M05.69, M05.70, M05.711, M05.712, M05.719, M05.721, M05.722, M05.729, M05.731, M05.732, M05.739, M05.741, M05.742, M05.749, M05.751, M05.752, M05.759, M05.761, M05.762, M05.769, M05.771, M05.772, M05.779, M05.79, M05.80, M05.811, M05.812, M05.819, M05.821, M05.822, M05.829, M05.831, M05.832, M05.839, M05.841, M05.842, M05.849, M05.851, M05.852, M05.859, M05.861, M05.862, M05.869, M05.871, M05.872, M05.879, M05.89, M05.9, M06.00, M06.011, M06.012, M06.019, M06.021, M06.022, M06.029, M06.031, M06.032, M06.039, M06.041, M06.042, M06.049, M06.051, M06.052, M06.059, M06.061, M06.062, M06.069, M06.071, M06.072, M06.079, M06.08, M06.09, M06.1, M06.30, M06.311, M06.312, M06.319, M06.321, M06.322, M06.329, M06.331, M06.332, M06.339, M06.341, M06.342, M06.349, M06.351, M06.352, M06.359, M06.361, M06.362, M06.369, M06.371, M06.372, M06.379, M06.38, M06.39

AND

Patient encounter during the reporting period (CPTor HCPCS): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, G0402

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 Otherwise 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.

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

RATIONALE:

After establishing a diagnosis of RA, risk assessment is crucial for guiding optimal treatment. For the purposes of selecting therapies, physicians should consider the patient's disease activity at the time of the treatment decisions.

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CLINICAL RECOMMENDATION STATEMENTS:

Several indices to measure RA disease activity have been developed each of which has advantages and disadvantages. Evidence-based guidelines require clear definitions of disease activity to make rational therapeutic choices, but it is not possible or appropriate to mandate use of a single disease activity score for the individual physician, and different studies have used different definitions. Therefore, the TFP was asked to consider a combined estimation of disease activity, which allowed reference to many past definitions. With these instruments as our guide, we rated RA disease activity in an ordinal manner as low, moderate, or high, as previously requested by the CEP.

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

2013 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

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

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for patients with RA seen during the reporting period. It is anticipated that clinicians who provide care for patients with a diagnosis of RA will submit this measure.

Measure Reporting via Claims:
ICD-9-CM diagnosis codes, CPT or HCPCS codes, and patient demographics are used to identify patients who are included in the measure's denominator. CPT Category II codes can be used to report the numerator of the measure.

When reporting the measure via claims, submit the listed ICD-9-CM diagnosis codes, CPT or HCPCS codes, and the appropriate CPT Category II codes OR the CPT Category II code(s) with the modifier. The reporting modifier allowed for this measure is: 8P- reason not otherwise specified. There are no allowable performance exclusions for this measure. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT or HCPCS codes, and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data. There are no allowable performance exclusions for this measure.

DENOMINATOR:
All patients aged 18 years and older with a diagnosis of rheumatoid arthritis (RA)

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Diagnosis for rheumatoid arthritis (RA) (ICD-9-CM): 714.0, 714.1, 714.2, 714.81
Diagnosis for rheumatoid arthritis (RA) (ICD-10-CM) [REFERENCE ONLY/Not Reportable]: M05.00, M05.011, M05.012, M05.019, M05.021, M05.022, M05.029, M05.031, M05.032, M05.039, M05.041, M05.042, M05.049, M05.051, M05.052, M05.059, M05.061, M05.062, M05.069, M05.071, M05.072, M05.079, M05.09, M05.111, M05.112, M05.119, M05.121, M05.122, M05.129, M05.131, M05.132, M05.139, M05.141, M05.142, M05.149, M05.151, M05.152, M05.159, M05.161, M05.162, M05.169, M05.171, M05.172, M05.179, M05.19, M05.20, M05.211, M05.212, M05.219, M05.221, M05.222, M05.229, M05.231, M05.232, M05.239, M05.241, M05.242, M05.249, M05.251, M05.252, M05.259, M05.261, M05.262, M05.269, M05.271, M05.272, M05.279, M05.29, M05.30, M05.311, M05.312, M05.319, M05.321, M05.322, M05.329, M05.331, M05.332, M05.339, M05.341, M05.342, M05.349, M05.351, M05.352, M05.359, M05.361, M05.362, M05.369, M05.371, M05.372, M05.379, M05.39, M05.40, M05.411, M05.412,

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M05.419, M05.421, M05.422, M05.429, M05.431, M05.432, M05.439, M05.441, M05.442, M05.449, M05.451, M05.452, M05.459, M05.461, M05.462, M05.469, M05.471, M05.472, M05.479, M05.49, M05.50, M05.511, M05.512, M05.519, M05.521, M05.522, M05.529, M05.531, M05.532, M05.539, M05.541, M05.542, M05.549, M05.551, M05.552, M05.559, M05.561, M05.562, M05.569, M05.571, M05.572, M05.579, M05.59, M05.60, M05.611, M05.612, M05.619, M05.621, M05.622, M05.629, M05.631, M05.632, M05.639, M05.641, M05.642, M05.649, M05.651, M05.652, M05.659, M05.661, M05.662, M05.669, M05.671, M05.672, M05.679, M05.69, M05.70, M05.711, M05.712, M05.719, M05.721, M05.722, M05.729, M05.731, M05.732, M05.739, M05.741, M05.742, M05.749, M05.751, M05.752, M05.759, M05.761, M05.762, M05.769, M05.771, M05.772, M05.779, M05.79, M05.80, M05.811, M05.812, M05.819, M05.821, M05.822, M05.829, M05.831, M05.832, M05.839, M05.841, M05.842, M05.849, M05.851, M05.852, M05.859, M05.861, M05.862, M05.869, M05.871, M05.872, M05.879, M05.89, M05.9, M06.00, M06.011, M06.012, M06.019, M06.021, M06.022, M06.029, M06.031, M06.032, M06.039, M06.041, M06.042, M06.049, M06.051, M06.052, M06.059, M06.061, M06.062, M06.069, M06.071, M06.072, M06.079, M06.08, M06.09, M06.1, M06.30, M06.311, M06.312, M06.319, M06.321, M06.322, M06.329, M06.331, M06.332, M06.339, M06.341, M06.342, M06.349, M06.351, M06.352, M06.359, M06.361, M06.362, M06.369, M06.371, M06.372, M06.379, M06.38, M06.39

AND

Patient encounter during the reporting period (CPT or HCPCS): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, G0402

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 Otherwise 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

RATIONALE:

Functional limitations are a significant and disruptive complication for patients living with RA. Assessments of functional limitations are used to assess prognosis and guide treatment and therapy decisions. Functional status should be assessed at the baseline and each follow-up visit, using questionnaires such as the ACR's Classification of Functional Status in RA or the Health Assessment Questionnaire or an assessment of activities of daily living. Regardless of the assessment tool used, it should indicate whether a functional decline is due to inflammation, mechanical damage, or both, as treatment strategies will vary accordingly.

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CLINICAL RECOMMENDATION STATEMENTS:

The management of RA is an iterative process, and patients should be periodically reassessed for evidence of disease or limitation of function with significant alteration of joint anatomy. Baseline evaluation of disease activity and damage in patients with rheumatoid arthritis through evaluation of functional status or quality of life assessments using standardized questionnaires, a physician's global assessment of disease activity, or patient's global assessment of disease activity. The initial evaluation of the patient with RA should document symptoms of active disease (i.e., presence of joint pain, duration of morning stiffness, degree of fatigue), functional status, objective evidence of disease activity (i.e., synovitis, as assessed by tender and swollen joint counts, and the ESR or CRP level), mechanical joint problems, etc.

At each follow up visit, the physician must assess whether the disease is active or inactive. Symptoms of inflammatory (as contrasted with mechanical) joint disease, which include prolonged morning stiffness, duration of fatigue, and active synovitis on joint examination, indicate active disease and necessitate consideration of changing the treatment program. Occasionally, findings of the joint examination alone may not adequately reflect disease activity and structural damage; therefore, periodic measurements of the ESR or CRP level and functional status, as well as radiographic examinations of involved joints should be performed. It is important to determine whether a decline in function is the result of inflammation, mechanical damage, or both; treatment strategies will differ accordingly.

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

2013 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

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

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for patients with RA seen during the reporting period. It is anticipated that clinicians who provide care for patients with a diagnosis of RA will submit this measure.

Measure Reporting via Claims:
ICD-9-CM diagnosis codes, CPT or HCPCS codes, and patient demographics are used to identify patients who are included in the measure's denominator. CPT Category II codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed ICD-9-CM diagnosis codes, CPT or HCPCS codes, and the appropriate CPT Category II codes OR the CPT Category II code(s) with the modifier. The reporting modifier allowed for this measure is: 8P- reason not otherwise specified. There are no allowable performance exclusions for this measure. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT or HCPCS codes, and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data. There are no allowable performance exclusions for this measure.

DENOMINATOR:
All patients aged 18 years and older with a diagnosis of rheumatoid arthritis (RA)

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Diagnosis for rheumatoid arthritis (RA) (ICD-9-CM): 714.0, 714.1, 714.2, 714.81
Diagnosis for rheumatoid arthritis (RA) (ICD-10-CM) [REFERENCE ONLY/Not Reportable]: M05.00, M05.011, M05.012, M05.019, M05.021, M05.022, M05.029, M05.031, M05.032, M05.039, M05.041, M05.042, M05.049, M05.051, M05.052, M05.059, M05.061, M05.062, M05.069, M05.071, M05.072, M05.079, M05.09, M05.111, M05.112, M05.119, M05.121, M05.122, M05.129, M05.131, M05.132, M05.139, M05.141, M05.142, M05.149, M05.151, M05.152, M05.159, M05.161, M05.162, M05.169, M05.171, M05.172, M05.179, M05.19, M05.20, M05.211, M05.212, M05.219, M05.221, M05.222, M05.229, M05.231, M05.232, M05.239, M05.241, M05.242, M05.249, M05.251, M05.252, M05.259, M05.261, M05.262, M05.269, M05.271, M05.272, M05.279, M05.29, M05.30, M05.311, M05.312, M05.319, M05.321, M05.322, M05.329, M05.331, M05.332, M05.339, M05.341, M05.342, M05.349, M05.351, M05.352, M05.359, M05.361, M05.362, M05.369, M05.371, M05.372, M05.379, M05.39, M05.40, M05.411, M05.412,

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M05.419, M05.421, M05.422, M05.429, M05.431, M05.432, M05.439, M05.441, M05.442, M05.449, M05.451, M05.452, M05.459, M05.461, M05.462, M05.469, M05.471, M05.472, M05.479, M05.49, M05.50, M05.511, M05.512, M05.519, M05.521, M05.522, M05.529, M05.531, M05.532, M05.539, M05.541, M05.542, M05.549, M05.551, M05.552, M05.559, M05.561, M05.562, M05.569, M05.571, M05.572, M05.579, M05.59, M05.60, M05.611, M05.612, M05.619, M05.621, M05.622, M05.629, M05.631, M05.632, M05.639, M05.641, M05.642, M05.649, M05.651, M05.652, M05.659, M05.661, M05.662, M05.669, M05.671, M05.672, M05.679, M05.69, M05.70, M05.711, M05.712, M05.719, M05.721, M05.722, M05.729, M05.731, M05.732, M05.739, M05.741, M05.742, M05.749, M05.751, M05.752, M05.759, M05.761, M05.762, M05.769, M05.771, M05.772, M05.779, M05.79, M05.80, M05.811, M05.812, M05.819, M05.821, M05.822, M05.829, M05.831, M05.832, M05.839, M05.841, M05.842, M05.849, M05.851, M05.852, M05.859, M05.861, M05.862, M05.869, M05.871, M05.872, M05.879, M05.89, M05.9, M06.00, M06.011, M06.012, M06.019, M06.021, M06.022, M06.029, M06.031, M06.032, M06.039, M06.041, M06.042, M06.049, M06.051, M06.052, M06.059, M06.061, M06.062, M06.069, M06.071, M06.072, M06.079, M06.08, M06.09, M06.1, M06.30, M06.311, M06.312, M06.319, M06.321, M06.322, M06.329, M06.331, M06.332, M06.339, M06.341, M06.342, M06.349, M06.351, M06.352, M06.359, M06.361, M06.362, M06.369, M06.371, M06.372, M06.379, M06.38, M06.39

AND

Patient encounter during the reporting period (CPT or HCPCS): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, G0402

NUMERATOR:

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

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

Definitions:

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

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

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Disease Prognosis Assessed and Classified

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

OR

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

OR

Disease Prognosis not Assessed and Classified, Reason not Otherwise 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

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RATIONALE:
After establishing a diagnosis of RA, risk assessment is crucial for guiding optimal treatment. For the purposes of selecting therapies, physicians should consider the presence of these prognostic factors at the time of the treatment decisions.

CLINICAL RECOMMENDATION STATEMENTS:
Important clinical markers of disease prognosis were reviewed by a recent expert panel convened by the American College of Rheumatology as part of an effort to update clinical recommendations. The American College of Rheumatology 2008 Recommendations for the Use of Nonbiologic and Biologic Therapies in Rheumatoid Arthritis were published in Arthritis & Rheumatism, June 2008.

Poor prognosis is suggested by earlier age at disease onset, high titer of RF, elevated ESR, and swelling of > 20 joints. Extraarticular manifestations of RA, such as rheumatoid nodules, Sjogren's syndrome, episcleritis and scleritis, interstitial lung disease, pericardial involvement, systemic vasculitis, and Felty's syndrome, may also indicate a worse prognosis. Since studies have demonstrated that treatment with DMARDs may alter the disease course in patients with recent-onset RA, particularly those with unfavorable prognostic factors, aggressive treatment should be initiated as soon as the diagnosis has been established. (Level C evidence)

Assessment of prognosis should be performed at baseline, before starting medications, to assess organ dysfunction due to comorbid diseases. The literature agrees that a thorough assessment includes recording a complete blood cell count, electrolyte levels, creatinine levels, hepatic enzyme levels (AST – aspartate aminotransferase, ALT – alanine aminotransferase, and albumin), and performing a urinalysis and stool guaiac. If necessary prognosis at baseline should rule out other diseases; this may be repeated during disease flares to rule out septic arthritis through synovial fluid analysis. (Level C evidence)

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

2013 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

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 ≥ 10 mg daily (or equivalent) with improvement or no change in disease activity, documentation of glucocorticoid management plan within 12 months

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for patients with RA seen during the reporting period. It is anticipated that clinicians who provide care for patients with a diagnosis of RA will submit this measure.

Measure Reporting via Claims:
ICD-9-CM diagnosis codes, CPT or HCPCS codes, and patient demographics are used to identify patients who are included in the measure's denominator. CPT Category II codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed ICD-9-CM diagnosis codes, CPT or HCPCS codes, and the appropriate CPT Category II code(s) OR the CPT Category II code(s) with the modifier. The modifiers allowed for this measure are: 1P- medical reasons, 8P- reason not otherwise specified. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT or HCPCS codes, and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All patients aged 18 years and older with a diagnosis of rheumatoid arthritis (RA)

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Diagnosis for rheumatoid arthritis (RA) (ICD-9-CM): 714.0, 714.1, 714.2, 714.81
Diagnosis for rheumatoid arthritis (RA) (ICD-10-CM) [REFERENCE ONLY/Not Reportable]: M05.00, M05.011, M05.012, M05.019, M05.021, M05.022, M05.029, M05.031, M05.032, M05.039, M05.041, M05.042, M05.049, M05.051, M05.052, M05.059, M05.061, M05.062, M05.069, M05.071, M05.072, M05.079, M05.09, M05.111, M05.112, M05.119, M05.121, M05.122, M05.129, M05.131, M05.132, M05.139, M05.141, M05.142, M05.149, M05.151, M05.152, M05.159, M05.161, M05.162, M05.169, M05.171, M05.172, M05.179, M05.19, M05.20, M05.211, M05.212, M05.219, M05.221, M05.222, M05.229, M05.231, M05.232, M05.239, M05.241, M05.242, M05.249, M05.251, M05.252, M05.259, M05.261, M05.262, M05.269, M05.271, M05.272, M05.279, M05.29, M05.30, M05.311, M05.312, M05.319, M05.321, M05.322, M05.329, M05.331, M05.332, M05.339, M05.341, M05.342, M05.349, M05.351, M05.352, M05.359, M05.361, M05.362, M05.369, M05.371, M05.372, M05.379, M05.39, M05.40, M05.411, M05.412,

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M05.419, M05.421, M05.422, M05.429, M05.431, M05.432, M05.439, M05.441, M05.442, M05.449, M05.451, M05.452, M05.459, M05.461, M05.462, M05.469, M05.471, M05.472, M05.479, M05.49, M05.50, M05.511, M05.512, M05.519, M05.521, M05.522, M05.529, M05.531, M05.532, M05.539, M05.541, M05.542, M05.549, M05.551, M05.552, M05.559, M05.561, M05.562, M05.569, M05.571, M05.572, M05.579, M05.59, M05.60, M05.611, M05.612, M05.619, M05.621, M05.622, M05.629, M05.631, M05.632, M05.639, M05.641, M05.642, M05.649, M05.651, M05.652, M05.659, M05.661, M05.662, M05.669, M05.671, M05.672, M05.679, M05.69, M05.70, M05.711, M05.712, M05.719, M05.721, M05.722, M05.729, M05.731, M05.732, M05.739, M05.741, M05.742, M05.749, M05.751, M05.752, M05.759, M05.761, M05.762, M05.769, M05.771, M05.772, M05.779, M05.79, M05.80, M05.811, M05.812, M05.819, M05.821, M05.822, M05.829, M05.831, M05.832, M05.839, M05.841, M05.842, M05.849, M05.851, M05.852, M05.859, M05.861, M05.862, M05.869, M05.871, M05.872, M05.879, M05.89, M05.9, M06.00, M06.011, M06.012, M06.019, M06.021, M06.022, M06.029, M06.031, M06.032, M06.039, M06.041, M06.042, M06.049, M06.051, M06.052, M06.059, M06.061, M06.062, M06.069, M06.071, M06.072, M06.079, M06.08, M06.09, M06.1, M06.30, M06.311, M06.312, M06.319, M06.321, M06.322, M06.329, M06.331, M06.332, M06.339, M06.341, M06.342, M06.349, M06.351, M06.352, M06.359, M06.361, M06.362, M06.369, M06.371, M06.372, M06.379, M06.38, M06.39

AND

Patient encounter during the reporting period (CPT or HCPCS): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, G0402

NUMERATOR:

Patients who have been assessed for glucocorticoid use and for those on prolonged doses of prednisone ≥ 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

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Glucocorticoid Use Assessed and Management Plan Documented
(Two CPT II codes [4194F & 0540F] are required on the claim form to submit this numerator option)
CPT II 4194F: Patient receiving ≥ 10 mg daily prednisone (or equivalent) for longer than 6 months, and improvement or no change in disease activity
AND
CPT II 0540F: Glucocorticoid Management Plan documented

OR

Glucocorticoid Plan not Documented for Medical Reasons
(Two CPT II codes [0540F-1P & 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 ≥ 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 Otherwise 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 Otherwise Specified
(Two CPT II codes [0540F-8P & 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 ≥ 10 mg daily prednisone (or equivalent) for longer than 6 months, and improvement or no change in disease activity

RATIONALE:
Glucocorticoids are an important part of RA treatment as they inhibit inflammation and may control synovitis. However, long-term use of glucocorticoids, especially at high doses, should be avoided, due to the potential health complications. Monitoring length and dose of glucocorticoid treatment for patients with RA is integral to making other clinical decisions.

CLINICAL RECOMMENDATION STATEMENTS:
The 1993 American College of Rheumatology guidelines acknowledge the importance of the use and the tracking of glucocorticoid as a RA symptom reliever. The benefits of low-dose systemic glucocorticoids, however, should always be weighed against their adverse effects. The adverse effects of long-term oral glucocorticoids at low doses are protean and include osteoporosis, hypertension, weight gain, fluid retention, hyperglycemia, cataracts, and skin fragility, as well as the potential for premature atherosclerosis. These adverse effects should be considered and should be discussed in detail with the patient before glucocorticoid therapy is begun. For long term disease control, the glucocorticoid dosage should be kept to a minimum. For the majority of patients with RA, this means equal or less than 10 mg of prednisone per day.

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♠ Measure #181: Elder Maltreatment Screen and Follow-Up Plan

2013 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of patients aged 65 years and older with a documented elder maltreatment screen on the date of encounter AND a documented follow-up plan on the date of positive screen

INSTRUCTIONS:
This measure is to be reported once during the reporting period for patients seen during the reporting period. This measure may be reported by eligible professionals who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding at the time of the qualifying visit. The documented follow up plan must be related to positive elder maltreatment screening, example: "Patient referred for social services due to positive elder maltreatment screening."

Measure Reporting via Claims:
CPT or HCPCS codes and patient demographics are used to identify patients who are included in the measure's denominator. G-codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed CPT or HCPCS codes, and the appropriate numerator G-code. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
CPT or HCPCS codes, and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All patients aged 65 years and older

> Denominator Criteria (Eligible Cases):
> Patients aged ≥ 65 years on date of encounter
> AND
> Patient encounter during the reporting period (CPT or HCPCS): 90791, 90792, 96116, 96150, 97003, 97802, 97803, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, G0101, G0270, G0402, G0438, G0439

NUMERATOR:
Patients with a documented elder maltreatment screen on the date of the encounter and follow-up plan documented on the date of the positive screen

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Definitions:

Screen for Elder Maltreatment – An elder maltreatment screen includes assessment and documentation of ***all*** of the following components: (1) physical abuse, (2) emotional or psychological abuse, (3) neglect (active or passive), (4) sexual abuse, (5) abandonment, (6) financial or material exploitation, (7) self-neglect, and (8) unwanted control.

Physical Abuse – Infliction of physical injury by punching, beating, kicking, biting, burning, shaking, or other actions that result in harm.

Emotional or Psychological Abuse – Involves psychological abuse, verbal abuse, or mental injury and includes acts or omissions by loved ones or caregivers that have caused or could cause serious behavioral, cognitive, emotional, or mental disorders.

Neglect – Involves attitudes of others or actions caused by others-such as family members, friends, or institutional caregivers-that have an extremely detrimental effect upon well-being.

Active – Behavior that is willful or when the caregiver intentionally withholds care or necessities. The neglect may be motivated by financial gain or reflect interpersonal conflicts.

Passive – Situations where the caregiver is unable to fulfill his or her care giving responsibilities as a result of illness, disability, stress, ignorance, lack of maturity, or lack of resources.

Sexual Abuse – The forcing of undesired sexual behavior by one person upon another against their will who are either competent or unable to fully comprehend and/or give consent. This may also be called molestation.

Elder Abandonment – Desertion of an elderly person by an individual who has assumed responsibility for providing care for an elder, or by a person with physical custody of an elder.

Financial or Material Exploitation – Taking advantage of a person for monetary gain or profit.

Self-Neglect – Self-imposed attitudes or actions that contribute to decline in the persons overall health and well being, may be associated with an inappropriate or nontraditional lifestyle. Other names used may include Diogenes syndrome (DS), aged reclusion, social breakdown, and squalor syndrome.

Unwarranted Control – Controlling a person's ability to make choices about living situations, household finances, and medical care.

Follow-Up Plan – May include but is not limited to documentation of a referral or discussion with other providers, on-going monitoring or assessment, and/or a direct intervention.

Not Eligible – A patient is not eligible if one of more of the following conditions exist:

- Patient refuses to participate
- 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:

Elder Maltreatment Screen Documented as Positive and Follow-Up Plan Documented

*(One G-code [*G873x*] is required on the claim form to submit this numerator option)*

G8733: Documentation of a positive elder maltreatment screen and documented follow-up plan at the time of the positive screen

OR

Elder Maltreatment Screen Documented as Negative, Follow-Up Plan not Required

G8734: Elder maltreatment screen documented as negative, no follow-up required

OR

Elder Maltreatment Screen not Documented, Patient not Eligible

*(One G-code [*G8535 or G8941*] is required on the claim form to submit this numerator option)*

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G8535: No documentation of an elder maltreatment screen, patient not eligible
OR
Elder Maltreatment Screen Documented, Patient not Eligible for Follow-Up
G8941: Elder Maltreatment Screen Documented, Patient not Eligible for Follow-Up

OR

Elder Maltreatment Screen not Documented, Reason not Given
(One G-code [G8536 or G8735] is required on the claim form to submit this numerator option)
G8536: No documentation of an elder maltreatment screen, reason not given
OR
Elder Maltreatment Screen Documented as Positive, Follow-Up Plan not Documented, Reason not Given
G8735: Elder maltreatment screen documented as positive, follow-up plan not documented, reason not given

RATIONALE:
Elder abuse is the infliction of physical, emotional, or psychological harm on an older adult, but also can take the form of financial exploitation or intentional or unintentional neglect of an older adult by the caregiver. Over the past ten years there has been an increase in elder abuse, which is not being identified and reported to appropriate authorities. The reasons for underreporting are two-fold: health care professionals may not ask patients if they are being abused and patients may not disclose potential or existing abuse for fear of retaliation by their caregivers (American Psychological Association (APA), 2010). In *Elder Abuse and Neglect: In Search of Solutions*, it is reported every year an estimated 2.1 million older Americans are victims of physical, psychological, or other forms of abuse and neglect and for every reported case of elder abuse and neglect there may be as many as five unreported cases. Recent research suggests that elders who have been abused tend to die earlier than those who are not abused, even in the absence of chronic conditions or life threatening disease.

One in nine seniors reported being abused, neglected or exploited in the past twelve months. Elder abuse is vastly under-reported; only one in 23.5 cases are reported to any agency; for financial abuse it is one in 44; and for neglect it is one in 57. Elder abuse victims are four times more likely to go into a nursing home (Lachs et al., 2011). Financial exploitation is extremely high, with 1 in 20 older adults indicating some form of perceived financial mistreatment occurring at least one time in the recent past. Financial exploitation by family members and by strangers was increased among the more physically disabled adults, indicating perhaps a greater need for monitoring for this subgroup of elders (Acierno et al., 2009).

In a 2010 study performed by Natan et al., more than half of nursing facility surveyed staff reported they identified abuse of elderly residents over the past year in one or more than one type of maltreatment with approximately two-thirds reporting incidents of neglect. The study further found 75% of respondents were present at incidents in which another staff member abused an elderly resident in one or more types of maltreatment, and in such situations mental abuse and mental neglect were the most prevalent forms of maltreatment.

The extent to which elder maltreatment affects the health care system is largely unknown. Common clinical findings associated with maltreatment include bruises, lacerations, abrasions, head injury, fractures, dehydration, and malnutrition. These injuries commonly result in hospitalization. In one descriptive study that tracked the emergency department utilization of known elderly victims of physical abuse identified through adult protective services, 114 individuals had 628 emergency department visits during a 5-year window surrounding the referral; 30 percent of these visits resulted in hospital admission (IOM, 2002).

CLINICAL RECOMMENDATION STATEMENTS:
Health care professionals should assess older persons in domestic and institutional settings who are at risk for elder abuse and recommend interventions to reduce the incidence of mistreatment.

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♠ Measure #182: Functional Outcome Assessment

2013 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of visits for patients aged 18 years and older with documentation of a current functional outcome assessment using a standardized functional outcome assessment tool on the date of the encounter AND documentation of a care plan based on identified functional outcome deficiencies on the date of the identified deficiencies

INSTRUCTIONS:
This measure is to be reported each visit indicating the appropriate numerator code; however, the assessment is required to be current as defined for patients seen during the reporting period. This measure may be reported by eligible professionals who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

Documentation of a current functional outcomes assessment must include identification of the standardized tool used.

> Clarification:
> The intent of the measure is for the functional outcome assessment tool to be utilized at a minimum of every 30 days but reporting is required at each visit due to coding limitations. Therefore, for visits occurring within 30 days of a previously documented functional outcome assessment, the numerator quality-data code G8942 should be used for reporting purposes.

Measure Reporting via Claims:
CPT codes and patient demographics are used to identify patients that are included in the measure's denominator. G-codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed CPT codes, and the appropriate numerator G-code. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
CPT codes and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All visits for patients aged 18 years and older

> Denominator Criteria (Eligible Cases):
> Patients aged ≥ 18 years on date of encounter
> AND
> Patient encounter during the reporting period (CPT): 97001, 97002, 98940, 98941, 98942

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NUMERATOR:
Patients with a documented current functional outcome assessment using a standardized tool AND a documented care plan

Definitions:
Standardized Tool – An assessment tool that has been appropriately normalized and validated for the population in which it is used. Examples of tools for functional outcome assessment include, but are not limited to: Oswestry Disability Index (ODI), Roland Morris Disability/Activity Questionnaire (RM), Neck Disability Index (NDI), and Patient-Reported Outcomes Measurement Information System (PROMIS). The use of a standardized tool assessing pain alone, such as the visual analog scale (VAS), does ***not*** meet the criteria of a functional outcome assessment standardized tool.
Functional Outcome Assessment – Patient completed questionnaires designed to measure a patient's limitations in performing the usual human tasks of living and to directly quantify functional and behavioral symptoms.
Current – A patient having a documented functional assessment within the previous 30 days.
Functional Outcome Deficiencies – Impairment or loss of physical function related to neuromusculoskeletal capacity, may include but are not limited to: restricted flexion, extension and rotation, back pain, neck pain, pain in the joints of the arms or legs, and headaches.
Care Plan – A care plan is an ordered assembly of expected/planned activities or actionable elements based on identified deficiencies. These may include observations goals, services, appointments and procedures, usually organized in phases or sessions, which have the objective of organizing and managing health care activity for the patient, often focused on one or more of the patient's health care problems. Care plans may also be known as a treatment plan.
Not Eligible – A patient is not eligible if the following reasons(s) exist:

- Patient refuses to participate
- Patient unable to complete questionnaire

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Functional Outcome Assessment and Care Plan Documented
*(One G-code [*G8539 or G8542 or G8942*] is required on the claim form to submit this numerator option)*
G8539: Documentation of a functional outcome assessment using a standardized tool AND documentation of a care plan based on identified deficiencies on the date of the functional outcome assessment
OR
Functional Outcome Assessment Documented, No Functional Deficiencies Identified, Care Plan not Required
G8542: Documentation of a functional outcome assessment using a standardized tool; no functional deficiencies identified, care plan not required
OR
Functional Outcome Assessment and Care Plan Documented with in the previous 30 days
G8942: Documented functional outcomes assessment and care plan within the previous 30 days

OR

Functional Outcome Assessment not Documented, Patient not Eligible
*(One G-code [*G8540*] is required on the claim form to submit this numerator option)*
G8540: Documentation that the patient is not eligible for a functional outcome assessment using a standardized tool

OR

Functional Outcome Assessment not Documented, Reason not Given
*(One G-code [*G854x*] is required on the claim form to submit this numerator option)*
G8541: Functional outcome assessment using a standardized tool not documented, reason not given
OR

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Functional Assessment Documented, Care Plan not Documented, Reason not Given
G8543: Documentation of a functional outcome assessment using a standardized tool; care plan not documented, reason not given

RATIONALE:
Standardized outcome assessments, questionnaires or tools are a vital part of evidence-based practice. Despite the recognition of the importance of outcomes assessments, questionnaires and tools, recent evidence suggests their use in clinical practice is limited. Selecting the most appropriate outcomes assessment, questionnaire or tool enhances clinical practice by (1) identifying and quantifying body function and structure limitations; (2) formulating the evaluation, diagnosis, and prognosis; (3) informing the plan of care; and (4) helping to evaluate the success of physical therapy interventions (Potter et al., 2011).

CLINICAL RECOMMENDATION STATEMENTS:
As a category, functional outcome assessments of everyday tasks are very suitable for evaluating treatment of dysfunctions of the neuromusculoskeletal system. Many questionnaires could be used; choice should depend upon the validity, reliability, responsiveness, and practicality demonstrated in the scientific literature. Functional questionnaires seek to directly quantify symptoms, function and behavior, rather than draw inferences from relevant physiological tests. Clinicians contemplating the use of functional instruments should be aware of differences between questionnaires and choose the most appropriate assessment tool for the specific purpose (Haldeman et al., 2005) (Evidence Class: I, II, III, Consensus Level: 1).

Outcome measures/standardized assessments are used by physical therapists to evaluate patient response to therapeutic interventions. In a 2006 Centers for Medicare & Medicaid Services report, *Uniform Patient Assessment for Post-Acute Care,* the Division of Health Care Policy and Research recommended there is a role for uniform outcome assessments to determine long term function for patients leaving the acute care hospital.

Farrel (2004) recommended the use of screening tools that allow therapists to identify patient's overall function, degree of frailty, risk of falls and endurance and can act as a communication tool for collaboration of physical therapists with other health care professionals potentially leading to improved outcomes.

The Council on Chiropractic Education (2012) recommended keeping appropriate records of the patient's evaluation and case management needs to aptly respond to changes in patient status, or failure of the patient to respond to care.

The Institute of Medicine's (2012) *Living Well with Chronic Illness: A Call for Public Health Action* stated the surveillance systems need to be improved to assess health-related quality of life and functional status of patients. Such systems need to inform the planning, development, implementation, and evaluation of public health policies, programs and interventions relevant to individuals with chronic illness.

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▲Measure #183 (NQF 0399): Hepatitis C: Hepatitis A Vaccination in Patients with HCV

2013 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

If reporting Measure #183 - Hepatitis C: Hepatitis A Vaccination in Patients with HCV, also report 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 A vaccine, or who have documented immunity to hepatitis A

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for patients with a diagnosis of hepatitis C seen during the reporting period. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

Measure Reporting via Claims:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. CPT Category II codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed ICD-9-CM diagnosis codes, CPT codes and the appropriate CPT Category II codes OR the CPT Category II codes with the modifier. The modifiers allowed for this measure are: 1P- medical reasons, 2P- patient reasons, 8P- reason not otherwise specified. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All patients aged 18 years and older with a diagnosis of hepatitis C

> Denominator Criteria (Eligible Cases):
> Patients aged ≥ 18 years on date of encounter
> AND
> Diagnosis for hepatitis C (ICD-9-CM): 070.51, 070.54, 070.70
> Diagnosis for hepatitis C (ICD-10-CM) [REFERENCE ONLY/Not Reportable]: B17.10, B18.2, B19.20
> AND
> Patient encounter during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215

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

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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 Otherwise 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

RATIONALE:

A single report has suggested that superimposition of hepatitis A virus infection in persons with chronic liver disease, particularly those with hepatitis C, was associated with fulminant hepatitis. Therefore, it is recommended that persons with chronic HCV infection who lack evidence of preexisting antibody to hepatitis A be administered the hepatitis A vaccine. (AASLD 2009)

CLINICAL RECOMMENDATION STATEMENTS:

All persons with chronic HCV infection who lack antibodies to hepatitis A and B should be offered vaccination against these two viral infections. (AASLD 2009)

Patients with chronic hepatitis C should be vaccinated against HAV and HBV. (EASL 2011)

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▲Measure #184 (NQF0400): Hepatitis C: Hepatitis B Vaccination in Patients with HCV

2013 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

If reporting Measure #184 - Hepatitis C: Hepatitis B Vaccination in Patients with HCV, also report 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 B vaccine, or who have documented immunity to hepatitis B

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for patients with a diagnosis of hepatitis C seen during the reporting period. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

Measure Reporting via Claims:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. CPT Category II codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed ICD-9-CM diagnosis codes, CPT codes, and the appropriate CPT Category II codes OR the CPT Category II codes with the modifier. The modifiers allowed for this measure are: 1P- medical reasons, 2P- patient reasons, 8P- reason not otherwise specified. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All patients aged 18 years and older with a diagnosis of hepatitis C

> Denominator Criteria (Eligible Cases):
> Patients aged ≥ 18 years on date of encounter
> AND
> Diagnosis for hepatitis C (ICD-9-CM): 070.51, 070.54, 070.70
> Diagnosis for hepatitis C (ICD-10-CM) [REFERENCE ONLY/Not Reportable]: B17.10, B18.2, B19.20
> AND
> Patient encounter during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215

NUMERATOR:
Patients who have received at least one injection of hepatitis B vaccine or who have documented immunity to hepatitis B

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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 Otherwise 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

RATIONALE:

Although no specific recommendation has been advanced for vaccination against hepatitis B, the evidence that persons co-infected with hepatitis B and C have a worse prognosis than those with HCV infection alone suggests that hepatitis B vaccination should be offered to persons who are at risk for exposure to hepatitis B if they lack preexisting antibody to hepatitis B. (AASLD, 2009)

CLINICAL RECOMMENDATION STATEMENTS:

All persons with chronic HCV infection who lack antibodies to hepatitis A and B should be offered vaccination against these two viral infections. (AASLD, 2009)

Patients with chronic hepatitis C should be vaccinated against HAV and HBV. (EASL, 2011)

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Measure #185 (NQF 0659): Endoscopy & Polyp Surveillance: Colonoscopy Interval for Patients with a History of Adenomatous Polyps – Avoidance of Inappropriate Use

2013 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of patients aged 18 years and older receiving a surveillance colonoscopy, with a history of a prior colonic polyp(s) in previous colonoscopy findings, who had an interval of 3 or more years since their last colonoscopy

INSTRUCTIONS:
This measure is to be reported each time a surveillance colonoscopy is performed during the reporting period. It is anticipated the clinician who performs the listed procedures, as specified in the denominator coding, will report on this measure. Patients who have a coded colonoscopy procedure that has a modifier 52, 53, 73 or 74 will not qualify for inclusion into this measure.

Measure Reporting via Claims:
The ICD-9-CM diagnosis code, CPT or HCPCS codes, and patient demographics are used to identify patients who are included in the measure's denominator. CPT Category II codes are used to report the numerator of the measure.
When reporting the measure via claims, submit the listed ICD-9-CM diagnosis code, CPT or HCPCS codes, and the appropriate CPT Category II codes OR the CPT Category II code(s) with the modifier. The modifiers allowed for this measure are: 1P- medical reasons, 3P- system reasons, 8P- reason not otherwise specified. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
The ICD-9-CM diagnosis code, CPT or HCPCS codes and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All patients aged 18 years and older receiving a surveillance colonoscopy, with a history of a prior colonic polyp(s) in previous colonoscopy findings

> Denominator Instructions: Clinicians who indicate that the colonoscopy procedure is incomplete or was discontinued should use the procedure number and the addition (as appropriate) of modifier 52, 53, 73, or 74. Patients who have a coded colonoscopy procedure that has a modifier 52, 53, 73, or 74 will not qualify for inclusion into this measure.
>
> Denominator Criteria (Eligible Cases):
> Patients aged ≥ 18 years on date of encounter
> AND
> Diagnosis for history of colonic polyp(s) (ICD-9-CM): V12.72
> Diagnosis for history of colonic polyp(s) (ICD-10-CM) [REFERENCE ONLY/Not Reportable]: Z86.010
> AND

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Patient encounter during the reporting period (CPT or HCPCS): 44388, 44389, 44392, 44393, 44394, 45355, 45378, 45380, 45381, 45383, 45384, 45385, G0105
WITHOUT
CPT Category I Modifiers: 52, 53, 73 or 74

NUMERATOR:
Patients who had an interval of 3 or more years since their last colonoscopy

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Interval of Three or More Years Since Patient's Last Colonoscopy
CPT II 0529F: Interval of 3 or more years since patient's last colonoscopy, documented

OR

Interval of Less Than Three Years Since Patient's Last Colonoscopy for Medical or System Reasons
Append a modifier (1P or 3P) to CPT Category II code 0529F to report documented circumstances that appropriately exclude patients from the denominator.
0529F *with* 1P: Documentation of medical reason(s) for an interval of less than 3 years since the last colonoscopy (eg, last colonoscopy incomplete, last colonoscopy had inadequate prep, piecemeal removal of adenomas, or last colonoscopy found greater than 10 adenomas)
0529F *with* 3P: Documentation of system reason(s) for an interval of less than 3 years since the last colonoscopy (eg, unable to locate previous colonoscopy report, previous colonoscopy report was incomplete)

OR

Interval of Less Than Three Years Since Patient's Last Colonoscopy, Reason not Otherwise Specified
Append a reporting modifier (8P) to CPT Category II code 0529F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.
0529F *with* 8P: Interval of less than 3 years since patient's last colonoscopy, reason not otherwise specified

RATIONALE:
Colorectal cancer is the 2nd leading cause of cancer death in the United States. Colonoscopy is the recommended method of surveillance after the removal of adenomatous polyps because it has been shown to significantly reduce subsequent colorectal cancer incidence. The time interval for the development of malignant changes in adenomatous polyps is estimated at 5 to 25 years (ICSI, 2006). Inappropriate interval recommendations can result in overuse of resources and can lead to significant patient harm. Performing colonoscopy too often not only increases patients' exposure to procedural harm, but also drains resources that could be more effectively used to adequately screen those in need (Lieberman et al, 2009).

CLINICAL RECOMMENDATION STATEMENTS:
Patients with only 1 or 2 small (< 1 cm) tubular adenomas with only low-grade dysplasia should have their next follow-up colonoscopy in 5–10 years; the precise timing within this interval should be based on other clinical factors (such as prior colonoscopy findings, family history, and the preferences of the patient and judgment of the physician). Patients with 3 to 10 adenomas, or any adenoma ≥1 cm, or any adenoma with villous features, or high-grade dysplasia should have their next follow-up colonoscopy in 3 years providing that piecemeal removal has not been performed and the adenoma(s) are removed completely; if the follow-up colonoscopy is normal or shows only 1 or 2 small tubular adenomas with low-grade dysplasia, then the interval for the subsequent examination should be 5 years. (Winawer, et al, 2006)

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Measure #187 (NQF 0437): Stroke and Stroke Rehabilitation: Thrombolytic Therapy

2013 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Percentage of patients aged 18 years and older with a diagnosis of acute ischemic stroke who arrive at the hospital within two hours of time last known well and for whom IV t-PA was initiated within three hours of time last known well

INSTRUCTIONS:
This measure is to be reported for each episode of acute ischemic stroke for patients who arrive at the hospital within two hours of time last known well and for whom IV t-PA was initiated within three hours of time last known well. It is anticipated that clinicians providing care for patients with acute ischemic stroke in the hospital setting will submit this measure.

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All patients aged 18 years and older with a diagnosis of acute ischemic stroke whose time of arrival is within two hours (≤ 120 minutes) of time last known well

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter.
AND
Diagnosis for ischemic stroke (ICD-9-CM): 433.01, 433.10, 433.11, 433.21, 433.31, 433.81, 433.91, 434.00, 434.01, 434.11, 434.91, 436
Diagnosis for ischemic stroke (ICD-10-CM) (ICD-10-CM) [REFERENCE ONLY/Not Reportable]: I63.111, I63.112, I63.119, I63.139, I63.19, I63.20, I63.219, I63.22, I63.231, I63.232, I63.239, I63.30, I63.40, I63.50, I63.59, I65.29, I66.02, I66.03, I66.09, I66.19, I66.29
AND
Patient encounter during reporting period (CPT): 99221, 99222, 99223, 99291
AND
Time last known well to arrival in the emergency department less than or equal to two hours **(≤ 120** minutes)

NUMERATOR:
Patients for whom IV thrombolytic therapy was initiated at the hospital within three hours (≤ 180 minutes) of time last known well

Definition:
Last Known Well – The date and time prior to hospital arrival at which it was witnessed or reported that the patient was last known to be without the signs and symptoms of the current stroke or at his or her baseline state of health.

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Numerator Options:
IV t-PA initiated within three hours (≤ 180 minutes) of time last known well (G8600)

OR

IV t-PA not initiated within three hours (≤ 180 minutes) of time last known well for reasons documented by clinician (e.g., patient enrolled in clinical trial for stroke, patient admitted for elective carotid intervention) (G8601)

OR

IV t-PA not initiated within three hours (≤ 180 minutes) of time last known well, reason not given (G8602)

RATIONALE:
The administration of thrombolytic agents to carefully screened, eligible patients with acute ischemic stroke has been shown to be beneficial in several clinical trials. These included two positive randomized controlled trials in the United States; The National Institute of Neurological Disorders and Stroke (NINDS) Studies, Part I and Part II. Based on the results of these studies, the Food and Drug Administration approved the use of intravenous recombinant tissue plasminogen activator (IV r-TPA or t-PA) for the treatment of acute ischemic stroke when given within 3 hours of stroke symptom onset. A large meta-analysis controlling for factors associated with stroke outcome confirmed the benefit of IV t-PA in patients treated within 3 hours of symptom onset. While controversy still exists among some specialists, the major society practice guidelines developed in the United States all recommend the use of IV t-PA for eligible patients. Physicians with experience and skill in stroke management and the interpretation of CT scans should supervise treatment.

CLINICAL RECOMMENDATION STATEMENTS:
Intravenous r-TPA (0.9 mg/kg, maximum dose 90 mg) is recommended for selected patients who may be treated within 3 hours of onset of ischemic stroke (Class 1, Level of Evidence A) (AHA/ASA).

For eligible patients (see inclusion and exclusion criteria listed below), we recommend administration of IV t-PA in a dose of 0.9 mg/kg (maximum of 90 mg), with 10% of the total dose given as an initial bolus and the remainder infused over 60 min, provided that treatment is initiated within 3 hours of clearly defined symptom onset (Class 1, Grade 1A) (ACP).

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Measure #188: Referral for Otologic Evaluation for Patients with Congenital or Traumatic Deformity of the Ear

2013 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of patients aged birth and older referred to a physician (preferably a physician with training in disorders of the ear) for an otologic evaluation subsequent to an audiologic evaluation after presenting with a congenital or traumatic deformity of the ear (internal or external)

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for all patients seen during the reporting period who present with congenital or traumatic deformity of the ear. This measure is intended to ensure that patients with congenital or traumatic deformity of the ear receive a referral in order to facilitate appropriate care and follow-up. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

Measure Reporting via Claims:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. G-codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed ICD-9-CM diagnosis codes, CPT codes and appropriate numerator G-code. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
Patients age birth and older who present with congenital or traumatic deformity of the ear

Denominator Criteria (Eligible Cases):
Patients age birth and older on date of encounter
AND
Diagnosis for congenital and traumatic anomalies (ICD-9-CM): 380.00, 380.01, 380.02, 380.03, 380.10, 380.30, 380.31, 380.32, 380.39, 380.51, 380.81, 380.89, 380.9, 744.01, 744.02, 744.03, 744.09
Diagnosis for congenital and traumatic anomalies (ICD-10-CM) [REFERENCE ONLY/Not Reportable]: H60.00, H60.01, H60.02, H60.03, H60.10, H60.11, H60.12, H60.13, H60.311, H60.312, H60.313, H60.319, H60.321, H60.322, H60.323, H60.329, H60.391, H60.392, H60.393, H60.399, H61.001, H61.002, H61.003, H61.009, H61.011, H61.012, H61.013, H61.019, H61.021, H61.022, H61.023, H61.029, H61.031, H61.032, H61.033, H61.039, H61.101, H61.102, H61.103, H61.109, H61.111, H61.112, H61.113, H61.119, H61.121, H61.122, H61.123, H61.129, H61.191, H61.192, H61.193, H61.199, H61.311, H61.312, H61.313, H61.319,

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H61.811, H61.812, H61.813, H61.819, H61.891, H61.892, H61.893, H61.899, H61.90, H61.91, H61.92, H61.93, Q16.0, Q16.1, Q16.4, Q16.9
AND
Patient encounter during reporting period (CPT): 92550, 92557, 92567, 92568, 92570, 92575

NUMERATOR:
Patients referred to a physician (preferably a physician with training in disorders of the ear) for an otologic evaluation subsequent to an audiologic evaluation who present with congenital or traumatic deformity of the ear

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Referral for Otologic Evaluation
G8556: Referred to a physician (preferably a physician with training in disorders of the ear) for an otologic evaluation

OR

Referral for Otologic Evaluation not Performed for Documented Reasons
G8557: Patient is not eligible for the referral for otologic evaluation measure (e.g., patients for whom an assessment of the congenital or traumatic deformity of the ear has been performed by a physician [preferably a physician with training in disorders of the ear] within the past six months, patients who are already under the care of a physician [preferably a physician with training in disorders of the ear] for congenital or traumatic deformity of the ear)

OR

Referral for Otologic Evaluation not Performed, Reason not Given
G8558: Not referred to a physician (preferably a physician with training in disorders of the ear) for an otologic evaluation, reason not given

RATIONALE:
Studies demonstrate that patients who present with congenital or traumatic deformity of the ear may suffer from underlying problems, so therefore referral is necessary. Without referral, patients may suffer consequences of the underlying problems.

CLINICAL RECOMMENDATION STATEMENTS:
The American Academy of Otolaryngology-Head and Neck Surgery policy statement (approved 9/12/2002): Hearing loss and balance disorders are medical conditions. Only licensed physicians with medical training may diagnose and direct the management of disease and medical disorders. A full history and physical examination by a physician (preferably a physician specially trained in disorders of the ear) to determine the accurate medical diagnosis and appropriate medical/surgical treatment for hearing loss and balance disorders are indicated for patients with the following "red flags":

1) Hearing loss with a positive history of familial hearing loss, TB, syphilis, HIV, Meniere's disease, autoimmune disorder, otosclerosis, von Recklinghausen's neurofibromatosis, Paget's disease of bone, head trauma related to onset.
2) History of pain, active drainage, or bleeding from an ear.
3) Sudden onset or rapidly progressive hearing loss.
4) Acute, chronic, or recurrent episodes of dizziness.
5) Evidence of congenital or traumatic deformity of the ear.
6) Visualization of blood, pus, cerumen plug, or foreign body in the ear canal.
7) Conductive hearing loss or abnormal tympanogram.
8) Unilateral or asymmetric hearing loss; or bilateral hearing loss > 80 dB.
9) Unilateral or pulsatile tinnitus.
10) Unilateral or asymmetrically poor speech discrimination scores.

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The red flags do not include all indications for a medical referral and are not intended to replace clinical judgment in determining the need for consultation with an otolaryngologist.

21 C.F.R. Section 801.420:

A hearing aid dispenser should advise a prospective hearing aid user to consult promptly with a licensed physician (preferably an ear specialist) before dispensing a hearing aid if the hearing aid dispenser determines through inquiry, actual observation, or review of any other available information concerning the prospective user, that the prospective user has any of the following conditions:

I. Congenital or traumatic deformity of the ear.
II. History of active drainage from the ear within the previous 90 days.
III. History of sudden or rapidly progressive hearing loss within the previous 90 days.
IV. Acute or chronic dizziness.
V. Unilateral hearing loss of sudden or recent onset within the previous 90 days.
VI. Audiometric air-bone gap equal to or greater than 15 decibels at 500 hertz (Hz), 1,000 Hz, and 2,000 Hz.
VII. Evidence of significant cerumen accumulation or a foreign body in the ear canal.
VIII. Pain or discomfort in the ear.

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***Measure #191 (NQF 0565): Cataracts: 20/40 or Better Visual Acuity within 90 Days Following Cataract Surgery**

2013 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

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

INSTRUCTIONS:
This measure is to be calculated each time a procedure for uncomplicated cataracts is performed during the reporting period. This measure is intended to reflect the quality of services provided for the patients receiving uncomplicated 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 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.*

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT codes and patient demographics are used to determine patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data. There are no allowable performance exclusions for this measure.

DENOMINATOR:
All patients aged 18 years and older who had cataract surgery and no significant pre-operative ocular conditions impacting the visual outcome of surgery

Denominator Instructions: Clinicians who indicate modifier 56, preoperative management only, will not qualify for this measure.

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Patient encounter during the reporting period (CPT): 66840, 66850, 66852, 66920, 66930, 66940, 66982, 66983, 66984

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AND NOT
Any of the following comorbid conditions that impact the visual outcome of surgery

(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)

Comorbid Condition	Corresponding ICD-9-CM Codes
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
Central Corneal Ulcer	370.03
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, 362.57
Degenerative Disorders of Globe	360.20, 360.21, 360.23, 360.24, 360.29
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
Injury to Optic Nerve and Pathways	950.0, 950.1, 950.2, 950.3, 950.9

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Comorbid Condition	Corresponding ICD-9-CM Codes
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 Proliferative Retinopathy	362.20, 362.21, 362.22, 362.23, 362.24, 362.25, 362.26, 362.27
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
Pathologic Myopia	360.20, 360.21
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
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

Comorbid Condition	Corresponding ICD-10-CM Codes
Acute and Subacute Iridocyclitis	H20.00, H20.011, H20.012, H20.013, H20.019, H20.021, H20.022, H20.023, H20.029, H20.031, H20.032, H20.033, H20.039, H20.041, H20.042, H20.043, H20.049, H20.051, H20.052, H20.053, H20.059
Amblyopia	H53.011, H53.012, H53.013, H53.019, H53.021, H53.022, H53.023, H53.029, H53.031, H53.032, H53.033, H53.039
Burn Confined to Eye and Adnexa	T26.00XA, T26.01XA, T26.02XA, T26.10XA, T26.11XA, T26.12XA, T26.20XA, T26.21XA, T26.22XA, T26.30XA, T26.31XA, T26.32XA, T26.40XA, T26.41XA, T26.42XA, T26.50XA, T26.51XA, T26.52XA, T26.60XA, T26.61XA, T26.62XA, T26.70XA, T26.71XA, T26.72XA, T26.80XA, T26.81XA, T26.82XA, T26.90XA, T26.91XA, T26.92XA
Cataract Secondary to Ocular Disorders	H26.211, H26.212, H26.213, H26.219, H26.221, H26.222, H26.223, H26.229

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Comorbid Condition	Corresponding ICD-10-CM Codes
Central Corneal Ulcer	H16.011, H16.012, H16.013, H16.019
Certain Types of Iridocyclitis	H20.20, H20.21, H20.22, H20.23, H20.811, H20.812, H20.813, H20.819, H20.821, H20.822, H20.823, H20.829, H20.9, H40.40X0
Choroidal Degenerations	H35.33
Choroidal Detachment	H31.411, H31.412, H31.413, H31.419
Choroidal Hemorrhage and Rupture	H31.301, H31.302, H31.303, H31.309, H31.311, H31.312, H31.313, H31.319, H31.321, H31.322, H31.323, H31.329
Chorioretinal Scars	H31.001, H31.002, H31.003, H31.009, H31.011, H31.012, H31.013, H31.019, H31.021, H31.022, H31.023, H31.029, H31.091, H31.092, H31.093, H31.099
Chronic Iridocyclitis	A18.54, H20.10, H20.11, H20.12, H20.13, H20.9
Cloudy Cornea	H17.00, H17.01, H17.02, H17.03, H17.10, H17.11, H17.12, H17.13, H17.811, H17.812, H17.813, H17.819, H17.821, H17.822, H17.823, H17.829
Corneal Opacity and Other Disorders of Cornea	H17.00, H17.01, H17.02, H17.03, H17.10, H17.11, H17.12, H17.13, H17.89, H17.9
Corneal Edema	H18.10, H18.11, H18.12, H18.13, H18.20, H18.221, H18.222, H18.223, H18.229, H18.231, H18.232, H18.233, H18.239, H18.421, H18.422, H18.423, H18.429, H18.43
Degeneration of Macula and Posterior Pole	H35.30, H35.31, H35.32, H35.341, H35.342, H35.343, H35.349, H35.351, H35.352, H35.353, H35.359, H35.361, H35.362, H35.363, H35.369, H35.371, H35.372, H35.373, H35.379, H35.381, H35.382, H35.383, H35.389
Degenerative Disorders of Globe	H44.20, H44.21, H44.22, H44.23, H44.321, H44.322, H44.323, H44.329, H44.311, H44.312, H44.313, H44.319, H44.391, H44.392, H44.393, H44.399
Diabetic Macular Edema	E08.311, E08.321, E08.331, E08.341, E08.351, E09.311, E09.321, E09.331, E09.341, E09.351, E10.311, E10.321, E10.331, E10.341, E10.351, E11.311, E11.321, E11.331, E11.341, E11.351, E13.311, E13.321, E13.331, E13.341, E13.351
Diabetic Retinopathy	E08.311, E08.319, E08.321, E08.329, E08.331, E08.339, E08.341, E08.349, E08.351, E08.359, E09.311, E09.319, E09.321, E09.329, E09.331, E09.339, E09.341, E09.349, E09.351, E09.359, E10.311, E10.319, E10.321, E10.329, E10.331, E10.339, E10.341, E10.349, E10.351, E10.359, E11.311, E11.319, E11.321, E11.329, E11.331, E11.339, E11.341, E11.349, E11.351, E11.359, E13.311, E13.319, E13.321, E13.329, E13.331, E13.339, E13.341, E13.349, E13.351, E13.359
Disorders of Optic Chiasm	H47.41, H47.42, H47.43, H47.49
Disorders of Visual Cortex	H47.611, H47.612, H47.619
Disseminated Chorioretinitis and Disseminated Retinochoroiditis	A18.53, H30.101, H30.102, H30.103, H30.109, H30.111, H30.112, H30.113, H30.119, H30.121, H30.122, H30.123, H30.129, H30.131, H30.132, H30.133, H30.139, H30.141, H30.142, H30.143, H30.149

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Comorbid Condition	Corresponding ICD-10-CM Codes
Focal Chorioretinitis and Focal Retinochoroiditis	H30.001, H30.002, H30.003, H30.009, H30.011, H30.012, H30.013, H30.019, H30.021, H30.022, H30.023, H30.029, H30.031, H30.032, H30.033, H30.039, H30.041, H30.042, H30.043, H30.049
Glaucoma	H40.10X0, H40.10X1, H40.10X2, H40.10X3, H40.10X4, H40.11X0, H40.11X1, H40.11X2, H40.11X3, H40.11X4, H40.1210, H40.1211, H40.1212, H40.1213, H40.1214, H40.1220, H40.1221, H40.1222, H40.1223, H40.1224, H40.1230, H40.1231, H40.1232, H40.1233, H40.1234, H40.1290, H40.1291, H40.1292, H40.1293, H40.1294, H40.1310, H40.1311, H40.1312, H40.1313, H40.1314, H40.1320, H40.1321, H40.1322, H40.1323, H40.1324, H40.1330, H40.1331, H40.1332, H40.1333, H40.1334, H40.1390, H40.1391, H40.1392, H40.1393, H40.1394, H40.141, H40.142, H40.143, H40.149, H40.1510, H40.1511, H40.1512, H40.1513, H40.1514, H40.1520, H40.1521, H40.1522, H40.1523, H40.1524, H40.1530, H40.1531, H40.1532, H40.1533, H40.1534, H40.1590, H40.1591, H40.1592, H40.1593, H40.1594, H40.20X0, H40.20X1, H40.20X2, H40.20X3, H40.20X4, H40.211, H40.212, H40.213, H40.219, H40.2210, H40.2211, H40.2212, H40.2213, H40.2214, H40.2220, H40.2221, H40.2222, H40.2223, H40.2224, H40.2230, H40.2231, H40.2232, H40.2233, H40.2234, H40.2290, H40.2291, H40.2292, H40.2293, H40.2294, H40.231, H40.232, H40.233, H40.239, H40.241, H40.242, H40.243, H40.249, H40.30X0, H40.30X1, H40.30X2, H40.30X3, H40.30X4, H40.31X0, H40.31X1, H40.31X2, H40.31X3, H40.31X4, H40.32X0, H40.32X1, H40.32X2, H40.32X3, H40.32X4, H40.33X0, H40.33X1, H40.33X2, H40.33X3, H40.33X4, H40.40X0, H40.40X1, H40.40X2, H40.40X3, H40.40X4, H40.41X0, H40.41X1, H40.41X2, H40.41X3, H40.41X4, H40.42X0, H40.42X1, H40.42X2, H40.42X3, H40.42X4, H40.43X0, H40.43X1, H40.43X2, H40.43X3, H40.43X4, H40.50X0, H40.50X1, H40.50X2, H40.50X3, H40.50X4, H40.51X0, H40.51X1, H40.51X2, H40.51X3, H40.51X4, H40.52X0, H40.52X1, H40.52X2, H40.52X3, H40.52X4, H40.53X0, H40.53X1, H40.53X2, H40.53X3, H40.53X4, H40.60X0, H40.60X1, H40.60X2, H40.60X3, H40.60X4, H40.61X0, H40.61X1, H40.61X2, H40.61X3, H40.61X4, H40.62X0, H40.62X1, H40.62X2, H40.62X3, H40.62X4, H40.63X0, H40.63X1, H40.63X2, H40.63X3, H40.63X4, H40.811, H40.812, H40.813, H40.819, H40.821, H40.822, H40.823, H40.829, H40.831, H40.832, H40.833, H40.839, H40.89, Q15.0

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Comorbid Condition	Corresponding ICD-10-CM Codes
Glaucoma Associated with Congenital Anomalies, Dystrophies, and Systemic Syndromes	H40.30X0, H40.30X1, H40.30X2, H40.30X3, H40.30X4, H40.31X0, H40.31X1, H40.31X2, H40.31X3, H40.31X4, H40.32X0, H40.32X1, H40.32X2, H40.32X3, H40.32X4, H40.33X0, H40.33X1, H40.33X2, H40.33X3, H40.33X4, H40.40X0, H40.40X1, H40.40X2, H40.40X3, H40.40X4, H40.41X0, H40.41X1, H40.41X2, H40.41X3, H40.41X4, H40.42X0, H40.42X1, H40.42X2, H40.42X3, H40.42X4, H40.43X0, H40.43X1, H40.43X2, H40.43X3, H40.43X4, H40.50X0, H40.50X1, H40.50X2, H40.50X3, H40.50X4, H40.51X0, H40.51X1, H40.51X2, H40.51X3, H40.51X4, H40.52X0, H40.52X1, H40.52X2, H40.52X3, H40.52X4, H40.53X0, H40.53X1, H40.53X2, H40.53X3, H40.53X4, H40.811, H40.812, H40.813, H40.819, H40.821, H40.822, H40.823, H40.829, H40.831, H40.832, H40.833, H40.839, H40.89, H40.9, H42
Hereditary Corneal Dystrophies	H18.50, H18.51, H18.52, H18.53, H18.54, H18.55, H18.59
Hereditary Choroidal Dystrophies	H31.20, H31.21, H31.22, H31.23, H31.29
Hereditary Retinal Dystrophies	H35.50, H35.51, H35.52, H35.53, H35.54, H36
Injury to Optic Nerve and Pathways	S04.011A, S04.012A, S04.019A, S04.02XA, S04.031A, S04.032A, S04.039A, S04.041A, S04.042A, S04.049A
Moderate or Severe Impairment, Better Eye, Profound Impairment Lesser Eye	H54.10, H54.11, H54.12
Nystagmus and Other Irregular Eye Movements	H55.01
Open Wound of Eyeball	S05.10XA, S05.11XA, S05.12XA, S05.20XA, S05.21XA, S05.22XA, S05.30XA, S05.31XA, S05.32XA, S05.50XA, S05.51XA, S05.52XA, S05.60XA, S05.61XA, S05.62XA, S05.70XA, S05.71XA, S05.72XA, S05.8X1A, S05.8X2A, S05.8X9A, S05.90XA, S05.91XA, S05.92XA
Optic Atrophy	H47.20, H47.211, H47.212, H47.213, H47.219, H47.22, H47.231, H47.232, H47.233, H47.239, H47.291, H47.292, H47.293, H47.299
Optic Neuritis	H46.00, H46.01, H46.02, H46.03, H46.10, H46.11, H46.12, H46.13, H46.2, H46.3, H46.8, H46.9
Other Background Retinopathy and Retinal Vascular Changes	H35.021, H35.022, H35.023, H35.029, H35.051, H35.052, H35.053, H35.059, H35.061, H35.062, H35.063, H35.069
Other Corneal Deformities	H18.70, H18.711, H18.712, H18.713, H18.719, H18.721, H18.722, H18.723, H18.729, H18.731, H18.732, H18.733, H18.739, H18.791, H18.792, H18.793, H18.799
Other Disorders of Optic Nerve	H47.011, H47.012, H47.013, H47.019
Other Disorders of Sclera	H15.831, H15.832, H15.833, H15.839, H15.841, H15.842, H15.843, H15.849
Other Endophthalmitis	H16.241, H16.242, H16.243, H16.249, H21.331, H21.332, H21.333, H21.339, H33.121, H33.122, H33.123, H33.129, H44.111, H44.112, H44.113, H44.119, H44.121, H44.122, H44.123, H44.129, H44.131, H44.132, H44.133, H44.139, H44.19

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Comorbid Condition	Corresponding ICD-10-CM Codes
Other Proliferative Retinopathy	H35.101, H35.102, H35.103, H35.109, H35.111, H35.112, H35.113, H35.119, H35.121, H35.122, H35.123, H35.129, H35.131, H35.132, H35.133, H35.139, H35.141, H35.142, H35.143, H35.149, H35.151, H35.152, H35.153, H35.159, H35.161, H35.162, H35.163, H35.169, H35.171, H35.172, H35.173, H35.179
Other Retinal Disorders	H35.60, H35.61, H35.62, H35.63, H35.81, H35.89, H35.82
Other and Unspecified Forms of Chorioretinitis and Retinochoroiditis	H30.20, H30.21, H30.22, H30.23, H30.811, H30.812, H30.813, H30.819, H30.891, H30.892, H30.893, H30.899, H30.90, H30.91, H30.92, H30.93
Pathologic Myopia	H44.20, H44.21, H44.22, H44.23, H44.30
Prior Penetrating Keratoplasty	H18.601, H18.602, H18.603, H18.609, H18.611, H18.612, H18.613, H18.619, H18.621, H18.622, H18.623, H18.629
Profound Impairment, Both Eyes	H54.0, H54.10
Purulent Endophthalmitis	H44.001, H44.002, H44.003, H44.009, H44.011, H44.012, H44.013, H44.019, H44.021, H44.022, H44.023, H44.029
Retinal Detachment with Retinal Defect	H33.001, H33.002, H33.003, H33.009, H33.011, H33.012, H33.013, H33.019, H33.021, H33.022, H33.023, H33.029, H33.031, H33.032, H33.033, H33.039, H33.041, H33.042, H33.043, H33.049, H33.051, H33.052, H33.053, H33.059, H33.8
Retinal Vascular Occlusion	H34.10, H34.11, H34.12, H34.13, H34.231, H34.232, H34.233, H34.239, H34.811, H34.812, H34.813, H34.819, H34.831, H34.832, H34.833, H34.839
Scleritis and Episcleritis	A18.51, H15.021, H15.022, H15.023, H15.029, H15.031, H15.032, H15.033, H15.039, H15.041, H15.042, H15.043, H15.049, H15.051, H15.052, H15.053, H15.059, H15.091, H15.092, H15.093, H15.099
Separation of Retinal Layers	H35.711, H35.712, H35.713, H35.719, H35.721, H35.722, H35.723, H35.729, H35.731, H35.732, H35.733, H35.739
Uveitis	H44.111, H44.112, H44.113, H44.119, H44.131, H44.132, H44.133, H44.139
Visual Field Defects	H53.411, H53.412, H53.413, H53.419

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)

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RATIONALE:

1. Scientific basis for measuring visual acuity outcomes after cataract surgery

The only reason to perform cataract surgery (other than for a limited set of medical indications) is to improve a patient's vision and associated functioning. The use of a 20/40 visual acuity threshold is based on several considerations. First, it is the level for unrestricted operation of a motor vehicle in the US. Second, it has been consistently used by the FDA in its assessment for approval of IOL and other vision devices. Third, it is the literature standard to denote success in cataract surgery. Fourth, work by West et al in the Salisbury Eye Study suggests that 20/40 is a useful threshold for 50th percentile functioning for several vision-related tasks.

Most patients achieve excellent visual acuity after cataract surgery (20/40 or better). This outcome is achieved consistently through careful attention through the accurate measurement of axial length and corneal power and the appropriate selection of an IOL power calculation formula. As such, it reflects the care and diligence with which the surgery is assessed, planned and executed. Failure to achieve this after surgery in eyes without comorbid ocular conditions that would impact the success of the surgery would reflect care that should be assessed for opportunities for improvement.

The exclusion of patients with other ocular and systemic conditions known to increase the risk of an adverse outcome reflects the findings of the two published prediction rule papers for cataract surgery outcomes, by Mangione et al and Steinberg et al. In both papers, the presence of comorbid glaucoma and macular degeneration negatively impacted the likelihood of successful outcomes of surgery. Further, as noted in the prior indicator, exclusion of eyes with ocular conditions that could impact the success of the surgery would NOT eliminate the large majority of eyes undergoing surgery while also minimizing the potential adverse selection that might otherwise occur relative to those patients with the most complex situations who might benefit the most from having surgery to maximize their remaining vision.

2. Evidence of a gap in care

This is an outcome of surgery indicator of direct relevance to patients and referring providers. The available evidence suggests that cataract surgery achieves this in between 86% and 98% of surgeries in eyes without comorbid ocular conditions (this indicator). While small, the volume of cataract surgery in the US of over 2.8 million surgeries suggests that the impact could affect more than 100,000 patients per year. Because of the exclusion of comorbid ocular conditions, one would expect performance on this indicator to be as high as possible, with significantly lower rates suggestive of opportunities for improvement.

The ASCRS National Cataract Database reported that at 3 months postoperatively, 85.5% of all patients had a 20/40 or better best-corrected visual acuity, 57.2% of patients had 20/25 or better postoperative best-corrected visual acuity, and 74.6% of patients were within ± 1.0 D of target spherical equivalent. Based on 5,788 responses, the mean visual function index score at 3 months postoperatively was 70.3% compared with 55.0% preoperatively. (The score is based on a scale of 0 to 100, with 0 indicating an inability to perform any of the activities.) The European Cataract Outcome Study reported for 1999 that 89% of patients achieved a postoperative visual acuity of 0.5 or more (20/40 or better), the average induced astigmatism was 0.59 D, and 86% of patients had an induced astigmatism within ± 1.0 D.

The AAO National Eyecare Outcomes Network (NEON) database also found similar rates of success, with an improvement in visual acuity in 92.2% of patients and improvement in VF-14 in over 90% of patients. Best-corrected visual acuity of 20/40 was achieved by 89% of all NEON patients and 96% of NEON patients without preoperative ocular comorbid conditions. Seventy-eight percent of patients were within ± 1.0 D of target spherical equivalent. Ninety-five percent of patients reported being satisfied with the results of their surgery. Patients who were dissatisfied with the results of their surgery were slightly older and more likely to have ocular comorbidity.
In studies of phacoemulsification cataract surgery performed by ophthalmology residents, the reported range of patients with postoperative BCVA of 20/40 or better is 80% to 91%. Eyes with ocular comorbidities are excluded, the reported range of patients with postoperative BCVA of 20/40 or better is 86% to 98%. (AAO)

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CLINICAL RECOMMENDATION STATEMENTS:

This is an outcomes measure. As such, there are no statements in the guideline specific to this measurement topic.

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*Measure #192 (NQF 0564): Cataracts: Complications within 30 Days Following Cataract Surgery Requiring Additional Surgical Procedures

2013 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

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

INSTRUCTIONS:
This measure is to be calculated each time a procedure for non-complicated cataracts is performed during the reporting period. This measure is intended to reflect the quality of services provided for the patients receiving uncomplicated 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 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.*

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT codes and patient demographics are used to determine patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data. There are no allowable performance exclusions for this measure.

DENOMINATOR:
All patients aged 18 years and older who had cataract surgery and no significant pre-operative ocular conditions impacting the surgical complication rate

Denominator Instructions: Clinicians who indicate modifier 56, preoperative management only, will not qualify for this measure.

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Patient encounter during the reporting period (CPT): 66840, 66850, 66852, 66920, 66930, 66940, 66982, 66983, 66984
AND NOT
Comorbid conditions that impact the visual outcome of surgery

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(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 Puillary 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
Central Corneal Ulcer	370.03
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
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
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
Retrolental Fibroplasias	362.21
Senile Cataract	366.11
Traumatic Cataract	366.20, 366.21, 366.22, 366.23

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Comorbid Condition	Corresponding ICD-9-CM Codes
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

Comorbid Condition	Corresponding ICD-10-CM Codes
Acute and Subacute Iridocyclitis	H20.00, H20.011, H20.012, H20.013, H20.019, H20.021, H20.022, H20.023, H20.029, H20.031, H20.032, H20.033, H20.039, H20.041, H20.042, H20.043, H20.049, H20.051, H20.052, H20.053, H20.059
Adhesions and Disruptions of Iris and Ciliary Body	H21.40, H21.41, H21.42, H21.43, H21.501, H21.502, H21.503, H21.509, H21.511, H21.512, H21.513, H21.519, H21.521, H21.522, H21.523, H21.529, H21.531, H21.532, H21.533, H21.539, H21.541, H21.542, H21.543, H21.549, H21.551, H21.552, H21.553, H21.559, H21.561, H21.562, H21.563, H21.569, H21.81, H21.82, H21.89, H22
Anomalies of Puillary Function	H57.03
Aphakia and Other Disorders of Lens	H27.10, H27.111, H27.112, H27.113, H27.119, H27.121, H27.122, H27.123, H27.129, H27.131, H27.132, H27.133, H27.139
Burn Confined to Eye and Adnexa	T26.00XA, T26.01XA, T26.02XA, T26.10XA, T26.11XA, T26.12XA, T26.20XA, T26.21XA, T26.22XA, T26.30XA, T26.31XA, T26.32XA, T26.40XA, T26.41XA, T26.42XA, T26.50XA, T26.51XA, T26.52XA, T26.60XA, T26.61XA, T26.62XA, T26.70XA, T26.71XA, T26.72XA, T26.80XA, T26.81XA, T26.82XA, T26.90XA, T26.91XA, T26.92XA
Cataract Secondary to Ocular Disorders	H26.211, H26.212, H26.213, H26.219, H26.221, H26.222, H26.223, H26.229
Cataract, Congenital	Q12.0
Cataract, Mature or Hypermature	H26.9
Cataract, Posterior Polar	Q12.0
Central Corneal Ulcer	H16.011, H16.012, H16.013, H16.019
Certain Types of Iridocyclitis	H20.20, H20.21, H20.22, H20.23, H20.811, H20.812, H20.813, H20.819, H20.821, H20.822, H20.823, H20.829, H20.9, H40.40X0
Chronic Iridocyclitis	A18.54, H20.10, H20.11, H20.12, H20.13, H20.9
Cloudy Cornea	H17.00, H17.01, H17.02, H17.03, H17.10, H17.11, H17.12, H17.13, H17.811, H17.812, H17.813, H17.819, H17.821, H17.822, H17.823, H17.829
Corneal Opacity and Other Disorders of Cornea	H17.00, H17.01, H17.02, H17.03, H17.10, H17.11, H17.12, H17.13, H17.89, H17.9
Corneal Edema	H18.10, H18.11, H18.12, H18.13, H18.20, H18.221, H18.222, H18.223, H18.229, H18.231, H18.232, H18.233, H18.239, H18.421, H18.422, H18.423, H18.429, H18.43

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Comorbid Condition	Corresponding ICD-10-CM Codes
Cysts of Iris, Ciliary Body, and Anterior Chamber	H21.301, H21.302, H21.303, H21.309, H21.311, H21.312, H21.313, H21.319, H21.321, H21.322, H21.323, H21.329, H21.341, H21.342, H21.343, H21.349, H21.351, H21.352, H21.353, H21.359
Enophthalmos	H05.401, H05.402, H05.403, H05.409, H05.411, H05.412, H05.413, H05.419, H05.421, H05.422, H05.423, H05.429
Glaucoma	H40.10X0, H40.10X1, H40.10X2, H40.10X3, H40.10X4, H40.11X0, H40.11X1, H40.11X2, H40.11X3, H40.11X4, H40.1210, H40.1211, H40.1212, H40.1213, H40.1214, H40.1220, H40.1221, H40.1222, H40.1223, H40.1224, H40.1230, H40.1231, H40.1232, H40.1233, H40.1234, H40.1290, H40.1291, H40.1292, H40.1293, H40.1294, H40.1310, H40.1311, H40.1312, H40.1313, H40.1314, H40.1320, H40.1321, H40.1322, H40.1323, H40.1324, H40.1330, H40.1331, H40.1332, H40.1333, H40.1334, H40.1390, H40.1391, H40.1392, H40.1393, H40.1394, H40.141, H40.142, H40.143, H40.149, H40.1510, H40.1511, H40.1512, H40.1513, H40.1514, H40.1520, H40.1521, H40.1522, H40.1523, H40.1524, H40.1530, H40.1531, H40.1532, H40.1533, H40.1534, H40.1590, H40.1591, H40.1592, H40.1593, H40.1594, H40.20X0, H40.20X1, H40.20X2, H40.20X3, H40.20X4, H40.211, H40.212, H40.213, H40.219, H40.2210, H40.2211, H40.2212, H40.2213, H40.2214, H40.2220, H40.2221, H40.2222, H40.2223, H40.2224, H40.2230, H40.2231, H40.2232, H40.2233, H40.2234, H40.2290, H40.2291, H40.2292, H40.2293, H40.2294, H40.231, H40.232, H40.233, H40.239, H40.241, H40.242, H40.243, H40.249, H40.30X0, H40.30X1, H40.30X2, H40.30X3, H40.30X4, H40.31X0, H40.31X1, H40.31X2, H40.31X3, H40.31X4, H40.32X0, H40.32X1, H40.32X2, H40.32X3, H40.32X4, H40.33X0, H40.33X1, H40.33X2, H40.33X3, H40.33X4, H40.40X0, H40.40X1, H40.40X2, H40.40X3, H40.40X4, H40.41X0, H40.41X1, H40.41X2, H40.41X3, H40.41X4, H40.42X0, H40.42X1, H40.42X2, H40.42X3, H40.42X4, H40.43X0, H40.43X1, H40.43X2, H40.43X3, H40.43X4, H40.50X0, H40.50X1, H40.50X2, H40.50X3, H40.50X4, H40.51X0, H40.51X1, H40.51X2, H40.51X3, H40.51X4, H40.52X0, H40.52X1, H40.52X2, H40.52X3, H40.52X4, H40.53X0, H40.53X1, H40.53X2, H40.53X3, H40.53X4, H40.60X0, H40.60X1, H40.60X2, H40.60X3, H40.60X4, H40.61X0, H40.61X1, H40.61X2, H40.61X3, H40.61X4, H40.62X0, H40.62X1, H40.62X2, H40.62X3, H40.62X4, H40.63X0, H40.63X1, H40.63X2, H40.63X3, H40.63X4, H40.811, H40.812, H40.813, H40.819, H40.821, H40.822, H40.823, H40.829, H40.831, H40.832, H40.833, H40.839, H40.89, Q15.0

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Comorbid Condition	Corresponding ICD-10-CM Codes
Hereditary Corneal Dystrophies	H18.50, H18.51, H18.52, H18.53, H18.54, H18.55, H18.59
High Hyperopia	H52.00, H52.01, H52.02, H52.03
High Myopia	H44.20, H44.21, H44.22, H44.23
Hypotony of Eye	H44.40, H44.411, H44.412, H44.413, H44.419, H44.421, H44.422, H44.423, H44.429, H44.431, H44.432, H44.433, H44.439, H44.441, H44.442, H44.443, H44.449
Injury to Optic Nerve and Pathways	S04.011A, S04.012A, S04.019A, S04.02XA, S04.031A, S04.032A, S04.039A, S04.041A, S04.042A, S04.049A
Open Wound of Eyeball	S05.10XA, S05.11XA, S05.12XA, S05.20XA, S05.21XA, S05.22XA, S05.30XA, S05.31XA, S05.32XA, S05.50XA, S05.51XA, S05.52XA, S05.60XA, S05.61XA, S05.62XA, S05.70XA, S05.71XA, S05.72XA, S05.8X1A, S05.8X2A, S05.8X9A, S05.90XA, S05.91XA, S05.92XA
Pathologic Myopia	H44.20, H44.21, H44.22, H44.23, H44.30
Posterior Lenticonus	Q12.2, Q12.4, Q12.8
Prior Pars Plana Vitrectomy	67036, 67039, 67040, 67041, 67042, 67043 (patient with history of this procedure)
Pseudoexfoliation Syndrome	H40.141, H40.142, H40.143, H40.149
Retrolental Fibroplasias	H35.171, H35.172, H35.173, H35.179
Senile Cataract	H25.89
Traumatic Cataract	H26.101, H26.102, H26.103, H26.109, H26.111, H26.112, H26.113, H26.119, H26.121, H26.122, H26.123, H26.129, H26.131, H26.132, H26.133, H26.139
Use of Systemic Sympathetic Alpha-1a Antagonist Medication for Treatment of Prostatic Hypertrophy	Patient taking tamsulosin hydrochloride
Uveitis	H44.111, H44.112, H44.113, H44.119, H44.131, H44.132, H44.133, H44.139
Vascular Disorders of Iris and Ciliary Body	H21.1X1, H21.1X2, H21.1X3, H21.1X9

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

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.

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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)

RATIONALE:

1. Scientific basis for assessing short-term complications following cataract surgery.

Complications that may result in a permanent loss of vision following cataract surgery are uncommon. This short-term outcomes of surgery indicator seeks to identify those complications from surgery that can reasonably be attributed to the surgery and surgeon and which reflect situations which - if untreated - generally result in significant avoidable vision loss that would negatively impact patient functioning. Further, it seeks to reduce surgeon burden and enhance accuracy in reporting by focusing on those significant complications that can be assessed from administrative data alone and which can be captured by the care of another physician or the provision of additional, separately coded, post-operative services. Finally, it focuses on patient safety and monitoring for events that, while hopefully uncommon, can signify important issues in the care being provided. For example, the need to reposition or exchange an IOL reflects in part "wrong power" IOL placement, a major patient safety issue.

In order to achieve these ends, the indicator excludes patients with other known, pre-operative ocular conditions that could impact the likelihood of developing a complication. Based on the results of the Cataract Appropriateness Project at RAND, other published studies, and one analysis performed on a national MCO data base, the exclusion codes would preserve over 2/3 of all cataract surgery cases for analysis. Thus, this provides a "clean" indicator that captures care for the large majority of patients undergoing cataract surgery.

2. Evidence for gap in care.

The advances in technology and surgical skills over the last 30 years have made cataract surgery much safer and more effective. An analysis of a single company's database (commercial age MCO) demonstrated that the rate of complications found for this indicator was approximately 1 to 2%. Nevertheless, as noted above, the occurrence of one of these events is associated with a significant potential for vision loss that is otherwise avoidable. Furthermore, with an annual volume of 2.8 million cataract surgeries in the US, a 2% rate would mean that over 36,000 surgeries are accompanied by these complications (2/3 of 56,000 surgeries).

A synthesis of the literature published prior to 1992 found weighted mean complication rates among all patients undergoing cataract surgery of 0.13% for endophthalmitis, 0.3% for bullous keratopathy, 1.4% clinically detectable CME, 3.5% for angiographically demonstrated CME, 0.7% for retinal detachment, and 1.1% for IOL dislocation. Bullous keratopathy and CME are not included in this indicator because they are conditions that are almost always temporary and resolve without additional intervention through additional procedures and associated care in this population of patients without prior known ocular conditions.

Additional studies similarly demonstrate the low occurrence of complications, including many that are temporary in nature and without a significant impact on patient outcomes. A national survey of over 100 hospitals from 1997 to 1998 found the following results on 18,454 patients 50 years old or older. Seventy-seven percent of these patients had surgery performed by phacoemulsification. Rates for events that occurred during surgery were 4.4% for posterior capsule rupture and vitreous loss, 1.0% for incomplete cortical cleanup, 1.0% for anterior chamber hemorrhage and or collapse, and 0.77% for iris damage. Short-term (within 48 hours) perioperative complications included corneal edema (9.5%), increased IOP (7.9%), uveitis (5.6%), wound leak (1.2%), hyphema (1.1%), and retained lens material (1.1%).

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A retrospective study from New Zealand of 1,793 consecutive patients undergoing phacoemulsification reported a rate of 1.8% for posterior capsule rupture and a rate of 1.2% for rhegmatogenous retinal detachment. (AAO)

CLINICAL RECOMMENDATION STATEMENTS:
This is an outcomes measure. As such, there are no statements in the guideline specific to this measurement topic.

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▲Measure #193 (NQF 0454): Perioperative Temperature Management

2013 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of patients, regardless of age, undergoing surgical or therapeutic procedures under general or neuraxial anesthesia of 60 minutes duration or longer, except patients undergoing cardiopulmonary bypass, for whom *either* active warming was used intraoperatively for the purpose of maintaining normothermia, OR at least one body temperature equal to or greater than 36 degrees Centigrade (or 96.8 degrees Fahrenheit) was recorded within the 30 minutes immediately before or the 15 minutes immediately after anesthesia end time

INSTRUCTIONS:
This measure is to be reported each time a surgical or therapeutic procedure not involving cardiopulmonary bypass is performed under general or neuraxial anesthesia during the reporting period. There is no diagnosis associated with this measure. It is anticipated that clinicians who provide the listed anesthesia services as specified in the denominator coding will submit this measure.

Measure Reporting via Claims:
CPT codes are used to identify patients who are included in the measure's denominator. CPT Category II codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed CPT Procedure code and the appropriate CPT Category II codes OR the CPT Category II code(s) with the modifier. The modifiers allowed for this measure are: 1P- Medical reasons, 8P- reasons not otherwise specified. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
CPT codes are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All patients, regardless of age, undergoing surgical or therapeutic procedures under general or neuraxial anesthesia of 60 minutes duration or longer, except patients undergoing cardiopulmonary bypass

Denominator Criteria (Eligible Cases):
Patient encounter during the reporting period (CPT): Anesthesia codes for surgical or therapeutic procedures under general or neuraxial anesthesia: 00100, 00102, 00103, 00104, 00120, 00124, 00126, 00140, 00142, 00144, 00145, 00147, 00148, 00160, 00162, 00164, 00170, 00172, 00174, 00176, 00190, 00192, 00210, 00211, 00212, 00214, 00215, 00216, 00218, 00220, 00222, 00300, 00320, 00322, 00326, 00350, 00352, 00400, 00402, 00404, 00406, 00410, 00450, 00452, 00454, 00470, 00472, 00474, 00500, 00520, 00522, 00524, 00528, 00529, 00530, 00532, 00534, 00537, 00539, 00540, 00541, 00542, 00546, 00548, 00550, 00560, 00566, 00580, 00600, 00604, 00620, 00622, 00625, 00626, 00630, 00632, 00634, 00635, 00640, 00670, 00700, 00702, 00730, 00740, 00750, 00752, 00754, 00756, 00770, 00790, 00792, 00794, 00796, 00797, 00800, 00802, 00810, 00820, 00830, 00832, 00834, 00836, 00840, 00842, 00844, 00846, 00848, 00851, 00860, 00862, 00864, 00865, 00866, 00868, 00870, 00872, 00873, 00880, 00882,

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00902, 00904, 00906, 00908, 00910, 00912, 00914, 00916, 00918, 00920, 00921, 00922, 00924, 00926, 00928, 00930, 00932, 00934, 00936, 00938, 00940, 00942, 00944, 00948, 00950, 00952, 01112, 01120, 01130, 01140, 01150, 01160, 01170, 01173, 01180, 01190, 01200, 01202, 01210, 01212, 01214, 01215, 01220, 01230, 01232, 01234, 01250, 01260, 01270, 01272, 01274, 01320, 01340, 01360, 01380, 01382, 01390, 01392, 01400, 01402, 01404, 01420, 01430, 01432, 01440, 01442, 01444, 01462, 01464, 01470, 01472, 01474, 01480, 01482, 01484, 01486, 01490, 01500, 01502, 01520, 01522, 01610, 01620, 01622, 01630, 01634, 01636, 01638, 01650, 01652, 01654, 01656, 01670, 01680, 01682, 01710, 01712, 01714, 01716, 01730, 01732, 01740, 01742, 01744, 01756, 01758, 01760, 01770, 01772, 01780, 01782, 01810, 01820, 01829, 01830, 01832, 01840, 01842, 01844, 01850, 01852, 01860, 01924, 01925, 01926, 01930, 01931, 01932, 01933, 01935, 01936, 01951, 01952, 01961, 01962, 01963, 01965, 01966, 01968, 01969

NUMERATOR:
Patients for whom *either*

- Active warming was used intraoperatively for the purpose of maintaining normothermia
  OR
- At least one body temperature equal to or greater than 36 degrees Centigrade (or 96.8 degrees Fahrenheit) was recorded within the 30 minutes immediately before or the 15 minutes immediately after anesthesia end time

Numerator Instructions: The anesthesia time used for this measure should be the time recorded in the anesthesia record.

Definition:
For purposes of this measure, "active warming" – is limited to over-the-body active warming (e.g., forced air, warm-water garments, and resistive heating blankets).

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Active Warming Used Intraoperatively OR At Least One Body Temperature Equal to or Greater than 36 Degrees Centigrade Recorded Within Designated Timeframe
*(Two CPT II codes [*4250F & 4255F*] are required on the claim form to submit this numerator option)*
CPT II 4250F: Active warming used intraoperatively for the purpose of maintaining normothermia, OR at least one body temperature equal to or greater than 36 degrees Centigrade (or 96.8 degrees Fahrenheit) recorded within the 30 minutes immediately before or the 15 minutes immediately after anesthesia end time
AND
CPT II 4255F: Duration of general or neuraxial anesthesia 60 minutes or longer, as documented in the anesthesia record

OR

Active Warming Not Performed OR at Least One Body Temperature Equal to or Greater than 36 Degrees Centigrade not Achieved Within Designated Timeframe for one of the following Medical Reasons:
*(Two CPT II codes [*4250F-1P & 4255F*] are required on the claim form to submit this numerator option)*
Append a modifier (1P) to CPT Category II code 4250F to report one of the following documented circumstances that appropriately exclude patients from the denominator.
4250F *with* 1P: Intentional hypothermia OR active warming not indicated due to anesthetic technique: peripheral nerve block without general anesthesia, OR monitored anesthesia care
AND
CPT II 4255F: Duration of general or neuraxial anesthesia 60 minutes or longer, as documented in the anesthesia record

OR

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If patient does not meet denominator inclusion because anesthesia time as indicated on the anesthesia record is less than 60 minutes duration (including anesthesia services provided using monitored anesthesia care [MAC] or peripheral nerve block [PNB] less than 60 minutes duration):
(One CPT II code [4256F] is required on the claim form to submit this numerator option)
CPT II 4256F: Duration of general or neuraxial anesthesia less than 60 minutes, as documented in the anesthesia record

OR

Active Warming Not Performed OR at Least One Body Temperature Equal to or Greater than 36 Degrees Centigrade Not Achieved Within Designated Timeframe, Reason Not Otherwise Specified
(Two CPT II codes [4250F-8P & 4255F] are required on the claim form to submit this numerator option)
Append a reporting modifier (8P) to CPT Category II code 4250F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.
4250F *with* 8P: Active warming not performed OR at least one body temperature equal to or greater than 36 degrees Centigrade not achieved within designated timeframe, reason not otherwise specified

AND

CPT II 4255F: Duration of general or neuraxial anesthesia 60 minutes or longer, as documented in the anesthesia record

RATIONALE:
Anesthetic-induced impairment of thermoregulatory control is the primary cause of perioperative hypothermia. Even mild hypothermia (1-2°C below normal) has been associated in randomized trials with a number of adverse consequences, including: increased susceptibility to infection, impaired coagulation and increased transfusion requirements, cardiovascular stress and cardiac complications, post-anesthetic shivering and thermal discomfort. Whether the benefits of avoiding hypothermia in patients undergoing cardiopulmonary bypass (CPB) outweigh potential harm is uncertain, because known complications of CPB include cerebral injury, which may be mitigated by mild hypothermia. Therefore, patients undergoing CPB are excluded from the denominator population for this measure. Several methods to maintain normothermia are available to the anesthesiologist in the perioperative period; various studies have demonstrated the superior efficacy of over-the-body active warming (e.g., forced air, warm-water garments, and resistive heating blankets). Data elements required for the measure can be captured and the measure is actionable by the physician.

Existing hospital-level measures for this topic were consulted and, to the extent feasible, harmonization between physician- and hospital-level measurement was achieved.

CLINICAL RECOMMENDATION STATEMENTS:
Preoperative patient management
Assessment: Identify patient's risk factors for unplanned perioperative hypothermia. Measure patient temperature on admission. Determine patient's thermal comfort level (ask the patients if they are cold). Assess for other signs and symptoms of hypothermia (shivering, piloerection, and/or cold extremities).
Interventions: Institute preventive warming measures for patients who are normothermic (normothermia is defined as a core temperature range from 36°C-38°C [96.8°F-100.4°F]). A variety of measures may be used, unless contraindicated. Passive insulation may include warmed cotton blankets, socks, head covering, limited skin exposure, circulating water mattresses, and increase in ambient room temperature (minimum 68ºF- 75ºF). Institute active warming measures for patients who are hypothermic (defined as a core temperature less than 36°C). Active warming is the application of a forced air convection warming system. Apply appropriate passive insulation and increase the ambient room temperature (minimum 68ºF-75ºF). Consider warmed intravenous (IV) fluids. (ASPAN)

Intraoperative patient management

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Assessment: Identify patient's risk factors for unplanned perioperative hypothermia. Determine patient's thermal comfort level (ask the patients if they are cold). Assess for other signs and symptoms of hypothermia (shivering, piloerection, and/or cold extremities). Monitor patient's temperature intraoperatively.
Intervention: Implement warming methods. (ASPAN)
Maintenance of body temperature in a normothermic range is recommended for most procedures other than during periods in which mild hypothermia is intended to provide organ protection (e.g., during high aortic cross-clamping). (Class I Recommendation, Level of Evidence B) (ACC/AHA)

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Measure #194 (NQF 0386): Oncology: Cancer Stage Documented

2013 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of patients, regardless of age, with a diagnosis of cancer who are seen in the ambulatory setting who have a baseline AJCC cancer stage or documentation that the cancer is metastatic in the medical record at least once within 12 months

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for patients with cancer seen during the reporting period. This measure is limited to cancer diagnoses for which AJCC staging or equivalent is available. This measure is intended to reflect the quality of services provided for the primary management of patients with cancer who are seen in the ambulatory setting or receiving radiation treatment planning.

Measure Reporting via Claims:
ICD-9-CM diagnosis codes and CPT codes are used to identify patients who are included in the measure's denominator. CPT Category II codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed CPT Procedure code, ICD-9-CM diagnosis codes, and the appropriate CPT Category II codes OR the CPT Category II code(s) with the modifier. The reporting modifier allowed for this measure is: 8P-reasons not otherwise specified. There are no allowable performance exclusions for this measure. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
ICD-9-CM diagnosis codes and CPT codes are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data. There are no allowable performance exclusions for this measure.

DENOMINATOR:
All patients, regardless of age, with a diagnosis of cancer who are seen in the ambulatory setting

Denominator Criteria (Eligible Cases):
Diagnosis for cancer (ICD-9-CM): 140.0, 140.1, 140.3, 140.4, 140.5, 140.6, 140.8, 140.9, 141.0, 141.1, 141.2, 141.3, 141.4, 141.5, 141.6, 141.8, 141.9, 142.0, 142.1, 142.2, 142.8, 142.9, 143.0, 143.1, 143.8, 143.9, 144.0, 144.1, 144.8, 144.9, 145.0, 145.1, 145.2, 145.3, 145.4, 145.5, 145.6, 145.8, 145.9, 146.0, 146.1, 146.2, 146.3, 146.4, 146.5, 146.6, 146.7, 146.8, 146.9, 147.0, 147.1, 147.2, 147.3, 147.8, 147.9, 148.0, 148.1, 148.2, 148.3, 148.8, 148.9, 150.0, 150.1, 150.2, 150.3, 150.4, 150.5, 150.8, 150.9, 151.0, 151.1, 151.2, 151.3, 151.4, 151.5, 151.6, 151.8, 151.9, 152.0, 152.1, 152.2, 152.3, 152.8, 152.9, 153.0, 153.1, 153.2, 153.3, 153.4, 153.5, 153.6, 153.7, 153.8, 153.9, 154.0, 154.1, 154.2, 154.3, 154.8, 155.0, 155.1, 155.2, 156.0, 156.1, 156.2, 157.0, 157.1, 157.2, 157.3, 157.4, 157.8, 157.9, 158.0, 158.8, 158.9, 160.0, 160.2, 160.3, 161.0, 161.1, 161.2, 161.3, 161.8, 161.9, 162.2, 162.3, 162.4, 162.5, 162.8, 162.9, 163.0, 163.1, 163.8, 163.9, 164.0, 164.1, 164.2, 164.3, 164.8, 164.9, 170.0, 170.1, 170.2, 170.3, 170.4, 170.5, 170.6, 170.7, 170.8, 170.9, 171.0, 171.2, 171.3, 171.4, 171.5, 171.6, 171.7, 171.8, 171.9, 172.0,

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172.1, 172.2, 172.3, 172.4, 172.5, 172.6, 172.7, 172.8, 172.9, 173.00, 173.01, 173.02, 173.09, 173.10, 173.11, 173.12, 173.19, 173.20, 173.21, 173.22, 173.29, 173.30, 173.31, 173.32, 173.39, 173.40, 173.41, 173.42, 173.49, 173.50, 173.51, 173.52, 173.59, 173.60, 173.61, 173.62, 173.69, 173.70, 173.71, 173.72, 173.79, 173.80, 173.81, 173.82, 173.89, 173.90, 173.91, 173.92, 173.99 174.0, 174.1, 174.2, 174.3, 174.4, 174.5, 174.6, 174.8, 174.9, 175.0, 175.9, 179, 180.0, 180.1, 180.8, 180.9, 181, 182.0, 182.1, 182.8, 183.0, 183.2, 184.0, 184.1, 184.2, 184.3,185, 186.0, 187.1, 187.2, 187.3, 187.5, 187.6, 187.7, 188.0, 188.1, 188.2, 188.3, 188.4, 188.5, 188.6, 188.7, 188.8, 188.9, 189.0, 189.1, 189.2, 189.3, 190.1, 190.2, 190.3, 193, 200.20, 200.21, 200.22, 200.23, 200.24, 200.25, 200.26, 200.27, 200.28, 200.30, 200.31, 200.32, 200.33, 200.34, 200.35, 200.36, 200.37, 200.38, 200.40, 200.41, 200.42, 200.43, 200.44, 200.45, 200.46, 200.47, 200.48, 200.50, 200.51, 200.52, 200.53, 200.54, 200.55, 200.56, 200.57, 200.58, 200.60, 200.61, 200.62, 200.63, 200.64, 200.65, 200.66, 200.67, 200.68, 200.70, 200.71, 200.72, 200.73, 200.74, 200.75, 200.76, 200.77, 200.78, 201.00, 201.01, 201.02, 201.03, 201.04, 201.05, 201.06, 201.07, 201.08, 201.10, 201.11, 201.12, 201.13, 201.14, 201.15, 201.16, 201.17, 201.18, 201.20, 201.21, 201.22, 201.23, 201.24, 201.25, 201.26, 201.27, 201.28, 201.40, 201.41, 201.42, 201.43, 201.44, 201.45, 201.46, 201.47, 201.48, 201.50, 201.51, 201.52, 201.53, 201.54, 201.55, 201.56, 201.57, 201.58, 201.60, 201.61, 201.62, 201.63, 201.64, 201.65, 201.66, 201.67, 201.68, 201.70, 201.71, 201.72, 201.73, 201.74, 201.75, 201.76, 201.77, 201.78, 201.90, 201.91, 201.92, 201.93, 201.94, 201.95, 201.96, 201.97, 201.98, 202.00, 202.01, 202.02, 202.03, 202.04, 202.05, 202.06, 202.07, 202.08, 202.10, 202.11, 202.12, 202.13, 202.14, 202.15, 202.16, 202.17, 202.18, 202.20, 202.21, 202.22, 202.23, 202.24, 202.25, 202.26, 202.27, 202.28, 202.70, 202.71, 202.72, 202.73, 202.74, 202.75, 202.76, 202.77, 202.78, 202.80, 202.81, 202.82, 202.83, 202.84, 202.85, 202.86, 202.87, 202.88, 209.00, 209.01, 209.02, 209.03, 209.10, 209.11, 209.12, 209.13, 209.14, 209.15, 209.16, 209.17, 209.20, 209.21, 209.22, 209.23, 209.24, 209.25, 209.26, 209.27, 209.29, 209.30, 209.31, 209.32, 209.33, 209.34, 209.35, 209.36

Diagnosis for cancer (ICD-10-CM) [REFERENCE ONLY/Not Reportable]: C00.0, C00.1, C00.2, C00.3, C00.4, C00.5, C00.6, C00.8, C00.9, C01, C02.0, C02.1, C02.2, C02.3, C02.4, C02.8, C02.9, C03.0, C03.1, C03.9, C04.0, C04.1, C04.8, C04.9, C05.0, C05.1, C05.2, C05.8, C05.9, C06.0, C06.1, C06.2, C06.80, C06.89, C06.9, C07, C08.0, C08.1, C08.9, C09.0, C09.1, C09.8, C09.9, C10.0, C10.1, C10.2, C10.3, C10.4, C10.8, C10.9, C11.0, C11.1, C11.2, C11.3, C11.8, C11.9, C12, C13.0, C13.1, C13.2, C13.8, C13.9, C15.3, C15.4, C15.5, C15.8, C15.9, C16.0, C16.1, C16.2, C16.3, C16.4, C16.5, C16.6, C16.8, C16.9, C17.0, C17.1, C17.2, C17.3, C17.8, C17.9, C18.0, C18.1, C18.2, C18.3, C18.4, C18.5, C18.6, C18.7, C18.8, C18.9, C19, C20, C21.0, C21.1, C21.2, C21.8, C22.0, C22.1, C22.2, C22.3, C22.4, C22.7, C22.8, C22.9, C23, C24.0, C24.1, C25.0, C25.1, C25.2, C25.3, C25.4, C25.7, C25.8, C25.9, C30.0, C31.0, C31.1, C32.0, C32.1, C32.2, C32.3, C32.8, C32.9, C34.00, C34.01, C34.02, C34.10, C34.11, C34.12, C34.2, C34.30, C34.31, C34.32, C34.80, C34.81, C34.82, C34.90, C34.91, C34.92, C37, C38.0, C38.1, C38.2, C38.3, C38.4, C38.8, C40.00, C40.01, C40.02, C40.10, C40.11, C40.12, C40.20, C40.21, C40.22, C40.30, C40.31, C40.32, C40.80, C40.81, C40.82, C40.90, C40.91, C40.92, C41.0, C41.1, C41.2, C41.3, C41.4, C41.9, C43.0, C43.10, C43.11, C43.12, C43.20, C43.21, C43.22, C43.30, C43.31, C43.39, C43.4, C43.51, C43.52, C43.59, C43.60, C43.61, C43.62, C43.70, C43.71, C43.72, C43.8, C43.9, C44.00, C44.01, C44.02, C44.09, C44.101, C44.102, C44.109, C44.111, C44.112, C44.119, C44.121, C44.122, C44.129, C44.191, C44.192, C44.199, C44.201, C44.202, C44.209, C44.211, C44.212, C44.219, C44.221, C44.222, C44.229, C44.291, C44.292, C44.299, C44.300, C44.301, C44.309, C44.310, C44.311, C44.319, C44.320, C44.321, C44.329, C44.390, C44.391, C44.399, C44.40, C44.41, C44.42, C44.49, C44.500, C44.501, C44.509, C44.510, C44.511, C44.519, C44.520, C44.521, C44.529, C44.590, C44.591, C44.599, C44.601, C44.602, C44.609, C44.611, C44.612, C44.619, C44.621, C44.622, C44.629, C44.691, C44.692, C44.699, C44.701, C44.702, C44.709, C44.711, C44.712, C44.719, C44.721, C44.722, C44.729, C44.791, C44.792, C44.799, C44.80, C44.81, C44.82, C44.89, C44.90, C44.91, C44.92, C44.99, C45.0, C45.1, C45.2, C47.0, C47.10, C47.11, C47.12, C47.20, C47.21, C47.22, C47.3, C47.4, C47.5, C47.6, C47.8, C47.9, C48.0, C48.1, C48.2, C48.8, C49.0, C49.10, C49.11, C49.12, C49.20, C49.21, C49.22, C49.3, C49.4, C49.5, C49.6, C49.8, C49.9, C4A.0, C4A.10, C4A.11, C4A.12, C4A.20, C4A.21, C4A.22, C4A.30, C4A.31, C4A.39, C4A.4, C4A.51, C4A.52, C4A.59, C4A.60, C4A.61, C4A.62, C4A.70, C4A.71, C4A.72, C4A.8, C4A.9, C50.011, C50.012,

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C50.019, C50.021, C50.022, C50.029, C50.111, C50.112, C50.119, C50.121, C50.122, C50.129, C50.211, C50.212, C50.219, C50.221, C50.222, C50.229, C50.311, C50.312, C50.319, C50.321, C50.322, C50.329, C50.411, C50.412, C50.419, C50.421, C50.422, C50.429, C50.511, C50.512, C50.519, C50.521, C50.522, C50.529, C50.611, C50.612, C50.619, C50.621, C50.622, C50.629, C50.811, C50.812, C50.819, C50.821, C50.822, C50.829, C50.911, C50.912, C50.919, C50.921, C50.922, C50.929, C51.0, C51.1, C51.2, C52, C53.0, C53.1, C53.8, C53.9, C54.0, C54.1, C54.2, C54.3, C54.8, C54.9, C55, C56.1, C56.2, C56.9, C57.00, C57.01, C57.02, C58, C60.0, C60.1, C60.2, C61, C62.00, C62.01, C62.02, C63.00, C63.01, C63.02, C63.10, C63.11, C63.12, C63.2, C64.1, C64.2, C64.9, C65.1, C65.2, C65.9, C66.1, C66.2, C66.9, C67.0, C67.1, C67.2, C67.3, C67.4, C67.5, C67.6, C67.7, C67.8, C67.9, C68.0, C69.00, C69.01, C69.02, C69.50, C69.51, C69.52, C69.60, C69.61, C69.62, C73, C7A.00, C7A.010, C7A.011, C7A.012, C7A.019, C7A.020, C7A.021, C7A.022, C7A.023, C7A.024, C7A.025, C7A.026, C7A.029, C7A.090, C7A.091, C7A.092, C7A.093, C7A.094, C7A.095, C7A.096, C7A.098, C7A.1, C7A.8, C81.00, C81.01, C81.02, C81.03, C81.04, C81.05, C81.06, C81.07, C81.08, C81.09, C81.10, C81.11, C81.12, C81.13, C81.14, C81.15, C81.16, C81.17, C81.18, C81.19, C81.20, C81.21, C81.22, C81.23, C81.24, C81.25, C81.26, C81.27, C81.28, C81.29, C81.30, C81.31, C81.32, C81.33, C81.34, C81.35, C81.36, C81.37, C81.38, C81.39, C81.40, C81.41, C81.42, C81.43, C81.44, C81.45, C81.46, C81.47, C81.48, C81.49, C81.70, C81.71, C81.72, C81.73, C81.74, C81.75, C81.76, C81.77, C81.78, C81.79, C81.90, C81.91, C81.92, C81.93, C81.94, C81.95, C81.96, C81.97, C81.98, C81.99, C82.00, C82.01, C82.02, C82.03, C82.04, C82.05, C82.06, C82.07, C82.08, C82.09, C82.10, C82.11, C82.12, C82.13, C82.14, C82.15, C82.16, C82.17, C82.18, C82.19, C82.20, C82.21, C82.22, C82.23, C82.24, C82.25, C82.26, C82.27, C82.28, C82.29, C82.30, C82.31, C82.32, C82.33, C82.34, C82.35, C82.36, C82.37, C82.38, C82.39, C82.40, C82.41, C82.42, C82.43, C82.44, C82.45, C82.46, C82.47, C82.48, C82.49, C82.50, C82.51, C82.52, C82.53, C82.54, C82.55, C82.56, C82.57, C82.58, C82.59, C82.60, C82.61, C82.62, C82.63, C82.64, C82.65, C82.66, C82.67, C82.68, C82.69, C82.80, C82.81, C82.82, C82.83, C82.84, C82.85, C82.86, C82.87, C82.88, C82.89, C82.90, C82.91, C82.92, C82.93, C82.94, C82.95, C82.96, C82.97, C82.98, C82.99, C83.10, C83.11, C83.12, C83.13, C83.14, C83.15, C83.16, C83.17, C83.18, C83.19, C83.31, C83.32, C83.33, C83.34, C83.35, C83.36, C83.37, C83.38, C83.39, C83.70, C83.71, C83.72, C83.73, C83.74, C83.75, C83.76, C83.77, C83.78, C83.79, C83.80, C83.81, C83.82, C83.83, C83.84, C83.85, C83.86, C83.87, C83.88, C83.89, C84.00, C84.01, C84.02, C84.03, C84.04, C84.05, C84.06, C84.07, C84.08, C84.09, C84.10, C84.11, C84.12, C84.13, C84.14, C84.15, C84.16, C84.17, C84.18, C84.19, C84.40, C84.41, C84.42, C84.43, C84.44, C84.45, C84.46, C84.47, C84.48, C84.49, C84.60, C84.61, C84.62, C84.63, C84.64, C84.65, C84.66, C84.67, C84.68, C84.69, C84.70, C84.71, C84.72, C84.73, C84.74, C84.75, C84.76, C84.77, C84.78, C84.79, C84.90, C84.91, C84.92, C84.93, C84.94, C84.95, C84.96, C84.97, C84.98, C84.99, C84.A0, C84.A1, C84.A2, C84.A3, C84.A4, C84.A5, C84.A6, C84.A7, C84.A8, C84.A9, C84.Z0, C84.Z1, C84.Z2, C84.Z3, C84.Z4, C84.Z5, C84.Z6, C84.Z7, C84.Z8, C84.Z9, C85.10, C85.11, C85.12, C85.13, C85.14, C85.15, C85.16, C85.17, C85.18, C85.19, C85.20, C85.21, C85.22, C85.23, C85.24, C85.25, C85.26, C85.27, C85.28, C85.29, C85.80, C85.81, C85.82, C85.83, C85.84, C85.85, C85.86, C85.87, C85.88, C85.89, C85.90, C85.91, C85.92, C85.93, C85.94, C85.95, C85.96, C85.97, C85.98, C85.99, C86.0, C86.1, C86.2, C86.3, C86.4, C88.4, D03.0, D03.10, D03.11, D03.12, D03.20, D03.21, D03.22, D03.30, D03.39, D03.4, D03.51, D03.52, D03.59, D03.60, D03.61, D03.62, D03.70, D03.71, D03.72, D03.8, D03.9

AND

Patient encounter during reporting period (CPT): 77261, 77262, 77263, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215

NUMERATOR:

Patients who have a baseline American Joint Committee on Cancer (AJCC)* cancer stage** or documentation that the cancer is metastatic in the medical record at least once within the 12 month reporting period

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Numerator Instructions:
* For certain malignancies, staging or classification systems included in the AJCC Staging Manual would also satisfy the requirements of this measure (e.g., Ann Arbor).
**Cancer stage refers to stage at diagnosis. Documentation that the cancer is metastatic at diagnosis would also satisfy the requirements of the measure.

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Cancer Stage Documented and Reviewed
CPT II 3300F: American Joint Committee on Cancer (AJCC) stage documented and reviewed
OR
CPT II 3301F: Cancer stage documented in medical record as metastatic and reviewed

OR

Cancer Stage not Documented, Reason not Otherwise Specified
Append a reporting modifier (8P) to CPT Category II code 3301F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.
3301F *with* 8P: Cancer stage not documented, reason not otherwise specified

RATIONALE:
Cancer stage is a critical component in determining treatment options for patients with cancer. Though critically important, cancer stage is not always documented in the medical record. This measure is intended to be reported at least once per 12 month reporting period.

CLINICAL RECOMMENDATION STATEMENTS:
A simple classification scheme, which can be incorporated into a form for staging and can be universally applied, is the goal of the TNM system as proposed by the [American Joint Committee on Cancer (AJCC).] Thus, examination during the surgical procedure and histologic examination of the surgically removed tissues may identify significant additional indicators of the prognosis of the patient (T, N, and M) as different from what could be discerned clinically before therapy. Because this is that pathologic (pTNM) classification and stage grouping (based on examination of a surgically resected specimen with sufficient tissue to evaluate the highest T, N, or M classification), it is recorded in addition to the clinical classification. It does not replace the clinical classification. Both should be maintained in the patient's permanent medical record…It is intended to provide a means by which this information can readily be communicated to others, to assist in therapeutic decisions, and to help estimate prognosis. (American Joint Committee on Cancer, 2010)

The following represent a sample of guideline recommendation statements supporting the measure for a variety of cancers:

Breast Cancer
All patients with breast cancer should be assigned a clinical stage of disease, and if appropriate evaluation is available, a pathologic stage of disease. The routine use of staging allows for efficient identification of local treatment options, assists in identifying systemic treatment options, allows the comparison of outcome results across institutions and clinical trials, and provides baseline prognostic information….A central component of the treatment of breast cancer is full knowledge of extent of disease and biologic features. These factors contribute to the determination of the stage of disease, assist in the estimation of the risk that cancer will recur, and provide information that predicts response to therapy (e.g., hormone receptors and human epidermal growth factor receptor 2 [HER2]). (NCCN, 2011)

Colon Cancer
Some of the criteria that should be included in the report of the pathologic evaluation include the following: grade of the cancer; depth of penetration and extension to adjacent structures (T); number of regional lymph nodes evaluated;

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number of positive regional lymph nodes (N); an assessment of the presence of distant metastases to other organs, the peritoneum of an abdominal structure, or in non-regional lymph nodes (M); the status of proximal, distal, and radial margins; lymphovascular invasion; perineural invasion; and extra-nodal tumor deposits. (NCCN, 2012)

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*Measure #195 (NQF 0507): Radiology: Stenosis Measurement in Carotid Imaging Reports

2013 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of final reports for carotid imaging studies (neck magnetic resonance angiography [MRA], neck computed tomography angiography [CTA], neck duplex ultrasound, carotid angiogram) performed that include direct or indirect reference to measurements of distal internal carotid diameter as the denominator for stenosis measurement

INSTRUCTIONS:
This measure is to be reported each time a carotid imaging study is performed during the reporting period for all patients, regardless of age. There is no diagnosis associated with these measures. Clinicians who provide component of diagnostic imaging studies of the carotids will submit this measure.

Measure Reporting via Claims:
CPT codes are used to identify patients who are included in the measure's denominator. CPT Category II codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed CPT procedure codes and the appropriate CPT Category II code OR the CPT Category II code with the modifier. The reporting modifier allowed for this measure is: 8P- reason not otherwise specified. There are no allowable performance exclusions for this measure. All measure-specific coding should be reporting on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
CPT codes are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data. There are no allowable performance exclusions for this measure.

DENOMINATOR:
All final reports for carotid imaging studies (neck MR angiography [MRA], neck CT angiography [CTA], neck duplex ultrasound, carotid angiogram) performed

> Denominator Criteria (Eligible Cases):
> Patient encounter during the reporting period (CPT): 36222, 36223, 36224, 70498, 70547, 70548, 70549, 93880, 93882

NUMERATOR:
Final carotid imaging study reports that include direct or indirect reference to measurements of distal internal carotid diameter as the denominator for stenosis measurement

> Numerator Instructions: This measure requires that the estimate of stenosis included in the report of the imaging study employ a method such as the North American Symptomatic Carotid Endarterectomy Trial (NASCET) method for calculating the degree of stenosis. The NASCET method calculates the degree of stenosis with reference to the lumen of the carotid artery distal to the stenosis.

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For duplex imaging studies the reference is indirect, since the degree of stenosis is inferred from velocity parameters and cross referenced to published or self-generated correlations among velocity parameters and results of angiography or other imaging studies which serve as the gold standard. In Doppler ultrasound, the degree of stenosis can be estimated using Doppler parameter of the peak systolic velocity (PSV) of the internal carotid artery (ICA), with concordance of the degree of narrowing of the ICA lumen. Additional Doppler parameters of ICA-to-common carotid artery (CCA) PSV ratio and ICA end-diastolic velocity (EDV) can be used when degree of stenosis is uncertain from ICA PSV. Reference Grant et al, Society of Radiologists in Ultrasound, 2003.

A short note can be made in the final report, such as:

- *"Severe left ICA stenosis of 70-80% by NASCET criteria"* or
- *"Severe left ICA stenosis of 70-80% by criteria similar to NASCET"* or
- *"70% stenosis derived by comparing the narrowest segment with the distal luminal diameter as related to the reported measure of arterial narrowing"* or
- *"Severe stenosis of 70-80% - validated velocity measurements with angiographic measurements, velocity criteria are extrapolated from diameter data as defined by the Society of Radiologists in Ultrasound Consensus Conference Radiology 2003; 229;340-346."*

Definition:
"Direct or indirect reference to measurements of distal internal carotid diameter as the denominator for stenosis measurement" – includes direct angiographic stenosis calculation based on the distal lumen as the denominator for stenosis measurement OR an equivalent validated method referenced to the above method (e.g., for duplex ultrasound studies, velocity parameters that correlate with anatomic measurements that use the distal internal carotid lumen as the denominator for stenosis measurement).

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Reference to Measurements of Distal Internal Carotid Diameter as the Denominator for Stenosis Measurement Referenced
CPT II 3100F: Carotid imaging study report (includes direct or indirect reference to measurements of distal internal carotid diameter as the denominator for stenosis measurement)

OR

Measurements of Distal Internal Carotid Diameter not Referenced, Reason not Otherwise Specified
Append a reporting modifier (8P) to CPT Category II code 3100F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.
3100F *with* 8P: Carotid imaging study report did not include direct or indirect reference to measurements of distal internal carotid diameter as the denominator for stenosis measurement, reason not otherwise specified

RATIONALE:
Since the clinical decision-making is based on randomized trial evidence and degree of stenosis is an important element of the decision for carotid intervention, characterization of the degree of stenosis needs to be standardized. Requiring that stenosis calculation be based on a denominator of distal internal carotid diameter or, in the case of duplex ultrasound, velocity measurements that have been correlated to angiographic stenosis calculation based on distal internal carotid diameter, makes the measure applicable to both imaging and duplex studies.

CLINICAL RECOMMENDATION STATEMENTS:
……the NASCET method of calculating stenosis measurement should be employed when angiography is used to correlate US findings. (Grant et al., SRU, 2003)

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For patients with symptomatic atherosclerotic carotid stenosis > 70%, as defined using the NASCET criteria, the value of carotid endarterectomy (CEA) has been clearly established from the results of 3 major prospective randomized trials: the NASCET, the European Carotid Surgery Trial (ECST), and the Veterans Affairs Cooperative Study Program. Among symptomatic patients with TIAs or minor strokes and high-grade carotid stenosis, each trial showed impressive relative and absolute risk reductions for those randomized to surgery. For patients with carotid stenosis < 50%, these trials showed that there was no significant benefit of surgery. (Sacco, ASA, 2006)

It is important to consider that the degree of carotid stenosis in ECST was measured differently than that in NASCET. The degree of carotid stenosis is significantly higher if calculated by the NASCET rather than the ECST method. In summary, it appears that patients with a recent TIA or nondisabling stroke with ipsilateral carotid stenosis benefit from surgery if the stenosis is > 50% as measured by the NASCET method; however, this benefit appears to be less pronounced in women. Recently symptomatic patients with > 70% stenosis as measured by the NASCET method can expect a far greater benefit from carotid endarterectomy. (Albers, AHA, 1999)

When MRA techniques are used for determining carotid stenosis, the report should reflect the methodology and reference the criteria for percent stenosis outlined in the NASCET. Also, the percent stenosis must be calculated using the distal cervical ICA diameter, where the walls are parallel, for the denominator. Similar to CTA, MRA with attention to the acquisition parameters and post-processing techniques can provide cross sectional measurements of stenosis that correlate with properly performed NASCET estimates of percent stenosis obtained with catheter angiography. In the setting of near occlusion, it may not be accurate to calculate percent stenosis ratios in the presence of post-stenotic arterial diameter decrease. Some MRA techniques may not be amenable to quantitative measurements, in which case qualitative assessment of stenosis should be provided. (ACR-ASNR-SNIS-SPR, 2010)

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Measure #197 (NQF 0074): Coronary Artery Disease (CAD): Lipid Control

2013 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

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 ≥ 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

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for patients with CAD seen during the reporting period. This measure may be reported by clinicians who perform the quality actions described in the measure for the primary management of patients with CAD based on the services provided and the measure-specific denominator coding.

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All patients aged 18 years and older with a diagnosis of coronary artery disease seen within a 12 month period

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Diagnosis for CAD (ICD-9-CM): 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
Diagnosis for coronary artery disease (ICD-10-CM) [REFERENCE ONLY/Not Reportable]: I20.0, I20.1, I20.8, I20.9, I21.01, I21.02, I21.09, I21.11, I21.19, I21.21, I21.29, I21.3, I21.4, I22.0, I22.1, I22.2, I22.8, I22.9, I24.0, I24.1, I24.8, I24.9, I25.10, I25.110, I25.111, I25.118, I25.119, I25.2, I25.5, I25.6, I25.700, I25.701, I25.708, I25.709, I25.710, I25.711, I25.718, I25.719, I25.720, I25.721, I25.728, I25.729, I25.730, I25.731, I25.738, I25.739, I25.750, I25.751, I25.758, I25.759, I25.760, I25.761, I25.768, I25.769, I25.798, I25.790, I25.791, I25.799, I25.82, I25.83, I25.89, I25.9, Z95.1, Z95.5, Z98.61

AND
Patient encounter during the reporting period (CPT): 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

NUMERATOR:
Patients who have a LDL-C result < 100 mg/dL OR patients who have a LDL-C result ≥ 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

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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). All patients that meet denominator criteria without an LDL-C result will NOT meet performance for the measure.

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 ≥ 100mg/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 ≥ 100mg/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 (eg, 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 (eg, patient declined, other patient reasons) (4013F *with* 2P)
OR
Documentation of system reason(s) for statin therapy not prescribed or currently being taken (eg, financial reasons, other system reasons) (4013F *with* 3P)

OR

Most current LDL-C ≥ 100mg/dL (G8737)
AND
Statin therapy not prescribed or currently being taken, reason not otherwise specified (4013F *with* 8P)

OR

Most current LDL-C ≥ 100mg/dL (G8737)
AND
Plan of care to achieve lipid control not documented (0556F *with* 8P)
OR
LDL-C result not present or not within 12 months prior (G8943)

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RATIONALE:
Managing LDL-C to less than 100 mg/dL through use of statins reduces risk of cardiovascular events.

CLINICAL RECOMMENDATION STATEMENTS:
The following evidence statements are quoted verbatim from the referenced clinical guidelines:

Recommended lipid management includes assessment of a fasting lipid profile (Class I Recommendation, Level A Evidence). (ACC/AHA, 2007)

a. LDL-C should be less than 100 mg/dL (Class I Recommendation, Level A Evidence)
b. Reduction of LDL-C to less than 70 mg/dL or high-dose statin therapy is reasonable (Class IIa Recommendation, Level A Evidence).
c. If baseline LDL-C is greater than or equal to 100 mg/dL, LDL-lowering medications are used in high-risk or moderately high-risk persons, it is recommended that intensity of the therapy be sufficient to achieve a 30% to 40% reduction in LDL-C levels (Class I Recommendation, Level A Evidence).
d. If on-treatment LDL-C is greater than or equal to 100 mg/dL, LDL-lowering therapy should be intensified (Class I Recommendation, Level A Evidence).
e. If baseline LDL-C is 70 to 100 mg/dL, it is reasonable to treat LDL-C to less than 70 mg/dL (Class IIa Recommendation, Level B Evidence).

Statins should be considered as first-line drugs when LDL-lowering drugs are indicated to achieve LDL treatment goals. (The Third Report of the National Cholesterol Education Program [NCEP] Adult Treatment Panel III [ATPII], 2002)

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➧Measure #198 (NQF 0079): Heart Failure: Left Ventricular Ejection Fraction (LVEF) Assessment

2013 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

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

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for patients with heart failure seen during the reporting period, regardless of when the evaluation of left ventricular function was performed. This measure is intended to reflect the quality of services provided for the primary management of patients with heart failure. 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. This measure may be reported by clinicians who perform the quality actions described based on the services provided and the measure-specific denominator coding.

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT codes and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.
The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data. There are no allowable performance exclusions for this measure.

DENOMINATOR:
All patients aged 18 years and older with a diagnosis of heart failure

> Denominator Criteria (Eligible Cases):
> Patients aged ≥ 18 years on date of encounter
> AND
> Diagnosis for HF (ICD-9-CM): 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
> Diagnosis for HF (ICD-10-CM) [REFERENCE ONLY/Not Reportable]: I11.0, I13.0, I13.2, I50.1, I50.20, I50.21, I50.22, I50.23, I50.30, I50.31, I50.32, I50.33, I50.40, I50.41, I50.42, I50.43, I50.9
> AND
> Patient encounter during the reporting period (CPT): 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

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

> Numerator 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.

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Definition:
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 of severely or moderately depressed left ventricular systolic function (G8738)

OR

Left ventricular ejection fraction (LVEF) ≥ 40% or documentation as normal or mildly depressed left ventricular systolic function (G8739)

OR

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

RATIONALE:
Evaluation of LVEF in patients with heart failure provides important information that is required to appropriately direct treatment. Several pharmacologic therapies have demonstrated efficacy in slowing disease progression and improving outcomes in patients with left ventricular systolic dysfunction. LVEF assessed during the initial evaluation of patients presenting with heart failure can be considered valid unless the patient has demonstrated a major change in clinical status, experienced or recovered from a clinical event, or received therapy that might have a significant effect on cardiac function.

A comprehensive 2-dimensional echocardiogram with Doppler flow studies has been identified as the single most useful diagnostic test in the evaluation of patients with heart failure.

CLINICAL RECOMMENDATION STATEMENTS:
The following evidence statements are quoted verbatim from the referenced clinical guidelines:

Two-dimensional echocardiography with Doppler should be performed during initial evaluation of patients presenting with HF to assess LVEF, LV size, wall thickness, and valve function. Radionuclide ventriculography can be performed to assess LVEF and volumes. Radionuclide ventriculography can be performed to assess LVEF and volumes. (Class I, Level of Evidence: C) (ACC/AHA, 2009)

Magnetic resonance imaging or computed tomography may be useful in evaluating chamber size and ventricular mass, detecting right ventricular dysplasia, or recognizing the presence of pericardial disease, as well as in assessing cardiac function and wall motion. (ACCF/AHA, 2009)

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Measure #201 (NQF 0073): Ischemic Vascular Disease (IVD): Blood Pressure Management

2013 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of patients aged 18 to 75 years with Ischemic Vascular Disease (IVD) who had most recent blood pressure in control (less than 140/90 mmHg)

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for patients with ischemic vascular disease seen during the reporting period. The performance period for this measure is 12 months. The most recent quality code submitted will be used for performance calculation. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

Measure Reporting via Claims:
ICD-9-CM diagnosis codes, CPT or HCPCS codes, and patient demographics are used to identify patients who are included in the measure's denominator. G-codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed ICD-9-CM diagnosis codes, CPT or HCPCS codes, and the appropriate G-code(s). There are no allowable performance exclusions for this measure. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT or HCPCS codes, and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions however these codes may be submitted for those registries that utilize claims data. There are no allowable performance exclusions for this measure.

DENOMINATOR:
Patients aged 18 to 75 years with the diagnosis of ischemic vascular disease, or who were discharged alive for acute myocardial infarction (AMI), coronary artery bypass graft (CABG) or percutaneous coronary interventions (PCI)

> Denominator Criteria (Eligible Cases):
> Patients aged 18 to 75 years on date of encounter
> AND
> Diagnosis for ischemic vascular disease (ICD-9-CM): 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, 444.01, 444.09, 444.1, 444.21, 444.22, 444.81, 444.89, 444.9, 445.01, 445.02, 445.81, 445.89
> Diagnosis for ischemic vascular disease (ICD-10-CM) [REFERENCE ONLY/Not Reportable]: I20.0, I20.1, I20.8, I20.9, I21.01, I21.02, I21.09, I21.11, I21.19, I21.21, I21.29, I21.3, I21.4, I24.0, I24.1, I24.8, I24.9, I25.10, I25.110, I25.111, I25.118, I25.119, I25.5, I25.6, I25.700, I25.701, I25.708, I25.709, I25.710,

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I25.711, I25.718, I25.719, I25.720, I25.721, I25.728, I25.729, I25.730, I25.731, I25.738, I25.739, I25.750, I25.751, I25.758, I25.759, I25.760, I25.761, I25.768, I25.769, I25.790, I25.791, I25.798, I25.799, I25.810, I25.811, I25.812, I25.82, I25.89, I25.9, I63.00, I63.011, I63.012, I63.019, I63.02, I63.031, I63.032, I63.039, I63.09, I63.10, I63.111, I63.112, I63.119, I63.12, I63.131, I63.132, I63.139, I63.19, I63.20, I63.211, I63.212, I63.219, I63.22, I63.231, I63.232, I63.239, I63.29, I63.30, I63.311, I63.312, I63.319, I63.321, I63.322, I63.329, I63.331, I63.332, I63.339, I63.341, I63.342, I63.349, I63.39, I63.40, I63.411, I63.412, I63.419, I63.421, I63.422, I63.429, I63.431, I63.432, I63.439, I63.441, I63.442, I63.449, I63.49, I63.50, I63.511, I63.512, I63.519, I63.521, I63.522, I63.529, I63.531, I63.532, I63.539, I63.541, I63.542, I63.549, I63.59, I63.6, I63.8, I63.9, I65.01, I65.02, I65.03, I65.09, I65.1, I65.21, I65.22, I65.23, I65.29, I65.8, I65.9, I66.01, I66.02, I66.03, I66.09, I66.11, I66.12, I66.13, I66.19, I66.21, I66.22, I66.23, I66.29, I66.3, I66.8, I66.9, I70.1, I70.201, I70.202, I70.203, I70.208, I70.209, I70.211, I70.212, I70.213, I70.218, I70.219, I70.221, I70.222, I70.223, I70.228, I70.229, I70.231, I70.232, I70.233, I70.234, I70.235, I70.238, I70.239, I70.241, I70.242, I70.243, I70.244, I70.245, I70.248, I70.249, I70.25, I70.261, I70.262, I70.263, I70.268, I70.269, I70.291, I70.292, I70.293, I70.298, I70.299, I70.92, I74.01, I74.09, I74.10, I74.11, I74.19, I74.2, I74.3, I74.4, I74.5, I74.8, I74.9, I75.011, I75.012, I75.013, I75.019, I75.021, I75.022, I75.023, I75.029, I75.81, I75.89

AND

Patient encounter during reporting period (CPT or HCPCS): 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, G0402

OR

Patient encounter during the reporting period (CPT) - Procedure: 33140, 33510, 33511, 33512, 33513, 33514, 33516, 33517, 33518, 33519, 33521, 33522, 33523, 33533, 33534, 33535, 33536, 92920, 92924, 92928, 92933, 92937, 92941, 92943

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):

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 Given

G8592: No documentation of blood pressure measurement, reason not given

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RATIONALE:
Fifty million or more Americans have high blood pressure that warrants treatment, according to the NHANES survey (JNC-7, 2003). The USPSTF recommends that clinicians screen adults aged 18 and older for high blood pressure. (USPSTF, 2007)

The most frequent and serious complications of uncontrolled hypertension include coronary heart disease, congestive heart failure, stroke, ruptured aortic aneurysm, renal disease, and retinopathy. The increased risks of hypertension are present in individuals ranging from 40 to 89 years of age. For every 20 mmHg systolic or 10 mmHg diastolic increase in BP, there is a doubling of mortality from both IHD and stroke. (JNC-7, 2003)

Better control of BP has been shown to significantly reduce the probability that these undesirable and costly outcomes will occur. Thus, the relationship between the measure (control of hypertension) and the long-term clinical outcomes listed is well established. In clinical trials, antihypertensive therapy has been associated with reductions in stroke incidence (35-40%), myocardial infarction (20-25%) and heart failure (> 50%). (JNC-7, 2003)

CLINICAL RECOMMENDATION STATEMENTS:
The U.S. Preventive Services Task Force (USPSTF) recommends screening for high blood pressure in adults age 18 years and older.

The JNC-7 indicates that treating systolic BP and diastolic BP to targets that are < 140/90 mmHg is associated with a decrease in CVD complications.

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♦ Measure #204 (NQF 0068) : Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic

2013 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of patients aged 18 years and older with Ischemic Vascular Disease (IVD) with documented use of aspirin or another antithrombotic

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for patients with IVD seen during the reporting period. The performance period for this measure is 12 months from the date of service. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

Measure Reporting via Claims:
ICD-9-CM diagnosis codes, CPT or HCPCS codes, and patient demographics are used to identify patients who are included in the measure's denominator. G-codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed ICD-9-CM diagnosis codes, CPT or HCPCS codes, and the appropriate G-code. There are no allowable performance exclusions for this measure. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT or HCPCS codes, and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions however these codes may be submitted for those registries that utilize claims data. There are no allowable performance exclusions for this measure.

DENOMINATOR:
Patients aged 18 years and older with the diagnosis of ischemic vascular disease, or who were discharged alive for acute myocardial infarction (AMI), coronary artery bypass graft (CABG) or percutaneous coronary interventions (PCI)

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Diagnosis for Ischemic Vascular Disease (ICD-9-CM): 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, 444.01, 444.09, 444.1, 444.21, 444.22, 444.81, 444.89, 444.9, 445.01, 445.02, 445.81, 445.89
Diagnosis for Ischemic Vascular Disease (ICD-10-CM) [REFERENCE ONLY/Not Reportable]: I20.0, I20.1, I20.8, I20.9, I21.01, I21.02, I21.09, I21.11, I21.19, I21.21, I21.29, I21.3, I21.4, I24.0, I24.1, I24.8, I24.9, I25.10, I25.110, I25.111, I25.118, I25.119, I25.5, I25.6, I25.700, I25.701, I25.708, I25.709, I25.710,

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I25.711, I25.718, I25.719, I25.720, I25.721, I25.728, I25.729, I25.730, I25.731, I25.738, I25.739, I25.750, I25.751, I25.758, I25.759, I25.760, I25.761, I25.768, I25.769, I25.790, I25.791, I25.798, I25.799, I25.810, I25.811, I25.812, I25.82, I25.89, I25.9, I63.00, I63.011, I63.012, I63.019, I63.02, I63.031, I63.032, I63.039, I63.09, I63.10, I63.111, I63.112, I63.119, I63.12, I63.131, I63.132, I63.139, I63.19, I63.20, I63.211, I63.212, I63.219, I63.22, I63.231, I63.232, I63.239, I63.29, I63.30, I63.311, I63.312, I63.319, I63.321, I63.322, I63.329, I63.331, I63.332, I63.339, I63.341, I63.342, I63.349, I63.39, I63.40, I63.411, I63.412, I63.419, I63.421, I63.422, I63.429, I63.431, I63.432, I63.439, I63.441, I63.442, I63.449, I63.49, I63.50, I63.511, I63.512, I63.519, I63.521, I63.522, I63.529, I63.531, I63.532, I63.539, I63.541, I63.542, I63.549, I63.59, I63.6, I63.8, I63.9, I65.01, I65.02, I65.03, I65.09, I65.1, I65.21, I65.22, I65.23, I65.29, I65.8, I65.9, I66.01, I66.02, I66.03, I66.09, I66.11, I66.12, I66.13, I66.19, I66.21, I66.22, I66.23, I66.29, I66.3, I66.8, I66.9, I70.1, I70.201, I70.202, I70.203, I70.208, I70.209, I70.211, I70.212, I70.213, I70.218, I70.219, I70.221, I70.222, I70.223, I70.228, I70.229, I70.231, I70.232, I70.233, I70.234, I70.235, I70.238, I70.239, I70.241, I70.242, I70.243, I70.244, I70.245, I70.248, I70.249, I70.25, I70.261, I70.262, I70.263, I70.268, I70.269, I70.291, I70.292, I70.293, I70.298, I70.299, I70.92, I74.01, I74.09, I74.10, I74.11, I74.19, I74.2, I74.3, I74.4, I74.5, I74.8, I74.9, I75.011, I75.012, I75.013, I75.019, I75.021, I75.022, I75.023, I75.029, I75.81, I75.89

AND

Patient encounter during reporting period (CPT or HCPCS): 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, G0402

OR

Patient encounter during the reporting period (CPT) - Procedure: 33140, 33510, 33511, 33512, 33513, 33514, 33516, 33517, 33518, 33519, 33521, 33522, 33523, 33533, 33534, 33535, 33536, 92920, 92924, 92928, 92933, 92937, 92941, 92943

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 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 Given

G8599: Aspirin or another antithrombotic therapy not used, reason not given

RATIONALE:

Aspirin therapy has been shown to directly reduce 14% of the odds of cardiovascular events among men and 12% of the odds for women. (Berger, 2006) Aspirin use reduced the number of strokes by 20%, MI by 30%, and other vascular events by 30%. (Weisman, 2002) Also, aspirin treatments have been shown to prevent 1 cardiovascular event over an average follow-up of 6.4 years. This means that on average in a 6.4 year time period the use of aspirin therapy results in a benefit of 3 cardiovascular events prevented per 1000 women and 4 events prevented per 1000 men. (Berger, 2006) Even for patients with peripheral arterial disease, aspirin has been shown to reduce CHD in people. (Kikano, 2007)

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CLINICAL RECOMMENDATION STATEMENTS:

The U.S. Preventive Services Task Force (USPSTF) strongly recommends that clinicians discuss aspirin chemoprevention with adults who are at increased risk (5-year risk of greater than or equal to 3 percent) for coronary heart disease (CHD). Discussions with patients should address both the potential benefits and harms of aspirin therapy.

The USPSTF found good evidence that aspirin decreases the incidence of coronary heart disease in adults who are at increased risk for heart disease. They also found good evidence that aspirin increases the incidence of gastrointestinal bleeding and fair evidence that aspirin increases the incidence of hemorrhagic strokes. The USPSTF concluded that the balance of benefits and harms is most favorable in patients at high risk of CHD (5-year risk of greater than or equal to 3 percent) but is also influenced by patient preferences.

USPSTF encourages men age 45 to 79 years to use aspirin when the potential benefit of a reduction in myocardial infarctions outweighs the potential harm of an increase in gastrointestinal hemorrhage. They encourage women age 55 to 79 years to use aspirin when the potential benefit of a reduction in ischemic strokes outweighs the potential harm of an increase in gastrointestinal hemorrhage.

The ADA recommends use aspirin therapy (75-162 mg/day) as a primary prevention strategy in those with type 1 or 2 diabetes at increased cardiovascular risk, including those who are 40 years of age or who have additional risk factors (family history of CVD, hypertension, smoking, dyslipidemia, or albuminuria).

AHA/ACC: Start aspirin 75 to 162 mg/d and continue indefinitely in all patients with coronary and other vascular disease unless contraindicated.

ICSI: Aspirin should be prescribed to all patients with stable coronary disease. If a patient is aspirin intolerant, then use clopidogrel.

VA/DoD: Ensure that all patients with ischemic heart disease or angina symptoms receive antiplatelet therapy (aspirin 81-325 mg/day). For patients who require warfarin therapy, aspirin may be safely used at a dose of 80 mg/day. If use of aspirin is contraindicated, clopidogrel (75 mg/day) may be used.

AHA/ASA: The use of aspirin is recommended for cardiovascular (including but not specific to stroke) prophylaxis among persons whose risk is sufficiently high for the benefits to outweigh the risks associated with treatment (a 10-year risk of cardiovascular events of 6% to 10%).

ACCP: For long-term treatment after PCI, the guideline developers recommend aspirin, 75 to 162 mg/day. For long-term treatment after PCI in patients who receive antithrombotic agents such as clopidogrel or warfarin, the guideline developers recommend lower-dose aspirin, 75 to 100 mg/day. For patients with ischemic stroke who are not receiving thrombolysis, the guideline developers recommend early aspirin therapy, 160 to 325 mg/day.

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❑ Measure #205 (NQF 0409): HIV/AIDS: Sexually Transmitted Disease Screening for Chlamydia and Gonorrhea

2013 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

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

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for patients with HIV/AIDS seen during the reporting period. Only patients who had at least two visits during the reporting period, with at least 60 days between each visit will be counted in the denominator for this measure. This measure is intended to reflect the quality of services provided for the primary management of patients with HIV/AIDS.

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT or HCPCS codes, and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
Patients aged 13 and older with a diagnosis of HIV/AIDS who had at least two medical visits during the measurement year, with at least 60 days between each visit

Denominator Criteria (Eligible Cases):
Patients aged ≥ 13 years of age on date of encounter
AND
Diagnosis for HIV/AIDS (ICD-9-CM): 042, V08
Diagnosis for HIV/AIDS (ICD-10-CM) [REFERENCE ONLY/Not Reportable]: B20, Z21
AND
Patient encounters during the reporting period (CPT or HCPCS): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, G0402

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 otherwise specified (3511F *with* 8P)

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RATIONALE:
Sexually transmitted diseases that cause mucosal inflammation (such as gonorrhea and chlamydia) increase the risk for HIV-infection (as these diseases and other sexually transmitted diseases can increase the infectiousness of and a person's susceptibility to HIV) (Galvin, 2004).

CLINICAL RECOMMENDATION STATEMENTS:
All patients should be screened with laboratory tests for STDs at the initial encounter (A-II for syphilis, for trichomoniasis in women, and for chlamydial infection in women aged less than 25 years; B-II for gonorrhea and chlamydial infection in all men and women), and thereafter, depending on reported high-risk behavior, the presence of other STDs, and the prevalence of STDs in the community (B-III). (Aberg, 2004)

Consideration should be given to screening all HIV-infected men and women for gonorrhea and chlamydial infections. However, because of the cost of screening and the variability of prevalence of these infections, decisions about routine screening for these infections should be based on epidemiologic factors (including prevalence of infection in the community or the population being served), availability of tests, and cost. (Some HIV specialists also recommend type-specific serologic testing for herpes simplex virus type 2 for both men and women.) (B-II, for identifying STDs) (CDC, HRSA, NIH, HIVMA of IDSA, 2003)

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❑ Measure #208 (NQF 0410): HIV/AIDS: Sexually Transmitted Disease Screening for Syphilis

2013 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

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

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for patients with HIV/AIDS seen during the reporting period. Only patients who had at least two visits during the reporting period, with at least 60 days between each visit will be counted in the denominator for this measure. This measure is intended to reflect the quality of services provided for the primary management of patients with HIV/AIDS.

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT or HCPCS codes, and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
Patients aged 13 and older with a diagnosis of HIV/AIDS who had at least two medical visits during the measurement year, with at least 60 days between each visit

Denominator Criteria (Eligible Cases):
Patients aged ≥ 13 years on date of encounter
AND
Diagnosis for HIV/AIDS (ICD-9-CM): 042, V08
Diagnosis for HIV/AIDS (ICD-10-CM) [REFERENCE ONLY/Not Reportable]: B20, Z21
AND
Patient encounters during the reporting period (CPT or HCPCS): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, G0402

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 otherwise specified (3512F *with* 8P)

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RATIONALE:
A 2000 literature review investigated the rates of HIV prevalence in U.S. patients with syphilis. Data from the thirty studies identified and analyzed for the review revealed that HIV prevalence is high among patients infected with syphilis. The mean rate for HIV-infection among patients with syphilis was 15.7 (with an interquartile range of 13.6-21.8). This study would indicate that identifying and treating HIV among patients with syphilis (and vice versa) is an important goal for health systems (Blocker, 2000).

Another study investigated the effect of syphilis infection on the health of patients infected with HIV. HIV viral loads and CD4 cell counts were analyzed for 52 patients in the San Francisco and Los Angeles areas for three time periods: before syphilis infection, during syphilis infection and after syphilis treatment). When compared to levels before syphilis infection, HIV viral loads were significantly higher during syphilis infection. Patients' CD4 cell counts were also significantly lower during syphilis infection than before syphilis infection (Buchacz, 2004). This study further supports the need to identify and treat syphilis infection among HIV-infected patient.

Currently, the Centers for Disease Prevention and Control, the Health Resources and Services Administration, the National Institutes of Health, and the Infectious Diseases Society of America/HIV Medicine Association recommend that all HIV-infected patients should be screened annually for syphilis. However, according to data collected for 3,840 HIV-infected patients within the Veterans Affairs system, only 74% had been screened for syphilis (serum RPR or VDRL) in the past year. The same study reports data from the HIV Cost and Services Utilization Study (HCSUS), the only national probability sample of HIV-infected persons, which indicates that only 49% of participants had been screened for syphilis (Korthius, 2004). These data would indicate that there is indeed room for improvement.

Data from the HIVQual Continuous Quality Program also indicates that there is room for improvement. According to data from 2006, the median rate for syphilis screening among patients infected with HIV/AIDS was 86%. It is important to note that these rates represent only those Title III and IV grantees that are participating in the HIVQUAL Project, a continuous quality improvement project sponsored by the Ryan White Division of Community Based Programs and managed by the New York State Department of Health AIDS institute. Nationwide rates are likely to vary (and be lower) than the rates reported by HIVQUAL. (NYSDOH AIDS Institute, 2007)

CLINICAL RECOMMENDATION STATEMENTS:
Because many STDs are asymptomatic, routine screening for curable STDs (e.g., syphilis, gonorrhea, and Chlamydia) should be performed at least yearly for sexually active persons. (CDC, 2006)

Screening for STDs should be repeated periodically (i.e., at least annually) if the patient is sexually active or if earlier screening revealed STDs. (Grade B-III) (CDC, HRSA, NIH, HIVMA of IDSA, 2003)

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🗝 Measure #209 (NQF 0445): Functional Communication Measure – Spoken LanguageComprehension

2013 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Percentage of patients aged 16 years and older with a diagnosis of late effects of cerebrovascular disease (CVD) that make progress on the Spoken Language Comprehension Functional Communication Measure

INSTRUCTIONS:
This measure is to be reported once per episode of treatment for all patients with late effects of CVD who are treated for a spoken language comprehension deficit by a speech-language pathologist (SLP) during the reporting period. Only patients who had at least two visits in the reporting period will be counted in the denominator for this measure. This is an outcome measure, and its calculation requires reporting of the patient's score (see below under numerator) on the measure at the admission to and discharge from SLP treatment for spoken language comprehension. The admission score is noted by the SLP at the conclusion of the first treatment session, and the discharge score at the conclusion of the final treatment session for spoken language comprehension.

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data. There are no allowable performance exclusions for this measure.

DENOMINATOR:
Patients ≥ 16 years and older with late effects of CVD who received SLP treatment for spoken language comprehension

Denominator Criteria (Eligible Cases):
Patients aged ≥ 16 years on date of encounter
AND
Diagnosis of late effects of CVD (ICD-9-CM): 438.10, 438.11, 438.12, 438.13, 438.14, 438.19, 438.20, 438.21, 438.22, 438.30, 438.31, 438.32, 438.40, 438.41, 438.42, 438.50, 438.51, 438.52, 438.53, 438.6, 438.7, 438.81, 438.82, 438.83, 438.84, 438.85, 438.89, 438.9, 784.3
Diagnosis of late effects of CVD (ICD-10-CM) [Reference ONLY/Not Reportable]: I69.00, I69.020, I69.021, I69.022, I69.023, I69.028, I69.031, I69.032, I69.033, I69.034, I69.039, I69.041, I69.042, I69.043, I69.044, I69.049, I69.051, I69.052, I69.053, I69.054, I69.059, I69.061, I69.062, I69.063, I69.064, I69.065, I69.069, I69.090, I69.091, I69.092, I69.093, I69.098, I69.10, I69.120, I69.121, I69.122, I69.123, I69.128, I69.131, I69.132, I69.133, I69.134, I69.139, I69.141, I69.142, I69.143, I69.144, I69.149, I69.151, I69.152, I69.153, I69.154, I69.159, I69.161, I69.162, I69.163, I69.164, I69.165, I69.169, I69.190, I69.191, I69.192, I69.193, I69.198, I69.20, I69.220, I69.221, I69.222, I69.223, I69.228, I69.231, I69.232, I69.233, I69.234, I69.239, I69.241, I69.242, I69.243, I69.244, I69.249, I69.251, I69.252, I69.253, I69.254, I69.259, I69.261, I69.262, I69.263, I69.264, I69.265, I69.269, I69.290, I69.291, I69.292, I69.293, I69.298, I69.30, I69.320, I69.321, I69.322, I69.323, I69.328, I69.331, I69.332, I69.333, I69.334, I69.339, I69.341, I69.342, I69.343, I69.344, I69.349, I69.351, I69.352, I69.353, I69.354, I69.359, I69.361, I69.362, I69.363, I69.364, I69.365, I69.369, I69.390, I69.391, I69.392, I69.393, I69.398, I69.80, I69.820, I69.821, I69.822, I69.823, I69.828, I69.831, I69.832, I69.833, I69.834, I69.839, I69.841, I69.842, I69.843, I69.844, I69.849, I69.851, I69.852,

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I69.853, I69.854, I69.859, I69.861, I69.862, I69.863, I69.864, I69.865, I69.869, I69.890, I69.891, I69.892, I69.893, I69.898, I69.90, I69.920, I69.921, I69.922, I69.923, I69.928, I69.931, I69.932, I69.933, I69.934, I69.939, I69.941, I69.942, I69.943, I69.944, I69.949, I69.951, I69.952, I69.953, I69.954, I69.959, I69.961, I69.962, I69.963, I69.964, I69.965, I69.969, I69.990, I69.991, I69.992, I69.993, I69.998, R47.01
AND
Two (2) or more patient encounters during reporting period (CPT): 92507, 92508
AND
Patient treated for spoken language comprehension disorder

NUMERATOR:
Patients whose score on the functional communication measure at discharge were higher than at admission

Definitions:
Admission – The conclusion of the first treatment session for spoken language comprehension by an SLP.
Discharge – The conclusion of the final treatment session for spoken language comprehension by an SLP, regardless of whether the patient is also being discharged from the facility and/or other SLP services.
Patient's Score –

LEVEL 1: The individual is alert, but unable to follow simple directions or respond to yes/no questions, even with cues.

LEVEL 2: With consistent, maximal cues, the individual is able to follow simple directions, respond to simple yes/no questions in context, and respond to simple words or phrases related to personal needs.

LEVEL 3: The individual usually responds accurately to simple yes/no questions. The individual is able to follow simple directions out of context, although moderate cueing is consistently needed. Accurate comprehension of more complex directions/messages is infrequent.

LEVEL 4: The individual consistently responds accurately to simple yes/no questions and occasionally follows simple directions without cues. Moderate contextual support is usually needed to understand complex sentences/messages. The individual is able to understand limited conversations about routine daily activities with familiar communication partners.

LEVEL 5: The individual is able to understand communication in structured conversations with both familiar and unfamiliar communication partners. The individual occasionally requires minimal cueing to understand more complex sentences/messages. The individual occasionally initiates the use of compensatory strategies when encountering difficulty.

LEVEL 6: The individual is able to understand communication in most activities, but some limitations in comprehension are still apparent in vocational, avocational, and social activities. The individual rarely requires minimal cueing to understand complex sentences. The individual usually uses compensatory strategies when encountering difficulty.

LEVEL 7: The individual's ability to independently participate in vocational, avocational, and social activities are not limited by spoken language comprehension. When difficulty with comprehension occurs, the individual consistently uses a compensatory strategy.

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Numerator Options:
Score on the spoken language comprehension functional communication measure at discharge was higher than at admission (G8603)

OR

Score on the spoken language comprehension functional communication measure at discharge was not higher than at admission, reason not given (G8604)

OR

Patient treated for spoken language comprehension but not scored on the spoken language comprehension functional communication measure either at admission or at discharge (G8605)

RATIONALE:
Assessment of communication ability is important for determining the patient's capabilities and limitations in expressing their wants, needs, and understanding; their ability to contribute to their plan of care (including consent forms and advanced directives), and their ability to comprehend instructions affecting the success of the rehabilitation process. The results of the assessment may impact the choice of treatment and disposition.

Disorders of communication (i.e., problems with speaking, listening, reading, writing, gesturing, and/or pragmatics) and related cognitive impairments may occur in as many as 40% of post-stroke patients. The most common communication disorders occurring after stroke are aphasia and dysarthria. Rapid spontaneous improvement is common, but early evaluation can identify communication problems and monitor change. If indicated, intervention can help maximize recovery of communication abilities and prevent learning of ineffective or inappropriate compensatory behaviors. Goals of speech and language treatment are to (1) facilitate the recovery of communication, (2) assist patients in developing strategies to compensate for communication disorders, and (3) counsel and educate people in the patient's environment to facilitate communication, decrease isolation, and meet the patient's desires and needs.

CLINICAL RECOMMENDATION STATEMENTS:
Aphasic stroke patients should be referred for speech and language therapy. Where the patient is sufficiently well and motivated, aim for minimum of two hours per week. (Scottish Intercollegiate Guidelines Network)

Recommend that the clinician use standardized, valid assessments to evaluate the patient's stroke-related impairments and functional status and encourage patient's participation in community and social activities. Recommend that the standardized assessment results be used to assess probability of outcome, determine the appropriate level of care, and develop interventions. (US Department of Veterans' Affairs; endorsed by the American Heart Association)

Recommend that all patients be evaluated and treated by the SLP for residual communication difficulties (i.e., speaking, listening, reading, writing, and pragmatics). (US Department of Veterans' Affairs; endorsed by the American Heart Association)

Interventions for people with aphasia may include: treatment of phonological and semantic deficits following models derived from cognitive neuropsychology, constraint-induced therapy, and computer-based therapy programs. (National Stroke Foundation of Australia)

It is recommended that patients who are conscious with communication difficulties be evaluated by a SLP who can develop appropriate communication techniques. SLP assessment should include screening for hearing and vision and restoration of glasses or hearing aids. Appropriate patients (with reasonable cognition and language skills) should be considered for alternative or augmentative communication. Patients with communication difficulties should be monitored and assessed regularly to determine appropriateness for speech and language therapy. An appropriate treatment program with a system for monitoring progress should be in place for any individuals receiving speech-

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language therapy. In developing a communication program, consideration for premorbid communication style, underlying cognitive deficits, environmental context, social needs, and necessary communication aids should be given. (Royal College of Medicine and the British Society of Rehabilitation Medicine)

Where achievable goals can be identified, and continuing progress demonstrated, patients with communication difficulties should be offered an appropriate treatment program, with monitoring of progress. The program should: take into account the patient's premorbid communication style and any underlying cognitive deficits; give the opportunity to rehearse communication skills in situations appropriate to the context in which the patient will live/work/study/socialize after discharge; include the family and caregivers in developing strategies for optimum communication within the immediate social circle; and consider the need for communication aids including gesture drawing, communication charts and computerized systems. (Royal College of Medicine and the British Society of Rehabilitation Medicine)

The speech and language therapist will be involved in all cases where there are communication problems following stroke. (Republic of South Africa Department of Health; Stroke Foundation of South Africa)

People with aphasia following stroke should be referred to a speech and language therapist for assessment and appropriate management of their communication difficulty. (Stroke Foundation of New Zealand)

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🗝 Measure #210 (NQF 0449): Functional Communication Measure - Attention

2013 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Percentage of patients aged 16 years and older with a diagnosis of late effects of cerebrovascular disease (CVD) that make progress on the Attention Functional Communication Measure

INSTRUCTIONS:
This measure is to be reported once per episode of treatment for all patients with late effects of CVD who are treated for an attention deficit by a speech-language pathologist (SLP) during the reporting period. Only patients who had at least two visits in the reporting period will be counted in the denominator for this measure. This is an outcome measure, and its calculation requires reporting of the patient's score (see below under numerator) on the measure at the admission to and discharge from SLP treatment for attention. The admission score is noted by the SLP at the conclusion of the first treatment session, and the discharge score at the conclusion of the final treatment session for attention.

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data. There are no allowable performance exclusions for this measure.

DENOMINATOR:
Patients aged 16 years and older with late effects of CVD who received SLP treatment for attention

Denominator Criteria (Eligible Cases):
Patients aged ≥ 16 years on date of encounter
AND
Diagnosis of late effects of CVD (ICD-9-CM): 438.0, 438.10, 438.11, 438.12, 438.13, 438.14, 438.19, 438.20, 438.21, 438.22, 438.30, 438.31, 438.32, 438.40, 438.41, 438.42, 438.50, 438.51, 438.52, 438.53, 438.6, 438.7, 438.81, 438.82, 438.83, 438.84, 438.85, 438.89, 438.9
Diagnosis of late effects of CVD (ICD-10-CM) [Reference ONLY/Not Reportable]: I69.00, I69.01, I69.020, I69.021, I69.022, I69.023, I69.028, I69.031, I69.032, I69.033, I69.034, I69.039, I69.041, I69.042, I69.043, I69.044, I69.049, I69.051, I69.052, I69.053, I69.054, I69.059, I69.061, I69.062, I69.063, I69.064, I69.065, I69.069, I69.090, I69.091, I69.092, I69.093, I69.098, I69.10, I69.11, I69.120, I69.121, I69.122, I69.123, I69.128, I69.131, I69.132, I69.133, I69.134, I69.139, I69.141, I69.142, I69.143, I69.144, I69.149, I69.151, I69.152, I69.153, I69.154, I69.159, I69.161, I69.162, I69.163, I69.164, I69.165, I69.169, I69.190, I69.191, I69.192, I69.193, I69.198, I69.20, I69.21, I69.220, I69.221, I69.222, I69.223, I69.228, I69.231, I69.232, I69.233, I69.234, I69.239, I69.241, I69.242, I69.243, I69.244, I69.249, I69.251, I69.252, I69.253, I69.254, I69.259, I69.261, I69.262, I69.263, I69.264, I69.265, I69.269, I69.290, I69.291, I69.292, I69.293, I69.298, I69.30, I69.31, I69.320, I69.321, I69.322, I69.323, I69.328, I69.331, I69.332, I69.333, I69.334, I69.339, I69.341, I69.342, I69.343, I69.344, I69.349, I69.351, I69.352, I69.353, I69.354, I69.359, I69.361, I69.362, I69.363, I69.364, I69.365, I69.369, I69.390, I69.391, I69.392, I69.393, I69.398, I69.80, I69.81, I69.820, I69.821, I69.822, I69.823, I69.828, I69.831, I69.832, I69.833, I69.834, I69.839, I69.841, I69.842, I69.843, I69.844, I69.849, I69.851, I69.852, I69.853, I69.854, I69.859, I69.861, I69.862, I69.863, I69.864,

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I69.865, I69.869, I69.890, I69.891, I69.892, I69.893, I69.898, I69.90, I69.91, I69.920, I69.921, I69.922, I69.923, I69.928, I69.931, I69.932, I69.933, I69.934, I69.939, I69.941, I69.942, I69.943, I69.944, I69.949, I69.951, I69.952, I69.953, I69.954, I69.959, I69.961, I69.962, I69.963, I69.964, I69.965, I69.969, I69.990, I69.991, I69.992, I69.993, I69.998

AND

Two (2) or more patient encounters during reporting period (CPT): 97532

AND

Patient treated for attention disorder

NUMERATOR:

Patients whose score on the functional communication measure at discharge were higher than at admission

Definitions:

Admission – The conclusion of the first treatment session for attention by an SLP.

Discharge – The conclusion of the final treatment session for attention by an SLP, regardless of whether the patient is also being discharged from the facility and/or other SLP services.

Patient's Score –

LEVEL 1: Attention is nonfunctional. The individual is generally unresponsive to most stimuli.

LEVEL 2: The individual can briefly attend with consistent maximal stimulation, but not long enough to complete even simple living tasks.

LEVEL 3: The individual maintains attention over time to complete simple living tasks of short duration with consistent maximal cueing in the absence of distracting stimuli.

LEVEL 4: The individual maintains attention during simple living tasks of multiple steps and long duration within a minimally distracting environment with consistent minimal cueing.

LEVEL 5: The individual maintains attention within simple living activities with occasional minimal cues within distracting environments. The individual requires increased cueing to start, continue, and change attention during complex activities.

LEVEL 6: The individual maintains attention within complex activities, and can attend simultaneously to multiple demands with rare minimal cues. The individual usually uses compensatory strategies when encountering difficulty. The individual has mild difficulty or takes more than a reasonable amount of time to attend to multiple tasks/stimuli.

LEVEL 7: The individual's ability to participate in vocational, avocational, or social activities is not limited by attentional abilities. Independent functioning may occasionally include the use of compensatory strategies.

Numerator Options:

Score on the attention functional communication measure at discharge was higher than at admission (G8606)

OR

Score on the attention functional communication measure at discharge was not higher than at admission, reason not given (G8607)

OR

Patient treated for attention but not scored on the attention functional communication measure either at admission or at discharge (G8608)

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RATIONALE:
Assessment of cognition and arousal is important for determining the patient's capabilities and limitations for coping with their stroke and assuring success of the rehabilitation process. The results of the assessment may impact the choice of treatment and disposition.

Impairments in cognitive functioning are common after a stroke. In particular, impairments in attention, memory, and executive functioning (i.e., integrating multiple and complex processes) can be especially disabling. The treatment of cognitive deficits through cognitive remediation designed to reduce deficits can be approached in a variety of ways. Cicerone and colleagues completed a comprehensive review of the evidence-based literature for cognitive remediation for both traumatic brain injury (TBI) and stroke.

The review revealed a large number of randomized control trials (RCTs) in a variety of areas of cognitive functioning and provided comprehensive guidelines for cognitive rehabilitation specific to these populations. There is support for cognitive remediation of deficits in both the acute and post-acute phases of recovery from stroke and TBI, although some of the improvements were relatively small and task-specific. Some benefits were specific to the TBI population, although it seems reasonable to extend some of these results to the stroke population.

CLINICAL RECOMMENDATION STATEMENTS:
Recommend that the clinician use standardized, valid assessments to evaluate the patient's stroke-related impairments and functional status and encourage patient's participation in community and social activities. Recommend that the standardized assessment results be used to assess probability of outcome, determine the appropriate level of care, and develop interventions. (US Department of Veterans' Affairs; endorsed by the American Heart Association)

Recommend that patients be assessed for cognitive deficits and be given cognitive retraining, if any of the following conditions are present:
• Attention deficits
• Visual neglect
• Memory deficits
• Executive function and problem-solving difficulties
(US Department of Veterans' Affairs; endorsed by the American Heart Association)

Cognitive therapy may be used in rehabilitation of attention and concentration deficits. (National Stroke Foundation of Australia)

Patients with persistent cognitive deficits following acquired brain injury (ABI) should be offered cognitive rehabilitation which may include management in a structured and distraction-free environment and targeted programs for those with executive difficulties (i.e., problems with planning, organization, problem solving and divided attention), and attempts to improve attention and information processing skills. (Royal College of Medicine and the British Society of Rehabilitation Medicine)

The speech and language therapist will be involved in all cases where there are communication problems following stroke. (Republic of South Africa Department of Health; Stroke Foundation of South Africa)

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🗝 Measure #211 (NQF 0448): Functional Communication Measure - Memory

2013 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Percentage of patients aged 16 years and older with a diagnosis of late effects of cerebrovascular disease (CVD) that make progress on the Memory Functional Communication Measure

INSTRUCTIONS:
This measure is to be reported once per episode of treatment for all patients with late effects of CVD who are treated for a memory deficit by a speech-language pathologist (SLP) during the reporting period. Only patients who had at least two visits in the reporting period will be counted in the denominator for this measure. This is an outcome measure, and its calculation requires reporting of the patient's score (see below under numerator) on the measure at the admission to and discharge from SLP treatment for memory. The admission score is noted by the SLP at the conclusion of the first treatment session, and the discharge score at the conclusion of the final treatment session for memory.

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data. There are no allowable performance exclusions for this measure.

DENOMINATOR:
Patients aged 16 years and older with late effects of CVD who received SLP treatment for memory

Denominator Criteria (Eligible Cases):
Patients aged ≥ 16 years on date of encounter
AND
Diagnosis of late effects of CVD (ICD-9-CM): 438.0, 438.10, 438.11, 438.12, 438.13, 438.14, 438.19, 438.20, 438.21, 438.22, 438.30, 438.31, 438.32, 438.40, 438.41, 438.42, 438.50, 438.51, 438.52, 438.53, 438.6, 438.7, 438.81, 438.82, 438.83, 438.84, 438.85, 438.89, 438.9
Diagnosis of late effects of CVD (ICD-10-CM) [Reference ONLY/Not Reportable]: I69.00, I69.01, I69.020, I69.021, I69.022, I69.023, I69.028, I69.031, I69.032, I69.033, I69.034, I69.039, I69.041, I69.042, I69.043, I69.044, I69.049, I69.051, I69.052, I69.053, I69.054, I69.059, I69.061, I69.062, I69.063, I69.064, I69.065, I69.069, I69.090, I69.091, I69.092, I69.093, I69.098, I69.10, I69.11, I69.120, I69.121, I69.122, I69.123, I69.128, I69.131, I69.132, I69.133, I69.134, I 69.139, I69.141, I69.142, I69.143, I69.144, I69.149, I69.151, I69.152, I69.153, I69.154, I69.159, I69.161, I69.162, I69.163, I69.164, I69.165, I69.169, I69.190, I69.191, I69.192, I69.193, I69.198, I69.20, I69.21, I69.220, I69.221, I69.222, I69.223, I69.228, I69.231, I69.232, I69.233, I69.234, I69.239, I69.241, I69.242, I69.243, I69.244, I69.249, I69.251, I69.252, I69.253, I69.254, I69.259, I69.261, I69.262, I69.263, I69.264, I69.265, I69.269, I69.290, I69.291, I69.292, I69.293, I69.298, I69.30, I69.31, I69.320, I69.321, I69.322, I69.323, I69.328, I69.331, I69.332, I69.333, I69.334, I69.339, I69.341, I69.342, I69.343, I69.344, I69.349, I69.351, I69.352, I69.353, I69.354, I69.359, I69.361, I69.362, I69.363, I69.364, I69.365, I69.369, I69.390, I69.391, I69.392, I69.393, I69.398, I69.80, I69.81, I69.820, I69.821, I69.822, I69.823, I69.828, I69.831, I69.832, I69.833, I69.834, I69.839, I69.841, I69.842, I69.843, I69.844, I69.849, I69.851, I69.852, I69.853, I69.854, I69.859, I69.861, I69.862, I69.863, I69.864,

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I69.865, I69.869, I69.890, I69.891, I69.892, I69.893, I69.898, I69.90, I69.91, I69.920, I69.921, I69.922, I69.923, I69.928, I69.931, I69.932, I69.933, I69.934, I69.939, I69.941, I69.942, I69.943, I69.944, I69.949, I69.951, I69.952, I69.953, I69.954, I69.959, I69.961, I69.962, I69.963, I69.964, I69.965, I69.969, I69.990, I69.991, I69.992, I69.993, I69.998

AND

Two (2) or more patient encounters during reporting period (CPT): 97532

AND

Patient treated for memory disorder

NUMERATOR:

Patients whose score on the functional communication measure at discharge were higher than at admission

Definitions:

Admission – The conclusion of the first treatment session for memory by an SLP.

Discharge – The conclusion of the final treatment session for memory by an SLP, regardless of whether the patient is also being discharged from the facility and/or other SLP services.

Patient's Score –

LEVEL 1: The individual is unable to recall any information, regardless of cueing.

LEVEL 2: The individual consistently requires maximal verbal cues or uses external aids to recall personal information (e.g., family members, biographical information, physical location, etc.) in structured environments.

LEVEL 3: The individual usually requires maximum cues to recall or use external aids for simple routine and personal information (e.g., schedule, names of familiar staff, location of therapy areas, etc.) in structured environments.

LEVEL 4: The individual occasionally requires minimal cues to recall or use external memory aids for simple routine and personal information in structured environments. The individual requires consistent maximal cues to recall or use memory aids for complex and novel information (e.g., carry out multiple steps activities, accommodate schedule changes, anticipate meal times, etc.), plan and follow through on simple future events (e.g., use calendar to keep appointments, use log books to complete a single assignment/task, etc.) in structured environments.

LEVEL 5: The individual consistently requires minimal cues to recall or use external memory aids for complex and novel information. The individual consistently requires minimal cues to plan and follow through on complex future events (e.g., menu planning and meal preparation, planning a party, etc.).

LEVEL 6: The individual is able to recall or use external aids/memory strategies for complex information and planning complex future events most of the time. When there is a breakdown in the use of recall/memory strategies/external memory aids, the individual occasionally requires minimal cues. These breakdowns may occasionally interfere with the individual's functioning in vocational, avocational, and social activities.

LEVEL 7: The individual is successful and independent in recalling or using external aids/memory strategies for complex information and planning future events in all vocational, avocational, and social activities.

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Numerator Options:
Score on the memory functional communication measure at discharge was higher than at admission (G8609)

OR

Score on the memory functional communication measure at discharge was not higher than at admission, reason not given (G8610)

OR

Patient treated for memory but not scored on the memory functional communication measure either at admission or at discharge (G8611)

RATIONALE:

Impairments in cognitive functioning are common after a stroke. In particular, impairments in attention, memory, and executive functioning (i.e., integrating multiple and complex processes) can be especially disabling. The treatment of cognitive deficits through cognitive remediation designed to reduce deficits can be approached in a variety of ways. Cicerone and colleagues completed a comprehensive review of the evidence-based literature for cognitive remediation for both traumatic brain injury (TBI) and stroke. The review revealed a large number of randomized control trials (RCTs) in a variety of areas of cognitive functioning and provided comprehensive guidelines for cognitive rehabilitation specific to these populations. There is support for cognitive remediation of deficits in both the acute and post-acute phases of recovery from stroke and TBI, although some of the improvements were relatively small and task specific. Some benefits were specific to the TBI population, although it seems reasonable to extend some of these results to the stroke population.

Assessment of cognition and arousal is important for determining the patient's capabilities and limitations for coping with their stroke and assuring success of the rehabilitation process. The results of the assessment may impact the choice of treatment and disposition.

CLINICAL RECOMMENDATION STATEMENTS:

Recommend that the clinician use standardized, valid assessments to evaluate the patient's stroke-related impairments and functional status and encourage patient's participation in community and social activities. Recommend that the standardized assessment results be used to assess probability of outcome, determine the appropriate level of care, and develop interventions. (US Department of Veterans' Affairs; endorsed by the American Heart Association)

Recommend the use of training to develop compensatory strategies for memory deficits in post-stroke patients who have mild short-term memory deficits. (US Department of Veterans' Affairs; endorsed by the American Heart Association)

Patients with persistent cognitive deficits following acquired brain injury (ABI) should be offered cognitive rehabilitation which may include the use of external memory aids to enhance independence in the presence of memory deficits. (Royal College of Medicine and the British Society of Rehabilitation Medicine)

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Measure #212 (NQF 0447): Functional Communication Measure – Motor Speech

2013PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Percentage of patients aged 16 years and older with a diagnosis of late effects of cerebrovascular disease (CVD) that make progress on the Motor Speech Functional Communication Measure

INSTRUCTIONS:
This measure is to be reported once per episode of treatment for all patients with late effects of CVD who are treated for a motor speech deficit by a speech-language pathologist (SLP) during the reporting period. Only patients who had at least two visits in the reporting period will be counted in the denominator for this measure. This is an outcome measure, and its calculation requires reporting of the patient's score (see below under numerator) on the measure at the admission to and discharge from SLP treatment for motor speech. The admission score is noted by the SLP at the conclusion of the first treatment session, and the discharge score at the conclusion of the final treatment session for motor speech.

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data. There are no allowable performance exclusions for this measure.

DENOMINATOR:
Patients aged 16 years and older with late effects of CVD who received SLP treatment for motor speech

Denominator Criteria (Eligible Cases):
Patients aged ≥ 16 years on date of encounter
AND
Diagnosis of late effects of CVD (ICD-9-CM): 438.10, 438.11, 438.12, 438.13, 438.14, 438.19, 438.20, 438.21, 438.22, 438.30, 438.31, 438.32, 438.40, 438.41, 438.42, 438.50, 438.51, 438.52, 438.53, 438.6, 438.7, 438.81, 438.82, 438.83, 438.84, 438.85, 438.89, 438.9, 784.3
Diagnosis of late effects of CVD (ICD-10-CM) [Reference ONLY/Not Reportable]: I69.00, I69.020, I69.021, I69.022, I69.023, I69.028, I69.031, I69.032, I69.033, I69.034, I69.039, I69.041, I69.042, I69.043, I69.044, I69.049, I69.051, I69.052, I69.053, I69.054, I69.059, I69.061, I69.062, I69.063, I69.064, I69.065, I69.069, I69.090, I69.091, I69.092, I69.093, I69.098, I69.10, I69.120, I69.121, I69.122, I69.123, I69.128, I69.131, I69.132, I69.133, I69.134, I69.139, I69.141, I69.142, I69.143, I69.144, I69.149, I69.151, I69.152, I69.153, I69.154, I69.159, I69.161, I69.162, I69.163, I69.164, I69.165, I69.169, I69.190, I69.191, I69.192, I69.193, I69.198, I69.20, I69.220, I69.221, I69.222, I69.223, I69.228, I69.231, I69.232, I69.233, I69.234, I69.239, I69.241, I69.242, I69.243, I69.244, I69.249, I69.251, I69.252, I69.253, I69.254, I69.259, I69.261, I69.262, I69.263, I69.264, I69.265, I69.269, I69.290, I69.291, I69.292, I69.293, I69.298, I69.30, I69.320, I69.321, I69.322, I69.323, I69.328, I69.331, I69.332, I69.333, I69.334, I69.339, I69.341, I69.342, I69.343, I69.344, I69.349, I69.351, I69.352, I69.353, I69.354, I69.359, I69.361, I69.362, I69.363, I69.364, I69.365, I69.369, I69.390, I69.391, I69.392, I69.393, I69.398, I69.80, I69.820, I69.821, I69.822, I69.823, I69.828, I69.831, I69.832, I69.833, I69.834, I69.839, I69.841, I69.842, I69.843, I69.844, I69.849, I69.851, I69.852, I69.853, I69.854, I69.859, I69.861, I69.862, I69.863, I69.864, I69.865, I69.869, I69.890, I69.891, I69.892,

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I69.893, I69.898, I69.90, I69.920, I69.921, I69.922, I69.923, I69.928, I69.931, I69.932, I69.933, I69.934, I69.939, I69.941, I69.942, I69.943, I69.944, I69.949, I69.951, I69.952, I69.953, I69.954, I69.959, I69.961, I69.962, I69.963, I69.964, I69.965, I69.969, I69.990, I69.991, I69.992, I69.993, I69.998, R47.01
AND
Two (2) or more patient encounters during reporting period (CPT): 92507, 92508
AND
Patient treated for motor speech disorder

NUMERATOR:
Patients whose score on the functional communication measure at discharge were higher than at admission

Definitions:
Admission – The conclusion of the first treatment session for motor speech by an SLP.
Discharge – The conclusion of the final treatment session for motor speech by an SLP, regardless of whether the patient is also being discharged from the facility and/or other SLP services.
Patient's Score –

LEVEL 1: The individual attempts to speak, but speech cannot be understood by familiar or unfamiliar listeners at any time.

LEVEL 2: The individual attempts to speak. The communication partner must assume responsibility for interpreting the message, and with consistent and maximal cues, the patient can produce short consonant-vowel combinations or automatic words that are rarely intelligible in context.

LEVEL 3: The communication partner must assume primary responsibility for interpreting the communication exchange. However, the individual is able to produce short consonant-vowel combinations or automatic words intelligibly. With consistent and moderate cueing, the individual can produce simple words and phrases intelligibly, although accuracy may vary.

LEVEL 4: In simple structured conversation with familiar communication partners, the individual can produce simple words and phrases intelligibly. The individual usually requires moderate cueing in order to produce simple sentences intelligibly, although accuracy may vary.

LEVEL 5: The individual is able to speak intelligibly using simple sentences in daily routine activities with both familiar and unfamiliar communication partners. The individual occasionally requires minimal cueing to produce more complex sentences/ messages in routine activities, although accuracy may vary and the individual may occasionally use compensatory strategies.

LEVEL 6: The individual is successfully able to communicate intelligibly in most activities, but some limitations in intelligibility are still apparent in vocational, avocational, and social activities. The individual rarely requires minimal cueing to produce complex sentences/messages intelligibly. The individual usually uses compensatory strategies when encountering difficulty.

LEVEL 7: The individual's ability to successfully and independently participate in vocational, avocational, or social activities is not limited by speech production. Independent functioning may occasionally include the use of compensatory techniques.

Numerator Options:
Score on the motor speech functional communication measure at discharge was higher than at admission (G8612)
OR

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Score on the motor speech functional communication measure at discharge was not higher than at admission, reason not given (G8613)
OR
Patient treated for motor speech but not scored on the motor speech comprehension functional communication measure either at admission or at discharge (G8614)

RATIONALE:
Assessment of communication ability is important for determining the patient's capabilities and limitations in expressing their wants, needs, and understanding; their ability to contribute to their plan of care (including consent forms and advanced directives), and their ability to comprehend instructions affecting the success of the rehabilitation process. The results of the assessment may impact the choice of treatment and disposition.

Disorders of communication (i.e., problems with speaking, listening, reading, writing, gesturing, and/or pragmatics) and related cognitive impairments may occur in as many as 40% of post-stroke patients. The most common communication disorders occurring after stroke are aphasia and dysarthria. Rapid spontaneous improvement is common, but early evaluation can identify communication problems and monitor change. If indicated, intervention can help maximize recovery of communication abilities and prevent learning of ineffective or inappropriate compensatory behaviors. Goals of speech and language treatment are to (1) facilitate the recovery of communication, (2) assist patients in developing strategies to compensate for communication disorders, and (3) counsel and educate people in the patient's environment to facilitate communication, decrease isolation, and meet the patient's desires and needs.

CLINICAL RECOMMENDATION STATEMENTS:
Recommend that the clinician use standardized, valid assessments to evaluate the patient's stroke-related impairments and functional status and encourage patient's participation in community and social activities. Recommend that the standardized assessment results be used to assess probability of outcome, determine the appropriate level of care, and develop interventions. (US Department of Veterans' Affairs; endorsed by the American Heart Association)

Recommend that all patients be evaluated and treated by the SLP for residual communication difficulties (i.e., speaking, listening, reading, writing, and pragmatics). (US Department of Veterans' Affairs; endorsed by the American Heart Association)

It is recommended that patients who are conscious with communication difficulties be evaluated by a SLP who can develop appropriate communication techniques. SLP assessment should include screening for hearing and vision and restoration of glasses or hearing aids. Appropriate patients (with reasonable cognition and language skills) should be considered for alternative or augmentative communication. Patients with communication difficulties should be monitored and assessed regularly to determine appropriateness for speech and language therapy. An appropriate treatment program with a system for monitoring progress should be in place for any individuals receiving speech-language therapy. In developing a communication program, consideration for premorbid communication style, underlying cognitive deficits, environmental context, social needs, and necessary communication aids should be given. (Royal College of Medicine and the British Society of Rehabilitation Medicine)

Where achievable goals can be identified, and continuing progress demonstrated, patients with communication difficulties should be offered an appropriate treatment program, with monitoring of progress. The program should: take into account the patient's premorbid communication style and any underlying cognitive deficits; give the opportunity to rehearse communication skills in situations appropriate to the context in which the patient will live/work/study/socialize after discharge; include the family and caregivers in developing strategies for optimum communication within the immediate social circle; consider the need for communication aids including gesture

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drawing, communication charts and computerized systems. (Royal College of Medicine and the British Society of Rehabilitation Medicine)

The speech and language therapist will be involved in all cases where there are communication problems following stroke. (Republic of South Africa Department of Health; Stroke Foundation of South Africa)

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🗝 Measure #213 (NQF 0446): Functional Communication Measure - Reading

2013 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Percentage of patients aged 16 years and older with a diagnosis of late effects of cerebrovascular disease (CVD) that make progress on the Reading Functional Communication Measure

INSTRUCTIONS:
This measure is to be reported once per episode of treatment for all patients with late effects of CVD who are treated for a reading deficit by a speech-language pathologist (SLP) during the reporting period. Only patients who had at least two visits in the reporting period will be counted in the denominator for this measure. This is an outcome measure, and its calculation requires reporting of the patient's score (see below under numerator) on the measure at the admission to and discharge from SLP treatment for reading. The admission score is noted by the SLP at the conclusion of the first treatment session, and the discharge score at the conclusion of the final treatment session for reading.

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data. There are no allowable performance exclusions for this measure.

DENOMINATOR:
Patients aged 16 years and older with late effects of CVD who received SLP treatment for reading

Denominator Criteria (Eligible Cases):
Patients aged ≥ 16 years on date of encounter
AND
Diagnosis of late effects of CVD (ICD-9-CM): 438.10, 438.11, 438.12, 438.13, 438.14, 438.19, 438.20, 438.21, 438.22, 438.30, 438.31, 438.32, 438.40, 438.41, 438.42, 438.50, 438.51, 438.52, 438.53, 438.6, 438.7, 438.81, 438.82, 438.83, 438.84, 438.85, 438.89, 438.9, 784.3
Diagnosis of late effects of CVD (ICD-10-CM) [Reference ONLY/Not Reportable]: I69.00, I69.020, I69.021, I69.022, I69.023, I69.028, I69.031, I69.032, I69.033, I69.034, I69.039, I69.041, I69.042, I69.043, I69.044, I69.049, I69.051, I69.052, I69.053, I69.054, I69.059, I69.061, I69.062, I69.063, I69.064, I69.065, I69.069, I69.090, I69.091, I69.092, I69.093, I69.098, I69.10, I69.120, I69.121, I69.122, I69.123, I69.128, I69.131, I69.132, I69.133, I69.134, I69.139, I69.141, I69.142, I69.143, I69.144, I69.149, I69.151, I69.152, I69.153, I69.154, I69.159, I69.161, I69.162, I69.163, I69.164, I69.165, I69.169, I69.190, I69.191, I69.192, I69.193, I69.198, I69.20, I69.220, I69.221, I69.222, I69.223, I69.228, I69.231, I69.232, I69.233, I69.234, I69.239, I69.241, I69.242, I69.243, I69.244, I69.249, I69.251, I69.252, I69.253, I69.254, I69.259, I69.261, I69.262, I69.263, I69.264, I69.265, I69.269, I69.290, I69.291, I69.292, I69.293, I69.298, I69.30, I69.320, I69.321, I69.322, I69.323, I69.328, I69.331, I69.332, I69.333, I69.334, I69.339, I69.341, I69.342, I69.343, I69.344, I69.349, I69.351, I69.352, I69.353, I69.354, I69.359, I69.361, I69.362, I69.363, I69.364, I69.365, I69.369, I69.390, I69.391, I69.392, I69.393, I69.398, I69.80, I69.820, I69.821, I69.822, I69.823, I69.828, I69.831, I69.832, I69.833, I69.834, I69.839, I69.841, I69.842, I69.843, I69.844, I69.849, I69.851, I69.852, I69.853, I69.854, I69.859, I69.861, I69.862, I69.863, I69.864, I69.865, I69.869, I69.890, I69.891, I69.892,

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I69.893, I69.898, I69.90, I69.920, I69.921, I69.922, I69.923, I69.928, I69.931, I69.932, I69.933, I69.934, I69.939, I69.941, I69.942, I69.943, I69.944, I69.949, I69.951, I69.952, I69.953, I69.954, I69.959, I69.961, I69.962, I69.963, I69.964, I69.965, I69.969, I69.990, I69.991, I69.992, I69.993, I69.998, R47.01
AND
Two (2) or more patient encounters during reporting period (CPT): 92507, 92508
AND
Patient treated for reading disorder

NUMERATOR:
Patients whose score on the functional communication measure at discharge were higher than at admission

Definitions:
Admission – The conclusion of the first treatment session for reading by an SLP.
Discharge – The conclusion of the final treatment session for reading by an SLP, regardless of whether the patient is also being discharged from the facility and/or other SLP services.
Patient's Score –

LEVEL 1: The individual attends to printed material, but doesn't recognize even single letters or common words.

LEVEL 2: The individual reads single letters and common words with consistent maximal cueing.

LEVEL 3: The individual reads single letters and common words, and with consistent moderate cueing, can read some words that are less familiar, longer, and more complex.

LEVEL 4: The individual reads words and phrases related to routine daily activities, and words that are less familiar, longer, and more complex. The individual usually requires moderate cueing to read sentences of approximately 5–7 words.

LEVEL 5: The individual reads sentence-level material containing some complex words. The individual occasionally requires minimal cueing to read more complex sentences and paragraph-level material. The individual occasionally uses compensatory strategies.

LEVEL 6: The individual is successfully able to read most material but some limitations in reading are still apparent in vocational, avocational, and social activities. The individual rarely requires minimal cueing to read complex material. Although reading is successful, it may take the individual longer to read the material. The individual usually uses compensatory strategies when encountering difficulty.

LEVEL 7: The individual's ability to successfully and independently participate in vocational, avocational, and social activities is not limited by reading skills. Independent functioning may occasionally include use of compensatory strategies.

Numerator Options:
Score on the reading functional communication measure at discharge was higher than at admission (G8615)
OR
Score on the reading functional communication measure at discharge was not higher than at admission, reason not given (G8616)
OR

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Patient treated for reading but not scored on the reading functional communication measure either at admission or at discharge (G8617)

RATIONALE:
Assessment of communication ability is important for determining the patient's capabilities and limitations in expressing their wants, needs, and understanding; their ability to contribute to their plan of care (including consent forms and advanced directives), and their ability to comprehend instructions affecting the success of the rehabilitation process. The results of the assessment may impact the choice of treatment and disposition.

Disorders of communication (i.e., problems with speaking, listening, reading, writing, gesturing, and/or pragmatics) and related cognitive impairments may occur in as many as 40% of post-stroke patients. The most common communication disorders occurring after stroke are aphasia and dysarthria. Rapid spontaneous improvement is common, but early evaluation can identify communication problems and monitor change. If indicated, intervention can help maximize recovery of communication abilities and prevent learning of ineffective or inappropriate compensatory behaviors. Goals of speech and language treatment are to (1) facilitate the recovery of communication, (2) assist patients in developing strategies to compensate for communication disorders, and (3) counsel and educate people in the patient's environment to facilitate communication, decrease isolation, and meet the patient's desires and needs.

CLINICAL RECOMMENDATION STATEMENTS:
Recommend that the clinician use standardized, valid assessments to evaluate the patient's stroke-related impairments and functional status and encourage patient's participation in community and social activities. Recommend that the standardized assessment results be used to assess probability of outcome, determine the appropriate level of care, and develop interventions. *(US Department of Veterans' Affairs; endorsed by the American Heart Association)*

Recommend that all patients be evaluated and treated by the SLP for residual communication difficulties (i.e., speaking, listening, reading, writing, and pragmatics). *(US Department of Veterans' Affairs; endorsed by the American Heart Association)*

Interventions for people with aphasia may include: treatment of phonological and semantic deficits following models derived from cognitive neuropsychology, constraint-induced therapy, and computer-based therapy programs. *(National Stroke Foundation of Australia)*

It is recommended that patients who are conscious with communication difficulties be evaluated by a SLP who can develop appropriate communication techniques. SLP assessment should include screening for hearing and vision and restoration of glasses or hearing aids. Appropriate patients (with reasonable cognition and language skills) should be considered for alternative or augmentative communication. Patients with communication difficulties should be monitored and assessed regularly to determine appropriateness for speech and language therapy. An appropriate treatment program with a system for monitoring progress should be in place for any individuals receiving speech-language therapy. In developing a communication program, consideration for premorbid communication style, underlying cognitive deficits, environmental context, social needs, and necessary communication aids should be given. *(Royal College of Medicine and the British Society of Rehabilitation Medicine)*

Where achievable goals can be identified, and continuing progress demonstrated, patients with communication difficulties should be offered an appropriate treatment program, with monitoring of progress. The program should: take into account the patient's premorbid communication style and any underlying cognitive deficits; give the opportunity to rehearse communication skills in situations appropriate to the context in which the patient will live/work/study/socialize after discharge; include the family and caregivers in developing strategies for optimum communication within the immediate social circle; and consider the need for communication aids including gesture

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drawing, communication charts and computerized systems. *(Royal College of Medicine and the British Society of Rehabilitation Medicine)*

The speech and language therapist will be involved in all cases where there are communication problems following stroke. *(Republic of South Africa Department of Health; Stroke Foundation of South Africa)*

People with aphasia following stroke should be referred to a speech and language therapist for assessment and appropriate management of their communication difficulty. *(Stroke Foundation of New Zealand)*

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🗝 Measure #214 (NQF 0444): Functional Communication Measure – Spoken Language Expression

2013 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Percentage of patients aged 16 years and older with a diagnosis of late effects of cerebrovascular disease (CVD) that make progress on the Spoken Language Expression Functional Communication Measure

INSTRUCTIONS:
This measure is to be reported once per episode of treatment for all patients with late effects of CVD who are treated for a spoken language expression deficit by a speech-language pathologist (SLP) during the reporting period. Only patients who had at least two visits in the reporting period will be counted in the denominator for this measure. This is an outcome measure, and its calculation requires reporting of the patient's score (see below under numerator) on the measure at the admission to and discharge from SLP treatment for spoken language expression. The admission score is noted by the SLP at the conclusion of the first treatment session, and the discharge score at the conclusion of the final treatment session for spoken language expression.

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data. There are no allowable performance exclusions for this measure.

DENOMINATOR:
Patients aged 16 years and older with late effects of CVD who received SLP treatment for spoken language expression

Denominator Criteria (Eligible Cases):
Patients aged ≥ 16 years on date of encounter
AND
Diagnosis of late effects of CVD (ICD-9-CM): 438.10, 438.11, 438.12, 438.13, 438.14, 438.19, 438.20, 438.21, 438.22, 438.30, 438.31, 438.32, 438.40, 438.41, 438.42, 438.50, 438.51, 438.52, 438.53, 438.6, 438.7, 438.81, 438.82, 438.83, 438.84, 438.85, 438.89, 438.9, 784.3
Diagnosis of late effects of CVD (ICD-10-CM) [Reference ONLY/Not Reportable]: I69.00, I69.020, I69.021, I69.022, I69.023, I69.028, I69.031, I69.032, I69.033, I69.034, I69.039, I69.041, I69.042, I69.043, I69.044, I69.049, I69.051, I69.052, I69.053, I69.054, I69.059, I69.061, I69.062, I69.063, I69.064, I69.065, I69.069, I69.090, I69.091, I69.092, I69.093, I69.098, I69.10, I69.120, I69.121, I69.122, I69.123, I69.128, I69.131, I69.132, I69.133, I69.134, I69.139, I69.141, I69.142, I69.143, I69.144, I69.149, I69.151, I69.152, I69.153, I69.154, I69.159, I69.161, I69.162, I69.163, I69.164, I69.165, I69.169, I69.190, I69.191, I69.192, I69.193, I69.198, I69.20, I69.220, I69.221, I69.222, I69.223, I69.228, I69.231, I69.232, I69.233, I69.234, I69.239, I69.241, I69.242, I69.243, I69.244, I69.249, I69.251, I69.252, I69.253, I69.254, I69.259, I69.261, I69.262, I69.263, I69.264, I69.265, I69.269, I69.290, I69.291, I69.292, I69.293, I69.298, I69.30, I69.320, I69.321, I69.322, I69.323, I69.328, I69.331, I69.332, I69.333, I69.334, I69.339, I69.341, I69.342, I69.343, I69.344, I69.349, I69.351, I69.352, I69.353, I69.354, I69.359, I69.361, I69.362, I69.363, I69.364, I69.365, I69.369, I69.390, I69.391, I69.392, I69.393, I69.398, I69.80, I69.820, I69.821, I69.822, I69.823, I69.828, I69.831, I69.832, I69.833, I69.834, I69.839, I69.841, I69.842, I69.843, I69.844, I69.849, I69.851, I69.852,

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I69.853, I69.854, I69.859, I69.861, I69.862, I69.863, I69.864, I69.865, I69.869, I69.890, I69.891, I69.892, I69.893, I69.898, I69.90, I69.920, I69.921, I69.922, I69.923, I69.928, I69.931, I69.932, I69.933, I69.934, I69.939, I69.941, I69.942, I69.943, I69.944, I69.949, I69.951, I69.952, I69.953, I69.954, I69.959, I69.961, I69.962, I69.963, I69.964, I69.965, I69.969, I69.990, I69.991, I69.992, I69.993, I69.998, R47.01
AND
Two (2) or more patient encounters during reporting period (CPT): 92507, 92508
AND
Patient treated for spoken language expression disorder

NUMERATOR:
Patients whose score on the functional communication measure at discharge were higher than at admission

Definitions:
Admission – The conclusion of the first treatment session for spoken language expression by an SLP.
Discharge – The conclusion of the final treatment session for spoken language expression by an SLP, regardless of whether the patient is also being discharged from the facility and/or other SLP services.
Patient's Score –

LEVEL 1: The individual attempts to speak, but verbalizations are not meaningful to familiar or unfamiliar communication partners at any time.

LEVEL 2: The individual attempts to speak, although few attempts are accurate or appropriate. The communication partner must assume responsibility for structuring the communication exchange, and with consistent and maximal cueing, the individual can only occasionally produce automatic and/or imitative words and phrases that are rarely meaningful in context.

LEVEL 3: The communication partner must assume responsibility for structuring the communication exchange, and with consistent and moderate cueing, the individual can produce words and phrases that are appropriate and meaningful in context.

LEVEL 4: The individual is successfully able to initiate communication using spoken language in simple, structured conversations in routine daily activities with familiar communication partners. The individual usually requires moderate cueing, but is able to demonstrate use of simple sentences (i.e., semantics, syntax, and morphology) and rarely uses complex sentences/messages.

LEVEL 5: The individual is successfully able to initiate communication using spoken language in structured conversations with both familiar and unfamiliar communication partners. The individual occasionally requires minimal cueing to frame more complex sentences in messages. The individual occasionally self-cues when encountering difficulty.

LEVEL 6: The individual is successfully able to communicate in most activities, but some limitations in spoken language are still apparent in vocational, avocational, and social activities. The individual rarely requires minimal cueing to frame complex sentences. The individual usually self-cues when encountering difficulty.

LEVEL 7: The individual's ability to successfully and independently participate in vocational, avocational, and social activities is not limited by spoken language skills. Independent functioning may occasionally include use of self-cueing.

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Numerator Options:
Score on the spoken language expression functional communication measure at discharge was higher than at admission (G8618)

OR

Score on the spoken language expression functional communication measure at discharge was not higher than at admission, reason not given (G8619)

OR

Patient treated for spoken language expression but not scored on the spoken language expression functional communication measure either at admission or at discharge (G8620)

RATIONALE:
Assessment of communication ability is important for determining the patient's capabilities and limitations in expressing their wants, needs, and understanding; their ability to contribute to their plan of care (including consent forms and advanced directives), and their ability to comprehend instructions affecting the success of the rehabilitation process. The results of the assessment may impact the choice of treatment and disposition.

Disorders of communication (i.e., problems with speaking, listening, reading, writing, gesturing, and/or pragmatics) and related cognitive impairments may occur in as many as 40% of post-stroke patients. The most common communication disorders occurring after stroke are aphasia and dysarthria. Rapid spontaneous improvement is common, but early evaluation can identify communication problems and monitor change. If indicated, intervention can help maximize recovery of communication abilities and prevent learning of ineffective or inappropriate compensatory behaviors. Goals of speech and language treatment are to (1) facilitate the recovery of communication, (2) assist patients in developing strategies to compensate for communication disorders, and (3) counsel and educate people in the patient's environment to facilitate communication, decrease isolation, and meet the patient's desires and needs.

CLINICAL RECOMMENDATION STATEMENTS:
Aphasic stroke patients should be referred for speech and language therapy. Where the patient is sufficiently well and motivated, aim for minimum of two hours per week. *(Scottish Intercollegiate Guidelines Network)*

Recommend that the clinician use standardized, valid assessments to evaluate the patient's stroke-related impairments and functional status and encourage patient's participation in community and social activities. Recommend that the standardized assessment results be used to assess probability of outcome, determine the appropriate level of care, and develop interventions. *(US Department of Veterans' Affairs; endorsed by the American Heart Association)*

Recommend that all patients be evaluated and treated by the SLP for residual communication difficulties (i.e., speaking, listening, reading, writing, and pragmatics). *(US Department of Veterans' Affairs; endorsed by the American Heart Association)*

Interventions for people with aphasia may include: treatment of phonological and semantic deficits following models derived from cognitive neuropsychology, constraint-induced therapy, and computer-based therapy programs. *(National Stroke Foundation of Australia)*

It is recommended that patients who are conscious with communication difficulties be evaluated by a SLP who can develop appropriate communication techniques. SLP assessment should include screening for hearing and vision and restoration of glasses or hearing aids. Appropriate patients (with reasonable cognition and language skills) should be considered for alternative or augmentative communication. Patients with communication difficulties should be monitored and assessed regularly to determine appropriateness for speech and language therapy. An appropriate treatment program with a system for monitoring progress should be in place for any individuals receiving speech-

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language therapy. In developing a communication program, consideration for premorbid communication style, underlying cognitive deficits, environmental context, social needs, and necessary communication aids should be given. *(Royal College of Medicine and the British Society of Rehabilitation Medicine)*

Where achievable goals can be identified, and continuing progress demonstrated, patients with communication difficulties should be offered an appropriate treatment program, with monitoring of progress. The program should: take into account the patient's premorbid communication style and any underlying cognitive deficits; give the opportunity to rehearse communication skills in situations appropriate to the context in which the patient will live/work/study/socialize after discharge; include the family and caregivers in developing strategies for optimum communication within the immediate social circle; and consider the need for communication aids including gesture drawing, communication charts and computerized systems. *(Royal College of Medicine and the British Society of Rehabilitation Medicine)*

The speech and language therapist will be involved in all cases where there are communication problems following stroke. *(Republic of South Africa Department of Health; Stroke Foundation of South Africa)*

People with aphasia following stroke should be referred to a speech and language therapist for assessment and appropriate management of their communication difficulty. *(Stroke Foundation of New Zealand)*

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🗝 Measure #215 (NQF 0442): Functional Communication Measure - Writing

2013 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Percentage of patients aged 16 years and older with a diagnosis of late effects of cerebrovascular disease (CVD) that make progress on the Writing Functional Communication Measure

INSTRUCTIONS:
This measure is to be reported once per episode of treatment for all patients with late effects of CVD who are treated for a writing deficit by a speech-language pathologist (SLP) during the reporting period. Only patients who had at least two visits in the reporting period will be counted in the denominator for this measure. This is an outcome measure, and its calculation requires reporting of the patient's score (see below under numerator) on the measure at the admission to and discharge from SLP treatment for writing. The admission score is noted by the SLP at the conclusion of the first treatment session, and the discharge score at the conclusion of the final treatment session for writing.

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data. There are no allowable performance exclusions for this measure.

DENOMINATOR:
Patients aged 16 years and older on date of encounter who received SLP treatment for writing

Denominator Criteria (Eligible Cases):
Patients aged ≥ 16 years on date of encounter
AND
Diagnosis of late effects of CVD (ICD-9-CM): 438.10, 438.11, 438.12, 438.13, 438.14, 438.19, 438.20, 438.21, 438.22, 438.30, 438.31, 438.32, 438.40, 438.41, 438.42, 438.50, 438.51, 438.52, 438.53, 438.6, 438.7, 438.81, 438.82, 438.83, 438.84, 438.85, 438.89, 438.9, 784.3
Diagnosis of late effects of CVD (ICD-10-CM) [Reference ONLY/Not Reportable]: I69.00, I69.020, I69.021, I69.022, I69.023, I69.028, I69.031, I69.032, I69.033, I69.034, I69.039, I69.041, I69.042, I69.043, I69.044, I69.049, I69.051, I69.052, I69.053, I69.054, I69.059, I69.061, I69.062, I69.063, I69.064, I69.065, I69.069, I69.090, I69.091, I69.092, I69.093, I69.098, I69.10, I69.120, I69.121, I69.122, I69.123, I69.128, I69.131, I69.132, I69.133, I69.134, I69.139, I69.141, I69.142, I69.143, I69.144, I69.149, I69.151, I69.152, I69.153, I69.154, I69.159, I69.161, I69.162, I69.163, I69.164, I69.165, I69.169, I69.190, I69.191, I69.192, I69.193, I69.198, I69.20, I69.220, I69.221, I69.222, I69.223, I69.228, I69.231, I69.232, I69.233, I69.234, I69.239, I69.241, I69.242, I69.243, I69.244, I69.249, I69.251, I69.252, I69.253, I69.254, I69.259, I69.261, I69.262, I69.263, I69.264, I69.265, I69.269, I69.290, I69.291, I69.292, I69.293, I69.298, I69.30, I69.320, I69.321, I69.322, I69.323, I69.328, I69.331, I69.332, I69.333, I69.334, I69.339, I69.341, I69.342, I69.343, I69.344, I69.349, I69.351, I69.352, I69.353, I69.354, I69.359, I69.361, I69.362, I69.363, I69.364, I69.365, I69.369, I69.390, I69.391, I69.392, I69.393, I69.398, I69.80, I69.820, I69.821, I69.822, I69.823, I69.828, I69.831, I69.832, I69.833, I69.834, I69.839, I69.841, I69.842, I69.843, I69.844, I69.849, I69.851, I69.852, I69.853, I69.854, I69.859, I69.861, I69.862, I69.863, I69.864, I69.865, I69.869, I69.890, I69.891, I69.892,

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I69.893, I69.898, I69.90, I69.920, I69.921, I69.922, I69.923, I69.928, I69.931, I69.932, I69.933, I69.934, I69.939, I69.941, I69.942, I69.943, I69.944, I69.949, I69.951, I69.952, I69.953, I69.954, I69.959, I69.961, I69.962, I69.963, I69.964, I69.965, I69.969, I69.990, I69.991, I69.992, I69.993, I69.998, R47.01
AND
Two (2) or more patient encounters during reporting period (CPT): 92507, 92508
AND
Patient treated for writing disorder

NUMERATOR:
Patients whose score on the functional communication measure at discharge were higher than at admission

Definitions:
Admission – The conclusion of the first treatment session for writing by an SLP.
Discharge – The conclusion of the final treatment session for writing by an SLP, regardless of whether the patient is also being discharged from the facility and/or other SLP services.
Patient's Score –

LEVEL 1: The individual attempts to write, but doesn't produce recognizable single Letters or common words.

LEVEL 2: The individual writes single letters and common words with consistent maximal cueing.

LEVEL 3: The individual writes single letters and common words, and with consistent moderate cueing, can write some words that are less familiar, longer, and more complex.

LEVEL 4: The individual writes words and phrases related to routine daily activities and words that are less familiar, longer, and more complex. The individual usually requires moderate cueing to write sentences of approximately 5–7 words.

LEVEL 5: The individual writes sentence-level material containing some complex words. The individual occasionally requires minimal cueing to write more complex sentences and paragraph-level material. The individual occasionally uses compensatory strategies.

LEVEL 6: The individual is successfully able to write most material, but some limitations in writing are still apparent in vocational, avocational, and social activities. The individual rarely requires minimal cueing to write complex material. The individual usually uses compensatory strategies when encountering difficulty.

LEVEL 7: The individual's ability to successfully and independently participate in vocational, avocational, and social activities is not limited by writing skills. Independent functioning may occasionally include use of compensatory strategies.

Numerator Options:
Score on the writing functional communication measure at discharge was higher than at admission (G8621)
OR
Score on the writing functional communication measure at discharge was not higher than at admission, reason not given (G8622)
OR
Patient treated for writing but not scored on the writing functional communication measure either at admission or at discharge (G8623)

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RATIONALE:
Assessment of communication ability is important for determining the patient's capabilities and limitations in expressing their wants, needs, and understanding; their ability to contribute to their plan of care (including consent forms and advanced directives), and their ability to comprehend instructions affecting the success of the rehabilitation process. The results of the assessment may impact the choice of treatment and disposition.

Disorders of communication (i.e., problems with speaking, listening, reading, writing, gesturing, and/or pragmatics) and related cognitive impairments may occur in as many as 40% of post stroke patients. The most common communication disorders occurring after stroke are aphasia and dysarthria. Rapid spontaneous improvement is common, but early evaluation can identify communication problems and monitor change. If indicated, intervention can help maximize recovery of communication abilities and prevent learning of ineffective or inappropriate compensatory behaviors. Goals of speech and language treatment are to (1) facilitate the recovery of communication, (2) assist patients in developing strategies to compensate for communication disorders, and (3) counsel and educate people in the patient's environment to facilitate communication, decrease isolation, and meet the patient's desires and needs.

CLINICAL RECOMMENDATION STATEMENTS:
Recommend that the clinician use standardized, valid assessments to evaluate the patient's stroke-related impairments and functional status and encourage patient's participation in community and social activities. Recommend that the standardized assessment results be used to assess probability of outcome, determine the appropriate level of care, and develop interventions. *(US Department of Veterans' Affairs; endorsed by the American Heart Association)*

Recommend that all patients be evaluated and treated by the SLP for residual communication difficulties (i.e., speaking, listening, reading, writing, and pragmatics). *(US Department of Veterans' Affairs; endorsed by the American Heart Association)*

Interventions for people with aphasia may include: treatment of phonological and semantic deficits following models derived from cognitive neuropsychology, constraint-induced therapy, and computer-based therapy programs. *(National Stroke Foundation of Australia)*

It is recommended that patients who are conscious with communication difficulties be evaluated by a speech-language pathologist who can develop appropriate communication techniques. SLP assessment should include screening for hearing and vision and restoration of glasses or hearing aids. Appropriate patients (with reasonable cognition and language skills) should be considered for alternative or augmentative communication. Patients with communication difficulties should be monitored and assessed regularly to determine appropriateness for speech and language therapy. An appropriate treatment program with a system for monitoring progress should be in place for any individuals receiving speech-language therapy. In developing a communication program, consideration for premorbid communication style, underlying cognitive deficits, environmental context, social needs, and necessary communication aids should be given. *(Royal College of Medicine and the British Society of Rehabilitation Medicine)*

Where achievable goals can be identified, and continuing progress demonstrated, patients with communication difficulties should be offered an appropriate treatment program, with monitoring of progress. The program should: take into account the patient's premorbid communication style and any underlying cognitive deficits; give the opportunity to rehearse communication skills in situations appropriate to the context in which the patient will live/work/study/socialize after discharge; include the family and caregivers in developing strategies for optimum communication within the immediate social circle; consider the need for communication aids including gesture drawing, communication charts and computerized systems. *(Royal College of Medicine and the British Society of Rehabilitation Medicine)*

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The speech and language therapist will be involved in all cases where there are communication problems following stroke. *(Republic of South Africa Department of Health; Stroke Foundation of South Africa)*

People with aphasia following stroke should be referred to a speech and language therapist for assessment and appropriate management of their communication difficulty. *(Stroke Foundation of New Zealand)*

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🗝 Measure #216 (NQF 0443): Functional Communication Measure - Swallowing

2013 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Percentage of patients aged 16 years and older with a diagnosis of late effects of cerebrovascular disease (CVD) that make progress on the Swallowing Functional Communication Measure

INSTRUCTIONS:
This measure is to be reported once per episode of treatment for all patients with late effects of CVD who are treated for dysphagia by a speech-language pathologist (SLP) during the reporting period. Only patients who had at least two visits in the reporting period will be counted in the denominator for this measure. This is an outcome measure, and its calculation requires reporting of the patient's score (see below under numerator) on the measure at the admission to and discharge from SLP treatment for attention. The admission score is noted by the SLP at the conclusion of the first treatment session, and the discharge score at the conclusion of the final treatment session for dysphagia.

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data. There are no allowable performance exclusions for this measure.

DENOMINATOR:
Patients aged 16 years and older with late effects of CVD who received SLP treatment for dysphagia

> Denominator Criteria (Eligible Cases):
> Patients aged ≥ 16 years on date of encounter
> AND
> Diagnosis of late effects of CVD (ICD-9-CM): 438.82, 784.51, 787.20, 787.21, 787.22, 787.23, 787.24, 787.29
> Diagnosis of late effects of CVD (ICD-10-CM) [Reference ONLY/Not Reportable]: I69.091, I69.191, I69.291, I69.391, I69.891, I69.991, R13.0, R13.10, R13.11, R13.12, R13.13, R13.14, R13.19, R47.1
> AND
> Two (2) or more patient encounters during reporting period (CPT): 92526
> AND
> Patient treated for swallowing disorder

NUMERATOR:
Patients whose score on the functional communication measure at discharge were higher than at admission

> Definitions:
> Admission – The conclusion of the first treatment session for dysphagia by an SLP.
> Discharge – The conclusion of the final treatment session for dysphagia by an SLP, regardless of whether the patient is also being discharged from the facility and/or other SLP services.
> Patient's Score –

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LEVEL 1: Individual is not able to swallow anything safely by mouth. All nutrition and hydration is received through non-oral means (e.g., nasogastric tube, PEG).

LEVEL 2: Individual is not able to swallow safely by mouth for nutrition and hydration, but may take some consistency with consistent maximal cues in therapy only. Alternative method of feeding required.

LEVEL 3: Alternative method of feeding required as individual takes less than 50% of nutrition and hydration by mouth, and/or swallowing is safe with consistent use of moderate cues to use compensatory strategies and/or requires maximum diet restriction.

LEVEL 4: Swallowing is safe, but usually requires moderate cues to use compensatory strategies, and/or the individual has moderate diet restrictions and/or still requires tube feeding and/or oral supplements.

LEVEL 5: Swallowing is safe with minimal diet restriction and/or occasionally requires minimal cueing to use compensatory strategies. The individual may occasionally self-cue. All nutrition and hydration needs are met by mouth at mealtime.

LEVEL 6: Swallowing is safe, and the individual eats and drinks independently and may rarely require minimal cueing. The individual usually self-cues when difficulty occurs. May need to avoid specific food items (e.g., popcorn and nuts), or require additional time (due to dysphasia).

LEVEL 7: The individual's ability to eat independently is not limited by swallow function. Swallowing would be safe and efficient for all consistencies. Compensatory strategies are effectively used when needed.

Numerator Options:

Score on the swallowing functional communication measure at discharge was higher than at admission (G8624)

OR

Score on the swallowing functional communication measure at discharge was not higher than at admission, reason not given (G8625)

OR

Patient treated for swallowing but not scored on the swallowing functional communication measure either at admission or at discharge (G8626)

RATIONALE:

Dysphagia, an abnormality in swallowing fluids or food, is common, occurring in about 45% of all stroke patients admitted to the hospital. It can seriously affect the patient's quality of life and potentially lead to death. It is associated with severe strokes and with worse outcome. The presence of aspiration may be associated with an increased risk of developing pneumonia after stroke. Malnutrition is also common, being present in about 15% of all patients admitted to the hospital, and increasing to about 30% over the first week after stroke.

Malnutrition is associated with a worse outcome and a slower rate of recovery. Assessment of dysphagia by personnel who are not adequately trained in the anatomy and physiology of swallowing is often times problematic. Traditionally, SLPs receive formal training in oropharyngeal anatomy and physiology.

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CLINICAL RECOMMENDATION STATEMENTS:

Treatment outcome studies have provided evidence that compensatory strategies designed to have an immediate effect on the swallow (i.e., postural changes or diet manipulation) can improve swallowing safety and efficiency. Postural techniques eliminated aspiration on thin liquids in 75 to 80% of dysphagic patients. Likewise, data are beginning to emerge that demonstrate the utility of pharyngeal muscle strengthening exercises for improving swallowing physiology. Treatment approaches improve nutritional status and hydration, and reduce morbidity from pneumonia. The speech-language pathologist's intervention in swallowing disorders helps contain medical costs by reducing the length of hospital stays, decreasing the need for non oral feedings, reducing nutritional problems, and decreasing expenses associated with pneumonia and other pulmonary complications. *(American Speech-Language-Hearing Association)*

Recommend that the clinician use standardized, valid assessments to evaluate the patient's stroke-related impairments and functional status and encourage patient's participation in community and social activities. Recommend that the standardized assessment results be used to assess probability of outcome, determine the appropriate level of care, and develop interventions. *(US Department of Veterans' Affairs; endorsed by the American Heart Association)*

Recommend that the dysphagic stroke patient receive both direct swallowing treatment and management by the SLP, when available, when a treatable disorder in swallow anatomy or physiology is identified. *(US Department of Veterans' Affairs; endorsed by the American Heart Association)*

The speech and language therapist will be involved in all cases where there are communication problems following stroke. Such therapy should include augmentative communication systems in cases where intelligible speech is not a reasonable goal. The role of the speech therapist includes diagnosis and treatment of swallowing disorders. *(Republic of South Africa Department of Health; Stroke Foundation of South Africa)*

Any person with an abnormal swallow should be seen by a speech and language therapist, who should assess the person further and advise the person and staff on safe swallowing techniques and strategies and the consistency of diet and fluids. *(Stroke Foundation of New Zealand)*

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☾ Measure #217 (NQF 0422): Functional Deficit: Change in Risk-Adjusted Functional Status for Patients with Knee Impairments

2013 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Percentage of patients aged 18 or older that receive treatment for a functional deficit secondary to a diagnosis that affects the knee in which the change in their Risk-Adjusted Functional Status is measured

INSTRUCTIONS:
This outcomes measure is to be reported once per treatment episode for all patients with a functional deficit related to the knee. This is an outcomes measure and its calculation requires reporting of the patient's functional status score, as a minimum, at admission to and again at discharge from an episode of rehabilitation. The admission score, estimated using patient self-report surveys, is recorded during the first rehabilitation treatment encounter and the discharge score is recorded at or near the conclusion of the final rehabilitation treatment encounter. It is anticipated that physical and occupational therapists providing treatment for functional knee deficits will report this measure.

Definitions:
Treatment Episode – A Treatment Episode is defined as beginning with an Admission for a functional knee deficit, progressing to development of a plan of care, including treatment, without interruption of care (for example a hospitalization or surgical intervention), and ending with Discharge from clinical care by the Eligible Professional. A patient currently under clinical care for a knee deficit remains in a single episode of care until the Discharge is conducted and documented by the Eligible Professional.
Admission – An Admission is the first encounter for a functional deficit involving the knee and includes an evaluation (CPT 97001 or 97003) and development of a plan of care by the Eligible Professional. A patient presenting with a knee impairment, who has had an interruption of a Treatment Episode for the same functional knee deficit secondary to an appropriate reason like hospitalization or surgical intervention, is a new Admission.
Discharge – Discharge is accompanied by a re-evaluation (CPT 97002 or 97004) identifying the close of a Treatment Episode for the same knee deficit identified at admission and documented by a discharge report by the Eligible Professional. An interruption in clinical care for an appropriate reason like hospitalization or surgical intervention requires a discharge from the current Treatment Episode.
Encounter – A face to face visit between the patient and the provider for the purpose of assessing and/or improving a functional deficit.
Patient Reported – The patient directly, or through a proxy, provides answers to functional status survey items using standardized, reliable and valid, computerized adaptive testing or paper and pencil survey methods.

Measure Reporting via Registry:
CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All patients aged 18 years and older who receive a treatment episode for a functional deficit related to the knee

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Option 1 – Physical Therapy Denominator Criteria (Eligible Cases):
All patients aged ≥ 18 years on date of encounter
AND
Patient encounter during the reporting period identifying evaluation (CPT): 97001
AND
Patient encounter during the reporting period identifying re-evaluation (CPT): 97002
AND
Functional deficit affecting knee

OR

Option 2 – Occupational Therapy Denominator Criteria (Eligible Cases):
All patients aged ≥ 18 years on date of encounter
AND
Patient encounter during the reporting period identifying evaluation (CPT): 97003
AND
Patient encounter during the reporting period identifying re-evaluation (CPT): 97004
AND
Functional deficit affecting knee

NUMERATOR:
Patients presented FOTO's Functional Intake Survey for the Knee at admission and FOTO's Functional Status Survey at discharge for the purpose of calculating the patient's Risk-adjusted Functional Status Change Residual Score

Definitions:
Patient's Functional Status Score – A functional status score is produced when the patient completes the FOTO functional status survey (either by paper and pencil or computerized adaptive testing administration). The functional status score is continuous and linear. Scores range from 0 (low function) to 100 (high function). The survey is standardized, and the scores are validated for the measurement of function for this population.
Patient's Functional Status Change Score – A functional status change score is calculated by subtracting the Patient's Functional Status Score at Admission from the Patient's Functional Status Score at Discharge.
Predicted Functional Status Change Score – Functional Status Change Scores for patients are risk adjusted using multiple linear regression methods that include the following independent variables: Patient's Functional Status Score at Admission, patient age, symptom acuity, surgical history, gender, number of co-morbidities and level of fear-avoidance. The Patient's Functional Status Change Score is the dependent variable. The statistical regression produces a Risk-Adjusted Predicted Functional Status Change Score.
Risk-Adjusted Functional Status Change Residual Score – The difference between the raw non-risk-adjusted Patient's Functional Status Change Score and the Risk-Adjusted Predicted Functional Status Change Score (raw minus predicted) is the Risk-Adjusted Functional Status Change Residual Score, which is in the same units as the Patient's Functional Status Scores, and should be interpreted as the unit of functional status change different than predicted given the risk-adjustment variables of the patient being treated. As such, the Risk-Adjusted Residual Change Score represents Risk-Adjusted Change corrected for the level of severity of the patient. Risk-Adjusted Residual Change Scores of zero (0) or greater (> 0) should be interpreted as functional status change scores that were predicted or better than predicted given the risk-adjustment variables of the patient and risk-adjusted residual change scores less than zero (< 0) should be interpreted as functional status change scores that were less than predicted given the risk-adjustment

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variables of the patient. Aggregated Risk-Adjusted Residual Scores allow meaningful comparisons amongst clinicians or clinics.

Not Eligible/Not Appropriate – A patient is not eligible if one or more of the following conditions exist:

- Patient refused to participate
- Patient unable to complete the questionnaire due to blindness, illiteracy, severe mental incapacity or language incompatibility and an adequate proxy is not available
- Prior to conclusion of Plan of Care, intervention was interrupted or discontinued for any reason including by the referring physician, the provider, the payer or the patient, and attempts by the provider to complete a follow-up functional status survey near Discharge were unsuccessful.

Numerator Options:

Risk-Adjusted Functional Status Change Residual Score for the knee successfully calculated and the score was equal to zero (0) or greater than zero (> 0) (G8647)

OR

Risk-Adjusted Functional Status Change Residual Score for the knee successfully calculated and the score was less than zero (< 0) (G8648)

OR

Risk-Adjusted Functional Status Change Residual Scores for the knee not measured because the patient did not complete FOTO's Functional Intake on admission and/or follow up Status Survey near discharge, patient Not Eligible/Not Appropriate (G8649)

OR

Risk-Adjusted Functional Status Change Residual Scores for the knee not measured because the patient did not complete FOTO's Functional Intake on admission and/or follow up Status Survey near discharge, reason not given (G8650)

RATIONALE:

Functional deficits are common in the general population and are costly to the individual, their family and society. Improved functional status has been associated with greater quality of life, self-efficacy, improved financial well-being and lower future medical costs. Improving functional status in people seeking rehabilitation has become a goal of the American Physical Therapy Association. Therefore, measuring change in functional status is important for providers treating patients in rehabilitation and can be used to assess the success of treatment and direct modification of treatment.

Change in functional status represents the activity domain of the International Classification of Function. If treatment is designed to improve the functional deficit, it is logical to assess functional status at discharge using a standardized score to determine if treatment improved the functional status of the patient over the treatment episode.

The National Quality Measures Clearinghouse has approved the measurement of change in functional status, using this survey. (NQMC-1873)

CLINICAL RECOMMENDATION STATEMENTS:

The American Physical Therapy Association (APTA), in their *Guide to Physical Therapy Practice*, described five recommended elements of patient management: examination, evaluation, diagnosis, prognosis and intervention. The elements were intended to direct therapists in their approach to patient treatment for the purpose of optimizing patient outcomes. The APTA clearly indentifies functional status data as one of the major forms of data to be collected for patients receiving rehabilitation. The functional status measures should be used to assist in the planning, implementation and modification of treatment interventions and should be used as measures of outcomes. The current functional status scores can be used by therapists to fulfill the recommended methods of the APTA in the management of patients in rehabilitation.

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☾ Measure #218 (NQF 0423): Functional Deficit: Change in Risk-Adjusted Functional Status for Patients with Hip Impairments

2013 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Percentage of patients aged 18 or older that receive treatment for a functional deficit secondary to a diagnosis that affects the hip in which the change in their Risk-Adjusted Functional Status is measured

INSTRUCTIONS:
This outcomes measure is to be reported once per treatment episode for all patients with a functional deficit related to the hip. This is an outcomes measure and its calculation requires reporting of the patient's functional status score, as a minimum, at admission to and again at discharge from an episode of rehabilitation. The admission score, estimated using patient self-report surveys, is recorded during the first rehabilitation treatment encounter and the discharge score is recorded at or near the conclusion of the final rehabilitation treatment encounter. It is anticipated that physical and occupational therapists providing treatment for functional hip deficits will report this measure.

Definitions:
Treatment Episode – A Treatment Episode is defined as beginning with an Admission for a functional hip deficit, progressing to development of a plan of care, including treatment, without interruption of care (for example, a hospitalization or surgical intervention), and ending with Discharge from clinical care by the Eligible Professional. A patient currently under clinical care for a hip deficit remains in a single episode of care until the Discharge is conducted and documented by the Eligible Professional.
Admission – An Admission is the first encounter for a functional deficit involving the hip and includes an evaluation (CPT 97001 or 97003) and development of a plan of care by the Eligible Professional. A patient presenting with a hip impairment, who has had an interruption of a Treatment Episode for the same functional hip deficit secondary to an appropriate reason like hospitalization or surgical intervention, is a new Admission.
Discharge – Discharge is accompanied by a re-evaluation (CPT 97002 or 97004) identifying the close of a Treatment Episode for the same hip deficit identified at admission and documented by a discharge report by the Eligible Professional. An interruption in clinical care for an appropriate reason like hospitalization or surgical intervention requires a discharge from the current Treatment Episode.
Encounter – A face to face visit between the patient and the provider for the purpose of assessing and/or improving a functional deficit.
Patient Reported – The patient directly, or through a proxy, provides answers to functional status survey items using standardized, reliable and valid, computerized adaptive testing or paper and pencil survey methods.

Measure Reporting via Registry:
CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All patients aged 18 years and older who receive a treatment episode for a functional deficit related to the hip

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Option 1 – Physical Therapy Denominator Criteria (Eligible Cases):
All patients aged ≥ 18 years on date of encounter
AND
Patient encounter during the reporting period identifying evaluation (CPT): 97001
AND
Patient encounter during the reporting period identifying re-evaluation (CPT): 97002
AND
Functional deficit affecting the hip

OR

Option 2 – Occupational Therapy Denominator Criteria (Eligible Cases):
All patients aged ≥ 18 years on date of encounter
AND
Patient encounter during the reporting period identifying evaluation (CPT): 97003
AND
Patient encounter during the reporting period identifying re-evaluation (CPT): 97004
AND
Functional deficit affecting the hip

NUMERATOR:
Patients presented FOTO's Functional Intake Survey for the Hip at admission and FOTO's Functional Status Survey at discharge for the purpose of calculating the patient's Risk-adjusted Functional Status Change Residual Score

Definitions:
Patient's Functional Status Score – A functional status score is produced when the patient completes the FOTO functional status survey (either by paper and pencil or computerized adaptive testing administration). The functional status score is continuous and linear. Scores range from 0 (low function) to 100 (high function). The survey is standardized, and the scores are validated for the measurement of function for this population.
Patient's Functional Status Change Score – A functional status change score is calculated by subtracting the Patient's Functional Status Score at Admission from the Patient's Functional Status Score at Discharge.
Predicted Functional Status Change Score – Functional Status Change Scores for patients are risk adjusted using multiple linear regression methods that include the following independent variables: Patient's Functional Status Score at Admission, patient age, symptom acuity, surgical history, gender, number of co-morbidities and level of fear-avoidance. The Patient's Functional Status Change Score is the dependent variable. The statistical regression produces a Risk-Adjusted Predicted Functional Status Change Score.
Risk-Adjusted Functional Status Change Residual Score – The difference between the raw non-risk-adjusted Patient's Functional Status Change Score and the Risk-Adjusted Predicted Functional Status Change Score (raw minus predicted) is the Risk-Adjusted Functional Status Change Residual Score, which is in the same units as the Patient's Functional Status Scores, and should be interpreted as the unit of functional status change different than predicted given the risk-adjustment variables of the patient being treated. As such, the Risk-Adjusted Residual Change Score represents Risk-Adjusted Change corrected for the level of severity of the patient. Risk-Adjusted Residual Change Scores of zero (0) or greater (> 0) should be interpreted as functional status change scores that were predicted or better than predicted given the risk-adjustment variables of the patient and risk-adjusted residual change scores less than zero (< 0) should be interpreted as functional status change scores that were less than predicted given the risk-adjustment variables of the patient. Aggregated Risk-Adjusted Residual Scores allow meaningful comparisons amongst clinicians or clinics.

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Not Eligible/Not Appropriate – A patient is not eligible if one or more of the following conditions exist:

- Patient refused to participate
- Patient unable to complete the questionnaire due to blindness, illiteracy, severe mental incapacity or language incompatibility and an adequate proxy is not available
- Prior to conclusion of Plan of Care, intervention was interrupted or discontinued for any reason including by the referring physician, the provider, the payer or the patient, and attempts by the provider to complete a follow-up functional status survey near Discharge were unsuccessful.

Numerator Options:

Risk-Adjusted Functional Status Change Residual Score for the hip successfully calculated and the score was equal to zero (0) or greater than zero (> 0) (G8651)

OR

Risk-Adjusted Functional Status Change Residual Score for the hip successfully calculated and the score was less than zero (< 0) (G8652)

OR

Risk-Adjusted Functional Status Change Residual Scores for the hip not measured because the patient did not complete FOTO's Functional Intake on admission and/or follow up Status Survey near discharge, patient Not Eligible/Not Appropriate (G8653)

OR

Risk-Adjusted Functional Status Change Residual Scores for the hip not measured because the patient did not complete FOTO's Functional Intake on admission and/or follow up Status Survey near discharge, reason not given (G8654)

RATIONALE:

Functional deficits are common in the general population and are costly to the individual, their family and society. Improved functional status has been associated with greater quality of life, self-efficacy, improved financial well-being and lower future medical costs. Improving functional status in people seeking rehabilitation has become a goal of the American Physical Therapy Association. Therefore, measuring change in functional status is important for providers treating patients in rehabilitation and can be used to assess the success of treatment and direct modification of treatment.

Change in functional status represents the activity domain of the International Classification of Function. If treatment is designed to improve the functional deficit, it is logical to assess functional status at discharge using a standardized score to determine if treatment improved the functional status of the patient over the treatment episode.

The National Quality Measures Clearinghouse has approved the measurement of change in functional status, using this survey. (NQMC-1872)

CLINICAL RECOMMENDATION STATEMENTS:

The American Physical Therapy Association (APTA), in their *Guide to Physical Therapy Practice*, described five recommended elements of patient management: examination, evaluation, diagnosis, prognosis and intervention. The elements were intended to direct therapists in their approach to patient treatment for the purpose of optimizing patient outcomes. The APTA clearly indentifies functional status data as one of the major forms of data to be collected for patients receiving rehabilitation. The functional status measures should be used to assist in the planning, implementation and modification of treatment interventions and should be used as measures of outcomes. The current functional status scores can be used by therapists to fulfill the recommended methods of the APTA in the management of patients in rehabilitation.

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☾ Measure #219 (NQF 0424): Functional Deficit: Change in Risk-Adjusted Functional Status for Patients with Lower Leg, Foot or Ankle Impairments

2013 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Percentage of patients aged 18 or older that receive treatment for a functional deficit secondary to a diagnosis that affects the lower leg, foot or ankle in which the change in their Risk-Adjusted Functional Status is measured

INSTRUCTIONS:
This outcomes measure is to be reported once per treatment episode for all patients with a functional deficit related to the lower leg, foot or ankle. This is an outcomes measure and its calculation requires reporting of the patient's functional status score, as a minimum, at admission to and again at discharge from an episode of rehabilitation. The admission score, estimated using patient self-report surveys, is recorded during the first rehabilitation treatment encounter and the discharge score is recorded at or near the conclusion of the final rehabilitation treatment encounter. It is anticipated that physical and occupational therapists providing treatment for functional lower leg, foot or ankle deficits will report this measure.

Definitions:
Treatment Episode – A Treatment Episode is defined as beginning with an Admission for a functional lower leg, foot or ankle deficit, progressing to development of a plan of care, including treatment, without interruption of care (for example, a hospitalization or surgical intervention), and ending with Discharge from clinical care by the Eligible Professional. A patient currently under clinical care for a lower leg, foot or ankle deficit remains in a single episode of care until the Discharge is conducted and documented by the Eligible Professional.
Admission – An Admission is the first encounter for a functional deficit involving the lower leg, foot or ankle and includes an evaluation (CPT 97001 or 97003) and development of a plan of care by the Eligible Professional. A patient presenting with a lower leg, foot or ankle impairment, who has had an interruption of a Treatment Episode for the same functional lower leg, foot or ankle deficit secondary to an appropriate reason like hospitalization or surgical intervention, is a new Admission.
Discharge – Discharge is accompanied by a re-evaluation (CPT 97002 or 97004) identifying the close of a Treatment Episode for the same lower leg, foot or ankle deficit identified at admission and documented by a discharge report by the Eligible Professional. An interruption in clinical care for an appropriate reason like hospitalization or surgical intervention requires a discharge from the current Treatment Episode.
Encounter – A face to face visit between the patient and the provider for the purpose of assessing and/or improving a functional deficit.
Patient Reported – The patient directly, or through a proxy, provides answers to functional status survey items using standardized, reliable and valid, computerized adaptive testing or paper and pencil survey methods.

Measure Reporting via Registry:
CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

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DENOMINATOR:
All patients aged 18 years and older who receive a treatment episode for a functional deficit related to the lower leg, foot or ankle

Option 1 – Physical Therapy Denominator Criteria (Eligible Cases):
All patients aged ≥ 18 years on date of encounter
AND
Patient encounter during the reporting period identifying evaluation (CPT): 97001
AND
Patient encounter during the reporting period identifying re-evaluation (CPT): 97002
AND
Functional deficit affecting the lower leg, foot or ankle

OR

Option 2 – Occupational Therapy Denominator Criteria (Eligible Cases):
All patients aged ≥ 18 years on date of encounter
AND
Patient encounter during the reporting period identifying evaluation (CPT): 97003
AND
Patient encounter during the reporting period identifying re-evaluation (CPT): 97004
AND
Functional deficit affecting the lower leg, foot or ankle

NUMERATOR:
Patients presented FOTO's Functional Intake Survey for the Lower Leg, Foot or Ankle at admission and FOTO's Functional Status Survey at discharge for the purpose of calculating the patient's Risk-adjusted Functional Status Change Residual Score

Definitions:
Patient's Functional Status Score – A functional status score is produced when the patient completes the FOTO functional status survey (either by paper and pencil or computerized adaptive testing administration). The functional status score is continuous and linear. Scores range from 0 (low function) to 100 (high function). The survey is standardized, and the scores are validated for the measurement of function for this population.
Patient's Functional Status Change Score – A functional status change score is calculated by subtracting the Patient's Functional Status Score at Admission from the Patient's Functional Status Score at Discharge.
Predicted Functional Status Change Score – Functional Status Change Scores for patients are risk adjusted using multiple linear regression methods that include the following independent variables: Patient's Functional Status Score at Admission, patient age, symptom acuity, surgical history, gender, number of co-morbidities, and level of fear-avoidance. The Patient's Functional Status Change Score is the dependent variable. The statistical regression produces a Risk-Adjusted Predicted Functional Status Change Score.
Risk-Adjusted Functional Status Change Residual Score – The difference between the raw non-risk-adjusted Patient's Functional Status Change Score and the Risk-Adjusted Predicted Functional Status Change Score (raw minus predicted) is the Risk-Adjusted Functional Status Change Residual Score, which is in the same units as the Patient's Functional Status Scores, and should be interpreted as the unit of functional status change different than predicted given the risk-adjustment variables of the patient being treated. As such, the Risk-Adjusted Residual Change Score represents Risk-Adjusted Change corrected for the level of severity of the patient. Risk-Adjusted Residual Change Scores of zero (0) or greater (> 0) should be interpreted as functional status change scores that were predicted or better than predicted given the risk-

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adjustment variables of the patient, and risk-adjusted residual change scores less than zero (< 0) should be interpreted as functional status change scores that were less than predicted given the risk-adjustment variables of the patient. Aggregated Risk-Adjusted Residual Scores allow meaningful comparisons amongst clinicians or clinics.

Not Eligible/Not Appropriate – A patient is not eligible if one or more of the following conditions exist:

- Patient refused to participate
- Patient unable to complete the questionnaire due to blindness, illiteracy, severe mental incapacity or language incompatibility and an adequate proxy is not available
- Prior to conclusion of Plan of Care, intervention was interrupted or discontinued for any reason including by the referring physician, the provider, the payer or the patient, and attempts by the provider to complete a follow-up functional status survey near Discharge were unsuccessful.

Numerator Options:

Risk-Adjusted Functional Status Change Residual Score for the lower leg, foot or ankle successfully calculated and the score was equal to zero (0) or greater than zero (> 0) (G8655)

OR

Risk-Adjusted Functional Status Change Residual Score for the lower leg, foot or ankle successfully calculated and the score was less than zero (< 0) (G8656)

OR

Risk-Adjusted Functional Status Change Residual Scores for the lower leg, foot or ankle not measured because the patient did not complete FOTO's Functional Intake on admission and/or follow up Status Survey near discharge, patient Not Eligible/Not Appropriate (G8657)

OR

Risk-Adjusted Functional Status Change Residual Scores for the lower leg, foot or ankle not measured because the patient did not complete FOTO's Functional Intake on admission and/or follow up Status Survey near discharge, reason not given (G8658)

RATIONALE:

Functional deficits are common in the general population and are costly to the individual, their family and society. Improved functional status has been associated with greater quality of life, self-efficacy, improved financial well-being and lower future medical costs. Improving functional status in people seeking rehabilitation has become a goal of the American Physical Therapy Association. Therefore, measuring change in functional status is important for providers treating patients in rehabilitation and can be used to assess the success of treatment and direct modification of treatment.

Change in functional status represents the activity domain of the International Classification of Function. If treatment is designed to improve the functional deficit, it is logical to assess functional status at discharge using a standardized score to determine if treatment improved the functional status of the patient over the treatment episode.

The National Quality Measures Clearinghouse has approved the measurement of change in functional status, using this survey. (NQMC-1874)

CLINICAL RECOMMENDATION STATEMENTS:

The American Physical Therapy Association (APTA), in their *Guide to Physical Therapy Practice*, described five recommended elements of patient management: examination, evaluation, diagnosis, prognosis and intervention. The elements were intended to direct therapists in their approach to patient treatment for the purpose of optimizing patient outcomes. The APTA clearly indentifies functional status data as one of the major forms of data to be collected for patients receiving rehabilitation. The functional status measures should be used to assist in the planning, implementation and modification of treatment interventions and should be used as measures of outcomes. The

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current functional status scores can be used by therapists to fulfill the recommended methods of the APTA in the management of patients in rehabilitation.

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☾ Measure #220 (NQF 0425): Functional Deficit: Change in Risk-Adjusted Functional Status for Patients with Lumbar Spine Impairments

2013 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Percentage of patients aged 18 or older that receive treatment for a functional deficit secondary to a diagnosis that affects the lumbar spine in which the change in their Risk-Adjusted Functional Status is measured

INSTRUCTIONS:
This outcomes measure is to be reported once per treatment episode for all patients with a functional deficit related to the lumbar spine. This is an outcomes measure, and its calculation requires reporting of the patient's functional status score, as a minimum, at admission to and again at discharge from an episode of rehabilitation. The admission score, estimated using patient self-report surveys, is recorded during the first rehabilitation treatment encounter, and the discharge score is recorded at or near the conclusion of the final rehabilitation treatment encounter. It is anticipated that physical and occupational therapists providing treatment for functional lumbar spine deficits will report this measure.

Definitions:
Treatment Episode – A Treatment Episode is defined as beginning with an Admission for a functional lumbar spine deficit, progressing to development of a plan of care, including treatment, without interruption of care (for example, a hospitalization or surgical intervention), and ending with Discharge from clinical care by the Eligible Professional. A patient currently under clinical care for a lumbar spine deficit remains in a single episode of care until the Discharge is conducted and documented by the Eligible Professional.
Admission – An Admission is the first encounter for a functional deficit involving the lumbar spine and includes an evaluation (CPT 97001 or 97003) and development of a plan of care by the Eligible Professional. A patient presenting with a lumbar spine impairment, who has had an interruption of a Treatment Episode for the same functional lumbar spine deficit secondary to an appropriate reason like hospitalization or surgical intervention, is a new Admission.
Discharge – Discharge is accompanied by a re-evaluation (CPT 97002 or 97004) identifying the close of a Treatment Episode for the same lumbar spine deficit identified at admission and documented by a discharge report by the Eligible Professional. An interruption in clinical care for an appropriate reason like hospitalization or surgical intervention requires a discharge from the current Treatment Episode.
Encounter – A face to face visit between the patient and the provider for the purpose of assessing and/or improving a functional deficit.
Patient Reported – The patient directly, or through a proxy, provides answers to functional status survey items using standardized, reliable and valid, computerized adaptive testing or paper and pencil survey methods.

Measure Reporting via Registry:
CPT codes and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

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DENOMINATOR:
All patients aged 18 years and older who receive a treatment episode for a functional deficit related to the lumbar spine

Option 1 – Physical Therapy Denominator Criteria (Eligible Cases):
All patients aged ≥ 18 years on date of encounter
AND
Patient encounter during the reporting period identifying evaluation (CPT): 97001
AND
Patient encounter during the reporting period identifying re-evaluation (CPT): 97002
AND
Functional deficit affecting the lumbar spine

OR

Option 2 – Occupational Therapy Denominator Criteria (Eligible Cases):
All patients aged ≥ 18 years on date of encounter
AND
Patient encounter during the reporting period identifying evaluation (CPT): 97003
AND
Patient encounter during the reporting period identifying re-evaluation (CPT): 97004
AND
Functional deficit affecting the lumbar spine

NUMERATOR:
Patients presented FOTO's Functional Intake Survey for the Lumbar Spine at admission and FOTO's Functional Status Survey at discharge for the purpose of calculating the patient's Risk-adjusted Functional Status Change Residual Score

Definitions:
Patient's Functional Status Score – A functional status score is produced when the patient completes the FOTO functional status survey (either by paper and pencil or computerized adaptive testing administration). The functional status score is continuous and linear. Scores range from 0 (low function) to 100 (high function). The survey is standardized, and the scores are validated for the measurement of function for this population.
Patient's Functional Status Change Score – A functional status change score is calculated by subtracting the Patient's Functional Status Score at Admission from the Patient's Functional Status Score at Discharge.
Predicted Functional Status Change Score – Functional Status Change Scores for patients are risk adjusted using multiple linear regression methods that include the following independent variables: Patient's Functional Status Score at Admission, patient age, symptom acuity, surgical history, gender, number of co-morbidities and level of fear-avoidance. The Patient's Functional Status Change Score is the dependent variable. The statistical regression produces a Risk-Adjusted Predicted Functional Status Change Score.
Risk-Adjusted Functional Status Change Residual Score – The difference between the raw non-risk-adjusted Patient's Functional Status Change Score and the Risk-Adjusted Predicted Functional Status Change Score (raw minus predicted) is the Risk-Adjusted Functional Status Change Residual Score, which is in the same units as the Patient's Functional Status Scores, and should be interpreted as the unit of functional status change different than predicted given the risk-adjustment variables of the patient being treated. As such, the Risk-Adjusted Residual Change Score represents Risk-Adjusted Change corrected for the level of severity of the patient. Risk-Adjusted Residual Change Scores of zero (0) or greater (> 0) should be interpreted as functional status change scores that were predicted or better than predicted given the risk-

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adjustment variables of the patient and risk-adjusted residual change scores less than zero (< 0) should be interpreted as functional status change scores that were less than predicted given the risk-adjustment variables of the patient. Aggregated Risk-Adjusted Residual Scores allow meaningful comparisons amongst clinicians or clinics.

Not Eligible/Not Appropriate – A patient is not eligible if one or more of the following conditions exist:

- Patient refused to participate
- Patient unable to complete the questionnaire due to blindness, illiteracy, severe mental incapacity or language incompatibility and an adequate proxy is not available
- Prior to conclusion of Plan of Care, intervention was interrupted or discontinued for any reason including by the referring physician, the provider, the payer or the patient, and attempts by the provider to complete a follow-up functional status survey near Discharge were unsuccessful.

Numerator Options:

Risk-Adjusted Functional Status Change Residual Score for the lumbar spine successfully calculated and the score was equal to zero (0) or greater than zero (> 0) (G8659)

OR

Risk-Adjusted Functional Status Change Residual Score for the lumbar spine successfully calculated and the score was less than zero (< 0) (G8660)

OR

Risk-Adjusted Functional Status Change Residual Scores for the lumbar spine not measured because the patient did not complete FOTO's Functional Intake on admission and/or follow up Status Survey near discharge, patient Not Eligible/Not Appropriate (G8661)

OR

Risk-Adjusted Functional Status Change Residual Scores for the lumbar spine not measured because the patient did not complete FOTO's Functional Intake on admission and/or follow up Status Survey near discharge, reason not given (G8662)

RATIONALE:

Functional deficits are common in the general population and are costly to the individual, their family and society. Improved functional status has been associated with greater quality of life, self-efficacy, improved financial well-being and lower future medical costs. Improving functional status in people seeking rehabilitation has become a goal of the American Physical Therapy Association. Therefore, measuring change in functional status is important for providers treating patients in rehabilitation and can be used to assess the success of treatment and direct modification of treatment.

Change in functional status represents the activity domain of the International Classification of Function. If treatment is designed to improve the functional deficit, it is logical to assess functional status at discharge using a standardized score to determine if treatment improved the functional status of the patient over the treatment episode.

The National Quality Measures Clearinghouse has approved the measurement of change in functional status, using this survey. (NQMC-2632)

CLINICAL RECOMMENDATION STATEMENTS:

The American Physical Therapy Association (APTA), in their *Guide to Physical Therapy Practice*, described five recommended elements of patient management: examination, evaluation, diagnosis, prognosis and intervention. The elements were intended to direct therapists in their approach to patient treatment for the purpose of optimizing patient outcomes. The APTA clearly indentifies functional status data as one of the major forms of data to be collected for patients receiving rehabilitation. The functional status measures should be used to assist in the planning, implementation and modification of treatment interventions and should be used as measures of outcomes. The

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current functional status scores can be used by therapists to fulfill the recommended methods of the APTA in the management of patients in rehabilitation.

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☾ Measure #221 (NQF 0426): Functional Deficit: Change in Risk-Adjusted Functional Status for Patients with Shoulder Impairments

2013 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Percentage of patients aged 18 or older that receive treatment for a functional deficit secondary to a diagnosis that affects the shoulder in which the change in their Risk-Adjusted Functional Status is measured

INSTRUCTIONS:
This outcomes measure is to be reported once per treatment episode for all patients with a functional deficit related to the shoulder. This is an outcomes measure and its calculation requires reporting of the patient's functional status score, as a minimum, at admission to and again at discharge from an episode of rehabilitation. The admission score, estimated using patient self-report surveys, is recorded during the first rehabilitation treatment encounter and the discharge score is recorded at or near the conclusion of the final rehabilitation treatment encounter. It is anticipated that physical and occupational therapists providing treatment for functional shoulder deficits will report this measure.

Definitions:
Treatment Episode – A Treatment Episode is defined as beginning with an Admission for a functional shoulder deficit, progressing to development of a plan of care, including treatment, without interruption of care (for example, a hospitalization or surgical intervention), and ending with Discharge from clinical care by the Eligible Professional. A patient currently under clinical care for a shoulder deficit remains in a single episode of care until the Discharge is conducted and documented by the Eligible Professional.
Admission – An Admission is the first encounter for a functional deficit involving the shoulder and includes an evaluation (CPT 97001 or 97003) and development of a plan of care by the Eligible Professional. A patient presenting with a shoulder impairment, who has had an interruption of a Treatment Episode for the same functional shoulder deficit secondary to an appropriate reason like hospitalization or surgical intervention, is a new Admission.
Discharge – Discharge is accompanied by a re-evaluation (CPT 97002 or 97004) identifying the close of a Treatment Episode for the same shoulder deficit identified at admission and documented by a discharge report by the Eligible Professional. An interruption in clinical care for an appropriate reason like hospitalization or surgical intervention requires a discharge from the current Treatment Episode.
Encounter – A face to face visit between the patient and the provider for the purpose of assessing and/or improving a functional deficit.
Patient Reported – The patient directly, or through a proxy, provides answers to functional status survey items using standardized, reliable and valid, computerized adaptive testing or paper and pencil survey methods.

Measure Reporting via Registry:
CPT codes and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All patients aged 18 years and older who receive a treatment episode for a functional deficit related to the shoulder

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Option 1 – Physical Therapy Denominator Criteria (Eligible Cases):
All patients aged ≥ 18 years on date of encounter
AND
Patient encounter during the reporting period identifying evaluation (CPT): 97001
AND
Patient encounter during the reporting period identifying re-evaluation (CPT): 97002
AND
Functional deficit affecting the shoulder

OR

Option 2 – Occupational Therapy Denominator Criteria (Eligible Cases):
All patients aged ≥ 18 years on date of encounter
AND
Patient encounter during the reporting period identifying evaluation (CPT): 97003
AND
Patient encounter during the reporting period identifying re-evaluation (CPT): 97004
AND
Functional deficit affecting the shoulder

NUMERATOR:
Patients presented FOTO's Functional Intake Survey for the Shoulder at admission and FOTO's Functional Status Survey at discharge for the purpose of calculating the patient's Risk-adjusted Functional Status Change Residual Score

Definitions:
Patient's Functional Status Score – A functional status score is produced when the patient completes the FOTO functional status survey (either by paper and pencil or computerized adaptive testing administration). The functional status score is continuous and linear. Scores range from 0 (low function) to 100 (high function). The survey is standardized, and the scores are validated for the measurement of function for this population.
Patient's Functional Status Change Score – A functional status change score is calculated by subtracting the Patient's Functional Status Score at Admission from the Patient's Functional Status Score at Discharge.
Predicted Functional Status Change Score – Functional Status Change Scores for patients are risk adjusted using multiple linear regression methods that include the following independent variables: Patient's Functional Status Score at Admission, patient age, symptom acuity, surgical history, gender, number of co-morbidities and level of fear-avoidance. The Patient's Functional Status Change Score is the dependent variable. The statistical regression produces a Risk-Adjusted Predicted Functional Status Change Score.
Risk-Adjusted Functional Status Change Residual Score – The difference between the raw non-risk-adjusted Patient's Functional Status Change Score and the Risk-Adjusted Predicted Functional Status Change Score (raw minus predicted) is the Risk-Adjusted Functional Status Change Residual Score, which is in the same units as the Patient's Functional Status Scores, and should be interpreted as the unit of functional status change different than predicted given the risk-adjustment variables of the patient being treated. As such, the Risk-Adjusted Residual Change Score represents Risk-Adjusted Change corrected for the level of severity of the patient. Risk-Adjusted Residual Change Scores of zero (0) or greater (> 0) should be interpreted as functional status change scores that were predicted or better than predicted given the risk-adjustment variables of the patient and risk-adjusted residual change scores less than zero (< 0) should be interpreted as functional status change scores that were less than predicted given the risk-adjustment

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variables of the patient. Aggregated Risk-Adjusted Residual Scores allow meaningful comparisons amongst clinicians or clinics.

Not Eligible/Not Appropriate – A patient is not eligible if one or more of the following conditions exist:

- Patient refused to participate
- Patient unable to complete the questionnaire due to blindness, illiteracy, severe mental incapacity or language incompatibility and an adequate proxy is not available
- Prior to conclusion of Plan of Care, intervention was interrupted or discontinued for any reason including by the referring physician, the provider, the payer or the patient, and attempts by the provider to complete a follow-up functional status survey near Discharge were unsuccessful.

Numerator Options:

Risk-Adjusted Functional Status Change Residual Score for the shoulder successfully calculated and the score was equal to zero (0) or greater than zero (> 0) (G8663)

OR

Risk-Adjusted Functional Status Change Residual Score for the shoulder successfully calculated and the score was less than zero (< 0) (G8664)

OR

Risk-Adjusted Functional Status Change Residual Scores for the shoulder not measured because the patient did not complete FOTO's Functional Intake on admission and/or follow up Status Survey near discharge, patient Not Eligible/Not Appropriate (G8665)

OR

Risk-Adjusted Functional Status Change Residual Scores for the shoulder not measured because the patient did not complete FOTO's Functional Intake on admission and/or follow up Status Survey near discharge, reason not given (G8666)

RATIONALE:

Functional deficits are common in the general population and are costly to the individual, their family and society. Improved functional status has been associated with greater quality of life, self-efficacy, improved financial well-being and lower future medical costs. Improving functional status in people seeking rehabilitation has become a goal of the American Physical Therapy Association. Therefore, measuring change in functional status is important for providers treating patients in rehabilitation and can be used to assess the success of treatment and direct modification of treatment.

Change in functional status represents the activity domain of the International Classification of Function. If treatment is designed to improve the functional deficit, it is logical to assess functional status at discharge using a standardized score to determine if treatment improved the functional status of the patient over the treatment episode.

The National Quality Measures Clearinghouse has approved the measurement of change in functional status, using this survey. (NQMC-2633)

CLINICAL RECOMMENDATION STATEMENTS:

The American Physical Therapy Association (APTA), in their *Guide to Physical Therapy Practice*, described five recommended elements of patient management: examination, evaluation, diagnosis, prognosis and intervention. The elements were intended to direct therapists in their approach to patient treatment for the purpose of optimizing patient outcomes. The APTA clearly indentifies functional status data as one of the major forms of data to be collected for patients receiving rehabilitation. The functional status measures should be used to assist in the planning, implementation and modification of treatment interventions and should be used as measures of outcomes. The current functional status scores can be used by therapists to fulfill the recommended methods of the APTA in the management of patients in rehabilitation.

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☾ Measure #222 (NQF 0427): Functional Deficit: Change in Risk-Adjusted Functional Status for Patients with Elbow, Wrist or Hand Impairments

2013 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Percentage of patients aged 18 or older that receive treatment for a functional deficit secondary to a diagnosis that affects the elbow, wrist or hand in which the change in their Risk-Adjusted Functional Status is measured

INSTRUCTIONS:
This outcomes measure is to be reported once per treatment episode for all patients with a functional deficit related to the elbow, wrist or hand. This is an outcomes measure and its calculation requires reporting of the patient's functional status score, as a minimum, at admission to and again at discharge from an episode of rehabilitation. The admission score, estimated using patient self-report surveys, is recorded during the first rehabilitation treatment encounter and the discharge score is recorded at or near the conclusion of the final rehabilitation treatment encounter. It is anticipated that physical and occupational therapists providing treatment for functional elbow, wrist or hand deficits will report this measure.

Definitions:
Treatment Episode – A Treatment Episode is defined as beginning with an Admission for a functional elbow, wrist or hand deficit, progressing to development of a plan of care, including treatment, without interruption of care (for example, a hospitalization or surgical intervention), and ending with Discharge from clinical care by the Eligible Professional. A patient currently under clinical care for an elbow, wrist or hand deficit remains in a single episode of care until the Discharge is conducted and documented by the Eligible Professional.
Admission – An Admission is the first encounter for a functional deficit involving the elbow, wrist or hand and includes an evaluation (CPT 97001 or 97003) and development of a plan of care by the Eligible Professional. A patient presenting with an elbow, wrist or hand impairment, who has had an interruption of a Treatment Episode for the same functional elbow, wrist or hand deficit secondary to an appropriate reason like hospitalization or surgical intervention, is a new Admission.
Discharge – Discharge is accompanied by a re-evaluation (CPT 97002 or 97004) identifying the close of a Treatment Episode for the same elbow, wrist or hand deficit identified at admission and documented by a discharge report by the Eligible Professional. An interruption in clinical care for an appropriate reason like hospitalization or surgical intervention requires a discharge from the current Treatment Episode.
Encounter – A face to face visit between the patient and the provider for the purpose of assessing and/or improving a functional deficit.
Patient Reported – The patient directly, or through a proxy, provides answers to functional status survey items using standardized, reliable and valid, computerized adaptive testing or paper and pencil survey methods.

Measure Reporting via Registry:
CPT codes and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:

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All patients aged 18 years and older who receive a treatment episode for a functional deficit related to the elbow, wrist or hand

Option 1 – Physical Therapy Denominator Criteria (Eligible Cases):
All patients aged ≥ 18 years on date of encounter
AND
Patient encounter during the reporting period identifying evaluation (CPT): 97001
AND
Patient encounter during the reporting period identifying re-evaluation (CPT): 97002
AND
Functional deficit affecting elbow, wrist or hand

OR

Option 2 – Occupational Therapy Denominator Criteria (Eligible Cases):
All patients aged ≥ 18 years on date of encounter
AND
Patient encounter during the reporting period identifying evaluation (CPT): 97003
AND
Patient encounter during the reporting period identifying re-evaluation (CPT): 97004
AND
Functional deficit affecting elbow, wrist or hand

NUMERATOR:
Patients presented FOTO's Functional Intake Survey for the Elbow, Wrist or Hand at admission and FOTO's Functional Status Survey at discharge for the purpose of calculating the patient's Risk-adjusted Functional Status Change Residual Score

Definitions:
Patient's Functional Status Score – A functional status score is produced when the patient completes the FOTO functional status survey (either by paper and pencil or computerized adaptive testing administration). The functional status score is continuous and linear. Scores range from 0 (low function) to 100 (high function). The survey is standardized, and the scores are validated for the measurement of function for this population.
Patient's Functional Status Change Score – A functional status change score is calculated by subtracting the Patient's Functional Status Score at Admission from the Patient's Functional Status Score at Discharge.
Predicted Functional Status Change Score – Functional Status Change Scores for patients are risk adjusted using multiple linear regression methods that include the following independent variables: Patient's Functional Status Score at Admission, patient age, symptom acuity, surgical history, gender, number of co-morbidities and level of fear-avoidance. The Patient's Functional Status Change Score is the dependent variable. The statistical regression produces a Risk-Adjusted Predicted Functional Status Change Score.
Risk-Adjusted Functional Status Change Residual Score – The difference between the raw non-risk-adjusted Patient's Functional Status Change Score and the Risk-Adjusted Predicted Functional Status Change Score (raw minus predicted) is the Risk-Adjusted Functional Status Change Residual Score, which is in the same units as the Patient's Functional Status Scores, and should be interpreted as the unit of functional status change different than predicted given the risk-adjustment variables of the patient being treated. As such, the Risk-Adjusted Residual Change Score represents Risk-Adjusted Change corrected for the level of severity of the patient. Risk-Adjusted Residual Change Scores of zero (0) or greater (> 0) should be interpreted as functional status change scores that were predicted or better than predicted given the risk-adjustment variables of the patient and risk-adjusted residual change scores less than zero (< 0) should be

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interpreted as functional status change scores that were less than predicted given the risk-adjustment variables of the patient. Aggregated Risk-Adjusted Residual Scores allow meaningful comparisons amongst clinicians or clinics.

Not Eligible/Not Appropriate – A patient is not eligible if one or more of the following conditions exist:

- Patient refused to participate
- Patient unable to complete the questionnaire due to blindness, illiteracy, severe mental incapacity or language incompatibility and an adequate proxy is not available
- Prior to conclusion of Plan of Care, intervention was interrupted or discontinued for any reason including by the referring physician, the provider, the payer or the patient, and attempts by the provider to complete a follow-up functional status survey near Discharge were unsuccessful.

Numerator Options:

Risk-Adjusted Functional Status Change Residual Score for the elbow, wrist or hand successfully calculated and the score was equal to zero (0) or greater than zero (> 0) (G8667)

OR

Risk-Adjusted Functional Status Change Residual Score for the elbow, wrist or hand successfully calculated and the score was less than zero (< 0) (G8668)

OR

Risk-Adjusted Functional Status Change Residual Scores for the elbow, wrist or hand not measured because the patient did not complete FOTO's Functional Intake on admission and/or follow up Status Survey near discharge, patient Not Eligible/Not Appropriate (G8669)

OR

Risk-Adjusted Functional Status Change Residual Scores for the elbow, wrist or hand not measured because the patient did not complete FOTO's Functional Intake on admission and/or follow up Status Survey near discharge, reason not given (G8670)

RATIONALE:

Functional deficits are common in the general population and are costly to the individual, their family and society. Improved functional status has been associated with greater quality of life, self-efficacy, improved financial well-being and lower future medical costs. Improving functional status in people seeking rehabilitation has become a goal of the American Physical Therapy Association. Therefore, measuring change in functional status is important for providers treating patients in rehabilitation and can be used to assess the success of treatment and direct modification of treatment.

Change in functional status represents the activity domain of the International Classification of Function. If treatment is designed to improve the functional deficit, it is logical to assess functional status at discharge using a standardized score to determine if treatment improved the functional status of the patient over the treatment episode.

The National Quality Measures Clearinghouse has approved the measurement of change in functional status, using this survey. (NQMC-1874)

CLINICAL RECOMMENDATION STATEMENTS:

The American Physical Therapy Association (APTA), in their *Guide to Physical Therapy Practice*, described five recommended elements of patient management: examination, evaluation, diagnosis, prognosis and intervention. The elements were intended to direct therapists in their approach to patient treatment for the purpose of optimizing patient outcomes. The APTA clearly indentifies functional status data as one of the major forms of data to be collected for patients receiving rehabilitation. The functional status measures should be used to assist in the planning, implementation and modification of treatment interventions and should be used as measures of outcomes. The current functional status scores can be used by therapists to fulfill the recommended methods of the APTA in the management of patients in rehabilitation.

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☾ Measure #223 (NQF 0428): Functional Deficit: Change in Risk-Adjusted Functional Status for Patients with Neck, Cranium, Mandible, Thoracic Spine, Ribs, or Other General Orthopedic Impairments

2013 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Percentage of patients aged 18 or older that receive treatment for a functional deficit secondary to a diagnosis that affects the neck, cranium, mandible, thoracic spine, ribs, or other general orthopedic impairment in which the change in their Risk-Adjusted Functional Status is measured

INSTRUCTIONS:
This outcomes measure is to be reported once per treatment episode for all patients with a functional deficit related to the neck, cranium, mandible, thoracic spine, ribs or other general orthopedic impairment. This is an outcomes measure and its calculation requires reporting of the patient's functional status score, as a minimum, at admission to and again at discharge from an episode of rehabilitation. The admission score, estimated using patient self-report surveys, is recorded during the first rehabilitation treatment encounter and the discharge score is recorded at or near the conclusion of the final rehabilitation treatment encounter. It is anticipated that physical and occupational therapists providing treatment for functional neck, cranium, mandible, thoracic spine, ribs or other general orthopedic deficits will report this measure.

Definitions:
Treatment Episode – A Treatment Episode is defined as beginning with an Admission for a functional neck, cranium, mandible, thoracic spine, ribs or other general orthopedic deficit, progressing to development of a plan of care, including treatment, without interruption of care (for example, a hospitalization or surgical intervention), and ending with Discharge from clinical care by the Eligible Professional. A patient currently under clinical care for a neck, cranium, mandible, thoracic spine, ribs or other general orthopedic deficit remains in a single episode of care until the Discharge is conducted and documented by the Eligible Professional.
Admission – An Admission is the first encounter for a functional deficit involving the neck, cranium, mandible, thoracic spine, ribs or other general orthopedic impairment and includes an evaluation (CPT 97001 or 97003) and development of a plan of care by the Eligible Professional. A patient presenting with a neck, cranium, mandible, thoracic spine, ribs or other general orthopedic impairment, who has had an interruption of a Treatment Episode for the same functional neck, cranium, mandible, thoracic spine, ribs or other general orthopedic deficit secondary to an appropriate reason like hospitalization or surgical intervention, is a new Admission.
Discharge – Discharge is accompanied by a re-evaluation (CPT 97002 or 97004) identifying the close of a Treatment Episode for the same neck, cranium, mandible, thoracic spine, ribs or other general orthopedic deficit identified at admission and documented by a discharge report by the Eligible Professional. An interruption in clinical care for an appropriate reason like hospitalization or surgical intervention requires a discharge from the current Treatment Episode.
Encounter – A face to face visit between the patient and the provider for the purpose of assessing and/or improving a functional deficit.
Patient Reported – The patient directly, or through a proxy, provides answers to functional status survey items using standardized, reliable and valid, computerized adaptive testing or paper and pencil survey methods.

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Measure Reporting via Registry:
CPT codes and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All patients aged 18 years and older who receive a treatment episode for a functional deficit related to the neck, cranium, mandible, thoracic spine, ribs or other general orthopedic impairment

Option 1 – Physical Therapy Denominator Criteria (Eligible Cases):
All patients aged ≥ 18 years on date of encounter
AND
Patient encounter during the reporting period identifying evaluation (CPT): 97001
AND
Patient encounter during the reporting period identifying re-evaluation (CPT): 97002
AND
Functional deficit affecting neck, cranium, mandible, thoracic spine, ribs or other general orthopedic impairment

OR

Option 2 – Occupational Therapy Denominator Criteria (Eligible Cases):
All patients aged ≥ 18 years on date of encounter
AND
Patient encounter during the reporting period identifying evaluation (CPT): 97003
AND
Patient encounter during the reporting period identifying re-evaluation (CPT): 97004
AND
Functional deficit affecting neck, cranium, mandible, thoracic spine, ribs or other general orthopedic impairment

NUMERATOR:
Patients presented FOTO's Functional Intake Survey for the Neck, Cranium, Mandible, Thoracic Spine, Ribs, or Other General Orthopedic Impairment at admission and FOTO's Functional Status Survey at discharge for the purpose of calculating the patient's Risk-adjusted Functional Status Change Residual Score

Definitions:
Patient's Functional Status Score – A functional status score is produced when the patient completes the FOTO functional status survey (either by paper and pencil or computerized adaptive testing administration). The functional status score is continuous and linear. Scores range from 0 (low function) to 100 (high function). The survey is standardized, and the scores are validated for the measurement of function for this population.
Patient's Functional Status Change Score – A functional status change score is calculated by subtracting the Patient's Functional Status Score at Admission from the Patient's Functional Status Score at Discharge.
Predicted Functional Status Change Score – Functional Status Change Scores for patients are risk adjusted using multiple linear regression methods that include the following independent variables: Patient's Functional Status Score at Admission, patient age, symptom acuity, surgical history, gender, number of co-

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morbidities, and level of fear-avoidance. The Patient's Functional Status Change Score is the dependent variable. The statistical regression produces a Risk-Adjusted Predicted Functional Status Change Score.
Risk-Adjusted Functional Status Change Residual Score – The difference between the raw non-risk-adjusted Patient's Functional Status Change Score and the Risk-Adjusted Predicted Functional Status Change Score (raw minus predicted) is the Risk-Adjusted Functional Status Change Residual Score, which is in the same units as the Patient's Functional Status Scores, and should be interpreted as the unit of functional status change different than predicted given the risk-adjustment variables of the patient being treated. As such, the Risk-Adjusted Residual Change Score represents Risk-Adjusted Change corrected for the level of severity of the patient. Risk-Adjusted Residual Change Scores of zero (0) or greater (> 0) should be interpreted as functional status change scores that were predicted or better than predicted given the risk-adjustment variables of the patient, and risk-adjusted residual change scores less than zero (< 0) should be interpreted as functional status change scores that were less than predicted given the risk-adjustment variables of the patient. Aggregated Risk-Adjusted Residual Scores allow meaningful comparisons amongst clinicians or clinics.
Not Eligible/Not Appropriate – A patient is not eligible if one or more of the following conditions exist:

- Patient refused to participate
- Patient unable to complete the questionnaire due to blindness, illiteracy, severe mental incapacity or language incompatibility and an adequate proxy is not available
- Prior to conclusion of Plan of Care, intervention was interrupted or discontinued for any reason including by the referring physician, the provider, the payer or the patient, and attempts by the provider to complete a follow-up functional status survey near Discharge were unsuccessful.

Numerator Options:
Risk-Adjusted Functional Status Change Residual Score for the neck, cranium, mandible, thoracic spine, ribs or other general orthopedic impairment successfully calculated and the score was equal to zero (0) or greater than zero (> 0) (G8671)
OR
Risk-Adjusted Functional Status Change Residual Score for the neck, cranium, mandible, thoracic spine, ribs or other general orthopedic impairment successfully calculated and the score was less than zero (< 0) (G8672)

OR

Risk-Adjusted Functional Status Change Residual Scores for the neck, cranium, mandible, thoracic spine, ribs or other general orthopedic impairment not measured because the patient did not complete FOTO's Functional Intake on admission and/or follow up Status Survey near discharge, patient Not Eligible/Not Appropriate (G8673)

OR

Risk-Adjusted Functional Status Change Residual Scores for the neck, cranium, mandible, thoracic spine, ribs or other general orthopedic impairment not measured because the patient did not complete FOTO's Functional Intake on admission and/or follow up Status Survey near discharge, reason not given (G8674)

RATIONALE:
Functional deficits are common in the general population and are costly to the individual, their family and society. Improved functional status has been associated with greater quality of life, self-efficacy, improved financial well-being and lower future medical costs. Improving functional status in people seeking rehabilitation has become a goal of the American Physical Therapy Association. Therefore, measuring change in functional status is important for providers treating patients in rehabilitation and can be used to assess the success of treatment and direct modification of treatment.

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Change in functional status represents the activity domain of the International Classification of Function. If treatment is designed to improve the functional deficit, it is logical to assess functional status at discharge using a standardized score to determine if treatment improved the functional status of the patient over the treatment episode.

The National Quality Measures Clearinghouse has approved the measurement of change in functional status, using this survey. (NQMC-0022)

CLINICAL RECOMMENDATION STATEMENTS:

The American Physical Therapy Association (APTA), in their *Guide to Physical Therapy Practice*, described five recommended elements of patient management: examination, evaluation, diagnosis, prognosis and intervention. The elements were intended to direct therapists in their approach to patient treatment for the purpose of optimizing patient outcomes. The APTA clearly indentifies functional status data as one of the major forms of data to be collected for patients receiving rehabilitation. The functional status measures should be used to assist in the planning, implementation and modification of treatment interventions and should be used as measures of outcomes. The current functional status scores can be used by therapists to fulfill the recommended methods of the APTA in the management of patients in rehabilitation.

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*Measure #224 (NQF 0562): Melanoma: Overutilization of Imaging Studies in Melanoma

2013 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Percentage of patients, regardless of age, with a current diagnosis of stage 0 through IIC melanoma or a history of melanoma of any stage, without signs or symptoms suggesting systemic spread, seen for an office visit during the one-year measurement period, for whom no diagnostic imaging studies were ordered

INSTRUCTIONS:
This measure is to be reported once per reporting period for patients with a current diagnosis of melanoma or a history of melanoma who are seen for an office visit during the reporting period. This measure is intended to reflect the quality of services provided for the primary management of patients with melanoma who have an office visit during the reporting period.

Measure Reporting via Registry
ICD-9-CM diagnosis codes, CPT codes, HCPCS codes, and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All patients, regardless of age, with a current diagnosis of stage 0 through IIC melanoma or a history of melanoma of any stage, without signs or symptoms suggesting systematic spread, seen for an office visit during the one-year measurement period

Definitions:
Signs - For the purposes of this measure, signs include tenderness, jaundice, localized neurologic signs such as weakness, or any other sign.
Symptoms - For the purposes of this measure, symptoms include cough, dyspnea, pain, paresthesia, or any other symptom suggesting the possibility of systemic spread.

Denominator Criteria (Eligible Cases):
Diagnosis for melanoma (ICD-9-CM): 172.0, 172.1, 172.2, 172.3, 172.4, 172.5, 172.6, 172.7, 172.8, 172.9, V10.82
Diagnosis for melanoma (ICD-10-CM) [REFERENCE ONLY/Not Reportable]: C43.0, C43.10, C43.11, C43.12, C43.20, C43.21, C43.22, C43.30, C43.31, C43.39, C43.4, C43.51, C43.52, C43.59, C43.60, C43.61, C43.62, C43.70, C43.71, C43.72, C43.8, C43.9, D03.0, D03.10, D03.11, D03.12, D03.20, D03.21, D03.22, D03.30, D03.39, D03.4, D03.51, D03.52, D03.59, D03.60, D03.61, D03.62, D03.70, D03.71, D03.72, D03.8, D03.9, Z85.820
AND
Patient encounter during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215
AND
AJCC Melanoma Cancer Stage 0 through IIC Melanoma: G8944
AND

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Absence of signs of melanoma (cough, dyspnea, tenderness, localized neurologic signs such as weakness, jaundice, or any other sign suggesting systemic spread) or absence of symptoms of melanoma (pain, paresthesia, or any other symptom suggesting the possibility of systemic spread of melanoma): G8749

NUMERATOR:
Patients for whom no diagnostic imaging studies were ordered

Numerator Instructions: A higher score indicates appropriate treatment of patients with melanoma without additional signs or symptoms.

Definition:
Diagnostic Imaging Studies – CXR, CT, MRI, PET, and nuclear medicine scans. Ordering any of these imaging studies during the one year measurement period is considered a failure of the measure, unless a justified reason is documented through use of a medical or system reason for exception.

Numerator Options:
None of the following diagnostic imaging studies ordered: CXR, CT, Ultrasound, MRI, PET, and nuclear medicine scans (3320F)

OR

Documentation of medical reason(s) for ordering diagnostic imaging studies (e.g., patient has co-morbid condition that warrants imaging, other medical reasons) (3319F *with* 1P)
OR
Documentation of system reason(s) for ordering diagnostic imaging studies (e.g., requirement for clinical trial enrollment, ordered by another provider, other system reasons) (3319F *with* 3P)

OR

One of the following diagnostic imaging studies ordered; chest x-ray, CT, Ultrasound, MRI, PET, or nuclear medicine scans (3319F)

RATIONALE:
There is no valid indication for expensive imaging studies in early stage melanoma in the absence of signs or symptoms. There is a perception that radiologic studies are being administered for melanoma that are clinically unnecessary and create economic burden to the patient and payer. This measure is addressing the over-utilization of diagnostic imaging studies in patients with melanoma.

CLINICAL RECOMMENDATION STATEMENTS:
Routine cross-sectional imaging (CT, PET/CT, MRI) is not recommended for patients with stage I to II melanoma. These tests should only be used to investigate specific signs or symptoms. For patients with stage IIB-IIC, chest x-ray is optional. Routine blood tests are not recommended for stage I and II disease. (NCCN, 2012) Baseline laboratory test and imaging studies are generally not recommended in asymptomatic patients with newly diagnosed primary melanoma of any thickness. (AAD, 2011)

No investigations are necessary for patients with stage I disease. Stage I and IIA melanoma patients should not be staged by imaging, as the true-positive pick-up rate is low and the false-positive rate is high. Patients at intermediate or high risk of recurrent disease (stage IIB and over) should have the following staging investigations: chest x-ray; liver ultrasound or computed tomographic (CT) scan with contrast of the chest, abdomen + pelvis; liver function tests/lactate dehydrogenase; and full blood count. In the absence of effective chemotherapy for melanoma, however, it may be reasonable to omit scanning in individual stage IIB patients. There is no place for a bone scan in staging except where symptoms point to possible bone disease. (NICE, 2006)

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❑ Measure #225 (NQF 0509): Radiology: Reminder System for Mammograms

2013 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of patients aged 40 years and older undergoing a screening mammogram whose information is entered into a reminder system with a target due date for the next mammogram

INSTRUCTIONS:
This measure is to be reported each time a screening mammogram is performed during the reporting period for patients seen during the reporting period. This measure is intended to reflect the quality of services provided for reminding patients when follow-up mammograms are due.

Measure Reporting via Claims:
ICD-9-CM diagnosis codes, CPT or HCPCS codes, and patient demographics are used to identify patients who are included in the measure's denominator. CPT Category II codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the appropriate ICD-9-CM diagnosis codes, CPT or HCPCS codes, and the appropriate CPT Category II code OR the CPT Category II code with the modifier. The modifier allowed for this measure is: 8P- reasons not otherwise specified. There are no allowable performance exclusions for this measure. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT or HCPCS codes, and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data. There are no allowable performance exclusions for this measure.

DENOMINATOR:
All patients aged 40 years and older undergoing a screening mammogram

> Denominator Criteria (Eligible Cases):
> Patients aged ≥ 40 years on date of encounter
> AND
> Diagnosis for mammogram screening (ICD-9-CM): V76.11, V76.12
> Diagnosis for mammogram screening (ICD-10-CM) [REFERENCE ONLY/Not Reportable]: Z12.31
> AND
> Patient encounter during the reporting period (CPT or HCPCS): 77057, G0202

NUMERATOR:
Patients whose information is entered into a reminder system with a target due date for the next mammogram

> Numerator Instructions: The reminder system should be linked to a process for notifying patients when their next mammogram is due and should include the following elements at a minimum: patient identifier,

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patient contact information, dates(s) of prior screening mammogram(s) (if known), and the target due date for the next mammogram.

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Patient Information Entered into a Reminder System with Target Due Date for the Next Mammogram
CPT II 7025F: Patient information entered into a reminder system with a target due date for the next mammogram

OR

Patient Information not Entered into a Reminder System, Reason Not Otherwise Specified
Append a reporting modifier (8P) to CPT Category II code 7025F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.
7025F *with* 8P: Patient Information not entered into a reminder system, reason not otherwise specified

RATIONALE:
Although screening mammograms can reduce breast cancer mortality by 20-35% in women aged 40 years and older, recent evidence has suggested a decreasing trend in screening rates and a need for intervention. (MMWR, 2007) Moreover, many American women do not receive mammograms at recommended intervals, as illustrated by a multiyear study of mammography utilization in a large screening center at Massachusetts General Hospital. The study found that more than half of women who received a mammogram in 1992 had fewer than five mammograms during the subsequent 10 years (the expected number if following a 2-year screening interval), and that only 6 percent received annual mammograms during the entire 10 years. (Blanchard, K., Colbart JA, Puri D, et al., 2004) The use of patient reminders is associated with an increase in screening mammography and is currently recommended based on the results of a systematic review of studies conducted by the Task Force on Community Preventive Services. (Nass S, Ball J, eds., 2005) Encouraging the implementation of a reminder system could therefore help to reverse the trend and lead to an increase in mammography.

CLINICAL RECOMMENDATION STATEMENTS:
The U.S. Preventive Services Task Force (USPSTF) recommends screening mammography, with or without clinical breast examination (CBE), every 1-2 years for women aged 40 and older. (B Recommendation) (USPSTF, 2002)

Asymptomatic women 40 years of age or older should have an annual screening mammogram. (ACR, 2003)

The Task Force [on Community Preventive Services] recommends client reminders to increase breast cancer screening on the basis of strong evidence of effectiveness. (TFCPS, 2005)

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▲Measure #226 (NQF 0028): Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention

2013 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

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

INSTRUCTIONS:
This measure is to be reported once per reporting period for patients seen during the reporting period. This measure is intended to reflect the quality of services provided for preventive screening for tobacco use.

Measure Reporting via Claims:
CPT or HCPCS codes, and patient demographics are used to identify patients who are included in the measure's denominator. CPT Category II codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the appropriate CPT or HCPCS codes, and the appropriate CPT Category II code OR the CPT Category II code with the modifier. The modifiers allowed for this measure are: 1P- medical reasons, 8P- reason not otherwise specified. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
CPT or HCPCS codes and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All patients aged 18 years and older

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Patient encounter during the reporting period (CPT or HCPCS): 90791, 90792, 90832, 90834, 90837, 90839, 90845, 92002, 92004, 92012, 92014, 96150, 96151, 96152, 97003, 97004, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99406, 99407, G0438, G0439

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 use of any type of tobacco.
Cessation Counseling Intervention – Includes brief counseling (3 minutes or less), and/or pharmacotherapy.

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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, other medical reason)

OR

Tobacco Screening OR Tobacco Cessation Intervention not Performed Reason Not Otherwise 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 OR tobacco cessation intervention not performed, reason not otherwise specified

RATIONALE:
There is good evidence that tobacco screening and brief cessation intervention (including counseling and pharmacotherapy) in the primary care setting is successful in helping tobacco users quit. (USPSTF, 2003) Tobacco users who are able to stop smoking lower their risk for heart disease, lung disease, and stroke. (USPSTF, 2003)

CLINICAL RECOMMENDATION STATEMENTS:
The following evidence statements are quoted verbatim from the referenced clinical guidelines:

The USPSTF strongly recommends that clinicians screen all adults for tobacco use and provide tobacco cessation interventions for those who use tobacco products. (A Recommendation) (USPSTF, 2003)

During new patient encounters and at least annually, patients in general and mental healthcare settings should be screened for at-risk drinking, alcohol use problems and illnesses, and any tobacco use. (NQF, 2007)

All patients should be asked if they use tobacco and should have their tobacco-use status documented on a regular basis. Evidence has shown that clinic screening systems, such as expanding the vital signs to include tobacco status or the use of other reminder systems such as chart stickers or computer prompts, significantly increase rates of clinician intervention. (Strength of Evidence = A) (U.S. Department of Health & Human Services-Public Health Service, 2008)

All *physicians* should strongly advise every patient who smokes to quit because evidence shows that physician advice to quit smoking increases abstinence rates. (Strength of Evidence = A) (U.S. Department of Health & Human Services-Public Health Service, 2008)

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Minimal interventions lasting less than 3 minutes increase overall tobacco abstinence rates. Every tobacco user should be offered at least a minimal intervention whether or not he or she is referred to an intensive intervention. (Strength of Evidence = A) (U.S. Department of Health & Human Services-Public Health Service, 2008)

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♠ Measure #228: Heart Failure (HF): Left Ventricular Function (LVF) Testing

2013 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Percentage of patients 18 years and older with Left Ventricular Function (LVF) testing performed within the previous 12 months for patients who are hospitalized with a principal diagnosis of Heart Failure (HF) during the reporting period

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for patients hospitalized with a principal diagnosis of HF during the reporting period. This measure is intended to reflect the quality of services provided for patients hospitalized with a principal diagnosis of HF during hospitalization or within the previous 12 months. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All patients aged 18 years and older hospitalized with a principal diagnosis of HF during the reporting period

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Principal diagnosis for HF (ICD-9-CM): 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
Principal diagnosis for HF (ICD-10-CM) [REFERENCE ONLY/Not Reportable]: I11.0, I13.0, I13.2, I50.1, I50.20, I50.21, I50.22, I50.23, I50.30, I50.31, I50.32, I50.33, I50.40, I50.41, I50.42, I50.43, I50.9
AND
Patient encounter during reporting period (CPT): 99221, 99222, 99223, 99231, 99232, 99233, 99238, 99239, 99291

NUMERATOR:
Patients with LVF testing performed during the measurement period

Definitions:
Left ventricular function (LVF) testing - Assessment of the hearts function to determine the stroke volume (SV), the end-diastolic volume (EDV), and the ejection fraction (EF).
Stroke volume (SV) - The amount of blood in the heart that exits the ventricles with each beat.
End-diastolic volume (EDV) - The total amount of blood in the ventricles at the end of diastole.

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Ejection fraction (EF) - The proportion of the volume of blood in the ventricles at the end of diastole that is ejected during systole. EF is expressed as a percentage and is calculated by dividing the (SV) by the (EDV).
Not Eligible - A patient is not eligible if one or more of the following reasons exist:

- Patient refuses LVF testing
- Other reason documented by the eligible professional the patient is not eligible for LVF testing

Numerator Options:
LVF testing performed during the measurement period (G8682)

OR

LVF testing not performed for a documented reason (G8683)

OR

LVF testing is not performed, reason not given (G8685)

RATIONALE:
Evaluation of LVF in HF patients provides important information required to direct appropriate treatment. (Bonow et al. 2012) National guidelines advocate the evaluation of left ventricular systolic function as the single most important diagnostic test in the management of all patients with HF. (Jessup et al., 2009)

CLINICAL RECOMMENDATION STATEMENTS:
Two-dimensional echocardiography with Doppler should be performed during initial evaluation of patients presenting with HF to assess LVF, left ventricular size, wall thickness, and valve function. Radionuclide ventriculography can be performed to assess LVF and volumes. (Jessup et al. 2009; Lindenfeld et al. 2010) (Class I Recommendation, Level of Evidence: C) (ACC/AHA/HFSA)

Repeat measurement of EF and the severity of structural remodeling can be useful to provide information in patients with HF who have had a change in clinical status or who have experienced or recovered from a clinical event or received treatment that might have had a significant effect on cardiac function. (Jessup et al. 2009; Lindenfeld et al. 2010) (Class IIa Recommendation, Level of Evidence: C) (ACC/AHA/HFSA)

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❑ Measure #231: Asthma: Tobacco Use: Screening - Ambulatory Care Setting

2013 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

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

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for patients with asthma seen during the measurement period. This measure is intended to reflect the quality of services provided for the primary management of patients with asthma.

Measure Reporting via Claims:
ICD-9-CM diagnosis codes, CPT codes and patient demographics are used to identify patients who are included in the measure's denominator. CPT Category II codes are used to report the numerator of the measures.

When reporting the measure via claims, submit the listed ICD-9-CM diagnosis codes, CPT codes, and the appropriate CPT Category II code OR the CPT Category II code with the modifier. The reporting modifier allowed for this measure is: 8P- reason not otherwise specified. There are no allowable performance exclusions for this measure. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT codes and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data. There are no allowable performance exclusions for this measure.

DENOMINATOR:
All patients aged 5 through 50 years with a diagnosis of asthma during the one-year measurement period

> Denominator Criteria (Eligible Cases):
> Patients aged 5 through 50 years of age on date of encounter
> AND
> Diagnosis for asthma (ICD-9-CM): 493.00, 493.01, 493.02, 493.10, 493.11, 493.12, 493.20, 493.21, 493.22, 493.81, 493.82, 493.90, 493.91, 493.92
> Diagnosis for asthma (ICD-10-CM) [REFERENCE ONLY/Not Reportable]: J45.20, J45.21, J45.22, J45.30, J45.31, J45.32, J45.40, J45.41, J45.42, J45.50, J45.51, J45.52, J45.901, J45.902, J45.909, J45.990, J45.991, J45.998
> AND
> Patient encounter during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99217, 99218, 99219, 99220, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350

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NUMERATOR:
Patients (or their primary caregiver) who were queried about tobacco use and exposure to second hand smoke within 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 Second hand Smoke
CPT II 1031F: Smoking status and exposure to second hand smoke in the home assessed

OR

Tobacco Use, Including Exposure to Second hand Smoke not Assessed, Reason Not Otherwise 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 second hand smoke in the home not assessed, reason not otherwise specified

RATIONALE:
Patients with asthma who smoke or are exposed to second hand smoke are at greater risk for experiencing increased frequency in asthma symptoms, a decrease in lung function, and an increased use of health services. (Sippel JM 1999; Eisner MD 2007) By identifying patients who are tobacco users or who are exposed to second hand smoke, intervention can be offered, resulting in the possibility of decreasing the adverse effects.

CLINICAL RECOMMENDATION STATEMENTS:
The following evidence statements are quoted verbatim from the referenced clinical guidelines.

The Expert Panel recommends that clinicians advise persons who have asthma not to smoke or be exposed to environmental tobacco smoke (ETS). (Evidence C) (NHLBI August 2007)

Query patients about their smoking status and specifically consider referring to smoking cessation programs adults who smoke and have young children who have asthma in the household. (Evidence B) (NHLBI August 2007)

All patients should be asked if they use tobacco and should have their tobacco-use status documented on a regular basis. Evidence has shown that clinic screening systems, such as expanding the vital signs to include tobacco status or the use of other reminder systems such as chart stickers or computer prompts, significantly increase rates of clinician intervention. (Strength of Evidence = A) (Fiore, Jaen et al. 2008)

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❑ Measure #232: Asthma: Tobacco Use Intervention - Ambulatory Care Setting

2013 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

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

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for patients with asthma seen during the reporting period. This measure is intended to reflect the quality of services provided for the primary management of patients with asthma.

Measure Reporting via Claims:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. CPT Category II and/or G-codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed ICD-9-CM diagnosis codes, CPT codes, and the appropriate G-code OR CPT Category II code OR the CPT Category II code with the modifier. The reporting modifier allowed for this measure is: 8P- reason not otherwise specified. There are no allowable performance exclusions for this measure. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All patients aged 5 through 50 years with a diagnosis of asthma identified as tobacco users during the measurement period

Definition:
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.

Denominator Criteria (Eligible Cases):
Patients aged 5 through 50 years on date of encounter
AND
Diagnosis for asthma (ICD-9-CM): 493.00, 493.01, 493.02, 493.10, 493.11, 493.12, 493.20, 493.21, 493.22, 493.81, 493.82, 493.90, 493.91, 493.92
Diagnosis for asthma (ICD-10-CM) [REFERENCE ONLY/Not Reportable]: J45.20, J45.21, J45.22, J45.30, J45.31, J45.32, J45.40, J45.41, J45.42, J45.50, J45.51, J45.52, J45.901, J45.902, J45.909, J45.990, J45.991, J45.998

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AND
Patient encounter during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99217, 99218, 99219, 99220, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350

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 Second Hand Smoke
CPT II 1032F: Current tobacco smoker OR currently exposed to second hand smoke
OR
If patient is not eligible for this measure because patient is a non-tobacco user AND has no exposure to second hand 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 second hand smoke
OR
Tobacco Use, not Assessed, Reason Not Given
(One G-code [G8751] is required on the claim form to submit this numerator option)
G8751: Smoking status and exposure to second hand smoke in the home not assessed, reason not given

OR

Tobacco Use Cessation Intervention not Performed, Reason Not Otherwise Specified
Append a reporting modifier (8P) to CPT Category II code 4000F OR 4001F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.
(Two CPT II codes [400xF-8P & 1032F] are required on the claim form to submit this numerator option)
4000F *with* 8P: Tobacco use cessation intervention, counseling, not performed, reason not otherwise specified
OR

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4001F *with* 8P: Tobacco use cessation intervention, pharmacologic therapy, not performed, reason not otherwise specified

AND
Current Tobacco Smoker OR Currently Exposed to Second Hand Smoke
CPT II 1032F: Current tobacco smoker OR currently exposed to second hand smoke

RATIONALE:
There is good evidence that tobacco screening and brief cessation intervention (including counseling and pharmacotherapy) in both the primary care setting and hospital settings is successful in helping tobacco users quit. (Fiore MC May 2008) Patients who are able to stop smoking or their exposure to second hand smoke may experience an increase in quality of life, a decrease in asthma symptoms, and may not use health resources as often. (NHLBI August 2007)

CLINICAL RECOMMENDATION STATEMENTS:
The following evidence statements are quoted verbatim from the referenced clinical guidelines.

The Expert Panel recommends that clinicians advise persons who have asthma not to smoke or be exposed to environmental tobacco smoke (ETS). (Evidence C) (NHLBI August 2007)

Query patients about their smoking status and specifically consider referring to smoking cessation programs adults who smoke and have young children who have asthma in the household. (Evidence B) (NHLBI August 2007)

All *physicians* should strongly advise every patient who smokes to quit because evidence shows that physician advice to quit smoking increases abstinence rates. (Strength of Evidence = A) (Fiore, Jaen et al. 2008).

Minimal interventions lasting less than 3 minutes increase overall tobacco abstinence rates. Every tobacco user should be offered at least a minimal intervention whether or not he or she is referred to an intensive intervention. (Strength of Evidence = A) (Fiore MC 2008)

The interventions found to be effective in this Guideline have been shown to be effective in a variety of populations. In addition, many of the studies supporting these interventions comprised diverse samples of tobacco users. Therefore, interventions identified as effective in this Guideline are recommended for all individuals who use tobacco, except when the medication use is contraindicated or with specific populations in which medication has not been shown to be effective (pregnant women, smokeless tobacco users, light smokers, and adolescents). (Strength of Evidence = B) (Fiore MC 2008)

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Ω Measure #233 (NQF 0457): Thoracic Surgery: Recording of Performance Status Prior to Lung or Esophageal Cancer Resection

2013 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Percentage of patients aged 18 years and older undergoing resection for lung or esophageal cancer who had performance status documented and reviewed within 2 weeks prior to surgery

INSTRUCTIONS:
This measure is to be reported each time a major cancer resection of the lung or esophagus is performed. This measure is intended to reflect the quality of services provided for patients undergoing resection for lung or esophageal cancer. The performance status of lung and esophageal cancer patients guides the decision-making process when choosing optimal treatment modality which may or may not include surgery. It is anticipated that clinicians who perform the listed surgical procedures with a diagnosis of lung or esophageal cancer will submit this measure.

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data. There are no allowable performance exclusions for this measure.

DENOMINATOR:
All patients aged 18 years and older undergoing resection for lung or esophageal cancer

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Diagnosis for lung or esophageal cancer (ICD-9-CM): 150.3, 150.4, 150.5, 150.8, 151.0, 162.2, 162.3, 162.4, 162.5, 162.9
Diagnosis for lung or esophageal cancer (ICD-10-CM) [REFERENCE ONLY/Not Reportable]: C15.3, C15.4, C15.5, C15.8, C16.0, C34.00, C34.01, C34.02, C34.10, C34.11, C34.12, C34.2, C34.30, C34.31, C34.32, C34.80, C34.81, C34.82, C34.90, C34.91, C34.92
AND
Patient encounter during the reporting period (CPT): 32440, 32442, 32445, 32480, 32482, 32484, 32486, 32488, 32503, 32504, 32505, 32506, 32507, 32663, 32666, 32667, 32668, 32669, 32670, 32671, 43107, 43108, 43112, 43113, 43116, 43117, 43118, 43121, 43122, 43123, 43124

NUMERATOR:
Patients undergoing resection for lung and esophageal cancer who had performance status documented and reviewed within 2 weeks prior to surgery

Numerator Options:
Performance status documented and reviewed within 2 weeks prior to surgery (3328F)

OR

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Performance status not documented and reviewed within 2 weeks prior to surgery, reason not otherwise specified (3328F *with* 8P)

RATIONALE:
There is wide consensus, supported by the source documentation, that preoperative assessment (within two weeks of surgery) of performance status in lung and esophageal cancer resection is a necessary step in evaluating and appropriately selecting patients for surgical therapy. For lung and esophageal cancer, the patient's functional status or performance status (PS) is a key determinant of not only the patient's ability to undergo therapy, but also the patient's prognosis. PS is a general measure of a patient's physiologic status, taking into account the cancer and its associated effects along with other concurrent medical problems, such as cardiac or pulmonary disease. Preoperative assessment of PS provides a standardized measure to compare patient and treatment outcomes in order to provide continuing quality improvement.

Review of the current STS General Thoracic Database identified a 10% gap in recording for PS in patients undergoing major pulmonary resection for cancer. Remediation of this gap should decrease the morbidity and mortality rates for these procedures by reducing the number of high-risk patients inappropriately selected to undergo surgery.

CLINICAL RECOMMENDATION STATEMENTS:
We identified 3 preoperative factors that were associated with an increased risk of pulmonary complications: age, spirometric values, and PS. Others have demonstrated that advanced age and preoperative respiratory dysfunction are associated with postoperative pulmonary complications. It may be intuitively apparent that the factors we identified are predictive of the relative risk of development of pulmonary complications. The benefit of this analysis does not lie in the uniqueness of our observations. Instead, it directs the clinician to focus on a few specific factors and provides the ability to quantitate the relative effect of these factors before making treatment recommendations. (Annuals of Thoracic Surgery, 2000) & (Journal Thoracic Cardiovascular Surgery, 2002)

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Ω Measure #234 (NQF 0458): Thoracic Surgery: Pulmonary Function Tests Before Major Anatomic Lung Resection (Pneumonectomy, Lobectomy, or Formal Segmentectomy)

2013 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Percentage of thoracic surgical patients aged 18 years and older undergoing at least one pulmonary function test within 12 months prior to a major lung resection (pneumonectomy, lobectomy, or formal segmentectomy)

INSTRUCTIONS:
This measure is to be reported each time a major resection of the lung is performed. This measure is intended to reflect the quality of services provided for patients undergoing lung resection. There is wide consensus that preoperative pulmonary function testing is a necessary step in evaluating and appropriately selecting patients with lung cancer for major anatomic resection. Preoperative pulmonary function testing also provides a standardized measure to compare patient and treatment outcomes in order to provide continuing quality improvement.

Measure Reporting via Registry:
CPT codes and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All patients undergoing major anatomic lung resection

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Patient encounter during the reporting period (CPT): 32440, 32442, 32445, 32480, 32482, 32484, 32486, 32488, 32503, 32504, 32663, 32669, 32670, 32671
AND
Operation status is elective

NUMERATOR:
Patients who had a pulmonary function test performed within 12 months prior to a major anatomic lung resection

Numerator Options:
Pulmonary function test performed within 12 months prior to surgery (3038F)

OR

Documentation of medical reason(s) for pulmonary function test not being performed within 12 months prior to surgery. Acceptable medical reasons include: Patients who are unable to perform pulmonary function testing (tracheostomy, patient inability to cooperate with pulmonary function test) or those with urgent/emergent need of lung resection (lung abscess, massive hemoptysis, bronchopleural fistula, etc.) (3038F *with* 1P)

OR

Pulmonary function test not performed within 12 months prior to surgery, reason not otherwise specified (3038F *with* 8P)

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RATIONALE:
Evaluation of lung function for patients having thoracic surgery, for patients having thoracotomies, for patients having surgery in which the chest is opened and in patients with respiratory disease, eg esophagectomy, lung excision or resection is vital to determine what treatment is needed, safe and effective. Evaluation of lung function for patients being considered for lung cancer resection is critical to assessing suitability for resection and prediction of post-operative lung function.

Review of the 6,723 eligible patients in the STS General Thoracic Database identified a significant gap with respect to preoperative pulmonary function testing.

PFT testing was done in 89% of eligible patients, and hospital-specific estimates ranged from 28.2% to 99.0%. Remediation of this process gap should improve quality by reducing inappropriate selection of high-risk patients for surgery.

CLINICAL RECOMMENDATION STATEMENTS:
"Lung function tests were considered to be appropriate for patients undergoing spinal surgery, for ASA grade 3 patients having thoracic surgery, for patients having thoracotomies and for surgery in which the chest is opened in patients with respiratory disease, e.g. esophagectomy, lung excision or resection. (Chest, 2003)
ASA grade 3 - A patient with severe systemic disease
ASA grade 4 - A patient with severe systemic disease that is a constant threat to life
Preoperative tests: The use of routine preoperative tests for elective surgery

In patients being considered for lung cancer resection, spirometry should be performed. If the forced expiratory volume in 1 second (FEV1) is > 80% predicted normal or > 2 L, the patient is suitable for resection including pneumonectomy without further evaluation. If the FEV1 is > 1.5 L, the patient is suitable for a lobectomy without further evaluation. Level of evidence, fair; benefit, substantial; grade of recommendation, B. (National Institute for Clinical Excellence, 2003)

In patients being considered for lung cancer resection, if either the FEV1 or DLCO are < 80% predicted, postoperative lung function should be predicted through additional testing. Level of evidence, fair; benefit, substantial; grade of recommendation, B. (National Institute for Clinical Excellence, 2003)

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♦Measure #236 (NQF 0018): Hypertension (HTN): Controlling High Blood Pressure

2013 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

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)

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for patients with hypertension seen during the reporting period. The performance period for this measure is 12 months. The most recent quality code submitted will be used for performance calculation. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

Measure Reporting via Claims:
ICD-9-CM diagnosis codes, CPT or HCPCS code and patient demographics are used to identify patients who are included in the measure's denominator. G-codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed ICD-9-CM diagnosis codes, CPT or HCPCS codes and the appropriate G-code. The reporting modifier allowed for this measure is: 8P- reason not otherwise specified. There are no allowable performance exclusions for this measure. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT or HCPCS codes and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data. There are no allowable performance exclusions for this measure.

DENOMINATOR:
Patients aged 18 through 85 years with the diagnosis of hypertension

> Denominator Criteria (Eligible Cases):
> Patients aged 18 through 85 years on date of encounter
> AND
> Diagnosis for hypertension (ICD-9-CM): 401.0, 401.1, 401.9
> Diagnosis for hypertension (ICD-10-CM) [REFERENCE ONLY/Not Reportable]: I10
> AND
> Patient encounter during reporting period (CPT or HCPCS): 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, G0402

NUMERATOR:
Patients whose most recent blood pressure < 140/90 mmHg

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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 Given
G8756: No documentation of blood pressure measurement, reason not given

RATIONALE:
Hypertension is a very significant health issue in the United States especially for individuals 40 to 89 years of age who may be at higher risk. NHANES data suggest that over fifty million Americans have high blood pressure that warrant treatment (JNC-7, 2003). The most frequent and serious complications of uncontrolled hypertension include coronary heart disease, congestive heart failure, stroke, ruptured aortic aneurysm, renal disease, and retinopathy. Moreover, a majority of the people have hypertension prior to developing heart failure. (JNC-7, 2003)

According to the Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure, treating systolic blood pressure and diastolic blood pressure to targets that are < 140/90 mmHg is associated with a decrease in cardiovascular disease complications. (JNC-7, 2003) The outcomes that are principally affected by controlling blood pressure are morbidity and mortality related to cerebrovascular and cardiovascular events (e.g., stroke, heart failure and myocardial infarction). (JNC-7, 2003) For every 20 mmHg systolic or 10 mmHg diastolic increase in BP, there is a doubling of mortality from both IHD and stroke. (JNC-7, 2003) The percentage of individuals receiving treatment for their hypertension has increased from 31% (1976-1980) to 59% in 1999-2000. Thirty-four percent of persons with hypertension from 1999-2000 have their blood pressure controlled below 140/90 mmHg compared to only 10% from 1976-1980. Although the prevalence and hospitalization rates of heart failure have continued to increase, better control of BP has been shown to significantly reduce the probability of undesirable and costly outcomes. (JNC-7, 2003)

CLINICAL RECOMMENDATION STATEMENTS:
JNC 7 suggests that all people with hypertension (stages 1 and 2) be treated where stage 1 is defined as: 140-159 mmHg systolic/90-99 mmHg diastolic and stage 2 is defined as: greater than or equal to 160 mmHg systolic/greater than or equal to 100 mmHg diastolic. The treatment goal for individuals with hypertension and no other compelling conditions is < 140/90 mmHg.

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♦Measure #241 (NQF 0075): Ischemic Vascular Disease (IVD): Complete Lipid Panel and Low Density Lipoprotein (LDL-C) Control

2013 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

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)

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for patients with IVD seen during the reporting period. *The performance period for this measure is 12 months from the date of service.* This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

Measure Reporting via Claims:
ICD-9-CM diagnosis codes, CPT or HCPCS codes, and patient demographics are used to identify patients who are included in the measure's denominator. G-codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed ICD-9-CM diagnosis codes, CPT or HCPCS codes, and the appropriate G-code(s). There are no allowable performance exclusions for this measure. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT or HCPCS codes, and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions however these codes may be submitted for those registries that utilize claims data. There are no allowable performance exclusions for this measure.

DENOMINATOR:
Patients aged 18 years and older with the diagnosis of ischemic vascular disease, or who were discharged alive for acute myocardial infarction (AMI), coronary artery bypass graft (CABG) or percutaneous transluminal coronary angioplasty (PTCA)

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Diagnosis for ischemic vascular disease (ICD-9-CM): 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, 444.01, 444.09, 444.1, 444.21, 444.22, 444.81, 444.89, 444.9, 445.01, 445.02, 445.81, 445.89
Diagnosis for ischemic vascular disease (ICD-10-CM) [REFERENCE ONLY/Not Reportable]: I20.0, I20.1, I20.8, I20.9, I21.01, I21.02, I21.09, I21.11, I21.19, I21.21, I21.29, I21.3, I21.4, I24.0, I24.1, I24.8,

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I24.9, I25.10, I25.110, I25.111, I25.118, I25.119, I25.5, I25.6, I25.700, I25.701, I25.708, I25.709, I25.710, I25.711, I25.718, I25.719, I25.720, I25.721, I25.728, I25.729, I25.730, I25.731, I25.738, I25.739, I25.750, I25.751, I25.758, I25.759, I25.760, I25.761, I25.768, I25.769, I25.790, I25.791, I25.798, I25.799, I25.810, I25.811, I25.812, I25.82, I25.89, I25.9, I63.00, I63.011, I63.012, I63.019, I63.02, I63.031, I63.032, I63.039, I63.09, I63.10, I63.111, I63.112, I63.119, I63.12, I63.131, I63.132, I63.139, I63.19, I63.20, I63.211, I63.212, I63.219, I63.22, I63.231, I63.232, I63.239, I63.29, I63.30, I63.311, I63.312, I63.319, I63.321, I63.322, I63.329, I63.331, I63.332, I63.339, I63.341, I63.342, I63.349, I63.39, I63.40, I63.411, I63.412, I63.419, I63.421, I63.422, I63.429, I63.431, I63.432, I63.439, I63.441, I63.442, I63.449, I63.49, I63.50, I63.511, I63.512, I63.519, I63.521, I63.522, I63.529, I63.531, I63.532, I63.539, I63.541, I63.542, I63.549, I63.59, I63.6, I63.8, I63.9, I65.01, I65.02, I65.03, I65.09, I65.1, I65.21, I65.22, I65.23, I65.29, I65.8, I65.9, I66.01, I66.02, I66.03, I66.09, I66.11, I66.12, I66.13, I66.19, I66.21, I66.22, I66.23, I66.29, I66.3, I66.8, I66.9, I70.1, I70.201, I70.202, I70.203, I70.208, I70.209, I70.211, I70.212, I70.213, I70.218, I70.219, I70.221, I70.222, I70.223, I70.228, I70.229, I70.231, I70.232, I70.233, I70.234, I70.235, I70.238, I70.239, I70.241, I70.242, I70.243, I70.244, I70.245, I70.248, I70.249, I70.25, I70.261, I70.262, I70.263, I70.268, I70.269, I70.291, I70.292, I70.293, I70.298, I70.299, I70.92, I74.01, I74.09, I74.10, I74.11, I74.19, I74.2, I74.3, I74.4, I74.5, I74.8, I74.9, I75.011, I75.012, I75.013, I75.019, I75.021, I75.022, I75.023, I75.029, I75.81, I75.89

AND

Patient encounter during reporting period (CPT or HCPCS): 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, G0402

OR

Patient encounter during the reporting period (CPT) - Procedure: 33140, 33510, 33511, 33512, 33513, 33514, 33516, 33517, 33518, 33519, 33521, 33522, 33523, 33533, 33534, 33535, 33536, 92920, 92924, 92928, 92933, 92937, 92941, 92943

NUMERATOR:

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

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

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

*(Two G-codes [*G8593 & G8595*] are required on the claim form to submit this numerator option)*

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 Given

*(One G-code [*G8594*] is required on the claim form to submit this numerator option)*

G8594: Lipid profile not performed, reason not given

OR

Most Recent LDL-C **≥ 100 mg/dL**

*(Two G-codes [*G8593 & G8597*] are required on the claim form to submit this numerator option)*

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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

RATIONALE:
There is general agreement in the literature that individuals with existing coronary artery disease can reduce their risk of subsequent morbidity and premature mortality by management of cholesterol levels. Total cholesterol in general and LDL level specifically, is the leading indicator for management of these patients. Treatments include limits on dietary fat and cholesterol, or in certain cases, cholesterol lowering medications.
A 10% decrease in total cholesterol levels (population wide) may result in an estimated 30% reduction in the incidence of CHD (CDC, 2000). Based on data from the Third Report of the Expert Panel on Detection, Evaluation, and Treatment of High Blood Cholesterol in Adults:

- Less than half of persons who qualify for any kind of lipid-modifying treatment for CHD risk reduction are receiving it.
- Less than half of even the highest-risk persons, those who have symptomatic CHD, are receiving lipid-lowering treatment.
- Only about a third of treated patients are achieving their LDL goal; less than 20% of CHD patients are at their LDL goal. (2002)

Several studies have shown that reducing high lipid levels will reduce cardiovascular morbidity and mortality. These studies include the Coronary Primary Prevention Trial, the Framingham Heart Study, the Oslo Study Diet and Anti-smoking Trial, the Helsinki Heart Study, the Coronary Drug Project, the Stockholm Ischemic Heart Study, the Scandinavian Simvastatin Survival Study, the West of Scotland Coronary Prevention Study, the Program on the Surgical Control of the Hyperlipidemias, and Cholesterol and Recurrent Events trial.

CLINICAL RECOMMENDATION STATEMENTS:
Third report of the National Cholesterol Education Program (NCEP) Expert Panel on Detection, Evaluation, and Treatment of High Blood Cholesterol in Adults (Adult Treatment Panel III). (2001) AND Implications of recent clinical trials for the National Cholesterol Education Program Adult Treatment Panel III guidelines (2004)
In high-risk persons, the recommended LDL-C goal is < 100 mg/dL.

- An LDL-C goal of < 70 mg/dL is a therapeutic option on the basis of available clinical trial evidence, especially for patients at very high risk.
- If LDL-C is >100 mg/dL, an LDL-lowering drug is indicated simultaneously with lifestyle changes.
- If baseline LDL-C is < 100 mg/dL, institution of an LDL-lowering drug to achieve an LDL-C level < 70 mg/dL is a therapeutic option on the basis of available clinical trial evidence.
- If a high-risk person has high triglycerides or low HDL-C, consideration can be given to combining a fibrate or nicotinic acid with an LDL-lowering drug. When triglycerides are > 200 mg/dL, non-HDL-C is a secondary target of therapy, with a goal 30 mg/dL higher than the identified LDL-C goal.

The U.S. Preventive Services Task Force (USPSTF) strongly recommends screening men aged 35 and older for lipid disorders and recommends screening men aged 20 to 35 for lipid disorders if they are at increased risk for coronary heart disease. The USPSTF also strongly recommends screening women aged 45 and older for lipid disorders if they are at increased risk for coronary heart disease and recommends screening women aged 20 to 45 for lipid disorders if they are at increased risk for coronary heart disease.

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Measure #242: Coronary Artery Disease (CAD): Symptom Management

2013 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Percentage of patients aged 18 years and older with a diagnosis of coronary artery disease seen within a 12 month period with an evaluation of level of activity and an assessment of whether anginal symptoms are present or absent with appropriate management of anginal symptoms within a 12 month period

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for patients with a diagnosis of coronary artery disease seen during the reporting period. This measure may be reported by clinicians who perform the quality actions described in the measure for the primary management of patients with CAD based on the services provided and the measure-specific denominator coding.

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All patients aged 18 years and older with a diagnosis of coronary artery disease seen within a 12 month period with an evaluation of level of activity and an assessment of whether anginal symptoms are present or absent

Denominator Instructions:
Evaluation of level of activity and evaluation of presence or absence of angina symptoms should include:

- Documentation 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
Class 4: Angina at any level of physical exertion

Denominator Criteria (Eligible Cases):
Patient aged ≥ 18 years on date of encounter
AND

Diagnosis for Coronary Artery Disease (ICD-9-CM): 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,

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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

Diagnosis for Coronary Artery Disease (ICD-10-CM) [REFERENCE ONLY/Not Reportable]: I20.0, I20.1, I20.8, I20.9, I21.01, I21.02, I21.09, I21.11, I21.19, I21.21, I21.29, I21.3, I21.4, I22.0, I22.1, I22.2, I22.8, I22.9, I24.0, I24.1, I24.8, I24.9, I25.10, I25.110, I25.111, I25.118, I25.119, I25.2, I25.5, I25.6, I25.700, I25.701, I25.708, I25.709, I25.710, I25.711, I25.718, I25.719, I25.720, I25.721, I25.728, I25.729, I25.730, I25.731, I25.738, I25.739, I25.750, I25.751, I25.758, I25.759, I25.760, I25.761, I25.768, I25.769, I25.790, I25.791, I25.798, I25.799, I25.82, I25.83, I25.89, I25.9, Z95.1, Z95.5, Z98.61

AND

Patient encounter during the reporting period (CPT): 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

AND

Severity of angina assessed by level of activity: 1010F

NUMERATOR:

Patients with appropriate management of anginal symptoms within a 12 month period

Definition:

Appropriate Management of Anginal Symptoms Includes the Following:

1. Absence of anginal symptoms as determined by evaluation of level of activity

OR

2. Presence of anginal symptoms as determined by evaluation of level of activity and a plan of care is documented to achieve control of anginal symptoms

   Documented plan of care may include:

   - 2 or more anti-anginal medications prescribed**, OR
   - Referral for consideration for coronary revascularization, OR
   - Referral for additional evaluation or treatment of anginal symptoms

   ** Prescribed may include prescription given to the patient for anti-anginal medication at one or more visits in the measurement period OR patient already taking 2 or more anti-anginal medications as documented in current medication list.

Numerator Options:

Angina present (1011F)

AND

Plan of care to manage anginal symptoms documented (0557F)

OR

Angina absent (1012F)

OR

Angina present (1011F)

AND

Documentation of medical reason(s) for not providing any specified element of plan of care to achieve control of anginal symptoms (eg, allergy, intolerance, other medical reasons) (0557F *with* 1P)

OR

Angina present (1011F)

AND

Plan of care to achieve control of angina symptoms was not performed, reason not otherwise specified (0557F *with* 8P)

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RATIONALE:
In order to effectively manage the symptoms of a patient with chronic stable coronary artery disease, an assessment of those symptoms needs to be performed. This assessment is the basis of any treatment modification that needs to be made. Effective management of the symptoms associated with chronic stable coronary artery disease (eg, chest pain, shortness of breath) through medication management or referral for consideration of revascularization or other additional treatment. This may lead to improved patient quality of life, an important patient-centered outcome.

CLINICAL RECOMMENDATION STATEMENTS:
The following evidence statements are quoted verbatim from the referenced clinical guidelines:

Beta-blockers as initial therapy in the absence of contraindications in patients with prior MI or without prior MI. (Class I Recommendation; Level of Evidence A [with prior MI]) (Class I Recommendation; Level of Evidence B [without prior MI] (ACC/AHA, 2002)

Sublingual nitroglycerin or nitroglycerin spray for the immediate relief of angina. (Class I Recommendation; Level of Evidence B) (ACC/AHA, 2002)

Calcium antagonists* or long-acting nitrates as initial therapy for reduction of symptoms when beta-blockers are contraindicated. (Class I Recommendation; Lev el of Evidence B) (ACC/AHA, 2002)

Calcium antagonists* or long-acting nitrates in combination with beta-blockers when initial treatment with beta-blockers is not successful. (Class I Recommendation; Level of Evidence B) (ACC/AHA, 2002)

Calcium antagonists* and long-acting nitrates as a substitute for beta-blockers if initial treatment with beta-blockers leads to unacceptable side effects. (Class I Recommendation; Level of Evidence C) (ACC/AHA, 2002)

*Short-acting, dihydropyridine calcium antagonists should be avoided.

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Measure #243 (NQF 0643): Cardiac Rehabilitation Patient Referral from an Outpatient Setting

2013 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Percentage of patients evaluated in an outpatient setting who within the previous 12 months have experienced an acute myocardial infarction (MI), coronary artery bypass graft (CABG) surgery, a percutaneous coronary intervention (PCI), cardiac valve surgery, or cardiac transplantation, or who have chronic stable angina (CSA) and have not already participated in an early outpatient cardiac rehabilitation/secondary prevention (CR) program for the qualifying event/diagnosis who were referred to a CR program

Definition:
Referral - A referral is defined as an official communication between the health care provider and the patient to recommend and carry out a referral order to an outpatient CR program. This includes the provision of all necessary information to the patient that will allow the patient to enroll in an outpatient CR program. This also includes a written or electronic communication between the healthcare provider or healthcare system and the cardiac rehabilitation program that includes the patient's enrollment information for the program. A hospital discharge summary or office note may potentially be formatted to include the necessary patient information to communicate to the CR program (the patient's cardiovascular history, testing, and treatments, for instance). According to standards of practice for cardiac rehabilitation programs, care coordination communications are sent to the referring provider, including any issues regarding treatment changes, adverse treatment responses, or new non-emergency condition (new symptoms, patient care questions, etc.) that need attention by the referring provider. These communications also include a progress report once the patient has completed the program. All communications must maintain an appropriate level of confidentiality as outlined by the 1996 Health Insurance Portability and Accountability Act (HIPAA).

Note: A patient with a qualifying diagnosis should have a referral to CR within the subsequent 12 months. In the event that the patient has a second (recurrent) qualifying event before the original 12 month "referral" period has ended, a new 12 month "referral" period for CR referral starts at the time of the second qualifying event, since the patient again becomes eligible for CR at that time.

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for all patients seen during the reporting period who had a qualifying diagnosis within the previous 12 months and who have not already participated in an outpatient CR program. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT or HCPCS codes, and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

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DENOMINATOR:
All patients age ≥ 18 years evaluated in the outpatient setting during the reporting period who have a qualifying event/diagnosis [chronic stable angina (CSA), or who within the previous 12 months have had an acute myocardial infarction (AMI) or have undergone coronary artery bypass graft (CABG) surgery, a percutaneous coronary intervention (PCI), cardiac valve surgery, or cardiac transplantation] who do not meet any of the exclusion criteria (patient factors, medical factors, health care system factors) and who have not already participated in an early outpatient cardiac rehabilitation/secondary prevention (CR) program.

Denominator Instructions:
Coronary Artery Bypass Graft, Percutaneous Coronary Intervention, Cardiac Valve surgery, Cardiac Transplant or Acute Myocardial Infarction, in order to meet the criteria for inclusion of the measure, must have occurred or been performed within 12 months of date of encounter.

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Patient encounter during the reporting period (CPT or HCPCS): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99387, 99395, 99396, G0438, G0439
AND

Diagnosis of Chronic Stable Angina (ICD-9-CM): 413.0, 413.1, 413.9
Diagnosis for Chronic Stable Angina (ICD-10-CM) [REFERENCE ONLY/Not Reportable]: I20.1, I20.8, I20.9
OR
Diagnosis of Acute Myocardial Infarction (ICD-9-CM): 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, 410.82, 410.81, 410.90, 410.91, 410.92, 412
Diagnosis of Acute Myocardial Infarction (ICD-10-CM) [REFERENCE ONLY/Not Reportable]: I21.01, I21.02, I21.09, I21.11, I21.19, I21.21, I21.29, I21.3, I21.4, I22.0, I22.1, I22.2, I22.8, I22.9, I25.2
OR
Coronary Artery Bypass Graft Surgery (CPT): 33510, 33511, 33512, 33513, 33514, 33516, 33517, 33518, 33519, 33521, 33522, 33523, 33530, 33533, 33534, 33535, 33536, 33572, 33999, 35500, 35600
OR:
Percutaneous Coronary Intervention (CPT): 92920, 92924, 92928, 92933, 92937, 92941, 92943, G0290, G0291
OR:
Cardiac Valve Surgery (CPT): 33361, 33362, 33363, 33364, 33365, 33400, 33401, 33403, 33404, 33405, 33406, 33410, 33411, 33412, 33413, 33414, 33415, 33416, 33417, 33420, 33422, 33425, 33426, 33427, 33430, 33463, 33464, 33465, 33468, 33470, 33471, 33472, 33474, 33475, 33476, 33478, 33496, 33600, 33602
OR:
Cardiac Transplantation (CPT): 33945, 33935

AND
Qualifying cardiac event/diagnosis in previous 12 months: 1460F

NUMERATOR:
Patients who have had a qualifying event/diagnosis within the previous 12 months, who have been referred to an outpatient cardiac rehabilitation/secondary prevention (CR) program

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Numerator Instructions:
CR programs may include a traditional CR program based on face-to-face interactions and training sessions or other options that include home-based approaches. If alternative CR approaches are used, they should be designed to meet appropriate safety standards.

Numerator Options:
Referral to an outpatient cardiac rehabilitation/secondary prevention program
Referred to an outpatient cardiac rehabilitation program (4500F)

OR

Documentation of medical reason(s) for not referring to an outpatient CR program (4500F *with* 1P)
OR
Documentation of patient reason(s) for not referring to an outpatient CR program (4500F *with* 2P)
OR
Documentation of system reason(s) for not referring to an outpatient CR program (4500F *with* 3P)
OR
Previous cardiac rehabilitation for qualifying cardiac event completed (4510F)

OR

Patient not referred to outpatient CR/secondary prevention program, reason not otherwise specified (4500F *with* 8P)

RATIONALE:
Cardiac rehabilitation services have been shown to help reduce morbidity and mortality in persons who have experienced a recent coronary artery disease event, but these services are used in less than 30% of eligible patients(1). A key component to CR utilization is the appropriate and timely referral of patients to an outpatient CR program. While referral takes place generally while the patient is hospitalized for a qualifying event (MI, CSA, CABG, PCI, cardiac valve surgery, or heart transplantation), there are many instances in which a patient can and should be referred from an outpatient clinical practice setting (e.g., when a patient does not receive such a referral while in the hospital, or when the patient fails to follow through with the referral for whatever reason).

This performance measure has been developed to help health care systems implement effective steps in their systems of care that will optimize the appropriate referral of a patient to an outpatient CR program.

This measure is designed to serve as a stand-alone measure or, preferably, to be included within other performance measurement sets that involve disease states or other conditions for which CR services have been found to be appropriate and beneficial (e.g., following MI, CABG surgery)(2, 3). This performance measure is provided in a format that is meant to allow easy and flexible inclusion into such performance measurement sets.

Referral of appropriate outpatients to a CR program is the responsibility of the health care provider within a health care system that is providing the primary cardiovascular care to the patient in the outpatient setting.

CLINICAL RECOMMENDATION STATEMENTS:
2011 ACCF/AHA Guideline for Coronary Artery Bypass Graft Surgery(4)
Class I
Cardiac rehabilitation is recommended for all eligible patients after CABG. (Level of Evidence: A)

ACC/AHA 2007 Update of the Guidelines for the Management of Patients with ST-Elevation Myocardial Infarction(5)
Class I
Advising medically supervised programs (cardiac rehabilitation) for high-risk patients (e.g., recent acute coronary syndrome or revascularization, heart failure) is recommended. (Level of Evidence: B)

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ACC/AHA 2007 Guidelines for the Management of Patients with Unstable Angina and Non–ST-Segment Elevation Myocardial Infarction(6)
Class I
Cardiac rehabilitation/secondary prevention programs are recommended for patients with UA/NSTEMI, particularly those with multiple modifiable risk factors and/or those moderate- to high-risk patients in whom supervised exercise training is particularly warranted. (Level of Evidence: B)

Cardiac rehabilitation/secondary prevention programs, when available, are recommended for patients with UA/NSTEMI, particularly those with multiple modifiable risk factors and those moderate- to high-risk patients in whom supervised or monitored exercise training is warranted. (Level of Evidence: B)

ACC/AHA 2007 Chronic Angina Focused Update of the Guidelines for the Management of Patients With Chronic Stable Angina (7)
Class I
Medically supervised programs (cardiac rehabilitation) are recommended for at-risk patients (e.g., recent acute coronary syndrome or revascularization, heart failure). (Level of Evidence: B)

2009 Focused update incorporated into the ACC/AHA 2005 Guidelines for the Diagnosis and Management of Heart Failure in Adults (8)
Class I
Exercise training is beneficial as an adjunctive approach to improve clinical status in ambulatory patients with current or prior symptoms of HF and reduced LVEF. (Level of Evidence: B)

Effectiveness-based Guidelines for the Prevention of Cardiovascular Disease in Women--2011 update: A Guideline from the American Heart Association(9)*Class I*
A comprehensive CVD risk-reduction regimen such as cardiovascular or stroke rehabilitation or a physician-guided home- or community-based exercise training program should be recommended to women with a recent acute coronary syndrome or coronary revascularization, new-onset or chronic angina, recent cerebrovascular event, peripheral arterial disease (Class I; Level of Evidence A) or current/prior symptoms of heart failure and an LVEF ≤35%. (Class I; Level of Evidence B)

ACC/AHA/SCAI 2007 Focused Update of the Guidelines for Percutaneous Coronary Intervention(10)
Class I
Medically supervised exercise programs (cardiac rehabilitation) should be recommended to patients after PCI, particularly for patients at moderate to high risk, for whom supervised exercise training is warranted. (Class I; Level of Evidence A)

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Measure #244: Hypertension: Blood Pressure Management

2013 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Percentage of patients aged 18 years and older with a diagnosis of hypertension seen within a 12 month period with a blood pressure < 140/90 mmHg OR patients with a blood pressure ≥ 140/90 mmHg and prescribed two or more anti-hypertensive medications during the most recent office visit

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for patients with a diagnosis of hypertension seen during the reporting period. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All patients aged 18 years and older with a diagnosis of hypertension seen within a 12 month period

Denominator Criteria (Eligible Cases):
Patient aged ≥ 18 years on date of encounter
AND
Diagnosis for Hypertension (ICD-9-CM): 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, 405.01, 405.09, 405.11, 405.19, 405.91, 405.99
Diagnosis for Hypertension (ICD-10-CM) [REFERENCE ONLY/Not Reportable]: I10, I11.0, I11.9, I12.0, I12.9, I13.0, I13.10, I13.11, I13.2, I15.0, I15.1, I15.2, I15.8, I15.9
AND
Patient encounter during the reporting period (CPT): 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

NUMERATOR:
Patients with a blood pressure < 140/90 mmHg OR patients with a blood pressure ≥ 140/90 mmHg and prescribed two or more anti-hypertensive medications during the most recent office visit

BP value used for measure calculation:

- must be specified in medical record if > 1 value (systolic/diastolic) recorded, and
- must be value upon which treatment decision was based, and

- may be obtained by measurement during office visit or review of a home blood pressure log, OR of a 24 hour ambulatory blood pressure monitor, but the value on which the treatment decision is being made

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and which might represent the average of more than 1, reading must be documented as such in the medical record

Numerator Instructions: Report denominator eligible patients' blood pressure as separate (systolic and diastolic) values for measure. For patients who's systolic blood pressure ≥ 140 OR a diastolic blood pressure ≥ 90 mmHg and were prescribed two or more anti-hypertensive medications during the most recent office visit, then also report CPT II 4145F. All denominator eligible patients without a measurement of blood pressure would be reported as performance not met.

Definition:
Prescribed- May include prescriptions given to the patient for 2 or more anti-hypertensive medications at most recent office visit OR patient already taking 2 or more anti-hypertensive medications as documented in the current medication list (each anti-hypertensive component in a combination medication should be counted individually).

Numerator Options:
Patients with a blood pressure < 140/90 mmHg OR patients with a blood pressure ≥ 140/90 mmHg and prescribed 2 or more anti-hypertensive medications during the most recent office visit
Systolic codes *(Select one (1) code from this section):*
Most recent office visit systolic blood pressure, < 130 mmHg (G8790)
OR
Most recent office visit systolic blood pressure, 130 to 139 mmHg (G8791)
OR
Most recent office visit systolic blood pressure, ≥ 140 mmHg (G8792)

AND
Diastolic codes *(Select one (1) code from this section):*
Most recent office visit diastolic blood pressure, < 80 mmHg (G8793)
OR
Most recent office visit diastolic blood pressure, 80 - 89 mmHg (G8794)
OR
Most recent office visit diastolic blood pressure, ≥ 90 mmHg (G8795)

AND
If patient has a systolic blood pressure ≥ 140 mmHg OR **a diastolic blood pressure ≥ 90 mmHg, then**
ALSO REPORT CPT II 4145F
Two or more anti-hypertensive agents prescribed or currently being taken (CPT II 4145F)

OR

Documentation of medical reason(s) for not prescribing or patient not currently taking two or more anti-hypertensive agents (eg, allergy, intolerance, postural hypotension, other medical reasons) (4145F *with* 1P)
OR
Documentation of patient reason(s) for not prescribing or patient not currently taking two or more anti-hypertensive agents (eg, patient declined, other patient reasons) (4145F *with* 2P)
OR
Documentation of system reason(s) for not prescribing or patient not currently taking two or more anti-hypertensive agents (eg, financial reasons, other system reasons) (4145F *with* 3P)

OR

Patients with a blood pressure ≥ 140/90 mmHg AND not prescribed two or more anti-hypertensive medications during the most recent office visit

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Two or more anti-hypertensive agents were not prescribed or are not currently being taken, reason not otherwise specified (4145F *with* 8P)
OR
Blood pressure measurement not documented, reason not given (G8796)

RATIONALE:
Effective management of blood pressure in patients with hypertension can help prevent cardiovascular events, including myocardial infarction, stroke, and the development of heart failure.

CLINICAL RECOMMENDATION STATEMENTS:
The following evidence statements are quoted verbatim from the referenced clinical guidelines.

Classification of blood pressure for adults (JNC VII, 2004D):

Blood Pressure Classification	SBP mm Hg	DBP mm Hg
Normal	< 120	and < 80
Prehypertension	120-139	or 80-89
Stage 1 Hypertension	140-159	or 90-99
Stage 2 Hypertension	≥ 160	or ≥ 100

Treating systolic blood pressure (SBP) and diastolic blood pressure (DBP) to targets that are < 140/90 mm Hg is associated with a decrease in cardiovascular disease (CVD) risk complications. In patients with hypertension and diabetes or renal disease, the blood pressure (BP) goal is < 130/80 mm Hg. (JNC VII, 2004)

Therapy begins with lifestyle modification, and if BP goal is not achieved, thiazide-type diuretics should be used as initial therapy for most patients, either alone or in combination with one of the other classes (angiotensin converting enzyme inhibitors (ACE-I), angiotensin II receptor blockers (ARB), beta-blockers (BB), or calcium channel blockers (CCB) that have also been shown to reduce one or more hypertensive complications in randomized-controlled outcome trials. Selection of one of these other agents as initial therapy is recommended when a diuretic cannot be used or a competing indication is present that requires use of a specific drug…If the initial drug selected is not tolerated or contraindicated, and then a drug from one of the other classes proven to reduce cardiovascular events should be substituted. (JNC VII, 2004)

Compelling indications for use of individual drug classes for treatment of hypertension (JNC VII, 2004):

Stable Angina and Silent Ischemia
Unless contraindicated, pharmacologic therapy should be initiated with a BB. BBs will lower BP; reduce symptoms of angina; improve mortality; and reduce cardiac output, heart rate, and atrioventricular (AV) conduction. The reduced inotropy and heart rate decrease myocardial oxygen demand.

If angina and BP are not controlled by BB therapy alone, or if BBs are contraindicated, as in the presence of severe reactive airway disease, severe peripheral arterial disease, high-degree AV block, or the sick sinus syndrome, either long-acting dihydropyridine or nondihydropyridine CCBs may be used. CCBs decrease total peripheral resistance, which leads to reduction in BP and wall tension. CCBs also decrease coronary resistance and enhance post-stenotic coronary perfusion. Nondihyrdopyridine CCBs can decrease heart rate; when in combination with a BB however, they may cause severe bradycardia or high degrees of heart block. Therefore, long-acting dihydropyridine CCBs are preferred for combination therapy with BBs. If angina or BP is still not controlled with this two-drug regimen, nitrates can be added, but these should be used with caution in patients taking phosphodiesterase-5 inhibitors such as

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sildenafil. Short-acting dihydropyridine CCBs should not be used because of their potential to increase mortality, especially in the setting of acute myocardial infarction (MI).

Heart Failure

Heart failure (HF) is a "compelling indication" for the use of ACEI. Abundant evidence exists to justify their use with all stages of HF. In patients intolerant of ACEIs, ARBs may be used. BBs are also recommended for HF because of clinical studies demonstrating decreased morbidity and mortality, and improvement in HF symptoms.

Diabetes

Thiazide-type diuretics are beneficial in diabetics, either alone or as part of a combined regimen.

Therapy with an ACEI also is an important component of most regimens to control BP in diabetic patients. ACEIs may be used alone for BP lowering but are much more effective when combined with a thiazide –type diuretic or other antihypertensive drugs.

BBs, especially beta 1-selective agents, are beneficial to diabetics as part of multidrug therapy, but their value as mono-therapy is less clear. A BB is indicated in a diabetic with ischemic heart disease (IHD) but may be less effective in preventing stroke than an ARB as was found in the LIFE study. Although BBs can cause adverse effects on glucose homeostasis in diabetics, including worsening of insulin sensitivity and potential masking of the epinephrine-mediated symptoms of hypoglycemia, these problems are usually easily managed and are not absolute contraindication for BB use.

CCBs may be useful to diabetics, particularly as part of combination therapy to control BP.

Chronic Kidney Disease

The joint recommendation of the American Society of Nephrology and the National Kidney Foundation provide useful guidelines for the management of hypertensive patients with CKD. They recommend a goal BP for all CKD patients of < 130/80 mm Hg and the need for more than one antihypertensive drug to achieve this goal. The guidelines indicate that most patients with CKD should receive an ACEI or ARB in combination with a diuretic, and many will require a loop diuretic rather than a thiazide. In addition, if there is a conflict between the goals of slowing progression of CKD and cardiovascular (CV) risk reduction, individual decision making is recommended based on risk stratification.

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⌘Measure #245: Chronic Wound Care: Use of Wound Surface Culture Technique in Patients with Chronic Skin Ulcers (Overuse Measure)

2013 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of patient visits for those patients aged 18 years and older with a diagnosis of chronic skin ulcer without the use of a wound surface culture technique

INSTRUCTIONS:
This measure is to be reported at each visit occurring during the reporting period for patients with a diagnosis of a chronic skin ulcer seen during the reporting period. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

Measure Reporting via Claims:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. CPT Category II codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed ICD-9-CM diagnosis codes, CPT codes, and the appropriate CPT Category II code OR the CPT Category II code with the modifier. The modifier allowed for this measure is: 1P- medical reasons. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All patient visits for those patients aged 18 years and older with a diagnosis of chronic skin ulcer

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 on date of encounter
AND
Diagnosis for chronic skin ulcer (ICD-9-CM): 454.0, 454.2, 459.11, 459.13, 459.31, 459.33, 707.00, 707.01, 707.02, 707.03, 707.04, 707.05, 707.06, 707.07, 707.09, 707.10, 707.11, 707.12, 707.13, 707.14, 707.15, 707.19, 707.8, 707.9
Diagnosis for chronic skin ulcer (ICD-10-CM) [REFERENCE ONLY/Not Reportable]: I70.231, I70.232, I70.233, I70.234, I70.235, I70.238, I70.239, I70.241, I70.242, I70.243, I70.244, I70.245, I70.248, I70.249, I70.25, I70.331, I70.332, I70.333, I70.334, I70.335, I70.338, I70.339, I70.341, I70.342, I70.343, I70.344, I70.345, I70.348, I70.349, I70.35, I70.431, I70.432, I70.433, I70.434, I70.435, I70.438, I70.439, I70.441, I70.442, I70.443, I70.444, I70.445, I70.448, I70.449, I70.45, I70.531, I70.532, I70.533, I70.534, I70.535, I70.538, I70.539, I70.541, I70.542, I70.543, I70.544, I70.545, I70.548, I70.549, I70.55, I70.631, I70.632, I70.633, I70.634, I70.635, I70.638, I70.639, I70.641, I70.642, I70.643, I70.644, I70.645, I70.648, I70.649,

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I70.65, I70.731, I70.732, I70.733, I70.734, I70.735, I70.738, I70.739, I70.741, I70.742, I70.743, I70.744, I70.745, I70.748, I70.749, I70.75, I83.001, I83.002, I83.003, I83.004, I83.005, I83.008, I83.009, I83.011, I83.012, I83.013, I83.014, I83.015, I83.018, I83.019, I83.021, I83.022, I83.023, I83.024, I83.025, I83.028, I83.029, I83.201, I83.202, I83.203, I83.204, I83.205, I83.208, I83.209, I83.211, I83.212, I83.213, I83.214, I83.215, I83.218, I83.219, I83.221, I83.222, I83.223, I83.224, I83.225, I83.228, I83.229, I87.011, I87.012, I87.013, I87.019, I87.031, I87.032, I87.033, I87.039, I87.311, I87.312, I87.313, I87.319, I87.331, I87.332, I87.333, I87.339, L89.000, L89.001, L89.002, L89.003, L89.004, L89.009, L89.010, L89.011, L89.012, L89.013, L89.014, L89.019, L89.020, L89.021, L89.022, L89.023, L89.024, L89.029, L89.100, L89.101, L89.102, L89.103, L89.104, L89.109, L89.110, L89.111, L89.112, L89.113, L89.114, L89.119, L89.120, L89.121, L89.122, L89.123, L89.124, L89.129, L89.130, L89.131, L89.132, L89.133, L89.134, L89.139, L89.140 , L89.141, L89.142, L89.143, L89.144, L89.149, L89.150, L89.151, L89.152, L89.153, L89.154, L89.159, L89.200, L89.201, L89.202, L89.203, L89.204, L89.209, L89.210, L89.211, L89.212, L89.213, L89.214, L89.219, L89.220, L89.221, L89.222, L89.223, L89.224, L89.229, L89.300, L89.301, L89.302, L89.303, L89.304, L89.309, L89.310, L89.311, L89.312, L89.313, L89.314, L89.319, L89.320, L89.321, L89.322, L89.323, L89.324, L89.329, L89.40, L89.41, L89.42, L89.43, L89.44, L89.45, L89.500, L89.501, L89.502, L89.503, L89.504, L89.509, L89.510, L89.511, L89.512, L89.513, L89.514, L89.519, L89.520, L89.521, L89.522, L89.523, L89.524, L89.529, L89.600, L89.601, L89.602, L89.603, L89.604, L89.609, L89.610, L89.611, L89.612, L89.613, L89.614, L89.619, L89.620, L89.621, L89.622, L89.623, L89.624, L89.629, L89.810, L89.811, L89.812, L89.813, L89.814, L89.819, L89.890, L89.891, L89.892, L89.893, L89.894, L89.899, L89.90, L89.91, L89.92, L89.93, L89.94, L89.95, L97.101, L97.102, L97.103, L97.104, L97.109, L97.111, L97.112, L97.113, L97.114, L97.119, L97.121, L97.122, L97.123, L97.124, L97.129, L97.201, L97.202, L97.203, L97.204, L97.209, L97.211, L97.212, L97.213, L97.214, L97.219, L97.221, L97.222, L97.223, L97.224, L97.229, L97.301, L97.302, L97.303, L97.304, L97.309, L97.311, L97.312, L97.313, L97.314, L97.319, L97.321, L97.322, L97.323, L97.324, L97.329, L97.401, L97.402, L97.403, L97.404, L97.409, L97.411, L97.412, L97.413, L97.414, L97.419, L97.421, L97.422, L97.423, L97.424, L97.429, L97.501, L97.502, L97.503, L97.504, L97.509, L97.511, L97.512, L97.513, L97.514, L97.519, L97.521, L97.522, L97.523, L97.524, L97.529, L97.801, L97.802, L97.803, L97.804, L97.809, L97.811, L97.812, L97.813, L97.814, L97.819, L97.821, L97.822, L97.823, L97.824, L97.829, L97.901, L97.902, L97.903, L97.904, L97.909, L97.911, L97.912, L97.913, L97.914, L97.919, L97.921, L97.922, L97.923, L97.924, L97.929, L98.411, L98.412, L98.413, L98.414, L98.419, L98.421, L98.422, L98.423, L98.424, L98.429, L98.491, L98.492, L98.493, L98.494, L98.499

AND

Patient encounter during the reporting period (CPT): 97001, 97002, 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

NUMERATOR:
Patient visits without the use of a wound surface culture technique

Numerator Instructions: A higher score indicates appropriate treatment of patients with chronic skin ulcer.

NUMERATOR NOTE: *The numerator will be met if there is documentation that a technique other than surface culture of the wound exudate has been used to acquire the wound culture (e.g., Levine/deep swab technique, semiquantitative or quantitative swab technique).*

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Wound Surface Culture Technique Not Used
CPT II 4261F: Technique other than surface culture of the wound exudate used (eg, Levine/deep swab technique, semiquantitative or quantitative swab technique) OR wound surface culture technique not used

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OR

Wound Surface Culture Technique Used for Medical Reasons
Append a modifier (1P) to Category II code 4260F to report documented circumstances that appropriately exclude patients from the denominator.
4260F *with* 1P: Documentation of medical reason(s) for using a wound surface culture technique (eg, surface culture for methicillin-resistant staphylococcus aureus [MRSA] screening)

OR

Wound Surface Culture Technique Used
CPT II 4260F: Wound surface culture technique used

RATIONALE:
Infections are a potential complication in any patient with a chronic wound. Accurately determining the pathogenic cause of these clinically diagnosed infections has important implications in determining appropriate treatment regimens and minimizing patient complications. Surface swab cultures are inaccurate and unreliable for obtaining specimens for culture. A surface swab of an unprepared wound bed will not necessarily reveal the organism that resides within the tissue but rather only the surface contaminants. A basic tenet of infection within a chronic wound is that the organism must reside in living tissue. Swab culture of the surface may not reveal this in the presence of significant necrotic tissue or exudate. A recent survey of wound care practitioners in the US found that 54% of respondents routinely collect a swab culture while another 42% routinely collect both swab and biopsy specimens depending on the nature of the wound. More importantly, the study demonstrated considerable variability in the type of swab culture commonly obtained - including surface, deep swab and quantitative techniques. Despite their limited utility and the proven efficacy of quantitative swab and other techniques, surface cultures remain a common method for identifying chronic wound infection. The principle here is to avoid swabbing the unprepared wound exudate. Preparation of the wound with physiologic solution and removal of loose tissue matter prior to obtaining the wound culture will not impede the diagnosis of an offending organism, rather it will lessen the probability of identifying and treating a surface contaminant that will not impact progression to healing. In other words, no information is lost by wound bed preparation prior to swab or tissue biopsy technique culture. The goal is to obtain tissue microorganisms from the viable deeper tissue plane.

CLINICAL RECOMMENDATION STATEMENTS:
The following clinical recommendation statements are quoted verbatim from the referenced clinical guidelines and represent the evidence base for the measure:

Avoid swabbing undebrided ulcers or wound drainage. If swabbing the debrided wound base is the only available culture option, use a swab designed for culturing aerobic and anaerobic organisms and rapidly transport it to the laboratory (B-I). (Lipsky et al., IDSA, 2004)

…determine the type and level of infection in the debrided ulcer by tissue biopsy or by a validated quantitative swab technique. (Level II) (WHS, 2006)

[Q]uantitative culture has been shown to have high predictive value, sensitivity, and specificity. Most authors recommend the following technique for acquiring high quality wound cultures: After skin disinfection, a strip of necrotic wound tissue weighing 0.1 to 0.5 gram is excised for quantitative culture. This specimen is placed in an aerobic/anaerobic culture medium. Simultaneously, routine cotton swab is taken from the site of excision-debridement, taking care to avoid the ulcer's surface. It may occasionally be necessary to biopsy the ulcer in order to rule out [the] uncommon causes of lower extremity ulcers. (ASPS, 2007)

...swab specimens collected from wounds using Levine's technique performed better than swab specimens collected using either the wound exudate or Z-technique. Equally important, the findings suggest that swab specimens obtained using Levine's technique and processed using quantitative laboratory procedures are acceptably accurate

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when compared with the quantitative cultures of wound tissue. …swab specimens obtained with Levine's technique will enable a wider variety of wounds to be monitored for wound bioburden than tissue cultures. In addition, Levine's technique will be much more practical for repeating cultures in suspicious wounds that produce negative findings initially than tissue cultures. (Gardner et al., 2006)

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⌘Measure #246: Chronic Wound Care: Use of Wet to Dry Dressings in Patients with Chronic Skin Ulcers (Overuse Measure)

2013 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of patient visits for those patients aged 18 years and older with a diagnosis of chronic skin ulcer without a prescription or recommendation to use wet to dry dressings

INSTRUCTIONS:
This measure is to be reported at each visit occurring during the reporting period for patients with a diagnosis of a chronic skin ulcer seen during the reporting period. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

Measure Reporting via Claims:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. CPT Category II codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed ICD-9-CM diagnosis codes, CPT codes, and the appropriate CPT Category II code OR the CPT Category II code with the modifier. The modifier allowed for this measure is: 1P- medical reasons. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All patient visits for those patients aged 18 years and older with a diagnosis of chronic skin ulcer

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 on date of encounter
AND
Diagnosis for chronic skin ulcer (ICD-9-CM): 454.0, 454.2, 459.11, 459.13, 459.31, 459.33, 707.00, 707.01, 707.02, 707.03, 707.04, 707.05, 707.06, 707.07, 707.09, 707.10, 707.11, 707.12, 707.13, 707.14, 707.15, 707.19, 707.8, 707.9
Diagnosis for chronic skin ulcer (ICD-10-CM) [REFERENCE ONLY/Not Reportable]: I70.231, I70.232, I70.233, I70.234, I70.235, I70.238, I70.239, I70.241, I70.242, I70.243, I70.244, I70.245, I70.248, I70.249, I70.25, I70.331, I70.332, I70.333, I70.334, I70.335, I70.338, I70.339, I70.341, I70.342, I70.343, I70.344, I70.345, I70.348, I70.349, I70.35, I70.431, I70.432, I70.433, I70.434, I70.435, I70.438, I70.439, I70.441, I70.442, I70.443, I70.444, I70.445, I70.448, I70.449, I70.45, I70.531, I70.532, I70.533, I70.534, I70.535, I70.538, I70.539, I70.541, I70.542, I70.543, I70.544, I70.545, I70.548, I70.549, I70.55, I70.631, I70.632, I70.633, I70.634, I70.635, I70.638, I70.639, I70.641, I70.642, I70.643, I70.644, I70.645, I70.648, I70.649,

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I70.65, I70.731, I70.732, I70.733, I70.734, I70.735, I70.738, I70.739, I70.741, I70.742, I70.743, I70.744, I70.745, I70.748, I70.749, I70.75, I83.001, I83.002, I83.003, I83.004, I83.005, I83.008, I83.009, I83.011, I83.012, I83.013, I83.014, I83.015, I83.018, I83.019, I83.021, I83.022, I83.023, I83.024, I83.025, I83.028, I83.029, I83.201, I83.202, I83.203, I83.204, I83.205, I83.208, I83.209, I83.211, I83.212, I83.213, I83.214, I83.215, I83.218, I83.219, I83.221, I83.222, I83.223, I83.224, I83.225, I83.228, I83.229, I87.011, I87.012, I87.013, I87.019, I87.031, I87.032, I87.033, I87.039, I87.311, I87.312, I87.313, I87.319, I87.331, I87.332, I87.333, I87.339, L89.000, L89.001, L89.002, L89.003, L89.004, L89.009, L89.010, L89.011, L89.012, L89.013, L89.014, L89.019, L89.020, L89.021, L89.022, L89.023, L89.024, L89.029, L89.100, L89.101, L89.102, L89.103, L89.104, L89.109, L89.110, L89.111, L89.112, L89.113, L89.114, L89.119, L89.120, L89.121, L89.122, L89.123, L89.124, L89.129, L89.130, L89.131, L89.132, L89.133, L89.134, L89.139, L89.140 , L89.141, L89.142, L89.143, L89.144, L89.149, L89.150, L89.151, L89.152, L89.153, L89.154, L89.159, L89.200, L89.201, L89.202, L89.203, L89.204, L89.209, L89.210, L89.211, L89.212, L89.213, L89.214, L89.219, L89.220, L89.221, L89.222, L89.223, L89.224, L89.229, L89.300, L89.301, L89.302, L89.303, L89.304, L89.309, L89.310, L89.311, L89.312, L89.313, L89.314, L89.319, L89.320, L89.321, L89.322, L89.323, L89.324, L89.329, L89.40, L89.41, L89.42, L89.43, L89.44, L89.45, L89.500, L89.501, L89.502, L89.503, L89.504, L89.509, L89.510, L89.511, L89.512, L89.513, L89.514, L89.519, L89.520, L89.521, L89.522, L89.523, L89.524, L89.529, L89.600, L89.601, L89.602, L89.603, L89.604, L89.609, L89.610, L89.611, L89.612, L89.613, L89.614, L89.619, L89.620, L89.621, L89.622, L89.623, L89.624, L89.629, L89.810, L89.811, L89.812, L89.813, L89.814, L89.819, L89.890, L89.891, L89.892, L89.893, L89.894, L89.899, L89.90, L89.91, L89.92, L89.93, L89.94, L89.95, L97.101, L97.102, L97.103, L97.104, L97.109, L97.111, L97.112, L97.113, L97.114, L97.119, L97.121, L97.122, L97.123, L97.124, L97.129, L97.201, L97.202, L97.203, L97.204, L97.209, L97.211, L97.212, L97.213, L97.214, L97.219, L97.221, L97.222, L97.223, L97.224, L97.229, L97.301, L97.302, L97.303, L97.304, L97.309, L97.311, L97.312, L97.313, L97.314, L97.319, L97.321, L97.322, L97.323, L97.324, L97.329, L97.401, L97.402, L97.403, L97.404, L97.409, L97.411, L97.412, L97.413, L97.414, L97.419, L97.421, L97.422, L97.423, L97.424, L97.429, L97.501, L97.502, L97.503, L97.504, L97.509, L97.511, L97.512, L97.513, L97.514, L97.519, L97.521, L97.522, L97.523, L97.524, L97.529, L97.801, L97.802, L97.803, L97.804, L97.809, L97.811, L97.812, L97.813, L97.814, L97.819, L97.821, L97.822, L97.823, L97.824, L97.829, L97.901, L97.902, L97.903, L97.904, L97.909, L97.911, L97.912, L97.913, L97.914, L97.919, L97.921, L97.922, L97.923, L97.924, L97.929, L98.411, L98.412, L98.413, L98.414, L98.419, L98.421, L98.422, L98.423, L98.424, L98.429, L98.491, L98.492, L98.493, L98.494, L98.499

AND

Patient encounter during the reporting period (CPT): 97001, 97002, 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

NUMERATOR:

Patient visits without a prescription or recommendation to use wet to dry dressings

Numerator Instructions: A higher score indicates appropriate treatment of patients with chronic skin ulcer.

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

No Prescription or Recommendation for Use of Wet to Dry Dressings

CPT II 4266F: Use of wet to dry dressings neither prescribed nor recommended

OR

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Use of Wet to Dry Dressings Prescribed or Recommended for Medical Reasons
Append a modifier (1P) to Category II code 4265F to report documented circumstances that appropriately exclude patients from the denominator.
4265F *with* 1P: Documentation of medical reason(s) for prescribing/recommending wet to dry dressings (eg, presence of necrotic tissue requiring debridement, highly exudative wound that is unlikely to dry out between dressing changes)

OR

Use of Wet to Dry Dressings Prescribed or Recommended
CPT II 4265F: Use of wet to dry dressings prescribed or recommended

RATIONALE:
A moist wound environment is essential to accelerate wound healing. Nevertheless, "wet to dry and gauze dressings are the most widely used primary dressing material in the United States" and evidence suggests that they are used inappropriately. In a recent study examining wound care practices, the use of dressings to maintain moist wound conditions ranged from 41.7% to 58.5% for diabetic and venous ulcers, respectively. Wet-to-dry dressings should not be utilized in the care of patients with chronic wounds as they may actually impede healing and are associated with an increased risk of infection, prolonged inflammation, and increased patient discomfort.

CLINICAL RECOMMENDATION STATEMENTS:
The following clinical recommendation statements are quoted verbatim from the referenced clinical guidelines and represent the evidence base for the measure:

Use clinical judgment to select a wound dressing that facilitates continued moisture. (Level I) Wet-to-dry dressings are not considered continuously moist. Continuously moist saline gauze dressings are as effective as other types of moist wound healing in terms of healing rate, although they may have other drawbacks such as maceration of the peri-ulcer skin, practicality of use, and cost effectiveness. It can also be very difficult, practically, to keep gauze dressings continuously moist. (WHS, 2006)

Maintain moist environment
- Remove soluble factors detrimental to wound healing
- Use appropriate dressings (available evidence shows no superiority in dressing materials)
- Consider classic dressings (gauze, foam, hydrocolloid, hydrogels)
- Consider bioactive dressings (Grade B) (ASPS, 2007)

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⌘Measure #247: Substance Use Disorders: Counseling Regarding Psychosocial and Pharmacologic Treatment Options for Alcohol Dependence

2013 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of patients aged 18 years and older with a diagnosis of current alcohol dependence who were counseled regarding psychosocial AND pharmacologic treatment options for alcohol dependence within the 12-month reporting period

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for patients with a diagnosis of alcohol dependence seen during the reporting period. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding. There are no allowable performance exclusions for this measure.

Measure Reporting via Claims:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. CPT Category II codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed ICD-9-CM diagnosis codes, CPT codes, and the appropriate CPT Category II code OR the CPT Category II code with the modifier. The modifier allowed for this measure is: 8P- reason not otherwise specified. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data. There are no allowable performance exclusions for this measure.

DENOMINATOR:
All patients aged 18 years and older with a diagnosis of current alcohol dependence

Denominator Criteria (Eligible Cases):
Patient aged ≥ 18 years on date of encounter
AND
Diagnosis for alcohol dependence (ICD-9-CM): 303.90, 303.91, 303.92
Diagnosis for alcohol dependence (ICD-10-CM) [REFERENCE ONLY/Not Reportable]: F10.20, F10.220, F10.221, F10.229, F10.230, F10.231, F10.232, F10.239, F10.24, F10.250, F10.251, F10.259, F10.26, F10.27, F10.280, F10.281, F10.282, F10.288, F10.29
AND
Patient encounter during the reporting period (CPT): 90791, 90792, 90832, 90834, 90837, 90839, 90845, 96150, 96152, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215

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NUMERATOR:
Patients who were counseled regarding psychosocial AND pharmacologic treatment options for alcohol dependence within the 12 month reporting period

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Patient Counseled Regarding Psychosocial AND Pharmacologic Treatment Options for Alcohol Dependence
CPT II 4320F: Patient counseled regarding psychosocial AND pharmacologic treatment options for alcohol dependence

OR

Patient not Counseled Regarding Psychosocial AND Pharmacologic Treatment Options for Alcohol Dependence, Reason not Otherwise Specified
Append a reporting modifier (8P) to CPT Category II code 4320F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.
4320F *with* 8P: Patient was not counseled regarding psychosocial AND pharmacologic treatment options for alcohol dependence, reason not otherwise specified

RATIONALE:
Research has shown that among patients diagnosed with alcohol dependence, only 4.64% were referred for psychosocial treatment in the form of substance abuse counseling, inpatient rehabilitation programs, outpatient rehabilitation programs, or mutual help groups. While pharmacologic therapy has established efficacy, often in combination with psychosocial therapy, in promoting abstinence and preventing relapse in alcohol-dependent patients, physician rates of prescribing pharmacologic therapy for alcohol dependence are also considerably low. A recent study found that these low rates prevail even among addiction medicine physicians who prescribed naltrexone to only 13% of their alcohol-dependent patients. Pharmacotherapy and psychosocial treatment should be routinely considered for all patients with alcohol dependence, and patients should be informed of this option.

CLINICAL RECOMMENDATION STATEMENTS:
The following clinical recommendation statements are quoted verbatim from the referenced clinical guidelines and represent the evidence base for the measure:

Psychosocial treatments found effective for some patients with an alcohol use disorder include motivational enhancement therapy (MET) (Category I), cognitive-behavioral therapy (CBT) (Category I), behavioral therapies (Category I), 12-step facilitation (TSF) (Category I), marital and family therapies (Category I), group therapies (Category II), and psychodynamic therapy/interpersonal therapy (IPT) (Category III). (APA, 2006)
Specific pharmacotherapies for alcohol-dependent patients have well-established efficacy and moderate effectiveness:

- Naltrexone may attenuate some of the reinforcing effects of alcohol, although data on its long-term efficacy are limited. The use of long-acting, injectable naltrexone may promote adherence, but published research is limited and FDA approval is pending. *[Note: Extended-release naltrexone for injection has since received FDA approval]* (Category I)
- Acamprosate, a γ-aminobutyric acid (GABA) analog that may decrease alcohol craving in abstinent individuals, may also be an effective adjunctive medication in motivated patients who are concomitantly receiving psychosocial treatment. (Category I)
- Disulfiram is an effective adjunct to a comprehensive treatment program for reliable, motivated patients whose drinking may be triggered by events that suddenly increase alcohol craving. (Category II) (APA, 2006)

Empirically validated psychosocial treatment interventions should be initiated for all patients with substance use illnesses. Pharmacotherapy should be offered and available to all adult patients diagnosed with alcohol dependence

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and without medical contraindications. Pharmacotherapy, if prescribed, should be provided in addition to and directly linked with psychosocial treatment/support. (NQF, 2007)

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⌘Measure #248: Substance Use Disorders: Screening for Depression Among Patients with Substance Abuse or Dependence

2013 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of patients aged 18 years and older with a diagnosis of current substance abuse or dependence who were screened for depression within the 12-month reporting period

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for patients with a diagnosis of current substance abuse or dependence seen during the reporting period. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

Measure Reporting via Claims:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. CPT Category II codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed ICD-9-CM diagnosis codes, CPT codes, and the appropriate CPT Category II code OR the CPT Category II code with the modifier. The modifiers allowed for this measure are: 1P- medical reasons, 8P- reason not otherwise specified. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilizes claims data.

DENOMINATOR:
All patients aged 18 years and older with a diagnosis of current substance abuse or dependence

Denominator Criteria (Eligible Cases):
Patient aged ≥ 18 years on date of encounter
AND
Diagnosis for Alcohol Dependence (ICD-9-CM): 303.90, 303.91, 303.92, 304.00, 304.01, 304.02, 304.10, 304.11, 304.12, 304.20, 304.21, 304.22, 304.30, 304.31, 304.32, 304.40, 304.41, 304.42, 304.50, 304.51, 304.52, 304.60, 304.61, 304.62, 304.70, 304.71, 304.72, 304.80, 304.81, 304.82, 304.90, 304.91, 304.92, 305.00, 305.01, 305.02, 305.20, 305.21, 305.22, 305.30, 305.31, 305.32, 305.40, 305.41, 305.42, 305.50, 305.51, 305.52, 305.60, 305.61, 305.62, 305.70, 305.71, 305.72, 305.80, 305.81, 305.82, 305.90, 305.91, 305.92
Diagnosis for Alcohol Dependence (ICD-10-CM) [REFERENCE ONLY/Not Reportable]: F10.10, F10.120, F10.121, F10.129, F10.14, F10.150, F10.151, F10.159, F10.180, F10.181, F10.182, F10.188, F10.19, F10.20, F10.220, F10.221, F10.229, F10.230, F10.231, F10.232, F10.239, F10.24, F10.250, F10.251, F10.259, F10.26, F10.27, F10.280, F10.281, F10.282, F10.288, F10.29, F11.10, F11.120,

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F11.121, F11.122, F11.129, F11.14, F11.150, F11.151, F11.159, F11.181, F11.182, F11.188, F11.19, F11.20, F11.220, F11.221, F11.222, F11.229, F11.23, F11.24, F11.250, F11.251, F11.259, F11.281, F11.282, F11.288, F11.29, F12.10, F12.120, F12.121, F12.122, F12.129, F12.150, F12.151, F12.159, F12.180, F12.188, F12.19, F12.20, F12.220, F12.221, F12.222, F12.229, F12.250, F12.251, F12.259, F12.280, F12.288, F12.29, F13.10, F13.120, F13.121, F13.129, F13.14, F13.150, F13.151, F13.159, F13.180, F13.181, F13.182, F13.188, F13.19, F13.20, F13.220, F13.221, F13.229, F13.230, F13.231, F13.232, F13.239, F13.24, F13.250, F13.251, F13.259, F13.26, F13.27, F13.280, F13.281, F13.282, F13.288, F13.29, F14.10, F14.120, F14.121, F14.122, F14.129, F14.14, F14.150, F14.151, F14.159, F14.180, F14.181, F14.182, F14.188, F14.19, F14.20, F14.220, F14.221, F14.222, F14.229, F14.23, F14.24, F14.250, F14.251, F14.259, F14.280, F14.281, F14.282, F14.288, F14.29, F15.10, F15.120, F15.121, F15.122, F15.129, F15.14, F15.150, F15.151, F15.159, F15.180, F15.181, F15.182, F15.188, F15.19, F15.20, F15.220, F15.221, F15.222, F15.229, F15.23, F15.24, F15.250, F15.251, F15.259, F15.280, F15.281, F15.282, F15.288, F15.29, F16.10, F16.120, F16.121, F16.122, F16.129, F16.14, F16.150, F16.151, F16.159, F16.180, F16.183, F16.188, F16.19, F16.20, F16.220, F16.221, F16.229, F16.24, F16.250, F16.251, F16.259, F16.280, F16.283, F16.288, F16.29, F18.10, F18.120, F18.121, F18.129, F18.14, F18.150, F18.151, F18.159, F18.17, F18.180, F18.188, F18.19, F18.20, F18.220, F18.221, F18.229, F18.24, F18.250, F18.251, F18.259, F18.27, F18.280, F18.288, F18.29, F19.10, F19.120, F19.121, F19.122, F19.129, F19.14, F19.150, F19.151, F19.159, F19.16, F19.17, F19.180, F19.181, F19.182, F19.188, F19.19, F19.20, F19.220, F19.221, F19.222, F19.229, F19.230, F19.231, F19.232, F19.239, F19.24, F19.250, F19.251, F19.259, F19.26, F19.27, F19.280, F19.281, F19.282, F19.288, F19.29

AND

Patient encounter during the reporting period (CPT): 90791, 90792, 90832, 90834, 90837, 90839, 90845, 96150, 96152, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215

NUMERATOR:

Patients who were screened for depression within the 12 month reporting period

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Patient Screened for Depression

CPT II 1220F: Patient screened for depression

OR

Patient not Screened for Depression for Medical Reasons

Append a modifier (1P) to CPT Category II code 1220F to report documented circumstances that appropriately exclude patients from the denominator.

1220F *with* 1P: Documentation of medical reason(s) for not screening for depression

OR

Patient not Screened for Depression, Reason not Otherwise Specified

Append a reporting modifier (8P) to CPT Category II code 1220F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

1220F *with* 8P: Patient was not screened for depression, reason not otherwise specified

RATIONALE:

Depression is one of the most common co-occurring psychiatric conditions in patients with substance use disorders and a condition for which a variety of screening methods have proven effective. Identifying depression and other co-occurring psychiatric disorders in patients with substance use disorders is essential for proper management and key to developing an integrated treatment approach, which is associated with better outcomes. Despite its importance, research has shown that more than 30% of patients with risk factors for depression, including alcohol or other drug abuse, were not asked about the presence or absence of depression or depressive symptoms.

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CLINICAL RECOMMENDATION STATEMENTS:
The following clinical recommendation statements are quoted verbatim from the referenced clinical guidelines and represent the evidence base for the measure:

All patients with a substance use disorder should be carefully assessed for the presence of co-occurring psychiatric disorders, including additional substance use disorders. (APA, 2006)

All positive screening tests should trigger full diagnostic interviews that use standard diagnostic criteria (i.e., those from the fourth edition of Diagnostic and Statistical Manual of Mental Disorders [DSM-IV]) to determine the presence or absence of specific depressive disorders, such as major depression and/or dysthymia. The severity of depression and co-morbid psychological problems (e.g., anxiety, panic attacks, or substance abuse) should be addressed. (USPSTF, 2002)

In general, treatment of depressive symptoms of moderate to severe intensity should begin concurrently or soon after initiating treatment of the co-occurring substance use disorder, particularly if there is evidence of prior mood episodes. In individuals without prior episodes of depression or a family history of mood disorders, it may be appropriate to delay the treatment of mild to moderate depressive symptoms for the purpose of diagnostic clarification. Clinicians are advised to monitor symptoms, assess and reassess for suicidal ideation, provide education, encourage abstinence from substances, and observe changes in mental status during the substance-free period while actively considering whether antidepressant intervention is indicated. (APA, 2006).

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Measure #249: Barrett's Esophagus

2013 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of esophageal biopsy reports that document the presence of Barrett's mucosa that also include a statement about dysplasia

INSTRUCTIONS:
This measure is to be reported each time a patient's surgical pathology report demonstrates Barrett's Esophagus; however, only one QDC per date of service for a patient is required. This measure may be reported by eligible professionals who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

Measure Reporting via Claims:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. CPT Category II codes or G-codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed ICD-9-CM diagnosis codes, CPT codes, and the appropriate CPT Category II code OR G-code OR the CPT Category II code with the modifier. The modifiers allowed for this measure are: 1P- medical reasons, 8P- reason not otherwise specified. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All surgical pathology biopsy reports for Barrett's Esophagus

> Denominator Criteria (Eligible Cases):
> Diagnosis for Barrett's esophagus (ICD-9-CM): 530.85
> Diagnosis for Barrett's esophagus (ICD-10-CM) [Reference ONLY/Not Reportable]: K22.70, K22.710, K22.711, K22.719
> AND
> Patient encounter during the reporting period (CPT): 88305

NUMERATOR:
Esophageal biopsy report documents the presence of Barrett's mucosa and includes a statement about dysplasia

> *NUMERATOR NOTE: Report quality data codes once per patient for each date-of-service.*

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Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Esophageal Biopsy Reports with the Histological Finding of Barrett's Mucosa that Contains a Statement about Dysplasia (present, absent, or indefinite)
CPT II 3125F: Esophageal biopsy reports with the histological finding of Barrett's mucosa that contains a statement about dysplasia (present, absent, or indefinite)

OR

Esophageal Biopsy Reports with the Histological Finding of Barrett's Mucosa that Contains a Statement about Dysplasia (present, absent, or indefinite) not Performed for Medical Reasons
Append a modifier (1P) to Category II code 3125F to report documented circumstances that appropriately exclude patients from the denominator
3125F *with* 1P: Documentation of medical reason(s) for not reporting the histological finding of Barrett's mucosa (eg, malignant neoplasm or absence of intestinal metaplasia)

OR

If patient is not eligible for this measure because the specimen is not of esophageal origin report:
G8797: Specimen site other than anatomic location of esophagus

OR

Esophageal Biopsy Reports with the Histological Finding of Barrett's Mucosa that does not Contain a Statement about Dysplasia (present, absent, or indefinite), Reason not Otherwise Specified
Append a reporting modifier (8P) to CPT Category II code 3125F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.
3125F *with* 8P: Pathology report with the histological finding of Barrett's mucosa that does not contain a statement about dysplasia (present, absent, or indefinite), reason not otherwise specified

RATIONALE:
Endoscopy is the technique of choice used to identify suspected Barrett's esophagus and to diagnose complications of GERD. Biopsy must be added to confirm the presence of Barrett's epithelium and to evaluate for dysplasia (ACG, 2005).

There is a rapidly rising incidence of adenocarcinoma of the esophagus in the United States. A diagnosis of Barrett's esophagus increases a patient's risk for esophageal adenocarcinoma by 30 to 125 times that of people without Barrett's esophagus (although this risk is still small 0.4% to 0.5% per year). Esophageal adenocarcinoma is often not curable, partly because the disease is frequently discovered at a late stage and because treatments are not effective. A diagnosis of Barrett's esophagus could allow for appropriate screening of at risk patients as recommended by the American College of Gastroenterology.

Standard endoscopy with biopsy currently is the most reliable means of establishing a diagnosis of Barrett's esophagus. The definitive diagnosis of Barrett's esophagus requires a pathologist's review of an esophageal biopsy. Dysplasia is the first step in the neoplastic process, and information about dysplasia is crucial for clinical decision-making directing therapy. The presence and grade of dysplasia cannot be determined by routine endoscopy, and pathologist's review of a biopsy is essential for recognition of dysplasia. Endoscopic surveillance detects curable neoplasia in patients with Barrett's esophagus.

CLINICAL RECOMMENDATION STATEMENTS:
The diagnosis of Barrett's esophagus requires systematic biopsy of the abnormal-appearing esophageal mucosa to document intestinal metaplasia and to detect dysplasia.

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Measure #250: Radical Prostatectomy Pathology Reporting

2013 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of radical prostatectomy pathology reports that include the pT category, the pN category, the Gleason score and a statement about margin status

INSTRUCTIONS:
This measure is to be reported each time a radical prostatectomy surgical pathology examination is performed during the reporting period for prostate patients. Each unique CPT Category I code or G-code submitted on the claim will be counted for denominator inclusion. It is anticipated that clinicians who examine prostate tissue specimens following resection in a laboratory or institution will submit this measure. Independent Laboratories (ILs) and Independent Diagnostic Testing Facilities (IDTFs), using indicator Place of Service 81, are not included in PQRS. If the specimen is not primary prostate tissue (e.g., breast, lung), report only G8798.

Measure Reporting via Claims:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. CPT Category II codes or G-codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed ICD-9-CM diagnosis codes, CPT codes, and the appropriate CPT Category II code OR G-codes OR the CPT Category II code with the modifier. The modifiers allowed for this measure are: 1P- medical reasons, 8P- reason not otherwise specified. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All radical prostatectomy surgical pathology examinations performed during the measurement period for prostate cancer patients

> Denominator Criteria (Eligible Cases):
> Diagnosis for malignant neoplasm of prostate (ICD-9-CM): 185
> Diagnosis for malignant neoplasm of prostate (ICD-10-CM) [Reference ONLY/Not Reportable]: C61
> AND
> Patient encounter during the reporting period (CPT): 88309

NUMERATOR:
Radical Prostatectomy reports that include the pT category, the pN category, Gleason score and a statement about margin status

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Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Radical Prostatectomy Report includes pT category, pN category, Gleason Score and Statement about Margin Status
CPT II 3267F: Pathology report includes pT category, pN category, Gleason score and statement about margin status

OR

pT category, pN category, Gleason Score and Statement about Margin Status not Documented for Medical Reasons
Append a modifier (1P) to Category II code 3267F to report documented circumstances that appropriately exclude patients from the denominator.
3267F *with* 1P: Documentation of medical reason(s) for not including pT category, pN category, Gleason score and statement about margin status in the pathology report (eg, specimen originated from other malignant neoplasms, transurethral resections of the prostate (TURP), or secondary site prostatic carcinomas)

OR

If patient is not eligible for this measure because the specimen is not primary prostate tissue from a radical resection report:
G8798: Specimen site other than anatomic location of prostate

OR

pT category, pN category, Gleason Score and Statement about Margin Status not Documented, Reason not Otherwise Specified
Append a reporting modifier (8P) to CPT Category II code 3267F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.
3267F *with* 8P: pT category, pN category, Gleason score and statement about margin status were not documented in pathology report, reason not otherwise specified

RATIONALE:
Therapeutic decisions for prostate cancer management are stage driven and cannot be made without a complete set of pathology descriptors. Incomplete pathology reports for prostate cancer may result in misclassification of patients, rework and delays, and suboptimal management. The College of American Pathologists Cancer Committee has produced an evidence-based protocol/checklist of essential pathologic parameters that are recommended to be included in prostate cancer resection pathology reports. Conformance of pathology reports with the CAP checklist is a requirement for Cancer Center certification by the ACS.

The protocol recommends the use of the TNM Staging System for carcinoma of the prostate of the American Joint Committee on Cancer (AJCC) and the International Union Against Cancer (UICC). The radical prostatectomy checklist also includes extraprostatic extension.

In a study of cancer recurrence following radical prostatectomy, it was noted that "The relatively high proportion of patients who have biopsy-proven local recurrence who have organ-confined disease is probably inaccurate and, in large part, reflects under sampling and under recognition of extraprostatic extension."

The CAP Q probes data (2006) indicates that 11.6% of prostate pathology reports had missing elements. Extent of invasion (pTNM) was most frequently missing (52.1% of the reports missing elements), and extraprostatic extension was the second most frequently missing (41.7% of the reports missing elements). Margin status was missing in 8.3% of reports.

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A sampling from prostate cancer cases in 2000 through 2001 from the College of Surgeons National Cancer Data Base found only 48.2% of surgical pathology reports for prostate cancer documented pathologic stage similar to the more recent data from the CAP Q probes study. The NCDB data showed the Gleason score was present 86.3% of the time, slightly less than the 100% compliance found in the CAP Q probes study and that margin status was present in 84.9% of reports.

CLINICAL RECOMMENDATION STATEMENTS:

Patient management and treatment guidelines promote an organized approach to providing quality care. The (American College of Surgeons Committee on Cancer) CoC requires that 90% of pathology reports that include a cancer diagnosis contain the scientifically validated data elements outlined in the surgical case summary checklist of the College of American Pathologists (CAP) publication *Reporting on Cancer Specimens*. The College regards the reporting elements in the "Surgical Pathology Cancer Case Summary (Checklist)" portion of the protocols as essential elements of the pathology report. However, the manner in which these elements are reported is at the discretion of each specific pathologist, taking into account clinician preferences, institutional policies, and individual practice.

Pathologic staging is usually performed after surgical resection of the primary tumor. Pathologic staging depends on pathologic documentation of the anatomic extent of disease, whether or not the primary tumor has been completely removed.

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Measure #251: Immunohistochemical (IHC) Evaluation of Human Epidermal Growth Factor Receptor 2 Testing (HER2) for Breast Cancer Patients

2013 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
This is a measure based on whether quantitative evaluation of Human Epidermal Growth Factor Receptor 2 Testing (HER2) by immunohistochemistry (IHC) uses the system recommended in the ASCO/CAP Guidelines for Human Epidermal Growth Factor Receptor 2 Testing in breast cancer

INSTRUCTIONS:
This measure should be reported each time a quantitative HER2 IHC pathology examination is performed during the reporting period for patients with breast cancer; however, only one QDC per date of service for a patient is required. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

Measure Reporting via Claims:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. CPT Category II codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed ICD-9-CM diagnosis codes, CPT codes, and the appropriate CPT Category II code OR the CPT Category II code with the modifier. The modifiers allowed for this measure is: 8P- reason not otherwise specified. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All breast cancer patients with quantitative breast tumor evaluation by HER2 IHC

Denominator Criteria (Eligible Cases):
Diagnosis for breast cancer (ICD-9-CM): 174.0, 174.1, 174.2, 174.3, 174.4, 174.5, 174.6, 174.8, 174.9, 175.0, 175.9
Diagnosis for breast cancer (ICD-10-CM) [Reference ONLY/Not Reportable]: C50.011, C50.012, C50.019, C50.021, C50.022, C50.029, C50.111, C50.112, C50.119, C50.121, C50.122, C50.129, C50.211, C50.212, C50.219, C50.221, C50.222, C50.229, C50.311, C50.312, C50.319, C50.321, C50.322, C50.329, C50.411, C50.412, C50.419, C50.421, C50.422, C50.429, C50.511, C50.512, C50.519, C50.521, C50.522, C50.529, C50.611, C50.612, C50.619, C50.621, C50.622, C50.629, C50.811, C50.812, C50.819, C50.821, C50.822, C50.829, C50.911, C50.912, C50.919, C50.921, C50.922, C50.929
AND
Patient encounter during the reporting period (CPT): 88360, 88361

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NUMERATOR:
Breast cancer patients receiving quantitative breast tumor HER2 IHC evaluation using the ASCO/CAP recommended manual system or a computer-assisted system consistent with the optimal algorithm for HER2 testing as described in the ASCO/CAP guideline

NUMERATOR NOTE: Report CPT II quality data codes once per patient for each date-of-service.

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Quantitative Evaluation of HER2 by IHC Performed
CPT II 3394F: Quantitative HER2 by IHC evaluation consistent with scoring system defined in the ASCO/CAP guidelines

OR

If patient is not eligible for this measure because quantitative non-HER2 IHC evaluation was performed (eg, testing for estrogen or progesterone, receptors, [ER/PR]) report:
CPT II 3395F: Quantitative non-HER2 IHC evaluation (eg, testing for estrogen or progesterone receptors, [ER/PR]) performed

OR

Quantitative Evaluation of HER2 by IHC Performed but did not use the System Recommended in the ASCO/CAP Guidelines for Human Epidermal Growth Factor Receptor 2 Testing in Breast Cancer, Reason not Otherwise Specified
Append a reporting modifier (8P) to CPT Category II code 3394F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.
3394F *with* 8P: Quantitative evaluation of HER2 did not use the system recommended in the ASCO/CAP Guidelines for for Human Epidermal Growth Factor Receptor 2 Testing in breast cancer, reason not otherwise specified

RATIONALE:
Through a cooperative effort with the American Society of Clinical Oncologists (ASCO) and the CAP, new guidelines for Human Epidermal Growth Factor 2 testing in breast cancer were published in January 2007.

The ASCO/CAP Guideline recommendations for quantitative HER2 IHC evaluation were designed to enhance concordance with FISH assays for HER2 Amplified and Non-amplified tumor status. The recommendations are different from those provided by HER2 antibody manufacturers and compliance is likely to be considerably less than 100%. Implementation of Guideline scoring would promote uniformity and quality among interpreting pathologists.

CLINICAL RECOMMENDATION STATEMENTS:
"Positive HER2 test – Based on a literature review of clinical trials, international studies and protocols, expert consensus, and US Food and Drug Administration Panel findings, a positive HER2 test is defined as either … uniform intense membrane staining of > 30% of invasive tumor cells… or FISH result of amplified *HER2* gene copy number (average of > six gene copies/nucleus for test systems without internal control probe) or *HER2*/CEP 17 ratio of more than 2.2, where CEP 17 is a centromeric probe for chromosome 17 on which the *HER2* gene resides. The 30% [criterion] for a positive IHC is further discussed in Appendix G."

"For IHC assays of HER2 protein expression, the original US Food and Drug Administration-approved interpretation guidelines provide insufficient specificity. Several experts, including those serving as central reviewers on clinical trials, have specified that a threshold of more than 30% of tumor (rather than the originally specified 10%) should show strong circumferential membrane staining for a positive result. This means that according to this guideline, strong circumferential staining of 30% or less of cells would be considered equivocal and be subjected to confirmatory FISH testing."

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Measure #252 (NQF 0503): Anticoagulation for Acute Pulmonary Embolus Patients

2013 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Anticoagulation ordered for patients who have been discharged from the emergency department (ED) with a diagnosis of acute pulmonary embolus

INSTRUCTIONS:
This measure is to be reported each time a patient has been discharged from the emergency department (i.e., transferred to another unit within the facility, transferred to another facility, or discharged to home) with a discharge diagnosis of acute pulmonary embolus during the reporting period. Claims data will be analyzed to determine the emergency department discharge. Patients who were discharged from an emergency department with a diagnosis of acute pulmonary embolus should have documentation in the medical record of having anticoagulation ordered. It is anticipated that clinicians who provide care in the emergency department will submit this measure. The Part B claim form place of service field must indicate that the encounter has taken place in the emergency department.

Measure Reporting via Claims:
ICD-9-CM diagnosis codes, CPT codes, Place of Service Indicator, and patient demographics are used to identify patients who are included in the measure's denominator. G-codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed ICD-9-CM diagnosis codes, CPT codes, Place of Service Indicator, and the appropriate numerator G-code. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT codes, Place of Service Indicator, and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All patients, regardless of age, presenting to the emergency department (ED) with a diagnosis of pulmonary embolus

> Denominator Criteria (Eligible Cases):
> Diagnosis for Pulmonary Embolism (ICD-9-CM): 415.13, 415.19
> Diagnosis for Pulmonary Embolism (ICD-10-CM) [REFERENCE ONLY/Not Reportable]: I26.99
> AND
> Patient encounter during the reporting period (CPT): 99281, 99282, 99283, 99284, 99285, 99291
> AND
> Place of Service Indicator: 23
> (The Part B claim form Place of Service field must indicate emergency department)

NUMERATOR:
Patients who have orders for anticoagulation

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Definition:
Anticoagulation – Heparin or low-molecular weight heparin.

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Documentation of Anticoagulation Ordered
G8799: Anticoagulation ordered

OR

Anticoagulation not Ordered for Documented Reasons
G8800: Anticoagulation not ordered for reasons documented by clinician

OR

Documentation of Anticoagulation not Ordered, Reason not Given
G8801: Anticoagulation was not ordered, reason not given

RATIONALE:
Anticoagulation is the mainstay of treatment for pulmonary embolism. With the exception of cases presenting with hemodynamic compromise, recurrent pulmonary embolism and death are uncommon after the diagnosis is made and effective therapy is started.

CLINICAL RECOMMENDATION STATEMENTS:
Bleeding is the major complication of anticoagulant therapy. The criteria for defining the severity of bleeding varies considerably between studies, accounting in part for the variation in the rates of bleeding reported. The major determinants of vitamin K antagonist-induced bleeding are the intensity of the anticoagulant effect, underlying patient characteristics, and the length of therapy. There is good evidence that vitamin K antagonist therapy, targeted international normalized ratio (INR) of 2.5 (range, 2.0 to 3.0), is associated with a lower risk of bleeding than therapy targeted at an INR > 3.0. The risk of bleeding associated with IV unfractionated heparin (UFH) in patients with acute venous thromboembolism (VTE) is < 3% in recent trials. This bleeding risk may increase with increasing heparin dosages and age (> 70 years). Low molecular weight heparin (LMWH) is associated with less major bleeding compared with UFH in acute VTE. UFH and LMWH are not associated with an increase in major bleeding in ischemic coronary syndromes, but are associated with an increase in major bleeding in ischemic stroke. Information on bleeding associated with the newer generation of antithrombotic agents has begun to emerge. In terms of treatment decision making for anticoagulant therapy, bleeding risk cannot be considered alone, i.e., the potential decrease in thromboembolism must be balanced against the potential increased bleeding risk. (Hemorrhagic complications of anticoagulant treatment: the Seventh ACCP Conference on Antithrombotic and Thrombolytic Therapy. Levine MN; Raskob G; Beyth RJ; Kearon C; Schulman S., Chest 2004 Sep;126(3 Suppl):287S-310S.)

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Measure #254 (NQF 0651): Ultrasound Determination of Pregnancy Location for Pregnant Patients with Abdominal Pain

2013 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of pregnant female patients aged 14 to 50 who present to the emergency department (ED) with a chief complaint of abdominal pain or vaginal bleeding who receive a trans-abdominal or trans-vaginal ultrasound to determine pregnancy location

INSTRUCTIONS:
This measure is to be reported each time a patient who presents in the emergency department with a chief complaint of abdominal pain and/or vaginal bleeding who receive a trans-abdominal or trans-vaginal ultrasound during the reporting period. It is anticipated that clinicians who provide care in the emergency department will submit this measure. The Part B claim form place of service field must indicate that the encounter has taken place in the emergency department.

Measure Reporting via Claims:
ICD-9-CM diagnosis codes, CPT codes, Place of Service Indicator, and patient demographics are used to identify patients who are included in the measure's denominator. G-codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed ICD-9-CM diagnosis codes, CPT codes, Place of Service Indicator, and the appropriate numerator G-code. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT codes, Place of Service Indicator, and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All pregnant female patients aged 14 to 50 who present to the ED with a chief complaint of abdominal pain or vaginal bleeding

> Denominator Criteria (Eligible Cases):
> Pregnant females aged 14 to 50
> AND
> Diagnosis of Other Current Condition in the Mother Classifiable Elsewhere but Complicating Pregnancy, Childbirth, or the Puerperium (ICD-9-CM): 648.90, 648.93
> Diagnosis of Other Current Condition in the Mother Classifiable Elsewhere but Complicating Pregnancy, Childbirth, or the Puerperium (ICD-10-CM) [REFERENCE ONLY/Not Reportable]: O26.899, O26.90, O26.91
> AND
> Diagnosis for Abdominal Pain (ICD-9-CM): 789.00, 789.03, 789.04, 789.05, 789.06, 789.07, 789.09, 789.60, 789.63, 789.64, 789.65, 789.66, 789.67, 789.69

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Diagnosis for Abdominal Pain (ICD-10-CM) [REFERENCE ONLY/Not Reportable]: R10.0, R10.10, R10.13, R10.2, R10.30, R10.31, R10.32, R10.33, R10.813, R10.814, R10.815, R10.816, R10.817, R10.819, R10.823, R10.824, R10.825, R10.826, R10.827, R10.829, R10.84, R10.9

OR

Diagnosis for Vaginal Bleeding (ICD-9-CM): 640.00, 640.03, 640.80, 640.83, 640.90, 640.93, 641.10, 641.13, 641.20, 641.23, 641.30, 641.33, 641.80, 641.83, 641.90, 641.93
Diagnosis for Vaginal Bleeding (ICD-10-CM) [REFERENCE ONLY/Not Reportable]: O20.0, O20.8, O20.9, O44.10, O44.11, O45.001, O45.009, O45.011, O45.019, O45.021, O45.029, O45.091, O45.099, O45.8X1, O45.8X9, O45.90, O45.91, O46.001, O46.009, O46.011, O46.019, O46.021, O46.029, O46.8X1, O46.8X9, O46.90, O46.091, O46.099
AND
Patient encounter during the reporting period (CPT): 99281, 99282, 99283, 99284, 99285, 99291
AND
Place of Service Indicator: 23
(The Part B claim form Place of Service field must indicate emergency department)

NUMERATOR:
Patients who receive a trans-abdominal or trans-vaginal ultrasound with documentation of pregnancy location in medical record

Numerator Instructions: This measure is to be reported each time a patient meets the requirements as indicated in the denominator. If the clinician documents that the clinical event surrounding the patient, with or without performance of trans-abdominal or trans-vaginal ultrasound, does not meet the intent of the measure report quality-data code G8807.

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Trans-Abdominal or Trans-Vaginal Ultrasound Performed and Pregnancy Location Documented During ED Visit
G8806: Performance of trans-abdominal or trans-vaginal ultrasound

OR

Trans-Abdominal or Trans-Vaginal Ultrasound not Performed for Documented Reasons
G8807: Trans-abdominal or trans-vaginal ultrasound not performed for reasons documented by clinician (e.g., patient has visited the ED multiple times within 72 hours, patient has a documented Intrauterine Pregnancy [IUP])

OR

Trans-Abdominal or Trans-Vaginal Ultrasound not Performed, Reason not Given
G8808: Performance of trans-abdominal or trans-vaginal ultrasound not ordered, reason not given

RATIONALE:
Ectopic Pregnancy is a relatively common condition which can result in morbidity or mortality if misdiagnosed resulting in a delay to appropriate treatment. Abdominal pain is a frequent presenting complaint of women with ruptured ectopic pregnancy. Pelvic ultrasound can establish a pregnancy as intrauterine and identify high risk features for ectopic pregnancy (pelvic free fluid, complex adnexal mass). Early ultrasound can shorten the time to diagnosis of ectopic pregnancy and can help risk stratify pregnant patients with the complaint of abdominal pain or vaginal bleeding for discharge with routine follow-up, discharge with early follow-up or admission.

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CLINICAL RECOMMENDATION STATEMENTS:

Use of emergency ultrasound in pelvic disorders centers on the detection of intrauterine pregnancy (IUP), detection of ectopic pregnancy, detection of fetal heart rate in all stages of pregnancy, dating of the pregnancy, and detection of significant free fluid. Bedside pelvic ultrasound during the first trimester of pregnancy can be used to exclude ectopic pregnancy by demonstrating an intrauterine pregnancy. Studies of EP-performed ultrasound in this setting have demonstrated sensitivity of 76-90% and specificity of 88- 92% for the detection of ectopic pregnancy. In one study, EPs were able to detect an intrauterine pregnancy in 70% of patients with suspected ectopic pregnancy (first trimester pregnancy with abdominal pain or vaginal bleeding). When intrauterine fetal anatomy was visualized at the bedside, ectopic pregnancy was ruled out with a negative predictive value of essentially 100%. When bedside ultrasound evaluation was incorporated into a clinical algorithm for the evaluation of patients with suspected ectopic pregnancy, the incidence of discharged patients returning with ruptured ectopic pregnancy was significantly reduced.

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Measure #255 (NQF 0652): Rh Immunoglobulin (Rhogam) for Rh-Negative Pregnant Women at Risk of Fetal Blood Exposure

2013 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of Rh-negative pregnant women aged 14-50 years at risk of fetal blood exposure who receive Rh-Immunoglobulin (Rhogam) in the emergency department (ED)

INSTRUCTIONS:
This measure is to be reported each time a pregnant patient presents to the emergency department with complaints including blunt abdominal trauma, vaginal bleeding, ectopic pregnancy, and threatened or spontaneous abortion. Claims data will be analyzed to determine the emergency department discharge. Patients who present to the emergency department with these complaints should have documentation in the medical record of receiving an order for Rh-Immunoglobulin (Rhogam). It is anticipated that clinicians who provide care in the emergency department will submit this measure. The Part B claim form place of service field must indicate that the encounter has taken place in the emergency department.

Measure Reporting via Claims:
ICD-9-CM diagnosis codes, CPT codes, Place of Service Indicator, and patient demographics are used to identify patients who are included in the measure's denominator. G-codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed ICD-9-CM diagnosis codes, CPT codes, Place of Service Indicator, and the appropriate numerator G-code. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT codes, Place of Service Indicator, and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All pregnant female patients aged 14 to 50 years who are Rh-negative and at significant risk of fetal blood exposure

> Denominator Criteria (Eligible Cases):
> Female patients aged 14 to 50 years on date of encounter
> AND
> Diagnosis for Rh-Negative (ICD-9-CM): 656.10, 656.13
> Diagnosis for Rh-Negative (ICD-10-CM) [REFERENCE ONLY/Not Reportable]: O36.0110, O36.0111, O36.0190, O36.0191, O36.0910, O36.0911, O36.0990, O36.0991
> AND
> Diagnosis of High Risk Pregnancy Complications (ICD-9-CM): 632, 633.80, 633.81, 633.90, 633.91, 634.10, 634.11, 634.12, 636.10, 636.11, 636.12, 637.10, 637.11, 637.12, 638.1, 639.1, 640.00, 640.03, 640.80, 640.83, 640.90, 640.93, 641.10, 641.13, 641.20, 641.23, 641.30, 641.33, 641.80, 641.83, 641.90, 641.93, 656.00, 656.03

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Diagnosis of High Risk Pregnancy Complications (ICD-10-CM) [REFERENCE ONLY/Not Reportable]:
O00.8, O00.9, O02.1, O03.1, O03.6, O04.6, O07.1, O08.1, O20.0, O20.8, O20.9, O43.011, O43.019, O44.10, O44.11, O45.001, O45.009, O45.011, O45.019, O45.021, O45.029, O45.091, O45.099, O45.8X1, O45.8X9, O45.90, O45.91, O46.001, O46.011, O46.021, O46.8X1, O46.8X9, O46.90, O46.91
AND
Patient encounter during the reporting period (CPT): 99281, 99282, 99283, 99284, 99285, 99291
AND
Place of Service Indicator: 23
(The Part B claim form Place of Service field must indicate emergency department)

NUMERATOR:
Patients who receive an order for Rh-Immunoglobulin (Rhogam) in the ED

Numerator Instructions: This measure is to be reported each time a patient meets the requirements as indicated in the denominator. In the clinical event a patient has documented receipt of Rhogam report quality-data code G8810.

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Documentation in Medical Record that Rh-immunoglobulin (Rhogam) Ordered
G8809: Rh-immunoglobulin (Rhogam) ordered

OR

Rh-immunoglobulin (Rhogam) not Ordered for Documented Reasons
G8810: Rh-immunoglobulin (Rhogam) not ordered for reasons documented by clinician (e.g., patient had prior documented receipt of Rhogam within 12 weeks)

OR

Rh-immunoglobulin (Rhogam) not Ordered, Reason not Given
G8811: Documentation Rh-immunoglobulin (Rhogam) was not ordered, reason not given

RATIONALE:
The potential for maternal exposure to fetal blood is a concern among pregnant patients presenting to the emergency department with a number of common complaints or diagnoses including abdominal pain, blunt abdominal trauma, vaginal bleeding, ectopic pregnancy, threatened or spontaneous abortion, or pelvic instrumentation. This concern increases after the first trimester as fetal RBC mass increases.

CLINICAL RECOMMENDATION STATEMENTS:
Exposure to less than 0.1 ml of fetal blood of a different rhesus (Rh) antigenicity among Rh negative has been shown to increase the risk of maternal alloimmunization. Alloimmunization can result in hemolytic disease of the fetus or newborn including spontaneous abortion, fetal hemolytic anemia, hydrops fetalis and severe neonatal jaundice in subsequent pregnancies.

Anti-D-immunoglobulin reduces the likelihood of alloimmunization. Routine administration of antenatal anti-D-immunoglobulin has been demonstrated as an effective prophylaxis and is recommended by the American College of Obstetricians and Gynecologists (ACOG). Guidelines (UK) recommend administration of anti-D-immunogloblin after the first trimester for a number of sensitizing episodes including but not limited to uterine bleeding and for recurrent, painful or heavy uterine bleeding in the first trimester.

Routine use of anti-D prophylaxis is somewhat controversial as this is done to prevent so-called silent sensitization occurring in the absence of a clear hemorrhage, but this is generally performed in the UK and the US. As anti-D-immunoglobulin does cross the placenta, there are some concerns that this could cause fetal anemia, however, this was felt to be a minor concern relative to the benefits of administration.

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✦ Measure #256: Surveillance after Endovascular Abdominal Aortic Aneurysm Repair (EVAR)

2013 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Percentage of patients 18 years of age or older undergoing endovascular abdominal aortic aneurysm repair (EVAR) who have at least one follow-up imaging study after 3 months and within 15 months of EVAR placement that documents aneurysm sac diameter and endoleak status

INSTRUCTIONS:
This measure is to be reported each time an EVAR is performed during the reporting period. This measure is proposed for individual clinicians. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

A registry that includes surgical details or CPT procedure codes is required to identify patients for numerator inclusion, and this registry must link the original operation with outpatient followup information. The Society for Vascular Surgery Vascular Quality Initiative (SVS VQI) and the Vascular Study Group of New England (VSGNE) registries record such information, but the measure is not limited to these registries. Patients undergoing EVAR, recorded in the registry (CPT codes 34800, 34802, 34803, 34804, 34805) who undergo computed tomography angiography (CTA), magnetic resonance angiogram (MRA), or duplex imaging completed after 3 months but within 15 months of the original procedure with documentation of aneurysm sac size and presence or absence of endoleak as recorded in an appropriate registry during a subsequent physician office visit that is linked to the original procedure.

A registry that includes surgical details or CPT procedure codes is required to identify patients for denominator inclusion. This registry must also collect follow-up data based on an outpatient visit that links to the original EVAR procedure and documents aneurysm sac size and endoleak status based on an outpatient imaging study (CT, MR or ultrasound). The Society for Vascular Surgery Vascular Quality Initiative (SVS VQI) and the Vascular Study Group of New England (VSGNE) registries record this information. CPT codes that define the initial cohort of EVAR operations include: 34800, 34802, 34803, 34804, 34805, 34825, 34826, and 34900.

Measure Reporting via Registry:
CPT codes and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All endovascular repairs of non-ruptured, infrarenal abdominal aortic aneurysms

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Patient encounter during the reporting period (CPT): 34800, 34802, 34803, 34804, 34805, 34825, 34826, 34900

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NUMERATOR:
Patients who have at least one follow-up CTA, duplex, or MRA of the abdomen and pelvis after 3 months but within 15 months of EVAR, assessing for sac size and endoleak

Numerator Options:
Follow-up CTA, duplex, or MRA of the abdomen and pelvis performed (G8813)

OR

Patient is not eligible for follow-up CTA, duplex, or MRA (e.g., patient death, failure to return for scheduled follow-up exam, planned follow-up study which will meet numerator criteria has not yet occurred at the time of reporting) (G8812)

OR

Follow-up CTA, duplex, or MRA of the abdomen and pelvis not performed (G8814)

RATIONALE:
Complications of EVAR such as graft migration and endoleak can occur in a delayed fashion. These complications can result in aneurysm rupture. It is important that appropriate imaging is performed during the described time interval in order to detect these potential complications.

CLINICAL RECOMMENDATION STATEMENTS:
Despite the overall success rate of EVAR, there are multiple publications demonstrating the potential failure of endograft therapy. Wyss et al. just published a manuscript entitled "Rate and predictability of graft rupture after endovascular and open abdominal aortic aneurysm repair: data from the EVAR Trials." (Wyss TR, et al., Ann Surg, 2010) The authors describe 27 ruptures that occurred in EVAR patients (in 848 treated) as compared to 0 ruptures in 594 patients treated with open surgery. Five ruptures occurred in the first 30 days after surgery. The risk of rupture increased in the setting of an identified problem (endoleak type 1, type 2 with sac expansion, type 3, migration or kinking). The authors concluded that few ruptures after EVAR seem to be spontaneous without complications identified during optimal surveillance.

Brown and colleagues also published some concerning findings in regards to EVAR and initial anatomy. (Brown, et al., Br J surg, 2010) Elective EVAR was performed in 756 patients. Over almost four years of follow-up, 179 serious graft complications occurred (rate 6.5 per 100 person years) and 114 reinterventions (rate 3.8 per 100 person years) were needed. The highest rate of complication was during the first 6 months. In addition, graft-related complication and reintervention rates were common after EVAR in patients with a large aneurysm. The data from these two publications stress the need for CT imaging within one year of EVAR.

Persistent type 2 endoleak treatment is controversial. But, persistent type 2 endoleak can lead to complications of EVAR therapy. Jones et al. identified 164 patients with a type 2 endoleak on the initial CT scan performed within 30 days of treatment. (Jones, et al., J Vasc Surg, 2007) The majority of these endoleaks resolved on follow-up imaging, but 33 persisted. Persistent type 2 endoleak was associated with an increased incidence of adverse outcomes, including aneurysm sac growth, the need for conversion to open repair, reintervention rate, and rupture. Therefore, these data suggest that patients with persistent type 2 endoleak (> 6 months) should be considered for more frequent follow-up.

When can surveillance be minimized in the setting of possible EVAR failure? Houbballah et al. described the rate of significant sac retraction after EVAR. (Houbballah, et al., J Vasc Surg, 2010) SSR was observed in 24.8% (92/371) of the patients after an average of 26 ± 21 months of FU. In this series, SSR was accurately predictive of a durable success after EVAR. It occurred mostly in patients with a favorable anatomy. But, the percentage of patients was low. This data also suggests that failure can occur in a large number of patients unless surveillance is performed. This surveillance must include asessment of AAA sac diameter and determination of endoleak status by imaging (CT, MR or ultrasound).

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Current Surveillance Paradigms

The goal of aneurysm repair, whether open or endovascular is to prevent rupture. With EVAR, there is an ongoing risk of endoleak and/or migration which can lead to re-pressurization of the residual aneurysm sac and renew the possibility of subsequent rupture. Therefore, post-EVAR surveillance is necessary for monitoring of these complications. Current recommendations for post-EVAR surveillance include contrasted CT scans and four view abdominal radiographs at 1, 6, and 12 months and then annually thereafter. These recommendations were derived from early clinical trials without substantial data. A recent trial looking at surveillance for a single device found that if at 30 days there was absence of endoleak, 92 % of those patients remained free of aneurysm related morbidity at 1 year and the 6 month surveillance studies did not correlate with any difference in 5 year freedom from aneurysm related morbidity. (Sternbergh WC, et al., J Vasc Surg, 2008) As a result of their findings, the authors recommended continued aggressive surveillance for patients with endoleak present at 30 days but even in those without endoleak, a CT scan at one year was still recommended. In a separate study Go et al. looked at the utility of the 6 month CT scan in those patients with a normal CT scan at 1 month. (Go MR, et al., J Vasc Surg) In the 130 people who underwent CT scan at 6 month only two were abnormal. However among those who did and did not undergo 6 month CT scan (n=332), 11 had abnormal CT scans at 1 year. Therefore they recommended a CT at 1 month and if normal, eliminating the 6 month CT, but continuing to obtain the 1 year CT. As stated previously, the goal of EVAR is to prevent aneurysm rupture. In a literature search study looking at rupture after EVAR, Schlosser et al. identified 270 ruptures reported in the literature and found that the majority of them occurring within the first 3 years. (Schlosser FJV, et al., Eur J of Vasc Endo Surg) As a result, they also concluded that surveillance should focus on the first few years post EVAR.

Although CTA is considered the "gold standard" for followup, patients with renal insufficiency cannot safely receive contrast for CTA, so endoleak status must be determined by duplex ultasound or dynamic MRA.

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✦Measure #257: Statin Therapy at Discharge after Lower Extremity Bypass (LEB)

2013 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Percentage of patients aged 18 years and older undergoing infra-inguinal lower extremity bypass who are prescribed a statin medication at discharge

INSTRUCTIONS:
This measure is to be reported each time an infra-inguinal lower extremity is performed during the reporting period

ANY registry that includes anatomic details or CPT procedure codes and captures prescription of statin at hospital discharge as well as documented reasons for not prescribing statin medication is required to identify patients for numerator inclusion or denominator exclusion. The Society for Vascular Surgery Vascular Quality Initiative (SVS VQI) and the Vascular Study Group of New England (VSGNE) are examples of registries that capture detailed anatomic information, but the measure is not limited to these registries.

Measure Reporting via Registry:
CPT codes and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
Patients who received an infra-inguinal lower extremity bypass

Denominator Criteria (Eligible Cases):
All patients aged 18 years and older
AND
Patient encounter during the reporting period (CPT): 35556, 35566, 35571, 35583, 35585, 35587, 35656, 35666, 35671

NUMERATOR:
Patients prescribed a statin medication at discharge

Numerator Options:
Statin medication prescribed at discharge (G8816)

OR

Statin therapy not prescribed for documented reasons (e.g., medical intolerance to statin, death of patient prior to discharge, transfer of care to another acute care or federal hospital, hospice admission, left against medical advice) (G8815)

OR

Statin therapy not prescribed at discharge, reason not given (G8817)

RATIONALE:
Patients who require lower extremity revascularization procedures are at high risk of subsequent cardiovascular morbidity and mortality because of their widespread atherosclerotic disease. Statin therapy in this patient polulation

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has been associated with a significant decrease in cardiovascular events. Hospitalization for lower extremity revascularization provides an opportunity for initiating statin therapy on patients without contraindications who are not already on statin therapy.

CLINICAL RECOMMENDATION STATEMENTS:

Patients who present with lower extremity ischemia bear a large systemic burden of atherosclerotic disease, and therefore face not only the immediate risk of limb loss (Dormandy/Rutherford, TASC, 2000) but also an increased risk for cardiovascular events. (Criqui, et al., N Engl J Med, 1992; McKenna/Wolfson/Kuller, Atherosclerosis, 1991; Howell, et al., J Vasc Surg, 1989) The benefits of statin therapy for cardiovascular risk reduction in the PAD population have been demonstrated in several studies, most notably the Heart Protection Study.

(MRC/BHF, Lancet, 2002) The Heart Protection Study (HPS) is the largest trial to assess the effects of statins on major morbidity and mortality. The investigators enrolled over 20,000 patients deemed to be at high risk for cardiovascular events and randomized them to receive either 40mg of simvastatin or placebo. On survival analysis, they demonstrated that treatment with a statin was significantly associated with a decrease in all-cause mortality (12.9% vs. 14.7%, p=.0003) and that this effect was primarily driven by the reduction in death from vascular causes (7.6% vs. 9.1%, p < .0001). A recently published subgroup analysis (Randomized trial, J Vasc Surg, 2007) focusing specifically on patients with documented PAD (n=6748) did not include mortality data. However, the authors demonstrated a significant reduction in the rate of first major vascular event in the simvastatin treatment arm (relative reduction of 22%; p < .0001), when compared to placebo.

The PREVENT III trial was a prospective, randomized, double-blinded, multicenter trial designed to examine the efficacy of a novel pharmacologic agent (edifoligide) in preventing autogenous vein graft failure in 1404 patients who underwent infra-inguinal vein bypass at 83 hospitals exclusively for the treatment of critical limb ischemia. (Conte, et al., J Vasc Surg, 2006) This LEB trial, with its high-risk critical limb ischemia (CLI) population, provides another relevant database for examination of the role of statins. The salient finding from this study is that the use of statin drugs was associated with a significant one-year survival benefit in patients undergoing surgical bypass for CLI.(Schanzer, et al., J Vasc Surg, 2008) The Kaplan-Meier analysis also suggested that the benefit continues to increase with time, and might be even greater with longer term follow-up. In these 1404 patients, those not receiving statins experienced a 40% increase in the risk of death at one year. This effect was demonstrated both in the propensity score weighted analysis (HR 1.40, CI 1.02-1.92), and in the Cox proportional hazards model (HR 1.47, CI 1.11-1.96). These findings are consistent with prior observational studies that have examined the effects of statins, albeit, in heterogeneous PAD populations. (Feringa HH, et al., J Vasc Surg, 2007; Ward RP, et al., Int J Cardiol, 2005; Kertai MD, et al., Am J Med, 2004) The largest of these observational studies, conducted by Feringa and colleagues, enrolled 1374 patients with PAD and followed them for a mean duration of 6.4 years. The authors demonstrated a strong independent association between statin use and all-cause mortality (HR 1.41 for non-users, p < 0.0001). (Feringa HH, et al., J Vasc Surg, 2007)

The DECREASE study randomized 497 patients who had not previously been treated with a statin to receive either 80 mg of extended-release fluvastatin or placebo once daily before undergoing major non-cardiac vascular surgery. (Schouten O, et al., N Engl J Med, 2009) On evaluation of the primary endpoint, statin therapy conferred a 45% decreased hazard ratio (10.8% versus 19%, p=0.01) for peri-operative myocardial infarction. Furthermore, death from cardiovascular causes or myocardial infarction occurred in 4.8% of patients in the fluvastatin group and 10.1% of patients in the placebo group (hazard ratio, 0.47; 95% CI, 0.24 to 0.94; p= 0.03). Fluvastatin therapy was not associated with a significant increase in the rate of adverse events. Several additional studies in patients undergoing LEB have shown similar reductions in peri-operative morbidity and mortality associated with statin use. (Ward RP, et al., Int J Cardiol, 2005; Poldermans O, et al., Circulation, 2003; O'Neil-Callahan K, et al., J Am Coll Cardiol, 2005)

Recent studies have also demonstrated a specific benefit in graft patency after LEB in patients on statin therapy. (Christenson J, Cardiovasc Surg, 2001; Abbruzzese TA, et al., J Vasc Surg, 2004; Henke PK, et al., J Vasc Surg,

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2004) Abbruzzese et al. observed that statin use was associated with improved secondary patency (3-fold increased risk compared to non-users) among 197 patients who had undergone lower extremity bypass using saphenous vein, in a single-center retrospective analysis.(Abbruzzese TA, et al., J Vasc Surg, 2004)

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✦ Measure #258: Rate of Open Repair of Small or Moderate Non-Ruptured Abdominal Aortic Aneurysms (AAA) without Major Complications (Discharged to Home by Post-Operative Day #7)

2013 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Percent of patients undergoing open repair of small or moderate sized non-ruptured abdominal aortic aneurysms who do not experience a major complication (discharge to home no later than post-operative day #7)

INSTRUCTIONS:
This measure is to be reported each time an open repair AAA is performed during the reporting period. It is anticipated that clinicians who provide services of AAA repair, as described in the measure, based on the services provided and the measure-specific denominator coding will report this measure. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

Measure Reporting via Registry:
CPT codes and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data. There are no allowable performance exclusions for this measure.

DENOMINATOR:
All open repairs of non-ruptured, infrarenal abdominal aortic aneurysms

> Denominator Criteria (Eligible Cases):
> Patients aged ≥ 18 years on date of encounter
> AND
> Patient encounter during the reporting period (CPT): 35081, 35102
> AND
>
> *For women*:
> Aneurysm minor diameter < 5.5 cm: G8827
> OR
> *For men:*
> Aneurysm minor diameter < 6.0 cm: G8945

NUMERATOR:
Patients discharged to home no later than post-operative day #7

> Definition:
> Home – For purposes of reporting this measure, home is the point of origin prior to hospital admission prior to procedure of AAA. For example, if the patient comes from a skilled facility and returns to the skilled facility post AAA repair, this would meet criteria for discharged to home.

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Numerator Options:
Patient discharge to home no later than post-operative day #7 (G8818)

OR

Patient not discharged to home by post-operative day #7 (G8825)

RATIONALE:
Elective repair of a small or moderate sized AAA is a prophylactic procedure and the mortality/morbidity of the procedure must be contrasted with the risk of rupture over time. Surgeons should select patients for intervention who have a reasonable life expectancy and who do not have a high surgical risk. Discharge to home within one week of open AAA repair is an indicator of patients who were not frail prior to the procedure and who did not experience a major complication. The proposed measure will therefore serve as an indicator of both appropriateness and overall outcome.

CLINICAL RECOMMENDATION STATEMENTS:
The Care of Patients with an Abdominal Aortic Aneurysm: The Society for Vascular Surgery Practice Guidelines. (Chaikof et al, J Vasc Surg, 50:4, supplement, 2009)

Elective repair is recommended for patients that present with a fusiform AAA ≥ 5.5 cm in maximum diameter, in the absence of significant co-morbidities.
Level of recommendation: Strong
Quality of evidence: High

Surveillance is recommended for most patients with a fusiform AAA in the range of 4.0 cm to 5.4 cm in maximum diameter.
Level of recommendation: Strong
Quality of evidence: Moderate

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✦ Measure #259: Rate of Endovascular Aneurysm Repair (EVAR) of Small or Moderate Non-Ruptured Abdominal Aortic Aneurysms (AAA) without Major Complications (Discharged to Home by Post Operative Day #2)

2013 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Percent of patients undergoing endovascular repair of small or moderate non-ruptured abdominal aortic aneurysms (AAA) that do not experience a major complication (discharged to home no later than post-operative day #2)

INSTRUCTIONS:
This measure is to be reported each time an open repair AAA is performed during the reporting period. It is anticipated that clinicians who provide services of AAA repair, as described in the measure, based on the services provided and the measure-specific denominator coding will report this measure. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

Measure Reporting via Registry:
CPT codes and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data. There are no allowable performance exclusions for this measure.

DENOMINATOR:
All endovascular repairs of non-ruptured, infrarenal abdominal aortic aneurysms

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Patient encounter during the reporting period (CPT): 34800, 34802, 34803, 34804, 34805
AND

For women:
Aneurysm minor diameter < 5.5 cm: G8827
OR
For men:
Aneurysm minor diameter < 6.0 cm: G8945

NUMERATOR:
Patients discharged to home no later than post-operative day #2 following EVAR of AAA

Definition:
Home – For purposes of reporting this measure, home is the point of origin prior to hospital admission prior to procedure of AAA. For example, if the patient comes from a skilled facility and returns to the skilled facility post AAA repair, this would meet criteria for discharged to home.

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Numerator Options:
Patient discharged to home no later than post-operative day #2 following EVAR (G8826)

OR

Patient not discharge to home by post-operative day #2 following EVAR (G8833)

RATIONALE:
Elective repair of a small or moderate sized AAA is a prophylactic procedure and the mortality/morbidity of the procedure must be contrasted with the risk of rupture over time. Surgeons should select patients for intervention who have a reasonable life expectancy and who do not have a high surgical risk. Discharge to home within two days of endovascular AAA repair is an indicator of patients who were not frail prior to the procedure and who did not experience a major complication. The proposed measure will therefore serve as an indicator of both appropriateness and overall outcome.

CLINICAL RECOMMENDATION STATEMENTS:
The Care of Patients with an Abdominal Aortic Aneurysm: The Society for Vascular Surgery practice Guidelines. (Chaikof et al, J Vasc Surg, 50:4, supplement, 2009)

Elective repair is recommended for patients that present with a fusiform AAA ≥ 5.5 cm in maximum diameter, in the absence of significant comorbidities.
Level of recommendation: Strong
Quality of evidence: High

Surveillance is recommended for most patients with a fusiform AAA in the range of 4.0 cm to 5.4 cm in maximum diameter.
Level of recommendation: Strong
Quality of evidence: Moderate

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✦ Measure #260: Rate of Carotid Endarterectomy (CEA) for Asymptomatic Patients, without Major Complications (Discharged to Home by Post-Operative Day #2)

2013 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Percent of asymptomatic patients undergoing CEA who are discharged to home no later than post-operative day #2

INSTRUCTIONS:
This measure is to be reported each time a CEA is performed during the reporting period. It is anticipated that clinicians who provide services of CEA, as described in the measure, based on the services provided and the measure-specific denominator coding will report this measure. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

Measure Reporting via Registry:
CPT codes and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data. There are no allowable performance exclusions for this measure.

DENOMINATOR:
All carotid endarterectomy procedures

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Patient encounter during the reporting period (CPT): 35301
AND
Asymptomatic patient with no history of any transient ischemic attack or stroke in any carotid or vertebrobasilar territory: G8835

NUMERATOR:
Patients that are asymptomatic neurologically who were discharged alive, to home no later than post-operative day #2 following CEA

Definition:
Home – For purposes of reporting this measure, home is the point of origin prior to hospital admission for procedure of CEA. For example, if the patient comes from a skilled facility and returns to the skilled facility post CEA, this would meet criteria for discharged to home.

Numerator Options:
Patient discharged to home no later than post-operative day #2 following CEA (G8834)
OR
Patient not discharged to home by post-operative day #2 following CEA (G8838)

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RATIONALE:
Surgeons performing CEA on asymptomatic patients must select patients at low risk for morbidity and perform the procedure with a very low complication rate in order to achieve benefit. Discharge to home within two days of the procedure is an indicator of patients who were not frail prior to the procedure and who did not experience a major complication (e.g., disabling stroke, myocardial infarction). The proposed measure will therefore serve as an indicator of both appropriateness and overall outcome.

CLINICAL RECOMMENDATIONS:
Updated Society for Vascular Surgery guidelines for management of extracranial carotid disease. (Ricotta et al, J Vasc Surg, 54:3, 2011)

Neurologically asymptomatic patients with ≥ 60% diameter stenosis should be considered for CEA for reduction of long-term risk of stroke, provided the patient has a 3- to 5-year life expectancy and perioperative stroke/death rates can be ≤ 3% (GRADE 1, Level of Evidence A).

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Measure #261: Referral for Otologic Evaluation for Patients with Acute or Chronic Dizziness

2013 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of patients aged birth and older referred to a physician (preferably a physician specially trained in disorders of the ear) for an otologic evaluation subsequent to an audiologic evaluation after presenting with acute or chronic dizziness

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for all patients seen during the reporting period who present with acute or chronic dizziness. This measure is intended to ensure that patients with acute or chronic dizziness receive a referral in order to receive appropriate care. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

Measure Reporting via Claims:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. G-codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed ICD-9-CM diagnosis codes, CPT codes, and the appropriate G-code. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All patients aged birth and older presenting with acute or chronic dizziness

> Denominator Criteria (Eligible Cases):
> Patients aged birth and older
> AND
> Diagnosis for Dizziness (ICD-9-CM): 386.11, 780.4
> Diagnosis for Dizziness (ICD-10-CM) [REFERENCE ONLY/Not Reportable]: H81.10, H81.11, H81.12, H81.13, R42
> AND
> Patient encounter during the reporting period (CPT): 92540, 92541, 92542, 92543, 92544, 92545, 92546, 92547, 92548, 92550, 92557, 92567, 92568, 92570, 92575

NUMERATOR:
Patients referred to a physician for an otologic evaluation subsequent to an audiologic evaluation who present with acute or chronic dizziness

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NUMERATOR NOTE: The physician receiving the referral, or providing care currently, should preferably be specially trained in disorders of the ear.

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Referral for Otologic Evaluation
G8856: Referral to a physician for an otologic evaluation performed

OR

Referral for Otologic Evaluation not Performed for Documented Reasons
G8857: Patient is not eligible for the referral for otologic evaluation measure (e.g., patients who are already under the care of a physician for acute or chronic dizziness)

OR

Referral for Otologic Evaluation not Performed, Reason not Given
G8858: Referral to a physician for an otologic evaluation not performed, reason not given

RATIONALE:
Studies demonstrate that patients who present with acute or chronic dizziness may suffer from underlying problems, so therefore referral is necessary. Without referral, patients may suffer consequences of the underlying problems.

CLINICAL RECOMMENDATION STATEMENTS:
The American Academy of Otolaryngology-Head and Neck Surgery policy statement (approved 9/12/2002):
Hearing loss and balance disorders are medical conditions. Only licensed physicians with medical training may diagnose and direct the management of disease and medical disorders. A full history and physical examination by a physician (preferably a physician specially trained in disorders of the ear) to determine the accurate medical diagnosis and appropriate medical/surgical treatment for hearing loss and balance disorders are indicated for patients with the following "red flags":

1. Hearing loss with a positive history of familial hearing loss, TB, syphilis, HIV, Meniere's disease, autoimmune disorder, otosclerosis, von Recklinghausen's neurofibromatosis, Paget's disease of bone, head trauma related to onset.
2. History of pain, active drainage, or bleeding from an ear.
3. Sudden onset or rapidly progressive hearing loss.
4. Acute, chronic, or recurrent episodes of dizziness.
5. Evidence of congenital or traumatic deformity of the ear.
6. Visualization of blood, pus, cerumen plug, or foreign body in the ear canal.
7. Conductive hearing loss or abnormal tympanogram.
8. Unilateral or asymmetric hearing loss; or bilateral hearing loss > 80 dB.
9. Unilateral or pulsatile tinnitus.
10. Unilateral or asymmetrically poor speech discrimination scores.

The red flags do not include all indications for a medical referral and are not intended to replace clinical judgment in determining the need for consultation with an otolaryngologist.

21 C.F.R. Section 801.420:
A hearing aid dispenser should advise a prospective hearing aid user to consult promptly with a licensed physician (preferably an ear specialist) before dispensing a hearing aid if the hearing aid dispenser determines through inquiry, actual observation, or review of any other available information concerning the prospective user, that the prospective user has any of the following conditions:
(i) Visible congenital or traumatic deformity of the ear.
(ii) History of active drainage from the ear within the previous 90 days.
(iii) History of sudden or rapidly progressive hearing loss within the previous 90 days.

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(iv) Acute or chronic dizziness.
(v) Unilateral hearing loss of sudden or recent onset within the previous 90 days.
(vi) Audiometric air-bone gap equal to or greater than 15 decibels at 500 hertz (Hz), 1,000 Hz, and 2,000 Hz.
(vii) Visible evidence of significant cerumen accumulation or a foreign body in the ear canal.
(viii) Pain or discomfort in the ear.

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✿ Measure #262: Image Confirmation of Successful Excision of Image-Localized Breast Lesion

2013 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Image confirmation of lesion(s) targeted for image guided excisional biopsy or image guided partial mastectomy in patients with nonpalpable, image-detected breast lesion(s). Lesions may include: microcalcifications, mammographic or sonographic mass or architectural distortion, focal suspicious abnormalities on magnetic resonance imaging (MRI) or other breast imaging amenable to localization such as positron emission tomography (PET) mammography, or a biopsy marker demarcating site of confirmed pathology as established by previous core biopsy.

INSTRUCTIONS:
This measure is to be reported each time an image guided excisional biopsy or wire localized partial mastectomy is performed in patients with non-palpable, image-detected breast lesions. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

Measure Reporting via Claims:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. G-codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed ICD-9-CM diagnosis codes, CPT codes, and the appropriate numerator G-Code. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
Number of patients aged 18 years and older on date of encounter with non-palpable, image-detected (by mammogram, ultrasound, or breast MRI, PET mammography or other imaging modality) breast lesion requiring localization of lesion (benign or malignant) for targeted resection (either excisional biopsy or partial mastectomy)

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date on encounter
AND
Diagnosis for Breast Lesion (ICD-9-CM): 174.0, 174.1, 174.2, 174.3, 174.4, 174.5, 174.6, 174.8, 174.9, 175.0, 175.9, 198.81, 217, 239.3, 610.0, 610.1, 610.2, 610.3, 610.4, 610.8, 610.9, 611.0, 611.1, 611.2, 611.3, 611.4, 611.5, 611.6, 611.71, 611.72, 611.79, 611.81, 611.82, 611.83, 611.89, 611.9, 793.80, 793.81, 793.82, 793.89
Diagnosis for Breast Lesion (ICD-10-CM) [REFERENCE ONLY/Not Reportable]: C50.011, C50.012, C50.019, C50.021, C50.022, C50.029, C50.111, C50.112, C50.119, C50.121, C50.122, C50.129, C50.211, C50.212, C50.219, C50.221, C50.222, C50.229, C50.311, C50.312, C50.319, C50.321, C50.322, C50.329,

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C50.411, C50.412, C50.419, C50.421, C50.422, C50.429, C50.511, C50.512, C50.519, C50.521, C50.522, C50.529, C50.611, C50.612, C50.619, C50.621, C50.622, C50.629, C50.811, C50.812, C50.819, C50.821, C50.822, C50.829, C50.911, C50.912, C50.919, C50.921, C50.922, C50.929, C79.81, D24.1, D24.2, D24.9, D49.3, N60.01, N60.02, N60.09, N60.11, N60.12, N60.19, N60.21, N60.22, N60.29, N60.31, N60.32, N60.39, N60.41, N60.42, N60.49, N60.81, N60.82, N60.89, N60.91, N60.92, N60.99, N61, N62, N63, N64.0, N64.1, N64.2, N64.3, N64.4, N64.51, N64.52, N64.53, N64.59, N64.81, N64.82, N64.89, N64.9, R92.0, R92.1, R92.2, R92.8, T85.44, T85.44XA, T85.44XD, T85.44XS

AND

Patient encounter during the reporting period (CPT): 19125, 19301, 19302

NUMERATOR:

Patients undergoing excisional biopsy or partial mastectomy of a non-palpable lesion whose excised breast tissue was evaluated by imaging (x-ray, ultrasound, MRI, PET mammography or other imaging modality) intraoperatively to confirm successful inclusion of targeted lesion

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Image Confirmation of Lesion(s) Targeted for Image Guided Excisional Biopsy or Image Guided Partial Mastectomy in Patients with Non-palpable, Image-detected Breast Lesion(s)

G8872: Excised tissue evaluated by imaging intraoperatively to confirm successful inclusion of targeted lesion

OR

Imaging Abnormality was Visible Only on an MRI of the Breast or Other Imaging Modality that does not Permit Direct Imaging of Excised Tissue (e.g., PET mammography), Patient not Eligible

G8873: Patients with needle localization specimens which are not amenable to intraoperative imaging such as MRI needle wire localization, or targets which are tentatively identified on mammogram or ultrasound which do not contain a biopsy marker but which can be verified on intraoperative inspection or pathology (e.g., needle biopsy site where the biopsy marker is remote from the actual biopsy site)

OR

Image Confirmation of Lesion(s) Targeted for Image Guided Excisional Biopsy or Image Guided Partial Mastectomy in Patients with Non-palpable, Image-detected Breast Lesion(s) not Performed, Reason not Specified

G8874: Excised tissue not evaluated by imaging intraoperatively to confirm successful inclusion of targeted lesion

RATIONALE:

Many benign breast lesions and breast cancers are image-detected and will involve some form of image localization. Specimen radiography or specimen ultrasonography should routinely be performed for all excisions of image-detected abnormalities to document success of the procedure in excising the target

CLINICAL RECOMMENDATION STATEMENTS:

Specimen radiography or specimen ultrasonography should be routinely performed for all excisions of image-detected abnormalities to help document the success of the procedure in finding the target. Specimen radiography should use two 90-degree orthogonal views. (The American Society of Breast Surgeons, 2001)

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✿ Measure #263: Preoperative Diagnosis of Breast Cancer

2013 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
The percent of patients undergoing breast cancer operations who obtained the diagnosis of breast cancer preoperatively by a minimally invasive biopsy method

INSTRUCTIONS:
This measure is to be reported each time a patient aged 18 and older undergoes a breast cancer operation. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

Measure Reporting via Claims:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. G-codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed ICD-9-CM diagnosis codes, CPT codes, and the appropriate G-code. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
The number of patients aged 18 years and older on date of encounter undergoing breast cancer operations

> Denominator Criteria (Eligible Cases):
> Patients aged 18 and older on date of encounter
> AND
> Diagnosis for Female/Male Breast Cancer (ICD-9-CM): 174.0, 174.1, 174.2, 174.3, 174.4, 174.5, 174.6, 174.8, 174.9, 175.0, 175.9, 198.81
> Diagnosis for Female/Male Breast Cancer (ICD-10-CM) [REFERENCE ONLY/Not Reportable]: C50.011, C50.012, C50.019, C50.02, C50.021, C50.022, C50.029, C50.111, C50.112, C50.119, C50.121, C50.122, C50.129, C50.211, C50.212, C50.219, C50.221, C50.222, C50.229, C50.311, C50.312, C50.319, C50.321, C50.322, C50.329, C50.411, C50.412, C50.419, C50.421, C50.422, C50.429, C50.511, C50.512, C50.519, C50.521, C50.522, C50.529, C50.611, C50.612, C50.619, C50.621, C50.622, C50.629, C50.811, C50.812, C50.819, C50.821, C50.822, C50.829, C50.911, C50.912, C50.919, C50.921, C50.922, C50.929, C79.81
> AND
> Patient encounter during the reporting period (CPT): 19301, 19302, 19303, 19307

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NUMERATOR:
The number of patients aged 18 and older undergoing breast cancer operations who had breast cancer diagnosed preoperatively by a minimally invasive biopsy

Definition:
Minimally invasive biopsy methods: Includes fine needle aspiration, percutaneous core needle biopsy, percutaneous automated vacuum assisted rotating biopsy device, skin biopsy, skin shave or punch biopsy

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Breast Cancer Preoperatively Diagnosed by a Minimally Invasive Biopsy Method
G8875: Clinician diagnosed breast cancer preoperatively by a minimally invasive biopsy method

OR

Clinician Determination that a Minimally Invasive Biopsy Method was not Indicated in this Instance, Patient not Eligible
G8876: Documentation of reason(s) for not performing minimally invasive biopsy to diagnose breast cancer preoperatively (e.g., Clinical and imaging findings consistent with a benign lesion, lesion too close to skin, implant, chest wall, etc., lesion could not be adequately visualized for needle biopsy, patient condition prevents needle biopsy [weight, breast thickness, etc.], duct excision without imaging abnormality, prophylactic mastectomy, reduction mammoplasty, excisional biopsy performed by another physician)
OR
Minimally Invasive Biopsy Method was attempted but was not diagnostic of Breast Cancer
G8946: Minimally Invasive Biopsy Method attempted but not diagnostic of Breast Cancer (e.g., High Risk Lesion of Breast such as atypical ductal hyperplasia, lobular neoplasia, atypical lobular hyperplasia, lobular carcinoma in situ, atypical columnar hyperplasica, flat epithelial atypia, radial scar, complex sclerosing lesion, papillary lesion, or any lesion with spindle cells)

OR

Breast Cancer not Preoperatively Diagnosed by a Minimally Invasive Biopsy Method, Reason not Given
G8877: Clinician did not attempt to achieve the diagnosis of breast cancer preoperatively by a minimally invasive biopsy method, reason not given

RATIONALE:
The preoperative diagnosis of breast cancer by minimally invasive methods is recommended by the American Society of Breast Surgeons, the National Comprehensive Cancer Network, the European Society of Breast Cancer Specialists, the American College of Radiology, a recent consensus conference on image detected breast cancer, and a panel of experts who conducted a comparative effectiveness study of needle biopsy compared to open biopsy that was funded by Agency for Healthcare Research and Quality (AHRQ).

The policy of attempting to diagnose breast cancer by needle techniques has also been incorporated into quality measurement programs developed by the American Society of Breast Surgeons and the National Consortium of Breast Centers. (The American Society of Breast Surgeons, 2006)

The advantages of preoperative cancer diagnosis by minimally invasive method include the patient centered measures of a smaller scar, good cosmesis, timeliness, and good pain control. Other advantages include a greater likelihood of achieving negative lumpectomy surgical margins and allowing concurrent scheduling of axillary lymph node surgery, reducing the number of operations required to treat breast cancer.

CLINICAL RECOMMENDATION STATEMENTS:
A major goal of modern breast medicine is to minimize the number of patients with benign lesions who undergo open surgical breast biopsies for diagnosis. Image guided percutaneous needle biopsy is the diagnostic procedure of

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choice for image-detected breast abnormalities. Patients with a clearly palpable breast mass should also have a minimally invasive percutaneous biopsy with or without image guidance depending on the size of the mass. (The American Society of Breast Surgeons, 2006) It is not possible to achieve a 100% success rate for the diagnosis of breast cancer by a minimally invasive technique due to some technical issues described above or sampling issues with high risk lesions of the breast.

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✿ Measure #264: Sentinel Lymph Node Biopsy for Invasive Breast Cancer

2013 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
The percentage of clinically node negative (clinical stage T1N0M0 or T2N0M0) breast cancer patients who undergo a sentinel lymph node (SLN) procedure

INSTRUCTIONS:
This measure is to be reported each time a procedure is performed during the reporting period for patients age 18 years and older who are operated upon for invasive breast cancer that are clinically node negative (clinical stage T1N0M0 or T2N0M0). This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
Patients aged 18 and older with primary invasive breast cancer

Denominator Criteria (Eligible Cases):
Patients aged 18 and older at date of encounter
AND
Diagnosis for Female/Male Breast Cancer (ICD-9-CM): 174.0, 174.1, 174.2, 174.3, 174.4, 174.5, 174.6, 174.8, 174.9, 175.0, 175.9
Diagnosis for Female/Male Breast Cancer (ICD-10-CM) [REFERENCE ONLY/Not Reportable]: C50.011, C50.012, C50.019, C50.02, C50.021, C50.022, C50.029, C50.111, C50.112, C50.119, C50.121, C50.122, C50.129, C50.211, C50.212, C50.219, C50.221, C50.222, C50.229, C50.311, C50.312, C50.319, C50.321, C50.322, C50.329, C50.411, C50.412, C50.419, C50.421, C50.422, C50.429, C50.511, C50.512, C50.519, C50.521, C50.522, C50.529, C50.611, C50.612, C50.619, C50.621, C50.622, C50.629, C50.811, C50.812, C50.819, C50.821, C50.822, C50.829, C50.911, C50.912, C50.919, C50.921, C50.922, C50.929
AND
Patient encounter during the reporting period (CPT): 19301, 19302, 19307, 38500, 38510, 38520, 38525, 38530, 38542, 38740, 38745, 38900
AND
Clinically Node Negative (T1N0M0 or T2N0M0) Invasive Breast Cancer: G8879

NUMERATOR:
Patients who undergo a SLN procedure

Numerator Options:
Sentinel lymph node biopsy procedure performed (G8878)
OR

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Documentation of reason(s) sentinel lymph node biopsy not performed (e.g., cancer diagnosed at prophylactic mastectomy, non-invasive cancer, incidental discovery of breast cancer on prophylactic mastectomy, incidental discovery of breast cancer on reduction mammoplasty. Biopsy proven lymph node (LN) metastases [e.g., pre-op FNA or core biopsy, inflammatory carcinoma, recurrent invasive breast cancer] patient refusal after informed consent) (G8880)

OR

Sentinel lymph node biopsy procedure not performed (G8882)

RATIONALE:

A sentinel lymph node (SLN) procedure is defined as a method of axillary or other regional lymph node assessment that requires either a radioisotope and/or blue dye injection in the breast with subsequent identification of radioactive or blue stained node(s) in the axilla or other lymph node basin. There is level one evidence that breast cancer SLN biopsy is as accurate as axillary dissection for breast cancer staging and is associated with less morbidity than routine axillary dissection.

CLINICAL RECOMMENDATION STATEMENTS:

The current body of reported surgical experience shows that SLN biopsy is suitable for virtually all clinically node-negative T1-2 invasive breast cancers. (The American Society of Breast Surgeons, 2010)

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★Measure #265 (NQF 0645): Biopsy Follow-Up

2013 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Percentage of new patients whose biopsy results have been reviewed and communicated to the primary care/referring physician and patient by the performing physician

INSTRUCTIONS:
This measure is to be reported once per reporting period for patients who are seen for an office visit and have a biopsy performed during the reporting period. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

> *Note: While this measure is only required to be reported once per eligible patient per reporting period, it is recommended that the eligible professional performing the biopsy communicates the results to the primary care/referring physician and patient each time a biopsy is done.*

Measure Reporting via Registry:
CPT codes and demographics codes are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data. The listed denominator options are the codes used in practice for various biopsies.

DENOMINATOR:
All patients undergoing a biopsy

> Denominator Criteria (Eligible Cases):
> All patients regardless of age on date of encounter
> AND
> Patient procedure during the reporting period (CPT): 11100, 11755, 19100, 19101, 19102, 19103, 19125, 20200, 20205, 20206, 20220, 20225, 20240, 20245, 20250, 20251, 21550, 21920, 21925, 23065, 23066, 23100, 23101, 24065, 24066, 24100, 24101, 25065, 25066, 25100, 25101, 26100, 26105, 26110, 27040, 27041, 27050, 27052, 27323, 27324, 27330, 27331, 27613, 27614, 27620, 28050, 28052, 28054, 30100, 31050, 31051, 31237, 31510, 31576, 31625, 31628, 31629, 31717, 32100, 32400, 32405, 37200, 37609, 38221, 38500, 38505, 38510, 38520, 38525, 38530, 38570, 38572, 39400, 40490, 40808, 41100, 41108, 42100, 42400, 42405, 42800, 42802, 42804, 42806, 43202, 43239, 43261, 43605, 44010, 44020, 44025, 44100, 44322, 44361, 44377, 44382, 44389, 45100, 45305, 45331, 45380, 45392, 46606, 47000, 47001, 47100, 47553, 47561, 48100, 48102, 49000, 49010, 49180, 50200, 50205, 50555, 50557, 50574, 50576, 50955, 50957, 50974, 50976, 52007, 52204, 52224, 52250, 52354, 53200, 54100, 54105, 54500, 54505, 54800, 54865, 55700, 55705, 55706, 56605, 56821, 57100, 57105, 57421, 57454, 57455, 57460, 57500, 57520, 58100, 58558, 58900, 59015, 60540, 60545, 61140, 61575, 61576, 61750, 61751, 62269, 63275, 63276, 63277, 63278, 63280, 63281, 63282, 63283, 63285, 63286, 63287, 63290, 63615, 64795, 65410, 67346, 67400, 67415, 67450, 67810, 68100, 68510, 68525, 69100, 69105, 75970, 89290, 89291, 93505
> AND
> Patient encounter during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205

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NUMERATOR:
Patients whose biopsy results have been reviewed and communicated to the primary care/referring physician and the patient by the physician performing the biopsy. The physician performing the biopsy must also acknowledge and/or document the communication in a biopsy tracking log and document in the patient's medical record.

Numerator Instructions: To satisfy this measure, the biopsying physician must:

- Review the biopsy results with the patient
- Communicate those results to the primary care/referring physician
- Track communication in a log
- Document tracking process in the patient's medical record

Definition:
The components of a tracking log incorporate the following:

- Initials of physician performing the biopsy
- Patient name
- Date of biopsy
- Type of biopsy
- Biopsy result
- Date of biopsy result

Numerator Options:
Biopsy Results Reviewed and Communicated to the Patient and the Patient's Primary Care/Referring Physician, Communication Tracked in a Log, and Tracking Process Documented in the Patient's Medical Record.
Biopsy results reviewed, communicated, tracked, and documented (G8883)

OR

Documentation of Patient OR System Reason(s) for not Performing up to Three of the Four Components of the Numerator Instructions: Reviewing, Communicating, Tracking, and/or Documenting Biopsy Results, Patient not Eligible
Clinician documented reason that patient's biopsy results were not reviewed, [e.g., patient asks that biopsy results not be communicated to the primary care/referring physician, patient does not have a primary care/referring physician or is a self-referred patient] (G8884)

OR

Biopsy Results not Reviewed, not Communicated to the Patient and the Patient's Primary Care/Referring Physician, Communication not Tracked in a Log, and/or Tracking Process not Documented in the Patient's Medical Record.
Biopsy results not reviewed, communicated, tracked, or documented (G8885)

RATIONALE:
The purpose of this measure is to ensure that biopsy results with potentially serious consequences for patient care are not lost or ignored. Large health plan/delivery systems have identified a prominent quality of care issue as involving missing or overlooked biopsy pathology reports. All biopsy results should be accounted for and the results communicated to the patient or patient's guardian/caregiver and to the patient's primary care physician and/or other physician/professional responsible for follow-up care. Failure of the medical team to take appropriate action based on the result of a biopsy may lead to significant delays in obtaining appropriate treatment with subsequent poor outcomes, complications and even death. This measure will facilitate physician quality assurance that all biopsies are read, recorded and the results communicated.

CLINICAL RECOMMENDATION STATEMENTS:

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The measure does not directly address that follow-up care has been concluded, but rather addresses the critical first step in the treatment chain. Appropriate follow-up care must be specifically tailored to each clinical diagnosis. Biopsy results are not only essential to making a final diagnosis, but they are also essential to disease staging and treatment planning. The patient needs to be informed of the biopsy results so they can not only be completely aware of their condition, but also so they can make informed decisions about their care and treatment.

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♮ Measure #266: Epilepsy: Seizure Type(s) and Current Seizure Frequency(ies)

2013 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of patient visits with a diagnosis of epilepsy who had the type(s) of seizure(s) and current seizure frequency(ies) for each seizure type documented in the medical record

INSTRUCTIONS:
This measure is to be reported at **all visits** for patients with a diagnosis of epilepsy during the reporting period. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

Measure Reporting via Claims:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. CPT Category II codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed ICD-9-CM diagnosis codes, CPT codes, and the appropriate CPT Category II code OR the CPT Category II code with the modifier. The modifiers allowed for this measure are: 1P- medical reasons, 2P- patient reasons, 8P- reason not otherwise specified. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All visits for patients with a diagnosis of epilepsy

> Denominator Criteria (Eligible Cases):
> Diagnosis for Epilepsy (ICD-9-CM): 345.00, 345.01, 345.10, 345.11, 345.40, 345.41, 345.50, 345.51, 345.60, 345.61, 345.70, 345.71, 345.90, 345.91
> Diagnosis for Epilepsy (ICD-10-CM) [REFERENCE ONLY/Not Reportable]: G40.001, G40.009, G40.011, G40.019, G40.101, G40.109, G40.111, G40.119, G40.201, G40.209, G40.211, G40.219, G40.309, G40.311, G40.401, G40.409, G40.411, G40.419, G40.901, G40.909, G40.911, G40.919
> AND
> Patient encounter during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309

NUMERATOR:
Patient visits with seizure type(s) specified and current seizure frequency(ies) for each seizure type documented in the medical record

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Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Seizure type(s) and Current Seizure Frequency(ies) Documented
CPT II 1200F: Seizure type(s) and current seizure frequency(ies) documented

OR

Seizure type(s) and Current Seizure Frequency(ies) not Documented for Medical or Patient Reasons
Append a modifier (1P or 2P) to Category II code 1200F to report documented circumstances that appropriately exclude patients from the denominator.
1200F *with* 1P: Documentation of medical reason(s) for not documenting seizure type(s) and current seizure frequency(ies) (eg, patient is unable to communicate and no informant is available)
1200F *with* 2P: Documentation of patient reason(s) for not documenting seizure type(s) and current seizure frequency(ies) (eg, patient and/or informant refuses to answer or comply) for not documenting seizure type(s) and current seizure frequency for each seizure type

OR

Seizure type(s) and Current Seizure Frequency not Documented, Reason not Otherwise Specified
Append a reporting modifier (8P) to CPT Category II code 1200F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.
1200F *with* 8P: Seizure type(s) and current seizure frequency was not documented, reason not otherwise specified

RATIONALE:
Seizures are divided into generalized and partial (or focal) types based on whether they begin throughout the brain simultaneously or in one focal region (Dreifuss et al 1981). The main objective in treating epilepsy is to reduce the frequency of seizures and eventually achieve seizure freedom without medication side effects. In order to know that a treatment is effective, the patient's seizure frequency must be known before an intervention is begun so it can be compared to the seizure frequency determined during follow-up visits after an intervention is instituted. Antiepileptic drugs reduce the frequency of seizures in controlled clinical trials. Seizure freedom is associated with improvement in health-related quality of life, for example after epilepsy surgery. Therefore, accurate assessment of seizure frequency is necessary to provide most forms of care for epilepsy.

CLINICAL RECOMMENDATION STATEMENTS:
Detailed history of the attack should be obtained from the person who had the attack symptoms and from eyewitness(es) to the attack. (Level B) NICE (Oct. 2004)

The seizure type(s) and epilepsy syndrome should be identified. (Level C) SIGN (April 2003)

When a patient with epilepsy receives follow-up care, then an estimate of the number of seizures since the last visit and assessment of drug side-effects should be documented. (Level D 1+/ Primary) (Pugh, 2007)
IF a patient is thought to have a diagnosis of epilepsy THEN the diagnosis should include a best estimation of seizure types. (Level C 2+/Secondary) (Pugh, 2007)

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♮ Measure #267: Epilepsy: Documentation of Etiology of Epilepsy or Epilepsy Syndrome

2013 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
All visits for patients with a diagnosis of epilepsy who had their etiology of epilepsy or with epilepsy syndrome(s) reviewed and documented if known, or documented as unknown or cryptogenic

INSTRUCTIONS:
This measure is to be reported at **all visits** for patients with a diagnosis of epilepsy during the reporting period. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

Measure Reporting via Claims:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. CPT Category II codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed ICD-9-CM diagnosis codes, CPT codes, and the appropriate CPT Category II code OR the CPT Category II code **with** the modifier. The modifier allowed for this measure is: 8P- reason not otherwise specified. All measure-specific coding should be reported on the claim(s) representing the eligible encounter. There are no allowable performance exclusions for this measure.

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data. There are no allowable performance exclusions for this measure.

DENOMINATOR:
All visits for patients with a diagnosis of epilepsy

> Denominator Criteria (Eligible Cases):
> Diagnosis for Epilepsy (ICD-9-CM): 345.00, 345.01, 345.10, 345.11, 345.40, 345.41, 345.50, 345.51, 345.60, 345.61, 345.70, 345.71, 345.90, 345.91
> Diagnosis for Epilepsy (ICD-10-CM) [REFERENCE ONLY/Not Reportable]: G40.001, G40.009, G40.011, G40.019, G40.101, G40.109, G40.111, G40.119, G40.201, G40.209, G40.211, G40.219, G40.309, G40.311, G40.401, G40.409, G40.411, G40.419, G40.901, G40.909, G40.911, G40.919
> AND
> Patient encounter during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309

NUMERATOR:
Patient visits with documentation of etiology of epilepsy or with epilepsy syndrome(s) reviewed and documented if known, or documented as unknown or cryptogenic

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NUMERATOR NOTE: Report 1205F if documentation of etiology is known, unknown or cryptogenic.

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Etiology of Epilepsy or Epilepsy Syndrome(s) Reviewed and Documented
CPT II 1205F: Etiology of epilepsy or epilepsy syndrome(s) reviewed and documented

OR

Etiology of Epilepsy or Epilepsy Syndrome(s) not Reviewed and Documented, Reason not Otherwise Specified
Append a reporting modifier (8P) to CPT Category II code 1205F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.
1205F *with* 8P: Etiology of epilepsy or epilepsy syndrome(s) not reviewed and documented, reason not otherwise specified

RATIONALE:
The natural history, selection of treatment, expected response to treatment, and content of counseling are determined by the etiology of epilepsy or epilepsy syndrome (Commission on Classification 1989). Therefore, the etiology of epilepsy or epilepsy syndrome should be determined at the initial visit. Epilepsy is a chronic condition in which treatments must be instituted over long durations, such as achieving maximum tolerated doses of antiepileptic drugs. Since it is often a relatively long interval between starting an intervention and determining if it is effective, the etiology of epilepsy or syndrome should be reviewed at each visit to determine if an alternative therapy is warranted.

CLINICAL RECOMMENDATION STATEMENTS:
The seizure type(s) and epilepsy syndrome should be identified. (Level C) SIGN (April 2003)

Determine: seizure type(s), epilepsy syndrome, etiology and co-morbidity. (Level C) NICE (Oct. 2004)

If a patient is thought to have a diagnosis of epilepsy then the diagnosis should include a best estimation of seizure types. (Level C 2+/Secondary) (Pugh, 2007)

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♮ Measure #268: Epilepsy: Counseling for Women of Childbearing Potential with Epilepsy

2013 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
All female patients of childbearing potential (12-44 years old) diagnosed with epilepsy who were counseled about epilepsy and how its treatment may affect contraception and pregnancy at least once a year

INSTRUCTIONS:
This measure is to be reported at all visits for patients with a diagnosis of epilepsy during the reporting period. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

Measure Reporting via Claims:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. CPT Category II codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed ICD-9-CM diagnosis codes, CPT codes, and the appropriate CPT Category II code OR the CPT Category II code with the modifier. The modifiers allowed for this measure are: 1P- medical reasons, 8P- reason not otherwise specified. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All females of childbearing potential (12-44 years old) with a diagnosis of epilepsy

Denominator Criteria (Eligible Cases):
All females age 12-44 years old
AND
Diagnosis for Epilepsy (ICD-9-CM): 345.00, 345.01, 345.10, 345.11, 345.40, 345.41, 345.50, 345.51, 345.60, 345.61, 345.70, 345.71, 345.90, 345.91
Diagnosis for Epilepsy (ICD-10-CM) [REFERENCE ONLY/Not Reportable]: G40.001, G40.009, G40.011, G40.019, G40.101, G40.109, G40.111, G40.119, G40.201, G40.209, G40.211, G40.219, G40.309, G40.311, G40.401, G40.409, G40.411, G40.419, G40.901, G40.909, G40.911, G40.919
AND
Patient encounter during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309

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NUMERATOR:
Female patients counseled about epilepsy and how its treatment may affect contraception and pregnancy and documented in the medical record at least once a year

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Counseling for Women of Childbearing Potential with Epilepsy
CPT II 4340F: Counseling for women of childbearing potential with epilepsy

OR

Counseling for Women of Childbearing Potential with Epilepsy not Performed for Medical Reasons
Append a modifier (1P) to Category II code 4340F to report documented circumstances that appropriately exclude patients from the denominator.
4340F *with* 1P: Documentation of medical reason(s) why counseling was not performed for women of childbearing potential with epilepsy

OR

Counseling for Women of Childbearing Potential with Epilepsy not Performed, Reason not Otherwise Specified
Append a reporting modifier (8P) to CPT Category II code 4340F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.
4340F *with* 8P: Counseling about epilepsy specific safety issues provided to patient or caregiver was not performed, reason not otherwise specified

RATIONALE:
Epilepsy is associated with sexual dysfunction, reduced fertility, increased pregnancy risks, and risks for malformations in the infant. Seizures can transiently disrupt pituitary hormone secretion. Treatment of seizures with antiepileptic drugs may alter hormone levels, render oral contraceptives less effective and may interfere with embryonic and fetal development. Certain antiepileptic mediations may have specific malformation risks. Since unplanned pregnancy is common, patients need to be informed about the risks of epilepsy and antiepileptic drug therapy prior to pregnancy. Folic acid supplementation, monotherapy for epilepsy, using lower doses of medication when possible and proper obstetrical, prenatal and pre-pregnancy care should all be discussed with the patient so they understand the risks involved and how to mitigate these risks.

CLINICAL RECOMMENDATION STATEMENTS:
Women (and, if appropriate, their family and/or caregivers or others closely involved) should be given information about contraception, conception, pregnancy and breastfeeding. Information should be given in advance of sexual activity or pregnancy. (Level C) NICE 2004

IF a woman with epilepsy is of childbearing potential and receives oral contraceptives in conjunction with an enzyme inducing AED, THEN decreased effectiveness of oral contraception should be addressed. (higher doses of the oral contraceptive, alternative birth control methods, or change AED). (Level A 2++/Primary) (Pugh, 2007)

If AEDs are to be used in pregnancy the relative risks of seizures and fetal malformation should be discussed with the woman. (Level C) SIGN(April 2003)
Whenever possible, a woman should conceive on the lowest effective dose of one AED appropriate for her epilepsy syndrome. If she has good seizure control and presents already pregnant, there is probably little to be gained by altering her AEDs. (Level C) SIGN(April 2003)

Patients with epilepsy should receive an annual review of information including topics such as:

- Chronic effects of epilepsy and its treatment including drug side-effects, drug-drug interactions, effect on bone health

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- Contraception, family planning, and how pregnancy and menopause may affect seizures (EVIDENCE GRADE C)
- Screening for mood disorders
- Triggers and lifestyle issues that may affect seizures
- Impact of epilepsy on other chronic and acute diseases
- Driving and safety issues (Level D/Secondary) (Pugh, 2007)

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✤Measure #303: Cataracts: Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery

2013 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

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.

INSTRUCTIONS:
This measure is to be calculated when a procedure for cataracts is performed in the sample during the reporting period. This measure is intended to reflect the quality of services provided for the patient receiving cataract surgery.

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 before registries must submit data to CMS.*
- *It is the responsibility of a third party, which may be the registry or another third party designated by the eligible professional to administer, receive results, and review the surveys. Each registry must work directly with eligible professionals who wish to report these measures to determine who (a registry or another third party) will be administering, receiving and reviewing the surveys.*

Measure Reporting via Registry:
CPT codes and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data. There are no allowable performance exclusions for this measure.

DENOMINATOR:
All patients aged 18 years and older who had cataract surgery

Denominator Instructions: Clinicians who indicate modifier 56 (pre-operative management) or modifier 55 (post-operative management) only, will not qualify for this measure.

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Patient encounter during the reporting period (CPT): 66840, 66850, 66852, 66920, 66930, 66940, 66983, 66984

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

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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)

RATIONALE:

1. Scientific basis for measuring visual function outcomes after cataract surgery.

Visual function has been described as having multiple components, including central near, intermediate, and distance visual acuity; peripheral vision; visual search; binocular vision; depth perception; contrast sensitivity; perception of color; adaptation; and visual processing speed. Visual function also can be measured in terms of functional disability caused by visual impairment. Many activities are affected by more than one of these visual components.

Health services researchers have increasingly emphasized function and quality of life as the outcomes of treatment that are most critical and applicable to the patient. As previously stated, the primary purpose in managing a patient with cataract is to improve functional vision and the quality of life. In well-designed observational studies, cataract surgery consistently has been shown to have a significant impact on vision-dependent function. The Cataract Patient Outcomes Research Team (PORT) reported that 90% of patients under-going first-eye cataract surgery noted improvement in functional status and satisfaction with vision.

The Activities of Daily Vision Study of elderly patients with a high prevalence of coexisting ocular and medical diseases reported improved visual function in 80% of patients at 12 months after surgery. A National Cataract Study conducted in England of 1,139 patients who had cataract surgery found that preoperative functional impairment varied in relation to gender, age, and visual acuity. Men were more likely to have trouble with driving, glare, and employment, and women were more likely to have difficulties with activities of daily living and recreational activities. Studies have found that regardless of the preoperative visual acuity in the better eye, most patients reported improvement in their ability to perform visually dependent tasks after undergoing cataract surgery.

Several studies have reported an association between improved visual function after cataract surgery and improved health-related quality of life. Visual function plays an important role in physical function, particularly in terms of mobility. The loss of visual function in the elderly is associated with a decline in physical and mental functioning as well as in independence in activities of daily living, including night-time driving, daytime driving, community activities, and home activities. Elderly patients with visual impairment only (and no other physical or mental impairments) were 2.5 times as likely to experience functional decline than elderly patients without visual impairment.

Improved visual function following cataract surgery can ameliorate the progressive deterioration of quality of life seen in elderly patients. In a cohort of 464 patients 65 years old and older, cataract extraction improved visual function and health-related quality of life. Patients with an improvement in their Activities of Daily Vision Scale (ADVS), a brief measure of vision-specific functional status, had from 10% to 59% less decline in nearly all Short Form (SF)-36 dimensions. The SF-36 is a generic global measure of multidimensional health-related quality of life. A nationally representative population of 7,114 persons who were 70 years old and older showed that limitations in vision correlated with decreased functional status. The unadjusted functional score of a person with reported poor vision was four times worse than the score for a person with excellent vision. This difference was comparable with the differences found in other chronic conditions such as arthritis. This relationship with vision persisted, even after adjustment for health, demographics, and economic status. Individuals who rated their vision as other than excellent reported worse functional status, even when controlled for the presence of other medical conditions, education, income, general health status, and other symptoms. By improving visual function, cataract surgery may play an important role in preserving overall functional status, reducing associated injuries and accidents, and preventing

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disability in at-risk elderly patients.

An analysis of the Medical Outcomes Study found that having blurred vision more than once or twice a month has a significant impact on functional status and well-being, particularly on problems with work or other daily activities as a result of physical health. This impact was found to be greater than the impact of several other chronic conditions, such as hypertension, history of myocardial infarction, type 2 diabetes mellitus, indigestion, trouble urinating, and headache. In one study, patients planning to undergo cataract surgery assigned a mean preoperative preference value of 0.68 on a scale ranging from 0 to 1 (where 0 is death and 1 is excellent health), indicating that the visual impairment from cataracts had a substantial impact on their quality of life. Visual impairment is an important risk factor for falls and for hip fracture. Specifically, the Study for Osteoporotic Fractures Research Group found that poor depth perception and decreased contrast sensitivity independently increased the risk of hip fracture.

Visual impairment, in particular a decrease of visual acuity and contrast sensitivity, has been shown to be associated with difficulties in driving. In one study, older drivers with visually significant cataract were twice as likely as older drivers without cataract to report reduction in days driven and four times as likely to report difficulties in challenging driving situations. Drivers with visually significant cataract were 2.5 times more likely to have had an at-fault involvement in a motor vehicle crash in the past 5 years compared with drivers without cataract. This association was significant, even after accounting for other factors such as impaired general health, age, mental status deficit or depression. In this study, visually significant cataract was determined by reviewing the participant's medical record and most recent eye examination by an eye care specialist. The study required that cataract in both eyes was the cause of the visual impairment, based on the medical record; an additional inclusion criterion was best-corrected visual acuity in one eye of 20/40 or worse. A further study in the same group demonstrated that drivers with a history of crash involvement were eight times more likely to have a serious contrast sensitivity deficit (defined as a Pelli-Robson score of 1.25 or less) in the worse eye than those who had no history of crash involvement. A severe contrast sensitivity deficit in only one eye was still significantly associated with crash involvement.

Binocular vision is better than the vision of a single eye. The simultaneous use of the two eyes is complex and requires the integration of disparate images from each eye. A study demonstrated that binocular vision resulted in better perception of form, color, and the relationship of the body to the environment, which facilitated manipulation, reaching, and balance, particularly under dim illumination. However, if the vision of one eye is reduced due to cataract, visual performance can fall below the level of monocular vision by a mechanism known as binocular inhibition, which reduces patients' visual acuity and contrast sensitivity. A study of the Framingham Study Cohort found that poor vision in one or both eyes was associated with an increased risk of hip fracture. It also found that patients with good vision in one eye and moderately impaired vision in the other eye had a higher risk of fracture than those with similar visual impairment in both eyes. A study of 150 patients before and after cataract surgery found that poor binocular visual acuity was related to more problems in activities of daily living. Another study, based on patients who reported no beneficial outcomes after first-eye cataract surgery in the National Swedish Cataract Outcome register, found that anisometropia was the reason for the poor outcome in one-third of cases. These studies have shown that second-eye surgery is important to visual and physical function.

In summary, these studies demonstrate that physical function, emotional well-being, and overall quality of life can be enhanced when visual function is restored by cataract extraction.

Improved visual function as a result of cataract surgery includes the following:

- Better optically corrected vision.
- Better uncorrected vision with reduced spectacle dependence.
- Increased ability to read or do near work.
- Reduced glare.
- Improved ability to function in dim levels of light.
- Improved depth perception and binocular vision.

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- Improved color vision.

Improved physical function as a critical outcome of cataract surgery includes the following:
- Increased ability to perform activities of daily living.
- Increased opportunity to continue or resume an occupation.
- Increased mobility (walking, driving).

Improved mental health and emotional well-being as a second critical outcome of cataract surgery includes the following benefits:
- Improved self-esteem and independence.
- Increased ability to avoid injury.
- Increased social contact and ability to participate in social activities.
- Relief from fear of blindness.

Most patients achieve improved visual function after cataract surgery. This outcome is achieved consistently through careful attention through the patient selection process, accurate measurement of axial length and corneal power, appropriate selection of an IOL power calculation formula, etc. As such, it reflects the care and diligence with which the surgery is assessed, planned and executed. Failure to achieve this after surgery would reflect patterns of patient selection or treatment that should be assessed for opportunities for improvement.

Sometimes cataract surgery is performed for other medical reasons other than to improve impaired visual function caused by cataract. These circumstances include the following: clinically significant anisometropia in the presence of a cataract; when the lens opacity interferes with optimal diagnosis or management of posterior segment conditions, when the lens causes inflammation (phacolysis, phacoanaphylaxis) and when the lens induces angle closure (phacomorphic or phacotopic). In these situations, improved visual function as a result of the removal of the cataract is not expected, because of the pre-existing comorbid conditions.

2. Evidence of a gap in care

This is an outcome of surgery indicator of direct relevance and import to patients, their families and referring providers. The available evidence suggests that cataract surgery achieves this in about 90% of patients. While the potential for improvement is seemingly small, the volume of cataract surgery in the U.S. of over 2.8 million surgeries means that the impact could affect more than 100,000 patients per year. Ideally, performance on this indicator would be as high as possible, with lower rates suggestive of opportunities for improvement.

3. Sampling strategy

The survey methodology is described as follows. The survey would be administered by a third party (a registry for reporting of PQRS measures) to prevent or minimize bias which might be introduced if it is an in-office paper survey with questions asked by the office staff. Options would be provided to the patient, either online survey, mail survey or phone survey, depending on their preferences and abilities. The survey would be of a sample of those individuals with cataract surgery. The sample size would be postulated at 20, because this is a well-accepted statistical sample and used by the CMS for reporting on measure groups in PQRS. Because visual function is reported at 90 days after surgery, this would allow physicians to identify 20 cases from January – September for reporting purposes.

4. Improvement in Visual Function

The strategy to identify improvement in visual function is as follows. The instrument proposed for visual function evaluation is the Rasch-scaled Short Version of the Visual Function-14, VF-8R. Reliability and validity testing have been performed on the VF-14 as well as the VF-8R. This instrument is scored on a scale of 0-100, with 0 indicating the lack of ability to perform functional activities and 100 indicating complete ability to perform functional activities. The difference between the pre-operative and post-operative scores on the VF-8R indicates a change in functional

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activities. Improvement in visual function would be defined as an increase in the visual function score between pre-operative and post-operative assessment on the VF-8R in the range of 5 points or greater.

CLINICAL RECOMMENDATION STATEMENTS:

This is an outcomes measure. As such, there are no recommendation statements in the guideline specific to this measurement topic.

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✤Measure #304: Cataracts: Patient Satisfaction within 90 Days Following Cataract Surgery

2013 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

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.

INSTRUCTIONS:
This measure is to be calculated when a procedure for cataracts is performed in the sample during the reporting period. This measure is intended to reflect the quality of services provided for the patient receiving cataract surgery.

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 before registries must submit data to CMS.*
- *It is the responsibility of a third party, which may be the registry or another third party designated by the eligible professional to administer, receive results, and review the surveys. Each registry must work directly with eligible professionals who wish to report these measures to determine who (a registry or another third party) will be administering, receiving and reviewing the surveys.*

Measure Reporting via Registry:
CPT codes and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data. There are no allowable performance exclusions for this measure.

DENOMINATOR:
All patients aged 18 years and older in the sample who had cataract surgery

Denominator Instructions: Clinicians who indicate modifier 56 (pre-operative management) or modifier 55 (post-operative management) only, will not qualify for this measure.

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Patient encounter during the reporting period (CPT): 66840, 66850, 66852, 66920, 66930, 66940, 66983, 66984

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

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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)

RATIONALE:

1. Scientific basis for measuring patient satisfaction after cataract surgery

Patient satisfaction is a valuable performance indicator for measuring the quality of care delivered by ophthalmologists providing cataract surgery. In the broadest sense, patient satisfaction is an assessment of the patient's experience with the care process delivered by health plans, clinicians, health systems, hospitals, etc. This experience can cover domains as diverse as information/education, interpersonal manner, emotional support, accessibility, convenience, outcomes or results, environment, personalization, involvement in care, finances, etc.

In 1996, The American Academy of Ophthalmology launched the National Eyecare Outcomes Network (NEON) database. From January 1, 1996 through March 30, 2001, 249 ophthalmologists at 114 different practice sites submitted data to the NEON cataract surgery database. Post-operative patient satisfaction responses were collected for 6,154 patients, or about 34.5% of all patients who had pre-operative forms submitted. This assessment was performed at a median of 4.1 weeks postoperatively for all patients enrolled in the database. A 12-item questionnaire was used to assess patient satisfaction. Patient satisfaction was associated with younger age and absence of ocular comorbidity.

Other studies of patient satisfaction after cataract surgery were conducted in Austria and in Spain. The Austrian study found that patients with pre-existing eye disease, including those patients with improved visual acuity after surgery, were the least satisfied with the results of surgery. In these cases, improved patient education prior to surgery could be helpful in improving patient satisfaction. The Spanish study found that patient satisfaction was associated with expectations prior to surgery.

Most patients are satisfied with their care and results after cataract surgery. This outcome is achieved consistently through careful attention through the patient selection process, accurate measurement of axial length and corneal power, appropriate selection of an IOL power calculation formula, etc. As such, it reflects the care and diligence with which the surgery is assessed, planned and executed. Failure to achieve this satisfaction after surgery would reflect patterns of patient selection or treatment that should be assessed for opportunities for improvement.

Use of this indicator in PQRS claims-based reporting method would require some modification to the current reporting of post-operative care for patients undergoing cataract surgery, since this indicator would be operative during the 90 day global period. However, there is a strong and practical precedent for such modifications in that reporting arrangements have previously been made to accommodate co-management of care by different providers during the post-operative period. A similar adjustment to allow for filing of a claim of meeting this goal at one point in the 90 day global period would be sufficient, potentially drawing upon the methods to demarcate the onset of co-management transfer of post-operative care.

Various patient satisfaction instruments exist, but an instrument developed by the program, Consumer Assessment of Healthcare Providers and Systems (CAHPS), Agency for Healthcare Research and Quality develops and supports the use of a comprehensive and evolving family of standardized surveys that ask consumers and patients to report on and evaluate their experiences with health care. These surveys cover topics that are important to consumers, such as the communication skills of providers and the accessibility of services. AHRQ first launched the CAHPS program in October 1995 in response to concerns about the lack of good information about the quality of health plans

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from the enrollees' perspective. At that time, numerous public and private organizations collected information on enrollee and patient satisfaction, but the surveys varied from sponsor to sponsor and often changed from year to year.

The CAHPS Surgical Care Survey asks adult patients to report on surgical care, surgeons, their staff, and anesthesiologists. It was developed by the American College of Surgeons and the Surgical Quality Alliance to assess patients' experiences before, during, and after surgery. In early 2010, the CAHPS Consortium voted to adopt the Surgical Care Survey as an official CAHPS survey. The Surgical Care Survey expands on the current CAHPS Clinician & Group Survey, which focuses on primary and specialty care, by incorporating domains that are relevant to surgical care, such as informed consent, anesthesia care, and post-operative follow-up. The survey is unique in that it assesses patients' experiences with surgical care in both the inpatient and outpatient settings by asking respondents about their care before, during, and after surgery

The main purpose of the CAHPS Surgical Care Survey is to address the need to assess and improve the experiences of surgical patients. Like other CAHPS surveys, this questionnaire focuses on aspects of surgical quality that are important to patients and for which patients are the best source of information. The survey results are expected to be useful to everyone with a need for information on the quality of surgeons and surgical care, including patients, practice groups, health plans, insurers, and specialty boards. Patients can use the information to help make better and more informed choices about their surgical care. Practices, health plans, and insurers can use the survey results for quality improvement initiatives and incentives. Specialty boards may use the survey for maintenance of certification.

The composite measures of surgical quality from the S-CAPHS that are most relevant and significant for this physician-level performance measure include:

- How well surgeon communicates with patients before surgery
- How well surgeon communicates with patients after surgery
- Rating of overall care from this surgeon

2. Evidence of a gap in care

This is an outcome of surgery indicator of direct relevance and importance to patients, their families and referring providers. The available evidence suggests that cataract surgery achieves this in about 90% of patients. While the potential for improvement appears seemingly small, the volume of cataract surgery in the U.S. of over 2.8 million surgeries means that the impact could affect more than 100,000 patients per year. Ideally performance on this indicator should be as high as possible, with rates lower than 95-100% suggestive of opportunities for improvement.

3. Sampling strategy

The survey methodology is described as follows. The survey would be administered by a third party (a registry for reporting of PQRS measures) to prevent or minimize bias which might be introduced if it is an in office paper survey with questions asked by the office staff. Options would be provided to the patient, either online survey, mail survey or phone survey, depending on their preferences and abilities. The survey would be of a sample of those individuals with cataract surgery. The sample size would be postulated at 20, because this is a well-accepted statistical sample and used by the CMS for reporting on measure groups in PQRS. Because patient satisfaction is reported at 90 days after surgery, this would allow physicians to identify 20 cases from January – August for reporting purposes.

4. Definition of Patient Satisfaction

The strategy for defining patient satisfaction is described as follows. CAHPS scores are actually normative scores, that is, they provide relative rankings rather than absolute rankings (where a score is compared with an 'objective criterion'). Patient satisfaction would be defined as a score above the lowest 5% of scores on the CAHPS.

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CLINICAL RECOMMENDATION STATEMENTS:

This is an outcomes measure. As such, there are no recommendation statements in the guideline specific to this measurement topic.

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♠ Measure #317: Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented

2013 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of patients aged 18 years and older seen during the reporting period who were screened for high blood pressure (BP) AND a recommended follow-up plan is documented based on the current blood pressure reading as indicated

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for patients seen during the reporting period. Providers who report the measure must perform the blood pressure screening at the time of a qualifying visit by an eligible professional and may not obtain measurements from external sources. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding. The documented follow up plan must be related to the current BP reading as indicated, example: "Patient referred to primary care provider for BP management."

Measure Reporting via Claims:
CPT or HCPCS codes and patient demographics are used to identify patients who are included in the measure's denominator. G-codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed CPT or HCPCS codes, and the appropriate G-code. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
CPT or HCPCS codes and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
Percentage of patients aged 18 years and older on date of encounter

> Denominator Criteria (Eligible Cases):
> Patients aged ≥ 18 years
> AND
> Patient encounter during the reporting period (CPT or HCPCS): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99218, 99219, 99220, 99224, 99225, 99226, 99234, 99235, 99236, 99281, 99282, 99283, 99284, 99285, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99318, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99340, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, G0101, G0402, G0438, G0439

NUMERATOR:
Patients who were screened for high blood pressure and a recommended follow-up plan is documented as indicated if the blood pressure is pre-hypertensive or hypertensive

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NUMERATOR NOTE: Although recommended screening interval for a normal BP reading is every 2 years, to meet the intent of this measure, a BP screening must be performed once per measurement period. The intent of this measure is to screen patients for high blood pressure and provide recommended follow-up as indicated.

Definitions:
BP Classification - BP is defined by four BP reading classifications as listed in the "Recommended Blood Pressure Follow-Up" table below including Normal, Pre-Hypertensive, First Hypertensive, and Second Hypertensive Readings.
Recommended BP Follow-Up - The current *Report of the Joint National Committee on the Prevention, Detection, Evaluation, and Treatment of High Blood Pressure* (JNC) recommends BP screening intervals, lifestyle modifications and interventions based on BP Classification of the current BP reading as listed in the "Recommended Blood Pressure Follow-Up" table below.
Lifestyle Modifications - The current JNC report outlines lifestyle modifications which must include one or more of the following as indicated: Weight Reduction, Dietary Approaches to Stop Hypertension (DASH) Eating Plan, Dietary Sodium Restriction, Increased Physical Activity, or Moderation in Alcohol Consumption.
Second Hypertensive Reading - Requires both a BP reading of Systolic BP ≥ 140 mmHg OR Diastolic BP ≥ 90 mmHg during the current encounter AND a most recent BP reading within the last 12 months Systolic BP ≥ 140 mmHg OR Diastolic BP ≥ 90 mmHg.
Second Hypertensive Reading Interventions - The current JNC report outlines interventions based on BP Readings shown in the "Recommended Blood Pressure Follow-Up" table and must include one or more of the following as indicated: Anti-Hypertensive Pharmacologic Therapy, Laboratory Tests, or Electrocardiogram (ECG).

Recommended Blood Pressure Follow-Up Table

BP Classification	Systolic BP mmHg	Diastolic BP mmHg	Recommended Follow-Up *(must include all indicated actions for each BP Classification)*
Normal BP Reading	< 120	AND < 80	• No Follow-Up required
Pre-Hypertensive BP Reading	≥ 120 AND ≤ 139	OR ≥ 80 AND ≤ 89	• Rescreen BP within a minimum of 1 year *AND* Recommend Lifestyle Modifications OR • Referral to Alternative/Primary Care Provider
First Hypertensive BP Reading	≥ 140	OR ≥ 90	• Rescreen BP within a minimum of ≥ 1 day and ≤ 4 weeks *AND* Recommend Lifestyle Modifications OR • Referral to Alternative/Primary Care Provider
Second Hypertensive BP Reading	≥ 140	OR ≥ 90	• Recommend Lifestyle Modifications *AND* 1 or more of the Second Hypertensive Reading Interventions (see definitions) OR • Referral to Alternative/Primary Care Provider

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Not Eligible – A patient is not eligible if one or more of the following reasons exist:

- Patient has an active diagnosis of hypertension
- Patient refuses BP 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. This may include but is not limited to severely elevated BP when immediate medical treatment is indicated

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Normal Blood Pressure Reading Documented, Follow-Up not Required
G8783: Normal blood pressure reading documented, follow-up not required
OR
Pre-Hypertensive or Hypertensive Blood Pressure Reading Documented, Indicated Follow-Up Documented
G8950: Pre-hypertensive or Hypertensive blood pressure reading documented, indicated follow-up documented

OR

Blood Pressure Reading not Documented, Patient not Eligible/not Appropriate
G8784: Blood pressure reading not documented, patient not eligible/not appropriate
OR
Pre-Hypertensive or Hypertensive Blood Pressure Reading Documented, Indicated Follow-Up not Documented, Patient not Eligible/not Appropriate
G8951: Pre-Hypertensive or Hypertensive blood pressure reading documented, indicated follow-up not documented, patient not eligible/not appropriate

OR

Blood Pressure Reading not Documented, Reason not Given
G8785: Blood pressure reading not documented, reason not given
OR
Pre-Hypertensive or Hypertensive Blood Pressure Reading Documented, Indicated Follow-Up not Documented, Reason not Given
G8952: Pre-Hypertensive or Hypertensive blood pressure reading documented, indicated follow-up not documented, reason not given

RATIONALE:
This measure assesses the percentage of patients aged 18 and older without known hypertension who were screened for high blood pressure. Hypertension is a prevalent condition that contributes to important adverse health outcomes, including premature death, heart attack, renal insufficiency and stroke. The United States Preventive Services Task Force (USPSTF, 2007) found good evidence that blood pressure measurement can indentify adults at increased risk for cardiovascular disease from high blood pressure. The relationship between systolic blood pressure and diastolic blood pressure and cardiovascular risk is continuous and graded. The actual level of blood pressure elevation should not be the sole factor in determining treatment. Clinicians should consider the patient's overall cardiovascular risk profile, including smoking, diabetes, abnormal blood lipid values, age, sex, sedentary lifestyle, and obesity, when making treatment decisions. The seventh report of the Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure (JNC 7) recommends screening every 2 years for patients with blood pressure less than 120/80 mmHg and every year for patients with systolic blood pressure of 120 to 139 mmHg or diastolic blood pressure of 80 to 90 mmHg.

Appropriate follow-up after blood pressure measurement is a pivotal component in preventing the progression of hypertension and the development of heart disease. Detection of marginally or fully elevated blood pressure by a specialty clinician warrants referral to a provider familiar with the management of hypertension and prehypertension. Lifestyle modifications have demonstrated effectiveness in lowering blood pressure (JNC 7, 2003). The synergistic

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effect of several lifestyle modifications results in greater benefits than a single modification alone. Baseline diagnostic/laboratory testing establishes if a co-existing underlying condition is the etiology of hypertension and evaluates if end organ damage from hypertension has already occurred. Landmark trials such as ALLHAT have repeatedly proven the efficacy of pharmacologic therapy to control blood pressure and reduce the complications of hypertension. Follow-up intervals based on blood pressure control have been established by the JNC 7 and the USPSTF.

CLINICAL RECOMMENDATION STATEMENTS:

The U.S. Preventive Services Task Force (USPSTF) recommends screening for high blood pressure in adults age 18 years and older. This is a grade A recommendation.

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♣Measure #320 (NQF 0658): Endoscopy/Polyp Surveillance: Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients

2013 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of patients aged 50 years and older receiving a screening colonoscopy without biopsy or polypectomy who had a recommended follow-up interval of at least 10 years for repeat colonoscopy documented in their colonoscopy report

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for patients seen during the reporting period. There is no diagnosis associated with this measure. Performance for this measure is not limited to the reporting period. This measure may be reported by clinicians who perform the quality actions described in the measure based on services provided and the measure-specific denominator coding. Patients who have a coded colonoscopy procedure that has a modifier 52, 53, 73, or 74 will not qualify for inclusion into the measure.

Measure Reporting via Claims:
CPT or HCPCS codes and patient demographics are used to identify patients who are included in the measure's denominator. CPT Category II codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed CPT code and the appropriate CPT Category II code OR the CPT Category II code with the modifier. The modifiers allowed for this measure are: 1P- medical reasons, 8P- reason not otherwise specified. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
CPT or HCPCS codes and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All patients aged 50 years and older and receiving a screening colonoscopy without biopsy or polypectomy

> Denominator Instructions: Clinicians who indicate that the colonoscopy procedure is incomplete or was discontinued should use the procedure number and the addition (as appropriate) of modifier 52, 53, 73, or 74. Patients who have a coded colonoscopy procedure that has a modifier 52, 53, 73, or 74 will not qualify for inclusion into this measure.
>
> Denominator Criteria (Eligible Cases):
> Patients aged ≥ 50 on date of encounter
> AND
> Patient encounter during the reporting period (CPT or HCPCS): 45378, G0121
> *WITHOUT*
> CPT Category I Modifiers: 52, 53, 73, 74

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NUMERATOR:
Patients who had recommended follow-up interval of at least 10 years for repeat colonoscopy documented in their colonoscopy report

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
At Least 10 Year Follow-Up Interval for Colonoscopy Recommended
CPT II 0528F: Recommended follow-up interval for repeat colonoscopy of at least 10 years documented in colonoscopy report

OR

At Least 10 Year Follow-Up Interval for Colonoscopy not Recommended for Medical Reasons
Append a modifier (1P) to CPT Category II code 0528F to report documented circumstances that appropriately exclude patients from the denominator.
0528F *with* 1P: Documentation of medical reason(s) for not recommending at least a 10 year follow-up interval (eg, above average risk patient, inadequate prep)

OR

At Least 10 Year Follow-Up Interval for Colonoscopy not Recommended, Reason not Otherwise Specified
Append a reporting modifier (8P) to CPT Category II code 0528F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.
0528F *with* 8P: At least 10 year follow-up interval for colonoscopy not recommended, reason not otherwise specified

RATIONALE:
Guideline recommendations support screening colonoscopy at 10 year intervals, for average risk patients. Non-adherence to guideline recommendations increases patients to unnecessary risk via procedural harms and complications. Colonoscopy screening at more frequent intervals also contributes to increased costs to patients and insurers.

CLINICAL RECOMMENDATION STATEMENTS:
At present, CSPY (colonoscopy) every 10 years is an acceptable option for CRC screening in average-risk adults beginning at age 50 years. (ACS/USMSTF/ACR 2008)

The preferred CRC prevention test is colonoscopy every 10 years, beginning at age 50. (Grade 1B) (Rex, et al, 2009)

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Φ Measure #321 (NQF 0493): Participation by a Hospital, Physician, or Other Clinician in a Systematic Clinical Database Registry that Includes Consensus Endorsed Quality Measures

2013 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Participation in a systematic qualified clinical database registry involves:

a. Physician or other clinician submits standardized data elements to registry
b. Data elements are applicable to consensus endorsed quality measures
c. Registry measures shall include at least two (2) representative NQF consensus endorsed measures for registry's clinical topic(s) and report on all patients eligible for the selected measures
d. Registry provides calculated measures results, benchmarking, and quality improvement information to individual physicians and clinicians
e. Registry must receive data from more than 5 separate practices and may not be located (warehoused) at an individual group's practice. Participation in a national or state-wide registry is encouraged for this measure
f. Registry may provide feedback directly to the provider's local registry if one exists

INSTRUCTIONS:
This measure is to be reported once per patient seen during the reporting period, with no penalty for over reporting. There is no diagnosis associated with this measure. This measure may be reported by clinicians who are participating in a systematic clinical database registry that includes consensus endorsed quality.

Measure Reporting via Claims:
CPT or HCPCS codes are used to identify patients who are included in the measure's denominator. G-codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed CPT or HCPCS codes, and the appropriate numerator G-code. There are no allowable performance exclusions for this measure. All measure-specific coding should be reported on the claim(s) representing the eligible encounter. If no G-code is reported, this will count as a performance and reporting failure.

Measure Reporting via Registry:
CPT or HCPCS codes are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data. There are no allowable performance exclusions for this measure.

DENOMINATOR:
All patient encounters

Denominator Criteria (Eligible Cases):
Patient encounter during the reporting period (CPT or HCPCS): 90791, 90792, 90832, 90834, 90837, 90839, 92002, 92004, 92012, 92014, 92506, 92507, 92508, 92526, 92541, 92542, 92543, 92544, 92548, 92552, 92553, 92555, 92557, 92561, 92562, 92563, 92564, 92565, 92567, 92568, 92570, 92571, 92572, 92575, 92576, 92577, 92579, 92582, 92584, 92585, 92586, 92587, 92588, 92601, 92602, 92603, 92604,

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92610, 92611, 92612, 92620, 92621, 92625, 92626, 92627, 92640, 95920, 96150, 96151, 96152, 97001, 97002, 97003, 97004, 97532, 97750, 97802, 97803, 97804, 98940, 98941, 98942, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, D7140, D7210, G0101, G0108, G0109, G0270, G0271, G0402, G0438, G0439, G0442, G0443, G0445, G0446, G0447, G0448, G0449, G0450

NUMERATOR:

The clinician participates in a systematic qualified clinical database registry capable of the following:

a. Physician or other clinician submits standardized data elements to registry
b. Data elements are applicable to consensus endorsed quality measures.
c. Registry measures shall include at least two (2) representative NQF consensus endorsed measures for registry's clinical topic(s) and report on all patients eligible for the selected measures
d. Registry provides calculated measures results, benchmarking, and quality improvement information to individual physicians and clinicians
e. Registry must receive data from more than 5 separate practices and may not be located (warehoused) at an individual group's practice. Participation in a national or state-wide registry is encouraged for this measure
f. Registry may provide feedback directly to the provider's local registry if one exists

Definition:

Qualified Registry - Qualified is defined as receiving data from more than five hospitals and providing calculated measures, results, benchmarks, and quality improvement information to the participant (and to designated third parties).

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Clinician Reported Patient Data to Qualified Database Registry
G8954: Complete and appropriate patient data were reported to a qualified clinical database registry

RATIONALE:

Clinical database registries have been used in diverse settings to understand clinical practices, provide peer benchmarking and for quality improvement and improved treatment strategies (Adams et al., 2005; Bilimoria et al., 2008; Bufalino et al., 2011). Such registries can provide real-time and historical data (Herbert et al., 2004). These diverse databases can be triangulated with other data sources to link clinical practice data with long-term outcomes (Dokholyan et al., 2009). Statistical power and clinical relevancy of registries require that robust and diverse data are available (Fonarow, 2009). Numerous programs exist which serve as a benchmarking, quality of care/improvement, and in some cases outcomes data.

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Measure #322 (NQF 0670): Cardiac Stress Imaging Not Meeting Appropriate Use Criteria: Preoperative Evaluation in Low Risk Surgery Patients

2013 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Percentage of stress single-photon emission computed tomography (SPECT) myocardial perfusion imaging (MPI), stress echocardiogram (ECHO), cardiac computed tomography angiography (CCTA), or cardiac magnetic resonance (CMR) performed in low risk surgery patients 18 years or older for preoperative evaluation during the 12-month reporting period

INSTRUCTIONS:
This measure is to be reported once per procedure of cardiac stress imaging (i.e. SPECT, MPI, ECHO, CCTA, CMR) for patients seen during the reporting period. There is no diagnosis associated with this measure. It is anticipated that clinicians who provide the physician component of diagnostic imaging studies for cardiac stress will submit this measure.

Measure Reporting via Registry:
CPT codes and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data. There are no allowable performance exclusions for this measure.

DENOMINATOR:
All instances of stress single-photon emission computed tomography (SPECT) myocardial perfusion imaging (MPI), stress echocardiogram (ECHO), cardiac computed tomography angiography (CCTA), or cardiac magnetic resonance (CMR) performed on patients aged 18 years and older during the reporting period

> Denominator Criteria (Eligible Cases):
> Patients aged ≥ 18 years on date of encounter
> AND
> Cardiac Stress Imaging Performed – Procedure Codes (CPT): 75559, 75563, 75571, 75572, 75573, 75574, 78451, 78452, 78453, 78454, 78491, 78492, 78494, 93350, 93351

NUMERATOR:
Number of stress SPECT MPI, stress echo, CCTA, or CMR primarily performed in low risk surgery patients for preoperative evaluation within 30 days preceding low-risk non-cardiac surgery

> Definition:
> Low-Risk Surgery - cardiac death or MI less than 1% including, but are not limited to, endoscopic procedures, superficial procedures, cataract surgery, and excisional breast surgery.

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NUMERATOR NOTES:

- *For performance, a lower score indicates better performance. This measure is assessing overuse of cardiac stress imaging in low-risk surgery patients.*
- *Patients that did not have a surgery performed or had a surgery other than those defined as low-risk would report G8962.*
- *Clinical quality outcome is cardiac stress imaging NOT performed on patient who is a low risk surgery patient within 30 days preceding procedure.*

Numerator Options:

Cardiac Stress Imaging Test primarily performed on low-risk surgery patient for preoperative evaluation within 30 days preceding this surgery (G8961)

OR

Cardiac Stress Imaging Test performed on patient for any reason including those who did not have low-risk surgery or test that was performed more than 30 days preceding low-risk surgery (G8962)

RATIONALE:

Cardiac imaging is a mainstay in medical decision-making for patients with known or suspected heart disease. However, expenditures related to imaging comprise a significant portion of the health care budget. Much scrutiny has been focused on cardiovascular imaging with regard to the potential for overuse, especially in view of substantial geographic variation in ordering patterns and the limited amount of evidence-based data supporting the use of imaging as it relates to patient outcomes. Given the significant contribution of heart disease to morbidity and mortality and the prevalence of cardiovascular disease, it is important to determine the appropriate use of diagnostic tests such as stress echocardiography, stress SPECT MPI, CCTA, and CMR.

CLINICAL RECOMMENDATION STATEMENTS:

Diagnostic testing, such as stress SPECT MPI, stress echocardiography, CCTA, and CMR is used to detect disease and provide risk assessment used to modify treatment strategies and approaches. Information provided by such testing can initiate, modify and stop further treatments for coronary heart disease (medications and revascularization) which have an impact on patient outcomes.

In addition, false positives and false negatives can adversely impact the patient and their treatment outcomes. Lastly, radiation from stress SPECT MPI and CCTA poses a minimal but still important consideration for patient safety. Ensuring proper patient selection can avoid using resources in patients not expected to benefit from the testings and for which the associated risks would be unnecessary.

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Measure #323 (NQF 0671): Cardiac Stress Imaging Not Meeting Appropriate Use Criteria: Routine Testing After Percutaneous Coronary Intervention (PCI)

2013 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Percentage of all stress single-photon emission computed tomography (SPECT) myocardial perfusion imaging (MPI), stress echocardiogram (ECHO), cardiac computed tomography angiography (CCTA), and cardiovascular magnetic resonance (CMR) performed in patients aged 18 years and older routinely after percutaneous coronary intervention (PCI), with reference to timing of test after PCI and symptom status

INSTRUCTIONS:
This measure is to be reported once per procedure of cardiac stress imaging (i.e., SPECT, MPI, CCTA, and CMR) for patients seen during the reporting period. There is no diagnosis associated with this measure. It is anticipated that clinicians who provide the physician component of diagnostic imaging studies for cardiac stress will submit this measure.

Measure Reporting via Registry:
CPT codes and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions. These codes may be submitted for those registries that utilize claims data. There are no allowable performance exclusions for this measure.

DENOMINATOR:
All instances of stress single-photon emission computed tomography (SPECT) myocardial perfusion imaging (MPI), stress echocardiogram (ECHO), cardiac computed tomography angiography (CCTA), or cardiac magnetic resonance (CMR) performed on patients aged 18 years and older during the reporting period

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Cardiac Stress Imaging Performed – Procedure Codes (CPT): 75559, 75563, 75571, 75572, 75573, 75574, 78451, 78452, 78453, 78454, 78491, 78492, 78494, 93350, 93351

NUMERATOR:
Number of stress SPECT MPI, stress echo, CCTA and CMR performed in asymptomatic patients within 2 years of the most recent PCI

NUMERATOR NOTE: For performance, a lower score indicates better performance. This measure is assessing overuse of cardiac stress imaging in asymptomatic patients that received PCI. Clinical quality outcome is cardiac stress imaging NOT performed on patient who is asymptomatic or low CHD risk.

Numerator Options:
Cardiac Stress Imaging performed primarily for monitoring of asymptomatic patient who had PCI within 2 years (G8963)

OR

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Cardiac Stress Imaging test performed primarily for any other reason than monitoring of asymptomatic patient who had PCI within 2 years (e.g., symptomatic patient, patient greater than 2 years since PCI, initial evaluation, etc.) (G8964)

RATIONALE:
Diagnostic testing, such as stress SPECT MPI, stress echocardiography, CCTA and CMR, is used to detect disease and provide risk assessment used to modify treatment strategies and approaches. Information provided by such testing can initiate, modify and stop further treatments for coronary heart disease (medications and revascularization) which have an impact on patient outcomes.

In addition, false positives and false negatives can adversely impact the patient and their treatment outcomes. Lastly, radiation from stress SPECT MPI and CCTA poses a minimal but still important consideration for patient safety. Ensuring proper patient selection can avoid using resources in patients not expected to benefit from the testings and for which the associated risks would be unnecessary.

CLINICAL RECOMMENDATION STATEMENTS:
2005 PCI Guidelines
Text (No recommendations)
Neither exercise testing nor radionuclide imaging is indicated for the routine, periodic monitoring of asymptomatic patients after PCI without specific indications.

2011 ACCF/AHA/SCAI Guideline for Percutaneous Coronary Intervention A Report of the American College of Cardiology Foundation/American Heart Association Task Force on Practice Guidelines and the Society for Cardiovascular Angiography and Interventions (J Am Coll Cardiol, 2011)

AUC Indications
2008 Appropriateness Criteria for Stress Echocardiography Indication 39: Risk Assessment: Post-Revascularization (PCI or CABG): Asymptomatic: Asymptomatic (e.g. silent ischemia) prior to previous revascularization AND less than 2 years after PCI - Inappropriate (3)
Indication 40: Risk Assessment: Post-Revascularization (PCI or CABG): Asymptomatic: Symptomatic prior to previous revascularization AND less than 2 years after PCI - Inappropriate (2)
ACCF/ASE/AHA/ASNC/HFSA/HRS/SCAI/SCCM/SCCT/SCMR 2011 Appropriate Use Criteria for Echocardiography (J Am Coll Cardiol, 2011)

2009 Appropriate Use Criteria for Cardiac Radionuclide Imaging
Indication 59: Risk Assessment: Post Revascularization (PCI or CABG): Asymptomatic: Less than 2 years after PCI – Inappropriate (3)

2006 Appropriateness Criteria for CCT and CMR Indication 27. Detection of CAD: Post-Revascularization (PCI or CABG) (Use of CCTA): Evaluation for in-stent restenosis and coronary anatomy after
PCI - Inappropriate (2)
2010 Appropriate Use Criteria for Cardiac Computed Tomography (J Am Coll Cardiol, 2010)

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Measure #324 (NQF 0672): Cardiac Stress Imaging Not Meeting Appropriate Use Criteria: Testing in Asymptomatic, Low-Risk Patients

2013 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Percentage of all stress single-photon emission computed tomography (SPECT) myocardial perfusion imaging (MPI), stress echocardiogram (ECHO), cardiac computed tomography angiography (CCTA), and cardiovascular magnetic resonance (CMR) performed in asymptomatic, low coronary heart disease (CHD) risk patients 18 years and older for initial detection and risk assessment

INSTRUCTIONS:
This measure is to be reported once per procedure of cardiac stress imaging (i.e, SPECT, MPI, CCTA, and CMR) for patients seen during the reporting period. There is no diagnosis associated with this measure. It is anticipated that clinicians who provide the physician component of diagnostic imaging studies for cardiac stress will submit this measure.

Measure Reporting via Registry:
CPT codes and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data. There are no allowable performance exclusions for this measure.

DENOMINATOR:
All instances of stress single-photon emission computed tomography (SPECT) myocardial perfusion imaging (MPI), stress echocardiogram (ECHO), cardiac computed tomography angiography (CCTA), or cardiac magnetic resonance (CMR) performed on patients aged 18 years and older during the reporting period

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Cardiac Stress Imaging Performed – Procedure Codes (CPT): 75559, 75563, 75571, 75572, 75573, 75574, 78451, 78452, 78453, 78454, 78491, 78492, 78494, 93350, 93351

NUMERATOR:
Number of stress SPECT MPI, stress echo, CCTA, or CMR primarily performed for asymptomatic, low CHD risk patients for of initial detection and risk assessment

Definition:
Low CHD risk - clinicians should consider the maximum number of available patient factors used to estimate risk based on Framingham (ATP III criteria), typically age, gender, diabetes, smoking status, and use of blood pressure medication, and integrate age appropriate estimates for missing elements, such as LDL or standard blood pressure.

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NUMERATOR NOTE: For performance, a lower score indicates better performance. This measure is assessing overuse of cardiac stress imaging in low-risk CHD patients. Clinical quality outcome is cardiac stress imaging NOT performed on patient who is asymptomatic or low CHD risk.

Numerator Options:

Cardiac Stress Imaging Test primarily performed on low CHD risk patient for initial detection and risk assessment (G8965)

OR

Cardiac Stress Imaging Test performed on symptomatic or higher than low CHD risk patient or for any reason other than initial detection and risk assessment (G8966)

RATIONALE:

Diagnostic testing, such as stress SPECT MPI, stress echocardiography, CCTA, and CMR, is used to detect disease and provide risk assessment used to modify treatment strategies and approaches. Information provided by such testing can initiate, modify and stop further treatments for coronary heart disease (medications and revascularization) which have an impact on patient outcomes. In addition, false positives and false negatives can adversely impact the patient and their treatment outcomes. Lastly, radiation from stress SPECT MPI poses a minimal but still important consideration for patient safety. Ensuring proper patient selection can avoid using resources in patients not expected to benefit from the testings and for which the associated risks would be unnecessary.

CLINICAL RECOMMENDATION STATEMENTS:

2002 Stable Angina Guideline

"Asymptomatic patients with abnormal findings on ambulatory ECG or EBCT who are able to exercise can be evaluated with exercise ECG testing, although the efficacy of exercise ECG testing in asymptomatic patients is not well established. Stress imaging procedures (i.e., either stress myocardial perfusion imaging or stress echocardiography) are generally not indicated in most such patients."

AUC Indications

2008 Appropriateness Criteria for Stress Echocardiography Indication 11: Detection of CAD and Risk Assessment: Asymptomatic (without Chest Pain Syndrome or Anginal Equivalent): Low CHD risk (Framingham risk criteria) - Inappropriate (1)

2009 Appropriate Use Criteria for Cardiac Radionuclide Imaging Indication 12: Detection of CAD/Risk Assessment Without Ischemic Equivalent: Asymptomatic: Low CHD risk (ATP III risk criteria) - Inappropriate (1)

2006 Appropriateness Criteria for CCT and CMR Indication 10 - Detection of CAD: Asymptomatic (Use of CCTA) (Without Chest Pain Syndrome): Asymptomatic: Low CHD risk (Framingham risk criteria) - Inappropriate (1)

2002 Chronic Stable Angina Guideline

Class III

Recommendations for Cardiac Stress Imaging as the Initial Test for Diagnosis in Asymptomatic Patients

1. Exercise or dobutamine echocardiography in asymptomatic patients with left bundle-branch block. (Level of Evidence: C)
2. Exercise myocardial perfusion imaging, exercise echocardiography, adenosine or dipyridamole myocardial perfusion imaging, or dobutamine echocardiography as the initial stress test in an asymptomatic patient with a normal rest ECG who is not taking digoxin. (Level of Evidence: C)
3. Adenosine or dipyridamole myocardial perfusion imaging or dobutamine echocardiography in asymptomatic patients who are able to exercise and do not have left bundle-branch block or electronically paced ventricular rhythm. (Level of Evidence: C)

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▲Measure #325: Adult Major Depressive Disorder (MDD): Coordination of Care of Patients with Specific Comorbid Conditions

2013 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Percentage of medical records of patients aged 18 years and older with a diagnosis of major depressive disorder (MDD) and a specific diagnosed comorbid condition (diabetes, coronary artery disease, ischemic stroke, intracranial hemorrhage, chronic kidney disease [stages 4 or 5], ESRD or congestive heart failure) being treated by another clinician with communication to the other clinician treating the comorbid condition

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for patients with a diagnosis of MDD seen during the reporting period. This measure may be reported by clinicians who perform the quality actions described in the measure for the primary management of patients with major depressive disorder based on the services provided and the measure-specific denominator coding.

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data. There are no allowable performance exclusions for this measure.

DENOMINATOR:
All medical records of patients aged 18 years and older with a diagnosis of major depressive disorder (MDD) and a specific diagnosed comorbid condition being treated by another clinician

Definition:
Comorbid condition - For the purposes of this measure, only the following comorbid conditions will be included:

1. Diabetes
2. Coronary artery disease
3. Stroke, including ischemic stroke and intracranial hemorrhage
4. Chronic Kidney Disease (Stages 4 and 5) and End Stage Renal Disease
5. Congestive Heart Failure

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Diagnosis for MDD (ICD-9-CM): 296.20, 296.21, 296.22, 296.23, 296.24, 296.30, 296.31, 296.32, 296.33, 296.34
Diagnosis for MDD (ICD-10-CM) [REFERENCE ONLY/Not Reportable]: F32.0, F32.1, F32.2, F32.3, F32.9, F33.0, F33.1, F33.2, F33.3, F33.9
AND

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Patient encounter during the reporting period (CPT): 90791, 90792, 90832, 90834, 90837, 90839, 90845, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215
AND

Diagnosis for Diabetes (ICD-9-CM): 250.00, 250.01, 250.02, 250.03, 250.10, 250.11, 250.12, 250.13, 250.20, 250.21, 250.22, 250.23, 250.30, 250.31, 250.32, 250.33, 250.40, 250.41, 250.42, 250.43, 250.50, 250.51, 250.52, 250.53, 250.60, 250.61, 250.62, 250.63, 250.70, 250.71, 250.72, 250.73, 250.80, 250.81, 250.82, 250.83, 250.90, 250.91, 250.92, 250.93
Diagnosis for Diabetes (ICD-10-CM) [REFERENCE ONLY/Not Reportable]: E10.10, E10.11, E10.21, E10.22, E10.29, E10.311, E10.319, E10.321, E10.329, E10.331, E10.339, E10.341, E10.349, E10.351, E10.359, E10.36, E10.39, E10.40, E10.41, E10.42, E10.43, E10.44, E10.49, E10.51, E10.52, E10.59, E10.610, E10.618, E10.620, E10.621, E10.622, E10.628, E10.630, E10.638, E10.641, E10.649, E10.65, E10.69, E10.8, E10.9, E11.00, E11.01, E11.21, E11.22, E11.29, E11.311, E11.319, E11.321, E11.329, E11.331, E11.339, E11.341, E11.349, E11.351, E11.359, E11.36, E11.39, E11.40, E11.41, E11.42, E11.43, E11.44, E11.49, E11.51, E11.52, E11.59, E11.610, E11.618, E11.620, E11.621, E11.622, E11.628, E11.630, E11.638, E11.641, E11.649, E11.65, E11.69, E11.8, E11.9, E13.00, E13.01, E13.10, E13.11, E13.21, E13.22, E13.29, E13.311, E13.319, E13.321, E13.329, E13.331, E13.339, E13.341, E13.349, E13.351, E13.359, E13.36, E13.39, E13.40, E13.41, E13.42, E13.43, E13.44, E13.49, E13.51, E13.52, E13.59, E13.610, E13.618, E13.620, E13.621, E13.622, E13.628, E13.630, E13.638, E13.641, E13.649, E13.65, E13.69, E13.8, E13.9
OR
Diagnosis for CAD (ICD-9-CM): 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
Diagnosis for CAD (ICD-10-CM) [REFERENCE ONLY/Not Reportable]: I20.0, I20.1, I20.8, I20.9, I21.01, I21.02, I21.09, I21.11, I21.19, I21.21, I21.3, I21.4, I22.0, I22.1, I22.2, I21.29, I22.8, I22.9, I24.0, I24.1, I24.8, I24.9, I25.10, I25.110, I25.111, I25.118, I25.119, I25.2, I25.5, I25.6, I25.700, I25.701, I25.708, I25.709, I25.710, I25.711, I25.718, I25.719, I25.720, I25.721, I25.728, I25.729, I25.730, I25.731, I25.738, I25.739, I25.750, I25.751, I25.758, I25.759, I25.760, I25.761, I25.768, I25.769, I25.790, I25.791, I25.798, I25.799, I25.82, I25.83, I25.89, I25.9, Z95.1, Z95.5, Z98.61
OR
Diagnosis for Stroke, including ischemic stroke and intracranial hemorrhage (ICD-9-CM): 430, 431, 432.0, 432.1, 432.9, 433.01, 433.11, 433.21, 433.31, 433.81, 433.91, 434.01, 434.11, 434.91
Diagnosis for Stroke, including ischemic stroke and intracranial hemorrhage (ICD-10-CM) [REFERENCE ONLY/Not Reportable]: I60.00, I60.01, I60.02, I60.10, I60.11, I60.12, I60.20, I60.21, I60.22, I60.30, I60.31, I60.32, I60.4, I60.50, I60.51, I60.52, I60.6, I60.7, I60.8, I60.9, I61.0, I61.1, I61.2, I61.3, I61.4, I61.5, I61.6, I61.8, I61.9, I62.00, I62.01, I62.02, I62.03, I62.1, I62.9, I63.00, I63.011, I63.012, I63.019, I63.02, I63.031, I63.032, I63.039, I63.09, I63.10, I63.111, I63.112, I63.119, I63.12, I63.131, I63.132, I63.139, I63.19, I63.20, I63.211, I63.212, I63.219, I63.22, I63.231, I63.232, I63.239, I63.29, I63.30, I63.311, I63.312, I63.319, I63.321, I63.322, I63.329, I63.331, I63.332, I63.339, I63.341, I63.342, I63.349, I63.39, I63.40, I63.411, I63.412, I63.419, I63.421, I63.422, I63.429, I63.431, I63.432, I63.439, I63.441, I63.442, I63.449, I63.49, I63.50, I63.511, I63.512, I63.519, I63.521, I63.522, I63.529, I63.531, I63.532, I63.539, I63.541, I63.542, I63.549, I63.59, I63.6, I63.8, I63.9
OR
Diagnosis for Chronic Kidney Disease (Stages 4 and 5) and End Stage Renal Disease (ICD-9-CM): 585.4, 585.5, 585.6
Diagnosis for Chronic Kidney Disease (Stages 4 and 5) and End Stage Renal Disease (ICD-10-CM) [REFERENCE ONLY/Not Reportable]: N18.4, N18.5, N18.6

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OR

Diagnosis for heart failure (ICD-9-CM): 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

Diagnosis for heart failure (ICD-10-CM) [REFERENCE ONLY/Not Reportable]: I11.0, I13.0, I13.2, I50.1, I50.20, I50.21, I50.22, I50.23, I50.30, I50.31, I50.32, I50.33, I50.40, I50.41, I50.42, I50.43, I50.9

NUMERATOR:

Medical records of patients with communication to another clinician treating the comorbid condition

Definition:

Communication - Transmission of relevant clinical information which specifies that the patient has major depressive disorder (MDD) AND request for return communication.

Numerator Options:

Clinician treating Major Depressive Disorder communicates to clinician treating comorbid condition (G8959)

OR

Clinician treating Major Depressive Disorder did not communicate to clinician treating comorbid condition, reason not given (G8960)

RATIONALE:

Depressive disorders are more common among persons with chronic conditions (e.g., obesity, cardiovascular disease, diabetes, asthma, arthritis, and cancer) and among those with unhealthy behaviors (e.g., smoking, physical inactivity, and binge drinking). Comorbidities are more common in the elderly. The highest rates of depression are found in those with strokes (30% to 60%), coronary artery disease (up to 44%), cancer (up to 40%), Parkinson's disease (40%), and Alzheimer's disease (20% to 40%). The coordination of care for patients with depression and certain comorbid conditions is important for managing both the patient's depression and the other present medical condition. Improvements in the coordination of care between clinicians treating a patient with depression and other clinicians treating comorbid conditions can reduce the symptom exacerbation that depression and other conditions may cause to the other. Any [depression] treatment should be integrated with psychiatric management and any other treatments being provided for other diagnoses.

CLINICAL RECOMMENDATION STATEMENTS:

The following evidence statements are quoted verbatim from the referenced clinical guidelines. Only selected portions of the clinical guidelines are quoted here; for more details, please refer to the full guideline.

In patients with major depressive disorder, it is important to recognize and address the potential interplay between major depressive disorder and any co-occurring general medical conditions. (APA, 2010)

The clinical assessment should include identifying any potential interactions between medications used to treat depression and those used to treat general medical conditions. In addition, the psychiatrist (clinician) should consider the effects of prescribed psychotropic medications on the patient's general medical conditions, as well as the effects of interventions for such disorders on the patient's psychiatric condition. (APA, 2010)

Many patients with major depressive disorder will be evaluated by or receive treatment from other health care professionals in addition to the psychiatrist (clinician). If more than one clinician is involved in providing the care, all treating clinicians should have sufficient ongoing contact with the patient and with each other to ensure that care is coordinated, relevant information is available to guide treatment decisions, and treatments are synchronized. (APA, 2010)

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In ruling out general medical causes of depressive symptoms, it is important to ensure that a general medical evaluation has been done. (APA, 2010)

In patients with preexisting hypertension or cardiac conditions, treatment with specific antidepressant agents may suggest a need for monitoring of vital signs or cardiac rhythm (eg, electrocardiogram [ECG] with TCA treatment; heart rate and blood pressure assessment with SNRIs and TCAs). (APA, 2010)
In treating the depressive syndrome that commonly occurs following a stroke, consideration should be given to the potential for interactions between antidepressants and anticoagulating (including antiplatelet) medications. (APA, 2010)

The diagnostic work-up for MDD should include evaluation for existing or emerging medical conditions that may exacerbate the depression. These may include: Cardiovascular diseases, Chronic pain syndrome, Degenerative diseases, Immune disorders, Metabolic endocrine conditions (including kidney and lung diseases), Neoplasms, Trauma. Simultaneous treatment is often required for both the medical problem and psychiatric symptoms and can lead to overall improvement in function. (VA/DoD, 2009)

Indications for referral to a mental health specialist familiar with diabetes management may include gross noncompliance with medical regimen (by self or others), depression with the possibility of self-harm, debilitating anxiety (alone or with depression), indications of an eating disorder, or cognitive functioning that significantly impairs judgment. It is preferable to incorporate psychological assessment and treatment into routine care rather than waiting for identification of a specific problem or deterioration in psychological status. Although the clinician may not feel qualified to treat psychological problems, using the patient-provider relationship as a foundation for further treatment can increase the likelihood that the patient will accept referral for other services. It is important to establish that emotional well-being is part of diabetes management. (ADA, 2010)

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Measure #326 (NQF 1525): Atrial Fibrillation and Atrial Flutter: Chronic Anticoagulation Therapy

2013 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Patients aged 18 years and older with a diagnosis of nonvalvular atrial fibrillation (AF) or atrial flutter whose assessment of specified thromboembolic risk factors indicate one or more high-risk factors or more than one moderate risk factor, as determined by CHADS2 risk stratification, who are prescribed warfarin OR another oral anticoagulant drug that is FDA approved for the prevention of thromboembolism

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for patients with nonvalvular AF or atrial flutter seen during the reporting period. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

Measure Reporting via Claims:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. G-codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed ICD-9-CM diagnosis codes, CPT codes, and the appropriate G-code(s). All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
Patients aged 18 years and older with a diagnosis of nonvalvular AF or atrial flutter whose assessment of specified thromboembolic risk factors indicate one or more high-risk factors or more than one moderate risk factor, as determined by CHADS2 risk stratification

> Denominator Criteria (Eligible Cases):
> Patients aged ≥ 18 years on date of encounter
> AND
> Diagnosis for nonvalvular atrial fibrillation or atrial flutter (ICD-9-CM): 427.31, 427.32
> Diagnosis for nonvalvular atrial fibrillation or atrial flutter (ICD-10-CM) [REFERENCE ONLY/Not Reportable]: I48.0, I48.1
> AND
> Patient encounter during the reporting period (CPT): 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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NUMERATOR:
Patients who are prescribed warfarin OR another oral anticoagulant drug that is FDA approved for the prevention of thromboembolism

Definition:
Prescribed - May include prescription given to the patient for a chronic anticoagulant at one or more visits in the measurement period OR patient already taking a chronic anticoagulant as documented in current medication list.

The assessment of patients with nonvalvular AF for thromboembolic risk factors should include the following criteria:

Risk Factors	Weighting
Prior stroke, TIA or systemic embolism	High risk
Age ≥ 75 years	Moderate risk
Hypertension	Moderate risk
Diabetes Mellitus	Moderate risk
Heart failure or impaired left ventricular systolic function	Moderate risk

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Warfarin OR Another Oral Anticoagulant that is FDA Approved Prescribed
(Two G-codes [G8967 & G8972] are required on the claim form to submit this numerator option)
G8967: Warfarin OR another oral anticoagulant that is FDA approved prescribed
AND
G8972: One or more high risk factors for thromboembolism OR more than one moderate risk factor for thromboembolism

OR

Warfarin OR Another Oral Anticoagulant that is FDA Approved not Prescribed for Medical, or Patient Reasons
(Two G-codes [G896x & G8972] are required on the claim form to submit this numerator option)
G8968: Documentation of medical reason(s) for not prescribing warfarin OR another oral anticoagulant that is FDA approved (e.g., allergy, risk of bleeding, transient or reversible causes of atrial fibrillation, other medical reasons including, but not limited to, pregnancy, mitral stenosis, prosthetic heart valve or patient is in the postoperative period)
OR
G8969: Documentation of patient reason(s) for not prescribing warfarin OR another oral anticoagulant that is FDA approved (e.g., economic, social, and/or religious impediments, noncompliance or patient refusal, other patient reasons)

AND
G8972: One or more high risk factors for thromboembolism OR more than one moderate risk factor for thromboembolism

OR

No Risk Factors or One Moderate Risk Factor for Thromboembolism, Patient not Eligible
(One G-code [G8970] is required on the claim form to submit this numerator option)
G8970: No risk factors or one moderate risk factor for thromboembolism

OR

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Warfarin OR Another Oral Anticoagulant that is FDA Approved not Prescribed, Reason not Given
*(Two G-codes [*G8971 & G8972*] are required on the claim form to submit this numerator option)*
G8971: Warfarin OR another oral anticoagulant that is FDA approved not prescribed, reason not given
AND
G8972: One or more high risk factors for thromboembolism OR more than one moderate risk factor for thromboembolism

RATIONALE:
Anticoagulation should be prescribed for all high risk patients with AF or atrial flutter except those with contraindications to anticoagulation. Aspirin is preferred in patients without risk factors or in those with contraindications to anticoagulation, and is an alternative to anticoagulation in those with only one moderate risk factor.

CLINICAL RECOMMENDATION STATEMENTS:
ACCF/AHA/HRS 2011 Focused Update on the Management of Patients with Atrial Fibrillation (Update on Dabigatran) Emerging Antithrombotic Agents

Class I
Dabigatran is useful as an alternative to warfarin for the prevention of stroke and systemic thromboembolism in patients with paroxysmal to permanent AF and risk factors for stroke or systemic embolization who do not have a prosthetic heart valve or hemodynamically significant valve disease, sever renal failure (Creatinne clearance < 15 mL/min) or advanced liver disease (impaired baseline clotting function) *(Level of Evidence: B)*
2006 ACC/AHA/ESC Guidelines for the Management of Atrial Fibrillation Patients with AF Chronic Anticoagulation Therapy (Recommendations other than those listed below pertain to antithrombotic therapy for patients with AF undergoing cardioversion) (4)

Class I
1. Antithrombotic therapy to prevent thromboembolism is recommended for all patients with AF, except those with lone AF or contraindications. (Level of Evidence: A)
2. The selection of the antithrombotic agent should be based upon the absolute risks of stroke and bleeding and the relative risk and benefit for a given patient. (Level of Evidence: A)
3. Anticoagulation with a vitamin K antagonist is recommended for patients with more than one moderate risk factor. Such factors include age 75 y or greater, hypertension, HF, impaired LV systolic function (ejection fraction 35% or less or fractional shortening less than 25%), and diabetes mellitus. (Level of Evidence: A)
4. For patients without mechanical heart valves at high risk of stroke, chronic oral anticoagulant therapy with a vitamin K antagonist is recommended in a dose adjusted to achieve the target intensity INR of 2.0 to 3.0, unless contraindicated. Factors associated with highest risk for stroke in patients with AF are prior thromboembolism (stroke, TIA, or systemic embolism) and rheumatic mitral stenosis. (Level of Evidence: A)
5. The INR should be measured at least weekly during initiation of therapy and monthly when anticoagulation is stable. (Level of Evidence: A)
6. Aspirin, 81–325 mg daily, is recommended as an alternative to vitamin K antagonists in low-risk patients or in those with contraindications to anticoagulation. (Level of Evidence: A)
7. Antithrombotic therapy is recommended for patients with atrial flutter as for those with AF. (Level of Evidence: C)

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Antithrombotic Therapy for Patients with Atrial Fibrillation*

	Risk Category	Recommended Therapy
Low Risk	No risk factors	Aspirin, 81 to 325 mg daily
Intermediate Risk	One moderate-risk factor	Aspirin, 81 to 325 mg daily, or warfarin (INR 2.0 to 3.0, target 2.5)
High Risk	Any high-risk factor or more than one moderate-risk factor	Warfarin (INR 2.0 to 3.0, target 2.5)

*Adapted from Fuster et al. (reference 4)

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▲Measure #327: Pediatric Kidney Disease: Adequacy of Volume Management

2013 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of calendar months within a 12-month period during which patients aged 17 years and younger with a diagnosis of End Stage Renal Disease (ESRD) undergoing maintenance hemodialysis in an outpatient dialysis facility have an assessment of the adequacy of volume management from a nephrologist

INSTRUCTIONS:
This measure is to be reported each calendar month patients are seen with a diagnosis of ESRD (who are undergoing maintenance hemodialysis in an outpatient dialysis facility) during the reporting period. The most recent quality code submitted will be used for performance calculation. It is anticipated that clinicians providing care for patients with ESRD will submit this measure.

Measure Reporting via Claims:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. G-codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed ICD-9-CM diagnosis codes, CPT codes, and the appropriate G-code(s). All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All calendar months for patients aged 17 years and younger with a diagnosis of ESRD are undergoing maintenance hemodialysis in an outpatient dialysis facility

> Denominator Criteria (Eligible Cases):
> Patients aged ≤ 17 years on date of encounter
> AND
> Diagnosis for ESRD (ICD-9-CM): 585.6
> Diagnosis for ESRD (ICD-10-CM) [REFERENCE ONLY/Not Reportable]: N18.6
> AND
> Patient encounter during the reporting period (CPT): 90951, 90952, 90953, 90954, 90955, 90956, 90957, 90958, 90959, 90963, 90964, 90965, 90967, 90968, 90969

NUMERATOR:
Calendar months during which patients have an assessment of the adequacy of volume management from a nephrologist

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Definition:
Adequacy of Volume Management – Adequacy of volume management for a patient on dialysis is determined by assessing whether or not the patient achieved a target end dialysis weight after receiving dialysis, by a comparison of the patient-specific target end dialysis weight and the actual post dialysis weight.

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 Assessment of the Adequacy of Volume Management
(Two G-codes [G8955 & G8956] are required on the claim form to submit this numerator option)
G8955: Most recent assessment of adequacy of volume management
AND
G8956: Patient receiving maintenance hemodialysis in an outpatient dialysis facility

OR

Patient not Receiving Maintainance Hemodialysis, Patient not Eligible
(One G-code [G8957] is required on the claim form to submit this numerator option)
G8957: Patient not receiving maintenance hemodialysis in an outpatient dialysis facility

OR

Assessment of Adequacy of Volume Management not Performed, Reason not Given
(Two G-codes [G8958 & G8956] are required on the claim form to submit this numerator option)
G8958: Assessment of adequacy of volume management not documented, reason not given
AND
G8956: Patient receiving maintenance hemodialysis in an outpatient dialysis facility

RATIONALE:
Management of hypertension in dialysis patients includes the management of the fluid status. Poor extracellular volume control may exacerbate hypertension and so it is important to optimize ultrafiltration, volume status and dry weight to control blood pressure in an effort to improve patient outcomes.

CLINICAL RECOMMENDATION STATEMENTS:
The following evidence statements are quoted verbatim from the referenced clinical guidelines. Only selected portions of the clinical guidelines are quoted here; for more details, please refer to the full guideline.

1.2 The following parameters of nutritional status and growth should be considered in combination for evaluation in children with CKD stages 2 to 5 and 5D. *(B)*
i Dietary intake (3-day diet record or three 24-hour dietary recalls)
ii Length- or height-for-age percentile or standard deviation score (SDS)
iii Length or height velocity-for-age percentile or SDS
iv Estimated dry weight and weight-forage percentile or SDS
v BMI-for-height-age percentile or SDS
vi Head circumference-for-age percentile or SDS (< 3 years old only)
vii Normalized protein catabolic rate (nPCR) in hemodialyzed adolescents with CKD stage 5D. (KDOQI, 2009)

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▲Measure #328 (NQF 1667): Pediatric Kidney Disease: ESRD Patients Receiving Dialysis: Hemoglobin Level < 10 g/dL

2013 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of calendar months within a 12-month period during which patients aged 17 years and younger with a diagnosis of End-Stage Renal Disease (ESRD) receiving hemodialysis or peritoneal dialysis have a hemoglobin level < 10 g/dL

INSTRUCTIONS:
This measure is to be reported each calendar month patients are seen with a diagnosis of ESRD (who are on hemodialysis or peritoneal dialysis) during the reporting period. The most recent quality code submitted will be used for performance calculation. It is anticipated that clinicians providing care for patients with ESRD will submit this measure.

Measure Reporting via Claims:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. G-codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed ICD-9-CM diagnosis codes, CPT codes, and the appropriate G-code. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All calendar months during which patients aged 17 years and younger with a diagnosis of ESRD are receiving hemodialysis or peritoneal dialysis

Denominator Criteria (Eligible Cases):
Patients aged ≤ 17 years on date of encounter
AND
Diagnosis for ESRD (ICD-9-CM): 585.6
Diagnosis for ESRD (ICD-10-CM) [REFERENCE ONLY/Not Reportable]: N18.6
AND
Patient encounter during the reporting period (CPT): 90945, 90947, 90951, 90952, 90953, 90954, 90955, 90956, 90957, 90958, 90959, 90963, 90964, 90965, 90967, 90968, 90969

NUMERATOR:
Calendar months during which patients have a hemoglobin level < 10 g/dL

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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.

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Most Recent Hemoglobin level < 10 g/dL
G8973: Most recent hemoglobin (Hgb) level < 10 g/dL

OR

Hemoglobin Level Measurement not Performed, Reason not Given
G8974: Hemoglobin level measurement not documented, reason not given

OR

Documented Clinical Reason Patient has Hemoglobin Level < 10 g/dL
G8975: Documentation of medical reason(s) for patient having a hemoglobin level < 10 g/dL (e.g., patients who have non-renal etiologies of anemia (e.g., sickle cell anemia or other hemoglobinopathies, hypersplenism, primary bone marrow disease, anemia related to chemotherapy for diagnosis of malignancy, postoperative bleeding, active bloodstream or peritoneal infection), other medical reasons)

OR

Most Recent Hemoglobin Level ≥ 10.0 g/dL
G8976: Most recent hemoglobin (Hgb) level ≥ 10 g/dL

RATIONALE:
The clinical issues that impact achievement of the target hemoglobin in the pediatric population differ from the adult population. Normative, adult population data should not be used to assess performance in the pediatric population. Consideration(s) should be given to using age-specific normative data across the pediatric age range.

Anemia is a common complication of chronic kidney disease (CKD). The prevalence of anemia varies with the degree of renal impairment in predialysis patients with CKD, but once end-stage kidney failure occurs, all patients are eventually affected. Anemia develops once renal function decreases to < 50% because of a deficiency in endogenous erythropoietin (EPO) production by the kidney, decreased red cell survival, blood losses, and increased red blood cell destruction once the patient begins dialysis treatment, particularly hemodialysis. Anemia reduces physical capacity, well-being, neurocognitive function, and energy level and worsens quality of life both in predialysis and dialysis patients. Anemia also induces adaptive cardiovascular mechanisms to maintain tissue oxygen supply. This leads to left ventricular hypertrophy, left ventricular dilation, and myocardial ischemia, which are risk factors for cardiovascular disease and death. It is plausible that reversing anemia may reduce this risk. (Strippoli et al., 2004)

CLINICAL RECOMMENDATION STATEMENTS:
The following evidence statements are quoted verbatim from the referenced clinical guidelines. Only selected portions of the clinical guidelines are quoted here; for more details, please refer to the full guideline.

CLINICAL PRACTICE RECOMMENDATIONS FOR ANEMIA IN CHRONIC KIDNEY DISEASE IN CHILDREN:
2.1.2 *(FULLY APPLICABLE TO CHILDREN)* In the opinion of the [KDOQI] Work Group, in pediatric dialysis and nondialysis patients with CKD receiving ESA therapy, the selected Hb target should generally be in the range of 11.0 to 12.0 g/dL. *(Clinical Practice RECOMMENDATION)* (KDOQI, 2007)

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