



2013 Physician Quality Reporting System (PQRS)

Measures Groups Specifications Manual

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2013 PQRS Measures Groups Specifications Manual

This manual contains specific guidance for reporting 2013 Physician Quality Reporting System (PQRS) Measures Groups. Measures Groups are a subset of four or more PQRS measures that have a particular clinical condition or focus in common. Only those measures groups defined in this document can be utilized when reporting the measures group options. All other individual measures that are included in PQRS but not defined in this manual as included in a measures group cannot be grouped together to define a measures group.

Twenty-two (22) measures groups have been established for 2013 PQRS: Diabetes Mellitus (DM), Chronic Kidney Disease (CKD), Preventive Care, Coronary Artery Bypass Graft (CABG), Rheumatoid Arthritis (RA), Perioperative Care, Back Pain, Hepatitis C, Heart Failure (HF), Coronary Artery Disease (CAD), Ischemic Vascular Disease (IVD), HIV/AIDS, Asthma, Chronic Obstructive Pulmonary Disease (COPD), Inflammatory Bowel Disease (IBD), Sleep Apnea, Dementia, Parkinson's Disease, Hypertension, Cardiovascular Prevention, Cataracts, and Oncology. As required by applicable statutes, through formal notice-and-comment rulemaking in 2012, these 22 measures groups consist of individual measures established for use in the 2013 PQRS. An eligible professional may choose to report one or more measures groups through claims-based and/or registry-based submission. Note that denominator coding has been modified from the original individual measures specified by the measure developer to allow for implementation in PQRS as a measures group. An overview for each measures group is included in this manual followed by specific reporting instructions for each measure within the group.

There are two reporting periods available for eligible professionals to report 2013 PQRS measures groups: a) 12-month reporting period from January 1 through December 31, 2013 OR b) a 6-month reporting period from July 1 through December 31, 2013 (available only via Registry). The 6-month reporting period allows those eligible professionals who may have decided to participate later in the year to begin reporting. Measures groups containing a measure with a 0% performance rate will not be counted as satisfactorily reporting the measures group. Those eligible professionals who satisfactorily report quality-data under the measures groups reporting option may earn an incentive payment equal to 0.5% of their total estimated allowed charges for Medicare Part B Physician Fee Schedule (PFS) covered professional services furnished during the applicable reporting period.

Please note, eligible professionals may choose to pursue more than one 2013 PQRS option. However, an eligible professional who satisfactorily reports under more than one reporting option will earn a maximum of one incentive payment equal to 0.5% of their total estimated allowed charges for Medicare Part B PFS covered professional services furnished during the longest reporting period for which he or she satisfied reporting requirements. This manual describes how to implement 2013 reporting of PQRS measures groups to facilitate satisfactory reporting of quality-data by eligible professionals who wish to participate under this reporting alternative. Additional information describing how to implement 2013 measures groups can be found in the *2013 Physician Quality Reporting System (PQRS) Getting Started with Measures Groups* and *Physician Quality Reporting Made Simple - Reporting the Preventive Care Measures Group* at: <http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS>.

Note: This document 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 at <http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS>.

Measures Group Reporting via Claims and Registry:

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

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

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

- G8485: I intend to report the Diabetes Mellitus (DM) Measures Group
- G8487: I intend to report the Chronic Kidney Disease (CKD) Measures Group
- G8486: I intend to report the Preventive Care Measures Group
- G8490: I intend to report the Rheumatoid Arthritis (RA) Measures Group
- G8492: I intend to report the Perioperative Care Measures Group
- G8493: I intend to report the Back Pain Measures Group
- G8545: I intend to report the Hepatitis C Measures Group
- G8547: I intend to report the Ischemic Vascular Disease (IVD) Measures Group
- G8645: I intend to report the Asthma Measures Group
- G8898: I intend to report the Chronic Obstructive Pulmonary Disease (COPD) Measures Group
- G8902: I intend to report the Dementia Measures Group
- G8905: I intend to report the Cardiovascular Prevention Measures Group

Measures Group Reporting via Registry-only:

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

- G8544: I intend to report the Coronary Artery Bypass Graft (CABG) Measures Group
- G8489: I intend to report the Coronary Artery Disease (CAD) Measures Group
- G8548: I intend to report the Heart Failure (HF) Measures Group
- G8491: I intend to report the HIV/AIDS Measures Group
- G8899: I intend to report the Inflammatory Bowel Disease (IBD) Measures Group
- G8900: I intend to report the Sleep Apnea Measures Group
- G8903: I intend to report the Parkinson's Disease Measures Group
- G8904: I intend to report the Hypertension (HTN) Measures Group
- G8906: I intend to report the Cataracts Measures Group
- G8977: I intend to report the Oncology Measures Group

Measures Groups Reporting Methods:

There are two reporting methods for submission of measures groups:

- 1) **20 Patient Sample Method via claims** – 12-month reporting period only:
 - o For claims-based submissions, a participating eligible professional must report on all applicable measures within the selected measures group when billing measure-eligible claims for a minimum sample of 20 unique Medicare Part B FFS patients who meet patient sample criteria for the measures group (include Medicare Secondary Payer claims and claims for Railroad Retirement beneficiaries; exclude Medicare Advantage beneficiaries). If the eligible professional does not have a minimum of 20 unique Medicare Part B FFS patients who meet patient sample criteria for the measures group, the eligible professional will need to choose another measures group or choose another reporting

option. Please refer to the *2013 Physician Quality Reporting System (PQRS) Getting Started with Measures Groups* to determine the proper reporting option.

- For **claims-based** submissions, the measures group-specific intent G-code must be submitted once during the reporting period to indicate the eligible professional's selection of the measures group.
- 2) **20 Patient Sample Method via registry** – 12-month or 6-month reporting period:
 - For **registry-based** submissions, a participating eligible professional must report on all applicable measures within the selected measures group for a minimum sample of 20 unique patients, a majority of which must be Medicare Part B FFS patients, who meet patient sample criteria for the measures group. If the eligible professional does not have at least 11 unique Medicare Part B FFS patients who meet patient sample criteria for the measures group, the eligible professional will need to choose another measures group or choose another reporting option. Please refer to the *2013 Physician Quality Reporting System (PQRS) Getting Started with Measures Groups* to determine the proper reporting option.

For both claims-based and registry-based 12-month reporting option submissions, all applicable measures within the group must be reported during the reporting period (January 1 through December 31, 2013), according to each measures group's reporting instructions contained within each group's overview section.

For registry-based 6-month reporting option submissions, all applicable measures within the group must be reported during the reporting period (July 1 through December 31, 2013), according to each measures group's reporting instructions contained within each group's overview section.

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

The patient sample for the 20 Patient Sample Method is determined by diagnosis and/or specific encounter parameters common to all measures within a selected measures group. All applicable measures within a group must be reported for each patient within the sample that meets the criteria (e.g., age or gender) required in accordance with this manual. For example, if an eligible professional is reporting on the Preventive Care Measures Group, the *Screening or Therapy for Osteoporosis* measure would only need to be reported on **women** within the eligible professional's patient sample.

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122	Adult Kidney Disease: Blood Pressure Management		23
123	Adult Kidney Disease: Patients On Erythropoiesis-Stimulating Agent (ESA) - Hemoglobin Level > 12.0 g/dL		25
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170	Coronary Artery Bypass Graft (CABG): Beta-Blockers Administered at Discharge		50
171	Coronary Artery Bypass Graft (CABG): Anti-Lipid Treatment at Discharge		51
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180	Rheumatoid Arthritis (RA): Glucocorticoid Management		62
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DIABETES MELLITUS MEASURES GROUP OVERVIEW

2013 PQRS OPTIONS FOR MEASURES GROUPS: CLAIMS, REGISTRY

2013 PQRS MEASURES IN DIABETES MELLITUS MEASURES GROUP:

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

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

- Indicate your intention to report the Diabetes Mellitus Measures Group by submitting the measures group-specific intent G-code at least once during the reporting period when billing a patient claim for the 20 Patient Sample Method. It is not necessary to submit the measures group-specific intent G-code on more than one claim. It is not necessary to submit the measures group-specific intent G-code for registry-based submissions.

G8485: I intend to report the Diabetes Mellitus Measures Group

- Select patient sample method:
20 Patient Sample Method via claims: 20 unique Medicare Part B FFS (fee for service) patients meeting patient sample criteria for the measures group.

OR

20 Patient Sample Method via registries: 20 unique patients (a majority of which must be Medicare Part B FFS patients) meeting patient sample criteria for the measures group during the reporting period (January 1 through December 31, 2013 **OR** July 1 through December 31, 2013).

- Patient sample criteria for the Diabetes Mellitus Measures Group are patients aged 18 through 75 years with a specific diagnosis of diabetes accompanied by a specific patient encounter:

The following diagnosis codes indicating diabetes mellitus:

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

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, O24.011, O24.012, O24.013, O24.019, O24.02, O24.03, O24.111, O24.112, O24.113, O24.119, O24.12, O24.13

Accompanied by

One of the following patient encounter codes: 97802, 97803, 97804, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, G0270, G0271, G0402

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

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

- To report satisfactorily the Diabetes Mellitus Measures Group requires all measures for each patient within the eligible professional's patient sample to be reported a minimum of once during the reporting period.
- Measures groups containing a measure with a 0% performance rate will not be counted as satisfactorily reporting the measures group. The recommended clinical quality action must be performed on at least one patient for each measure within the measures group reported by the eligible professional. When a lower rate indicates better performance, such as Measure #1, a 0% performance rate will be counted as satisfactorily reporting (100% performance rate would not be considered satisfactorily reporting). Performance exclusion quality-data codes are not counted in the performance denominator. If the eligible professional submits all performance exclusion quality-data codes, the performance rate would be 0/0 and would be considered satisfactorily reporting.
- When using the 20 Patient Sample Method via claims, report all measures for the 20 unique Medicare Part B FFS patients seen. When using the 20 Patient Sample Method via registries, report all measures for the 20 unique patients seen, a majority of which must be Medicare Part B FFS patients.
- For claims-based submissions, the Carrier/MAC remittance advice notice sent to the practice will show a denial remark code (N365) for the line item on the claim containing G8485 (and G8494 if reported) as well as all other line items containing QDCs. N365 indicates the code is not payable and is used for reporting/informational purposes only. Other services/codes on the claim will not be affected by the addition of a measures group-specific intent G-code or other QDCs. The N365 remark code does NOT indicate whether the QDC is accurate for that claim or for the measure the eligible professional is attempting to report, but does indicate that the QDC was processed and transmitted to the NCH.

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2013 Physician Quality Reporting System (PQRS) Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS PQRS website.

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

DESCRIPTION:

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

NUMERATOR:

Patients with most recent hemoglobin A1c level > 9.0%

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

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

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Most Recent Hemoglobin A1c Level > 9.0%

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

OR

Hemoglobin A1c not Performed, 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%

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2013 Physician Quality Reporting System (PQRS) Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS PQRS website.

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

DESCRIPTION:

Percentage of patients aged 18 through 75 years with diabetes mellitus who had most recent LDL-C level in control (less than 100 mg/dL)

NUMERATOR:

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

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

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Most Recent LDL-C Level < 100 mg/dL

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

OR

Most Recent LDL-C Level \geq 100 mg/dL

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

OR

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

OR

LDL-C Level not Performed, 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)

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2013 Physician Quality Reporting System (PQRS) Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS PQRS website.

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

DESCRIPTION:

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

NUMERATOR:

Patients whose most recent blood pressure < 140/90 mmHg

Numerator Instructions: To describe both systolic and diastolic blood pressure values, two CPT II codes must be reported – 1) One to describe the systolic value; AND 2) One to describe the diastolic value. If there are multiple blood pressures on the same date of service, use the lowest systolic and lowest diastolic blood pressure on that date as the representative blood pressure.

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

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Most Recent Blood Pressure Measurement Performed

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

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

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2013 Physician Quality Reporting System (PQRS) Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS PQRS website.

♦Measure #117 (NQF 0055): Diabetes Mellitus: Dilated Eye Exam

DESCRIPTION:

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

NUMERATOR:

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

Numerator Instructions: This measure includes patients with diabetes who had one of the following: A retinal or dilated eye exam by an eye care professional (optometrist or ophthalmologist) during the reporting period, or a negative retinal exam (no evidence of retinopathy) by an eye care professional in the year prior to the reporting period. For dilated eye exams performed 12 months prior to the reporting period, an automated result must be available.

Definition:

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

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Dilated Eye Exam Performed by an Eye Care Professional

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

OR

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

OR

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

OR

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

OR

Dilated Eye Exam not Performed, Reason not 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.

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

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2013 Physician Quality Reporting System (PQRS) Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS PQRS website.

♦Measure #119 (NQF 0062): Diabetes Mellitus: Medical Attention for Nephropathy

DESCRIPTION:

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

NUMERATOR:

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

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

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Nephropathy Screening Performed

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

OR

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

OR

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

OR

CPT II 3066F: Documentation of treatment for nephropathy (eg, patient receiving dialysis, patient being treated for ESRD, CRF, ARF, or renal insufficiency, any visit to a nephrologist)

OR

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

OR

Nephropathy Screening not Performed, Reason not 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

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2013 Physician Quality Reporting System (PQRS) Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS PQRS website.

♦Measure #163 (NQF 0056): Diabetes Mellitus: Foot Exam

DESCRIPTION:

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

NUMERATOR:

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

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

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Foot Exam Performed

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

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2013 Physician Quality Reporting System (PQRS) Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS PQRS website.

CHRONIC KIDNEY DISEASE (CKD) MEASURES GROUP OVERVIEW

2013 PQRS OPTIONS FOR MEASURES GROUPS: CLAIMS, REGISTRY

2013 PQRS MEASURES IN THE CHRONIC KIDNEY DISEASE (CKD) MEASURES GROUP:

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

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

Indicate your intention to report the CKD Measures Group by submitting the measures group-specific intent G-code at least once during the reporting period when billing a patient claim for the 20 Patient Sample Method. It is not necessary to submit the measures group-specific intent G-code on more than one claim. It is not necessary to submit the measures group-specific intent G-code for registry-based submissions.

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

- Select patient sample method:
20 Patient Sample Method via claims: 20 unique Medicare Part B FFS (fee for service) patients meeting patient sample criteria for the measures group.
OR
20 Patient Sample Method via registries: 20 unique patients (a majority of which must be Medicare Part B FFS patients) meeting patient sample criteria for the measures group during the reporting period (January 1 through December 31, 2013 **OR** July 1 through December 31, 2013).
- Patient sample criteria for the CKD Measures Group are patients aged 18 years and older with a specific diagnosis of CKD accompanied by a specific patient encounter:

One of the following diagnosis codes indicating stage 4 or 5 chronic kidney disease:

ICD-9-CM: 585.4, 585.5

ICD-10-CM [Reference ONLY/Not Reportable]: N18.4, N18.5

Accompanied by

One of the following patient encounter codes: 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350

- Report quality-data codes (QDCs) on **all applicable** measures within the CKD Measures Group for each patient within the eligible professional's patient sample. Report measures #122 and #123 once during the month the patient is included in the patient sample population. For these measures, subsequent months do not need to be reported.
- Measure #122 only needs to be reported when the patient also has the following diagnosis code indicating Proteinuria:
ICD-9-CM: 791.0
ICD-10-CM [Reference ONLY/Not Reportable]: R80.1 R80.8, R80.9

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

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

- To report satisfactorily the CKD Measures Group requires all applicable measures for each patient within the eligible professional's patient sample to be reported a minimum of once during the reporting period.
- Measure #110 only needs to be reported a minimum of once during the reporting period when the patient's visit included in the patient sample population is between January and March for the 2012-2013 influenza season OR between October and December for the 2013-2014 influenza season. When the patient's office visit is between April and September, Measure #110 is not applicable and will not affect the eligible provider's reporting or performance rate. Measure #110 need only be reported on patients 18 years and older.
- Measures groups containing a measure with a 0% performance rate will not be counted as satisfactorily reporting the measures group. The recommended clinical quality action must be performed on at least one patient for each measure within the measures group reported by the eligible professional. If a measure within a measures group is not applicable to a patient, the patient would not be counted in the performance denominator for that measure (e.g., Preventive Care Measures Group - Measure #39: Screening or Therapy for Osteoporosis for Women Aged 65 Years and Older would not be applicable to male patients according to the patient sample criteria). If the measure is not applicable for all patients within the sample, the performance rate would be 0/0 and would be considered satisfactorily reporting. Performance exclusion quality-data codes are not counted in the performance denominator. If the eligible professional submits all performance exclusion quality-data codes, the performance rate would be 0/0 and would be considered satisfactorily reporting. When a lower rate indicates better performance, such as Measure #123, a 0% performance rate will be counted as satisfactorily reporting (100% performance rate would not be considered satisfactorily reporting).
- When using the 20 Patient Sample Method via claims, report all applicable measures for the 20 unique Medicare Part B FFS patients seen. When using the 20 Patient Sample Method via registries, report all applicable measures for the 20 unique patients seen, a majority of which must be Medicare Part B FFS patients.
- For claims-based submissions, the Carrier/MAC remittance advice notice sent to the practice will show a denial remark code (N365) for the line item on the claim containing G8487 (and G8495 if reported) as well as all other line items containing QDCs. N365 indicates that the code is not payable and is used for reporting/informational purposes only. Other services/codes on the claim will not be affected by the addition of a measures group-specific intent G-code or other QDCs. The N365 remark code does NOT indicate whether the QDC is accurate for that claim or for the measure the eligible professional is attempting to report, but does indicate that the QDC was processed and transmitted to the NCH.

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2013 Physician Quality Reporting System (PQRS) Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS PQRS website.

▲Measure #110 (NQF 0041): Preventive Care and Screening: Influenza Immunization

DESCRIPTION:

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

NUMERATOR:

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

Numerator Instructions:

- 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 (October 1 - March 31). In these cases, **G8482** should be reported.

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

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2013 Physician Quality Reporting System (PQRS) Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS PQRS website.

▲Measure #121: Adult Kidney Disease: Laboratory Testing (Lipid Profile)

DESCRIPTION:

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

NUMERATOR:

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

Definition:

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

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Fasting Lipid Profile Performed

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

OR

Fasting Lipid Profile not Performed, for Documented Reason

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

OR

Fasting Lipid Profile not Performed, Reason not Given

G8728: Fasting lipid profile not performed, reason not given

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2013 Physician Quality Reporting System (PQRS) Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS PQRS website.

▲Measure #122: Adult Kidney Disease: Blood Pressure Management

DESCRIPTION:

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

NUMERATOR:

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

Definitions:

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

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

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

NUMERATOR NOTE: *The correct combination of numerator code(s) must be reported on the claim form in order to properly report this measure. The "correct combination" of codes may require the submission of multiple numerator codes.*

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Patient Visits with Blood Pressure < 130/80 mmHg

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

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

OR

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

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

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

AND

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

OR

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

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

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2013 Physician Quality Reporting System (PQRS) Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS PQRS website.

▲Measure #123: Adult Kidney Disease: Patients On Erythropoiesis-Stimulating Agent (ESA) - Hemoglobin Level > 12.0 g/dL

DESCRIPTION:

Percentage of calendar months within a 12-month period during which a hemoglobin level is measured for patients aged 18 years and older with a diagnosis of advanced CKD (stage 4 or 5, not receiving RRT [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

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 the most recent (last) hemoglobin value recorded for each calendar month

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

Definition:

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

NUMERATOR NOTE: *The correct combination of numerator code(s) must be reported on the claim form in order to properly report this measure. The "correct combination" of codes may require the submission of multiple numerator codes.*

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Most Recent Hemoglobin level > 12.0 g/dL

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

G0908: Most Recent Hemoglobin (Hgb) level > 12.0 g/dL

AND

CPT II 4171F: Patient receiving erythropoiesis-stimulating agents (ESA) therapy

OR

Hemoglobin Level Measurement not Performed, Reason not Given

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

G0909: Hemoglobin level measurement not documented, reason not 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 \leq 12.0 g/dL

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

G0910: Most Recent Hemoglobin Level \leq 12.0 g/dL

AND

CPT II 4171F: Patient receiving erythropoiesis-stimulating agents (ESA) therapy

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NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2013 Physician Quality Reporting System (PQRS) Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS PQRS website.

PREVENTIVE CARE MEASURES GROUP OVERVIEW

2013 PQRS OPTIONS FOR MEASURES GROUPS: CLAIMS, REGISTRY

2013 PQRS MEASURES IN THE PREVENTIVE CARE MEASURES GROUP:

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

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

- Indicate your intention to report the Preventive Care Measures Group by submitting the measures group-specific intent G-code at least once during the reporting period when billing a patient claim for the 20 Patient Sample Method. It is not necessary to submit the measures group-specific intent G-code on more than one claim. It is not necessary to submit the measures group-specific intent G-code for registry-based submissions.

G8486: I intend to report the Preventive Care Measures Group

- Select patient sample method:
20 Patient Sample Method via claims: 20 unique Medicare Part B FFS (fee for service) patients meeting patient sample criteria for the measures group.
OR
20 Patient Sample Method via registries: 20 unique patients (a majority of which must be Medicare Part B FFS patients) meeting patient sample criteria for the measures group during the reporting period (January 1 through December 31, 2013 **OR** July 1 through December 31, 2013).
- Patient sample criteria for the Preventive Care Measures Group are for patients aged 50 years and older with a specific patient encounter:

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

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

Applicable measures contain patient demographic criteria specific to the measure. For example, Screening or Therapy for Osteoporosis is applicable to *women aged 65 years and older* within the sample population, while the Influenza Vaccination measure within this group is applicable to *all patients* aged 50 years and older. Eligible professionals may find it more efficient to report all measures in the group for each patient within their sample. Reporting measure(s) from the group that are inapplicable to an individual patient will not affect the eligible provider's reporting or performance rate.

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

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

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

- To report satisfactorily the Preventive Care Measures Group, it requires **all applicable** measures for each patient within the eligible professional's patient sample to be reported a minimum of once during the reporting period.
- Measure #110 need only be reported a minimum of once during the reporting period when the patient's visit included in the patient sample population is between January and March for the 2012-2013 influenza season **OR** between October and December for the 2013-2014 influenza season. When the patient's office visit is between April and September, Measure #110 is not applicable and will not affect the eligible provider's reporting or performance rate.
- Measures groups containing a measure with a 0% performance rate will not be counted as satisfactorily reporting the measures group. The recommended clinical quality action must be performed on at least one patient for each measure within the measures group reported by the eligible professional. Performance exclusion quality-data codes are not counted in the performance denominator. If the eligible professional submits all performance exclusion quality-data codes, the performance rate would be 0/0 and would be considered satisfactorily reporting. If a measure within a measures group is not applicable to a patient, the patient would not be counted in the performance denominator for that measure (e.g., Preventive Care Measures Group - Measure #39: Screening or Therapy for Osteoporosis for Women Aged 65 Years and Older would not be applicable to male patients according to the patient sample criteria). If the measure is not applicable for all patients within the sample, the performance rate would be 0/0 and would be considered satisfactorily reporting.
- When using the 20 Patient Sample Method via claims, report all measures for the 20 unique Medicare Part B FFS patients seen. When using the 20 Patient Sample Method via registries, report all measures for the 20 unique patients seen, a majority of which must be Medicare Part B FFS patients.

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- For claims-based submissions, the Carrier/MAC remittance advice notice sent to the practice will show a denial remark code (N365) for the line item on the claim containing G8486 (and G8496 if reported) as well as all other line items containing N365 indicates that the code is not payable and is used for reporting/informational purposes only. Other services/codes on the claim will not be affected by the addition of a measures group-specific intent G-code or other QDCs. The N365 remark code does NOT indicate whether the QDC is accurate for that claim or for the measure the eligible professional is attempting to report, but does indicate that the QDC was processed and transmitted to the NCH.

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2013 Physician Quality Reporting System (PQRS) Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS PQRS website.

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

DESCRIPTION:

Percentage of female patients aged 65 years and older who have a central dual-energy X-ray absorptiometry (DXA) measurement ordered or performed at least once since age 60 or pharmacologic therapy prescribed within 12 months

NUMERATOR:

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

Definitions:

Pharmacologic Therapy – U.S. Food and Drug Administration approved pharmacologic options for osteoporosis prevention and/or treatment of postmenopausal osteoporosis include, in alphabetical order: bisphosphonates (alendronate, ibandronate, and risedronate), calcitonin, estrogens (estrogens and/or hormone therapy), parathyroid hormone [PTH (1-34), teriparatide], and selective estrogen receptor modulators 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

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2013 Physician Quality Reporting System (PQRS) Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS PQRS website.

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

DESCRIPTION:

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

NUMERATOR:

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

Definition:

Urinary Incontinence – Any involuntary leakage of urine

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Presence or Absence of Urinary Incontinence Assessed

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

OR

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

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

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

OR

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

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2013 Physician Quality Reporting System (PQRS) Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS PQRS website.

▲Measure #110 (NQF 0041): Preventive Care and Screening: Influenza Immunization

DESCRIPTION:

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

NUMERATOR:

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

Numerator Instructions:

- 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 (October 1 - March 31). In these cases, **G8482** should be reported.

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

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2013 Physician Quality Reporting System (PQRS) Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS PQRS website.

◆ Measure #111 (NQF 0043): Preventive Care and Screening: Pneumococcal Vaccination for Patients 65 Years and Older

DESCRIPTION:

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

NUMERATOR:

Patients who have ever received a pneumococcal vaccination

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Pneumococcal Vaccination Administered or Previously Received

CPT II 4040F: Pneumococcal vaccine administered or previously received

OR

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

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2013 Physician Quality Reporting System (PQRS) Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS PQRS website.

◆ Measure #112 (NQF 0031): Preventive Care and Screening: Breast Cancer Screening

DESCRIPTION:

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

NUMERATOR:

Patients who had a mammogram at least once within 24 months

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Mammogram Performed

CPT II 3014F: Screening mammography results documented and reviewed

OR

Mammogram **not** Performed for Medical Reasons

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

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

OR

Mammogram **not** Performed, Reason not 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

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2013 Physician Quality Reporting System (PQRS) Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS PQRS website.

◆ Measure #113 (NQF 0034): Preventive Care and Screening: Colorectal Cancer Screening

DESCRIPTION:

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

NUMERATOR:

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

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

- Fecal occult blood test (FOBT) within the last 12 months
- Flexible sigmoidoscopy during the reporting period or the four years prior to the reporting period
- Colonoscopy during the reporting period or the nine years prior to the reporting period

NUMERATOR 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

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2013 Physician Quality Reporting System (PQRS) Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS PQRS website.

♦ Measure #128 (NQF 0421): Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up

DESCRIPTION:

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

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 (BMI; kg/m²) 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 dietitian, 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 Note: The most recent quality code submitted will be used for performance calculation.

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".

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

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2013 Physician Quality Reporting System (PQRS) Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS PQRS website.

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

DESCRIPTION:

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

NUMERATOR:

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

Definition:

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

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Unhealthy Alcohol Use Screening Performed

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

OR

Unhealthy Alcohol Use Screening not Performed, for Medical Reasons

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

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

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2013 Physician Quality Reporting System (PQRS) Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS PQRS website.

▲Measure #226 (NQF 0028): Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention

DESCRIPTION:

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

NUMERATOR:

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

Definitions:

Tobacco Use – Includes use of any type of tobacco

Cessation Counseling Intervention – Includes brief counseling (3 minutes or less), and/or pharmacotherapy

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

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

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 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 **not** performed, reason not otherwise specified

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2013 Physician Quality Reporting System (PQRS) Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS PQRS website.

CORONARY ARTERY BYPASS GRAFT (CABG) MEASURES GROUP OVERVIEW

2013 PQRS OPTIONS FOR MEASURES GROUPS: REGISTRY ONLY

2013 PQRS MEASURES IN CORONARY ARTERY BYPASS GRAFT (CABG) MEASURES GROUP:

- #43. Coronary Artery Bypass Graft (CABG): Use of Internal Mammary Artery (IMA) in Patients with Isolated CABG Surgery
- #44. Coronary Artery Bypass Graft (CABG): Preoperative Beta-Blocker in Patients with Isolated CABG Surgery
- #164. Coronary Artery Bypass Graft (CABG): Prolonged Intubation
- #165. Coronary Artery Bypass Graft (CABG): Deep Sternal Wound Infection Rate
- #166. Coronary Artery Bypass Graft (CABG): Stroke
- #167. Coronary Artery Bypass Graft (CABG): Postoperative Renal Failure
- #168. Coronary Artery Bypass Graft (CABG): Surgical Re-Exploration
- #169. Coronary Artery Bypass Graft (CABG): Anti-Platelet Medications at Discharge
- #170. Coronary Artery Bypass Graft (CABG): Beta-Blockers Administered at Discharge
- #171. Coronary Artery Bypass Graft (CABG): Anti-Lipid Treatment at Discharge

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

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

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

- Report the patient sample method:

20 Patient Sample Method: 20 unique procedures (patients – a majority of which must be Medicare Part B FFS [fee for service] patients) meeting patient sample criteria for the measures group during the reporting period (January 1 through December 31, 2013 OR July 1 through December 31, 2013).

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

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

- Measure #167 need only be reported when the patient does not have a history renal failure or a baseline serum creatinine ≥ 4.0 mg/dL. Measure #169, #170, and #171 need only be reported when the patient is not deceased prior to discharge. Therefore, these measures are only applicable to a patient when these additional criteria are indicated.
- Report a numerator option on all applicable measures within the CABG Measures Group for each procedure (patient) within the eligible professional's patient sample.

Instructions for qualifying numerator option reporting for each of the measures within the CABG Measures Group are displayed on the next several pages. The following composite G-code has been created for registry only measures groups for use by registries that utilize claims data. This composite G-code may be reported in lieu of the individual quality-data codes for each of the

measures within the group, if all quality actions for the patient have been performed for all the measures within the group. However, it is not necessary to submit the following composite G-code for registry-based submissions.

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

- To report satisfactorily the CABG Measures Group it requires all applicable measures for each patient within the eligible professional's patient sample to be reported each time an isolated CABG procedure is performed during the reporting period.
- Measures groups containing a measure with a 0% performance rate will not be counted as satisfactorily reporting the measures group. The recommended clinical quality action must be performed on at least one patient for each measure within the measures group reported by the eligible professional. Performance exclusion quality-data codes are not counted in the performance denominator. If the eligible professional submits all performance exclusion quality-data codes, the performance rate would be 0/0 and would be considered satisfactorily reporting. If a measure within a measures group is not applicable to a patient, the patient would not be counted in the performance denominator for that measure (e.g., Preventive Care Measures Group - Measure #39: Screening or Therapy for Osteoporosis for Women would not be applicable to male patients according to the patient sample criteria). If the measure is not applicable for all patients within the sample, the performance rate would be 0/0 and would be considered satisfactorily reporting. When a lower rate indicates better performance, such as Measure #164, a 0% performance rate will be counted as satisfactorily reporting (100% performance rate would not be considered satisfactorily reporting).
- When using the 20 Patient Sample Method, report all applicable measures for the 20 unique procedures performed (patients seen) a majority of which must be Medicare Part B FFS procedures (patients) for the 12-month or 6-month reporting period.

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2013 Physician Quality Reporting System (PQRS) Measure Specifications Manual for Claims and Registry Reporting of Individual Measures" available for download from the CMS PQRS website.

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

DESCRIPTION:

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

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

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

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2013 Physician Quality Reporting System (PQRS) Measure Specifications Manual for Claims and Registry Reporting of Individual Measures" available for download from the CMS PQRS website.

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

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

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

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

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2012 Physician Quality Reporting System (PQRS) Measure Specifications Manual for Claims and Registry Reporting of Individual Measures" available for download from the CMS PQRS website.

ΩMeasure #164 (NQF 0129): Coronary Artery Bypass Graft (CABG): Prolonged Intubation

DESCRIPTION:

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

NUMERATOR:

Patients undergoing isolated CABG who require intubation > 24 hours

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

Numerator Options:

Prolonged intubation (> 24 hrs) required (G8569)

OR

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

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2013 Physician Quality Reporting System (PQRS) Measure Specifications Manual for Claims and Registry Reporting of Individual Measures" available for download from the CMS PQRS website.

ΩMeasure #165 (NQF 0130): Coronary Artery Bypass Graft (CABG): Deep Sternal Wound Infection Rate

DESCRIPTION:

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

NUMERATOR:

Patients who, within 30 days postoperatively, develop 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 is on antibiotics at time of culture or no culture obtained, and 3. treatment with antibiotics beyond perioperative prophylaxis

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

Numerator Options:

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

OR

No deep sternal wound infection (G8572)

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2013 Physician Quality Reporting System (PQRS) Measure Specifications Manual for Claims and Registry Reporting of Individual Measures" available for download from the CMS PQRS website.

ΩMeasure #166 (NQF 0131): Coronary Artery Bypass Graft (CABG): Stroke

DESCRIPTION:

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

NUMERATOR:

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

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

Numerator Options:

Stroke following isolated CABG surgery (G8573)

OR

No stroke following isolated CABG surgery (G8574)

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2013 Physician Quality Reporting System (PQRS) Measure Specifications Manual for Claims and Registry Reporting of Individual Measures" available for download from the CMS PQRS website.

ΩMeasure #167 (NQF 0114): Coronary Artery Bypass Graft (CABG): Postoperative Renal Failure

DESCRIPTION:

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

NUMERATOR:

Patients who develop postoperative renal failure or require dialysis; (Definition of renal failure/dialysis requirement - patient had acute renal failure or worsening renal function resulting in one of the following: 1) increase of serum creatinine to ≥ 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)

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2013 Physician Quality Reporting System (PQRS) Measure Specifications Manual for Claims and Registry Reporting of Individual Measures" available for download from the CMS PQRS website.

Measure #168 (NQF 0115): Coronary Artery Bypass Graft (CABG): Surgical Re-Exploration

DESCRIPTION:

Percentage of patients aged 18 years and older undergoing isolated CABG surgery who require a return to the operating room (OR) during the current hospitalization for mediastinal bleeding with or without tamponade, graft occlusion, valve dysfunction, or other cardiac reason

NUMERATOR:

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

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

Numerator Options:

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**)

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2013 Physician Quality Reporting System (PQRS) Measure Specifications Manual for Claims and Registry Reporting of Individual Measures" available for download from the CMS PQRS website.

ΩMeasure #169 (NQF 0116): Coronary Artery Bypass Graft (CABG): Antiplatelet Medications at Discharge

DESCRIPTION:

Percentage of patients aged 18 years and older undergoing isolated CABG surgery who were discharged on antiplatelet medication

NUMERATOR:

Patients who were discharged on antiplatelet medication

Numerator Options:

Antiplatelet medication at discharge (G8579)

OR

Antiplatelet medication contraindicated (G8580)

OR

No antiplatelet medication at discharge (G8581)

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2013 Physician Quality Reporting System (PQRS) Measure Specifications Manual for Claims and Registry Reporting of Individual Measures" available for download from the CMS PQRS website.

ΩMeasure #170 (NQF 0117): Coronary Artery Bypass Graft (CABG): Beta-Blockers Administered at Discharge

DESCRIPTION:

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

NUMERATOR:

Patients who were discharged on beta-blockers

Numerator Options:

Beta-blocker at discharge (G8582)

OR

Beta-blocker contraindicated (G8583)

OR

No beta-blocker at discharge (G8584)

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2013 Physician Quality Reporting System (PQRS) Measure Specifications Manual for Claims and Registry Reporting of Individual Measures" available for download from the CMS PQRS website.

ΩMeasure #171 (NQF 0118): Coronary Artery Bypass Graft (CABG): Anti-Lipid Treatment at Discharge

DESCRIPTION:

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

NUMERATOR:

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

Numerator Options:

Anti-lipid treatment at discharge (G8585)

OR

Anti-lipid treatment contraindicated (G8586)

OR

No anti-lipid treatment at discharge (G8587)

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2013 Physician Quality Reporting System (PQRS) Measure Specifications Manual for Claims and Registry Reporting of Individual Measures" available for download from the CMS PQRS website.

RHEUMATOID ARTHRITIS (RA) MEASURES GROUP OVERVIEW

2013 PQRS OPTIONS FOR MEASURES GROUPS: CLAIMS, REGISTRY

2013 PQRS MEASURES IN RHEUMATOID ARTHRITIS (RA) MEASURES GROUP:

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

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

- Indicate your intention to report the RA Measures Group by submitting the measures group-specific intent G-code at least once during the reporting period when billing a patient claim for the 20 Patient Sample Method. It is not necessary to submit the measures group-specific intent G-code on more than one claim. It is not necessary to submit the measures group-specific intent G-code for registry-based submissions.

G8490: I intend to report the Rheumatoid Arthritis Measures Group

- Select patient sample method:
20 Patient Sample Method via claims: 20 unique Medicare Part B FFS (fee for service) patients meeting patient sample criteria for the measures group.
OR
20 Patient Sample Method via registries: 20 unique patients (a majority of which must be Medicare Part B FFS patients) meeting patient sample criteria for the measures group during the reporting period (January 1 through December 31, 2013 OR July 1 through December 31, 2013).
- Patient sample criteria for the RA Measures Group are patients aged 18 years and older with a specific diagnosis of RA accompanied by a specific patient encounter:

One of the following diagnosis codes indicating rheumatoid arthritis:

ICD-9-CM: 714.0, 714.1, 714.2, 714.81

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, 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

Accompanied by

One of the following patient encounter codes: 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, G0402

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

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

- To report satisfactorily the RA Measures Group it requires all measures for each patient within the eligible professional's patient sample to be reported a minimum of once during the reporting period.
- Measures groups containing a measure with a 0% performance rate will not be counted as satisfactorily reporting the measures group. The recommended clinical quality action must be performed on at least one patient for each measure within the measures group reported by the eligible professional. Performance exclusion quality-data codes are not counted in the performance denominator. If the eligible professional submits all performance exclusion quality-data codes, the performance rate would be 0/0 and would be considered satisfactorily reporting.
- When using the 20 Patient Sample Method via claims, report all measures for the 20 unique Medicare Part B FFS patients seen. When using the 20 Patient Sample Method via registries, report all measures for the 20 unique patients seen, a majority of which must be Medicare Part B FFS patients.
- For claims-based submissions, the Carrier/MAC remittance advice notice sent to the practice will show a denial remark code (N365) for the line item on the claim containing G8490 (and G8499 if reported) as well as all other line items containing QDCs. N365 indicates that the code is not payable and is used for reporting/informational purposes only. Other services/codes on the claim will not be affected by the addition of a measures group-specific intent G-code or other QDCs. The N365 remark code does NOT indicate whether the QDC is accurate for that claim or for the measure the eligible professional is attempting to report, but does indicate that the QDC was processed and transmitted to the NCH.

2013 PQRS Measures Groups Specifications Manual

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2013 Physician Quality Reporting System (PQRS) Measure Specifications Manual for Claims and Registry Reporting of Individual Measures" available for download from the CMS PQRS website.

◆Measure #108 (NQF 0054): Rheumatoid Arthritis (RA): Disease Modifying Anti-Rheumatic Drug (DMARD) Therapy

DESCRIPTION:

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

NUMERATOR:

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

Definitions:

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

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

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

2013 PQRS Measures Groups Specifications Manual

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2013 Physician Quality Reporting System (PQRS) Measure Specifications Manual for Claims and Registry Reporting of Individual Measures" available for download from the CMS PQRS website.

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

DESCRIPTION:

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

NUMERATOR:

Patients for whom a TB screening was performed and results interpreted within 6 months prior to receiving a first course of therapy using a biologic disease-modifying anti-rheumatic drug (DMARD)

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

Definition:

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

NUMERATOR NOTE: *The correct combination of numerator code(s) must be reported on the claim form in order to properly report this measure. The "correct combination" of codes may require the submission of multiple numerator codes.*

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Tuberculosis Screening Performed and Results Interpreted

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

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

AND

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

OR

TB Screening not Performed or Results not Interpreted for Medical Reasons

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

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

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

AND

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

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

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2013 Physician Quality Reporting System (PQRS) Measure Specifications Manual for Claims and Registry Reporting of Individual Measures" available for download from the CMS PQRS website.

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

DESCRIPTION:

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

NUMERATOR:

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

Definition:

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

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Disease Activity Assessed and Classified

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

OR

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

OR

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

OR

Disease Activity not Assessed and Classified, Reason not 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.

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

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2013 Physician Quality Reporting System (PQRS) Measure Specifications Manual for Claims and Registry Reporting of Individual Measures" available for download from the CMS PQRS website.

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

DESCRIPTION:

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

NUMERATOR:

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

Definitions:

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

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

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Functional Status Assessed

CPT II 1170F: Functional status assessed

OR

Functional Status not Assessed, Reason not 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

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2013 Physician Quality Reporting System (PQRS) Measure Specifications Manual for Claims and Registry Reporting of Individual Measures" available for download from the CMS PQRS website.

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

DESCRIPTION:

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

NUMERATOR:

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

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

Definitions:

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

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

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Disease Prognosis Assessed and Classified

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

OR

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

OR

Disease Prognosis not Assessed and Classified, Reason not 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

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document '2013 Physician Quality Reporting System (PQRS) Measure Specifications Manual for Claims and Registry Reporting of Individual Measures' available for download from the CMS PQRS website.

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

DESCRIPTION:

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

NUMERATOR:

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

Definitions:

Prolonged Dose – Doses > 6 months in duration

Prednisone Equivalents – Determine using the following:

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

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

NUMERATOR NOTE: *The correct combination of numerator code(s) must be reported on the claim form in order to properly report this measure. The "correct combination" of codes may require the submission of multiple numerator codes.*

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Glucocorticoid Use Assessed

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

CPT II 4192F: Patient not receiving glucocorticoid therapy

OR

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

OR

Glucocorticoid Use Assessed and Management Plan Documented

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

CPT II 4194F: Patient receiving ≥ 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 and 4194F] are required on the claim form to submit this numerator option)

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

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

AND

CPT II 4194F: Patient receiving ≥ 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 and 4194F] are required on the claim form to submit this numerator option)

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

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

AND

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

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2013 Physician Quality Reporting System (PQRS) Measure Specifications Manual for Claims and Registry Reporting of Individual Measures" available for download from the CMS PQRS website.

PERIOPERATIVE CARE MEASURES GROUP OVERVIEW

2013 PQRS OPTIONS FOR MEASURES GROUPS: CLAIMS, REGISTRY

2013 PQRS MEASURES IN PERIOPERATIVE CARE MEASURES GROUP:

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

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

- Indicate your intention to report the Perioperative Care Measures Group by submitting the measures group-specific intent G-code at least once during the reporting period when billing a patient claim for the 20 Patient Sample Method. It is not necessary to submit the measures group-specific intent G-code on more than one claim. It is not necessary to submit the measures group-specific intent G-code for registry-based submissions.

G8492: I intend to report the Perioperative Care Measures Group

- Select patient sample method:
20 Patient Sample Method via claims: 20 unique Medicare Part B FFS (fee for service) procedures (patients) meeting patient sample criteria for the measures group.
OR
20 Patient Sample Method via registries: 20 unique procedures (patients - a majority of which must be Medicare Part B FFS patients) meeting patient sample criteria for the measures group during the reporting period (January 1 through December 31, 2013 **OR** July 1 through December 31, 2013).
- Patient sample criteria for the Perioperative Care Measures Group are patients aged 18 years and older that have a specific surgical procedure performed:

One of the following surgical procedure codes: 0236T, 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, 21627, 21632, 21740, 21750, 21805, 21825, 22558, 22600, 22612, 22630, 27080, 27125, 27130, 27132, 27134, 27137, 27138, 27158, 27202, 27215, 27216, 27217, 27218, 27235, 27236, 27244, 27245, 27269, 27280, 27282, 27440, 27441, 27442, 27443, 27445, 27446, 27447, 27880, 27881, 27882, 27884, 27886, 27888, 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, 33877, 33880, 33881, 33883, 33886, 33889, 33891, 34051, 34800, 34802, 34803, 34804, 34805, 34812, 34820, 34825, 34830, 34831, 34832, 34833, 34834, 34900, 35011, 35013, 35021, 35081, 35082, 35091, 35092, 35102, 35103, 35131, 35141, 35142, 35151, 35152, 35206, 35216, 35246, 35266, 35271, 35276, 35301, 35311, 35363, 35371, 35372, 35460, 35512, 35521, 35522, 35523, 35525, 35526, 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, 37235, 37616, 37617, 38100, 38101, 38115, 38120, 38381, 38571, 38572, 38700, 38720, 38724, 38740, 38745, 38746, 38747, 38760, 38765, 38770, 38780, 39000, 39010, 39200, 39220, 39545, 39561, 42020, 42030, 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, 43635, 43640, 43641, 43644, 43645, 43651, 43652, 43653, 43800, 43810, 43820, 43825, 43830, 43832, 43840, 43842, 43843, 43845, 43846, 43847, 43848, 43849, 43850, 43855, 43860, 43865, 43870, 43880, 44005, 44010, 44020, 44021, 44050, 44055, 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, 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, 47100, 47120, 47122, 47125, 47130, 47140, 47141, 47142, 47350, 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, 48000, 48001, 48020, 48100, 48102, 48105, 48120, 48140, 48145, 48146, 48148, 48150, 48152, 48153, 48154, 48155, 48160, 48500, 48510, 48520, 48540, 48545, 48547, 48548, 48554, 48556, 49000, 49002, 49010, 49020, 49021, 49040, 49041, 49060, 49203, 49204, 49205, 49215, 49220, 49250, 49320, 49321, 49322, 49323, 49505, 49507, 49568, 50320, 50340, 50360, 50365, 50370, 50380, 57267, 58150, 58152, 58180, 58200, 58210, 58240, 58260, 58262, 58263, 58267, 58270, 58275, 58280, 58285, 58290, 58291, 58292, 58293, 58294, 58951, 58953, 58954, 58956, 60521, 60522, 61312, 61313, 61315, 61510, 61512, 61518, 61548, 61697, 61700, 62230, 63015, 63020, 63047, 63056, 63081, 63267, 63276, 64746

NOTE: CPT Category I procedure codes billed by surgeons performing surgery on the same patient, submitted with modifier 62 (indicating two surgeons, i.e., dual procedures) will be included in the denominator population. Both surgeons participating in PQRS will be fully accountable for the clinical action described in the measure.

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

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

- To report satisfactorily the Perioperative Care Measures Group it requires all measures for each patient within the eligible professional's patient sample to be reported each time a surgical procedure is performed during the reporting period.

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- Measures groups containing a measure with a 0% performance rate will not be counted as satisfactorily reporting the measures group. The recommended clinical quality action must be performed on at least one patient for each measure within the measures group reported by the eligible professional. Performance exclusion quality-data codes are not counted in the performance denominator. If the eligible professional submits all performance exclusion quality-data codes, the performance rate would be 0/0 and would be considered satisfactorily reporting.
- When using the 20 Patient Sample Method via claims, report all measures for the 20 unique Medicare Part B FFS procedures performed (patients seen). When using the 20 Patient Sample Method via registries, report all measures for the 20 unique procedures performed (patients seen), a majority of which must be Medicare Part B FFS patients.
- For claims-based submissions, the Carrier/MAC remittance advice notice sent to the practice will show a denial remark code (N365) for the line item on the claim containing G8492 (and G8501 if reported) as well as all other line items containing QDCs. N365 indicates that the code is not payable and is used for reporting/informational purposes only. Other services/codes on the claim will not be affected by the addition of a measures group-specific intent G-code or other QDCs. The N365 remark code does NOT indicate whether the QDC is accurate for that claim or for the measure the eligible professional is attempting to report, but does indicate that the QDC was processed and transmitted to the NCH.

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2013 Physician Quality Reporting System (PQRS) Measure Specifications Manual for Claims and Registry Reporting of Individual Measures" available for download from the CMS PQRS website.

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

DESCRIPTION:

Percentage of surgical patients aged 18 years and older undergoing procedures with the indications for prophylactic parenteral antibiotics, who have an order for prophylactic parenteral antibiotic to be given within one hour (if fluoroquinolone or vancomycin, two hours), prior to the surgical incision (or start of procedure when no incision is required)

NUMERATOR:

Surgical patients who have an order for prophylactic parenteral antibiotic to be given within one hour (if fluoroquinolone or vancomycin, two hours) prior to the surgical incision (or start of procedure when no incision is required)

Numerator Instructions: There must be documentation of order (written order, verbal order, or standing order/protocol) specifying that prophylactic parenteral antibiotic is to be given within one hour (if fluoroquinolone or vancomycin, two hours) prior to the surgical incision (or start of procedure when no incision is required) OR documentation that prophylactic parenteral antibiotic has been given within one hour (if fluoroquinolone or vancomycin, two hours) prior to the surgical incision (or start of procedure when no incision is required).

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.

<ul style="list-style-type: none"> • Ampicillin/sulbactam • Aztreonam • Cefazolin • Cefmetazole • Cefotetan • Cefoxitin 	<ul style="list-style-type: none"> • Cefuroxime • Ciprofloxacin • Clindamycin • Ertapenem • Erythromycin base • Gatifloxacin 	<ul style="list-style-type: none"> • Gentamicin • Levofloxacin • Metronidazole • Moxifloxacin • Neomycin • Vancomycin
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Documentation of Order for Prophylactic Parenteral Antibiotic (written order, verbal order, or standing order/protocol)

G8629: Documentation of order for prophylactic parenteral antibiotics to be given within one hour (if fluoroquinolone or vancomycin, two hours) prior to surgical incision (or start of procedure when no incision is required)

OR

Documentation that Prophylactic Parenteral Antibiotic has been Given within One Hour Prior to the Surgical Incision (or start of procedure when no incision is required)

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

OR

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

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

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2013 Physician Quality Reporting System (PQRS) Measure Specifications Manual for Claims and Registry Reporting of Individual Measures" available for download from the CMS PQRS website.

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

DESCRIPTION:

Percentage of surgical patients aged 18 years and older undergoing procedures with the indications for a first OR second generation cephalosporin prophylactic antibiotic, who had an order for cefazolin OR cefuroxime for antimicrobial prophylaxis

NUMERATOR:

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

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

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

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2013 Physician Quality Reporting System (PQRS) Measure Specifications Manual for Claims and Registry Reporting of Individual Measures" available for download from the CMS PQRS website.

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

DESCRIPTION:

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

NUMERATOR:

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

Numerator Instructions: There must be documentation of order (written order, verbal order, or standing order/protocol) specifying that prophylactic parenteral antibiotic is to be discontinued within 24 hours of surgical end time OR specifying a course of antibiotic administration limited to that 24-hour period (e.g., "to be given every 8 hours for three doses" or for "one time" IV dose orders) OR documentation that prophylactic parenteral was discontinued within 24 hours of surgical end time.

NUMERATOR NOTE: *The correct combination of numerator code(s) must be reported on the claim form in order to properly report this measure. The "correct combination" of codes may require the submission of multiple numerator codes.*

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Documentation of Order for Discontinuation of Prophylactic Parenteral Antibiotics (written order, verbal order, or standing order/protocol) Within 24 Hours of Surgical End Time
(Two CPT II codes [4049F & 4046F] are required on the claim form to submit this numerator option)

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

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

AND

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

OR

Prophylactic Parenteral Antibiotics not Discontinued for Medical Reasons

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

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

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

AND

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

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2013 Physician Quality Reporting System (PQRS) Measure Specifications Manual for Claims and Registry Reporting of Individual Measures" available for download from the CMS PQRS website.

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

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

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

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2013 Physician Quality Reporting System (PQRS) Measure Specifications Manual for Claims and Registry Reporting of Individual Measures" available for download from the CMS PQRS website.

BACK PAIN MEASURES GROUP OVERVIEW

2013 PQRS OPTIONS FOR MEASURES GROUPS: CLAIMS, REGISTRY

2013 PQRS MEASURES IN BACK PAIN MEASURES GROUP:

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

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

- Indicate your intention to report the Back Pain Measures Group by submitting the measures group-specific intent G-code at least once during the reporting period when billing a patient claim for the 20 Patient Sample Method. It is not necessary to submit the measures group-specific intent G-code on more than one claim. It is not necessary to submit the measures group-specific intent G-code for registry-based submissions.

G8493: I intend to report the Back Pain Measures Group

- Select patient sample method:
20 Patient Sample Method via claims: 20 unique Medicare Part B FFS (fee for service) patients meeting patient sample criteria for the measures group.
OR
20 Patient Sample Method via registries: 20 unique patients (a majority of which must be Medicare Part B FFS patients) meeting patient sample criteria for the measures group during the reporting period (January 1 through December 31, 2013 **OR** July 1 through December 31, 2013).
- Patient sample criteria for the Back Pain Measures Group are patients aged 18 through 79 years with a specific diagnosis for back pain accompanied by a specific patient encounter **OR** patients aged 18-79 years that have a specific back surgical procedure performed:

One of the following diagnosis codes indicating back pain:

ICD-9-CM: 721.3, 721.41, 721.42, 721.90, 722.0, 722.10, 722.11, 722.2, 722.30, 722.31, 722.32, 722.39, 722.4, 722.51, 722.52, 722.6, 722.70, 722.71, 722.72, 722.73, 722.80, 722.81, 722.82, 722.83, 722.90, 722.91, 722.92, 722.93, 723.0, 724.00, 724.01, 724.02, 724.09, 724.2, 724.3, 724.4, 724.5, 724.6, 724.70, 724.71, 724.79, 738.4, 738.5, 739.3, 739.4, 756.12, 846.0, 846.1, 846.2, 846.3, 846.8, 846.9, 847.2

ICD-10-CM [Reference ONLY/Not reportable]: M43.00, M43.10, M43.27, M43.28, M46.40, M46.41, M46.42, M46.43, M46.44, M46.45, M46.46, M46.47, M46.48, M46.49, M47.14, M47.15, M47.16, M47.17, M47.18, M47.20, M47.26, M47.27, M47.28, M47.816, M47.817, M47.818, M47.819, M47.896, M47.897, M47.898, M47.899, M47.9, M48.00, M48.01, M48.02, M48.03, M48.04, M48.05, M48.06, M48.07, M48.08, M50.00, M50.01, M50.02, M50.03, M50.20, M50.21, M50.22, M50.23, M50.30, M50.31, M50.32, M50.33, M50.80, M50.81, M50.82, M50.83, M50.90, M50.91, M50.92, M50.93, M51.04, M51.05, M51.06, M51.07, M51.14, M51.15, M51.16, M51.17, M51.24, M51.26, M51.27, M51.34, M51.35, M51.36, M51.37, M51.44, M51.45, M51.47, M51.87, M51.9, M53.2X7, M53.2X8, M53.86, M53.87, M53.88, M54.14, M54.15, M54.16, M54.17, M54.30, M54.31, M54.32, M54.40, M54.41, M54.42, M54.5, M54.89, M54.9, M96.1, M99.03, M99.04, M99.20, M99.21, M99.22, M99.23, M99.24, M99.25, M99.26, M99.27, M99.28, M99.29, M99.30, M99.31, M99.32, M99.33, M99.34, M99.35, M99.36, M99.37, M99.38, M99.39, M99.40, M99.41, M99.42, M99.43, M99.44, M99.45, M99.46, M99.47, M99.48, M99.49, M99.50, M99.51, M99.52,

M99.53, M99.54, M99.55, M99.56, M99.57, M99.58, M99.59, M99.60, M99.61, M99.62, M99.63, M99.64, M99.65, M99.66, M99.67, M99.68, M99.69, M99.70, M99.71, M99.72, M99.73, M99.74, M99.75, M99.76, M99.77, M99.78, M99.79, M99.83, M99.84, Q76.2, S33.5XXA, S33.6XXA, S33.8XXA, S33.9XXA

AND

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

OR

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

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

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

- To report satisfactorily the Back Pain Measures Group for the 20 Patient Sample Method it requires all measures for each patient within the sample to be reported where the initial visit to the clinician for each episode of back pain or each surgery for back pain that occurred during the corresponding reporting period. If the patient's initial visit for this episode of back pain occurred prior to the beginning of the reporting period, report that the visit in the sample is a subsequent visit for the episode and this will not count toward the 20 patient sample. This measures group may be reported by more than one clinician if multiple clinicians evaluate or treat the patient for the back pain episode.
- Measures groups containing a measure with a 0% performance rate will not be counted as satisfactorily reporting the measures group. The recommended clinical quality action must be performed on at least one patient for each measure within the measures group reported by the eligible professional.
- When using the 20 Patient Sample Method via claims, report all measures for 20 unique Medicare Part B FFS patients seen. When using the 20 Patient Sample Method via registries, report all measures for 20 unique patients seen, a majority of which must be Medicare Part B FFS patients.
- For claims-based submissions, the Carrier/MAC remittance advice notice sent to the practice will show a denial remark code (N365) for the line item on the claim containing G8493 (and G8502 if

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reported) as well as all other line items containing QDCs. N365 indicates that the code is not payable and is used for reporting/informational purposes only. Other services/codes on the claim will not be affected by the addition of a measures group-specific intent G-code or other QDCs. The N365 remark code does NOT indicate whether the QDC is accurate for that claim or for the measure the eligible professional is attempting to report, but does indicate that the QDC was processed and transmitted to the NCH.

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2013 Physician Quality Reporting System (PQRS) Measure Specifications Manual for Claims and Registry Reporting of Individual Measures" available for download from the CMS PQRS website.

♦Measure #148 (NQF 0322): Back Pain: Initial Visit

DESCRIPTION:

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

NUMERATOR:

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

Definitions:

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

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

OR

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

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

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

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

OR

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

- Eating
- Bathing
- Using the toilet
- Dressing
- Getting up from bed or a chair

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

- Indication/notation of presence or absence of red flags

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

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

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

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

- Sickness Impact Profile
- Multidimensional Pain Inventory

OR

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

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

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

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

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Back Pain and Function Assessed

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

OR

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

CPT II 0526F: Subsequent visit for episode

OR

Back Pain and Function not Assessed, Reason not Otherwise Specified

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

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

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2013 Physician Quality Reporting System (PQRS) Measure Specifications Manual for Claims and Registry Reporting of Individual Measures" available for download from the CMS PQRS website.

♦Measure #149 (NQF 0319): Back Pain: Physical Exam

DESCRIPTION:

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

NUMERATOR:

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

Definitions:

Physical Examination:

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

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

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

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

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

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

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Physical Exam Performed

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

OR

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

CPT II 0526F: Subsequent visit for episode

OR

Physical Exam not Performed, Reason not Otherwise Specified

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

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

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NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2013 Physician Quality Reporting System (PQRS) Measure Specifications Manual for Claims and Registry Reporting of Individual Measures" available for download from the CMS PQRS website.

♦Measure #150 (NQF 0314): Back Pain: Advice for Normal Activities

DESCRIPTION:

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

NUMERATOR:

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

Definitions:

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

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

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Advice for Normal Activities Performed

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

OR

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

CPT II 0526F: Subsequent visit for the episode

OR

Advice for Normal Activities not Performed, Reason not Otherwise Specified

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

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

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2013 Physician Quality Reporting System (PQRS) Measure Specifications Manual for Claims and Registry Reporting of Individual Measures" available for download from the CMS PQRS website.

♦Measure #151 (NQF 0313): Back Pain: Advice Against Bed Rest

DESCRIPTION:

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

NUMERATOR:

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

Definitions:

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

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

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Advice Against Bed Rest Performed

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

OR

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

CPT II 0526F: Subsequent visit for episode

OR

Advice Against Bed Rest not Performed, Reason not Otherwise Specified

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

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

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2013 Physician Quality Reporting System (PQRS) Measure Specifications Manual for Claims and Registry Reporting of Individual Measures" available for download from the CMS PQRS website.

HEPATITIS C MEASURES GROUP OVERVIEW

2013 PQRS OPTIONS FOR MEASURES GROUPS: CLAIMS, REGISTRY

2013 PQRS MEASURES IN HEPATITIS C MEASURES GROUP:

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

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

- Indicate your intention to report the Hepatitis C Measures Group by submitting the measures group-specific intent G-code at least once during the reporting period when billing a patient claim for the 20 Patient Sample Method. It is not necessary to submit the measures group-specific intent G-code on more than one claim. It is not necessary to submit the measures group-specific intent G-code for registry-based submissions.

G8545: I intend to report the Hepatitis C Measures Group

- Select patient sample method:
20 Patient Sample Method via claims: 20 unique Medicare Part B FFS (fee for service) patients meeting patient sample criteria for the measures group.
OR
20 Patient Sample Method via registries: 20 unique patients (a majority of which must be Medicare Part B FFS patients) meeting patient sample criteria for the measures group during the reporting period (January 1 through December 31, 2013 **OR** July 1 through December 31, 2013).
- Patient sample criteria for the Hepatitis C Measures Group are patients aged 18 years and older with a specific diagnosis of chronic hepatitis C accompanied by a specific patient encounter:

One of the following diagnosis codes indicating chronic hepatitis C:

ICD-9-CM: 070.54

ICD-10-CM [Reference ONLY/Not Reportable]: B18.2

Accompanied by

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

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

Applicable measures contain patient demographic criteria specific to the measure. For example, Counseling Regarding Use of Contraception Prior to Antiviral Therapy is applicable to female patients *aged 18 through 44 years and all men aged 18 years and older* within the sample population, while the Antiviral Treatment Prescribed measure within this group is applicable to *all*

patients aged 18 years and older. Eligible professionals may find it more efficient to report all measures in the group for each patient within their sample. Reporting measure(s) from the group that are inapplicable to an individual patient will not affect the eligible provider's reporting or performance rate.

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

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

- To report satisfactorily the Hepatitis C Measures Group it requires **all applicable** measures for each patient within the eligible professional's patient sample to be reported a minimum of once during the reporting period.
- Measures groups containing a measure with a 0% performance rate will not be counted as satisfactorily reporting the measures group. The recommended clinical quality action must be performed on at least one patient for each measure within the measures group reported by the eligible professional. Performance exclusion quality-data codes are not counted in the performance denominator. If the eligible professional submits all performance exclusion quality-data codes, the performance rate would be 0/0 and would be considered satisfactorily reporting. If a measure within a measures group is not applicable to a patient, the patient would not be counted in the performance denominator for that measure (e.g., Preventive Care Measures Group - Measure #39: Screening or Therapy for Osteoporosis for Women would not be applicable to male patients according to the patient sample criteria). If the measure is not applicable for all patients within the sample, the performance rate would be 0/0 and would be considered satisfactorily reporting.
- When using the 20 Patient Sample Method via claims, report all measures for the 20 unique Medicare Part B FFS patients seen. When using the 20 Patient Sample Method via registries, report all measures for the 20 unique patients seen, a majority of which must be Medicare Part B FFS patients.
- For claims-based submissions, the Carrier/MAC remittance advice notice sent to the practice will show a denial remark code (N365) for the line item on the claim containing **G8545** (and **G8549** if reported) as well as all other line items containing QDCs. N365 indicates that the code is not payable and is used for reporting/informational purposes only. Other services/codes on the claim will not be affected by the addition of a measures group-specific intent G-code or other QDCs. The N365 remark code does NOT indicate whether the QDC is accurate for that claim or for the measure the eligible professional is attempting to report, but does indicate that the QDC was processed and transmitted to the NCH.

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2013 Physician Quality Reporting System (PQRS) Measure Specifications Manual for Claims and Registry Reporting of Individual Measures" available for download from the CMS PQRS website.

▲Measure #84 (NQF 0395): Hepatitis C: Ribonucleic Acid (RNA) Testing Before Initiating Treatment

DESCRIPTION:

Percentage of patients aged 18 years and older with a diagnosis of chronic hepatitis C who are receiving antiviral treatment for whom quantitative HCV RNA testing was performed within 6 months prior to initiation of antiviral treatment

NUMERATOR:

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

NUMERATOR NOTE: *The correct combination of numerator code(s) must be reported on the claim form in order to properly report this measure. The "correct combination" of codes may require the submission of multiple numerator codes.*

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

RNA Testing Performed within Six Months

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

CPT II 3218F: RNA testing for Hepatitis C documented as performed within 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 (e.g., if patient is first seen by physician after initiation of treatment)

AND

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

OR

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

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

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

OR

RNA Testing not Performed within Six Months, Reason not 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

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NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2013 Physician Quality Reporting System (PQRS) Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS PQRS website.

▲Measure #85 (NQF 0396): Hepatitis C: HCV Genotype Testing Prior to Treatment

DESCRIPTION:

Percentage of patients aged 18 years and older with a diagnosis of chronic hepatitis C who are receiving antiviral treatment for whom HCV genotype testing was performed prior to initiation of antiviral treatment

NUMERATOR:

Patients for whom HCV genotype testing was performed 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

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2013 Physician Quality Reporting System (PQRS) Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS PQRS website.

▲Measure #86 (NQF 0397): Hepatitis C: Antiviral Treatment Prescribed

DESCRIPTION:

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

NUMERATOR:

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

Definition:

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

NUMERATOR 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 ribavirin therapy within 12-month reporting period (eg, patient was not a candidate for therapy, could not tolerate)

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

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

OR

Peginterferon and Ribavirin Therapy not Prescribed, Reason not 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

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2013 Physician Quality Reporting System (PQRS) Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS PQRS website.

▲Measure #87 (NQF 0398): Hepatitis C: HCV Ribonucleic Acid (RNA) Testing at Week 12 of Treatment

DESCRIPTION:

Percentage of patients aged 18 years and older with a diagnosis of chronic hepatitis C who are receiving antiviral treatment for whom quantitative HCV RNA testing was performed at no greater than 12 weeks from the initiation of antiviral treatment

NUMERATOR:

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

Definition:

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

NUMERATOR NOTE: *The correct combination of numerator code(s) must be reported on the claim form in order to properly report this measure. The "correct combination" of codes may require the submission of multiple numerator codes.*

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Hepatitis C Quantitative RNA Testing at 12 weeks

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

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

AND

G8461: Patient receiving antiviral treatment for Hepatitis C

OR

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

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

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

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

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

AND

G8461: Patient receiving antiviral treatment for Hepatitis C

OR

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

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

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

OR

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

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

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

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

AND

G8461: Patient receiving antiviral treatment for Hepatitis C

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2013 Physician Quality Reporting System (PQRS) Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS PQRS website.

▲Measure #89 (NQF 0401): Hepatitis C: Counseling Regarding Risk of Alcohol Consumption

DESCRIPTION:

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

NUMERATOR:

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

Definition:

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

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Counseling Regarding Risk of Alcohol Consumption

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

OR

Counseling Regarding Risk of Alcohol Consumption not Performed, Reason not 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

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2013 Physician Quality Reporting System (PQRS) Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS PQRS website.

▲Measure #90 (NQF 0394): Hepatitis C: Counseling Regarding Use of Contraception Prior to Antiviral Therapy

DESCRIPTION:

Percentage of female patients aged 18 through 44 years and all men aged 18 years and older with a diagnosis of chronic hepatitis C who are receiving antiviral treatment who were counseled regarding contraception prior to the initiation of treatment

NUMERATOR:

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

NUMERATOR NOTE: *The correct combination of numerator code(s) must be reported on the claim form in order to properly report this measure. The "correct combination" of codes may require the submission of multiple numerator codes.*

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Counseling Regarding Contraception Received

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

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

AND

G8463: Patient receiving antiviral treatment for Hepatitis C documented

OR

Counseling Regarding Contraception not Received for Medical Reason

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

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

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

AND

G8463: Patient receiving antiviral treatment for Hepatitis C documented

OR

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

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

G8462: Clinician documented that patient is not an eligible candidate for counseling regarding contraception prior to antiviral treatment; patient not receiving antiviral treatment for Hepatitis C

OR

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

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NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2013 Physician Quality Reporting System (PQRS) Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS PQRS website.

▲Measure #183 (NQF 0399): Hepatitis C: Hepatitis A Vaccination in Patients with HCV

DESCRIPTION:

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

NUMERATOR:

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

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

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

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

OR

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

OR

Hepatitis A Vaccine Injection not Received for Medical or Patient Reasons

Append a modifier (1P or 2P) to CPT Category II code **4148F** to report documented circumstances that appropriately exclude patients from the denominator.

4148F with 1P: Documentation of medical reason(s) for not administering at least one injection of hepatitis A vaccine

4148F with 2P: Documentation of patient reason(s) for not administering at least one injection of hepatitis A vaccine

OR

Hepatitis A Vaccine Injection not Received, Reason not 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

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2013 Physician Quality Reporting System (PQRS) Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS PQRS website.

▲Measure #184 (NQF 0400): Hepatitis C: Hepatitis B Vaccination in Patients with HCV

DESCRIPTION:

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

NUMERATOR:

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

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Hepatitis B Vaccine Injection Received or Patient Has Documented Immunity to Hepatitis B

CPT II 4149F: Hepatitis B vaccine injection administered or previously received

OR

CPT II 3216F: Patient has documented immunity to Hepatitis B

OR

Hepatitis B Vaccine Injection not Received for Medical or Patient Reasons

Append a modifier (1P or 2P) to CPT Category II code **4149F** to report documented circumstances that appropriately exclude patients from the denominator.

4149F with 1P: Documentation of medical reason(s) for not administering at least one injection of Hepatitis B vaccine

4149F with 2P: Documentation of patient reason(s) for not administering at least one injection of Hepatitis B vaccine

OR

Hepatitis B Vaccine not Received, Reason not 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

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2013 Physician Quality Reporting System (PQRS) Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS PQRS website.

HEART FAILURE (HF) MEASURES GROUP OVERVIEW

2013 PQRS OPTIONS FOR MEASURES GROUPS: REGISTRY ONLY

2013 PQRS MEASURES IN HEART FAILURE (HF) MEASURES GROUP:

- #5. Heart Failure: Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD)
- #8. Heart Failure: Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)
- #198. Heart Failure: Left Ventricular Ejection Fraction (LVEF) Assessment
- #226. Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention

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

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

G8548: I intend to report the Heart Failure (HF) Measures Group

- Report the patient sample method:
20 Patient Sample Method: 20 unique patients (a majority of which must be Medicare Part B FFS [fee for service] patients) meeting patient sample criteria for the measures group during the reporting period (January 1 through December 31, 2013 OR July 1 through December 31, 2013).
- Patient sample criteria for the HF Measures Group are patients aged 18 years and older with a specific diagnosis of HF accompanied by a specific patient encounter:

One of the following diagnosis codes indicating 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

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

Accompanied by

One of the following patient encounter codes: 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350

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

Composite G-code G8551: All quality actions for the applicable measures in the Heart Failure (HF) Measures Group have been performed for this patient

- To report satisfactorily the HF Measures Group it requires all applicable measures for each patient within the eligible professional's patient sample to be reported a minimum of once during the reporting period.
- Measures #5 and #8 are represented differently from the corresponding individual measures. Therefore the individual measures are specified and analyzed in a slightly different manner than the same measures contained within the measures group. Use the measure specifications as defined within the measures group for reporting purposes in order to satisfactorily report the measures group.
- Measures groups containing a measure with a 0% performance rate will not be counted as satisfactorily reporting the measures group. The recommended clinical quality action must be performed on at least one patient for each measure within the measures group reported by the eligible professional. Performance exclusion quality-data codes are not counted in the performance denominator. If the eligible professional submits all performance exclusion quality-data codes, the performance rate would be 0/0 and would be considered satisfactorily reporting.
- When using the 20 Patient Sample Method, report all applicable measures for the 20 unique patients seen a majority of which must be Medicare Part B FFS patients for the 12-month or 6-month reporting period.

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2013 Physician Quality Reporting System (PQRS) Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS PQRS website.

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

DESCRIPTION:

Percentage of patients aged 18 years and older with a diagnosis of heart failure (HF) with a current or prior left ventricular ejection fraction (LVEF) < 40% who were prescribed ACE inhibitor or ARB therapy either within a 12 month period when seen in the outpatient setting OR at each hospital discharge

NUMERATOR:

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

NUMERATOR NOTE: *The reporting numerator options contained within this specification are represented differently than the corresponding individual measure. Reference this specification only in order to satisfactorily report the measures group.*

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

Numerator Instructions: The LVSD may be determined by quantitative or qualitative assessment, which may be current or historical. Examples of a quantitative or qualitative assessment may include an echocardiogram: 1) that provides a numerical value of LVSD or 2) that uses descriptive terms such as moderately or severely depressed left ventricular systolic function. Any current or prior ejection fraction study documenting LVSD can be used to identify patients. LVEF < 40% corresponds to qualitative documentation of moderate dysfunction or severe dysfunction.

Definition:

Prescribed - 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)

AND

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

OR

Documentation of medical reason(s) for not prescribing angiotensin converting enzyme (ACE) inhibitor or angiotensin receptor blocker (ARB) therapy (eg, hypotensive patients who are at immediate risk of cardiogenic shock, hospitalized patients who have experienced marked azotemia) (4010F ***with 1P***)

OR

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

OR

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

AND

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

OR

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

OR

Left ventricular ejection fraction (LVEF) was not performed or documented (3021F *with 8P*)

OR

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

AND

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

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2013 Physician Quality Reporting System (PQRS) Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS PQRS website.

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

DESCRIPTION:

Percentage of patients aged 18 years and older with a diagnosis of heart failure (HF) with a current or prior left ventricular ejection fraction (LVEF) < 40% who were prescribed beta-blocker therapy either within a 12 month period when seen in the outpatient setting OR at each hospital discharge

NUMERATOR:

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

NUMERATOR NOTE: *The reporting numerator options contained within this specification are represented differently than the corresponding individual measure. Reference this specification only in order to satisfactorily report the measures group.*

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

Numerator Instructions: The left ventricular systolic dysfunction may be determined by quantitative or qualitative assessment, which may be current or historical. Examples of a quantitative or qualitative assessment may include an echocardiogram: 1) that provides a numerical value of left ventricular systolic dysfunction or 2) that uses descriptive terms such as moderately or severely depressed left ventricular systolic function. Any current or prior ejection fraction study documenting LVSD can be used to identify patients. LVEF < 40% corresponds to qualitative documentation of moderate dysfunction or severe left ventricular systolic dysfunction.

Definitions:

Prescribed – 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)

AND

Left ventricular ejection fraction (LVEF) < 40% or documentation of moderately or severely depressed left ventricular systolic function (G8923)

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

Left ventricular ejection fraction (LVEF) \geq 40% or documentation as normal or mildly depressed left ventricular systolic function (G8395)

OR

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Left ventricular ejection fraction (LVEF) not performed or documented (G8396)

OR

Beta-blocker therapy not prescribed (G8452)

AND

Left ventricular ejection fraction (LVEF) < 40% or documentation of moderately or severely depressed left ventricular systolic function (G8923)

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2013 Physician Quality Reporting System (PQRS) Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS PQRS website.

► Measure #198 (NQF 0079): Heart Failure: Left Ventricular Ejection Fraction (LVEF) Assessment

DESCRIPTION:

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

NUMERATOR:

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

Numerator Instructions: The left ventricular systolic dysfunction may be determined by quantitative or qualitative assessment, which may be current or historical. Examples of a quantitative or qualitative assessment may include an echocardiogram: 1) that provides a numerical value of left ventricular systolic function or 2) that uses descriptive terms such as moderately or severely depressed left ventricular systolic function.

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

Definitions:

Qualitative Results Correspond to Numeric Equivalents as Follows:

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

Numerator Options:

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

OR

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

OR

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

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2013 Physician Quality Reporting System (PQRS) Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS PQRS website.

▲Measure #226 (NQF 0028): Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention

DESCRIPTION:

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

NUMERATOR:

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

Definitions:

Tobacco Use – Includes use of any type of tobacco

Cessation Counseling Intervention – Includes brief counseling (3 minutes or less), and/or pharmacotherapy

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

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Patient Screened for Tobacco Use

CPT II 4004F: Patient screened for tobacco use AND received tobacco cessation intervention (counseling, pharmacotherapy, or both), if identified as a tobacco user

OR

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

CPT II 1036F: Current tobacco non-user

OR

Tobacco Screening not Performed for Medical Reasons

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

4004F with 1P: Documentation of medical reason(s) for not screening for tobacco use (e.g., limited life expectancy, other medical reason)

OR

Tobacco Screening OR Tobacco Cessation 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 not performed, reason not otherwise specified

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2013 Physician Quality Reporting System (PQRS) Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS PQRS website.

CORONARY ARTERY DISEASE (CAD) MEASURES GROUP OVERVIEW

2013 PQRS OPTIONS FOR MEASURES GROUPS: REGISTRY ONLY

2013 PQRS MEASURES IN CORONARY ARTERY DISEASE (CAD) MEASURES GROUP:

- #6. Coronary Artery Disease (CAD): Antiplatelet Therapy
- #197. Coronary Artery Disease (CAD): Lipid Control
- #226. Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention
- #242. Coronary Artery Disease (CAD): Symptom Management

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

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

G8489: I intend to report the Coronary Artery Disease (CAD) Measures Group

- Report the patient sample method:
20 Patient Sample Method: 20 unique patients (a majority of which must be Medicare Part B FFS [fee for service] patients) meeting patient sample criteria for the measures group during the reporting period (January 1 through December 31, 2013 **OR** July 1 through December 31, 2013).
- Patient sample criteria for the CAD Measures Group are patients aged 18 years and older with a specific diagnosis of CAD accompanied by a specific patient encounter:

One of the following diagnosis codes indicating 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

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

Accompanied by

One of the following patient encounter codes: 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350

- Report a numerator option on **all applicable** measures within the CAD Measures Group for each patient within the eligible professional's patient sample.
- Instructions for qualifying numerator option reporting for each of the measures within the CAD Measures Group are displayed on the next several pages. The following composite G-code has

been created for registry only measures groups for use by registries that utilize claims data. This composite G-code may be reported in lieu of the individual quality-data codes for each of the measures within the group, if all quality actions for the patient have been performed for all the measures within the group. However, it is not necessary to submit the following composite G-code for registry-based submissions.

Composite G-code G8498: All quality actions for the applicable measures in the Coronary Artery Disease (CAD) Measures Group have been performed for this patient

- To report satisfactorily for the CAD Measures Group it requires all applicable measures for each patient within the eligible professional's patient sample to be reported a minimum of once during the reporting period.
- Measure #242 is represented differently from the corresponding individual measure. Therefore the individual measures are specified and analyzed in a slightly different manner than the same measures contained within the measures group. Use the measure specifications as defined within the measures group for reporting purposes in order to satisfactorily report the measures group.
- Measures groups containing a measure with a 0% performance rate will not be counted as satisfactorily reporting the measures group. The recommended clinical quality action must be performed on at least one patient for each measure within the measures group reported by the eligible professional. Performance exclusion quality-data codes are not counted in the performance denominator. If the eligible professional submits all performance exclusion quality-data codes, the performance rate would be 0/0 and would be considered satisfactorily reporting.
- When using the 20 Patient Sample Method, report all applicable measures for the 20 unique patients seen a majority of which must be Medicare Part B FFS patients for the 12-month or 6-month reporting period.

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2013 Physician Quality Reporting System (PQRS) Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS PQRS website.

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

DESCRIPTION:

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

NUMERATOR:

Patients who were prescribed aspirin or clopidogrel

Definition:

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

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Aspirin or Clopidogrel Prescribed

CPT II 4086F: Aspirin or clopidogrel prescribed

OR

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

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

4086F *with* 1P: Documentation of medical reason(s) for not prescribing aspirin or clopidogrel (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 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

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2013 Physician Quality Reporting System (PQRS) Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS PQRS website.

► Measure #197 (NQF 0074): Coronary Artery Disease (CAD): Lipid Control

DESCRIPTION:

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

NUMERATOR:

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

Numerator Instructions: The first numerator option can be reported for patients who have a documented LDL-C < 100 mg/dL at any time during the measurement period (if more than one result, report most current) All patients aged 18 years and older with a diagnosis of coronary artery disease must have an LDL-C result in order to satisfy 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 \geq 100 mg/dL (G8737)

AND

Statin therapy prescribed or currently being taken (4013F)

AND

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

OR

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

AND

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

AND

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

OR

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

OR

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

OR

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

AND

2013 PQRS Measures Groups Specifications Manual

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

OR

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

AND

Plan of care to achieve lipid control not documented (0556F *with* 8P)

OR

LDL-C result not present or not within 12 months prior (G8943)

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2013 Physician Quality Reporting System (PQRS) Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS PQRS website.

▲Measure #226 (NQF 0028): Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention

DESCRIPTION:

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

NUMERATOR:

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

Definitions:

Tobacco Use – Includes use of any type of tobacco

Cessation Counseling Intervention – Includes brief counseling (3 minutes or less), and/or pharmacotherapy

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

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Patient Screened for Tobacco Use

CPT II 4004F: Patient screened for tobacco use AND received tobacco cessation intervention (counseling, pharmacotherapy, or both), if identified as a tobacco user

OR

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

CPT II 1036F: Current tobacco non-user

OR

Tobacco Screening not Performed for Medical Reasons

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

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

OR

Tobacco Screening OR Tobacco Cessation 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 not performed, reason not otherwise specified

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2013 Physician Quality Reporting System (PQRS) Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS PQRS website.

► Measure #242: Coronary Artery Disease (CAD): Symptom Management

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

NUMERATOR:

Patients with appropriate management of anginal symptoms within a 12 month period

NUMERATOR NOTE: *The reporting numerator options contained within this specification are represented differently than the corresponding individual measure. Reference this specification only in order to satisfactorily report the measures group.*

Numerator Instruction: Patients with an evaluation of level of activity and an assessment of whether anginal symptoms are present or absent are included within this measure

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

Definitions:

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

Appropriate Management of Anginal Symptoms Includes the Following:

1. Absence of angina symptoms as determined by evaluation of level of activity

OR

2. Presence of angina 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:

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

AND

Angina present (1011F)

AND

Plan of care to manage anginal symptoms documented (0557F)

OR

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

AND

Angina absent (1012F)

OR

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

AND

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, intolerant, other medical reasons) (0557F *with 1P*)

OR

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

AND

Angina present (1011F)

AND

Plan of care to achieve control of angina symptoms was not performed, reason not otherwise specified (0557F *with 8P*)

OR

Severity of angina not assessed, reason not otherwise specified (1010F *with 8P*)

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2013 Physician Quality Reporting System (PQRS) Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS PQRS website.

ISCHEMIC VASCULAR DISEASE (IVD) MEASURES GROUP OVERVIEW

2013 PQRS OPTIONS FOR MEASURES GROUPS: CLAIMS, REGISTRY

2013 PQRS MEASURES IN ISCHEMIC VASCULAR DISEASE (IVD) MEASURES GROUP:

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

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

- Indicate your intention to report the IVD Measures Group by submitting the measures group-specific intent G-code at least once during the reporting period when billing a patient claim for the 20 Patient Sample Method. It is not necessary to submit the measures group-specific intent G-code on more than one claim. It is not necessary to submit the measures group-specific intent G-code for registry-based submissions.

G8547: I intend to report the Ischemic Vascular Disease (IVD) Measures Group

- Select patient sample method:
20 Patient Sample Method via claims: 20 unique Medicare Part B FFS (fee for service) patients meeting patient sample criteria for the measures group.
OR
20 Patient Sample Method via registries: 20 unique patients (a majority of which must be Medicare Part B FFS patients) meeting patient sample criteria for the measures group during the reporting period (January 1 through December 31, 2013 **OR** July 1 through December 31, 2013).
- Patient sample criteria for the IVD Measures Group are patients aged 18 years and older with a specific diagnosis of IVD accompanied by a specific patient encounter OR patients aged 18 years and older with a coronary artery bypass graft (CABG) or percutaneous coronary interventions (PCI):

One of the following diagnosis codes indicating 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

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, 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

Accompanied by

One of the following patient encounter codes: 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99217, 99218, 99219, 99220, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, 99455, 99456, G0402

OR

One of the following coronary artery bypass graft (CABG) or percutaneous coronary interventions (PCI) surgical procedure codes: 33140, 33510, 33511, 33512, 33513, 33514, 33516, 33517, 33518, 33519, 33521, 33522, 33523, 33533, 33534, 33535, 33536 92920, 92924, 92928, 92933, 92937, 92941, 92943

- Measure #201: IVD Blood Pressure Management contains patient demographic criteria specific to the measure. For example, the age criterion is only applicable *to patients 18-75 years* within the sample population.
- Report quality-data codes (QDCs) on **all applicable** measures within the IVD Measures Group for each patient within the eligible professional's patient sample.
- Instructions for quality-data code reporting for each of the measures within the IVD Measures Group are displayed on the next several pages. If all quality actions for the patient have been performed for all the measures within the group, the following composite G-code may be reported in lieu of the individual quality-data codes for each of the measures within the group. It is not necessary to submit the following composite G-code for registry-based submissions.

Composite G-code G8552: All quality actions for the applicable measures in the Ischemic Vascular Disease (IVD) Measures Group have been performed for this patient

- To report satisfactorily the IVD Measures Group requires **all applicable** measures for each patient within the eligible professional's patient sample to be reported a minimum of once during the reporting period.
- Measures groups containing a measure with a 0% performance rate will not be counted as satisfactorily reporting the measures group. The recommended clinical quality action must be performed on at least one patient for each measure within the measures group reported by the eligible professional. Performance exclusion quality-data codes are not counted in the performance denominator. If the eligible professional submits all performance exclusion quality-data codes, the performance rate would be 0/0 and would be considered satisfactorily reporting. If a measure within a measures group is not applicable to a patient, the patient would not be counted in the performance denominator for that measure (e.g., Preventive Care Measures Group - Measure #39: Screening or Therapy for Osteoporosis for Women Aged 65 Years and Older would not be

applicable to male patients according to the patient sample criteria). If the measure is not applicable for all patients within the sample, the performance rate would be 0/0 and would be considered satisfactorily reporting.

- When using the 20 Patient Sample Method via claims, report all measures for the 20 unique Medicare Part B FFS patients seen. When using the 20 Patient Sample Method via registries, report all measures for the 20 unique patients seen, a majority of which must be Medicare Part B FFS patients.
- For claims-based submissions, the Carrier/MAC remittance advice notice sent to the practice will show a denial remark code (N365) for the line item on the claim containing G8547 (and G8552 if reported) as well as all other line items containing QDCs. N365 indicates that the code is not payable and is used for reporting/informational purposes only. Other services/codes on the claim will not be affected by the addition of a measures group-specific intent G-code or other QDCs. The N365 remark code does NOT indicate whether the QDC is accurate for that claim or for the measure the eligible professional is attempting to report, but does indicate that the QDC was processed and transmitted to the NCH.

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2013 Physician Quality Reporting System (PQRS) Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS PQRS website

♦Measure #201 (NQF 0073): Ischemic Vascular Disease (IVD): Blood Pressure Management

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)

NUMERATOR:

Patients whose most recent blood pressure < 140/90 mmHg

Numerator Instructions: To describe both systolic and diastolic blood pressure values, each must be reported separately. If there are multiple blood pressures on the same date of service, use the lowest systolic and lowest diastolic blood pressure on that date as the representative blood pressure.

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

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Most Recent Blood Pressure Measurement Performed

Systolic Pressure (Select one (1) code from this section):

G8588: Most recent systolic blood pressure < 140 mmHg

OR

G8589: Most recent systolic blood pressure ≥ 140 mmHg

AND

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

G8590: Most recent diastolic blood pressure < 90 mmHg

OR

G8591: Most recent diastolic blood pressure ≥ 90 mmHg

OR

Blood Pressure Measurement not Documented, Reason not Given

G8592: No documentation of blood pressure measurement, reason not given

NOTE: *The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2013 Physician Quality Reporting System (PQRS) Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS PQRS website.*

♦Measure #204 (NQF 0068): Ischemic Vascular Disease (IVD): Use Aspirin or Another Antithrombotic

DESCRIPTION:

Percentage of patients aged 18 years and older with Ischemic Vascular Disease (IVD) with documented use of aspirin or another antithrombotic

NUMERATOR:

Patients who are using aspirin or another antithrombotic therapy

Numerator Instructions: Oral antithrombotic therapy consists of aspirin, clopidogrel or combination of aspirin and extended release dipyridamole

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

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Aspirin or Another Antithrombotic Therapy Used

G8598: Aspirin or another antithrombotic therapy used

OR

Aspirin or Another Antithrombotic Therapy not Used, Reason not Given

G8599: Aspirin or another antithrombotic therapy not used, reason not given

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2013 Physician Quality Reporting System (PQRS) Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS PQRS website.

▲Measure #226 (NQF 0028): Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention

DESCRIPTION:

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

NUMERATOR:

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

Definitions:

Tobacco Use – Includes use of any type of tobacco

Cessation Counseling Intervention – Includes brief counseling (3 minutes or less) and/or pharmacotherapy

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

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Patient Screened for Tobacco Use

CPT II 4004F: Patient screened for tobacco use AND received tobacco cessation intervention (counseling, pharmacotherapy, or both), if identified as a tobacco user

OR

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

CPT II 1036F: Current tobacco non-user

OR

Tobacco Screening not Performed for Medical Reasons

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

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

OR

Tobacco Screening OR Tobacco Cessation 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 not performed, reason not otherwise specified

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2013 Physician Quality Reporting System (PQRS) Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS PQRS website.

♦Measure #241 (NQF 0075): Ischemic Vascular Disease (IVD): Complete Lipid Panel and Low Density Lipoprotein (LDL-C) Control

DESCRIPTION:

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

NUMERATOR:

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

NUMERATOR NOTE:

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

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

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

(Two CPT II 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 CPT II 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 \geq 100 mg/dL

(Two CPT II codes [G8593 & G8597] 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)

AND

G8597: Most recent LDL-C \geq 100 mg/dL

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2013 Physician Quality Reporting System (PQRS) Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS PQRS website.

HIV/AIDS MEASURES GROUP OVERVIEW

2013 PQRS OPTIONS FOR MEASURES GROUPS: REGISTRY ONLY

2013 PQRS MEASURES IN HIV/AIDS MEASURES GROUP:

- #159. HIV/AIDS: CD4+ Cell Count or CD4+ Percentage
- #160. HIV/AIDS: Pneumocystis Jiroveci Pneumonia (PCP) Prophylaxis
- #161. HIV/AIDS: Adolescent and Adult Patients with HIV/AIDS Who Are Prescribed Potent Antiretroviral Therapy
- #162. HIV/AIDS: HIV RNA Control After Six Months of Potent Antiretroviral Therapy
- #205. HIV/AIDS: Sexually Transmitted Disease Screening for Chlamydia and Gonorrhea
- #208. HIV/AIDS: Sexually Transmitted Disease Screening for Syphilis

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

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

G8491: I intend to report the HIV/AIDS Measures Group

- Report the patient sample method:
20 Patient Sample Method: 20 unique patients (a majority of which must be Medicare Part B FFS [fee for service] patients) meeting patient sample criteria for the measures group during the reporting period (January 1 through December 31, 2013 **OR** July 1 through December 31, 2013).
- Patient sample criteria for the HIV/AIDS Measures Group are patients aged 13 years and older with a specific diagnosis of HIV/AIDS accompanied by a specific patient encounter:

One of the following diagnosis codes indicating HIV/AIDS:

ICD-9-CM: 042, V08

ICD-10-CM [Reference ONLY/Not Reportable]: Z21, B20

Accompanied by

One of the following patient encounter codes: 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, G0402

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

Composite G-code G8500: All quality actions for the applicable measures in the HIV/AIDS Measures Group have been performed for this patient

2013 PQRS Measures Groups Specifications Manual

- To report satisfactorily for the HIV/AIDS Measures Group it requires all measures for each patient within the eligible professional's patient sample to be reported a minimum of once during the reporting period. Measure #159 will be reported once during the reporting period for measures group purposes.
- Measures #160, #161 and #162 are represented differently from the corresponding individual measures. Therefore the individual measures are specified and analyzed in a slightly different manner than the same measures contained within the measures group. Use the measure specifications as defined within the measures group for reporting purposes in order to satisfactorily report the measures group.
- Measures groups containing a measure with a 0% performance rate will not be counted as satisfactorily reporting the measures group. The recommended clinical quality action must be performed on at least one patient for each measure within the measures group reported by the eligible professional. Performance exclusion quality-data codes are not counted in the performance denominator. If the eligible professional submits all performance exclusion quality-data codes, the performance rate would be 0/0 and would be considered satisfactorily reporting.
- When using the 20 Patient Sample Method, report all applicable measures for the 20 unique patients seen a majority of which must be Medicare Part B FFS patients for the 12-month or 6-month reporting period.

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2013 Physician Quality Reporting System (PQRS) Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS PQRS website.

Measure #159 (NQF 0404): HIV/AIDS: CD4+ Cell Count or CD4+ Percentage

DESCRIPTION:

Percentage of patients aged 6 months and older with a diagnosis of HIV/AIDS for whom a CD4+ cell count or CD4+ cell percentage was performed at least once every 6 months

NUMERATOR:

Patients with CD4+ cell count or CD4+ cell percentage performed at least once every 6 months

NUMERATOR NOTE: Report this measure once during the reporting period for measures group purposes.

Numerator Options:

CD4+ cell count or CD4+ cell percentage documented as performed (3500F)

OR

CD4+ cell count or percentage not documented as performed, reason not otherwise specified (3500F with 8P)

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2013 Physician Quality Reporting System (PQRS) Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS PQRS website.

SPECIFICATION FOR MEASURES GROUP REPORTING ONLY

Measure #160 (NQF 0405): HIV/AIDS: Pneumocystis Jiroveci Pneumonia (PCP) Prophylaxis

DESCRIPTION:

Percentage of patients aged 6 years and older with a diagnosis of HIV/AIDS and CD4+ cell count < 200 cells/mm³ who were prescribed PCP prophylaxis within 3 months of low CD4+ cell count

NUMERATOR:

Patients who were prescribed PCP prophylaxis within 3 months of low CD4+ cell count

NUMERATOR NOTE: *The reporting numerator options contained within this specification are represented differently than the corresponding individual measure. Reference this specification only in order to satisfactorily report the measures group.*

Definition:

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

Numerator Options:

Pneumocystis Jiroveci pneumonia prophylaxis prescribed within 3 months of low CD4+ cell count or percentage (4280F)

AND

CD4+ cell count < 200 cells/mm³ (3494F)

OR

Pneumocystis Jiroveci pneumonia prophylaxis not prescribed within 3 months of low CD4+ cell count or percentage for medical reason (4280F *with* 1P)

(i.e., patient's CD4+ cell count above threshold within 3 months after CD4+ cell count below threshold, indicating that the patient's CD4+ levels are within an acceptable range and the patient does not require PCP prophylaxis)

AND

CD4+ cell count < 200 cells/mm³ (3494F)

OR

CD4+ cell count 200 – 499 cells/mm³ (3495F)

OR

CD4+ cell count ≥ 500 cells/mm³ (3496F)

OR

CD4+ cell count not performed, reason not otherwise specified (3494F *with* 8P)

OR

PCP prophylaxis was not prescribed within 3 months of low CD4+ cell count, reason not otherwise specified (4280F *with* 8P)

AND

CD4+ cell count < 200 cells/mm³ (3494F)

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2013 Physician Quality Reporting System (PQRS) Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS PQRS website.

SPECIFICATION FOR MEASURES GROUP REPORTING ONLY

Measure #161(NQF 0406): HIV/AIDS: Adolescent and Adult Patients with HIV/AIDS Who Are Prescribed Potent Antiretroviral Therapy

DESCRIPTION:

Percentage of patients with a diagnosis of HIV/AIDS aged 13 years and older: who have a history of a nadir CD4+ cell count below 350/mm³ 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

NUMERATOR:

Patients who were prescribed potent antiretroviral therapy

NUMERATOR NOTE: *The reporting numerator options contained within this specification are represented differently than the corresponding individual measure. Reference this specification only in order to satisfactorily report the measures group.*

Numerator Instructions: Nadir (lowest ever) CD4+ cell count may be the present count

Definitions:

Potent Antiretroviral Therapy – Potent antiretroviral therapy is described as any antiretroviral therapy that has demonstrated optimal efficacy and results in durable suppression of HIV as shown by prior clinical trials. For potent antiretroviral therapy recommendations, refer to current DHHS guidelines available for download at Aids.gov.

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
- Coccidiomycosis, 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 (NYSDOH, 2007)

SPECIFICATION FOR MEASURES GROUP REPORTING ONLY

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

Numerator Options:

Potent antiretroviral therapy prescribed (4276F)

AND

History of nadir CD4+ cell count < 350 cells/mm³ (3492F)

OR

History of AIDS-defining condition (3490F)

OR

No history of nadir CD4+ cell count < 350 cells/mm³ AND no history of AIDS-defining condition (3493F)

OR

Potent antiretroviral therapy not prescribed, reason not otherwise specified (4276F *with* 8P)

AND

History of nadir CD4+ cell count < 350 cells/mm³ (3492F)

OR

History of AIDS-defining condition (3490F)

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document '2013 Physician Quality Reporting System (PQRS) Measure Specifications Manual for Claims and Registry Reporting for Individual Measures' available for download from the CMS PQRS website.

SPECIFICATION FOR MEASURES GROUP REPORTING ONLY

Measure #162 (NQF 0407): HIV/AIDS: HIV RNA Control After Six Months of Potent Antiretroviral Therapy

DESCRIPTION:

Percentage of patients aged 13 years and older with a diagnosis of HIV/AIDS who are receiving potent antiretroviral therapy, who have a viral load below limits of quantification after at least 6 months of potent antiretroviral therapy or patients whose viral load is not below limits of quantification after at least 6 months of potent antiretroviral therapy and have documentation of a plan of care

NUMERATOR:

Patients with viral load below limits of quantification or patients with viral load not below limits of quantification who have a documented plan of care

NUMERATOR NOTE: *The reporting numerator options contained within this specification are represented differently than the corresponding individual measure. Reference this specification only in order to satisfactorily report the measures group.*

Numerator Instructions: Viral load below limits of quantification is determined using laboratory cutoff levels for reference laboratory used by clinic or provider

Definitions:

Potent Antiretroviral Therapy – Potent antiretroviral therapy is described as any antiretroviral therapy that has demonstrated optimal efficacy and results in durable suppression of HIV as shown by prior clinical trials. For potent antiretroviral therapy recommendations, refer to current DHHS guidelines available for download at Aids.gov.

Plan of Care – May include altering the therapy regimen, reaffirming to the patient the importance of high adherence to the regimen, or reassessment of viral load at a specified future date

Numerator Options:

HIV RNA viral load below limits of quantification (3502F)

AND

Patient receiving potent antiretroviral therapy for 6 months or longer (4270F)

OR

HIV RNA viral load not below limits of quantification (3503F)

AND

HIV RNA control plan of care, documented (0575F)

AND

Patient receiving potent antiretroviral therapy for 6 months or longer (4270F)

OR

Patient receiving potent antiretroviral therapy for less than 6 months or not receiving potent antiretroviral therapy (4271F)

OR

Viral load not performed or documented, reason not otherwise specified (3502F *with* 8P)

AND

Patient receiving potent antiretroviral therapy for 6 months or longer (4270F)

OR

Plan of care for viral load not below limits of quantification was not documented, reason not otherwise specified (0575F *with* 8P)

AND

SPECIFICATION FOR MEASURES GROUP REPORTING ONLY

HIV RNA viral load not below limits of quantification (3503F)

AND

Patient receiving potent antiretroviral therapy for 6 months or longer (4270F)

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2013 Physician Quality Reporting System (PQRS) Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS PQRS website.

SPECIFICATION FOR MEASURES GROUP REPORTING ONLY

Measure #205 (NQF 0409): HIV/AIDS: Sexually Transmitted Disease Screening for Chlamydia and Gonorrhea

DESCRIPTION:

Percentage of patients aged 13 years and older with a diagnosis of HIV/AIDS for whom chlamydia and gonorrhea screenings were performed at least once since the diagnosis of HIV infection

NUMERATOR:

Patients with chlamydia and gonorrhea screenings performed at least once since the diagnosis of HIV infection

Numerator Options:

Chlamydia and gonorrhea screenings documented as performed (3511F)

OR

Chlamydia and gonorrhea screenings not documented as performed, due to patient reason (3511F *with 2P*)

OR

Chlamydia and gonorrhea screenings not documented as performed, reason not otherwise specified (3511F *with 8P*)

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2013 Physician Quality Reporting System (PQRS) Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS PQRS website.

SPECIFICATION FOR MEASURES GROUP REPORTING ONLY

Measure #208 (NQF 0410): HIV/AIDS: Sexually Transmitted Disease Screening for Syphilis

DESCRIPTION:

Percentage of patients aged 13 years and older with a diagnosis of HIV/AIDS who were screened for syphilis at least once within 12 months

NUMERATOR:

Patients who were screened for syphilis at least once within 12 months

Numerator Options:

Syphilis screening documented as performed (3512F)

OR

Syphilis screening not documented as performed, due to patient reason (3512F *with* 2P)

OR

Syphilis screening not documented as performed, reason not otherwise specified (3512F *with* 8P)

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2013 Physician Quality Reporting System (PQRS) Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS PQRS website.

SPECIFICATION FOR MEASURES GROUP REPORTING ONLY

ASTHMA MEASURES GROUP OVERVIEW

2013 PQRS OPTIONS FOR MEASURES GROUPS: **CLAIMS, REGISTRY**

2013 PQRS MEASURES IN ASTHMA MEASURES GROUP:

- #53. Asthma: Pharmacologic Therapy for Persistent Asthma – Ambulatory Care Setting
- #64. Asthma: Assessment of Asthma Control – Ambulatory Care Setting
- #231. Asthma: Tobacco use: Screening – Ambulatory Care Setting
- #232. Asthma: Tobacco Use: Intervention – Ambulatory Care Setting

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

- Indicate your intention to report the Asthma Measures Group by submitting the measures group-specific intent G-code at least once during the reporting period when billing a patient claim for the 20 Patient Sample Method. It is not necessary to submit the measures group-specific intent G-code on more than one claim. It is not necessary to submit the measures group-specific intent G-code for registry-based submissions.

G8645: I intend to report the Asthma Measures Group

- Select patient sample method:
20 Patient Sample Method via claims: 20 unique Medicare Part B FFS (fee for service) patients meeting patient sample criteria for the measures group.
OR
20 Patient Sample Method via registries: 20 unique patients (a majority of which must be Medicare Part B FFS patients) meeting patient sample criteria for the measures group during the reporting period (January 1 through December 31, 2013 **OR** July 1 through December 31, 2013).
- Patient sample criteria for the Asthma Measures Group are patients aged 5 through 50 years with a specific diagnosis of Asthma accompanied by a specific patient encounter:

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

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

Accompanied by

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

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

SPECIFICATION FOR MEASURES GROUP REPORTING ONLY

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

- To report satisfactorily the Asthma Measures Group requires all applicable measures for each patient within the eligible professional's patient sample to be reported a minimum of once during the reporting period.
- Measures groups containing a measure with a 0% performance rate will not be counted as satisfactorily reporting the measures group. The recommended clinical quality action must be performed on at least one patient for each measure within the measures group reported by the eligible professional. Performance exclusion quality-data codes are not counted in the performance denominator. If the eligible professional submits all performance exclusion quality-data codes, the performance rate would be 0/0 and would be considered satisfactorily reporting.
- When using the 20 Patient Sample Method via claims, report all measures for the 20 unique Medicare Part B FFS patients seen. When using the 20 Patient Sample Method via registries, report all measures for the 20 unique patients seen, a majority of which must be Medicare Part B FFS patients.
- For claims-based submissions, the Carrier/MAC remittance advice notice sent to the practice will show a denial remark code (N365) for the line item on the claim containing G8485 (and G8494 if reported) as well as all other line items containing QDCs. N365 indicates the code is not payable and is used for reporting/informational purposes only. Other services/codes on the claim will not be affected by the addition of a measures group-specific intent G-code or other QDCs. The N365 remark code does NOT indicate whether the QDC is accurate for that claim or for the measure the eligible professional is attempting to report, but does indicate that the QDC was processed and transmitted to the NCH.

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2013 Physician Quality Reporting System (PQRS) Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS PQRS website.

SPECIFICATION FOR MEASURES GROUP REPORTING ONLY

Measure #53 (NQF 0047): Asthma: Pharmacologic Therapy for Persistent Asthma – Ambulatory Care Setting

DESCRIPTION:

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

NUMERATOR:

Patients who were prescribed long-term control medication

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

Definitions:

Long-Term Control Medication Includes:

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

OR

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

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)

SPECIFICATION FOR MEASURES GROUP REPORTING ONLY

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)

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

4140F **with** 8P: Inhaled corticosteroids not prescribed, reason not otherwise specified

AND

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

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2013 Physician Quality Reporting System (PQRS) Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS PQRS website.

SPECIFICATION FOR MEASURES GROUP REPORTING ONLY

Measure #64 (NQF 0001): Asthma: Assessment of Asthma Control – Ambulatory Care Setting

DESCRIPTION:

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

NUMERATOR:

Patients who were evaluated 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 beta₂-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

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2013 Physician Quality Reporting System (PQRS) Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS PQRS website.

SPECIFICATION FOR MEASURES GROUP REPORTING ONLY

Measure #231: Asthma: Tobacco Use: Screening - Ambulatory Care Setting

DESCRIPTION:

Percentage of patients (or their primary caregiver) aged 5 through 50 years with a diagnosis of asthma who were queried about tobacco use and exposure to second hand smoke within their home environment at least once during the one-year measurement period

NUMERATOR:

Patients (or their primary caregiver) who were queried about tobacco use and exposure to second hand smoke 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

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2013 Physician Quality Reporting System (PQRS) Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS PQRS website.

SPECIFICATION FOR MEASURES GROUP REPORTING ONLY

Measure #232: Asthma: Tobacco Use: Intervention - Ambulatory Care Setting

DESCRIPTION:

Percentage of patients (or their primary caregiver) aged 5 through 50 years with a diagnosis of asthma who were identified as tobacco users (patients who currently use tobacco AND patients who do not currently use tobacco, but are exposed to second hand smoke in their home environment) who received tobacco cessation intervention at least once during the one-year measurement period

NUMERATOR:

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

Numerator Instructions: Practitioners providing tobacco cessation interventions to a pediatric patient's primary caregiver are still numerator compliant even if the primary caregiver is not the source of second hand smoke in the home.

Definitions:

Tobacco Users – Tobacco users include patients who currently use tobacco AND patients who do not currently use tobacco, but are exposed to second hand smoke in their home environment.

Tobacco Use Cessation Intervention – May include brief counseling (3 minutes or less) and/or pharmacotherapy.

NUMERATOR NOTE: For the purpose of this measure, "tobacco user" refers to tobacco smokers and "tobacco non-user" refers to non-smokers (including smokeless tobacco users e.g., chew, snuff).

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Patients who Received Tobacco Use Cessation Intervention

(Two CPT II codes [40xxF & 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.

SPECIFICATION FOR MEASURES GROUP REPORTING ONLY

(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

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

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2013 Physician Quality Reporting System (PQRS) Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS PQRS website.

SPECIFICATION FOR MEASURES GROUP REPORTING ONLY

CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD) MEASURES GROUP OVERVIEW

2013 PQRS OPTIONS FOR MEASURES GROUPS: **CLAIMS, REGISTRY**

2013 PQRS MEASURES IN COPD MEASURES GROUP:

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

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

- Indicate your intention to report the COPD Measures Group by submitting the measures group-specific intent G-code at least once during the reporting period when billing a patient claim for the 20 Patient Sample Method. It is not necessary to submit the measures group-specific intent G-code on more than one claim. It is not necessary to submit the measures group-specific intent G-code for registry-based submissions.

G8898: I intend to report the COPD Measures Group

- Select patient sample method:
20 Patient Sample Method via claims: 20 unique Medicare Part B FFS (fee for service) patients meeting patient sample criteria for the measures group.
OR
20 Patient Sample Method via registries: 20 unique patients (a majority of which must be Medicare Part B FFS patients) meeting patient sample criteria for the measures group during the reporting period (January 1 through December 31, 2013 **OR** July 1 through December 31, 2013).
- Patient sample criteria for the COPD Measures Group are patients aged \geq 18 years with a specific diagnosis of COPD accompanied by a specific patient encounter:

One of the following diagnosis codes indicating COPD:

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

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

Accompanied by

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

- Report quality-data codes (QDCs) on **all applicable** measures within the COPD Measures Group for each patient within the eligible professional's patient sample.
- Measure #111 is only applicable for patients aged 65 years and older.
- Measure #110 need only be reported a minimum of once during the reporting period when the patient's visit included in the patient sample population is between January and March for the 2012-2013 influenza season **OR** between October and December for the 2013-2014 influenza

SPECIFICATION FOR MEASURES GROUP REPORTING ONLY

season. When the patient's office visit is between April and September, Measure #110 is not applicable and will not affect the eligible provider's reporting or performance rate. Measure #110 need only be reported on patients 18 years and older.

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

Composite G-code G8757: All quality actions for the applicable measures in the COPD Measures Group have been performed for this patient

- To report satisfactorily for the COPD Measures Group it requires **all applicable** measures for each patient within the eligible professional's patient sample to be reported a minimum of once during the reporting period.
- Measures groups containing a measure with a 0% performance rate will not be counted as satisfactorily reporting the measures group. The recommended clinical quality action must be performed on at least one patient for each measure within the measures group reported by the eligible professional. Performance exclusion quality-data codes are not counted in the performance denominator. If the eligible professional submits all performance exclusion quality-data codes, the performance rate would be 0/0 and would be considered satisfactorily reporting. If a measure within a measures group is not applicable to a patient, the patient would not be counted in the performance denominator for that measure (e.g., Preventive Care Measures Group - Measure #39: Screening or Therapy for Osteoporosis for Women Aged 65 Years and Older would not be applicable to male patients according to the patient sample criteria). If the measure is not applicable for all patients within the sample, the performance rate would be 0/0 and would be considered satisfactorily reporting.
- When using the 20 Patient Sample Method via claims, report all measures for the 20 unique Medicare Part B FFS patients seen. When using the 20 Patient Sample Method via registries, report all measures for the 20 unique patients seen, a majority of which must be Medicare Part B FFS patients.
- For claims-based submissions, the Carrier/MAC remittance advice notice sent to the practice will show a denial remark code (N365) for the line item on the claim containing **G8546** (and **G8550** if reported) as well as all other line items containing QDCs. N365 indicates that the code is not payable and is used for reporting/informational purposes only. Other services/codes on the claim will not be affected by the addition of a measures group-specific intent G-code or other QDCs. The N365 remark code does NOT indicate whether the QDC is accurate for that claim or for the measure the eligible professional is attempting to report, but does indicate that the QDC was processed and transmitted to the NCH.

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2013 Physician Quality Reporting System (PQRS) Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS PQRS website.

SPECIFICATION FOR MEASURES GROUP REPORTING ONLY

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

DESCRIPTION:

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

NUMERATOR:

Patients with documented spirometry results in the medical record (FEV₁ and FEV₁/FVC)

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

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Spirometry Results Documented

CPT II 3023F: Spirometry results documented and reviewed

OR

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

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

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

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

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

OR

Spirometry Results not Documented, Reason not 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

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2013 Physician Quality Reporting System (PQRS) Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS PQRS website.

SPECIFICATION FOR MEASURES GROUP REPORTING ONLY

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

DESCRIPTION:

Percentage of patients aged 18 years and older with a diagnosis of COPD and who have an FEV₁/FVC less than 60% and have symptoms who were prescribed an inhaled bronchodilator

NUMERATOR:

Patients who were prescribed an inhaled bronchodilator

Definition:

Prescribed – Includes patients who are currently receiving medication(s) that follow the treatment plan recommended at an encounter during the reporting period, even if the prescription for that medication was ordered prior to the encounter.

NUMERATOR NOTE: *The correct combination of numerator code(s) must be reported on the claim form in order to properly report this measure. The "correct combination" of codes may require the submission of multiple numerator codes.*

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Patient Prescribed Inhaled Bronchodilator Therapy

(One CPT II code [4025F] & one G code [G8924] are required on the claim form to submit this numerator option)

CPT II 4025F: Inhaled bronchodilator prescribed

AND

G8924: Spirometry test results demonstrate FEV₁/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 [4025F-xP] & one G code [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 FEV₁/FVC < 60% with COPD symptoms (e.g., dyspnea, cough/sputum, wheezing)

OR

If patient is not eligible for this measure because spirometry results demonstrate FEV₁/FVC $\geq 60\%$ or patient does not have COPD symptoms, report:

Spirometry Results Demonstrate FEV₁/FVC $\geq 60\%$ 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 FEV₁/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

SPECIFICATION FOR MEASURES GROUP REPORTING ONLY

OR

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

(One CPT II code [4025F-8P] & one G-Code [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

G8924: Spirometry test results demonstrate FEV₁/FVC < 60% with COPD symptoms (e.g., dyspnea, cough/sputum, wheezing)

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2013 Physician Quality Reporting System (PQRS) Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS PQRS website.

SPECIFICATION FOR MEASURES GROUP REPORTING ONLY

▲Measure #110 (NQF 0041): Preventive Care and Screening: Influenza Immunization

DESCRIPTION:

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

NUMERATOR:

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

Numerator Instructions:

- 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 (October 1 - March 31). In these cases, **G8482** should be reported.

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

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2013 Physician Quality Reporting System (PQRS) Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS PQRS website.

SPECIFICATION FOR MEASURES GROUP REPORTING ONLY

- ♦Measure #111 (NQF 0043): Preventive Care and Screening: Pneumococcal Vaccination for Patients 65 Years and Older

DESCRIPTION:

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

NUMERATOR:

Patients who have ever received a pneumococcal vaccination

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Pneumococcal Vaccination Administered or Previously Received

CPT II 4040F: Pneumococcal vaccine administered or previously received

OR

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

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2013 Physician Quality Reporting System (PQRS) Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS PQRS website.

SPECIFICATION FOR MEASURES GROUP REPORTING ONLY

▲Measure #226 (NQF 0028): Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention

DESCRIPTION:

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

NUMERATOR:

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

Definitions:

Tobacco Use – Includes use of any type of tobacco

Cessation Counseling Intervention – Includes brief counseling (3 minutes or less), and/or pharmacotherapy

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

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Patient Screened for Tobacco Use

CPT II 4004F: Patient screened for tobacco use AND received tobacco cessation intervention (counseling, pharmacotherapy, or both), if identified as a tobacco user

OR

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

CPT II 1036F: Current tobacco non-user

OR

Tobacco Screening not Performed for Medical Reasons

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

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

OR

Tobacco Screening OR Tobacco Cessation 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 not performed, reason not otherwise specified

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2013 Physician Quality Reporting System (PQRS) Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS PQRS website.

SPECIFICATION FOR MEASURES GROUP REPORTING ONLY

INFLAMMATORY BOWEL DISEASE (IBD) MEASURES GROUP OVERVIEW

2013 PQRS OPTIONS FOR MEASURES GROUPS: **REGISTRY ONLY**

2013 PQRS MEASURES IN INFLAMMATORY BOWEL DISEASE (IBD) MEASURES GROUP:

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

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

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

G8899: I intend to report the Inflammatory Bowel Disease (IBD) Measures Group

- Report the patient sample method:
20 Patient Sample Method: 20 unique patients (a majority of which must be Medicare Part B FFS [fee for service] patients) meeting patient sample criteria for the measures group during the reporting period (January 1 through December 31, 2013 OR July 1 through December 31, 2013).
- Patient sample criteria for the IBD Measures Group are patients aged 18 years and older with a specific diagnosis of IBD accompanied by a specific patient encounter:

One of the following diagnosis codes indicating IBD:

ICD-9-CM: 555.0, 555.1, 555.2, 555.9, 556.0, 556.1, 556.2, 556.3, 556.4, 556.5, 556.6, 556.8, 556.9

ICD-10-CM [Reference ONLY/Not Reportable]: K50.00, K50.011, K50.012, K50.013, K50.014, K50.018, K50.019, K50.10, K50.111, K50.112, K50.113, K50.114, K50.118, K50.119, K50.80, K50.811, K50.812, K50.813, K50.814, K50.818, K50.819, K50.90, K50.911, K50.912, K50.913, K50.914, K50.918, K50.919, K51.00, K51.011, K51.012, K51.013, K51.014, K51.018, K51.019, K51.20, K51.211, K51.212, K51.213, K51.214, K51.218, K51.219, K51.30, K51.311, K51.312, K51.313, K51.314, K51.318, K51.319, K51.40, K51.411, K51.412, K51.413, K51.414, K51.418, K51.419, K51.50, K51.511, K51.512, K51.513, K51.514, K51.518, K51.519, K51.80, K51.811, K51.812, K51.813, K51.814, K51.818, K51.819, K51.90, K51.911, K51.912, K51.913, K51.914, K51.918, K51.919

Accompanied by

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

SPECIFICATION FOR MEASURES GROUP REPORTING ONLY

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

Composite G-code G8758: All quality actions for the applicable measures in the Inflammatory Bowel Disease (IBD) Measures Group have been performed for this patient

- To report satisfactorily the IBD Measures Group it requires all measures for each patient within the eligible professional's patient sample to be reported a minimum of once during the reporting period.
- Measures groups containing a measure with a 0% performance rate will not be counted as satisfactorily reporting the measures group. The recommended clinical quality action must be performed on at least one patient for each measure within the measures group reported by the eligible professional. Performance exclusion quality-data codes are not counted in the performance denominator. If the eligible professional submits all performance exclusion quality-data codes, the performance rate would be 0/0 and would be considered satisfactorily reporting.
- When using the 20 Patient Sample Method, report all applicable measures for the 20 unique patients seen a majority of which must be Medicare Part B FFS patients for the 12-month or 6-month reporting period.

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2013 Physician Quality Reporting System (PQRS) Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS PQRS website.

SPECIFICATION FOR MEASURES GROUP REPORTING ONLY

▲Measure #226 (NQF 0028): Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention

DESCRIPTION:

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

NUMERATOR:

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

Definitions:

Tobacco Use – Includes any type of tobacco

Cessation Counseling Intervention – Includes brief counseling (3 minutes or less) and/or pharmacotherapy

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

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Patient Screened for Tobacco Use

CPT II 4004F: Patient screened for tobacco use AND received tobacco cessation intervention (counseling, pharmacotherapy, or both), if identified as a tobacco user

OR

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

CPT II 1036F: Current tobacco non-user

OR

Tobacco Screening not Performed for Medical Reasons

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

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

OR

Tobacco Screening OR Tobacco Cessation 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 not performed, reason not otherwise specified

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2013 Physician Quality Reporting System (PQRS) Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS PQRS website.

SPECIFICATION FOR MEASURES GROUP REPORTING ONLY

■ Measure #269: Inflammatory Bowel Disease (IBD): Type, Anatomic Location and Activity All Documented

DESCRIPTION:

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

NUMERATOR:

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

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

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

Numerator Options:

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

OR

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

OR

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

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2013 Physician Quality Reporting System (PQRS) Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS PQRS website.

SPECIFICATION FOR MEASURES GROUP REPORTING ONLY

☐ Measure #270: Inflammatory Bowel Disease (IBD): Preventive Care: Corticosteroid Sparing Therapy

DESCRIPTION:

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

NUMERATOR:

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

Definition:

Corticosteroids - Prednisone equivalents used expressly for the treatment of IBD and not for other indications (including premedication before anti-TNF therapy, non-IBD indications) can be determined using the following: 1 mg of prednisone = 1 mg of prednisolone; 5 mg of cortisone; 4 mg of hydrocortisone; 0.8 mg of triamcinolone; 0.8 mg of methylprednisolone; 0.15 mg of dexamethasone; 0.15 mg of betamethasone.

Numerator Options:

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

AND

Corticosteroid sparing therapy prescribed (4142F)

OR

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

OR

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

AND

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

OR

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

AND

Documentation of patient reason(s) for not treating with corticosteroid sparing therapy (e.g., patient refuses to initiate steroid sparing therapy) (4142F *with* 2P)

OR

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

AND

Corticosteroid sparing therapy not prescribed, reason not otherwise specified (4142F *with* 8P)

SPECIFICATION FOR MEASURES GROUP REPORTING ONLY

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2013 Physician Quality Reporting System (PQRS) Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS PQRS website.

SPECIFICATION FOR MEASURES GROUP REPORTING ONLY

■ Measure #271: Inflammatory Bowel Disease (IBD): Preventive Care: Corticosteroid Related Iatrogenic Injury – Bone Loss Assessment

DESCRIPTION:

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

NUMERATOR:

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

Definitions:

Corticosteroids - Prednisone equivalents used expressly for the treatment of IBD and not for other indications (including premedication before anti-TNF therapy, non-IBD indications) can be determined using the following: 1 mg of prednisone = 1 mg of prednisolone; 5 mg of cortisone; 4 mg of hydrocortisone; 0.8 mg of triamcinolone; 0.8 mg of methylprednisolone; 0.15 mg of dexamethasone; 0.15 mg of betamethasone.

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

Numerator Options:

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

AND

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

OR

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

OR

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

AND

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

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2013 Physician Quality Reporting System (PQRS) Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS PQRS website.

SPECIFICATION FOR MEASURES GROUP REPORTING ONLY

Measure #272: Inflammatory Bowel Disease (IBD): Preventive Care: Influenza Immunization

DESCRIPTION:

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

NUMERATOR:

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

Numerator Options:

Influenza immunization recommended (4035F)

OR

Influenza immunization ordered or administered (4037F)

OR

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

OR

Documentation of medical reason(s) for not ordering or administering or having previously received influenza immunization (eg, patient allergic reaction, potential adverse drug reaction)

(4037F *with* 1P)

OR

Documentation of patient reason(s) for not recommending influenza immunization (eg, patient refusal) (4035F *with* 2P)

OR

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

OR

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

OR

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

OR

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

OR

Influenza immunization not ordered or administered, reason not otherwise specified

(4037F *with* 8P)

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2013 Physician Quality Reporting System (PQRS) Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS PQRS website.

SPECIFICATION FOR MEASURES GROUP REPORTING ONLY

Measure #273: Inflammatory Bowel Disease (IBD): Preventive Care: Pneumococcal Immunization

DESCRIPTION:

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

NUMERATOR:

Patients for whom pneumococcal vaccine administered or previously received

Numerator Options:

Pneumococcal vaccine administered or previously received (G8864)

OR

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

OR

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

OR

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

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2013 Physician Quality Reporting System (PQRS) Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS PQRS website.

SPECIFICATION FOR MEASURES GROUP REPORTING ONLY

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

DESCRIPTION:

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

NUMERATOR:

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

Definition:

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

Numerator Options:

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

AND

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

OR

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

OR

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

OR

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

AND

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

OR

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

AND

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

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2013 Physician Quality Reporting System (PQRS) Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS PQRS website.

SPECIFICATION FOR MEASURES GROUP REPORTING ONLY

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

DESCRIPTION:

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

NUMERATOR:

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

Numerator Instructions: HBV status must be assessed by one of the following:

HBsAG, HBsAG neutralization, HBcAb total, HBcAB IgM, HBsAB

Definition:

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

Numerator Options:

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

OR

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

OR

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

OR

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

OR

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

OR

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

OR

Hepatitis B Virus (HBV) status not assessed and results interpreted within one year prior to receiving a first course of anti-TNF (tumor necrosis factor) therapy, reason not otherwise specified (3517F *with* 8P)

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2013 Physician Quality Reporting System (PQRS) Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS PQRS website.

SPECIFICATION FOR MEASURES GROUP REPORTING ONLY

SLEEP APNEA MEASURES GROUP OVERVIEW

2013 PQRS OPTIONS FOR MEASURES GROUP: REGISTRY ONLY

2013 PQRS MEASURES IN SLEEP APNEA MEASURES GROUP:

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

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

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

G8900: I intend to report the Sleep Apnea Measures Group

- Report the patient sample method:
20 Patient Sample Method: 20 unique patients (a majority of which must be Medicare Part B FFS [fee for service] patients) meeting patient sample criteria for the measures group during the reporting period (January 1 through December 31, 2013 **OR** July 1 through December 31, 2013).
- Patient sample criteria for the Sleep Apnea Measures Group are patients aged 18 years and older with a specific diagnosis of Sleep Apnea accompanied by a specific patient encounter:

One of the following diagnosis codes indicating Sleep Apnea:

ICD-9-CM: 327.23, 780.51, 780.53, 780.57

ICD-10-CM [Reference ONLY/Not Reportable]: G47.30, G47.33

Accompanied by

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

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

Composite G-code G8759: All quality actions for the applicable measures in the Sleep Apnea Measures Group have been performed for this patient.

- To report satisfactorily the Sleep Apnea Measures Group it requires **all** measures for each patient within the eligible professional's patient sample to be reported a minimum of once during the

SPECIFICATION FOR MEASURES GROUP REPORTING ONLY

reporting period. In measures group reporting, measures that are based on patient visits need only be reported a minimum of once per reporting period – they do not need to be reported each visit.

- Measures groups containing a measure with a 0% performance rate will not be counted as satisfactorily reporting the measures group. The recommended clinical quality action must be performed on at least one patient for each measure within the measures group reported by the eligible professional. Performance exclusion quality-data codes are not counted in the performance denominator. If the eligible professional submits all performance exclusion quality-data codes, the performance rate would be 0/0 and would be considered satisfactorily reporting.
- When using the 20 Patient Sample Method, report all applicable measures for the 20 unique patients seen a majority of which must be Medicare Part B FFS patients for the 12-month or 6-month reporting period.

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2013 Physician Quality Reporting System (PQRS) Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS PQRS website.

Measure #276: Sleep Apnea: Assessment of Sleep Symptoms

DESCRIPTION:

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

NUMERATOR:

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

Numerator Options:

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

OR

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

OR

Sleep apnea symptoms not assessed, reason not given (G8841)

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2013 Physician Quality Reporting System (PQRS) Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS PQRS website.

Measure #277: Sleep Apnea: Severity Assessment at Initial Diagnosis

DESCRIPTION:

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

NUMERATOR:

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

Definitions:

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

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

Numerator Options:

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

OR

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

OR

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

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2013 Physician Quality Reporting System (PQRS) Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS PQRS website.

SPECIFICATION FOR MEASURES GROUP REPORTING ONLY

Measure #278: Sleep Apnea: Positive Airway Pressure Therapy Prescribed

DESCRIPTION:

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

NUMERATOR:

Patients who were prescribed positive airway pressure therapy

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

Numerator Options:

Positive airway pressure therapy prescribed (G8845)

AND

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

OR

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

OR

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

AND

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

OR

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

AND

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

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2013 Physician Quality Reporting System (PQRS) Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS PQRS website.

SPECIFICATION FOR MEASURES GROUP REPORTING ONLY

Measure #279: Sleep Apnea: Assessment of Adherence to Positive Airway Pressure Therapy

DESCRIPTION:

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

NUMERATOR:

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

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

Numerator Options:

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

AND

Positive airway pressure therapy was prescribed (G8852)

OR

Positive airway pressure therapy not prescribed (G8853)

OR

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

AND

Positive airway pressure therapy was prescribed (G8852)

OR

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

AND

Positive airway pressure therapy was prescribed (G8852)

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2013 Physician Quality Reporting System (PQRS) Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS PQRS website.

SPECIFICATION FOR MEASURES GROUP REPORTING ONLY

DEMENTIA MEASURES GROUP OVERVIEW

2013 PQRS OPTIONS FOR MEASURES GROUPS: **CLAIMS, REGISTRY**

2013 PQRS MEASURES IN DEMENTIA MEASURES GROUP:

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

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

- Indicate your intention to report the Dementia Measures Group by submitting the measures group-specific intent G-code at least once during the reporting period when billing a patient claim for the 20 Patient Sample Method. It is not necessary to submit the measures group-specific intent G-code on more than one claim. It is not necessary to submit the measures group-specific intent G-code for registry-based submissions.

G8902: I intend to report the Dementia Measures Group

- Select patient sample method:
20 Patient Sample Method via claims: 20 unique Medicare Part B FFS (fee for service) patients meeting patient sample criteria for the measures group.
OR
20 Patient Sample Method via registries: 20 unique patients (a majority of which must be Medicare Part B FFS patients) meeting patient sample criteria for the measures group during the reporting period (January 1 through December 31, 2013) **OR** July 1 through December 31, 2013).
- Patient sample criteria for the Dementia Measures Group are all patients regardless of age, with a specific diagnosis of dementia accompanied by a specific patient encounter:

One of the following diagnosis codes indicating Dementia:

ICD-9-CM: 094.1, 290.0, 290.10, 290.11, 290.12, 290.13, 290.20, 290.21, 290.3, 290.40, 290.41, 290.42, 290.43, 290.8, 290.9, 294.10, 294.11, 294.20, 294.21, 294.8, 331.0, 331.11, 331.19, 331.82

ICD-10-CM [Reference ONLY/Not Reportable]: A52.17, F01.50, F01.51, F02.80, F02.81, F03.90, F03.91, F05, F06.0, F06.8, G30.0, G30.1, G30.8, G30.9, G31.01, G31.09, G31.83

Accompanied by

One of the following patient encounter codes: 90791, 90792, 90832, 90834, 90837, 96116, 96118, 96119, 96120, 96150, 96151, 96152, 96154, 96155, 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

SPECIFICATION FOR MEASURES GROUP REPORTING ONLY

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

Composite G-code G8761: All quality actions for the applicable measures in the Dementia Measures Group have been performed for this patient

- To report satisfactorily the Dementia Measures Group it requires all measures for each patient within the eligible professional's patient sample to be reported a minimum of once during the reporting period.
- Measures groups containing a measure with a 0% performance rate will not be counted as satisfactorily reporting the measures group. The recommended clinical quality action must be performed on at least one patient for each measure within the measures group reported by the eligible professional. Performance exclusion quality-data codes are not counted in the performance denominator. If the eligible professional submits all performance exclusion quality-data codes, the performance rate would be 0/0 and would be considered satisfactorily reporting.
- When using the 20 Patient Sample Method via claims, report all measures for the 20 unique Medicare Part B FFS patients seen. When using the 20 Patient Sample Method via registries, report all measures for the 20 unique patients seen, a majority of which must be Medicare Part B FFS patients.
- For claims-based submissions, the Carrier/MAC remittance advice notice sent to the practice will show a denial remark code (N365) for the line item on the claim containing G8902 (and G8761 if reported) as well as all other line items containing QDCs. N365 indicates the code is not payable and is used for reporting/informational purposes only. Other services/codes on the claim will not be affected by the addition of a measures group-specific intent G-code or other QDCs. The N365 remark code does NOT indicate whether the QDC is accurate for that claim or for the measure the eligible professional is attempting to report, but does indicate that the QDC was processed and transmitted to the NCH.

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2013 Physician Quality Reporting System (PQRS) Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS PQRS website.

▲ Measure #280: Dementia: Staging of Dementia

DESCRIPTION:

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

NUMERATOR:

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

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

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

Definitions:

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

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

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

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

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Dementia Severity Classified

CPT II 1490F: Dementia severity classified, mild

OR

CPT II 1491F: Dementia severity classified, moderate

OR

CPT II 1493F: Dementia severity classified, severe

OR

Dementia Severity not Classified, Reason not Otherwise Specified

Append a reporting modifier (8P) to CPT Category II code 1490F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

1490F with 8P: Dementia severity not classified, reason not otherwise specified

SPECIFICATION FOR MEASURES GROUP REPORTING ONLY

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2013 Physician Quality Reporting System (PQRS) Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS PQRS website.

SPECIFICATION FOR MEASURES GROUP REPORTING ONLY

▲ Measure #281: Dementia: Cognitive Assessment

DESCRIPTION:

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

NUMERATOR:

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

Numerator Instructions:

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

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

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Cognition Assessed and Reviewed

CPT II 1494F: Cognition assessed and reviewed

OR

Cognition not Assessed and Reviewed for Medical or Patient Reasons

Append a modifier (1P) or (2P) to CPT Category II code **1494F** to report documented circumstances that appropriately exclude patients from the denominator.

1494F with 1P: Documentation of medical reason(s) for not assessing and reviewing cognition (eg, patient with very advanced stage dementia, other medical reason)

1494F with 2P: Documentation of patient reason(s) for not assessing and reviewing cognition

OR

Cognition not Assessed and Reviewed, Reason not Otherwise Specified

Append a reporting modifier (8P) to CPT Category II code **1494F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

1494F with 8P: Cognition not assessed and reviewed, reason not otherwise specified

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2013 Physician Quality Reporting System (PQRS) Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS PQRS website.

SPECIFICATION FOR MEASURES GROUP REPORTING ONLY

▲ Measure #282: Dementia: Functional Status Assessment

DESCRIPTION:

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

NUMERATOR:

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

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

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

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Functional Status for Dementia Assessed and Results Reviewed

CPT II 1175F: Functional status for dementia assessed and results reviewed

OR

Functional Status for Dementia not Assessed or Results not Reviewed for Medical Reasons

Append a reporting modifier (1P) to CPT Category II code 1175F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

1175F with 1P: Documentation of medical reason(s) for not assessing and reviewing functional status for dementia (eg, patient is severely impaired and caregiver knowledge is limited, other medical reason)

OR

Functional Status for Dementia not Assessed or Results not Reviewed, Reason not Otherwise Specified

Append a reporting modifier (8P) to CPT Category II code 1175F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

1175F with 8P: Functional status for dementia not assessed and results not reviewed, reason not otherwise specified

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2013 Physician Quality Reporting System (PQRS) Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS PQRS website.

SPECIFICATION FOR MEASURES GROUP REPORTING ONLY

▲ Measure #283: Dementia: Neuropsychiatric Symptom Assessment

DESCRIPTION:

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

NUMERATOR:

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

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

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

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

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

Definitions:

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

Activity disturbances:

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

Mood disturbances:

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

Thought and perceptual disturbances:

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

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Neuropsychiatric Symptoms Assessed and Results Reviewed

CPT II 1181F: Neuropsychiatric symptoms assessed and results reviewed

SPECIFICATION FOR MEASURES GROUP REPORTING ONLY

OR

Neuropsychiatric Symptoms not Assessed or Results not Reviewed

Append a reporting modifier (8P) to CPT Category II code **1181F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

1181F with 8P: Neuropsychiatric symptoms **not** assessed and results **not** reviewed, reason not otherwise specified

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2013 Physician Quality Reporting System (PQRS) Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS PQRS website

SPECIFICATION FOR MEASURES GROUP REPORTING ONLY

▲ Measure #284: Dementia: Management of Neuropsychiatric Symptoms

DESCRIPTION:

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

NUMERATOR:

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

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Neuropsychiatric Intervention Ordered or Received, if Neuropsychiatric Symptoms Present
(One G-code [G8947] & one CPT II code [452xF] are required on the claim form to submit this numerator option)

G8947: One or more neuropsychiatric symptoms

AND

CPT II 4525F: Neuropsychiatric intervention ordered

OR

CPT II 4526F: Neuropsychiatric intervention received

OR

G8948: No neuropsychiatric symptoms

OR

Neuropsychiatric Symptoms Present and Neuropsychiatric Intervention not Ordered or Received, Reason not Otherwise Specified

(One G-code [G8947] & one CPT II code [452xF-8P] are required on the claim form to submit this numerator option)

Append a modifier (8P) to CPT Category II code 4025F or 4026F to report documented circumstances that appropriately exclude patients from the denominator.

G8947: One or more neuropsychiatric symptoms

AND

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

OR

4526F *with* 8P: Neuropsychiatric Intervention not received, reason not otherwise specified

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2013 Physician Quality Reporting System (PQRS) Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS PQRS website.

SPECIFICATION FOR MEASURES GROUP REPORTING ONLY

▲ Measure #285: Dementia: Screening for Depressive Symptoms

DESCRIPTION:

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

NUMERATOR:

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

Numerator Instructions:

In addition to clinical qualitative approaches, dementia patients can be screened for depressive symptoms using one of a number of valid, reliable instruments available from the medical literature.

Examples include, but are not limited to:

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

Definition:

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

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Screening for Depression Performed

CPT II 3725F: Screening for depression performed

OR

Screening for Depression not Performed, Reason not Otherwise Specified

Append a reporting modifier (8P) to CPT Category II code 3725F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

3725F with 8P: Screening for depression not performed, reason not otherwise specified

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2013 Physician Quality Reporting System (PQRS) Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS PQRS website

SPECIFICATION FOR MEASURES GROUP REPORTING ONLY

▲ Measure #286: Dementia: Counseling Regarding Safety Concerns

DESCRIPTION:

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

NUMERATOR:

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

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

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

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

Definition:

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

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

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Safety Counseling for Dementia Provided or Ordered

CPTII 6101F: Safety counseling for dementia provided

OR

CPT II 6102F: Safety counseling for dementia ordered

OR

Safety Counseling for Dementia not Provided or Ordered for Medical Reasons

Append a reporting modifier (1P) to CPT Category II code **6101F** or **6102F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

6101F with 1P: Documentation of medical reason(s) for not providing counseling regarding safety concerns (eg, patient in palliative care, other medical reason)

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OR

6102F with 1P: Documentation of medical reason(s) for not ordering safety counseling (eg, patient in palliative care, other medical reason)

OR

Safety Counseling for Dementia not Provided or Ordered, Reason not Otherwise Specified
Append a reporting modifier (8P) to CPT Category II code **6101F** or **6102F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

6101F with 8P: Safety counseling for dementia not provided, reason not otherwise specified

OR

6102F with 8P: Safety counseling for dementia not ordered, reason not otherwise specified

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2013 Physician Quality Reporting System (PQRS) Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS PQRS website.

SPECIFICATION FOR MEASURES GROUP REPORTING ONLY

▲ Measure #287: Dementia: Counseling Regarding Risks of Driving

DESCRIPTION:

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

NUMERATOR:

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

Numerator Instructions:

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

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Counseling Provided Regarding Risks of Driving and the Alternatives to Driving

CPTII 6110F: Counseling provided regarding risks of driving and the alternatives to driving

OR

Counseling not Provided Regarding Risks of Driving and the Alternatives to Driving for Medical Reasons

Append a reporting modifier (1P) to CPT Category II code **6110F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

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

OR

Counseling not Provided Regarding Risks of Driving and the Alternatives to Driving, Reason not Otherwise Specified

Append a reporting modifier (8P) to CPT Category II code **6110F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

6110F with 8P: Counseling regarding risks of driving and alternatives to driving not performed, reason not otherwise specified

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2013 Physician Quality Reporting System (PQRS) Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS PQRS website

SPECIFICATION FOR MEASURES GROUP REPORTING ONLY

▲ Measure #288: Dementia: Caregiver Education and Support

DESCRIPTION:

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

NUMERATOR:

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

Numerator Instructions:

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

Definition:

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

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Caregiver Provided with Education and Referred to Additional Resources for Support

CPTII 4322F: Caregiver provided with education and referred to additional resources for support

OR

Caregiver not Provided with Education and Referred to Additional Resources for Support for Medical Reasons

Append a reporting modifier (1P) to CPT Category II code **4322F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

4322F with 1P: Documentation of medical reason(s) for not providing the caregiver with education on disease management and health behavior changes or referring to additional sources for support (eg, patient does not have a caregiver, other medical reason)

OR

Caregiver not Provided with Education and Referred to Additional Resources for Support, Reason not Otherwise Specified

Append a reporting modifier (8P) to CPT Category II code **4322F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

4322F with 8P: Caregiver not provided with education and not referred to additional resources for support, reason not otherwise specified

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2013 Physician Quality Reporting System (PQRS) Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS PQRS website.

SPECIFICATION FOR MEASURES GROUP REPORTING ONLY

PARKINSON'S DISEASE MEASURES GROUP OVERVIEW

2013 PQRS OPTIONS FOR MEASURES GROUPS: REGISTRY ONLY

2013 PQRS MEASURES IN PARKINSON'S DISEASE MEASURES GROUP:

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

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

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

G8903: I intend to report the Parkinson's Disease Measures Group

- Report the patient sample method:
20 Patient Sample Method: 20 unique patients (a majority of which must be Medicare Part B FFS [fee for service] patients) meeting patient sample criteria for the measures group during the reporting period (January 1 through December 31, 2013 **OR** July 1 through December 31, 2013).
- Patient sample criteria for the Parkinson's Disease Measures Group are patients aged 18 years and older with a specific diagnosis of Parkinson's Disease accompanied by a specific patient encounter:

The following diagnosis code indicating Parkinson's disease:

ICD-9-CM: 332.0

ICD-10-CM [Reference ONLY/Not Reportable]: G20

Accompanied by

One of the following patient encounter codes: 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309, 99310

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

Composite G-code G8762: All quality actions for the applicable measures in the Parkinson's Disease Measures Group have been performed for this patient

SPECIFICATION FOR MEASURES GROUP REPORTING ONLY

- To report satisfactorily the Parkinson's Disease Measures Group it requires all measures for each patient within the eligible professional's patient sample to be reported a minimum of once during the reporting period.
- Measures groups containing a measure with a 0% performance rate will not be counted as satisfactorily reporting the measures group. The recommended clinical quality action must be performed on at least one patient for each measure within the measures group reported by the eligible professional. Performance exclusion quality-data codes are not counted in the performance denominator. If the eligible professional submits all performance exclusion quality-data codes, the performance rate would be 0/0 and would be considered satisfactorily reporting.
- When using the 20 Patient Sample Method, report all applicable measures for the 20 unique patients seen a majority of which must be Medicare Part B FFS patients for the 12-month or 6-month reporting period.

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2013 Physician Quality Reporting System (PQRS) Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS PQRS website.

SPECIFICATION FOR MEASURES GROUP REPORTING ONLY

↳ Measure #289: Parkinson's Disease: Annual Parkinson's Disease Diagnosis Review

DESCRIPTION:

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

NUMERATOR:

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

Numerator Options:

Parkinson's disease diagnosis reviewed (1400F)

OR

Parkinson's disease diagnosis was not reviewed, reason not otherwise specified (1400F *with* 8P)

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2013 Physician Quality Reporting System (PQRS) Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS PQRS website.

SPECIFICATION FOR MEASURES GROUP REPORTING ONLY

↳ Measure #290: Parkinson's Disease: Psychiatric Disorders or Disturbances Assessment

DESCRIPTION:

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

NUMERATOR:

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

Numerator Options:

Psychiatric disorders or disturbances assessed (3700F)

OR

Psychiatric disorders or disturbances not assessed, reason not otherwise specified
(3700F *with* 8P)

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2013 Physician Quality Reporting System (PQRS) Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS PQRS website.

SPECIFICATION FOR MEASURES GROUP REPORTING ONLY

↳ Measure #291: Parkinson's Disease: Cognitive Impairment or Dysfunction Assessment

DESCRIPTION:

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

NUMERATOR:

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

Numerator Options:

Cognitive impairment or dysfunction assessed (3720F)

OR

Cognitive impairment or dysfunction was not assessed, reason not otherwise specified
(3720F with 8P)

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2013 Physician Quality Reporting System (PQRS) Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS PQRS website.

SPECIFICATION FOR MEASURES GROUP REPORTING ONLY

↳ Measure #292: Parkinson's Disease: Querying about Sleep Disturbances

DESCRIPTION:

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

NUMERATOR:

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

Numerator Options:

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

OR

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

OR

Patient (or caregiver) not queried about sleep disturbances, reason not otherwise specified (**4328F with 8P**)

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2013 Physician Quality Reporting System (PQRS) Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS PQRS website.

SPECIFICATION FOR MEASURES GROUP REPORTING ONLY

↳ Measure #293: Parkinson's Disease: Rehabilitative Therapy Options

DESCRIPTION:

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

NUMERATOR:

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

Numerator Options:

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

OR

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

OR

Rehabilitative therapy options was not discussed with patient (or caregiver), reason not otherwise specified (4400F *with* 8P)

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2013 Physician Quality Reporting System (PQRS) Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS PQRS website.

SPECIFICATION FOR MEASURES GROUP REPORTING ONLY

↳ Measure #294: Parkinson's Disease: Parkinson's Disease Medical and Surgical Treatment Options Reviewed

DESCRIPTION:

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

NUMERATOR:

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

Numerator Options:

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

OR

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

OR

Medical and surgical treatment options not reviewed with patient (or caregiver), reasons not specified (4325F *with* 8P)

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2013 Physician Quality Reporting System (PQRS) Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS PQRS website.

SPECIFICATION FOR MEASURES GROUP REPORTING ONLY

HYPERTENSION MEASURES GROUP OVERVIEW

2013 PQRS OPTIONS FOR MEASURES GROUPS: **REGISTRY ONLY**

2013 PQRS MEASURES IN HYPERTENSION MEASURES GROUP:

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

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

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

G8904: I intend to report the Hypertension (HTN) Measures Group

- Report the patient sample method:
20 Patient Sample Method: 20 unique patients (a majority of which must be Medicare Part B FFS [fee for service] patients) meeting patient sample criteria for the measures group during the reporting period (January 1 through December 31, 2013 **OR** July 1 through December 31, 2013).
- Patient sample criteria for the Hypertension Measures Group are patients aged 18 through 90 years with a specific diagnosis of hypertension, and without a diagnosis of stage 5 chronic kidney disease (GFR of < 15ml/min per 1.72 m² or end-stage kidney disease), accompanied by a specific patient encounter:

One of the following diagnosis codes indicating hypertension:

ICD-9-CM: 401.0, 401.1, 401.9, 402.00, 402.01, 402.10, 402.11, 402.90, 402.91, 403.00, 403.10, 403.90, 404.00, 404.01, 404.10, 404.11, 404.90, 404.91

ICD-10-CM [Reference ONLY/Not Reportable]: I10, I11.0, I11.9, I12.9, I13.0, I13.10

Accompanied by

One of the following patient encounter codes: 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, G0438, G0439

AND NOT

Diagnosis for stage 5 chronic kidney disease:

ICD-9-CM: 403.01, 403.11, 403.91, 404.02, 404.03, 404.12, 404.13, 404.92, 404.93, 585.5, 585.6

ICD-10-CM [Reference ONLY/Not Reportable]: I12.0, I13.11, I13.2, N18.5, N18.6

SPECIFICATION FOR MEASURES GROUP REPORTING ONLY

- Report a numerator option on **all applicable** measures within the Hypertension Measures Group for each patient within the eligible professional's patient sample.
- Applicable measures contain patient demographic criteria specific to the measure. For example, Hypertension: Appropriate Use of Aspirin or Other Antithrombotic Therapy criteria is applicable *only to patients 30-90 years* within the sample population, while all other measures within this group apply to *all* patients 18-90 years. Reporting measure(s) from the group that are inapplicable to an individual patient will not affect the eligible provider's reporting or performance rate.
- Instructions for qualifying numerator option reporting for each of the measures within the Hypertension Measures Group are displayed on the next several pages. The following composite G-code has been created for registry only measures groups for use by registries that utilize claims data. This composite G-code may be reported in lieu of the individual quality-data codes for each of the measures within the group, if all quality actions for the patient have been performed for all the measures within the group. However, it is not necessary to submit the following composite G-code for registry-based submissions.

Composite G-code G8763: All quality actions for the applicable measures in the Hypertension (HTN) Measures Group have been performed for this patient

- To report satisfactorily the Hypertension Measures Group it requires **all** measures for each patient within the eligible professional's patient sample to be reported a minimum of once during the reporting period.
- Measures groups containing a measure with a 0% performance rate will not be counted as satisfactorily reporting the measures group. The recommended clinical quality action must be performed on at least one patient for each measure within the measures group reported by the eligible professional. Performance exclusion quality-data codes are not counted in the performance denominator. If the eligible professional submits all performance exclusion quality-data codes, the performance rate would be 0/0 and would be considered satisfactorily reporting.
- When using the 20 Patient Sample Method, report all applicable measures for the 20 unique patients seen a majority of which must be Medicare Part B FFS patients for the 12-month or 6-month reporting period.

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2013 Physician Quality Reporting System (PQRS) Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS PQRS website.

SPECIFICATION FOR MEASURES GROUP REPORTING ONLY

● Measure #295: Hypertension: Appropriate Use of Aspirin or Other Antithrombotic Therapy

DESCRIPTION:

Percentage of patients aged 30 through 90 years old with a diagnosis of hypertension and are eligible for aspirin or other antithrombotic therapy who were prescribed aspirin or other antithrombotic therapy

NUMERATOR:

Patients who were prescribed aspirin or other antithrombotic therapy

Numerator Instructions: Oral antithrombotic therapy consists of aspirin, warfarin, clopidogrel, dabigatran, rivaroxaban, or combination of aspirin and extended release dipyridamole. Diagnosis of prior coronary heart disease, prior stroke or transient ischemic attack, prior peripheral artery disease, and/or prior diabetes, and Framingham risk assessment for estimating 10-year risk of developing CHD are used to determine whether a patient should be prescribed/recommended aspirin or other antithrombotic therapy or at low risk and therefore aspirin or other antithrombotic therapy should not be prescribed/recommended.

Patients for whom the goals of care are predominantly palliative or for whom treatment of hypertension with standard treatment goals is not clinically appropriate, or with low risk for CHD should be excluded.

Definition:

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

Treatment of hypertension with standard treatment goals is not clinically appropriate -For some patients, treatment of hypertension with standard goals may not be relevant, as might be the case for a patient with severe Alzheimer's disease.

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

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

Numerator Options:

Oral aspirin or other antithrombotic therapy prescribed (G8895)

OR

Documentation of medical reason(s) for not prescribing oral aspirin or other antithrombotic therapy (e.g., patient documented to be low risk, or patient with palliative care goals or treatment of hypertension with standard treatment goals is not clinically appropriate, or for whom risk of aspirin or other antithrombotic therapy exceeds potential benefits such as for individuals whose blood pressure is poorly controlled) (G8896)

OR

Oral aspirin or other antithrombotic therapy was not prescribed, reason not given (G8897)

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2013 Physician Quality Reporting System (PQRS) Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS PQRS website.

SPECIFICATION FOR MEASURES GROUP REPORTING ONLY

● Measure #296: Hypertension: Complete Lipid Profile

DESCRIPTION:

Percentage of patients aged 18 through 90 years old with a diagnosis of hypertension who received a complete lipid profile within **60 months**

NUMERATOR:

Patients who received at least one lipid profile (including total cholesterol, HDL-C, triglycerides and calculated LDL-C) within **60 months**

Numerator Instruction:

Patients for whom the goals of care are predominantly palliative or for whom treatment of hypertension with standard treatment goals is not clinically appropriate should be excluded.

Definitions:

Treatment of hypertension with standard treatment goals is not clinically appropriate - For some patients, treatment of hypertension with standard goals may not be relevant, as might be the case for a patient with severe Alzheimer's disease.

NUMERATOR NOTE: The performance period for this measure is 60 months.

Numerator Options:

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

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

OR

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

OR

Lipid profile **not** performed, reason not given (**G8769**)

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2013 Physician Quality Reporting System (PQRS) Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS PQRS website.

SPECIFICATION FOR MEASURES GROUP REPORTING ONLY

● **Measure #297: Hypertension: Urine Protein Test**

DESCRIPTION:

Percentage of patients aged 18 through 90 years old with a diagnosis of hypertension who either have chronic kidney disease diagnosis documented or had a urine protein test done within 36 months

NUMERATOR:

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

Numerator Instructions: This measure is looking for a urine protein screening test or evidence of existing chronic kidney disease. A urine protein test consists of tests for albuminuria, microalbuminuria, or proteinuria. Patients for whom the goals of care are predominantly palliative or for whom treatment of hypertension with standard treatment goals is not clinically appropriate should be excluded.

Definitions:

Treatment of hypertension with standard treatment goals is not clinically appropriate - For some patients, treatment of hypertension with standard goals may not be relevant, as might be the case for a patient with severe Alzheimer's disease.

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

Numerator Options:

Urine Protein test result documented and reviewed (G8770)

OR

Documentation of diagnosis of chronic kidney disease (G8771)

OR

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

OR

Urine protein test was not performed, reason not given (G8773)

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2013 Physician Quality Reporting System (PQRS) Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS PQRS website.

SPECIFICATION FOR MEASURES GROUP REPORTING ONLY

● Measure #298: Hypertension: Annual Serum Creatinine Test

DESCRIPTION:

Percentage of patients aged 18 through 90 years old with a diagnosis of hypertension who had a serum creatinine test done within 12 months

NUMERATOR:

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

Numerator Instructions: Patients for whom the goals of care are predominantly palliative or for whom treatment of hypertension with standard treatment goals is not clinically appropriate should be excluded.

Definitions:

Treatment of hypertension with standard treatment goals is not clinically appropriate - For some patients, treatment of hypertension with standard goals may not be relevant, as might be the case for a patient with severe Alzheimer's disease.

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

Numerator Options:

Serum creatinine test result documented and reviewed (G8774)

OR

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

OR

Serum creatinine test not performed, reason not given (G8776)

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2013 Physician Quality Reporting System (PQRS) Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS PQRS website.

SPECIFICATION FOR MEASURES GROUP REPORTING ONLY

● **Measure #299: Hypertension: Diabetes Mellitus Screening Test**

DESCRIPTION:

Percentage of patients aged 18 through 90 years old with a diagnosis of hypertension who had a diabetes screening test within 36 months

NUMERATOR:

Patients who had a diabetes screening test done within 36 months

Numerator Instructions: Diabetes screening test consists of either a fasting glucose measurement, glycosylated hemoglobin test, or a two hour glucose tolerance test (three specimens). Patients for whom the goals of care are predominantly palliative or for whom treatment of hypertension with standard treatment goals is not clinically appropriate should be excluded.

Definitions:

Treatment of hypertension with standard treatment goals is not clinically appropriate - For some patients, treatment of hypertension with standard goals may not be relevant, as might be the case for a patient with severe Alzheimer's disease.

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

Numerator Options:

Diabetes screening test performed (G8777)

OR

Documentation of medical reason(s) for not performing diabetes screening test (e.g., patients with palliative goals or for whom treatment of hypertension with standard treatment goals is not clinically appropriate) (G8778)

OR

Diabetes screening test not performed, reason not given (G8779)

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2013 Physician Quality Reporting System (PQRS) Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS PQRS website.

SPECIFICATION FOR MEASURES GROUP REPORTING ONLY

● Measure #300: Hypertension: Blood Pressure Control

DESCRIPTION:

Percentage of patients aged 18 through 90 years old with a diagnosis of hypertension who had most recent blood pressure level under control (at goal)

NUMERATOR:

Patients who had most recent blood pressure under control

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

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

If there are multiple blood pressures on the same date of service, use the lowest systolic and lowest diastolic blood pressure on that date as the representative blood pressure. To be "under control", both systolic and diastolic blood pressures must be below the target values (e.g., for a diabetes patient, systolic BP =136 mmHg and diastolic BP =70 mmHg is not "under control").

Patients for whom the goals of care are predominantly palliative or for whom treatment of hypertension with standard treatment goals is not clinically appropriate should be excluded.

Definitions:

Treatment of hypertension with standard treatment goals is not clinically appropriate - For some patients, treatment of hypertension with standard goals may not be relevant, as might be the case for a patient with severe Alzheimer's disease.

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

Numerator Options:

Most recent blood pressure under control (G8886)

OR

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

OR

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

OR

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

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2013 Physician Quality Reporting System (PQRS) Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS PQRS website.

SPECIFICATION FOR MEASURES GROUP REPORTING ONLY

● Measure #301: Hypertension: Low Density Lipoprotein (LDL-C) Control

DESCRIPTION:

Percentage of patients aged 18 through 90 years old with a diagnosis of hypertension who had most recent LDL cholesterol level under control (at goal)

NUMERATOR:

Patients who had most recent LDL-C level under control during the **60-month** period

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

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

Patients for whom the goals of care are predominantly palliative or for whom treatment of hypertension with standard treatment goals is not clinically appropriate should be excluded.

Definitions:

Treatment of hypertension with standard treatment goals is not clinically appropriate - For some patients, treatment of hypertension with standard goals may not be relevant, as might be the case for a patient with severe Alzheimer's disease.

NUMERATOR NOTE: The performance period for this measure is 60 months.

Numerator Options:

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

OR

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

OR

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

OR

Most recent LDL-C **not** under control, results documented and reviewed (G8893)

OR

LDL-C **not** performed, reason not given (G8894)

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2013 Physician Quality Reporting System (PQRS) Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS PQRS website.

SPECIFICATION FOR MEASURES GROUP REPORTING ONLY

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

DESCRIPTION: Percentage of patients aged 18 through 90 years old with a diagnosis of hypertension who received dietary and physical activity counseling at least once within 12 months

NUMERATOR:

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

Numerator Instructions: Patients for whom the goals of care are predominantly palliative or for whom treatment of hypertension with standard treatment goals is not clinically appropriate should be excluded.

Definitions:

Treatment of hypertension with standard treatment goals is not clinically appropriate - For some patients, treatment of hypertension with standard goals may not be relevant, as might be the case for a patient with severe Alzheimer's disease.

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

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

Numerator Options:

Counseling for Diet and Physical Activity Performed (G8780)

OR

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

OR

Documentation of patient reason(s) for patient not receiving counseling for diet and physical activity (e.g., patient is not willing to discuss diet or exercise interventions to help control blood pressure, or the patient said he/she refused to make these changes) (G8949)

OR

Counseling for Diet and Physical Activity not performed, reason not given (G8782)

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2013 Physician Quality Reporting System (PQRS) Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS PQRS website.

SPECIFICATION FOR MEASURES GROUP REPORTING ONLY

CARDIOVASCULAR PREVENTION MEASURES GROUP OVERVIEW

2013 PQRS OPTIONS FOR MEASURES GROUPS: **CLAIMS, REGISTRY**

2013 PQRS MEASURES IN CARDIOVASCULAR PREVENTION MEASURES GROUP:

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

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

- Indicate your intention to report the Cardiovascular Preventive Measures Group by submitting the measures group-specific intent G-code at least once during the reporting period when billing a patient claim for the 20 Patient Sample Method. It is not necessary to submit the measures group-specific intent G-code on more than one claim. It is not necessary to submit the measures group-specific intent G-code for registry-based submissions.

G8905: I intend to report the Cardiovascular Prevention Measures Group

- Select patient sample method:
20 Patient Sample Method via claims: 20 unique Medicare Part B FFS (fee for service) patients meeting patient sample criteria for the measures group.
OR
20 Patient Sample Method via registries: 20 unique patients (a majority of which must be Medicare Part B FFS patients) meeting patient sample criteria for the measures group during the reporting period (January 1 through December 31, 2013 **OR** July 1 through December 31, 2013).
- Patient sample criteria for the Cardiovascular Prevention Measures Group are patients aged ≥ 18 and older with a specific diagnosis of Diabetes Mellitus or Ischemic Vascular Disease and accompanied by a specific patient encounter:

One of the following diagnosis codes indicating diabetes mellitus:

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

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

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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/OR

One of the following diagnosis codes indicating 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, 444.01, 444.09, 440.1, 440.20, 440.21, 440.22, 440.23, 440.24, 440.29, 440.4, 444.1, 444.21, 444.22, 444.81, 444.89, 444.9, 445.01, 445.02, 445.81, 445.89

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, 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, I74.0, 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

Accompanied by

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

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

SPECIFICATION FOR MEASURES GROUP REPORTING ONLY

- If patient also has a diagnosis of HTN measure #236 should be reported.
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, 405.10, 405.19, 405.91, 405.99
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
- If a patient does not have a diagnosis of HTN, measure #317 should be reported.
- The table below illustrates the applicable measures to report based on the denominator criteria the patient meets.

Diagnosis	Has HTN Diagnosis – Report these measures	Does not have HTN Diagnosis – Report these measures
DM only	2*, 226, 236	2*, 226, 317
IVD Only	204, 226, 236, 241	204, 226, 241, 317
DM & IVD	2*, 204, 226, 236, 241	2*, 204, 226, 241, 317

*Only report for patients aged 18-75 years

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

Composite G-code G8764: All quality actions for the applicable measures in the Cardiovascular Prevention Measures Group have been performed for this patient

- To report satisfactorily the Cardiovascular Prevention Measures Group requires **all applicable** measures for each patient within the eligible professional's patient sample to be reported a minimum of once during the reporting period.
- Measures groups containing a measure with a 0% performance rate will not be counted as satisfactorily reporting the measures group. The recommended clinical quality action must be performed on at least one patient for each measure within the measures group reported by the eligible professional. Performance exclusion quality-data codes are not counted in the performance denominator. If the eligible professional submits all performance exclusion quality-data codes, the performance rate would be 0/0 and would be considered satisfactorily reporting. If a measure within a measures group is not applicable to a patient, the patient would not be counted in the performance denominator for that measure (e.g., Preventive Care Measures Group - Measure #39: Screening or Therapy for Osteoporosis for Women Aged 65 Years and Older would not be applicable to male patients according to the patient sample criteria). If the measure is not applicable for all patients within the sample, the performance rate would be 0/0 and would be considered satisfactorily reporting.
- When using the 20 Patient Sample Method via claims, report all measures for the 20 unique Medicare Part B FFS patients seen. When using the 20 Patient Sample Method via registries, report all measures for the 20 unique patients seen, a majority of which must be Medicare Part B FFS patients.

SPECIFICATION FOR MEASURES GROUP REPORTING ONLY

- For claims-based submissions, the Carrier/MAC remittance advice notice sent to the practice will show a denial remark code (N365) for the line item on the claim containing G8485 (and G8494 if reported) as well as all other line items containing QDCs. N365 indicates the code is not payable and is used for reporting/informational purposes only. Other services/codes on the claim will not be affected by the addition of a measures group-specific intent G-code or other QDCs. The N365 remark code does NOT indicate whether the QDC is accurate for that claim or for the measure the eligible professional is attempting to report, but does indicate that the QDC was processed and transmitted to the NCH.

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2013 Physician Quality Reporting System (PQRS) Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS PQRS website.

SPECIFICATION FOR MEASURES GROUP REPORTING ONLY

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

DESCRIPTION:

Percentage of patients aged 18 through 75 years with diabetes mellitus who had most recent LDL-C level in control (less than 100 mg/dL)

NUMERATOR:

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

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Most Recent LDL-C Level < 100 mg/dL

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

OR

Most Recent LDL-C Level \geq 100 mg/dL

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

OR

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

OR

LDL-C Level not Performed, Reason not 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)

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2013 Physician Quality Reporting System (PQRS) Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS PQRS website.

SPECIFICATION FOR MEASURES GROUP REPORTING ONLY

◆ Measure #204 (NQF 0068): Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic

DESCRIPTION:

Percentage of patients aged 18 years and older with Ischemic Vascular Disease (IVD) with documented use of aspirin or another antithrombotic

NUMERATOR:

Patients who are using aspirin or another antithrombotic therapy

Numerator Instructions: Oral antiarrhythmic therapy consists of aspirin, clopidogrel or combination of aspirin and extended release dipyridamole.

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

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Aspirin or Another Antithrombotic Therapy Used

G8598: Aspirin or another antithrombotic therapy used

OR

Aspirin or Another Antithrombotic Therapy not Used, Reason not Given

G8599: Aspirin or another antithrombotic therapy not used, reason not given

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2013 Physician Quality Reporting System (PQRS) Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS PQRS website.

SPECIFICATION FOR MEASURES GROUP REPORTING ONLY

▲ Measure #226 (NQF 0028): Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention

DESCRIPTION:

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

NUMERATOR:

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

Definitions:

Tobacco Use – Includes use of any type of tobacco

Cessation Counseling Intervention – Includes brief counseling (3 minutes or less), and/or pharmacotherapy

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

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Patient Screened for Tobacco Use

CPT II 4004F: Patient screened for tobacco use AND received tobacco cessation intervention (counseling, pharmacotherapy, or both), if identified as a tobacco user

OR

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

CPT II 1036F: Current tobacco non-user

OR

Tobacco Screening not Performed for Medical Reasons

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

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

OR

Tobacco Screening OR Tobacco Cessation 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 not performed, reason not otherwise specified

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2013 Physician Quality Reporting System (PQRS) Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS PQRS website.

SPECIFICATION FOR MEASURES GROUP REPORTING ONLY

◆ Measure #236 (NQF 0018): Hypertension (HTN): Controlling High Blood Pressure

DESCRIPTION:

Percentage of patients aged 18 through 85 years who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled (< 140/90 mmHg)

NUMERATOR:

Patients whose most recent blood pressure < 140/90 mmHg

Numerator Instructions: To describe both systolic and diastolic blood pressure values, each must be reported separately. If there are multiple blood pressures on the same date of service, use the lowest systolic and lowest diastolic blood pressure on that date as the representative blood pressure.

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Most Recent Blood Pressure Measurement Performed

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

G8752: Most recent systolic blood pressure < 140 mmHg

OR

G8753: Most recent systolic blood pressure \geq 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 \geq 90 mmHg

OR

Blood Pressure Measurement not Documented, Reason not Given

G8756: No documentation of blood pressure measurement, reason not given

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2013 Physician Quality Reporting System (PQRS) Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS PQRS website.

SPECIFICATION FOR MEASURES GROUP REPORTING ONLY

◆ Measure #241 (NQF 0075): Ischemic Vascular Disease (IVD): Complete Lipid Panel and Low Density Lipoprotein (LDL-C) Control

DESCRIPTION:

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

NUMERATOR:

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

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

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

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

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

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

AND

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

OR

Lipid Profile not Performed, Reason not Given

G8594: Lipid profile not performed, reason not given

OR

Most Recent LDL-C \geq 100 mg/dL

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

AND

G8597: Most recent LDL-C \geq 100 mg/dL

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2013 Physician Quality Reporting System (PQRS) Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS PQRS website.

SPECIFICATION FOR MEASURES GROUP REPORTING ONLY

♦ Measure #317: Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented

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

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

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 BP 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, 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 BP Follow-up" table and must include one or more of the following as indicated: Anti-Hypertensive Pharmacologic Therapy, Laboratory Tests, or Electrocardiogram (ECG)

SPECIFICATION FOR MEASURES GROUP REPORTING ONLY

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)
<i>Normal BP Reading</i>	< 120	AND < 80	<ul style="list-style-type: none"> • No Follow-Up required
<i>Pre-Hypertensive BP Reading</i>	≥ 120 AND ≤ 139	OR ≥ 80 AND ≤ 89	<ul style="list-style-type: none"> • Rescreen BP within a minimum of 1 year AND Recommend Lifestyle Modifications OR • Referral to Alternative / Primary Care Provider
<i>First Hypertensive BP Reading</i>	≥ 140	OR ≥ 90	<ul style="list-style-type: none"> • Rescreen BP within a minimum of ≥ 1 day and ≤ 4 weeks AND Recommend Lifestyle Modifications OR • Referral to Alternative / Primary Care Provider
<i>Second Hypertensive BP Reading</i>	≥ 140	OR ≥ 90	<ul style="list-style-type: none"> • Recommend Lifestyle Modifications AND one or more of the Second Hypertensive Reading Interventions (see definitions) OR • Referral to Alternative / Primary Care Provider

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

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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

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2013 Physician Quality Reporting System (PQRS) Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS PQRS website.

SPECIFICATION FOR MEASURES GROUP REPORTING ONLY

CATARACTS MEASURES GROUP OVERVIEW

2013 PQRS OPTIONS FOR MEASURES GROUPS: **REGISTRY ONLY**

2013 PQRS MEASURES IN CATARACTS MEASURES GROUP:

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

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

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

G8906: I intend to report the Cataracts Measures Group

- Report the patient sample method:
20 Patient Sample Method: 20 unique procedures (patients – a majority of which must be Medicare Part B FFS [fee for service] patients) meeting patient sample criteria for the measures group during the reporting period (January 1 through December 31, 2013 **OR** July 1 through December 31, 2013).
- Patient sample criteria for the Cataracts Measures Group are patients aged 18 years and older that have a specific procedure for cataract surgery performed:

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

WITHOUT

Modifier 56 (preoperative management only)

- For purposes of satisfactory reporting **all** measures contained within the Cataracts Measures Group, include only procedures performed through September 30 of the reporting period. Procedures performed October 1 through December 31 of the reporting period are not included.
- Measures #191 and #192 need only be reported when the patient also has a diagnosis of uncomplicated cataract. Refer to the measure specification on the following pages for specific codes indicating a diagnosis of uncomplicated cataract for each of these two measures. Measures #303 and #304 need **not** be reported when the cataract surgery includes a modifier 55 (post-operative management only).
- Report a numerator option on **all applicable** measures within the Cataracts Measures Group for each procedure (patient) within the eligible professional's patient sample.
- Instructions for qualifying numerator option reporting for each of the measures within the Cataracts Measures Group are displayed on the next several pages. The following composite G-code has been created for registry only measures groups for use by registries that utilize claims data. This composite G-code may be reported in lieu of the individual quality-data codes for each of the measures within the group, if all quality actions for the patient have been performed for all the

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measures within the group. However, it is not necessary to submit the following composite G-code for registry-based submissions.

Composite G-code G8765: All quality actions for the applicable measures in the Cataracts Measures Group have been performed for this patient

- To report satisfactorily the Cataracts Measures Group it requires **all applicable** measures for each patient within the eligible professional's patient sample to be reported each time a cataract surgery is performed during the reporting period.
- Measures groups containing a measure with a 0% performance rate will not be counted as satisfactorily reporting the measures group. The recommended clinical quality action must be performed on at least one patient for each measure within the measures group reported by the eligible professional. Performance exclusion quality-data codes are not counted in the performance denominator. If the eligible professional submits all performance exclusion quality-data codes, the performance rate would be 0/0 and would be considered satisfactorily reporting. If a measure within a measures group is not applicable to a patient, the patient would not be counted in the performance denominator for that measure (e.g., Preventive Care Measures Group - Measure #39: Screening or Therapy for Osteoporosis for Women Aged 65 Years and Older would not be applicable to male patients according to the patient sample criteria). If the measure is not applicable for all patients within the sample, the performance rate would be 0/0 and would be considered satisfactorily reporting. When a lower rate indicates better performance, such as Measure #192, a 0% performance rate will be counted as satisfactorily reporting (100% performance rate would not be considered satisfactorily reporting).
- When using the 20 Patient Sample Method, report all applicable measures for the 20 unique procedures performed (patients seen) a majority of which must be Medicare Part B FFS procedures (patients) for the 12-month or 6-month reporting period.

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2013 Physician Quality Reporting System (PQRS) Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS PQRS website

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***Measure #191 (NQF 0565): Cataracts: 20/40 or Better Visual Acuity within 90 Days Following Cataract Surgery**

DESCRIPTION:

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

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

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

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

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

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Comorbid Condition	Corresponding ICD-9-CM Codes
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
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

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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
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

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Comorbid Condition	Corresponding ICD-10-CM Codes
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
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

SPECIFICATION FOR MEASURES GROUP REPORTING ONLY

Comorbid Condition	Corresponding ICD-10-CM Codes
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

SPECIFICATION FOR MEASURES GROUP REPORTING ONLY

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)

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2013 Physician Quality Reporting System (PQRS) Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS PQRS website

SPECIFICATION FOR MEASURES GROUP REPORTING ONLY

***Measure #192 (NQF 0564): Cataracts: Complications within 30 Days Following Cataract Surgery Requiring Additional Surgical Procedures**

DESCRIPTION:

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

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

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

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

Comorbid Condition	Corresponding ICD-9-CM Codes
Acute and Subacute Iridocyclitis	364.00, 364.01, 364.02, 364.03, 364.04, 364.05
Adhesions and Disruptions of Iris and Ciliary Body	364.70, 364.71, 364.72, 364.73, 364.74, 364.75, 364.76, 364.77, 364.81, 364.82, 364.89
Anomalies of 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

SPECIFICATION FOR MEASURES GROUP REPORTING ONLY

Comorbid Condition	Corresponding ICD-9-CM Codes
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
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

SPECIFICATION FOR MEASURES GROUP REPORTING ONLY

Comorbid Condition	Corresponding ICD-10-CM Codes
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
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

SPECIFICATION FOR MEASURES GROUP REPORTING ONLY

Comorbid Condition	Corresponding ICD-10-CM Codes
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
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

SPECIFICATION FOR MEASURES GROUP REPORTING ONLY

Comorbid Condition	Corresponding ICD-10-CM Codes
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.

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

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

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2013 Physician Quality Reporting System (PQRS) Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS PQRS website.

SPECIFICATION FOR MEASURES GROUP REPORTING ONLY

❖ Measure #303: Cataracts: Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery

DESCRIPTION:

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

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

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

NUMERATOR:

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

Numerator Options:

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

OR

Patient care survey was not completed by patient (**G0914**)

OR

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

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2013 Physician Quality Reporting System (PQRS) Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS PQRS website.

SPECIFICATION FOR MEASURES GROUP REPORTING ONLY

❖ Measure #304: Cataracts: Patient Satisfaction within 90 Days Following Cataract Surgery

DESCRIPTION:

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

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

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

NUMERATOR:

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

Numerator Options:

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

OR

Patient care survey was not completed by patient (**G0917**)

OR

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

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2013 Physician Quality Reporting System (PQRS) Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS PQRS website.

SPECIFICATION FOR MEASURES GROUP REPORTING ONLY

ONCOLOGY MEASURES GROUP OVERVIEW

2013 PQRS OPTIONS FOR MEASURES GROUPS: **REGISTRY ONLY**

2013 PQRS MEASURES IN ONCOLOGY MEASURES GROUP:

- #71. Breast Cancer: Hormonal Therapy for Stage IC - IIIC Estrogen Receptor/Progesterone Receptor (ER/PR) Positive Breast Cancer
- #72. Colon Cancer: Chemotherapy for AJCC Stage III Colon Cancer Patients
- #110. Preventive Care and Screening: Influenza Immunization
- #130. Documentation of Current Medications in the Medical Record
- #143. Oncology: Medical and Radiation – Pain Intensity Quantified
- #144. Oncology: Medical and Radiation – Plan of Care for Pain
- #194. Oncology: Cancer Stage Documented
- #226. Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention

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

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

G8977: I intend to report the Oncology Measures Group

- Report the patient sample method:
20 Patient Sample Method: 20 unique procedures (patients – a majority of which must be Medicare Part B FFS [fee for service] patients) meeting patient sample criteria for the measures group during the reporting period (January 1 through December 31, 2013 **OR** July 1 through December 31, 2013).
- Patient sample criteria for the Oncology Measures Group are patients aged 18 years and older with a specific diagnosis of cancer, accompanied by a specific patient encounter:

One of the following diagnosis codes indicating 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,

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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, 238.79, 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, 238.8, 238.9, 239.0, 239.1, 239.2, 239.3, 239.4, 239.5, 239.6, 239.7, 239.81, 239.89, 239.9

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,

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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, 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, C43.31, C43.39, C43.4, C43.51, C43.52, C43.59, C43.60, C43.61, C43.62, C43.11, C43.70, C43.71, C43.72, C43.8, C43.12, C43.9, C43.20, C43.21, C43.22, C43.30, 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,

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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, C83.00, 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, D44.8, 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

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Accompanied by

One of the following patient encounter codes: 77427, 77431, 77432, 77435, 77470

OR

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

AND

One of the following patient encounter codes – 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

- Measure #71 only needs to be reported when the patient is female and has the following diagnosis code indicating breast cancer:
ICD-9-CM: 174.0, 174.1, 174.2, 174.3, 174.4, 174.5, 174.6, 174.8, 174.9
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
- Measure #72 only needs to be reported when the patient is 18 through 80 years old and has the following diagnosis code indicating colon cancer:
ICD-9-CM: 153.0, 153.1, 153.2, 153.3, 153.4, 153.6, 153.7, 153.8, 153.9
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
- Measure #144 only needs to be reported when patients are identified in Measure #143 with pain present (1125F).
- Report a numerator option on all applicable measures within the Oncology Measures Group for each patient within the eligible professional's patient sample.
- Instructions for qualifying numerator option reporting for each of the measures within the Oncology Measures Group are displayed on the next several pages. The following composite G-code has been created for registry only measures groups for use by registries that utilize claims data. This composite G-code may be reported in lieu of the individual quality-data codes for each of the measures within the group, if all quality actions for the patient have been performed for all the measures within the group. However, it is not necessary to submit the following composite G-code for registry-based submissions.

Composite G-code G8953: All quality actions for the applicable measures in the Oncology Measures Group have been performed for this patient

- To report satisfactorily the Oncology Measures Group requires all applicable measures for each patient within the eligible professional's patient sample to be reported a minimum of once during the reporting period.
- Measure #110 need only be reported a minimum of once during the reporting period when the patient's visit included in the patient sample population is between January and March for the 2012-2013 influenza season OR between October and December for the 2013-2014 influenza season. When the patient's office visit is between April and September, Measure #110 is not

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applicable and will not affect the eligible provider's reporting or performance rate. Measure #110 need only be reported on patients 18 years and older.

- Measures groups containing a measure with a 0% performance rate will not be counted as satisfactorily reporting the measures group. The recommended clinical quality action must be performed on at least one patient for each measure within the measures group reported by the eligible professional. Performance exclusion quality-data codes are not counted in the performance denominator. If the eligible professional submits all performance exclusion quality-data codes, the performance rate would be 0/0 and would be considered satisfactorily reporting. If a measure within a measures group is not applicable to a patient, the patient would not be counted in the performance denominator for that measure (e.g., Oncology Measures Group - Measure #71: Breast Cancer: Hormonal Therapy for Stage IC-IIIC Estrogen Receptor/Progesterone Receptor (ER/PR) Positive Breast Cancer would not be applicable to male patients according to the patient sample criteria). If the measure is not applicable for all patients within the sample, the performance rate would be 0/0 and would be considered satisfactorily reporting.
- When using the 20 Patient Sample Method, report all applicable measures for the 20 unique procedures performed (patients seen) a majority of which must be Medicare Part B FFS procedures (patients) for the 12-month or 6-month reporting period.

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2013 Physician Quality Reporting System (PQRS) Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS PQRS website.

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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

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

NUMERATOR:

Patients who were prescribed tamoxifen or aromatase inhibitor (AI) during the 12-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 \geq 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

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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

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 [33xxF] 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 \leq 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 [33xxF-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

SPECIFICATION FOR MEASURES GROUP REPORTING ONLY

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

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2013 Physician Quality Reporting System (PQRS) Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS PQRS website.

SPECIFICATION FOR MEASURES GROUP REPORTING ONLY

¥ Measure #72 (NQF 0385): Colon Cancer: Chemotherapy for AJCC Stage III Colon Cancer Patients

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

NUMERATOR:

Patients who are referred for adjuvant chemotherapy, prescribed adjuvant chemotherapy, or who have previously received adjuvant chemotherapy within the 12-month reporting period

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 [G8927] and one CPT II code [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 [G8928] and one CPT II code [3388F] are required on the claim form to submit this numerator option)

G8928: Adjuvant chemotherapy not prescribed or previously received, reason specified

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

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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

OR

Adjuvant Chemotherapy not Referred, Prescribed or Previously Received, Reason not Given

(One G-code [G8929] and one CPT II code [3388F] are required on the claim form to submit this numerator option)

G8929: Adjuvant chemotherapy not prescribed or previously received, reason not given

AND

CPT II 3388F: AJCC Colon Cancer Stage III, documented

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SPECIFICATION FOR MEASURES GROUP REPORTING ONLY

▲Measure #110 (NQF 0041): Preventive Care and Screening: Influenza Immunization

DESCRIPTION:

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

NUMERATOR:

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

Numerator Instructions:

- 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 (October 1 - March 31). In these cases, **G8482** should be reported.

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

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SPECIFICATION FOR MEASURES GROUP REPORTING ONLY

♣ Measure #130 (NQF 0419): Documentation of Current Medications in the Medical Record

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

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 exists:

- 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 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

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SPECIFICATION FOR MEASURES GROUP REPORTING ONLY

▲ Measure #143 (NQF 0384): Oncology: Medical and Radiation – Pain Intensity Quantified

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

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)

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2013 Physician Quality Reporting System (PQRS) Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS PQRS website.

SPECIFICATION FOR MEASURES GROUP REPORTING ONLY

▲ Measure #144 (NQF 0383): Oncology: Medical and Radiation – Plan of Care for Pain

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

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)

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2013 Physician Quality Reporting System (PQRS) Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS PQRS website.

SPECIFICATION FOR MEASURES GROUP REPORTING ONLY



Measure #194 (NQF 0386): Oncology: Cancer Stage Documented

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

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

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:

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

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SPECIFICATION FOR MEASURES GROUP REPORTING ONLY

▲ Measure #226 (NQF 0028): Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention

DESCRIPTION:

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

NUMERATOR:

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

Definitions:

Tobacco Use – Includes use of any type of tobacco.

Cessation Counseling Intervention – Includes brief counseling (3 minutes or less), and/or pharmacotherapy.

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

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Patient Screened for Tobacco Use

CPT II 4004F: Patient screened for tobacco use AND received tobacco cessation intervention (counseling, pharmacotherapy, or both), if identified as a tobacco user

OR

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

CPT II 1036F: Current tobacco non-user

OR

Tobacco Screening not Performed for Medical Reasons

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

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

OR

Tobacco Screening OR Tobacco Cessation 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 not performed, reason not otherwise specified

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