2015 Physician Quality Reporting System (PQRS) Measure Specifications Manual for Claims and Registry Reporting of Individual Measures

Utilized by Individual Eligible Professionals for Claims and Registry Reporting and Clinical Practices Participating in Group Practice Reporting Option (GPRO) for Registry Reporting

11/10/2014

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*Please note that PQRS 131 is incorrectly listed under the Communication and Care Coordination domain in the CY 2015 PFS Final Rule. PQRS 131 was finalized in the CY 2013 PFS Final Rule under the Community and Population Health domain and will therefore remain under the Community and Population Health domain for 2015

Measures by Domain List

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PQRS Introduction

The measure specifications contained in this manual are intended for individual eligible professionals reporting via claims or registry and group practices reporting via registry for the 2015 Physician Quality Reporting System (PQRS).

- Measure specifications for measures groups reporting are included in a separate manual, "2015 Physician Quality Reporting System Measures Groups Specifications Manual," which can be accessed at: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/MeasuresCodes.html
- Group practices electing to participate in the PQRS group practice reporting option (GPRO) reporting PQRS via GPRO Web-Interface may access the GPRO Web Interface Narrative Specifications at: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/GPRO_Web_Interface.html
- Meaningful Use measure specifications can access electronic clinical quality measures (eCQMs) at: http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/ClinicalQualityMeasures.html
- Information regarding CG-CAHPS may be found at: http://acocahps.cms.gov/Content/Default.aspx#aboutSurvey
  Please note that this link is directed to the Accredited Care Organization webpage.

Each measure is assigned a unique number. Measure numbers for 2015 PQRS represents a continuation in numbering from the 2014 measures. For 2015 PQRS measures that are continuing forward in the 2015 PQRS, measure specifications have been updated. In addition to the measure specifications manual, please refer to the "2015 Physician Quality Reporting System Implementation Guide" for additional information essential in assisting eligible professionals' understanding and submission of measures. This document can be accessed at: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/MeasuresCodes.html.

Those who report satisfactorily for the 2015 program year *may* avoid the 2017 payment adjustment. Additional information on how to avoid future PQRS payment adjustments can be found through supporting documentation available on the CMS website: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/**.**

Eligible Professionals

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

Frequency and Performance Timeframes

The measure instructions limit the frequency of reporting necessary in certain circumstances, such as for patients with chronic illness for whom a particular process of care is provided only periodically. Each individual eligible professional or group practices participating in 2015 PQRS should report according to the frequency and timeframe listed within each measure specification.

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

Quality measures consist of a numerator and a denominator that permit the calculation of the percentage of a defined patient population that receive a particular process of care or achieve a particular outcome. The denominator population may be defined by demographic information, certain International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) diagnosis (01/01/2015-9/30/2015), International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) diagnosis (10/01/2015-12/31/2015), Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) codes specified in the measure that are submitted **by individual eligible professionals** as part of a claim for **covered services** under the PFS for claims-based reporting. This same criteria is also applied for individual eligible professionals and group practices who chose to report via a registry although this data is not necessarily submitted via a claim.

If the specified denominator codes for a measure are not included on the patient's claim (for the same date of service) as submitted by the individual eligible professional, then the patient does not fall into the denominator population, and the PQRS measure does not apply to the patient. Likewise, if the specified denominator codes for a measure are not associated with a patient for an individual eligible professional or group practice submitting to a registry, then the patient does not fall into the denominator population, and the PQRS measure does not apply to the patient. Some measure specifications are adapted as needed for implementation in PQRS in agreement with the measure developer. For example, CPT codes for non-covered services such as preventive visits are not included in the denominator.

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

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

G-codes that are associated with billable charges and found within the denominator, within this reporting program, are referred to as HCPCS coding. G-codes that describe clinical outcomes or results and are found within the denominator are generally described as QDC's.

For eligible professionals reporting individually, PQRS measures, including patient-level measure(s), may be reported for the same patient by multiple eligible professionals practicing under the same Tax Identification Number (TIN). If a patient sees multiple providers during the reporting period, that patient can be counted for each individual NPI reporting if the patient encounter(s) meet denominator inclusion. The following is an example of two provider NPIs (National Provider Identifiers), billing under the same TIN who are intending to report PQRS Measure #6: Coronary Artery Disease (CAD): Antiplatelet Therapy. Provider A sees a patient on February 2, 2015 and prescribes an aspirin and reports the appropriate quality-data code (QDC) for measure #6. Provider B sees the same patient at an encounter on July 16, 2015 and verifies that the patient has been prescribed and is currently taking an aspirin. Provider B must also report the appropriate QDCs for the patient at the July encounter to receive credit for reporting measure #6.

Eligible professionals reporting under a group practice selecting to participate in the PQRS group practice reporting option (GPRO) under the same Tax Identification Number (TIN), should be reporting on the same patient, when instructed within the chosen measure. For example, if reporting measure #130: Documentation of Current Medications in the Medical Record all eligible professionals under the same TIN would report each denominator eligible instance as instructed by this measure.

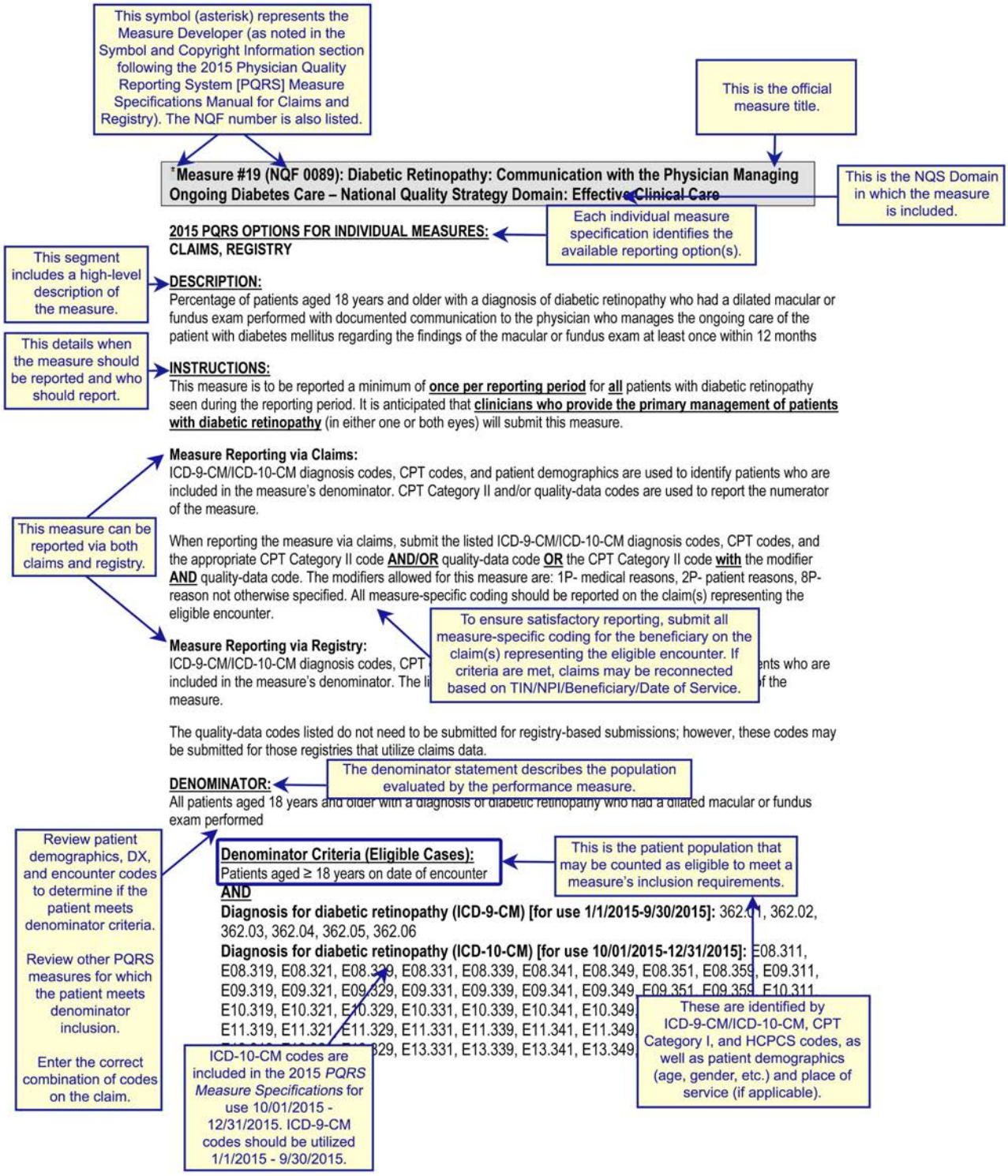
If the group practice choses a measure that is required to be reported once per reporting period, then this measure should be reported at least once during the measure period by at least one eligible professional under the TIN. Measure #6: Coronary Artery Disease (CAD): Antiplatelet Therapy is an example of a measure that would be reported once per reporting period under the TIN.

CMS recommends review of any measures that an individual eligible professional or group practice intend to report. Below is an example measure specification that will assist with satisfactorily reporting. For additional assistance please contact the QualityNet Help Desk at the following:

QualityNet Help Desk – Available Monday – Friday; 7:00 AM–7:00 PM CST
Phone: 1-866-288-8912
Email: Qnetsupport@hcqis.org

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

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



Patient encounter during the reporting period (CPT): 92002, 92004, 92012, 92014, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337

NUMERATOR: This is a clinical action counted as meeting the measure's requirements (i.e., patients who received the particular service or obtained a particular outcome that is being measured).

Patients with documentat[illegible] communication to the physician who manages the patient's diabetic care

Measures may or may not contain definitions.

Definitions:

Communication – May include documentation in the medical record indicating that the findings of the dilated macular or fundus exam were communicated (eg, verbally, by letter) with the clinician managing the patient's diabetic care OR a copy of a letter in the medical record to the clinician managing the patient's diabetic care outlining the findings of the dilated macular or fundus exam.

Findings – Includes level of severity of retinopathy (eg, mild nonproliferative, moderate nonproliferative, severe nonproliferative, very severe nonproliferative, proliferative) AND the presence or absence of macular edema.

This measure is an example of a complex measure. Review carefully to submit the quality-data codes (QDCs) that meet the quality action being reported.

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.*

The numerator section outlines applicable quality-data coding options for reporting the numerator.

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Dilated Macular or Fundus Exam Findings Communicated

(One CPT II code & one quality-data code [5010F & G8397] are required on the claim form to submit this numerator option)

Section 1: Satisfactory Reporting and Performance

Performance Met:

CPT II 5010F: Findings of dilated macular or fundus exam communicated to the physician or other qualified health care pro[illegible] diabetes care

These are examples of QDCs.

AND

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

OR

Dilated Macular or Fundus Exam Findings not Communicated for Medical Reasons or Patient Reasons

(One CPT II code & one quality-data code [5010F-xP & G8397] are required on the claim form to submit this numerator option)

Section 2: Satisfactory Reporting and Excluded from Performance

Append a modifier **(1P or 2P)** to CPT Category II code **5010F** to report documented circu[illegible] that appropriately exclude patients from the denominator.

Medical Performance Exclusion or Patient Performance Exclusion:

5010F *with* 1P: Documentation of medical reason(s) for not communicating the findings o[illegible] dilated macular or fundus exam to the physician who manages the ongoin[illegible] the patient with diabetes

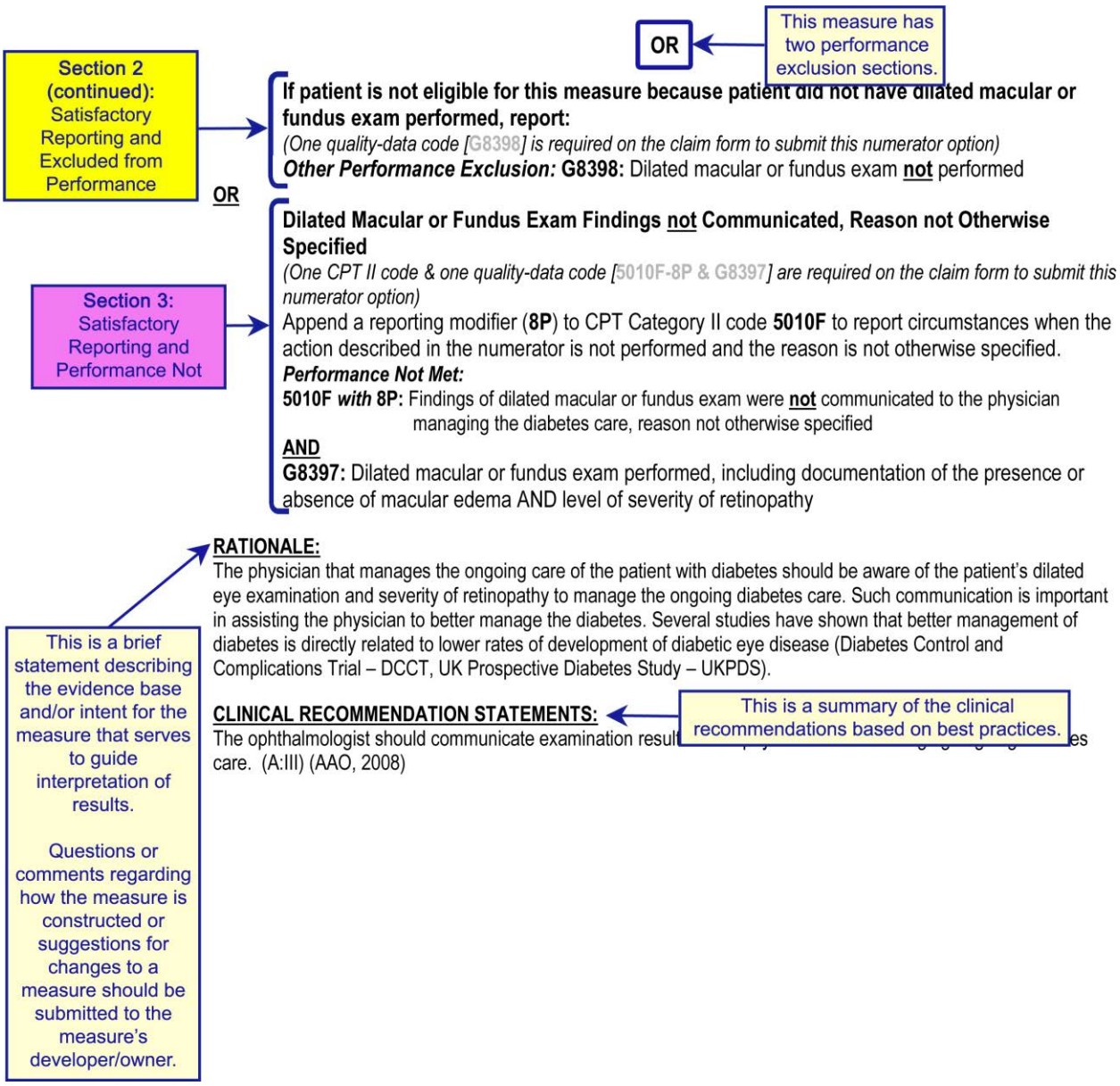
5010F *with* 2P: Documentation of patient reason(s) for not communicating the findings of the dila[illegible] macular or fundus exam to the physician who manages the ongoing care of the p[illegible] diabetes

These modifiers are developed exclusively for use with CPT II codes to indicate documented medical (1P), patient (2P), or system (3P) reasons for excluding patients from a measure's denominator.

Some measures allow no performance exclusions; some have only one or two.

AND

G8397: Dilated macular or fundus exam performed, including documentation of the prese[illegible] absence of macular edema AND level of severity of retinopathy



List of Retired PQRS Individual Claims/Registry Measure Specifications		
Measure #	**Measure Title**	**Retirement Effective Date**
2	Diabetes: Low Density Lipoprotein (LDL-C) Control (<100 mg/dL)	January 1, 2015
3	Diabetes Mellitus: High Blood Pressure Control	January 1, 2014
4	Screening for Future Fall Risk	January 1, 2009
9	Anti-Depressant Medication Management	January 1, 2015
10	Stroke and Stroke Rehabilitation: Computed Tomography (CT) or Magnetic Resonance Imaging (MRI) Reports	January 1, 2013
11	Stroke and Stroke Rehabilitation: Carotid Imaging Reports	January 1, 2010
13	Age-Related Macular Degeneration: Age-Related Eye Disease Study (AREDS) Prescribed/Recommended	January 1, 2008
15	Cataracts: Assessment of Visual Functional Status	January 1, 2008
16	Cataracts: Documentation of Pre-Surgical Axial Length, Corneal Power Measurement and Method of Intraocular Lens Power Calculation	January 1, 2008
17	Cataracts: Pre-Surgical Dilated Fundus Evaluation	January 1, 2008
18	Diabetic Retinopathy: Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy	January 1, 2015
20	Perioperative Care: Timing of Prophylactic Parenteral Antibiotic – Ordering Physician	January 1, 2015
22	Perioperative Care: Discontinuation of Prophylactic Parenteral Antibiotics (Non-Cardiac Procedures)	January 1, 2015
23	Perioperative Care: Venous Thromboembolism (VTE) Prohylaxis (when indicated in ALL Patients)	January 1, 2015
25	Melanoma: Patient Medical History	January 1, 2008
26	Melanoma: Complete Physical Skin Examination	January 1, 2008
27	Melanoma: Counseling on Self-Examination	January 1, 2008
28	Aspirin at Arrival for Acute Myocardial Infarction (AMI)	January 1, 2015
29	Beta-Blocker at Time of Arrival for Acute Myocardial Infarction (AMI)	January 1, 2008
30	Perioperative Care: Timing of Prophylactic Antibiotic - Administering Physician	January 1, 2015
31	Stroke and Stroke Rehabiliation: Venous Thromboembolism (VTE) Prophylaxis for Ischemic Stroke or Intracranial Hemorrhage	January 1, 2015
33	Stroke and Stroke Rehabilitation: Anticoagulant Therapy Prescribed for Atrial Fibrillation (AF) at Discharge	January 1, 2015
34	Stroke and Stroke Rehabilitation: Tissue Plasminogen Activator (t-PA) Considered	January 1, 2010
35	Stroke and Stroke Rehabilitation: Screening for Dysphagia	January 1, 2015
36	Stroke and Stroke Rehabilitation: Rehabilitation Services Ordered	January 1, 2015
37	Dialysis Dose in End Stage Renal Disease (ESRD) Patients	January 1, 2008
38	Hematocrit Level in End Stage Renal Disease (ESRD) Patients	January 1, 2008

List of Retired PQRS Individual Claims/Registry Measure Specifications		
Measure #	**Measure Title**	**Retirement Effective Date**
42	Osteoporosis: Counseling for Vitamin D, Calcium Intake, and Exercise	January 1, 2008
45	Perioperative Care: Discontinuation of Prophylactic Parenteral Antibiotics (Cardiac Procedures)	January 1, 2015
49	Urinary Incontinence: Characterization of Urinary Incontinence in Women Aged 65 Years and Older	January 1, 2015
55	Emergency Medicine: 12 Lead Electrocardiogram (ECG) Performed for Syncope	January 1, 2015
56	Emergency Medicine: Community Acquired Bacterial Pneumonia (CAP): Vital Signs	January 1, 2015
57	Emergency Medicine: Community-Acquired Pneumonia (CAP): Assessment of Oxygen Saturation	January 1, 2013
58	Emergency Medicine: Community-Acquired Pneumonia (CAP): Assessment of Mental Status	January 1, 2013
59	Emergency Medicine: Community Acquired Bacterial Pneumonia (CAP) Empire Antibiotic	January 1, 2015
60	Gastroesophageal Reflux Disease (GERD): Assessment for Alarm Symptoms	January 1, 2008
61	Gastroesophageal Reflux Disease (GERD): Upper Endoscopy for Patients with Alarm Symptoms	January 1, 2008
62	Gastroesophageal Reflux Disease (GERD): Biopsy for Barrett's Esophagus	January 1, 2008
63	Gastroesophageal Reflux Disease (GERD): Barium Swallow-Inappropriate Use	January 1, 2008
64	Asthma: Assessment of Asthma Control – Ambulatory Care Setting	January 1, 2015
73	Plan for Chemotherapy Documented Before Chemotherapy Administered	January 1, 2009
74	Radiation Therapy Recommended for Invasive Breast Cancer Patients Who Have Undergone Breast Conserving Surgery	January 1, 2009
75	Prevention of Ventilator-Associated Pneumonia – Head Elevation	January 1, 2009
77	Assessment of GERD Symptoms in Patients Receiving Chronic Medication for GERD	January 1, 2009
78	Vascular Access for Patients Undergoing Hemodialysis	January 1, 2009
79	End Stage Renal Disease (ESRD): Influenza Immunization in Patients with ESRD	January 1, 2012
80	End Stage Renal Disease (ESRD): Plan of Care for ESRD Patients with Anemia	January 1, 2009
83	Hepatitis C: Confirmation of Hepatitis C Viremia	January 1, 2015
84	Hepatitis C: Ribonucleic Acid (RNA) Testing Before Initiating Treatment	January 1, 2015
85	Hepatitis C: Virus (HCV) Genotype Testing Prior to Treatment	January 1, 2015
86	Hepatitis C: Antiviral Treatment Prescribed	January 1, 2014
87	Hepatitis C: Ribonucleic Acid (RNA) Testing Between 4-12 Weeks After Initiation of Treatment	January 1, 2015

List of Retired PQRS Individual Claims/Registry Measure Specifications		
Measure #	**Measure Title**	**Retirement Effective Date**
88	Hepatitis C: Hepatitis A and B Vaccination in Patients with HCV	January 1, 2009
89	Hepatitis C: Counseling Regarding Risk of Alcohol Consumption	January 1, 2014
90	Hepatitis C: Counseling Regarding Use of Contraception Prior to Antiviral Therapy	January 1, 2014
92	Acute Otitis Externa (AOE): Pain Assessment	January 1, 2013
94	Otitis Media with Effusion (OME): Diagnostic Evaluation – Assessment of Tympanic Membrane Mobility	January 1, 2012
95	Otitis Media with Effusion (OME): Hearing Testing	January 1, 2010
96	Otitis Media with Effusion (OME): Antihistamines or Decongestants – Avoidance of Inappropriate Use	January 1, 2009
97	Otitis Media with Effusion (OME): Systemic Antimicrobials – Avoidance of Inappropriate Use	January 1, 2009
98	Otitis Media with Effusion (OME): Systemic Corticosteroids – Avoidance of Inappropriate Use	January 1, 2009
101	Appropriate Initial Evaluation of Patients with Prostate Cancer	January 1, 2009
103	Prostate Cancer: Review of Treatment Options in Patients with Clinically Localized Prostate Cancer	January 1, 2009
105	Prostate Cancer: Three Dimensional (3D) Radiotherapy	January 1, 2013
106	Adult Major Depressive Disorder (MDD): Comprehensive Depression Evaluation: Diagnosis and Severity	January 1, 2015
107	Adult Major Depressive Disorder (MDD): Suicide Risk Assessment	January 1, 2015
108	Rheumatoid Arthritis (RA): Disease Modifying Anti-Rheumatic Drug (DMARD) Therapy	January 1, 2015
114	Preventive Care and Screening: Inquiry Regarding Tobacco Use	January 1, 2011
115	Preventive Care and Screening: Advising Smokers and Tobacco Users to Quit	January 1, 2011
120	Chronic Kidney Disease (CKD): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy	January 1, 2009
123	Adult Kidney Disease: Patients On Erythropoiesis-Stimulating Agent (ESA) – Hemoglobin Level > 12 g/dL	January 1, 2015
124	Health Information Technology (HIT): Adoption/Use of Electronic Health Records (EHR)	January 1, 2013
125	Health Information Technology (HIT): Adoption/Use of Medication Electronic Prescribing (e-Rx) *Refer to new Electronic Prescribing (e-Rx) incentive program*	January 1, 2009
129	Universal Influenza Vaccine Screening and Counseling	January 1, 2009
132	Patient Co-Development of Treatment Plan/Plan of Care	January 1, 2009
133	Screening for Cognitive Impairment	January 1, 2009

List of Retired PQRS Individual Claims/Registry Measure Specifications		
Measure #	**Measure Title**	**Retirement Effective Date**
135	Chronic Kidney Disease (CKD): Influenza Immunization	January 1, 2012
136	Melanoma: Follow-Up Aspects of Care	January 1, 2011
139	Cataracts: Comprehensive Preoperative Assessment for Cataract Surgery with Intraocular Lens (IOL) Placement	January 1, 2011
140	Age-Related Macular Degeneration (AMD): Counseling on Antioxidant Supplement	January 1, 2015
142	Osteoarthritis (OA): Assessment for Use of Anti-Inflammatory or Analgesic Over-the-Counter (OTC) Medications	January 1, 2015
146	Radiology: Inappropriate Use of "Probably Benign" Assessment Category in Mammography Screening	January 1, 2015
152	Coronary Artery Disease (CAD): Lipid Profile in Patients with CAD	January 1, 2010
153	Chronic Kidney Disease (CKD): Referral for Arteriovenous (AV) Fistula	January 1, 2012
157	Thoracic Surgery: Recording of Clinical Stage Prior to Lung Cancer or Esophageal Cancer Resection	January 1, 2015
158	Carotid Endarterectomy: Use of Patch During Conventional Carotid Endarterectomy	January 1, 2013
159	HIV/AIDS: CD4+ Cell Count or CD4+ Percentage Performed	January 1, 2015
160	HIV/AIDS: Pneumocystis Jiroveci Pneumonia (PCP) Prophylaxis	January 1, 2015
161	HIV/AIDS: Adolescent and Adult Patients with HIV/AIDS Who Are Prescribed Potent Antiretroviral Therapy	January 1, 2014
162	HIV/AIDS: HIV RNA Control After Six Months of Potent Antiretroviral Therapy	January 1, 2014
168	Coronary Artery Bypass Graft (CABG): Surgical Re-Exploration	January 1, 2015
169	Coronary Artery Bypass Graft (CABG): Antiplatelet Medications at Discharge	January 1, 2015
170	Coronary Artery Bypass Graft (CABG): Beta-Blockers Administered at Discharge	January 1, 2015
171	Coronary Artery Bypass Graft (CABG): Anti-Lipid Treatment at Discharge	January 1, 2015
174	Pediatric End Stage Renal Disease (ESRD): Plan of Care for Inadequate Hemodialysis	January 1, 2011
175	Pediatric End Stage Renal Disease (ESRD): Influenza Immunization	January 1, 2012
176	Rheumatoid Arthritis (RA): Tuberculosis Screening	January 1, 2015
177	Rheumatoid Arthritis (RA): Periodic Assessment of Disease Activity	January 1, 2015

List of Retired PQRS Individual Claims/Registry Measure Specifications		
Measure #	**Measure Title**	**Retirement Effective Date**
179	Rheumatoid Arthritis (RA): Assessment and Classification of Disease Prognosis	January 1, 2015
180	Rheumatoid Arthritis (RA): Glucocorticoid Management	January 1, 2015
183	Hepatitis C: Hepatitis A Vaccination in Patients with Hepatitis C Virus (HCV)	January 1, 2015
184	Hepatitis C: Hepatitis B Vaccination in Patients with HCV	January 1, 2014
186	Chronic Wound Care: Use of Compression System in Patients with Venous Ulcers	January 1, 2013
188	Referral for Otologic Evaluation for Patients with Congenital or Traumatic Deformity of the Ear	January 1, 2014
189	Referral for Otologic Evaluation for Patients with History of Active Drainage from the Ear Within the Previous 90 Days	January 1, 2013
190	Referral for Otologic Evaluation for Patients with a History of Sudden or Rapidly Progressive Hearing Loss	January 1, 2013
196	Coronary Artery Disease (CAD): Symptom and Activity Assessment	January 1, 2013
197	Coronary Artery Disease (CAD): Lipid Control	January 1, 2015
198	Heart Failure: Left Ventricular Ejection Fraction (LVEF) Assessment	January 1, 2015
199	Heart Failure: Patient Education	January 1, 2012
200	Heart Failure: Warfarin Therapy for Patients with Atrial Fibrillation (AF)	January 1, 2012
201	Ischemic Vascular Disease (IVD): Blood Pressure Management	January 1, 2014
202	Ischemic Vascular Disease (IVD): Complete Lipid Profile	January 1, 2012
203	Ischemic Vascular Disease (IVD): Low Density Lipoprotein (LDL-C) Control	January 1, 2012
204	Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic	January 1, 2015
205	HIV/AIDS: Sexually Transmitted Disease Screening for Chlamydia, Gonorrhea and Syphilis	January 1, 2015
206	HIV/AIDS: Screening for High Risk Sexual Behaviors	January 1, 2013
207	HIV/AIDS: Screening for Injection Drug Use	January 1, 2013
208	HIV/AIDS: Sexually Transmitted Disease Screening for Syphilis	January 1, 2014
209	Functional Communication Measure – Spoken Language Comprehension	January 1, 2014
210	Functional Communication Measure – Attention	January 1, 2014
211	Functional Communication Measure – Memory	January 1, 2014
212	Functional Communication Measure – Motor Speech	January 1, 2014

List of Retired PQRS Individual Claims/Registry Measure Specifications		
Measure #	**Measure Title**	**Retirement Effective Date**
213	Functional Communication Measure – Reading	January 1, 2014
214	Functional Communication Measure – Spoken Language Expression	January 1, 2014
215	Functional Communication Measure – Writing	January 1, 2014
216	Functional Communication Measure – Swallowing	January 1, 2014
228	Heart Failure (HF): Left Ventricular Function (LVF) Testing	January 1, 2015
231	Asthma: Tobacco Use: Screening – Ambulatory Care Setting	January 1, 2015
232	Asthma: Tobacco use: Intervention – Ambulatory Care Setting	January 1, 2015
233	Thoracic Surgery: Recording of Performance Status Prior to Lung or Esophageal Cancer Resection	January 1, 2015
235	Hypertension (HTN): Plan of Care	January 1, 2013
234	Thoracic Surgery: Pulmonary Function Tests Before Major Anatomic Lung Resection (Pneumonectomy, lobectomy, or Formal Segmentectomy)	January 1, 2015
241	Ischemic Vascular Disease (IVD): Complete Lipid Profile and LDL-C Control(<100mg/dL)	January 1, 2015
243	Cardiac Rehabilitation Patient Referral from an Outpatient Setting	January 1, 2015
244	Hypertension: Blood Pressure Management	January 1, 2014
245	Chronic Wound Care: Use of Wound Surface Culture Technique in Patients with Chronic Skin Ulcers (Overuse Measure)	January 1, 2015
246	Chronic Wound Care: Use of Wet to Dry Dressings in Patients with Chronic Skin Ulcers (Overuse Measure)	January 1, 2015
247	Substance Use Disorders: Counseling Regarding Psychosocial and Pharmacologic Treatment Options for Alcohol Dependence	January 1, 2015
248	Substance Use Disorders: Screening for Depression Among Patients with Substance Abuse or Dependence	January 1, 2015
252	Anticoagulation for Acute Pulmonary Embolus Patients	January 1, 2014
253	Pregnancy Test for Female Abdominal Pain Patients	January 1, 2013
256	Surveillance after Endovascular Abdominal Aortic Aneurysm Repair (EVAR)	January 1, 2014
257	Statin Therapy at Discharge after Lower Extremity Bypass (LEB)	January 1, 2015
261	Referral for Otologic Evaluation for Patients with Acute or Chronic Dizziness	January 1, 2015
266	Epilepsy: Seizure Type(s) and Current Seizure Frequency(ies)	January 1, 2015
267	Epilepsy: Documentation of Etiology of Epilepsy or Epilepsy Syndrome	January 1, 2015
321	Participation by a Hospital, Physician or Other Clinician in a Systematic Clinical Database Registry that Includes Consensus Endorsed Quality	January 1, 2014
335	Maternity Care: Elective Delivery or Early Induction Without Medical Indication at ≥ 37 and < 39 Weeks	January 1, 2015

List of Retired PQRS Individual Claims/Registry Measure Specifications		
Measure #	**Measure Title**	**Retirement Effective Date**
336	Maternity Care: Post-Partum Follow-Up and Care Coordination	January 1, 2015
338	HIV Viral Load Suppression	January 1, 2015
339	Prescription of HIV Antiretroviral Therapy	January 1, 2015

♦ Measure #1 (NQF 0059): Diabetes: Hemoglobin A1c Poor Control – National Quality Strategy Domain: Effective Clinical Care

2015 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of patients 18-75 years of age with diabetes who had hemoglobin A1c > 9.0% during the measurement period

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

Measure Reporting via Claims:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT or HCPCS codes, and patient demographics are used to identify patients who are included in the measure's denominator. CPT Category II codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed ICD-9-CM/ICD-10-CM diagnosis codes, CPT or HCPCS codes, and the appropriate CPT Category II code **OR** the CPT Category II code **with** the modifier. The reporting modifier allowed for this measure is: 8P- reason not otherwise specified. There are no allowable performance exclusions for this measure. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes or HCPCS codes and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

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

DENOMINATOR:
Patients 18 - 75 years of age with diabetes with a visit during the measurement period

Denominator Criteria (Eligible Cases):
Patients 18 through 75 years of age on date of encounter
AND
Diagnosis for diabetes (ICD-9-CM) [for use 1/1/2015-9/30/2015]: 250.00, 250.01, 250.02, 250.03, 250.10, 250.11, 250.12, 250.13, 250.20, 250.21, 250.22, 250.23, 250.30, 250.31, 250.32, 250.33, 250.40, 250.41, 250.42, 250.43, 250.50, 250.51, 250.52, 250.53, 250.60, 250.61, 250.62, 250.63, 250.70, 250.71, 250.72, 250.73, 250.80, 250.81, 250.82, 250.83, 250.90, 250.91, 250.92, 250.93, 357.2, 362.01, 362.02, 362.03, 362.04, 362.05, 362.06, 362.07, 366.41, 648.00, 648.01, 648.02, 648.03, 648.04
Diagnosis for diabetes (ICD-10-CM) [for use 10/01/2015-12/31/2015]: 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

AND

Patient encounter during reporting period (CPT or HCPCS): 97802, 97803, 97804, 99201, 99202, 99203, 99204, 99205, 99211,99212, 99213, 99214, 99215, 99217, 99218, 99219, 99220, 99221, 99222, 99223, 99231, 99232, 99233, 99238, 99239, 99281, 99282, 99283, 99284, 99285, 99291, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99315, 99316, 99318, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, G0270, G0271, G0402, G0438, G0439

NUMERATOR:

Patients whose most recent HbA1c level (performed during the measurement period) is > 9.0%

Numerator Instructions: A lower calculated performance rate for this measure indicates better clinical care or control. Patient is numerator compliant if most recent HbA1c level >9% or is missing a result or if an HbA1c test was not done during the measurement year.

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Most Recent Hemoglobin A1c Level > 9.0%

***Performance Met*: 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.

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

OR

Most Recent Hemoglobin A1c Level ≤ 9.0%

***Performance Not Met:* CPT II 3044F:** Most recent hemoglobin A1c (HbA1c) level < 7.0%

OR

***Performance Not Met:* CPT II 3045F:** Most recent hemoglobin A1c (HbA1c) level 7.0 to 9.0%

RATIONALE:

Diabetes mellitus (diabetes) is a group of diseases characterized by high blood glucose levels caused by the body's inability to correctly produce or utilize the hormone insulin. It is recognized as a leading cause of death and disability in the U.S. and is highly underreported as a cause of death. Diabetes may cause life-threatening, life ending or life-altering complications, including poor circulation, nerve damage or neuropathy in the feet and eventual amputation. Nearly 60-70 percent of diabetics suffer from mild or severe nervous system damage (American Diabetes Association 2009).

Randomized clinical trials have demonstrated that improved glycemic control, as evidenced by reduced levels of glycohemoglobin, correlates with a reduction in the development of microvascular complications in both Type 1 and Type 2 diabetes (Diabetes Control and Complications Trial Research Group 1993; Ohkubo 1995). In particular, the Diabetes Control and Complications Trial (DCCT) showed that for patients with Type 1 diabetes mellitus, important clinical outcomes such as retinopathy (an important precursor to blindness), nephropathy (which precedes renal failure), and neuropathy (a significant cause of foot ulcers and amputation in patients with diabetes) are directly related to level of glycemic control (Diabetes Control and Complications Trial Research Group 1993). Similar reductions in complications were noted in a smaller study of intensive therapy of patients with Type 2 diabetes by Ohkubo and co-workers, which was conducted in the Japanese population (Ohkubo et al. 1995).

CLINICAL RECOMMENDATION STATEMENTS:

American Geriatrics Society (Brown et al. 2003):

For frail older adults, persons with life expectancy of less than 5 years, and others in whom the risks of intensive glycemic control appear to outweigh the benefits, a less stringent target such as 8% is appropriate. (Quality of Evidence: Level III; Strength of Evidence: Grade B)

American Diabetes Association (2009):

Lowering A1C to below or around 7% has been shown to reduce microvascular and neuropathic complications of type 1 and type 2 diabetes. Therefore, for microvascular disease prevention, the A1C goal for non-pregnant adults in general is <7%. (Level of Evidence: A)

In type 1 and type 2 diabetes, randomized controlled trials of intensive versus standard glycemic control have not shown a significant reduction in CVD outcomes during the randomized portion of the trials. Long-term follow-up of the Diabetes Control and Complications Trial (DCCT) and UK Prospective Diabetes Study (UKPDS) cohorts suggests that treatment to A1C targets below or around 7% in the years soon after the diagnosis of diabetes is associated with long-term reduction in risk of macrovascular disease. Until more evidence becomes available, the general goal of <7% appears reasonable for many adults for macrovascular risk reduction. (Level of Evidence: B)

Subgroup analyses of clinical trials such as the DCCT and UKPDS and the microvascular evidence from the Action in Diabetes and Vascular Disease: Preterax and Diamicron MR Controlled Evaluation (ADVANCE) trial suggest a small but incremental benefit in microvascular outcomes with A1C values closer to normal. Therefore, for selected individual patients, providers might reasonably suggest even lower A1C goals than the general goal of <7%, if this can be achieved without significant hypoglycemia or other adverse effects of treatment. Such patients might include those with short duration of diabetes, long life expectancy, and no significant CVD. (Level of Evidence: B)

Conversely, less stringent A1C goals than the general goal of <7% may be appropriate for patients with a history of severe hypoglycemia, limited life expectancy, advanced microvascular or macrovascular complications, and extensive comorbid conditions and those with longstanding diabetes in whom the general goal is difficult to attain despite diabetes self-management education, appropriate glucose monitoring, and effective doses of multiple glucose lowering agents including insulin. (Level of Evidence: C)

➧ Measure #5 (NQF 0081): Heart Failure (HF): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD) – National Quality Strategy Domain: Effective Clinical Care

2015 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

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

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

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

This measure is intended to reflect the quality of services provided for patients with HF and decreased left ventricular systolic function. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding. Only patients who had at least two denominator eligible visits during the reporting period will be counted for Reporting Criteria 1.

Measure Reporting via Registry:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, CPT category II codes, and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data. It is expected that a single performance rate will be calculated for this measure.

There are two reporting criteria for this measure:

1) **Patients who are 18 years and older with a diagnosis of HF with a current or prior LVEF < 40% seen in the outpatient setting with two denominator eligible visits**

   OR

2) **Patients who are 18 years and older with a diagnosis of HF with a current or prior LVEF < 40% and discharged from hospital**

REPORTING CRITERIA 1: All patients with a diagnosis of HF assessed during an outpatient encounter

DENOMINATOR (REPORTING CRITERIA 1):
All patients aged 18 years and older with a diagnosis of heart failure with a current or prior LVEF < 40%

> ***DENOMINATOR NOTE:** LVEF < 40% corresponds to qualitative documentation of moderate dysfunction or severe dysfunction. 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.

In order for the patient to be included in Reporting Criteria 1, the patient must have two denominator eligible visits.

Denominator Criteria (Eligible Cases) 1:
Patients aged ≥ 18 years on date of encounter
AND
Diagnosis for heart failure (ICD-9-CM) [for use 1/1/2015-9/30/2015]: 402.01, 402.11, 402.91, 404.01, 404.03, 404.11, 404.13, 404.91, 404.93, 428.0, 428.1, 428.20, 428.21, 428.22, 428.23, 428.30, 428.31, 428.32, 428.33, 428.40, 428.41, 428.42, 428.43, 428.9
Diagnosis for heart failure (ICD-10-CM) [for use 10/01/2015-12/31/2015]: I11.0, I13.0, I13.2, I50.1, I50.20, I50.21, I50.22, I50.23, I50.30, I50.31, I50.32, I50.33, I50.40, I50.41, I50.42, I50.43, I50.9
AND
Patient encounter(s) during reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350
AND
Two Denominator Eligible Visits
AND
Left ventricular ejection fraction (LVEF) < 40% or documentation of moderately or severely depressed left ventricular systolic function: 3021F

NUMERATOR (REPORTING CRITERIA 1):
Patients who were prescribed ACE inhibitor or ARB therapy within a 12 month period when seen in the outpatient setting

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

Numerator Options

Performance Met:	Angiotensin converting enzyme (ACE) inhibitor or angiotensin receptor blocker (ARB) therapy prescribed or currently being taken **(4010F)**
OR	
Medical Performance Exclusion:	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, allergy, intolerance, other medical reasons) **(4010F *with* 1P)**
OR	
Patient Performance Exclusion:	Documentation of patient reason(s) for not prescribing angiotensin converting enzyme (ACE) inhibitor or angiotensin receptor blocker (ARB) therapy (eg, patient declined, other patient reasons) **(4010F *with* 2P)**
OR	

System Performance Exclusion: Documentation of system reason(s) for not prescribing angiotensin converting enzyme (ACE) inhibitor or angiotensin receptor blocker (ARB) therapy (eg, other system reasons) **(4010F *with* 3P)**

OR

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

OR

REPORTING CRITERIA 2: All patients with a diagnosis of HF and discharged from hospital

DENOMINATOR (REPORTING CRITERIA 2):
All patients aged 18 years and older with a diagnosis of heart failure with a current or prior LVEF < 40%

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

Denominator Criteria (Eligible Cases) 2:
Patients aged ≥ 18 years on date of encounter
AND
Diagnosis for heart failure (ICD-9-CM) [for use 1/1/2015-9/30/2015]: 402.01, 402.11, 402.91, 404.01, 404.03, 404.11, 404.13, 404.91, 404.93, 428.0, 428.1, 428.20, 428.21, 428.22, 428.23, 428.30, 428.31, 428.32, 428.33, 428.40, 428.41, 428.42, 428.43, 428.9
Diagnosis for heart failure (ICD-10-CM) [for use 10/01/2015-12/31/2015]: I11.0, I13.0, I13.2, I50.1, I50.20, I50.21, I50.22, I50.23, I50.30, I50.31, I50.32, I50.33, I50.40, I50.41, I50.42, I50.43, I50.9
AND
Patient encounter during reporting period (CPT): 99238, 99239
AND
Left ventricular ejection fraction (LVEF) < 40% or documentation of moderately or severely depressed left ventricular systolic function: 3021F

NUMERATOR (REPORTING CRITERIA 2):
Patients who were prescribed ACE inhibitor or ARB therapy at hospital discharge

Definitions:
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:
Performance Met: Angiotensin converting enzyme (ACE) inhibitor or angiotensin receptor blocker (ARB) therapy prescribed or currently being taken **(4010F)**

OR

Medical Performance Exclusion:	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, allergy, intolerance, other medical reasons) **(4010F with 1P)**
OR	
Patient Performance Exclusion:	Documentation of patient reason(s) for not prescribing angiotensin converting enzyme (ACE) inhibitor or angiotensin receptor blocker (ARB) therapy (eg, patient declined, other patient reasons) **(4010F with 2P)**
OR	
System Performance Exclusion:	Documentation of system reason(s) for not prescribing angiotensin converting enzyme (ACE) inhibitor or angiotensin receptor blocker (ARB) therapy (eg, other system reasons) **(4010F with 3P)**
OR	
Performance Not Met:	Angiotensin converting enzyme (ACE) inhibitor or angiotensin receptor blocker (ARB) therapy was **not** prescribed, reason not otherwise specified **(4010F with 8P)**

RATIONALE:

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

CLINICAL RECOMMENDATION STATEMENTS:

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

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

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

Drug	Initial Daily Dose(s)	Maximum Doses(s)
ACE Inhibitors		
Captopril	6.25 mg 3 times	50 mg 3 times
Enalapril	2.5 mg twice	10 to 20 mg twice
Fosinopril	5 to 10 mg once	40 mg once
Lisinopril	2.5 to 5 mg once	20 to 40 mg once
Perindopril	2 mg once	8 to 16 mg once
Quinapril	5 mg twice	20 mg twice

Drug	Initial Daily Dose(s)	Maximum Doses(s)
Ramipril	1.25 to 2.5 mg once	10 mg once
Trandolapril	1 mg once	4 mg once
Angiotensin Receptor Blockers		
Candesartan	4 to 8 mg once	32 mg once
Losartan**	25 to 50 mg once	50 to 100 mg once
Valsartan	20 to 40 mg twice	160 mg twice

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

An ARB should be administered to post - [myocardial infarction (MI)] patients without [heart failure] who are intolerant of [ACE inhibitors] and have a low LVEF. (Class I, Level of Evidence: B) (ACCF/AHA, 2009)

Angiotensin II receptor blockers are reasonable to use as alternatives to [ACE inhibitors] as first - line therapy for patients with mild to moderate [heart failure] and reduced LVEF, especially for patients already taking ARBs for other indications. (Class IIa, Level of Evidence: A) (ACCF/AHA, 2009)

For the hospitalized patient:

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

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

➧ Measure #6 (NQF 0067): Coronary Artery Disease (CAD): Antiplatelet Therapy – National Quality Strategy Domain: Effective Clinical Care

2015 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

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

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

Measure Reporting via Registry:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

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

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

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Diagnosis for coronary artery disease (ICD-9-CM) [for use 1/1/2015-9/30/2015]: 410.00, 410.01, 410.02, 410.10, 410.11, 410.12, 410.20, 410.21, 410.22, 410.30, 410.31, 410.32, 410.40, 410.41, 410.42, 410.50, 410.51, 410.52, 410.60, 410.61, 410.62, 410.70, 410.71, 410.72, 410.80, 410.81, 410.82, 410.90, 410.91, 410.92, 411.0, 411.1, 411.81, 411.89, 412, 413.0, 413.1, 413.9, 414.00, 414.01, 414.02, 414.03, 414.04, 414.05, 414.06, 414.07, 414.2, 414.3, 414.8, 414.9, V45.81, V45.82
Diagnosis for coronary artery disease (ICD-10-CM) [for use 10/01/2015-12/31/2015]: 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, I25.810, I25.811, I25.812, I25.82, I25.83, I25.89, I25.9, Z95.1, Z95.5, Z98.61
AND
Patient encounter during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350

NUMERATOR:
Patients who 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 Options:

Performance Met:	Aspirin or clopidogrel prescribed **(4086F)**
OR	
Medical Performance Exclusion:	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* 1P)**
OR	
Patient Performance Exclusion:	Documentation of patient reason(s) for not prescribing aspirin or clopidogrel (eg, patient declined, other patient reasons) **(4086F *with* 2P)**
OR	
System Performance Exclusion:	Documentation of system reason(s) for not prescribing aspirin or clopidogrel (eg, lack of drug availability, other reasons attributable to the health care system) **(4086F *with* 3P)**
OR	
Performance Not Met:	Aspirin or clopidogrel was **not** prescribed, reason not otherwise specified **(4086F *with* 8P)**

RATIONALE:

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

CLINICAL RECOMMENDATION STATEMENTS:

The following evidence statements are quoted verbatim from the referenced clinical guidelines.
2012 ACCF/AHA/ACP/AATS/PCNA/SCAI/STS Guideline for the Diagnosis and Management of Patients With Stable Ischemic Heart Disease (SIHD)

ANTIPLATELET THERAPY
Treatment with aspirin 75 to 162 mg daily should be continued indefinitely in the absence of contraindications in patients with SIHD. (Class I Recommendation, Level of Evidence: A)

Treatment with clopidogrel is reasonable when aspirin is contraindicated in patients with SIHD. (Class I Recommendation, Level of Evidence: B)

Measure #7 (NQF 0070): Coronary Artery Disease (CAD): Beta-Blocker Therapy – Prior Myocardial Infarction (MI) or Left Ventricular Systolic Dysfunction (LVEF < 40%) – National Quality Strategy Domain: Effective Clinical Care

2015 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

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

INSTRUCTIONS:
This measure is to be reported a minimum of **once per reporting period** for **all** patients with a diagnosis of CAD seen during the reporting period. Only patients who had at least two denominator eligible visits during the reporting period will be counted for Reporting Criteria 1 and Reporting Criteria 2 of this measure. This measure may be reported by clinicians who perform the quality actions described in the measure for the primary management of patients with CAD based on the services provided and the measure-specific denominator coding.

This measure will be calculated with 2 performance rates:

1) **Percentage of patients with a diagnosis of CAD or history of cardiac surgery who have a current or prior LVEF < 40% prescribed a beta-blocker**
2) **Percentage of patients with a diagnosis of CAD or history of cardiac surgery who have prior myocardial infarction prescribed a beta-blocker**

Measure Reporting via Registry:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, a G-code, and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

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

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

There are two reporting criteria for this measure:

1) **Patients who are 18 years and older with a diagnosis of CAD or history of cardiac surgery who have a current or prior LVEF < 40%**

   OR

2) **Patients who are 18 years and older with a diagnosis of CAD or history of cardiac surgery who have prior myocardial infarction**

REPORTING CRITERIA 1:
All patients with a diagnosis of CAD or history of cardiac surgery who have a current or prior LVEF < 40 %

DENOMINATOR (REPORTING CRITERIA 1):

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

DENOMINATOR NOTE: *In order for the patient to be considered for the measure, the diagnosis of CAD must be an active diagnosis and patient could have been diagnosed prior to the denominator eligible visits within the measurement year.*

OR

The cardiac surgery could have been performed prior to the denominator eligible visits within the measurement year.

In order for the patient to be included in the either of the measure denominators, the patient must have two denominator eligible visits.

Denominator Criteria (Eligible Cases) 1:

Patients aged ≥ 18 years on date of encounter

AND

Diagnosis for coronary artery disease (ICD-9-CM) [for use 1/1/2015-9/30/2015]: 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, 414.3, 414.8, 414.9, V45.81, V45.82

Diagnosis for coronary artery disease (ICD-10-CM) [for use 10/01/2015-12/31/2015]: I20.0, I20.1, I20.8, I20.9, 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, I25.83, I25.89, I25.9, Z95.1, Z95.5, Z98.61

OR

History of cardiac surgery (CPT): 33140, 33510, 33511, 33512, 33513, 33514, 33516, 33517, 33518, 33519, 33521, 33522, 33523, 33533, 33534, 33535, 33536, 92920, 92924, 92928, 92933, 92937, 92941, 92943

AND

Patient encounter(s) during reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350

AND

Two Denominator Eligible Visits

AND

Left ventricular ejection fraction (LVEF) < 40%: G8694

NUMERATOR (REPORTING CRITERIA 1):

Patients who were prescribed beta-blocker therapy

Definitions:

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

Beta-blocker Therapy – For patients with prior LVEF < 40%, beta-blocker therapy includes the following: bisoprolol, carvedilol, or sustained release metoprolol succinate.

Numerator Options:

Performance Met:	Beta-blocker therapy prescribed or currently being taken **(G9189)**

OR

Medical Performance Exclusion:	Documentation of medical reason(s) for not prescribing beta-blocker therapy (eg, allergy, intolerance, other medical reasons) **(G9190)**
OR	
Patient Performance Exclusion:	Documentation of patient reason(s) for not prescribing beta-blocker therapy (eg, patient declined, other patient reasons) **(G9191)**
OR	
System Performance Exclusion:	Documentation of system reason(s) for not prescribing beta-blocker therapy (eg, other reasons attributable to the health care system) **(G9192)**

OR

Performance Not Met:	Beta-blocker therapy not prescribed, reason not given **(G9188)**

OR

REPORTING CRITERIA 2: All patients with a diagnosis of CAD or history of cardiac surgery who have a prior (resolved) myocardial infarction

DENOMINATOR (REPORTING CRITERIA 2):
All patients aged 18 years and older with a diagnosis of coronary artery disease seen within a 12 month period who also have prior MI

DENOMINATOR NOTE: *In order for the patient to be considered for the measure, the diagnosis of CAD must be an active diagnosis and patient could have been diagnosed prior to the denominator eligible visits within the measurement year.*

OR

The cardiac surgery could have been performed prior to the denominator eligible visits within the measurement year.
**Inclusion for this reporting criteria requires the presence of a prior MI diagnosis AND at least two denominator eligible visits during the measurement period. Diagnosis codes for Coronary Artery Disease (which include MI diagnosis codes) may also accompany the MI diagnosis code, but are not required for inclusion in the measure.*
In order for the patient to be included in the either of the measure denominators, the patient must have two denominator eligible visits.

Denominator Criteria (Eligible Cases) 2:
Patients aged ≥ 18 years on date of encounter
AND
Diagnosis for coronary artery disease (ICD-9-CM) [for use 1/1/2015-9/30/2015]: 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, 414.3, 414.8, 414.9, V45.81, V45.82
Diagnosis for coronary artery disease (ICD-10-CM) [for use 10/01/2015-12/31/2015]: I20.0, I20.1, I20.8, I20.9, 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, I25.83, I25.89, I25.9, Z95.1, Z95.5, Z98.61

OR

History of cardiac surgery (CPT): 33140, 33510, 33511, 33512, 33513, 33514, 33516, 33517, 33518, 33519, 33521, 33522, 33523, 33533, 33534, 33535, 33536, 92920, 92924, 92928, 92933, 92937, 92941, 92943

AND

Diagnosis for myocardial infarction – includes patient that had a prior myocardial infarction at any time (ICD-9-CM) [for use 1/1/2015-9/30/2015]: 410.00, 410.01, 410.02, 410.10, 410.11, 410.12, 410.20, 410.21, 410.22, 410.30, 410.31, 410.32, 410.40, 410.41, 410.42, 410.50, 410.51, 410.52, 410.60, 410.61, 410.62, 410.70, 410.71, 410.72, 410.80, 410.81, 410.82, 410.90, 410.91, 410.92, 412

Diagnosis for myocardial infarction– includes patient that had a prior myocardial infarction at any time (ICD-10-CM) [for use 10/01/2015-12/31/2015]: I21.01, I21.02, I21.09, I21.11, I21.19, I21.21, I21.29, I21.3, I21.4, I22.0, I22.1, I22.2, I22.8, I22.9, I24.1, I25.2

AND

Patient encounter(s) during reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350

AND

Two Denominator Eligible Visits

NUMERATOR (REPORTING CRITERIA 2):

Patients who were prescribed beta-blocker therapy

Definitions:

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

Beta-blocker Therapy – For patients with prior MI, beta-blocker therapy includes any agent within the beta-blocker drug class. As of 2011, during the development process, no recommendations or evidence cited in current chronic stable angina guidelines for preferential use of specific agents.

Numerator Options:

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

RATIONALE:

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

A patient with a diagnosis of coronary artery disease seen within a 12 month period and LVEF < 40% should be taking either bisoprolol, carvedilol, or sustained release metoprolol succinate. While all beta-blockers appear to be of

equal efficacy in patients with chronic stable coronary artery disease, these three medications have specifically shown to reduce mortality in patients with reduced LVEF.

CLINICAL RECOMMENDATION STATEMENTS:

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

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

Measure #8 (NQF 0083): Heart Failure (HF): Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD) – National Quality Strategy Domain: Effective Clinical Care

2015 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

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

INSTRUCTIONS:
This measure is to be reported for all heart failure patients a minimum of **once per reporting period** when **seen in the outpatient setting AND reported at each hospital discharge** (99238* and 99239*) during the reporting period. Only patients who had at least two denominator eligible visits during the reporting period will be counted for Reporting Criteria 1.

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

This measure is intended to reflect the quality of services provided for patients with heart failure and decreased left ventricular systolic function. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding. Only patients who had at least two denominator eligible visits during the reporting period will be counted for Reporting Criteria 1.

Measure Reporting via Registry:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, a quality-data code (Reporting Criteria 1 and 2), and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data. It is expected that a single performance rate will be calculated for this measure.

There are two reporting criteria for this measure:

1) **Patients who are 18 years and older with a diagnosis of HF with a current or prior LVEF < 40% seen in the outpatient setting with two denominator eligible visits**

OR

2) **Patients who are 18 years and older with a diagnosis of HF with a current or prior LVEF < 40% and discharged from hospital**

REPORTING CRITERIA 1: All patients with a diagnosis of HF seen in the outpatient setting

DENOMINATOR (REPORTING CRITERIA 1):
All patients aged 18 years and older with a diagnosis of heart failure with a current or prior LVEF < 40%

> ***DENOMINATOR NOTE:*** *LVEF < 40% corresponds to qualitative documentation of moderate dysfunction or severe left ventricular systolic function. 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.

In order for the patient to be included in Reporting Criteria 1, the patient must have two denominator eligible visits

Denominator Criteria (Eligible Cases) 1:
Patients aged ≥ 18 years on date of encounter
AND
Diagnosis for heart failure (ICD-9-CM) [for use 1/1/2015-9/30/2015]: 402.01, 402.11, 402.91, 404.01, 404.03, 404.11, 404.13, 404.91, 404.93, 428.0, 428.1, 428.20, 428.21, 428.22, 428.23, 428.30, 428.31, 428.32, 428.33, 428.40, 428.41, 428.42, 428.43, 428.9
Diagnosis for heart failure (ICD-10-CM) [for use 10/01/2015-12/31/2015]: I11.0, I13.0, I13.2, I50.1, I50.20, I50.21, I50.22, I50.23, I50.30, I50.31, I50.32, I50.33, I50.40, I50.41, I50.42, I50.43, I50.9
AND
Patient encounter(s) during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350
AND
Two Denominator Eligible Visits
AND
Left ventricular ejection fraction (LVEF) < 40% or documentation of moderately or severely depressed left ventricular systolic function: G8923

NUMERATOR (REPORTING CRITERIA 1):
Patients who were prescribed beta-blocker therapy within a 12 month period when seen in the outpatient setting

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

Numerator Options:

Performance Met:	Beta-blocker therapy prescribed **(G8450)**
OR	
Other Performance Exclusion:	Beta-Blocker Therapy for LVEF < 40% not prescribed for reasons documented by the clinician (eg, 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	
Performance Not Met:	Beta-blocker therapy **not** prescribed **(G8452)**

OR

REPORTING CRITERIA 2: All patients with a diagnosis of HF and discharged from hospital

DENOMINATOR (REPORTING CRITERIA 2):
All patients aged 18 years and older with a diagnosis of heart failure with a current or prior LVEF < 40%

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

Denominator Criteria (Eligible Cases) 2:
Patients aged ≥ 18 years on date of encounter
AND
Diagnosis for heart failure (ICD-9-CM) [for use 1/1/2015-9/30/2015]: 402.01, 402.11, 402.91, 404.01, 404.03, 404.11, 404.13, 404.91, 404.93, 428.0, 428.1, 428.20, 428.21, 428.22, 428.23, 428.30, 428.31, 428.32, 428.33, 428.40, 428.41, 428.42, 428.43, 428.9
Diagnosis for heart failure (ICD-10-CM) [for use 10/01/2015-12/31/2015]: I11.0, I13.0, I13.2, I50.1, I50.20, I50.21, I50.22, I50.23, I50.30, I50.31, I50.32, I50.33, I50.40, I50.41, I50.42, I50.43, I50.9
AND
Patient encounter during reporting period (CPT): 99238*, 99239*
AND
Left ventricular ejection fraction (LVEF) < 40% or documentation of moderately or severely depressed left ventricular systolic function: 3021F

NUMERATOR (REPORTING CRITERIA 2):
Patients who were prescribed beta-blocker therapy at each hospital discharge

Definitions:
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%, beta-blocker therapy should include bisoprolol, carvedilol, or sustained release metoprolol succinate**.**

Numerator Options:

Performance Met:	Beta-blocker therapy prescribed **(G8450)**
OR	
Other Performance Exclusion:	Beta-Blocker Therapy for LVEF < 40% not prescribed for reasons documented by the clinician (eg, 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, other reasons attributable to the healthcare system) **(G8451)**
OR	
Performance Not Met:	Beta-blocker therapy **not** prescribed **(G8452)**

RATIONALE:
Beta-blockers are recommended for all patients with stable heart failure and left ventricular systolic dysfunction, unless contraindicated. Treatment should be initiated as soon as a patient is diagnosed with left ventricular systolic dysfunction and does not have low blood pressure, fluid overload, or recent treatment with an intravenous positive

inotropic agent. Beta-blockers have been shown to lessen the symptoms of heart failure, improve the clinical status of patients, reduce future clinical deterioration, and decrease the risk of mortality and the combined risk of mortality and hospitalization.

CLINICAL RECOMMENDATION STATEMENTS:

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

Treatment with a beta blocker should be initiated at very low doses [see excerpt from guideline table below], followed by gradual increments in dose if lower doses have been well tolerated physicians, especially cardiologists and primary care physicians, should make every effort to achieve the target doses of the beta blockers shown to be effective in major clinical trials. (ACCF/AHA, 2009)

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

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

For the hospitalized patient:

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

*Measure #12 (NQF 0086): Primary Open-Angle Glaucoma (POAG): Optic Nerve Evaluation – National Quality Strategy Domain: Effective Clinical Care

2015 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

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

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

Measure Reporting via Claims:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. CPT Category II codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and the appropriate CPT Category II code **OR** the CPT Category II code **with** the modifier. The modifiers allowed for this measure are: 1P- medical reasons, 8P- reason not otherwise specified. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

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

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

> **Denominator Criteria (Eligible Cases):**
> Patients aged ≥ 18 years on date of encounter
> **AND**
> **Diagnosis for primary open-angle glaucoma (ICD-9-CM) [for use 1/1/2015-9/30/2015]:** 365.10, 365.11, 365.12, 365.15
> **Diagnosis for primary open-angle glaucoma (ICD-10-CM) [for use 10/01/2015-12/31/2015]:** 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, H40.151, H40.152, H40.153, H40.159
> **AND**
> **Patient encounter during the reporting period (CPT):** 92002, 92004, 92012, 92014, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337

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

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Optic Nerve Head Evaluation Performed

***Performance Met:* CPT II 2027F:** Optic nerve head evaluation performed

OR

Optic Nerve Head Evaluation not Performed for Medical Reasons

Append a modifier (**1P**) to CPT Category II code **2027F** to report documented circumstances that appropriately exclude patients from the denominator.

***Medical Performance Exclusion:* 2027F *with* 1P:** Documentation of medical reason(s) for not performing an optic nerve head evaluation

OR

Optic Nerve Head Evaluation not Performed, Reason not Otherwise Specified

Append a reporting modifier (**8P**) to CPT Category II code **2027F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

***Performance Not Met:* 2027F *with* 8P:** Optic nerve head evaluation was **not** performed, reason not otherwise specified

RATIONALE:

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

CLINICAL RECOMMENDATION STATEMENTS:

Ophthalmic Evaluation

In completing the elements in the comprehensive adult medical eye evaluation, the ophthalmic evaluation specifically focuses on the following elements:

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

(AAO, 2010)

Measure #14 (NQF 0087): Age-Related Macular Degeneration (AMD): Dilated Macular Examination – National Quality Strategy Domain: Effective Clinical Care

2015 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

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

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

Measure Reporting via Claims:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. CPT Category II codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and the appropriate CPT Category II code **OR** the CPT Category II code **with** the modifier. The modifiers allowed for this measure are: 1P- medical reasons, 2P- patient reasons, 8P- reason not otherwise specified. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

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

DENOMINATOR:
All patients aged 50 years and older with a diagnosis of AMD

> **Denominator Criteria (Eligible Cases):**
> Patients aged ≥ 50 years on date of encounter
> **AND**
> **Diagnosis for age-related macular degeneration (ICD-9-CM) [for use 1/1/2015-9/30/2015]:** 362.50, 362.51, 362.52
> **Diagnosis for age-related macular degeneration (ICD-10-CM) [for use 10/01/2015-12/31/2015]:** H35.30, H35.31, H35.32
> **AND**
> Patient encounter during the reporting period (CPT): 92002, 92004, 92012, 92014, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337

NUMERATOR:

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

Definitions:
Macular Thickening – Acceptable synonyms for "macular thickening" include: intraretinal thickening, serous detachment of the retina, pigment epithelial detachment or macular edema.
Severity of Macular Degeneration – Early, intermediate and advanced.

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

OR

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

OR

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

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

CLINICAL RECOMMENDATION STATEMENTS:
According to the American Academy of Ophthalmology, a stereo biomicroscopic examination of the macula should be completed. Binocular slit-lamp biomicroscopy of the ocular fundus is often necessary to detect subtle clinical clues of CNV. These include small areas of hemorrhage, hard exudates, subretinal fluid, or pigment epithelial elevation. (A: III) (AAO, 2008)

*Measure #19 (NQF 0089): Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care – National Quality Strategy Domain: Effective Clinical Care

2015 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

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

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

Measure Reporting via Claims:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. CPT Category II and/or quality-data codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and the appropriate CPT Category II code **AND/OR** quality-data code **OR** the CPT Category II code **with** the modifier **AND** quality-data code. The modifiers allowed for this measure are: 1P- medical reasons, 2P- patient reasons, 8P- reason not otherwise specified. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

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

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

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Diagnosis for diabetic retinopathy (ICD-9-CM) [for use 1/1/2015-9/30/2015]: 362.01, 362.02, 362.03, 362.04, 362.05, 362.06
Diagnosis for diabetic retinopathy (ICD-10-CM) [for use 10/01/2015-12/31/2015]: E08.311, E08.319, E08.321, E08.329, E08.331, E08.339, E08.341, E08.349, E08.351, E08.359, E09.311, E09.319, E09.321, E09.329, E09.331, E09.339, E09.341, E09.349, E09.351, E09.359, E10.311, E10.319, E10.321, E10.329, E10.331, E10.339, E10.341, E10.349, E10.351, E10.359, E11.311, E11.319, E11.321, E11.329, E11.331, E11.339, E11.341, E11.349, E11.351, E11.359, E13.311, E13.319, E13.321, E13.329, E13.331, E13.339, E13.341, E13.349, E13.351, E13.359
AND

Patient encounter during the reporting period (CPT): 92002, 92004, 92012, 92014, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337

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

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

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

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Dilated Macular or Fundus Exam Findings Communicated
*(One CPT II code & one quality-data code **[5010F & G8397]** are required on the claim form to submit this numerator option)*
Performance Met:

CPT II 5010F:	Findings of dilated macular or fundus exam communicated to the physician or other qualified health care professional managing the diabetes care
AND	
G8397:	Dilated macular or fundus exam performed, including documentation of the presence or absence of macular edema AND level of severity of retinopathy

OR

Dilated Macular or Fundus Exam Findings not Communicated for Medical Reasons or Patient Reasons
*(One CPT II code & one quality-data code **[5010F-xP & G8397]** are required on the claim form to submit this numerator option)*
Append a modifier (1P or 2P) to CPT Category II code 5010F to report documented circumstances that appropriately exclude patients from the denominator.
Medical Performance Exclusion or Patient Performance Exclusion:

5010F *with* 1P:	Documentation of medical reason(s) for not communicating the findings of the dilated macular or fundus exam to the physician who manages the ongoing care of the patient with diabetes
5010F *with* 2P:	Documentation of patient reason(s) for not communicating the findings of the dilated macular or fundus exam to the physician who manages the ongoing care of the patient with diabetes

AND

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

OR

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

OR

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

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

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

CLINICAL RECOMMENDATION STATEMENTS:
The ophthalmologist should communicate examination results to the physician who is managing ongoing diabetes care. (A:III) (AAO, 2008)

+ Measure #21 (NQF 0268): Perioperative Care: Selection of Prophylactic Antibiotic – First OR Second Generation Cephalosporin – National Quality Strategy Domain: Patient Safety

2015 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

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

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

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

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

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

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

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

> **Denominator Instructions:** CPT Category I procedure codes billed by surgeons performing surgery on the same patient, submitted with modifier 62 (indicating two surgeons, ie, dual procedures) will be included in the denominator population. Both surgeons participating in PQRS will be fully accountable for the clinical action described in the measure.
>
> **Denominator Criteria (Eligible Cases):**
> Patients aged ≥ 18 years on date of encounter
> **AND**
> **Patient encounter during the reporting period (CPT):** Listed below are surgical procedures with indications for first or second generation cephalosporin prophylactic antibiotic

SURGICAL PROCEDURE	CPT CODE
Integumentary	15732, 15734, 15736, 15738, 15830, 15832, 15833, 15834, 15835, 15836, 15837, 19260, 19271, 19272, 19300, 19301, 19302, 19303,

SURGICAL PROCEDURE	CPT CODE
Integumentary	19304, 19305, 19306, 19307, 19316, 19318, 19324, 19325, 19328, 19330, 19340, 19342, 19350, 19355, 19357, 19361, 19364, 19366, 19367, 19368, 19369, 19370, 19371, 19380
Spine	22325, 22586, 22612, 22630, 22800, 22802, 22804, 63030, 63042
Hip Reconstruction	27125, 27130, 27132, 27134, 27137, 27138
Trauma (Fractures)	27235, 27236, 27244, 27245, 27269, 27758, 27759, 27766, 27769, 27792, 27814
Knee Reconstruction	27440, 27441, 27442, 27443, 27445, 27446, 27447
Vascular	27880, 27881, 27882, 27884, 27886, 27888, 33877, 33880, 33881, 33883, 33886, 33889, 33891, 34800, 34802, 34803, 34804, 34805, 34812, 34820, 34825, 34830, 34831, 34832, 34833, 34834, 34841, 34842, 34843, 34844, 34845, 34846, 34847, 34848,34900, 35011, 35013, 35081, 35082, 35091, 35092, 35102, 35103, 35131, 35141, 35142, 35151, 35152, 35206, 35266, 35301, 35363, 35371, 35372, 35460, 35512, 35521, 35522, 35523, 35525, 35533, 35537, 35538, 35539, 35540, 35556, 35558, 35565, 35566, 35570, 35571, 35572, 35583, 35585, 35587, 35601, 35606, 35612, 35616, 35621, 35623, 35626, 35631, 35632, 35633, 35634, 35636, 35637, 35638, 35642, 35645, 35646, 35647, 35650, 35654, 35656, 35661, 35663, 35665, 35666, 35671, 36830, 37224, 37225, 37226, 37227, 37228, 37229, 37230, 37231, 37617
Spleen and Lymph Nodes	38100, 38101, 38115, 38120, 38571, 38572, 38700, 38720, 38724, 38740, 38745, 38747, 38760, 38765, 38770, 38780
Esophagus	43020, 43030, 43045, 43100, 43101, 43107, 43108, 43112, 43113, 43116, 43117, 43118, 43121, 43122, 43123, 43124, 43130, 43135, 43279, 43280, 43281, 43282, 43300, 43305, 43310, 43312, 43313, 43314, 43320, 43325, 43327, 43328, 43330, 43331, 43332, 43333, 43334, 43335, 43336, 43337, 43340, 43341, 43350, 43351, 43352, 43360, 43361, 43400, 43401, 43405, 43410, 43415, 43420, 43425, 43496
Stomach	43500, 43501, 43502, 43510, 43520, 43605, 43610, 43611, 43620, 43621, 43622, 43631, 43632, 43633, 43634, 43640, 43641, 43644, 43645, 43651, 43652, 43653, 43800, 43810, 43820, 43825, 43830, 43832, 43840, 43843, 43845, 43846, 43847, 43848, 43850, 43855, 43860, 43865, 43870, 43880
Small Intestine	44005, 44010, 44020, 44021, 44050, 44055, 44100, 44120, 44125, 44126, 44127, 44130, 44132, 44133, 44135, 44136
Colon	44140, 44141, 44143, 44144, 44145, 44146, 44147, 44150, 44151, 44155, 44156, 44157, 44158, 44160, 44180, 44186, 44187, 44188, 44202, 44204, 44205, 44206, 44207, 44208, 44210, 44211, 44212, 44227, 44300, 44310, 44312, 44314, 44316, 44320, 44322, 44340, 44345, 44346, 44602, 44603, 44604, 44605, 44615, 44620, 44625, 44626, 44640, 44650, 44660, 44661, 44680, 44700
Rectum	45000, 45020, 45110, 45111, 45112, 45113, 45114, 45116, 45119, 45120, 45121, 45123, 45126, 45130, 45135, 45136, 45150, 45160, 45171, 45172, 45395, 45397, 45400, 45402, 45540, 45541, 45550, 45560, 45562, 45563, 45800, 45805, 45820, 45825
Biliary	47400, 47420, 47425, 47460, 47480, 47560, 47561, 47562, 47563, 47564, 47570, 47600, 47605, 47610, 47612, 47620, 47630, 47700,

SURGICAL PROCEDURE	CPT CODE
	47701, 47711, 47712, 47715, 47720, 47721, 47740, 47741, 47760, 47765, 47780, 47785, 47800, 47801, 47802, 47900
Pancreas	48000, 48001, 48020, 48100, 48102, 48105, 48120, 48140, 48145, 48146, 48148, 48150, 48152, 48153, 48154, 48155, 48500, 48510, 48520, 48540, 48545, 48547, 48548, 48554, 48556
Abdomen, Peritoneum & Omentum	27080, 27158, 27202, 27280, 27282, 49000, 49002, 49010, 49020, 49040, 49060, 49203, 49204, 49205, 49215, 49220, 49250, 49320, 49321, 49322, 49323, 49505, 49507, 49568
Renal Transplant	50320, 50340, 50360, 50365, 50370, 50380
Neurological Surgery	22524, 22551, 22554, 22558, 22600, 22612, 22630, 22633, 61154, 61312, 61313, 61315, 61510, 61512, 61518, 61548, 61697, 61700, 61750, 61751, 61867, 62223, 62230, 63015, 63020, 63030, 63042, 63045, 63046, 63047, 63056, 63075, 63081, 63267, 63276
Cardiothoracic Surgery	33120, 33130, 33140, 33141, 33202, 33250, 33251, 33256, 33261, 33305, 33315, 33321, 33322, 33332, 33335, 33365, 33366, 33400, 33401, 33403, 33404, 33405, 33406, 33410, 33411, 33413, 33416, 33422, 33425, 33426, 33427, 33430, 33460, 33463, 33464, 33465, 33475, 33496, 33510, 33511, 33512, 33513, 33514, 33516, 33517, 33518, 33519, 33521, 33522, 33523, 33530, 33533, 33534, 33535, 33536, 33542, 33545, 33548, 33572, 35211, 35241, 35271
General Thoracic Surgery	0236T, 21627, 21632, 21740, 21750, 21805, 21825, 31760, 31766, 31770, 31775, 31786, 31805, 32096, 32097, 32098, 32100, 32110, 32120, 32124, 32140, 32141, 32150, 32215, 32220, 32225, 32310, 32320, 32440, 32442, 32445, 32480, 32482, 32484, 32486, 32488, 32491, 32505, 32506, 32507 32800, 32810, 32815, 32900, 32905, 32906, 32940, 33020, 33025, 33030, 33031, 33050, 33300, 33310, 33320, 33361, 33362, 33363, 33364, 34051, 35021, 35216, 35246, 35276, 35311, 35526, 37616, 38381, 38746, 39000, 39010, 39200, 39220, 39545, 39561, 64746
Foot & Ankle	27702, 27703, 27704, 28192, 28193, 28293, 28415, 28420, 28445, 28465, 28485, 28505, 28525, 28531, 28555, 28585, 28615, 28645, 28675, 28705, 28715, 28725, 28730, 28735, 28737
Laryngectomy	31400, 31420
Mediastinum and Diaphragm	39501, 39540, 39541, 39545, 39560, 39561
Bariatric	43770, 43771, 43772, 43773, 43774, 43775, 43843, 43845, 43846, 43847, 43848, 43886, 43887, 43888
Meckel's Diverticulum and Appendix	44800, 44820, 44850, 44900, 44950, 44955, 44960, 44970
Liver	47100, 47120, 47122, 47125, 47130, 47140, 47141, 47142, 47350, 47370, 47371, 47380, 47381
Gynecologic Surgery	57267, 58150, 58152, 58180, 58200, 58210, 58240, 58260, 58262, 58263, 58267, 58270, 58275, 58280, 58285, 58290, 58291, 58292, 58293, 58294, 58951, 58953, 58954, 58956
General Surgery	23470, 23472, 23473, 23474, 23616, 24363, 24370, 24371, 60505

NUMERATOR:
Surgical patients who had an order for a first OR second generation cephalosporin for antimicrobial prophylaxis

Numerator Instructions: There must be documentation of an order (written order, verbal order, or standing order/protocol) for a first OR second generation cephalosporin for antimicrobial prophylaxis OR documentation that a first OR second generation cephalosporin 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:
Documentation of Order for First or Second Generation Cephalosporin for Antimicrobial Prophylaxis (written order, verbal order, or standing order/protocol)
Performance Met: **G9197:** Documentation of an order for first OR second generation cephalosporin for antimicrobial prophylaxis

Note: ***G9197*** *is provided for antibiotic* ***ordered*** *or antibiotic* ***given****. Report* ***G9197****if a first or second generation cephalosporin was given for antimicrobial prophylaxis.*

OR

Order for First or Second Generation Cephalosporin not Ordered for Medical Reasons
Medical Performance Exclusion: **G9196:** Documentation of medical reason(s) for not ordering a first OR second generation cephalosporin for antimicrobial prophylaxis (eg, patients enrolled in clinical trials, patients with documented infection prior to surgical procedure of interest, patients who were receiving antibiotics more than 24 hours prior to surgery [except colon surgery patients taking oral prophylactic antibiotics], patients who were receiving antibiotics within 24 hours prior to arrival [except colon surgery patients taking oral prophylactic antibiotics], other medical reason(s))

OR

Order for First or Second Generation Cephalosporin not Ordered, Reason not Given
Performance Not Met: **G9198:** Order for a first OR second generation cephalosporin for antimicrobial prophylaxis was **not** documented, reason not given

RATIONALE:
Presence of antibiotics in the blood and tissue during and after surgery can prevent infection. Cephalosporins are currently the drug of choice for antimicrobial prophylaxis due to their broad-spectrum effect and low occurrence of adverse reactions.

CLINICAL RECOMMENDATION STATEMENTS:
For most procedures, cefazolin is the drug of choice for prophylaxis because it is the most widely studied antimicrobial agent, with proven efficacy. It has a desirable duration of action, spectrum of activity against organisms commonly encountered in surgery, reasonable safety, and low cost. (ASHP, 2013)

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

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

The recommended antimicrobials for cardiothoracic and vascular operations include cefazolin or cefuroxime. For patients with serious allergy or adverse reaction to β-lactams, vancomycin is appropriate, and clindamycin may be an acceptable alternative. (SIPGWW, 2004)

+ Measure #22 (NQF 0271): Perioperative Care: Discontinuation of Prophylactic Parenteral Antibiotics (Non-Cardiac Procedures) – National Quality Strategy Domain: Patient Safety

2015 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

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

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

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

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

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

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

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

Denominator Instructions:

- CPT Category I procedure codes billed by surgeons performing surgery on the same patient, submitted with modifier 62 (indicating two surgeons, ie, dual procedures) will be included in the denominator population. Both surgeons participating in the PQRS will be fully accountable for the clinical action described in the measure.
- For the purpose of this measure of antibiotic discontinuation, patients may be counted as having "received a prophylactic parenteral antibiotic" if the antibiotic was received within 4 hours prior to the surgical incision (or start of procedure when no incision is required) or intraoperatively.

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND

Patient encounter during the reporting period (CPT): Listed below are non-cardiac surgical procedures for which prophylactic parenteral antibiotics are indicated

SURGICAL PROCEDURE	CPT CODE
Integumentary	15732, 15734, 15736, 15738, 15830, 15832, 15833, 15834, 15835, 15836, 15837, 19260, 19271, 19272, 19300, 19301, 19302, 19303, 19304, 19305, 19306, 19307, 19316, 19318, 19324, 19325, 19328, 19330, 19340, 19342, 19350, 19355, 19357, 19361, 19364, 19366, 19367, 19368, 19369, 19370, 19371, 19380
Le Fort Fractures	21346, 21347, 21348, 21422, 21423, 21432, 21433, 21435, 21436
Mandibular Fracture	21454, 21461, 21462, 21465, 21470
Spine	22325, 22586, 22612, 22630, 22800, 22802, 22804, 63030, 63042
Hip Reconstruction	27125, 27130, 27132, 27134, 27137, 27138
Trauma (Fractures)	27235, 27236, 27244, 27245, 27269, 27758, 27759, 27766, 27769, 27792, 27814
Knee Reconstruction	27440, 27441, 27442, 27443, 27445, 27446, 27447
Laryngectomy	31360, 31365, 31367, 31368, 31370, 31375, 31380, 31382, 31390, 31395, 31400, 31420
Vascular	27880, 27881, 27882, 27884, 27886, 27888, 33877, 33880, 33881, 33883, 33886, 33889, 33891, 34800, 34802, 34803, 34804, 34805, 34812, 34820, 34825, 34830, 34831, 34832, 34833, 34834, 34841, 34842, 34843, 34844, 34845, 34846, 34847, 34848, 34900, 35011, 35013, 35081, 35082, 35091, 35092, 35102, 35103, 35131, 35141, 35142, 35151, 35152, 35206, 35266, 35301, 35363, 35371, 35372, 35460, 35512, 35521, 35522, 35523, 35525, 35533, 35537, 35538, 35539, 35540, 35556, 35558, 35565, 35566, 35570, 35571, 35572, 35583, 35585, 35587, 35601, 35606, 35612, 35616, 35621, 35623, 35626, 35631, 35632, 35633, 35634, 35636, 35637, 35638, 35642, 35645, 35646, 35647, 35650, 35654, 35656, 35661, 35663, 35665, 35666, 35671, 36830, 37224, 37225, 37226, 37227, 37228, 37229, 37230, 37231, 37617
Glossectomy	41130, 41135, 41140, 41145, 41150, 41153, 41155
Esophagus	43020, 43030, 43045, 43100, 43101, 43107, 43108, 43112, 43113, 43116, 43117, 43118, 43121, 43122, 43123, 43124, 43130, 43135, 43279, 43280, 43281, 43282, 43300, 43305, 43310, 43312, 43313, 43314, 43320, 43325, 43327, 43328, 43330, 43331, 43332, 43333, 43334, 43335, 43336, 43337, 43340, 43341, 43350, 43351, 43352, 43360, 43361, 43400, 43401, 43405, 43410, 43415, 43420, 43425, 43496
Stomach	43500, 43501, 43502, 43510, 43520, 43605, 43610, 43611, 43620, 43621, 43622, 43631, 43632, 43633, 43634, 43640, 43641, 43644, 43645, 43651, 43652, 43653, 43800, 43810, 43820, 43825, 43830, 43832, 43840, 43843, 43845, 43846, 43847, 43848, 43850, 43855, 43860, 43865, 43870, 43880
Small Intestine	44005, 44010, 44020, 44021, 44050, 44055, 44100, 44120, 44125, 44126, 44127, 44130, 44132, 44133, 44135, 44136
Colon	44140, 44141, 44143, 44144, 44145, 44146, 44147, 44150, 44151, 44155, 44156, 44157, 44158, 44160, 44180, 44186, 44187, 44188, 44202, 44204, 44205, 44206, 44207, 44208, 44210, 44211, 44212, 44227, 44300, 44310, 44312, 44314, 44316, 44320, 44322, 44340,

SURGICAL PROCEDURE	CPT CODE
	44345, 44346, 44602, 44603, 44604, 44605, 44615, 44620, 44625, 44626, 44640, 44650, 44660, 44661, 44680, 44700
Rectum	45000, 45020, 45108, 45110, 45111, 45112, 45113, 45114, 45116, 45119, 45120, 45121, 45123, 45126, 45130, 45135, 45136, 45150, 45160, 45171, 45172, 45190, 45395, 45397, 45400, 45402, 45500, 45505, 45540, 45541, 45550, 45560, 45562, 45563, 45800, 45805, 45820, 45825
Biliary	47400, 47420, 47425, 47460, 47480, 47560, 47561, 47562, 47563, 47564, 47570, 47600, 47605, 47610, 47612, 47620, 47630, 47700, 47701, 47711, 47712, 47715, 47720, 47721, 47740, 47741, 47760, 47765, 47780, 47785, 47800, 47801, 47802, 47900
Pancreas	48000, 48001, 48020, 48100, 48102, 48105, 48120, 48140, 48145, 48146, 48148, 48150, 48152, 48153, 48154, 48155, 48500, 48510, 48520, 48540, 48545, 48547, 48548, 48554, 48556
Abdomen, Peritoneum, & Omentum	27080, 27158, 27202, 27280, 27282, 49000, 49002, 49010, 49020, 49040, 49060, 49203, 49204, 49205, 49215, 49220, 49250, 49320, 49321, 49322, 49323, 49505, 49507, 49568
Renal Transplant	50320, 50340, 50360, 50365, 50370, 50380
Gynecologic Surgery	57267, 58150, 58152, 58180, 58200, 58210, 58240, 58260, 58262, 58263, 58267, 58270, 58275, 58280, 58285, 58290, 58291, 58292, 58293, 58294, 58951, 58953, 58954, 58956
Acoustic Neuroma	61520, 61526, 61530, 61591, 61595, 61596, 61598, 61606, 61616, 61618, 61619, 69720, 69955, 69960, 69970
Cochlear Implants	69930
Neurological Surgery	22524, 22551, 22554, 22558, 22600, 22612, 22630, 22633, 61154, 61312, 61313, 61315, 61510, 61512, 61518, 61548, 61697, 61700, 61750, 61751, 61867, 62223, 62230, 63015, 63020, 63030, 63042, 63045, 63046, 63047, 63056, 63075, 63081, 63267, 63276
Cardiothoracic (Pacemaker)	33203, 33206, 33207, 33208, 33212, 33213, 33214, 33215, 33216, 33217, 33218, 33220, 33222, 33223, 33224, 33225, 33226, 33233, 33234, 33235, 33236, 33237, 33238, 33240, 33241, 33243, 33244, 33249, 33254, 33255
General Thoracic Surgery	0236T, 21627, 21632, 21740, 21750, 21805, 21825, 31760, 31766, 31770, 31775, 31786, 31805, 32096, 32097, 32098, 32100, 32110, 32120, 32124, 32140, 32141, 32150, 32215, 32220, 32225, 32310, 32320, 32440, 32442, 32445, 32480, 32482, 32484, 32486, 32488, 32491, 32505, 32506, 32507 32800, 32810, 32815, 32900, 32905, 32906, 32940, 33020, 33025, 33030, 33031, 33050, 33300, 33310, 33320, 33361, 33362, 33363, 33364, 34051, 35021, 35211, 35216, 35241, 35246, 35271, 35276, 35311, 35526, 37616, 38381, 38746, 39000, 39010, 39200, 39220, 39545, 39561, 64746
Foot & Ankle	27702, 27703, 27704, 28192, 28193, 28293, 28415, 28420, 28445, 28465, 28485, 28505, 28525, 28531, 28555, 28585, 28615, 28645, 28675, 28705, 28715, 28725, 28730, 28735, 28737
Spleen and Lymphatic	38100, 38101, 38115, 38120, 38571, 38572, 38700, 38720, 38724, 38740, 38745, 38747, 38760, 38765, 38770, 38780
Mediastinum and Diaphragm	39501, 39540, 39541, 39545, 39560, 39561
Bariatric	43770, 43771, 43772, 43773, 43774, 43775, 43843, 43845, 43846, 43847, 43848, 43886, 43887, 43888

SURGICAL PROCEDURE	CPT CODE
Meckel's Diverticulum and Appendix	44800, 44820, 44850, 44900, 44950, 44955, 44960, 44970
Liver	47100, 47120, 47122, 47125, 47130, 47140, 47141, 47142, 47350, 47370, 47371, 47380, 47381
General Surgery	23470, 23472, 23473, 23474, 23616, 24363, 24370, 24371, 60505

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 (eg, "to be given every 8 hours for three doses" or for "one time" IV dose orders) OR documentation that prophylactic parenteral antibiotic ***was*** discontinued within 24 hours of surgical end time.

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

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Documentation of Order for Discontinuation of Prophylactic Parenteral Antibiotics (written order, verbal order, or standing order/protocol) Within 24 Hours of Surgical End Time
*(Two CPT II codes **[4049F & 4046F]** are required on the claim form to submit this numerator option)*
Performance Met:
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.
Medical Performance Exclusion:
4049F *with* 1P: Documentation of medical reason(s) for not discontinuing prophylactic antibiotics within 24 hours of surgical end time (eg, patients enrolled in clinical trials, patients with documented infection prior to surgical procedure of interest, patients who had other procedures requiring general or spinal anesthesia that occurred within three days prior to the procedure of interest [during separate surgical episodes], patients who were receiving antibiotics more than 24 hours prior

to surgery [except colon surgery patients taking oral prophylactic antibiotics], patients who were receiving antibiotics within 24 hours prior to arrival [except colon surgery patients taking oral prophylactic antibiotics], patients who received urinary antiseptics only, other medical reason(s))

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)*

Other Performance Exclusion: **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.

Performance Not Met:

4049F *with* 8P: Order was **not** given to discontinue prophylactic antibiotics within 24 hours of surgical end time, non-cardiac procedure, reason not otherwise specified

AND

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

RATIONALE:

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

CLINICAL RECOMMENDATION STATEMENTS:

The shortest effective duration of antimicrobial administration for preventing SSI is not known; however, evidence is mounting that postoperative antimicrobial administration is not necessary for most procedures. The duration of an antimicrobial prophylaxis should be less than 24 hours for most procedures. (ASHP, 2013)

Prophylactic antimicrobials should be discontinued within 24 hours after the operation. (SIPGWW, 2004)

+ Measure #23 (NQF 0239): Perioperative Care: Venous Thromboembolism (VTE) Prophylaxis (When Indicated in ALL Patients) – National Quality Strategy Domain: Patient Safety

2015 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of surgical patients aged 18 years and older undergoing procedures for which VTE prophylaxis is indicated in all patients, who had an order for Low Molecular Weight Heparin (LMWH), Low-Dose Unfractionated Heparin (LDUH), adjusted-dose warfarin, fondaparinux or mechanical prophylaxis to be given within 24 hours prior to incision time or within 24 hours after surgery end time

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

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

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

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

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

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

> **Denominator Instructions:** CPT Category I procedure codes billed by surgeons performing surgery on the same patient, submitted with modifier 62 (indicating two surgeons, ie, dual procedures) will be included in the denominator population. Both surgeons participating in the PQRS will be fully accountable for the clinical action described in the measure.
>
> **Denominator Criteria (Eligible Cases):**
> Patients aged ≥ 18 years on date of encounter
> **AND**
> **Patient encounter during the reporting period (CPT):** Listed below are surgical procedures for which VTE prophylaxis is indicated

SURGICAL PROCEDURE	CPT CODE
Neurological Surgery	22551, 22554, 22558, 22600, 22612, 22630, 22633, 61312, 61313, 61315, 61510, 61512, 61518, 61548, 61697, 61700, 62223, 62230, 63015, 63020, 63030, 63042, 63045, 63046, 63047, 63056, 63075, 63081, 63267, 63276
Hip Reconstruction	27125, 27130, 27132, 27134, 27137, 27138
Knee Reconstruction	27440, 27441, 27442, 27443, 27445, 27446, 27447
Genitourinary Surgery	50020, 50220, 50225, 50230, 50234, 50236, 50240, 50543, 50545, 50546, 50547, 50548, 50715, 50722, 50725, 50727, 50728, 50760, 50770, 50780, 50782, 50783, 50785, 50800, 50810, 50815, 50820, 50947, 50948, 51550, 51555, 51565, 51570, 51575, 51580, 51585, 51590, 51595, 51596, 51597, 51800, 51820, 51900, 51920, 51925, 51960, 55810, 55812, 55815, 55821, 55831, 55840, 55842, 55845, 55866
Gynecologic Surgery	56630, 56631, 56632, 56633, 56634, 56637, 56640, 57267, 58150, 58152, 58180, 58200, 58210, 58240, 58260, 58262, 58263, 58267, 58270, 58275, 58280, 58285, 58290, 58291, 58292, 58293, 58294, 58951, 58953, 58954, 58956
Hip Fracture Surgery	27235, 27236, 27244, 27245, 27269
Le Fort Fractures	21346, 21347, 21348, 21422, 21423, 21432, 21433, 21435, 21436
Mandibular Fractures	21454, 21461, 21462, 21465, 21470
General Thoracic (Non-Cardiac)	0236T, 21627, 21632, 21740, 21750, 21805, 21825, 31760, 31766, 31770, 31775, 31786, 31805, 32096, 32097, 32098, 32100, 32110, 32120, 32124, 32140, 32141, 32150, 32215, 32220, 32225, 32310, 32320, 32440, 32442, 32445, 32480, 32482, 32484, 32486, 32488, 32491, 32505, 32506, 32507, 32800, 32810, 32815, 32900, 32905, 32906, 32940, 33020, 33025, 33030, 33031, 33050, 33300, 33310, 33320, 34051, 35021, 35211, 35216, 35241, 35246, 35271, 35276, 35311, 35526, 37616, 38381, 38746, 39000, 39010, 39200, 39220, 39545, 39561, 64746
Laryngectomy	31360, 31365, 31367, 31368, 31370, 31375, 31380, 31382, 31390, 31395
Vascular	27880, 27881, 27882, 27884, 27886, 27888, 33361, 33362, 33363, 33364, 33365, 33366, 33877, 33880, 33881, 33883, 33886, 33889, 33891, 34800, 34802, 34803, 34804, 34805, 34812, 34820, 34825, 34830, 34831, 34832, 34833, 34834, 34841, 34842, 34843, 34844, 34845, 34846, 34847, 34848, 34900, 35011, 35013, 35081, 35082, 35091, 35092, 35102, 35103, 35131, 35141, 35142, 35151, 35152, 35206, 35266, 35301, 35363, 35371, 35372, 35460, 35512, 35521, 35522, 35523, 35525, 35533, 35537, 35538, 35539, 35540, 35556, 35558, 35565, 35566, 35570, 35571, 35572, 35583, 35585, 35587, 35601, 35606, 35612, 35616, 35621, 35623, 35626, 35631, 35632, 35633, 35634, 35636, 35637, 35638, 35642, 35645, 35646, 35647, 35650, 35654, 35656, 35661, 35663, 35665, 35666, 35671, 36830, 37224, 37225, 37226, 37227, 37228, 37229, 37230, 37231, 37617
Glossectomy	41130, 41135, 41140, 41145, 41150, 41153, 41155
Acoustic Neuroma	61520, 61526, 61530, 61591, 61595, 61596, 61598, 61606, 61616, 61618, 61619, 69720, 69955, 69960, 69970

SURGICAL PROCEDURE	CPT CODE
General Surgery	15734, 15830, 15832, 15833, 15834, 15835, 15836, 15837, 19260, 19271, 19272, 19300, 19301, 19302, 19303, 19304, 19305, 19306, 19307, 19316, 19318, 19324, 19361, 19364, 19366, 19367, 19368, 19369, 19380, 27080, 27158, 27202, 27280, 27282, 38100, 38101, 38115, 38120, 38571, 38572, 38700, 38720, 38724, 38747, 38760, 38765, 38770, 38780, 39501, 39540, 39541, 39545, 39560, 39561, 43020, 43030, 43045, 43100, 43101, 43107, 43108, 43112, 43113, 43116, 43117, 43118, 43121, 43122, 43123, 43124, 43130, 43135, 43279, 43280, 43281, 43282, 43300, 43305, 43310, 43312, 43313, 43314, 43320, 43325, 43327, 43328, 43330, 43331, 43332, 43333, 43334, 43335, 43336, 43337, 43340, 43341, 43350, 43351, 43352, 43360, 43361, 43400, 43401, 43405, 43410, 43415, 43420, 43425, 43496, 43500, 43501, 43502, 43510, 43520, 43605, 43610, 43611, 43620, 43621, 43622, 43631, 43632, 43633, 43634, 43640, 43641, 43644, 43645, 43651, 43652, 43653, 43770, 43771, 43772, 43773, 43774, 43800, 43810, 43820, 43825, 43830, 43832, 43840, 43843, 43845, 43846, 43847, 43848, 43850, 43855, 43860, 43865, 43870, 43880, 43886, 43887, 43888, 44005, 44010, 44020, 44021, 44025, 44050, 44055, 44110, 44111, 44120, 44125, 44126, 44127, 44130, 44140, 44141, 44143, 44144, 44145, 44146, 44147, 44150, 44151, 44155, 44156, 44157, 44158, 44160, 44180, 44186, 44187, 44188, 44202, 44204, 44205, 44206, 44207, 44208, 44210, 44211, 44212, 44227, 44300, 44310, 44312, 44314, 44316, 44320, 44322, 44340, 44345, 44346, 44602, 44603, 44604, 44605, 44615, 44620, 44625, 44626, 44640, 44650, 44660, 44661, 44680, 44700, 44800, 44820, 44850, 44900, 44950, 44955, 44960, 44970, 45000, 45020, 45100, 45108, 45110, 45111, 45112, 45113, 45114, 45116, 45119, 45120, 45121, 45123, 45126, 45130, 45135, 45136, 45150, 45160, 45171, 45172, 45190, 45395, 45397, 45400, 45402, 45500, 45505, 45540, 45541, 45550, 45560, 45562, 45563, 45800, 45805, 45820, 45825, 46715, 46716, 46730, 46735, 46740, 46742, 46744, 46746, 46748, 46750, 46751, 46753, 46754, 46760, 46761, 46762, 47010, 47015, 47100, 47120, 47122, 47125, 47130, 47135, 47136, 47140, 47141, 47142, 47300, 47350, 47360, 47361, 47362, 47370, 47371, 47380, 47381, 47382, 47400, 47420, 47425, 47460, 47480, 47500, 47505, 47560, 47561, 47562, 47563, 47564, 47570, 47600, 47605, 47610, 47612, 47620, 47630, 47700, 47701, 47711, 47712, 47715, 47720, 47721, 47740, 47741, 47760, 47765, 47780, 47785, 47800, 47801, 47802, 47900, 48000, 48001, 48020, 48100, 48102, 48105, 48120, 48140, 48145, 48146, 48148, 48150, 48152, 48153, 48154, 48155, 48500, 48510, 48520, 48540, 48545, 48547, 48548, 48554, 48556, 49000, 49002, 49010, 49020, 49040, 49060, 49203, 49204, 49205, 49215, 49220, 49250, 49255, 49320, 49321, 49322, 49323, 49505, 49507, 49560, 49561, 49565, 49566, 49570, 50320, 50340, 50360, 50365, 50370, 50380, 60200, 60210, 60212, 60220, 60225, 60240, 60252, 60254, 60260, 60270, 60271, 60280, 60281, 60500, 60502, 60505, 60520, 60521, 60522, 60540, 60545, 60600, 60605, 60650

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

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

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

CLINICAL RECOMMENDATION STATEMENTS:
For general and abdominal-pelvic surgery patients at very low risk for VTE (< 0.5%; Rogers score, < 7; Caprini score, 0), we recommend that no specific pharmacologic (Grade 1B) or mechanical (Grade 2C) prophylaxis be used other than early ambulation. (ACCP, 2012)

For general and abdominal-pelvic surgery patients at low risk for VTE (~ 1.5%; Rogers score, 7-10; Caprini score, 1-2), we suggest mechanical prophylaxis, preferably with intermittent pneumatic compression (IPC), over no prophylaxis. (Grade 2C) (ACCP, 2012)

For general and abdominal-pelvic surgery patients at moderate risk for VTE (~ 3.0%; Rogers score, > 10; Caprini score, 3-4) who are not at high risk for major bleeding complications, we suggest LMWH (Grade 2B), LDUH (Grade 2B), or mechanical prophylaxis, preferably with IPC (Grade 2C), over no prophylaxis. (ACCP, 2012)

For general and abdominal-pelvic surgery patients at moderate risk for VTE (3.0%; Rogers score, > 10; Caprini score, 3-4) who are at high risk for major bleeding complications or those in whom the consequences of bleeding are thought to be particularly severe, we suggest mechanical prophylaxis, preferably with IPC, over no prophylaxis. (Grade 2C) (ACCP, 2012)

For general and abdominal-pelvic surgery patients at high risk for VTE (~ 6.0%; Caprini score, ≥ 5) who are not at high risk for major bleeding complications, we recommend pharmacologic prophylaxis with LMWH (Grade 1B) or LDUH (Grade 1B) over no prophylaxis. We suggest that mechanical prophylaxis with elastic stockings or IPC should be added to pharmacologic prophylaxis. (Grade 2C) (ACCP, 2012)

For high-VTE-risk patients undergoing abdominal or pelvic surgery for cancer who are not otherwise at high risk for major bleeding complications, we recommend extended-duration pharmacologic prophylaxis (4 weeks) with LMWH over limited-duration prophylaxis. (Grade 1B) (ACCP, 2012)

For high-VTE-risk general and abdominal pelvic surgery patients who are at high risk for major bleeding complications or those in whom the consequences of bleeding are thought to be particularly severe, we suggest use of mechanical prophylaxis, preferably with IPC, over no prophylaxis until the risk of bleeding diminishes and pharmacologic prophylaxis may be initiated. (Grade 2C) (ACCP, 2012)

For general and abdominal-pelvic surgery patients at high risk for VTE (6%; Caprini score, ≥ 5) in whom both LMWH and unfractionated heparin are contraindicated or unavailable and who are not at high risk for major bleeding complications, we suggest low-dose aspirin (Grade 2C), fondaparinux (Grade 2C), or mechanical prophylaxis, preferably with IPC (Grade 2C), over no prophylaxis. (ACCP, 2012)

For general and abdominal-pelvic surgery patients, we suggest that an inferior vena cava (IVC) filter should not be used for primary VTE prevention. (Grade 2C) (ACCP, 2012)

For general and abdominal-pelvic surgery patients, we suggest that periodic surveillance with venous compression ultrasound should not be performed. (Grade 2C) (ACCP, 2012)

For cardiac surgery patients with an uncomplicated postoperative course, we suggest use of mechanical prophylaxis, preferably with optimally applied IPC, over either no prophylaxis (Grade 2C) or pharmacologic prophylaxis. (Grade 2C) (ACCP, 2012)

For thoracic surgery patients at moderate risk for VTE who are not at high risk for perioperative bleeding, we suggest LDUH (Grade 2B), LMWH (Grade 2B), or mechanical prophylaxis with optimally applied IPC (Grade 2C) over no prophylaxis. (ACCP, 2012)

For thoracic surgery patients at high risk for VTE who are not at high risk for perioperative bleeding, we suggest LDUH (Grade 1B) or LMWH (Grade 1B) over no prophylaxis. In addition, we suggest that mechanical prophylaxis with elastic stockings or IPC should be added to pharmacologic prophylaxis. (Grade 2C) (ACCP, 2012)

For thoracic surgery patients who are at high risk for major bleeding, we suggest use of mechanical prophylaxis, preferably with optimally applied IPC, over no prophylaxis until the risk of bleeding diminishes and pharmacologic prophylaxis may be initiated. (Grade 2C) (ACCP, 2012)

For craniotomy patients, we suggest that mechanical prophylaxis, preferably with IPC, be used over no prophylaxis (Grade 2C) or pharmacologic prophylaxis (Grade 2C). (ACCP, 2012)

For craniotomy patients at very high risk for VTE (eg, those undergoing craniotomy for malignant disease), we suggest adding pharmacologic prophylaxis to mechanical prophylaxis once adequate hemostasis is established and the risk of bleeding decreases. (Grade 2C) (ACCP, 2012)

For patients undergoing spinal surgery, we suggest mechanical prophylaxis, preferably with IPC, over no prophylaxis (Grade 2C), unfractionated heparin (Grade 2C), or LMWH. (Grade 2C) (ACCP, 2012)

For patients undergoing spinal surgery at high risk for VTE (including those with malignant disease or those undergoing surgery with a combined anterior-posterior approach), we suggest adding pharmacologic prophylaxis to mechanical prophylaxis once adequate hemostasis is established and the risk of bleeding decreases. (Grade 2C) (ACCP, 2012)

For major trauma patients, we suggest use of LDUH (Grade 2C), LMWH (Grade 2C), or mechanical prophylaxis, preferably with IPC (Grade 2C), over no prophylaxis. (ACCP, 2012)

For major trauma patients at high risk for VTE (including those with acute spinal cord injury, traumatic brain injury, and spinal surgery for trauma), we suggest adding mechanical prophylaxis to pharmacologic prophylaxis (Grade 2C) when not contraindicated by lower extremity injury. (ACCP, 2012)

For major trauma patients in whom LMWH and LDUH are contraindicated, we suggest mechanical prophylaxis, preferably with IPC, over no prophylaxis (Grade 2C) when not contraindicated by lower-extremity injury. We suggest adding pharmacologic prophylaxis with either LMWH or LDUH when the risk of bleeding diminishes or the contraindication to heparin resolves. (Grade 2C) (ACCP, 2012)

For major trauma patients, we suggest that an IVC filter should not be used for primary VTE prevention. (Grade 2C) (ACCP, 2012)

For major trauma patients, we suggest that periodic surveillance with venous compression ultrasound should not be performed. (Grade 2C) (ACCP, 2012)

In patients undergoing THA or TKA, we recommend use of one of the following for a minimum of 10 to 14 days rather than no antithrombotic prophylaxis: low-molecular-weight heparin (LMWH), fondaparinux, apixaban, dabigatran, rivaroxaban, low-dose unfractionated heparin (LDUH), adjusted-dose VKA, aspirin (all Grade 1B), or an intermittent pneumatic compression device (IPCD) (Grade 1C). (ACCP, 2012)

In patients undergoing HFS, we recommend use of one of the following rather than no antithrombotic prophylaxis for a minimum of 10 to 14 days: LMWH, fondaparinux, LDUH, adjusted-dose VKA, aspirin (all Grade 1B), or an IPCD. (Grade 1C) (ACCP, 2012)

For patients undergoing major orthopedic surgery (THA, TKA, HFS) and receiving LMWH as thromboprophylaxis, we recommend starting either 12 h or more preoperatively or 12 h or more postoperatively rather than within 4 h or less preoperatively or 4 h or less postoperatively. (Grade 1B) (ACCP, 2012)

In patients undergoing THA or TKA, irrespective of the concomitant use of an IPCD or length of treatment, we suggest the use of LMWH in preference to the other agents we have recommended as alternatives: fondaparinux, apixaban, dabigatran, rivaroxaban, LDUH (all Grade 2B), adjusted-dose VKA, or aspirin. (all Grade 2C) (ACCP, 2012)

In patients undergoing HFS, irrespective of the concomitant use of an IPCD or length of treatment, we suggest the use of LMWH in preference to the other agents we have recommended as alternatives: fondaparinux, LDUH (Grade 2B), adjusted-dose VKA, or aspirin. (all Grade 2C) (ACCP, 2012)

For patients undergoing major orthopedic surgery, we suggest extending thromboprophylaxis in the outpatient period for up to 35 days from the day of surgery rather than for only 10 to 14 days. (Grade 2B) (ACCP, 2012)

In patients undergoing major orthopedic surgery, we suggest using dual prophylaxis with an antithrombotic agent and an IPCD during the hospital stay. (Grade 2C) (ACCP, 2012)

In patients undergoing major orthopedic surgery and increased risk of bleeding, we suggest using an IPCD or no prophylaxis rather than pharmacologic treatment. (Grade 2C) (ACCP, 2012)

In patients undergoing major orthopedic surgery and who decline or are uncooperative with injections or an IPCD, we recommend using apixaban or dabigatran (alternatively rivaroxaban or adjusted-dose VKA if apixaban or dabigatran are unavailable) rather than alternative forms of prophylaxis. (all Grade 1B) (ACCP, 2012)

In patients undergoing major orthopedic surgery, we suggest against using IVC filter placement for primary prevention over no thromboprophylaxis in patients with an increased bleeding risk or contraindications to both pharmacologic and mechanical thromboprophylaxis. (Grade 2C) (ACCP, 2012)

For asymptomatic patients following major orthopedic surgery, we recommend against Doppler (or duplex) ultrasound screening before hospital discharge. (Grade 1B) (ACCP, 2012)

We suggest no prophylaxis rather than pharmacologic thromboprophylaxis in patients with isolated lower-leg injuries requiring leg immobilization. (Grade 2C) (ACCP, 2012)

For patients undergoing knee arthroscopy without a history of prior VTE, we suggest no thromboprophylaxis rather than prophylaxis. (Grade 2B) (ACCP, 2012)

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

2015 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

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

INSTRUCTIONS:
This measure is to be reported after **each occurrence** of a fracture during the reporting period. It is anticipated that **clinicians who treat the hip, spine, or distal radial fracture** will submit this measure. Each occurrence of a fracture is identified by either an ICD-9-CM/ICD-10-CM diagnosis code for fracture or osteoporosis and a CPT service code OR an ICD-9-CM/ICD-10-CM diagnosis code for fracture or osteoporosis and a CPT procedure code for surgical treatment of a fracture**.**

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

Measure Reporting via Claims:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT or HCPCS codes, and patient demographics are used to identify patients who are included in the measure's denominator. CPT Category II codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed ICD-9-CM/ICD-10-CM diagnosis codes, CPT or HCPCS codes, and the appropriate CPT Category II code **OR** the CPT Category II code **with** the modifier. The modifiers allowed for this measure are: 1P- medical reasons, 2P- patient reasons, 8P- reason not otherwise specified. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT or HCPCS codes, and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

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

DENOMINATOR:
All patients aged 50 years and older treated for hip, spine, or distal radial fracture. Eligible cases are determined, and must be reported, if either of the following conditions are met:

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

AND

Diagnosis for hip, spine or distal radial fracture (ICD-9-CM) [for use 1/1/2015-9/30/2015]: 733.12, 733.13, 733.14, 733.15, 733.19, 805.00, 805.01, 805.02, 805.03, 805.04, 805.05, 805.06, 805.07, 805.08, 805.11, 805.12, 805.13, 805.14, 805.15, 805.16, 805.17, 805.2, 805.3, 805.4, 805.5, 805.6, 805.7, 805.8, 808.0, 808.1, 813.40, 813.41, 813.42, 813.43, 813.44, 813.45, 813.46, 813.47, 813.50, 813.51, 813.52, 813.53, 813.54, 820.00, 820.01, 820.02, 820.03, 820.09, 820.10, 820.11, 820.12, 820.13, 820.19, 820.20, 820.21, 820.22, 820.30, 820.31, 820.32, 820.8, 820.9

Diagnosis for hip, spine or distal radial fracture (ICD-10-CM) [for use 10/01/2015-12/31/2015]: M84.431A, M84.432A, M84.433A, M84.434A, M84.439A, M84.451A, M84.452A, M84.453A, M84.454A, M84.459A, M84.48XA, S12.000A, S12.000B, S12.001A, S12.001B, S12.01XA, S12.01XB, S12.02XA, S12.02XB, S12.030A, S12.030B, S12.031A, S12.031B, S12.040A, S12.040B, S12.041A, S12.041B, S12.090A, S12.090B, S12.091A, S12.091B, S12.100A, S12.100B, S12.101A, S12.101B, S12.110A, S12.110B, S12.111A, S12.111B, S12.112A, S12.112B, S12.120A, S12.120B, S12.121A, S12.121B, S12.130A, S12.130B, S12.131A, S12.131B, S12.14XA, S12.14XB, S12.150A, S12.150B, S12.151A, S12.151B, S12.190A, S12.190B, S12.191A, S12.191B, S12.200A, S12.200B, S12.201A, S12.201B, S12.230A, S12.230B, S12.231A, S12.231B, S12.24XA, S12.24XB, S12.250A, S12.250B, S12.251A, S12.251B, S12.290A, S12.290B, S12.291A, S12.291B, S12.300A, S12.300B, S12.301A, S12.301B, S12.330A, S12.330B, S12.331A, S12.331B, S12.34XA, S12.34XB, S12.350A, S12.350B, S12.351A, S12.351B, S12.390A, S12.390B, S12.391A, S12.391B, S12.400A, S12.400B, S12.401A, S12.401B, S12.430A, S12.430B, S12.431A, S12.431B, S12.44XA, S12.44XB, S12.450A, S12.450B, S12.451A, S12.451B, S12.490A, S12.490B, S12.491A, S12.491B, S12.500A, S12.500B, S12.501A, S12.501B, S12.530A, S12.530B, S12.531A, S12.531B, S12.54XA, S12.54XB, S12.550A, S12.550B, S12.551A, S12.551B, S12.590A, S12.590B, S12.591A, S12.591B, S12.600A, S12.600B, S12.601A, S12.601B, S12.630A, S12.630B, S12.631A, S12.631B, S12.64XA, S12.64XB, S12.650A, S12.650B, S12.651A, S12.651B, S12.690A, S12.690B, S12.691A, S12.691B, S12.8XXA, S12.9XXA, S22.000A, S22.000B, S22.001A, S22.001B, S22.002A, S22.002B, S22.008A, S22.008B, S22.009A, S22.009B, S22.010A, S22.010B, S22.011A, S22.011B, S22.012A, S22.012B, S22.018A, S22.018B, S22.019A, S22.019B, S22.020A, S22.020B, S22.021A, S22.021B, S22.022A, S22.022B, S22.028A, S22.028B, S22.029A, S22.029B, S22.030A, S22.030B, S22.031A, S22.031B, S22.032A, S22.032B, S22.038A, S22.038B, S22.039A, S22.039B, S22.040A, S22.040B, S22.041A, S22.041B, S22.042A, S22.042B, S22.048A, S22.048B, S22.049A, S22.049B, S22.050A, S22.050B, S22.051A, S22.051B, S22.052A, S22.052B, S22.058A, S22.058B, S22.059A, S22.059B, S22.060A, S22.060B, S22.061A, S22.061B, S22.062A, S22.062B, S22.068A, S22.068B, S22.069A, S22.069B, S22.070A, S22.070B, S22.071A, S22.071B, S22.072A, S22.072B, S22.078A, S22.078B, S22.079A, S22.079B, S22.080A, S22.080B, S22.081A, S22.081B, S22.082A, S22.082B, S22.088A, S22.088B, S22.089A, S22.089B, S32.000A, S32.000B, S32.001A, S32.001B, S32.002A, S32.002B, S32.008A, S32.008B, S32.009A, S32.009B, S32.010A, S32.010B, S32.011A, S32.011B, S32.012A, S32.012B, S32.018A, S32.018B, S32.019A, S32.019B, S32.020A, S32.020B, S32.021A, S32.021B, S32.022A, S32.022B, S32.028A, S32.028B, S32.029A, S32.029B, S32.030A, S32.030B, S32.031A, S32.031B, S32.032A, S32.032B, S32.038A, S32.038B, S32.039A, S32.039B, S32.040A, S32.040B, S32.041A, S32.041B, S32.042A, S32.042B, S32.048A, S32.048B, S32.049A, S32.049B, S32.050A, S32.050B, S32.051A, S32.051B, S32.052A, S32.052B, S32.058A, S32.058B, S32.059A, S32.059B, S32.10XA, S32.10XB, S32.110A, S32.110B, S32.111A, S32.111B, S32.112A, S32.112B, S32.119A, S32.119B, S32.120A, S32.120B, S32.121A, S32.121B, S32.122A, S32.122B, S32.129A, S32.129B, S32.130A, S32.130B, S32.131A, S32.131B, S32.132A, S32.132B, S32.139A, S32.139B, S32.14XA, S32.14XB, S32.15XA, S32.15XB, S32.16XA, S32.16XB, S32.17XA, S32.17XB, S32.19XA, S32.19XB, S32.2XXA, S32.2XXB, S32.401A, S32.401B, S32.402A, S32.402B, S32.409A, S32.409B, S32.411A, S32.411B, S32.412A, S32.412B, S32.413A, S32.413B, S32.414A, S32.414B, S32.415A, S32.415B, S32.416A, S32.416B, S32.421A, S32.421B, S32.422A, S32.422B, S32.423A, S32.423B, S32.424A, S32.424B, S32.425A, S32.425B, S32.426A, S32.426B, S32.431A, S32.431B, S32.432A, S32.432B, S32.433A, S32.433B, S32.434A, S32.434B, S32.435A, S32.435B, S32.436A, S32.436B, S32.441A, S32.441B, S32.442A, S32.442B, S32.443A, S32.443B,

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AND

Patient encounter during the reporting period (CPT or HCPCS): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99238, 99239, G0402

OR

Option 2 - Denominator Criteria (Eligible Cases):

Patients aged ≥ 50 years on the date of encounter

AND

Diagnosis for hip, spine or distal radial fracture (ICD-9-CM) [for use 1/1/2015-9/30/2015]: 733.12, 733.13, 733.14, 733.15, 733.19, 805.00, 805.01, 805.02, 805.03, 805.04, 805.05, 805.06, 805.07, 805.08, 805.11, 805.12, 805.13, 805.14, 805.15, 805.16, 805.17, 805.2, 805.3, 805.4, 805.5, 805.6, 805.7, 805.8, 808.0, 808.1, 813.40, 813.41, 813.42, 813.43, 813.44, 813.45, 813.46, 813.47, 813.50, 813.51, 813.52,

813.53, 813.54, 820.00, 820.01, 820.02, 820.03, 820.09, 820.10, 820.11, 820.12, 820.13, 820.19, 820.20, 820.21, 820.22, 820.30, 820.31, 820.32, 820.8, 820.9

Diagnosis for hip, spine or distal radial fracture (ICD-10-CM) [for use 10/01/2015-12/31/2015]:
M84.431A, M84.432A, M84.433A, M84.434A, M84.439A, M84.451A, M84.452A, M84.453A, M84.454A, M84.459A, M84.48XA**,** S12.000A, S12.000B, S12.001A, S12.001B, S12.01XA, S12.01XB, S12.02XA, S12.02XB, S12.030A, S12.030B, S12.031A, S12.031B, S12.040A, S12.040B, S12.041A, S12.041B, S12.090A, S12.090B, S12.091A, S12.091B, S12.100A, S12.100B, S12.101A, S12.101B, S12.110A, S12.110B, S12.111A, S12.111B, S12.112A, S12.112B, S12.120A, S12.120B, S12.121A, S12.121B, S12.130A, S12.130B, S12.131A, S12.131B, S12.14XA, S12.14XB, S12.150A, S12.150B, S12.151A, S12.151B, S12.190A, S12.190B, S12.191A, S12.191B, S12.200A, S12.200B, S12.201A, S12.201B, S12.230A, S12.230B, S12.231A, S12.231B, S12.24XA, S12.24XB, S12.250A, S12.250B, S12.251A, S12.251B, S12.290A, S12.290B, S12.291A, S12.291B, S12.300A, S12.300B, S12.301A, S12.301B, S12.330A, S12.330B, S12.331A, S12.331B, S12.34XA, S12.34XB, S12.350A, S12.350B, S12.351A, S12.351B, S12.390A, S12.390B, S12.391A, S12.391B, S12.400A, S12.400B, S12.401A, S12.401B, S12.430A, S12.430B, S12.431A, S12.431B, S12.44XA, S12.44XB, S12.450A, S12.450B, S12.451A, S12.451B, S12.490A, S12.490B, S12.491A, S12.491B, S12.500A, S12.500B, S12.501A, S12.501B, S12.530A, S12.530B, S12.531A, S12.531B, S12.54XA, S12.54XB, S12.550A, S12.550B, S12.551A, S12.551B, S12.590A, S12.590B, S12.591A, S12.591B, S12.600A, S12.600B, S12.601A, S12.601B, S12.630A, S12.630B, S12.631A, S12.631B, S12.64XA, S12.64XB, S12.650A, S12.650B, S12.651A, S12.651B, S12.690A, S12.690B, S12.691A, S12.691B, S12.8XXA, S12.9XXA, S22.000A, S22.000B, S22.001A, S22.001B, S22.002A, S22.002B, S22.008A, S22.008B, S22.009A, S22.009B, S22.010A, S22.010B, S22.011A, S22.011B, S22.012A, S22.012B, S22.018A, S22.018B, S22.019A, S22.019B, S22.020A, S22.020B, S22.021A, S22.021B, S22.022A, S22.022B, S22.028A, S22.028B, S22.029A, S22.029B, S22.030A, S22.030B, S22.031A, S22.031B, S22.032A, S22.032B, S22.038A, S22.038B, S22.039A, S22.039B, S22.040A, S22.040B, S22.041A, S22.041B, S22.042A, S22.042B, S22.048A, S22.048B, S22.049A, S22.049B, S22.050A, S22.050B, S22.051A, S22.051B, S22.052A, S22.052B, S22.058A, S22.058B, S22.059A, S22.059B, S22.060A, S22.060B, S22.061A, S22.061B, S22.062A, S22.062B, S22.068A, S22.068B, S22.069A, S22.069B, S22.070A, S22.070B, S22.071A, S22.071B, S22.072A, S22.072B, S22.078A, S22.078B, S22.079A, S22.079B, S22.080A, S22.080B, S22.081A, S22.081B, S22.082A, S22.082B, S22.088A, S22.088B, S22.089A, S22.089B, S32.000A, S32.000B, S32.001A, S32.001B, S32.002A, S32.002B, S32.008A, S32.008B, S32.009A, S32.009B, S32.010A, S32.010B, S32.011A, S32.011B, S32.012A, S32.012B, S32.018A, S32.018B, S32.019A, S32.019B, S32.020A, S32.020B, S32.021A, S32.021B, S32.022A, S32.022B, S32.028A, S32.028B, S32.029A, S32.029B, S32.030A, S32.030B, S32.031A, S32.031B, S32.032A, S32.032B, S32.038A, S32.038B, S32.039A, S32.039B, S32.040A, S32.040B, S32.041A, S32.041B, S32.042A, S32.042B, S32.048A, S32.048B, S32.049A, S32.049B, S32.050A, S32.050B, S32.051A, S32.051B, S32.052A, S32.052B, S32.058A, S32.058B, S32.059A, S32.059B, S32.10XA, S32.10XB, S32.110A, S32.110B, S32.111A, S32.111B, S32.112A, S32.112B, S32.119A, S32.119B, S32.120A, S32.120B, S32.121A, S32.121B, S32.122A, S32.122B, S32.129A, S32.129B, S32.130A, S32.130B, S32.131A, S32.131B, S32.132A, S32.132B, S32.139A, S32.139B, S32.14XA, S32.14XB, S32.15XA, S32.15XB, S32.16XA, S32.16XB, S32.17XA, S32.17XB, S32.19XA, S32.19XB, S32.2XXA, S32.2XXB, S32.401A, S32.401B, S32.402A, S32.402B, S32.409A, S32.409B, S32.411A, S32.411B, S32.412A, S32.412B, S32.413A, S32.413B, S32.414A, S32.414B, S32.415A, S32.415B, S32.416A, S32.416B, S32.421A, S32.421B, S32.422A, S32.422B, S32.423A, S32.423B, S32.424A, S32.424B, S32.425A, S32.425B, S32.426A, S32.426B, S32.431A, S32.431B, S32.432A, S32.432B, S32.433A, S32.433B, S32.434A, S32.434B, S32.435A, S32.435B, S32.436A, S32.436B, S32.441A, S32.441B, S32.442A, S32.442B, S32.443A, S32.443B, S32.444A, S32.444B, S32.445A, S32.445B, S32.446A, S32.446B, S32.451A, S32.451B, S32.452A, S32.452B, S32.453A, S32.453B, S32.454A, S32.454B, S32.455A, S32.455B, S32.456A, S32.456B, S32.461A, S32.461B, S32.462A, S32.462B, S32.463A, S32.463B, S32.464A, S32.464B, S32.465A, S32.465B, S32.466A, S32.466B, S32.471A, S32.471B, S32.472A, S32.472B, S32.473A, S32.473B, S32.474A, S32.474B, S32.475A, S32.475B, S32.476A, S32.476B, S32.481A, S32.481B, S32.482A,

S32.482B, S32.483A, S32.483B, S32.484A, S32.484B, S32.485A, S32.485B, S32.486A, S32.486B, S32.491A, S32.491B, S32.492A, S32.492B, S32.499A, S32.499B, S52.501A, S52.501B, S52.501C, S52.502A, S52.502B, S52.502C, S52.509A, S52.509B, S52.509C, S52.511A, S52.511B, S52.511C, S52.512A, S52.512B, S52.512C, S52.513A, S52.513B, S52.513C, S52.514A, S52.514B, S52.514C, S52.515A, S52.515B, S52.515C, S52.516A, S52.516B, S52.516C, S52.521A, S52.522A, S52.529A, S52.531A, S52.531B, S52.531C, S52.532A, S52.532B, S52.532C, S52.539A, S52.539B, S52.539C, S52.541A, S52.541B, S52.541C, S52.542A, S52.542B, S52.542C, S52.549A, S52.549B, S52.549C, S52.551A, S52.551B, S52.551C, S52.552A, S52.552B, S52.552C, S52.559A, S52.559B, S52.559C, S52.561A, S52.561B, S52.561C, S52.562A, S52.562B, S52.562C, S52.569A, S52.569B, S52.569C, S52.571A, S52.571B, S52.571C, S52.572A, S52.572B, S52.572C, S52.579A, S52.579B, S52.579C, S52.591A, S52.591B, S52.591C, S52.592A, S52.592B, S52.592C, S52.599A, S52.599B, S52.599C, S52.609A, S52.609B, S52.609C, S52.621A, S52.622A, S52.90XA, S52.90XB, S52.90XC, S72.001A, S72.001B, S72.001C, S72.002A, S72.002B, S72.002C, S72.009A, S72.009B, S72.009C, S72.011A, S72.011B, S72.011C, S72.012A, S72.012B, S72.012C, S72.019A, S72.019B, S72.019C, S72.021A, S72.021B, S72.021C, S72.022A, S72.022B, S72.022C, S72.023A, S72.023B, S72.023C, S72.024A, S72.024B, S72.024C, S72.025A, S72.025B, S72.025C, S72.026A, S72.026B, S72.026C, S72.031A, S72.031B, S72.031C, S72.032A, S72.032B, S72.032C, S72.033A, S72.033B, S72.033C, S72.034A, S72.034B, S72.034C, S72.035A, S72.035B, S72.035C, S72.036A, S72.036B, S72.036C, S72.041A, S72.041B, S72.041C, S72.042A, S72.042B, S72.042C, S72.043A, S72.043B, S72.043C, S72.044A, S72.044B, S72.044C, S72.045A, S72.045B, S72.045C, S72.046A, S72.046B, S72.046C, S72.051A, S72.051B, S72.051C, S72.052A, S72.052B, S72.052C, S72.059A, S72.059B, S72.059C, S72.061A, S72.061B, S72.061C, S72.062A, S72.062B, S72.062C, S72.063A, S72.063B, S72.063C, S72.064A, S72.064B, S72.064C, S72.065A, S72.065B, S72.065C, S72.066A, S72.066B, S72.066C, S72.091A, S72.091B, S72.091C, S72.092A, S72.092B, S72.092C, S72.099A, S72.099B, S72.099C, S72.101A, S72.101B, S72.101C, S72.102A, S72.102B, S72.102C, S72.109A, S72.109B, S72.109C, S72.111A, S72.111B, S72.111C, S72.112A, S72.112B, S72.112C, S72.113A, S72.113B, S72.113C, S72.114A, S72.114B, S72.114C, S72.115A, S72.115B, S72.115C, S72.116A, S72.116B, S72.116C, S72.121A, S72.121B, S72.121C, S72.122A, S72.122B, S72.122C, S72.123A, S72.123B, S72.123C, S72.124A, S72.124B, S72.124C, S72.125A, S72.125B, S72.125C, S72.126A, S72.126B, S72.126C, S72.131A, S72.131B, S72.131C, S72.132A, S72.132B, S72.132C, S72.133A, S72.133B, S72.133C, S72.134A, S72.134B, S72.134C, S72.135A, S72.135B, S72.135C, S72.136A, S72.136B, S72.136C, S72.141A, S72.141B, S72.141C, S72.142A, S72.142B, S72.142C, S72.143A, S72.143B, S72.143C, S72.144A, S72.144B, S72.144C, S72.145A, S72.145B, S72.145C, S72.146A, S72.146B, S72.146C, S72.21XA, S72.21XB, S72.21XC, S72.22XA, S72.22XB, S72.22XC, S72.23XA, S72.23XB, S72.23XC, S72.24XA, S72.24XB, S72.24XC, S72.25XA, S72.25XB, S72.25XC, S72.26XA, S72.26XB, S72.26XC

AND

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

NUMERATOR:

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

Definition:

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

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Post Fracture Care Communication Documented

***Performance Met:* CPT II 5015F:** Documentation of communication that a fracture occurred and that the patient was or should be tested or treated for osteoporosis

OR

Post Fracture Care not Communicated for Medical or Patient Reasons
Append a modifier (**1P or 2P**) to CPT Category II code **5015F** to report documented circumstances that appropriately exclude patients from the denominator.

***Medical Performance Exclusion:* 5015F *with* 1P:** Documentation of medical reason(s) for not communicating with physician managing on-going care of patient that a fracture occurred and that the patient was or should be tested or treated for osteoporosis

***Patient Performance Exclusion:* 5015F *with* 2P:** Documentation of patient reason(s) for not communicating with the physician managing on-going care of patient that a fracture occurred and that the patient was or should be tested or treated for osteoporosis

OR

Post Fracture Care not Communicated, Reason not Otherwise Specified
Append a reporting modifier (**8P**) to CPT Category II code **5015F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

***Performance Not Met:* 5015F *with* 8P:** **No** documentation of communication that a fracture occurred and that the patient was or should be tested or treated for osteoporosis, reason not otherwise specified

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

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

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

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

The most commonly used measurement to diagnose osteoporosis and predict fracture risk is based on assessment of BMD by dual-energy X-ray absorptiometry (DXA). (NIH) Measurements of BMD made at the hip predict hip fracture better than measurements made at other sites while BMD measurement at the spine predicts spine fracture better than measures at other sites. (NIH)

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

* Measure #32 (NQF 0325): Stroke and Stroke Rehabilitation: Discharged on Antithrombotic Therapy – National Quality Strategy Domain: Effective Clinical Care

2015 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

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

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

Measure Reporting via Claims:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. Quality-data codes are used to report the numerator of the measure.

When reporting the measures via claims, submit the listed ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and appropriate numerator quality-data code. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

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

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

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Diagnosis for ischemic stroke or transient ischemic attack (ICD-9-CM) [for use 1/1/2015-9/30/2015]: 433.01, 433.11, 433.21, 433.31, 433.81, 433.91, 434.01, 434.11, 434.91, 435.0, 435.1, 435.2, 435.3, 435.8, 435.9
Diagnosis for ischemic stroke or transient ischemic attack (ICD-10-CM) [for use 10/01/2015-12/31/2015]: G45.0, G45.1, G45.2, G45.8, G45.9, G46.0, G46.1, G46.2, I63.00, I63.011, I63.012, I63.019, I63.02, I63.031, I63.032, I63.039, I63.09, I63.10, I63.111, I63.112, I63.119, I63.12, I63.131, I63.132, I63.139, I63.19, I63.20, I63.211, I63.212, I63.219, I63.22, I63.231, I63.232, I63.239, I63.29, I63.30, I63.311, I63.312, I63.319, I63.321, I63.322, I63.329, I63.331, I63.332, I63.339, I63.341, I63.342, I63.349, I63.39, I63.40, I63.411, I63.412, I63.419, I63.421, I63.422, I63.429, I63.431, I63.432, I63.439, I63.441, I63.442, I63.449, I63.49, I63.50, I63.511, I63.512, I63.519, I63.521, I63.531, I63.532, I63.539, I63.541, I63.542, I63.549, I63.59, I63.6, I63.8, I63.9
AND

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

NUMERATOR:
Patients who were prescribed antithrombotic therapy at discharge

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

Definitions:
Antithrombotic Therapy – Aspirin, combination of aspirin and extended-release dipyridamole, clopidogrel, ticlopidine, warfarin, low molecular weight heparin, dabigatran, rivaroxaban.*
**The above list of medications/drug names is based on clinical guidelines and other evidence. The specified drugs were selected based on the strength of evidence for their clinical effectiveness. This list of selected drugs may not be all-inclusive or current. Physicians and other health care professionals should refer to the FDA's web site page entitled "Drug Safety Communications" for up-to-date drug recall and alert information when prescribing medications.*
Prescribed – May include prescription given to the patient for antithrombotic therapy at discharge or antithrombotic therapy to be continued after discharge as documented in the discharge medication list.

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

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

OR

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

OR

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

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

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

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

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

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

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

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

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

* Measure #33 (NQF 0241): Stroke and Stroke Rehabilitation: Anticoagulant Therapy Prescribed for Atrial Fibrillation (AF) at Discharge – National Quality Strategy Domain: Effective Clinical Care

2015 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

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

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

Measure Reporting via Registry:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

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

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

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

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Diagnosis for ischemic stroke or transient ischemic attack (TIA) (ICD-9-CM) [for use 1/1/2015-9/30/2015]: 433.01, 433.11, 433.21, 433.31, 433.81, 433.91, 434.01, 434.11, 434.91, 435.0, 435.1, 435.2, 435.3, 435.8, 435.9
Diagnosis for ischemic stroke or transient ischemic attack (TIA) (ICD-10-CM) [for use 10/01/2015-12/31/2015]: G45.0, G45.1, G45.2, G45.8, G45.9, G46.0, G46.1, G46.2, I63.00, I63.011, I63.012, I63.019, I63.02, I63.031, I63.032, I63.039, I63.09, I63.10, I63.111, I63.112, I63.119, I63.12, I63.131, I63.132, I63.139, I63.19, I63.20, I63.211, I63.212, I63.219, I63.22, I63.231, I63.232, I63.239, I63.29, I63.30, I63.311, I63.312, I63.319, I63.321, I63.322, I63.329, I63.331, I63.332, I63.339, I63.341, I63.342, I63.349, I63.39, I63.40, I63.411, I63.412, I63.419, I63.421, I63.422, I63.429, I63.431, I63.432, I63.439, I63.441, I63.442, I63.449, I63.49, I63.50, I63.511, I63.512, I63.519, I63.521, I63.522, I63.529, I63.531, I63.532, I63.539, I63.541, I63.542, I63.549, I63.59, I63.6, I63.8, I63.9
AND
Diagnosis for atrial fibrillation (ICD-9-CM) [for use 1/1/2014-9/30/2014]: 427.31
Diagnosis for atrial fibrillation (ICD-10-CM) [for use 10/01/2014-12/31/2014]: I48.0, I48.1, I48.2
AND

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

NUMERATOR:
Patients who were prescribed an anticoagulant at discharge

Definitions:
Anticoagulants – warfarin, low molecular weight heparin, dabigatran, rivaroxaban*
**The above list of medications/drug names is based on clinical guidelines and other evidence. The specified drugs were selected based on the strength of evidence for their clinical effectiveness. This list of selected drugs may not be all-inclusive or current. Physicians and other health care professionals should refer to the FDA's web site page entitled "Drug Safety Communications" for up-to-date drug recall and alert information when prescribing medications.*
Prescribed – May include prescription given to the patient for anticoagulant therapy at discharge OR anticoagulant to be continued after discharge as documented in the discharge medication list.

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

Numerator Options:

Performance Met:	Anticoagulant therapy prescribed at discharge **(4075F)**
OR	
Medical Performance Exclusion:	Anticoagulant therapy not prescribed at discharge for medical reason (eg, patient expired during inpatient stay, other medical reason(s)) **(4075F *with* 1P)**
OR	
Patient Performance Exclusion:	Anticoagulant therapy not prescribed at discharge for patient reason (eg, patient left against medical advice, other patient reason(s)) **(4075F *with* 2P)**
OR	
Performance Not Met:	Anticoagulant therapy **not** prescribed at discharge, reason not otherwise specified **(4075F *with* 8P)**

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

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

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

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

* Measure #39 (NQF 0046): Screening or Therapy for Osteoporosis for Women Aged 65 Years and Older – National Quality Strategy Domain: Effective Clinical Care

2015 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

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

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

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

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

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

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

DENOMINATOR:
All female patients aged 65 years and older

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

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

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

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

***Performance Met:* 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

***Other Performance Exclusion:* 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

***Performance Not Met:* G8400:** Patient with central Dual-energy X-Ray Absorptiometry (DXA) results **not** documented or **not** ordered or pharmacologic therapy (other than minerals/vitamins) for osteoporosis not prescribed, reason not given

RATIONALE:

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

CLINICAL RECOMMENDATION STATEMENTS:

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

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

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

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

BMD testing should be performed on:

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

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

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

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

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

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

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

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

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

* Measure #40 (NQF 0048): Osteoporosis: Management Following Fracture of Hip, Spine or Distal Radius for Men and Women Aged 50 Years and Older – National Quality Strategy Domain: Effective Clinical Care

2015 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

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

INSTRUCTIONS:
This measure is to be reported after **each occurrence** of a fracture during the reporting period. It is anticipated that **clinicians who treat hip, spine or distal radial fractures** will submit this measure. Each occurrence of a fracture is identified by either an ICD-9-CM/ICD-10-CM diagnosis code for fracture or osteoporosis and a CPT service code OR an ICD-9-CM/ICD-10-CM diagnosis code for a fracture or osteoporosis and a CPT procedure code for surgical treatment of fractures.

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

Measure Reporting via Claims:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT or HCPCS codes, and patient demographics are used to identify patients who are included in the measure's denominator. CPT Category II codes and/or quality-data codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed ICD-9-CM/ICD-10-CM diagnosis codes, CPT or HCPCS codes, and the appropriate CPT Category II code **OR** quality-data code **OR** the CPT Category II code **with** the modifier. The modifiers allowed for this measure are: 1P- medical reasons, 2P- patient reasons, 3P- system reasons, 8P- reason not otherwise specified. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

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

DENOMINATOR:
All patients aged 50 years and older with a fracture of the hip, spine, or distal radius
Eligible cases are determined, and must be reported, if either of the following conditions are met:

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

Diagnosis for hip, spine, or distal radial fracture (ICD-9-CM) [for use 1/1/2015-9/30/2015]: 733.12, 733.13, 733.14, 733.15, 733.19, 805.00, 805.01, 805.02, 805.03, 805.04, 805.05, 805.06, 805.07, 805.08, 805.11, 805.12, 805.13, 805.14, 805.15, 805.16, 805.17, 805.2, 805.3, 805.4, 805.5, 805.6, 805.7, 805.8, 813.40, 813.41, 813.42, 813.43, 813.44, 813.45, 813.46, 813.47, 813.50, 813.51, 813.52, 813.53, 813.54, 820.00, 820.01, 820.02, 820.03, 820.09, 820.10, 820.11, 820.12, 820.13, 820.19, 820.20, 820.21, 820.22, 820.30, 820.31, 820.32, 820.8, 820.9

Diagnosis for hip, spine, or distal radial fracture (ICD-10-CM) [for use 10/01/2015-12/31/2015]: M84.431A, M84.432A, M84.433A, M84.434A, M84.439A, M84.451A, M84.452A, M84.453A, M84.454A, M84.459A, M84.48XA, S12.000A, S12.000B, S12.001A, S12.001B, S12.01XA, S12.01XB,S12.02XA, S12.02XB, S12.030A, S12.030B, S12.031A, S12.031B, S12.040A, S12.040B, S12.041A, S12.041B, S12.090A, S12.090B, S12.091A, S12.091B, S12.100A, S12.100B, S12.101A, S12.101B, S12.110A, S12.110B, S12.111A, S12.111B, S12.112A, S12.112B, S12.120A, S12.120B, S12.121A, S12.121B, S12.130A, S12.130B, S12.131A, S12.131B, S12.14XA, S12.14XB, S12.150A, S12.150B, S12.151A, S12.151B, S12.190A, S12.190B, S12.191A, S12.191B, S12.200A, S12.200B, S12.201A, S12.201B, S12.230A, S12.230B, S12.231A, S12.231B, S12.24XA, S12.24XB, S12.250A, S12.250B, S12.251A, S12.251B, S12.290A, S12.290B, S12.291A, S12.291B, S12.300A, S12.300B, S12.301A, S12.301B, S12.330A, S12.330B, S12.331A, S12.331B, S12.34XA, S12.34XB, S12.350A, S12.350B, S12.351A, S12.351B, S12.390A, S12.390B, S12.391A, S12.391B, S12.400A, S12.400B, S12.401A, S12.401B, S12.430A, S12.430B, S12.431A, S12.431B, S12.44XA, S12.44XB, S12.450A, S12.450B, S12.451A, S12.451B, S12.490A, S12.490B, S12.491A, S12.491B, S12.500A, S12.500B, S12.501A, S12.501B, S12.530A, S12.530B, S12.531A, S12.531B, S12.54XA, S12.54XB, S12.550A, S12.550B, S12.551A, S12.551B, S12.590A, S12.590B, S12.591A, S12.591B, S12.600A, S12.600B, S12.601A, S12.601B, S12.630A, S12.630B, S12.631A, S12.631B, S12.64XA, S12.64XB, S12.650A, S12.650B, S12.651A, S12.651B, S12.690A, S12.690B, S12.691A, S12.691B, S12.8XXA, S12.9XXA, S22.000A, S22.000B, S22.001A, S22.001B, S22.002A, S22.002B, S22.008A, S22.008B, S22.009A, S22.009B, S22.010A, S22.010B, S22.011A, S22.011B, S22.012A, S22.012B, S22.018A, S22.018B, S22.019A, S22.019B, S22.020A, S22.020B, S22.021A, S22.021B, S22.022A, S22.022B, S22.028A, S22.028B, S22.029A, S22.029B, S22.030A, S22.030B, S22.031A, S22.031B, S22.032A, S22.032B, S22.038A, S22.038B, S22.039A, S22.039B, S22.040A, S22.040B, S22.041A, S22.041B, S22.042A, S22.042B, S22.048A, S22.048B, S22.049A, S22.049B, S22.050A, S22.050B, S22.051A, S22.051B, S22.052A, S22.052B, S22.058A, S22.058B, S22.059A, S22.059B, S22.060A, S22.060B, S22.061A, S22.061B, S22.062A, S22.062B, S22.068A, S22.068B, S22.069A, S22.069B, S22.070A, S22.070B, S22.071A, S22.071B, S22.072A, S22.072B, S22.078A, S22.078B, S22.079A, S22.079B, S22.080A, S22.080B, S22.081A, S22.081B, S22.082A, S22.082B, S22.088A, S22.088B, S22.089A, S22.089B, S32.000A, S32.000B, S32.001A, S32.001B, S32.002A, S32.002B, S32.008A, S32.008B, S32.009A, S32.009B, S32.010A, S32.010B, S32.011A, S32.011B, S32.012A, S32.012B, S32.018A, S32.018B, S32.019A, S32.019B, S32.020A, S32.020B, S32.021A, S32.021B, S32.022A, S32.022B, S32.028A, S32.028B, S32.029A, S32.029B, S32.030A, S32.030B, S32.031A, S32.031B, S32.032A, S32.032B, S32.038A, S32.038B, S32.039A, S32.039B, S32.040A, S32.040B, S32.041A, S32.041B, S32.042A, S32.042B, S32.048A, S32.048B, S32.049A, S32.049B, S32.050A, S32.050B, S32.051A, S32.051B, S32.052A, S32.052B, S32.058A, S32.058B, S32.059A, S32.059B, S32.10XA, S32.10XB, S32.110A, S32.110B, S32.111A, S32.111B, S32.112A, S32.112B, S32.119A, S32.119B, S32.120A, S32.120B, S32.121A, S32.121B, S32.122A, S32.122B, S32.129A, S32.129B, S32.130A, S32.130B, S32.131A, S32.131B, S32.132A, S32.132B, S32.139A, S32.139B, S32.14XA, S32.14XB, S32.15XA, S32.15XB, S32.16XA, S32.16XB, S32.17XA, S32.17XB, S32.19XA, S32.19XB, S32.2XXA, S32.2XXB, S32.401A, S32.401B, S32.402A, S32.402B, S32.409A, S32.409B, S32.411A, S32.411B, S32.412A, S32.412B, S32.413A, S32.413B, S32.414A, S32.414B, S32.415A, S32.415B, S32.416A, S32.416B, S32.421A, S32.421B, S32.422A, S32.422B, S32.423A, S32.423B, S32.424A, S32.424B, S32.425A, S32.425B, S32.426A, S32.426B, S32.431A, S32.431B, S32.432A, S32.432B, S32.433A, S32.433B, S32.434A, S32.434B, S32.435A, S32.435B, S32.436A, S32.436B, S32.441A, S32.441B, S32.442A, S32.442B, S32.443A, S32.443B, S32.444A, S32.444B, S32.445A, S32.445B, S32.446A, S32.446B, S32.451A, S32.451B, S32.452A,

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AND

Patient encounter during the reporting period (CPT or HCPCS) - 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99238, 99239, G0402

OR

Option 2 - Denominator Criteria (Eligible Cases):

Patients aged ≥ 50 years on date of encounter

AND

Diagnosis for hip, spine, or distal radial fracture (ICD-9-CM) [for use 1/1/2015-9/30/2015]: 733.12, 733.13, 733.14, 733.15, 733.19, 805.00, 805.01, 805.02, 805.03, 805.04, 805.05, 805.06, 805.07, 805.08, 805.2, 805.3, 805.4, 805.5, 805.6, 805.7, 805.8, 813.40, 813.41, 813.42, 813.43, 813.44, 813.45, 813.46, 813.47, 813.50, 813.51, 813.52, 813.53, 813.54, 820.00, 820.01, 820.02, 820.03, 820.09, 820.10, 820.11, 820.12, 820.13, 820.19, 820.20, 820.21, 820.22, 820.30, 820.31, 820.32, 820.8, 820.9

Diagnosis for hip, spine, or distal radial fracture (ICD-10-CM) [for use 10/01/2015-12/31/2015]:
M84.431A, M84.432A, M84.433A, M84.434A, M84.439A, M84.451A, M84.452A, M84.453A, M84.454A, M84.459A, M84.48XA, S12.000A, S12.000B, S12.001A, S12.001B, S12.01XA, S12.01XB, S12.02XA, S12.02XB, S12.030A, S12.030B, S12.031A, S12.031B, S12.040A, S12.040B, S12.041A, S12.041B, S12.090A, S12.090B, S12.091A, S12.091B, S12.100A, S12.100B, S12.101A, S12.101B, S12.110A, S12.110B, S12.111A, S12.111B, S12.112A, S12.112B, S12.120A, S12.120B, S12.121A, S12.121B, S12.130A, S12.130B, S12.131A, S12.131B, S12.14XA, S12.14XB, S12.150A, S12.150B, S12.151A, S12.151B, S12.190A, S12.190B, S12.191A, S12.191B, S12.200A, S12.200B, S12.201A, S12.201B, S12.230A, S12.230B, S12.231A, S12.231B, S12.24XA, S12.24XB, S12.250A, S12.250B, S12.251A, S12.251B, S12.290A, S12.290B, S12.291A, S12.291B, S12.300A, S12.300B, S12.301A, S12.301B, S12.330A, S12.330B, S12.331A, S12.331B, S12.34XA, S12.34XB, S12.350A, S12.350B, S12.351A, S12.351B, S12.390A, S12.390B, S12.391A, S12.391B, S12.400A, S12.400B, S12.401A, S12.401B, S12.430A, S12.430B, S12.431A, S12.431B, S12.44XA, S12.44XB, S12.450A, S12.450B, S12.451A, S12.451B, S12.490A, S12.490B, S12.491A, S12.491B, S12.500A, S12.500B, S12.501A, S12.501B, S12.530A, S12.530B, S12.531A, S12.531B, S12.54XA, S12.54XB, S12.550A, S12.550B, S12.551A, S12.551B, S12.590A, S12.590B, S12.591A, S12.591B, S12.600A, S12.600B, S12.601A, S12.601B, S12.630A, S12.630B, S12.631A, S12.631B, S12.64XA, S12.64XB, S12.650A, S12.650B, S12.651A, S12.651B, S12.690A, S12.690B, S12.691A, S12.691B, S12.8XXA, S12.9XXA, S22.000A, S22.000B, S22.001A, S22.001B, S22.002A, S22.002B, S22.008A, S22.008B, S22.009A, S22.009B, S22.010A, S22.010B, S22.011A, S22.011B, S22.012A, S22.012B, S22.018A, S22.018B, S22.019A, S22.019B, S22.020A, S22.020B, S22.021A, S22.021B, S22.022A, S22.022B, S22.028A, S22.028B, S22.029A, S22.029B, S22.030A, S22.030B, S22.031A, S22.031B, S22.032A, S22.032B, S22.038A, S22.038B, S22.039A, S22.039B, S22.040A, S22.040B, S22.041A, S22.041B, S22.042A, S22.042B, S22.048A, S22.048B, S22.049A, S22.049B, S22.050A, S22.050B, S22.051A, S22.051B, S22.052A, S22.052B, S22.058A, S22.058B, S22.059A, S22.059B, S22.060A, S22.060B, S22.061A, S22.061B, S22.062A, S22.062B, S22.068A, S22.068B, S22.069A, S22.069B, S22.070A, S22.070B, S22.071A, S22.071B, S22.072A, S22.072B, S22.078A, S22.078B, S22.079A, S22.079B, S22.080A, S22.080B, S22.081A, S22.081B, S22.082A, S22.082B, S22.088A, S22.088B, S22.089A, S22.089B, S32.000A, S32.000B, S32.001A, S32.001B, S32.002A, S32.002B, S32.008A, S32.008B, S32.009A, S32.009B, S32.010A, S32.010B, S32.011A, S32.011B, S32.012A, S32.012B, S32.018A, S32.018B, S32.019A, S32.019B, S32.020A, S32.020B, S32.021A, S32.021B, S32.022A, S32.022B, S32.028A, S32.028B, S32.029A, S32.029B, S32.030A, S32.030B, S32.031A, S32.031B, S32.032A, S32.032B, S32.038A, S32.038B, S32.039A, S32.039B, S32.040A, S32.040B, S32.041A, S32.041B, S32.042A, S32.042B, S32.048A, S32.048B, S32.049A, S32.049B, S32.050A, S32.050B, S32.051A, S32.051B, S32.052A, S32.052B, S32.058A, S32.058B, S32.059A, S32.059B, S32.10XA, S32.10XB, S32.110A, S32.110B, S32.111A, S32.111B, S32.112A, S32.112B, S32.119A, S32.119B, S32.120A, S32.120B, S32.121A, S32.121B, S32.122A, S32.122B, S32.129A, S32.129B, S32.130A, S32.130B, S32.131A, S32.131B, S32.132A, S32.132B, S32.139A, S32.139B, S32.14XA, S32.14XB, S32.15XA, S32.15XB, S32.16XA, S32.16XB, S32.17XA, S32.17XB, S32.19XA, S32.19XB, S32.2XXA, S32.2XXB, S32.401A, S32.401B, S32.402A, S32.402B, S32.409A, S32.409B, S32.411A, S32.411B, S32.412A, S32.412B, S32.413A, S32.413B, S32.414A, S32.414B, S32.415A, S32.415B, S32.416A, S32.416B, S32.421A, S32.421B, S32.422A, S32.422B, S32.423A, S32.423B, S32.424A, S32.424B, S32.425A, S32.425B, S32.426A, S32.426B, S32.431A, S32.431B, S32.432A, S32.432B, S32.433A, S32.433B, S32.434A, S32.434B, S32.435A, S32.435B, S32.436A, S32.436B, S32.441A, S32.441B, S32.442A, S32.442B, S32.443A, S32.443B, S32.444A, S32.444B, S32.445A, S32.445B, S32.446A, S32.446B, S32.451A, S32.451B, S32.452A, S32.452B, S32.453A, S32.453B, S32.454A, S32.454B, S32.455A, S32.455B, S32.456A, S32.456B, S32.461A, S32.461B, S32.462A, S32.462B, S32.463A, S32.463B, S32.464A, S32.464B, S32.465A, S32.465B, S32.466A, S32.466B, S32.471A, S32.471B, S32.472A, S32.472B, S32.473A, S32.473B, S32.474A, S32.474B, S32.475A, S32.475B, S32.476A, S32.476B, S32.481A, S32.481B, S32.482A, S32.482B, S32.483A, S32.483B, S32.484A, S32.484B, S32.485A, S32.485B, S32.486A, S32.486B, S32.491A, S32.491B, S32.492A, S32.492B, S32.499A, S32.499B, S52.501A, S52.501B, S52.501C,

S52.502A, S52.502B, S52.502C, S52.509A, S52.509B, S52.509C, S52.511A, S52.511B, S52.511C, S52.512A, S52.512B, S52.512C, S52.513A, S52.513B, S52.513C, S52.514A, S52.514B, S52.514C, S52.515A, S52.515B, S52.515C, S52.516A, S52.516B, S52.516C, S52.521A, S52.522A, S52.529A, S52.531A, S52.531B, S52.531C, S52.532A, S52.532B, S52.532C, S52.539A, S52.539B, S52.539C, S52.541A, S52.541B, S52.541C, S52.542A, S52.542B, S52.542C, S52.549A, S52.549B, S52.549C, S52.551A, S52.551B, S52.551C, S52.552A, S52.552B, S52.552C, S52.559A, S52.559B, S52.559C, S52.561A, S52.561B, S52.561C, S52.562A, S52.562B, S52.562C, S52.569A, S52.569B, S52.569C, S52.571A, S52.571B, S52.571C, S52.572A, S52.572B, S52.572C, S52.579A, S52.579B, S52.579C, S52.591A, S52.591B, S52.591C, S52.592A, S52.592B, S52.592C, S52.599A, S52.599B, S52.599C, S52.609A, S52.609B, S52.609C, S52.621A, S52.622A, S52.90XA, S52.90XB, S52.90XC, S72.001A, S72.001B, S72.001C, S72.002A, S72.002B, S72.002C, S72.009A, S72.009B, S72.009C, S72.011A, S72.011B, S72.011C, S72.012A, S72.012B, S72.012C, S72.019A, S72.019B, S72.019C, S72.021A, S72.021B, S72.021C, S72.022A, S72.022B, S72.022C, S72.023A, S72.023B, S72.023C, S72.024A, S72.024B, S72.024C, S72.025A, S72.025B, S72.025C, S72.026A, S72.026B, S72.026C, S72.031A, S72.031B, S72.031C, S72.032A, S72.032B, S72.032C, S72.033A, S72.033B, S72.033C, S72.034A, S72.034B, S72.034C, S72.035A, S72.035B, S72.035C, S72.036A, S72.036B, S72.036C, S72.041A, S72.041B, S72.041C, S72.042A, S72.042B, S72.042C, S72.043A, S72.043B, S72.043C, S72.044A, S72.044B, S72.044C, S72.045A, S72.045B, S72.045C, S72.046A, S72.046B, S72.046C, S72.051A, S72.051B, S72.051C, S72.052A, S72.052B, S72.052C, S72.059A, S72.059B, S72.059C, S72.061A, S72.061B, S72.061C, S72.062A, S72.062B, S72.062C, S72.063A, S72.063B, S72.063C, S72.064A, S72.064B, S72.064C, S72.065A, S72.065B, S72.065C, S72.066A, S72.066B, S72.066C, S72.091A, S72.091B, S72.091C, S72.092A, S72.092B, S72.092C, S72.099A, S72.099B, S72.099C, S72.101A, S72.101B, S72.101C, S72.102A, S72.102B, S72.102C, S72.109A, S72.109B, S72.109C, S72.111A, S72.111B, S72.111C, S72.112A, S72.112B, S72.112C, S72.113A, S72.113B, S72.113C, S72.114A, S72.114B, S72.114C, S72.115A, S72.115B, S72.115C, S72.116A, S72.116B, S72.116C, S72.121A, S72.121B, S72.121C, S72.122A, S72.122B, S72.122C, S72.123A, S72.123B, S72.123C, S72.124A, S72.124B, S72.124C, S72.125A, S72.125B, S72.125C, S72.126A, S72.126B, S72.126C, S72.131A, S72.131B, S72.131C, S72.132A, S72.132B, S72.132C, S72.133A, S72.133B, S72.133C, S72.134A, S72.134B, S72.134C, S72.135A, S72.135B, S72.135C, S72.136A, S72.136B, S72.136C, S72.141A, S72.141B, S72.141C, S72.142A, S72.142B, S72.142C, S72.143A, S72.143B, S72.143C, S72.144A, S72.144B, S72.144C, S72.145A, S72.145B, S72.145C, S72.146A, S72.146B, S72.146C, S72.21XA, S72.21XB, S72.21XC, S72.22XA, S72.22XB, S72.22XC, S72.23XA, S72.23XB, S72.23XC, S72.24XA, S72.24XB, S72.24XC, S72.25XA, S72.25XB, S72.25XC, S72.26XA, S72.26XB, S72.26XC

AND

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

NUMERATOR:

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

Definitions:

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

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

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Central DXA Measurement Ordered or Results Documented or Pharmacologic Therapy Prescribed

***Performance Met:* CPT II 3095F:** Central Dual-energy X-Ray Absorptiometry (DXA) results documented

OR

***Performance Met:* CPT II 3096F:** Central Dual-energy X-Ray Absorptiometry (DXA) ordered

OR

***Performance Met:* G8633:** Pharmacologic therapy (other than minerals/vitamins) for osteoporosis prescribed

OR

Central DXA Measurement not Ordered or Results not Documented for Medical, Patient, or System Reasons

Append a modifier (**1P, 2P or 3P**) to CPT Category II codes **3096F or 3095F** to report documented circumstances that appropriately exclude patients from the denominator.

***Medical Performance Exclusion:* 3096F or 3095F *with* 1P:** Documentation of medical reason(s) for not ordering or performing a central dual energy X-ray absorptiometry (DXA) measurement

***Patient Performance Exclusion:* 3096F or 3095F *with* 2P:** Documentation of patient reason(s) for not ordering or performing a central dual energy X-ray absorptiometry (DXA) measurement

***System Performance Exclusion:* 3096F or 3095F *with* 3P:** Documentation of system reason(s) for not ordering or performing a central dual energy X-ray absorptiometry (DXA) measurement

OR

Pharmacologic Therapy not Prescribed for Documented Reasons

***Other Performance Exclusion:* G8634:** Clinician documented patient not an eligible candidate to receive pharmacologic therapy for osteoporosis

OR

Central DXA Measurement not Ordered or Results not Documented, Reason not Otherwise Specified

Append a reporting modifier (**8P**) to CPT Category II code **3096F or 3095F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

***Performance Not Met:* 3096F or 3095F *with* 8P:** Central dual energy X-ray absorptiometry (DXA) measurement was **not** ordered or performed, reason not otherwise specified

OR

Pharmacologic Therapy not Prescribed, Reason not Given

***Performance Not Met:* G8635:** Pharmacologic therapy for osteoporosis was **not** prescribed, reason not given

RATIONALE:

Patients with a history of fracture should have a baseline bone mass measurement and/or receive treatment for osteoporosis. Given that the majority of osteoporotic fractures occur in patients with a diagnosis of osteoporosis by bone mass measurement, exclusion of osteoporosis by bone mass testing does not preclude treatment of osteoporosis in a patient with a history of fracture. There is a high degree of variability and consensus by experts of what constitutes a fragility fracture and predictor of an underlying problem of osteoporosis. The work group determined that only those fractures, which have the strongest consensus and evidence that they are predictive of

osteoporosis, should be included in the measure at this time. We anticipate that the list of fractures will expand as further evidence is published supporting the inclusion of other fractures.

CLINICAL RECOMMENDATION STATEMENTS:

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

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

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

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

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

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

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

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

* Measure #41 (NQF 0049): Osteoporosis: Pharmacologic Therapy for Men and Women Aged 50 Years and Older – National Quality Strategy Domain: Effective Clinical Care

2015 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

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

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

Measure Reporting via Claims:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT or HCPCS codes, and patient demographics are used to identify patients who are included in the measure's denominator. CPT Category II codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed ICD-9-CM/ICD-10-CM diagnosis codes, CPT or HCPCS codes, and the appropriate CPT Category II code **OR** the CPT Category II code **with** the modifier. The modifiers allowed for this measure are: 1P- medical reasons, 2P- patient reasons, 3P- system reasons, 8P- reason not otherwise specified. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT or HCPCS codes, and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

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

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

Denominator Criteria (Eligible Cases):
Patients aged ≥ 50 years on date of encounter
AND
Diagnosis for osteoporosis (ICD-9-CM) [for use 1/1/2015-9/30/2015]: 733.00, 733.01, 733.02, 733.03, 733.09
Diagnosis for osteoporosis (ICD-10-CM) [for use 10/01/2015-12/31/2015]: M80.00XA, M80.00XD, M80.00XG, M80.00XK, M80.00XP, M80.00XS, M80.011A, M80.011D, M80.011G, M80.011K, M80.011P, M80.011S, M80.012A, M80.012D, M80.012G, M80.012K, M80.012P, M80.012S, M80.019A, M80.019D, M80.019G, M80.019K, M80.019P, M80.019S, M80.021A, M80.021D, M80.021G, M80.021K, M80.021P, M80.021S, M80.022A, M80.022D, M80.022G, M80.022K, M80.022P, M80.022S, M80.029A, M80.029D, M80.029G, M80.029K, M80.029P, M80.029S, M80.031A, M80.031D, M80.031G, M80.031K, M80.031P, M80.031S, M80.032A, M80.032D, M80.032G, M80.032K, M80.032P, M80.032S, M80.039A, M80.039D, M80.039G, M80.039K, M80.039P, M80.039S, M80.041A, M80.041D, M80.041G, M80.041K, M80.041P, M80.041S, M80.042A, M80.042D, M80.042G, M80.042K, M80.042P, M80.042S, M80.049A, M80.049D,

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

AND

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

NUMERATOR:

Patients who were prescribed pharmacologic therapy for osteoporosis within 12 months

Definitions:

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

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

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Pharmacologic Therapy Prescribed

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

OR

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

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

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

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

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

OR

Pharmacologic Therapy not Prescribed, Reason not Otherwise Specified

Append a reporting modifier (**8P**) to CPT Category II code **4005F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

***Performance Not Met:* 4005F *with* 8P:** Pharmacologic therapy for osteoporosis was **not** prescribed, reason not otherwise specified

RATIONALE:

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

CLINICAL RECOMMENDATION STATEMENTS:

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

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

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

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

Ω Measure #43 (NQF 0134): Coronary Artery Bypass Graft (CABG): Use of Internal Mammary Artery (IMA) in Patients with Isolated CABG Surgery – National Quality Strategy Domain: Effective Clinical Care

2015 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

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

INSTRUCTIONS:
This measure is to be reported **each time** an isolated CABG procedure is performed during the reporting period. It is anticipated that **clinicians who provide services for isolated CABG** will submit this measure. This measure is intended to reflect the quality of the surgical services provided for isolated CABG patients. Isolated CABG refers to CABG using arterial and/or venous grafts only.

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

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

DENOMINATOR:
All patients undergoing isolated CABG

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

NUMERATOR:
Patients undergoing isolated CABG who received an IMA graft

Numerator Options:

Performance Met:	Internal mammary artery graft performed for primary, isolated coronary artery bypass graft procedure (CABG) **(4110F)**
OR	
Medical Performance Exclusion:	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 bypassable left anterior descending artery disease **(4110F *with* 1P)**
OR	
Performance Not Met:	Internal mammary artery graft **not** performed for primary, isolated coronary artery bypass graft

procedure, reason not otherwise specified **(4110F *with* 8P)**

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

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

♠ Measure #44 (NQF 0236): Coronary Artery Bypass Graft (CABG): Preoperative Beta-Blocker in Patients with Isolated CABG Surgery – National Quality Strategy Domain: Effective Clinical Care

2015 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

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

INSTRUCTIONS:
This measure is to be reported **each time** an isolated CABG procedure is performed during the reporting period. It is anticipated that **eligible professionals who provide services for isolated CABG** will submit this measure. The timeframe for this measure includes the entire 24 hour period prior to the surgical incision time.

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

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

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

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

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

Definitions:
Isolated CABG – Refers to CABG using arterial and/or venous grafts only. Part B claims data will be analyzed to determine "isolated" CABG.

DENOMINATOR NOTE: *In order to ensure the only surgeries allowed into the denominator for the measure are isolated CABG surgeries, the anesthesiologist CPT code (00562) (which is not specific to isolated CABG), would need to be in conjunction with the CPT indicated for the CABG surgery (33530) and one of the other CABG codes (33510, 33511, 33512, 33513, 33514, 33516, 33517, 33518, 33519, 33521, 33522, 33523, 33533, 33534, 33535, 33536)*

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Patient encounter during the reporting period (CPT): 00566, 00567, 33510, 33511, 33512, 33513, 33514, 33516, 33517, 33518, 33519, 33521, 33522, 33523, 33533, 33534, 33535, 33536

OR

Patient encounter during the reporting period (CPT): 33510, 33511, 33512, 33513, 33514, 33516, 33517, 33518, 33519, 33521, 33522, 33523, 33533, 33534, 33535, 33536
AND
Patient encounter during the reporting period (CPT): 00562, 33530

NUMERATOR:
Patients who received a beta-blocker within 24 hours prior to surgical incision of isolated CABG surgeries

Definitions:
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 Administration Documented
Performance Met: **CPT II 4115F:** Beta blocker administered within 24 hours prior to surgical incision

OR

Preoperative Beta-blocker not Administered for Documented Medical Reasons
Append a reporting modifier (**1P**) to CPT Category II code **4115F** to report documented circumstances that appropriately exclude patients from the denominator.
Medical Performance Exclusion: **4115F *with* 1P:** Documentation of medical reason(s) for not administering beta blocker within 24 hours prior to surgical incision (eg, not indicated, contraindicated, other medical reason)

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

RATIONALE:
Postoperative atrial fibrillation (POAF) is a common complication following cardiac surgery, occurring in 25-40% of patients (Crystal, 2004, Burgess, 2006). POAF has been associated with increased rates of post-operative morbidity and mortality and consequently, increased costs (Mariscalco, 2008, Crystal, 2004, Bramer, 2010). Prophylactic administration of beta-blockers have been shown to reduce the risk of POAF and mortality following isolated coronary artery bypass graft surgery (Connolly, 2003, Mariscalco, 2008, Ferguson, 2002). Khan's meta-analysis of RCTs found that "Preoperative BB initiation resulted in 52% reduction in the incidence of AF as compared to controls, however these results were not statistically significant". ElBardissi (2012) showed a 19.5% increase in preoperative use of beta-blockers from 2000-2009.

Coronary revascularization, comprising coronary artery bypass graft (CABG) surgery and percutaneous coronary intervention (PCI), is among the most common major medical procedures provided by the US health care system, with more than 1 million procedures performed annually. It is also among the most costly procedure. Medicare inpatient payments to hospitals for coronary revascularizations exceeded $6.7 billion in fiscal year 2006 and is larger than the reimbursement for any other medical or surgical procedure (Epstein, 2011).

CLINICAL RECOMMENDATION STATEMENTS:
Preoperative Beta-blockers:
Class I

1) Beta-blockers should be administered for at least 24 hours before CABG to all patients without contraindications to reduce the incidence or clinical sequelae of postoperative AF. *(Level of Evidence: B),* (ACCF/AHA, 2011)

Class IIa

1) Preoperative use of beta-blockers in patients without contraindications, particularly in those with an LV ejection fraction (LVEF) greater than 30%, can be effective in reducing the risk of in-hospital mortality. *(Level of Evidence: B),* (ACCF/AHA, 2011)
2) Beta-blockers can be effective in reducing the incidence of perioperative myocardial ischemia. *(Level of Evidence: B),* (ACCF/AHA, 2011)

Class IIb

1) The effectiveness of preoperative beta-blockers in reducing in-hospital mortality rate in patients with LVEF less than 30% is uncertain. *(Level of Evidence: B),* (ACCF/AHA, 2011)

* Measure #46 (NQF 0097): Medication Reconciliation – National Quality Strategy Domain: Communication and Care Coordination

2015 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of patients aged 18 years and older **discharged from any inpatient facility** (eg, hospital, skilled nursing facility, or rehabilitation facility) and **seen within 30 days following discharge** in the office by the physician, prescribing practitioner, registered nurse, or clinical pharmacist providing on-going care who had a reconciliation of the discharge medications with the current medication list in the outpatient medical record documented.

This measure is reported as two rates stratified by age group:

- Reporting Age Criteria 1: 18-64 years of age
- Reporting Age Criteria 2: 65 years and older

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

This measure will be calculated with 2 performance rates:

1) Percentage of patients 18-64 years of age who were discharged from any inpatient facility (eg, hospital, skilled nursing facility, or rehabilitation facility) and seen within 30 days following discharge in the office by the physician, prescribing practitioner, registered nurse, or clinical pharmacist providing on-going care who had a reconciliation of the discharge medications with the current medication list in the outpatient medical record documented

AND

2) Percentage of patients 65 years and older who were discharged from any inpatient facility (eg, hospital, skilled nursing facility, or rehabilitation facility) and seen within 30 days following discharge in the office by the physician, prescribing practitioner, registered nurse, or clinical pharmacist providing on-going care who had a reconciliation of the discharge medications with the current medication list in the outpatient medical record documented

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

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

Measure Reporting via Registry:

CPT or HCPCS codes and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

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

DENOMINATOR:
All patients 18 years of age and older discharged from any inpatient facility (eg, hospital, skilled nursing facility, or rehabilitation facility) and seen within 30 days following discharge in the office by the physician, prescribing practitioner, registered nurse, or clinical pharmacist providing on-going care

Denominator Criteria (Eligible Cases):
REPORTING CRITERIA 1: Patients 18-64 years of age on date of encounter
REPORTING CRITERIA 2: Patients aged 65 years and older on date of encounter

AND

Patient encounter during the reporting period (CPT or HCPCS): 90791, 90792, 90832, 90834, 90837, 90839, 90845, 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, 99495, 99496, G0402, G0438, G0439

NUMERATOR (Reporting Criteria 1 & 2):
Patients who had a reconciliation of the discharge medications with the current medication list in the outpatient medical record documented

Definition:
Medical Record – Must indicate: The physician, prescribing practitioner, registered nurse, or clinical pharmacist providing ongoing care is aware of the inpatient facility discharge medications and will either keep the inpatient facility discharge medications or change the inpatient facility discharge medications or the dosage of an inpatient facility discharge medication.

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

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

OR

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

OR

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

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

CLINICAL RECOMMENDATION STATEMENTS:
Medication reconciliation post-discharge is an important step to catch potentially harmful omissions or changes in prescribed medications, particularly in elderly patients that are prescribed a greater quantity and variety of medications (Leape, 1991). Although the magnitude of the effect of medication reconciliation alone on patient outcomes is not well studied, there is agreement among experts that potential benefits outweigh the harm (Coleman, 2003; Pronovost, 2003; IOM, 2002; IOM, 2006). Medication reconciliation post-discharge is recommended by the Joint Commission patient safety goals (Kienle, 2008), the American Geriatric Society (Coleman, 2003), Society of Hospital Medicine (Kripalani, 2007; Grennwald, 2010), ACOVE (Assessing Care of Vulnerable Elders; Knight, 2001),and the Task Force on Medicines Partnership (2005). Additionally, measurement of medication reconciliation post-discharge has been cited by the National Quality Forum and the National Priorities Partnership as a measurement priority area (NQF, 2010)

No trials of the effects of physician acknowledgment of medications post-discharge were found. However, patients are likely to have their medications changed during a hospitalization. Estimates suggest that 46% of medication errors occur on admission or discharge from a hospital (Pronovost, 2003). Therefore, medication reconciliation is a critical piece of care coordination post-discharge for all individuals who use prescription medications. Prescription medication use is common among adults of all ages, particularly older adults and adults with chronic conditions. On average, 82% of adults in the U.S. are taking at least one medication (prescription or nonprescription, vitamin/mineral, herbal/natural supplement); 29% are taking five or more. Older adults are the biggest consumers of medications with 17-19% of people 65 and older taking at least ten medications in a given week (Slone Survey, 2006).

One observational study showed that 1.5 new medications were initiated per patient during hospitalization, and 28% of chronic medications were canceled by the time of hospital discharge. Another observational study showed that at one week post-discharge, 72% of elderly patients were taking incorrectly at least one medication started in the inpatient setting, and 32% of medications were not being taken at all. One survey study faulted the quality of discharge communication as contributing to early hospital readmission, although this study did not implicate medication discontinuity as the cause. (ACOVE)

Implementing routine medication reconciliation after discharge from an inpatient facility is an important step to ensure medication errors are addressed and patients understand their new medications. The process of resolving discrepancies in a patient's medication list reduces the risk of these adverse drug interactions being overlooked and helps physicians minimize the duplication and complexity of the patient's medication regimen (Wenger, 2004). This in turn may increase patient adherence to the medication regimen and reduce hospital readmission rates.

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

At the end of the outpatient visit, a clinician needs to verify three questions:

1) Based on what occurred in the visit, should any medication that the patient was taking or receiving prior to the visit be discontinued or altered?
2) Based on what occurred in the visit, should any prior medication be suspended pending consultation with the prescriber?

3) Have any new prescriptions been added today?

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

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

*Measure #47 (NQF 0326): Care Plan – National Quality Strategy Domain: Communication and Care Coordination

2015 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

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

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

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

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

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

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

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

DENOMINATOR:
All patients aged 65 years and older

> ***DENOMINATOR NOTE:*** **Clinicians indicating the Place of Service as the emergency department will not be included in this measure.*
>
> **Denominator Criteria (Eligible Cases):**
> Patients aged ≥ 65 years on date of encounter
> **AND**
> **Patient encounter during the reporting period (CPT or HCPCS):** 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99218, 99219, 99220, 99221, 99222, 99223, 99231, 99232, 99233, 99234, 99235, 99236, 99291*, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, G0402, G0438, G0439

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

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

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

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

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Advance Care Planning Discussed and Documented

Performance Met: **CPT II 1123F:**	Advance Care Planning discussed and documented; advance care plan or surrogate decision maker documented in the medical record

OR

Performance Met: **CPT II 1124F:**	Advance Care Planning discussed and documented in the medical record; patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan

OR

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

Performance Not Met: **1123F *with* 8P:**	Advance care planning **not** documented, reason not otherwise specified

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

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

Oral statements:

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

Instructional advance directives (DNR orders, living wills):

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

Durable power of attorney for health care or health care proxy:

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

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

*Measure #48: Urinary Incontinence: Assessment of Presence or Absence of Urinary Incontinence in Women Aged 65 Years and Older – National Quality Strategy Domain: Effective Clinical Care

2015 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

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

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

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

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

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

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

DENOMINATOR:
All female patients aged 65 years and older with a visit during the measurement period.

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

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

Definition:
Urinary Incontinence – Any involuntary leakage of urine.

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Presence or Absence of Urinary Incontinence Assessed
Performance Met: **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.
Medical Performance Exclusion: **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.
Performance Not Met: **1090F *with* 8P:** Presence or absence of urinary incontinence **not** assessed, reason not otherwise specified

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

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

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

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

* Measure #50: Urinary Incontinence: Plan of Care for Urinary Incontinence in Women Aged 65 Years and Older – National Quality Strategy Domain: Person and Caregiver-Centered Experience and Outcomes

2015 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

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

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

Measure Reporting via Claims:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT or HCPCS codes, and patient demographics are used to identify patients who are included in the measure's denominator. CPT Category II codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed ICD-9-CM/ICD-10-CM diagnosis codes, CPT or HCPCS codes, and the appropriate CPT Category II code **OR** the CPT Category II code **with** the modifier. The reporting modifier allowed for this measure is: 8P- reason not otherwise specified. There are no allowable performance exclusions for this measure. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT or HCPCS codes, and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

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

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

Denominator Criteria (Eligible Cases):
All female patients aged ≥ 65 years on date of encounter
AND
Diagnosis for urinary incontinence (ICD-9-CM) [for use 1/1/2015-9/30/2015]: 307.6, 625.6, 788.30, 788.31, 788.33, 788.34, 788.35, 788.36, 788.37, 788.38, 788.39
Diagnosis for urinary incontinence (ICD-10-CM) [for use 10/01/2015-12/31/2015]: F98.0, N39.3, N39.41, N39.42, N39.43, N39.44, N39.45, N39.46, N39.490, N39.498, R32
AND
Patient encounter during the reporting period (CPT or HCPCS): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, G0402

NUMERATOR:

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

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

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

OR

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

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

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

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

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

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

▲ Measure #51 (NQF 0091): Chronic Obstructive Pulmonary Disease (COPD): Spirometry Evaluation – National Quality Domain: Effective Clinical Care

2015 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

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

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

Measure Reporting via Claims:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. CPT Category II codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed ICD-9-CM/ICD-10-CM diagnosis code, CPT codes, and the appropriate CPT Category II code **OR** the CPT Category II code **with** the modifier. The modifiers allowed for this measure are: 1P- medical reasons, 2P- patient reasons, 3P- system reasons, 8P- reason not otherwise specified. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

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

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

> **Denominator Criteria (Eligible Cases):**
> Patients aged ≥ 18 years on date of encounter
> **AND**
> **Diagnosis for COPD (ICD-9-CM) [for use 1/1/2015-9/30/2015]:** 491.0, 491.1, 491.20, 491.21, 491.22, 491.8, 491.9, 492.0, 492.8, 493.20, 493.21, 493.22, 496
> **Diagnosis for COPD (ICD-10-CM) [for use 10/01/2015-12/31/2015]:** J41.0, J41.1, J41.8, J42, J43.0, J43.1, J43.2, J43.8, J43.9, J44.0, J44.1, J44.9
> **AND**
> **Patient encounter during the reporting period (CPT):** 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215

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

> **Numerator Instructions:** Look for most recent documentation of spirometry 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

***Performance Met:* 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.

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

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

***System Performance Exclusion:* 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.

***Performance Not Met:* 3023F *with* 8P:** Spirometry results **not** documented and reviewed, reason not otherwise specified

RATIONALE:

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

CLINICAL RECOMMENDATION STATEMENTS:

A clinical diagnosis of COPD should be considered in any patient who has dyspnea, chronic cough or sputum production, and/or a history of exposure to risk factors for the disease. Spirometry is required to make the diagnosis in this clinical context; the presence of a post-bronchodilator $FEV_1/FVC < 0.70$ confirms the presence of persistent airflow limitation and thus of COPD. Spirometry is the most reproducible and objective measurement of airflow available. (GOLD, 2011)

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

▲ Measure #52 (NQF 0102): Chronic Obstructive Pulmonary Disease (COPD): Inhaled Bronchodilator Therapy – National Quality Domain: Effective Clinical Care

2015 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

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

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

Measure Reporting via Claims:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. CPT Category II codes and/or quality-data codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and the appropriate CPT Category II code(s) **AND/OR** a quality-data code **OR** the CPT Category II code(s) **with** the modifier **AND** quality-data code. The modifiers allowed for this measure are: 1P- medical reasons, 2P- patient reasons, 3P- system reasons, 8P- reason not otherwise specified. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

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

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

> **Denominator Criteria (Eligible Cases):**
> Patients aged ≥ 18 years on date of encounter
> **AND**
> **Diagnosis for COPD (ICD-9-CM) [for use 1/1/2015-9/30/2015]:** 491.0, 491.1, 491.20, 491.21, 491.22, 491.8, 491.9, 492.0, 492.8, 493.20, 493.21, 493.22, 496
> **Diagnosis for COPD (ICD-10-CM) [for use 10/01/2015-12/31/2015]:** J41.0, J41.1, J41.8, J42, J43.0, J43.1, J43.2, J43.8, J43.9, J44.0, J44.1, J44.9
> **AND**
> **Patient encounter during the reporting period (CPT):** 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215

NUMERATOR:
Patients who were prescribed an inhaled bronchodilator

Definition:
Prescribed – Includes patients who are currently receiving medication(s) that follow the treatment plan recommended at an encounter during the reporting period, even if the prescription for that medication was ordered prior to the encounter.

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

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Patient Prescribed Inhaled Bronchodilator Therapy
*(One CPT II code & one quality-data code [**4025F & G8924**] are required on the claim form to submit this numerator option)*
Performance Met:

CPT II 4025F:	Inhaled bronchodilator prescribed
AND	
G8924:	Spirometry test results demonstrate $FEV_1/FVC < 60\%$ and patient has COPD symptoms (eg, dyspnea, cough/sputum, wheezing)

OR

Patient not Documented to have Inhaled Bronchodilator Prescribed for Medical, Patient, or System Reasons
*(One CPT II code & one quality-data code [**4025F-xP & G8924**] are required on the claim form to submit this numerator option)*
Append a modifier (**1P, 2P or 3P**) to CPT Category II code **4025F** to report documented circumstances that appropriately exclude patients from the denominator.
Medical Performance Exclusion, Patient Performance Exclusion, or System Performance Exclusion:

4025F *with* 1P:	Documentation of medical reason(s) for not prescribing an inhaled bronchodilator
4025F *with* 2P:	Documentation of patient reason(s) for not prescribing an inhaled bronchodilator
4025F *with* 3P:	Documentation of system reason(s) for not prescribing an inhaled bronchodilator
AND	
G8924:	Spirometry test results demonstrate $FEV_1/FVC < 60\%$ and patient has COPD symptoms (eg, dyspnea, cough/sputum, wheezing)

OR

If patient is not eligible for this measure because spirometry results demonstrate FEV1/FVC ≥ 60% or patient does not have COPD symptoms, report:
Spirometry Results Demonstrate $FEV_1/FVC \geq 60\%$ or Patient does not have COPD symptoms
*(One quality-data code [**G8925 or G8926**] is required on the claim form to submit this numerator option)*

***Other Performance Exclusion:* G8925:**	Spirometry test results demonstrate $FEV_1/FVC \geq 60\%$ or patient does not have COPD symptoms
OR	
Spirometry Test not Performed or Documented	
***Other Performance Exclusion:* G8926:**	Spirometry test **not** performed or documented, reason not given

OR

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

*(One CPT II code & one quality-data code [**4025F-8P & G8924**] are required on the claim form to submit this numerator option)*

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

Performance Not Met:

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

AND

G8924: Spirometry test results demonstrate $FEV_1/FVC < 60\%$ and patient has COPD symptoms (eg, dyspnea, cough/sputum, wheezing)

RATIONALE:

Inhaled bronchodilator therapy is effective in treating and managing the symptoms of COPD, particularly, for those patients with moderate to very severe COPD, and improving a patient's quality of life. The Global Initiative for Chronic Obstructive Lung Disease (GOLD) guidelines recommend inhaled bronchodilators as a cornerstone of COPD symptom management; however, PCPs often turn to other agents as first-line COPD therapy. (Barr et al., 2005; Foster et al., 2007) In a recent study of general medicine practices, 154 clinicians completed a survey to identify barriers to implementing seven recommendations from the GOLD guidelines. Adherence was only 54% to prescribing long-acting bronchodilators when $FEV_1 < 80\%$ predicted. (Perez, et al., 2011)

CLINICAL RECOMMENDATION STATEMENTS:

For stable COPD patients with respiratory symptoms and $FEV_1 < 60\%$ predicted, ACP, ACCP, ATS, and ERS recommend treatment with inhaled bronchodilators (Grade: strong recommendation, moderate-quality evidence). (Qaseem et al, 2011)

Bronchodilator medications are given on either an as-needed basis or a regular basis to reduce or prevent symptoms (Evidence A). Bronchodilator medications are central to symptom management in COPD. Inhaled therapy is preferred. Long-acting inhaled bronchodilators are convenient and more effective at producing maintained symptom relief than short-acting bronchodilators. (GOLD, 2011)

+ Measure #53 (NQF 0047): Asthma: Pharmacologic Therapy for Persistent Asthma - Ambulatory Care Setting – National Quality Strategy Domain: Effective Clinical Care

2015 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Percentage of patients aged 5 years and older with a diagnosis of persistent asthma who were prescribed long-term control medication

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

This measure will be calculated with 3 performance rates:

1) Patients prescribed inhaled corticosteroids (ICS) as their long-term control medication
2) Patients prescribed alternative long-term control medications (non-ICS)
3) Total patients prescribed long-term control medication

Measure Reporting via Registry:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, QDC code and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

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

DENOMINATOR:
All patients aged 5 years and older with a diagnosis of persistent asthma

Denominator Instructions: Documentation of persistent asthma must be present. One method of identifying persistent asthma is, at a minimum, daily use of short-acting bronchodilators

Denominator Criteria (Eligible Cases):
Patients aged ≥ 5 years on date of encounter
AND
Diagnosis for asthma (ICD-9-CM) [for use 1/1/2015-9/30/2015]: 493.00, 493.01, 493.02, 493.10, 493.11, 493.12, 493.20, 493.21, 493.22, 493.81, 493.82, 493.90, 493.91, 493.92
Diagnosis for asthma (ICD-10-CM) [for use 10/01/2015-12/31/2015]: J45.30, J45.31, J45.32, J45.40, J45.41, J45.42, J45.50, J45.51, J45.52, J45.901, J45.902, J45.909, J45.990, J45.991, J45.998
AND
Patient encounter during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350
AND
Persistent Asthma (mild, moderate or severe) **(1038F)**

NUMERATOR:
Patients who were prescribed long-term control medication

Definition:

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) 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 Options:

Performance Met:	Inhaled corticosteroids prescribed **(4140F)**
OR	
Performance Met:	Alternative long-term control medication prescribed **(4144F)**
OR	
Patient Performance Exclusion:	Documentation of patient reason(s) for not prescribing inhaled corticosteroids or alternative long-term control medication (eg, patient declined, other patient reason) **(4140F *with* 2P)**
OR	
Performance Not Met:	Inhaled corticosteroids or alternative long-term control medication **not** prescribed, reason not otherwise specified (**4140F *with* 8P)**

RATIONALE:
The following statement is quoted verbatim from the NHLBI/NAEPP guideline (NHLBI, 2007):

"The broad action of ICS on the inflammatory process may account for their efficacy as preventive therapy. Their clinical effects include reduction in severity of symptoms; improvement in asthma control and quality of life; improvement in PEF and spirometry; diminished airway hyper-responsiveness; prevention of exacerbations; reduction in systemic corticosteroid courses; emergency department (ED) care; hospitalizations, and deaths due to asthma; and possibly the attenuation of loss of lung function in adults". (Rafferty P 1985; Haahtela T 1991; Jeffery PK 1992; Van Essesn-Zandvliet EE 1992; Barnes NC 1993; Fabbri L 1993; Gustafsson P 1993; Kamada AK 1996; Suissa S 2000; Pauwels RA 2003; Barnes PJ October 1992)

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

The Expert Panel recommends that long-term control medications be taken daily on a long-term basis to achieve and maintain control of persistent asthma. The most effective long-term control medications are those that attenuate the underlying inflammation characteristic of asthma. (Evidence A) (NHLBI, 2007)

The Expert Panel concludes that ICS is the most potent and clinically effective long-term control medication for asthma. (Evidence A) (NHLBI, 2007)

The Expert Panel concludes that ICS is the most effective long-term therapy available for patients who have persistent asthma, and, in general, ICS is well tolerated and safe at the recommended dosages. (Evidence A) (NHLBI, 2007)

+ Measure #54 (NQF 0090): Emergency Medicine: 12-Lead Electrocardiogram (ECG) Performed for Non-Traumatic Chest Pain – National Quality Strategy Domain: Effective Clinical Care

2015 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of patients aged 40 years and older with an emergency department discharge diagnosis of non-traumatic chest pain who had a 12-lead electrocardiogram (ECG) performed

INSTRUCTIONS:
This measure is to be reported **each time** a patient has been discharged from the emergency department with a discharge diagnosis of non-traumatic chest pain during the reporting period. Patients who were discharged from an emergency department with a diagnosis of non-traumatic chest pain should have documentation in the medical record of having a 12-lead ECG performed. It is anticipated that **clinicians who provide care in the emergency department** will submit this measure.

Measure Reporting via Claims:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, Place of Service Indicator, and patient demographics are used to identify patients who are included in the measure's denominator. CPT Category II codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, Place of Service Indicator, and the appropriate CPT Category II code **OR** the CPT Category II code **with** the modifier. The modifiers allowed for this measure are: 1P- medical reasons, 2P- patient reasons, 8P- reason not otherwise specified. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, Place of Service Indicator, and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

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

DENOMINATOR:
All patients aged 40 years and older with an emergency department discharge diagnosis of non-traumatic chest pain

Denominator Criteria (Eligible Cases):
Patients aged ≥ 40 years on date of encounter
AND
Diagnosis for non-traumatic chest pain (ICD-9-CM) [for use 1/1/2015-9/30/2015]: 413.0, 413.1, 413.9, 786.50, 786.51, 786.52, 786.59
Diagnosis for non-traumatic chest pain (ICD-10-CM) [for use 10/01/2015-12/31/2015]: I20.1, I20.8, I20.9, I25.111, I25.118, I25.119, I25.701, I25.708, I25.709, I25.711, I25.718, I25.719, I25.721, I25.728, I25.729, I25.731, I25.738, I25.739, I25.751, I25.758, I25.759, I25.761, I25.768, I25.769, I25.791, I25.798, I25.799, R07.1, R07.2, R07.81, R07.82, R07.89, R07.9
AND
Patient encounter during the reporting period (CPT): 99281, 99282, 99283, 99284, 99285, 99291
AND
Place of Service Indicator: 23
(The service must occur in the emergency department)

NUMERATOR:
Patients who had a 12-lead ECG performed

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
12-Lead ECG Performed
Performance Met: **CPT II 3120F:** 12-Lead ECG performed

OR

12-Lead ECG not Performed for Medical or Patient Reasons
Append a modifier (**1P or 2P**) to CPT Category II code **3120F** to report documented circumstances that appropriately exclude patients from the denominator.
Medical Performance Exclusion: **3120F *with* 1P:** Documentation of medical reason(s) for not performing a 12-Lead ECG

OR

Patient Performance Exclusion: **3120F *with* 2P:** Documentation of patient reason(s) for not performing a 12-Lead ECG

OR

12-Lead ECG not Performed, Reason not Otherwise Specified
Append a reporting modifier (**8P**) to CPT Category II code **3120F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.
Performance Not Met: **3120F *with* 8P:** 12-Lead ECG **not** performed, reason not otherwise specified

RATIONALE:
All patients in the age group for which CAD/ACS is part of the differential diagnosis, should have a 12-lead ECG performed.

CLINICAL RECOMMENDATION STATEMENTS:
Performance of a 12-lead ECG by EMS personnel at the site of first medical contact (FMC) is recommended in patients with symptoms consistent with STEMI. (ACC/AHA, 2013) (Level of evidence: B)

♦ Measure #65 (NQF 0069): Appropriate Treatment for Children with Upper Respiratory Infection (URI) – National Quality Strategy Domain: Efficiency and Cost Reduction

2015 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Percentage of children 3 months through 18 years of age who were diagnosed with upper respiratory infection (URI) and were not dispensed an antibiotic prescription on or three days after the episode

INSTRUCTIONS:
This measure is to be reported once for **each occurrence** of upper respiratory infection during the reporting period. Claims data will be analyzed to determine unique occurrences. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

Measure Reporting via Registry:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT or HCPCS codes, and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

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

DENOMINATOR:
Children 3 months through 18 years of age who had an outpatient or emergency department (ED) visit with only a diagnosis of upper respiratory infection (URI) during the measurement period

> **Denominator Instructions:** To determine eligibility, look for any of the listed antibiotic drugs below in the 30 days prior to the visit with the URI diagnosis. As long as there are no prescriptions for the listed antibiotics during this time period, the patient is eligible for denominator inclusion.
>
> **Denominator Criteria (Eligible Cases):**
> Patients aged 3 months through 18 years on date of encounter
> **AND**
> **Diagnosis for URI (ICD-9-CM) [for use 1/1/2015-9/30/2015]:** 460, 465.0, 465.8, 465.9
> **Diagnosis for URI (ICD-10-CM) [for use 10/01/2015-12/31/2015]:** J00, J06.0, J06.9
> **AND**
> **Patient encounter during the reporting period (CPT or HCPCS):** 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99217, 99218, 99219, 99220, 99281, 99282, 99283, 99284, 99285, G0402

Antibiotic Medications

Description	Prescription	
Aminopenicillins	• Amoxicillin	• Ampicillin
Beta-lactamase inhibitors	• Amoxicillin-clavulanate	
First generation cephalosporins	• Cefadroxil • Cefazolin	• Cephalexin
Folate antagonist	• Trimethoprim	

Description	Prescription	
Lincomycin derivatives	• Clindamycin	
Macrolides	• Azithromycin • Clarithromycin • Erythromycin	• Erythromycin ethylsuccinate • Erythromycin lactobionate • Erythromycin stearate
Miscellaneous antibiotics	• Erythromycin-sulfisoxazole	
Natural penicillins	• Penicillin G potassium • Penicillin G sodium	• Penicillin V potassium
Penicillinase-resistant penicillins	• Dicloxacillin	
Quinolones	• Ciprofloxacin • Levofloxacin	• Moxifloxacin • Ofloxacin
Second generation cephalosporins	• Cefaclor • Cefprozil	• Cefuroxime
Sulfonamides	• Sulfamethoxazole-trimethoprim	• Sulfisoxazole
Tetracyclines	• Doxycycline • Minocycline	• Tetracycline
Third generation cephalosporins	• Cefdinir • Cefixime • Cefpodoxime	• Ceftibuten • Cefditoren • Ceftriaxone

NUMERATOR:
Patients who were **not** prescribed or dispensed a prescription for antibiotic medication on or within 3 days after the URI Episode date

Numerator Instructions: For performance, the measure will be calculated as the number of patient's encounter(s) where antibiotics were neither prescribed nor dispensed on or within three days of the episode for URI over the total number of encounters in the denominator (patients aged 3 months through 18 years with an outpatient or ED visit for URI. A higher score indicates appropriate treatment of patients with URI (eg, the proportion for whom antibiotics were not prescribed or dispensed following the episode).

Numerator Options:
Performance Met: Patient **not** prescribed or dispensed antibiotic **(G8708)**

OR

Medical Performance Exclusion: Patient prescribed or dispensed antibiotic for documented medical reason(s) (eg,intestinal infection, pertussis, bacterial infection, Lyme disease, otitis media, acute sinusitis, acute pharyngitis, acute tonsillitis, chronic sinusitis, infection of the pharynx/larynx/tonsils/adenoids, prostatitis, cellulitis, mastoiditis, or bone infections, acute lymphadenitis, impetigo, skin staph infections, pneumonia/gonococcal infections, venereal disease (syphilis, chlamydia, inflammatory diseases [female reproductive organs]),

infections of the kidney, cystitis or UTI, and acne **(G8709)**

OR

Performance Not Met: Patient prescribed or dispensed antibiotic **(G8710)**

RATIONALE:

In 1998, 25 million patients (adults and children) sought care for non-specific upper respiratory infections (URI, also known as the common cold) and 30 percent received antibiotics (Gonzales 2001).

Inappropriate antibiotic prescriptions for URI, pharyngitis and bronchitis are estimated to amount to 55 percent (22.6 million) of all antibiotics prescribed for acute respiratory infections, costing $726 million in 1998 (Gonzales 2001).

Using antibiotics inappropriately can lead to antibiotic resistance, which can result in increased morbidity and mortality (Feikin 2000). The resulting increased effort to treat drug-resistant pathogens can also lead to more repeated health care visits, greater risk of disease complications and increased health care costs (Feikin 2000; Dagan 2000; Watanabe 2000).

CLINICAL RECOMMENDATION STATEMENTS:

American Family Physician (Wong, Blumberg, and Lowe 2006)

- A diagnosis of acute bacterial rhinosinusitis should be considered in patients with symptoms of a viral upper respiratory infection that have not improved after 10 days or that worsen after five to seven days. (C)
- Treatment of sinus infection with antibiotics in the first week of symptoms is not recommended. (C)
- Telling patients not to fill an antibiotic prescription unless symptoms worsen or fail to improve after several days can reduce the inappropriate use of antibiotics. (B)

♦ Measure #66 (NQF 0002): Appropriate Testing for Children with Pharyngitis – National Quality Strategy Domain: Efficiency and Cost Reduction

2015 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Percentage of children 2-18 years of age who were diagnosed with pharyngitis, ordered an antibiotic and received a group A streptococcus (strep) test for the episode

INSTRUCTIONS:
This measure is to be reported once for **each occurrence** of pharyngitis during the reporting period. Claims data will be analyzed to determine unique occurrences. This measure is intended to reflect the quality of services provided for the primary management of patients with pharyngitis who were dispensed an antibiotic. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

Measure Reporting via Registry:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT or HCPCS codes, and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

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

DENOMINATOR:
Children 2 through 18 years of age who had an outpatient or emergency department (ED) visit with a diagnosis of pharyngitis during the measurement period and an antibiotic ordered on or three days after the visit

> **Denominator Instructions:** To determine eligibility, look for any of the listed antibiotic drugs below in the 30 days prior to the visit with the pharyngitis diagnosis. As long as there are no prescriptions for the listed antibiotics during this time period, the patient is eligible for denominator inclusion.
>
> **Denominator Criteria (Eligible Cases):**
> Patients aged 2 through 18 years on date of encounter
> **AND**
> **Diagnosis for pharyngitis (ICD-9-CM) [for use 1/1/2015-9/30/2015]:** 034.0, 462, 463
> **Diagnosis for pharyngitis (ICD-10-CM) [for use 10/01/2015-12/31/2015]:** J02.0, J02.8, J02.9, J03.00, J03.01, J03.80, J03.81, J03.90, J03.91
> **AND**
> **Patient encounter during the reporting period (CPT or HCPCS):** 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99217, 99218, 99219, 99220, 99281, 99282, 99283, 99284, 99285, G0402
> **AND**
> Prescribed or dispensed antibiotic **(G8711)**

Antibiotic Medications

Description	Prescription	
Aminopenicillins	• Amoxicillin	• Ampicillin
Beta-lactamase inhibitors	• Amoxicillin-clavulanate	

Description	Prescription	
First generation cephalosporins	• Cefadroxil • Cefazolin	• Cephalexin
Folate antagonist	• Trimethoprim	
Lincomycin derivatives	• Clindamycin	
Macrolides	• Azithromycin • Clarithromycin • Erythromycin	• Erythromycin ethylsuccinate • Erythromycin lactobionate • Erythromycin stearate
Miscellaneous antibiotics	• Erythromycin-sulfisoxazole	
Natural penicillins	• Penicillin G potassium • Penicillin G sodium	• Penicillin V potassium
Penicillinase-resistant penicillins	• Dicloxacillin	
Quinolones	• Ciprofloxacin • Levofloxacin	• Moxifloxacin • Ofloxacin
Second generation cephalosporins	• Cefaclor • Cefprozil	• Cefuroxime
Sulfonamides	• Sulfamethoxazole-trimethoprim	• Sulfisoxazole
Tetracyclines	• Doxycycline • Minocycline	• Tetracycline
Third generation cephalosporins	• Cefdinir • Cefixime • Cefpodoxime	• Ceftibuten • Cefditoren • Ceftriaxone

NUMERATOR:
Children with a group A streptococcus test in the 7-day period from 3 days prior through 3 days after the pharyngitis episode date

Numerator Instructions: For performance, the measure will be calculated as the number of patient encounters where diagnosed with pharyngitis, dispensed an antibiotic and received a group A streptococcus (strep) test for the episode over the total number of encounters in the denominator (patients aged 2 through 18 years with an outpatient or ED visit and an antibiotic ordered on or three days after the visit). A higher score indicates appropriate treatment of children with pharyngitis (eg, the proportion for whom antibiotics were prescribed with an accompanying step test).

Numerator Options:

Performance Met: Group A Strep Test Performed **(3210F)**

OR

Performance Not Met: Group A Strep Test **not** Performed, reason not otherwise specified **(3210F *with* 8P)**

RATIONALE:

Group A streptococcal bacterial infections and other infections that cause pharyngitis (which are most often viral) often produce the same signs and symptoms (IDSA 2002). The American Academy of Pediatrics, the Centers for Disease Control and Prevention, and the Infectious Diseases Society of America all recommend a diagnostic test for Strep A to improve diagnostic accuracy and avoid unnecessary antibiotic treatment (Linder et al. 2005). A study on antibiotic treatment of children with sore throat found that although only 15 to 36 percent of children with sore throat have Strep A pharyngitis, physicians prescribed antibiotics to 53 percent of children with a chief complaint of sore throat between 1995 and 2003 (Linder et al., 2005).

CLINICAL RECOMMENDATION STATEMENTS:

Institute for Clinical Systems Improvement (ICSI) (2007)

Reduce unnecessary use of antibiotics. Antibiotic treatment should be reserved for a bacterial illness. Diagnosis of group A beta streptococcal Pharyngitis should be made by laboratory testing rather than clinically.

Infectious Disease Society of America (Bisno et al. 2002)

The signs and symptoms of group A streptococcal and other (most frequently viral) pharyngitides overlap broadly. Therefore, unless the physician is able with confidence to exclude the diagnosis of streptococcal pharyngitis on epidemiological and clinical grounds alone, a laboratory test should be done to determine whether group A streptococci are present in the pharynx.

With the exception of very rare infections by certain other pharyngeal bacterial pathogens (eg, Corynebacterium diphtheriae and Neisseria gonorrhoeae), antimicrobial therapy is of no proven benefit as treatment for acute pharyngitis due to bacteria other than group A streptococci. Therefore, it is extremely important that physicians exclude the diagnosis of group A streptococcal pharyngitis to prevent inappropriate administration of antimicrobials.

Michigan Quality Improvement Consortium (2007)

Probability of group A beta hemolytic streptococci (GABHS): Low; Testing: None; Treatment: Symptomatic treatment only. Avoid antibiotics. Probability of GABHS: Intermediate or High; Testing: Throat Culture (TC) OR Rapid Screen; Treatment: If TC is positive, use antibiotics. If TC is negative, use symptomatic treatment only. Avoid antibiotics. If treatment is started and culture result is negative, stop antibiotics. If Rapid Screen is positive, use antibiotics. If Rapid Screen is negative, culture (Culture is optional for age 16 and over) and only use antibiotics if throat culture is positive. (Michigan, 2007)

♣ Measure #67 (NQF 0377): Hematology: Myelodysplastic Syndrome (MDS) and Acute Leukemias: Baseline Cytogenetic Testing Performed on Bone Marrow – National Quality Strategy Domain: Effective Clinical Care

2015 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Percentage of patients aged 18 years and older with a diagnosis of myelodysplastic syndrome (MDS) or an acute leukemia who had baseline cytogenetic testing performed on bone marrow

INSTRUCTIONS:
This measure is to be reported a minimum of **once per reporting period** for **all** Myelodysplastic Syndrome (MDS) and Acute Leukemia patients seen during the reporting period, regardless of when MDS or Acute Leukemia diagnosis was made; the quality action being measured is that baseline cytogenetic testing on bone marrow was performed for each patient with MDS and Acute Leukemia at the time of diagnosis or prior to initiating treatment. It is anticipated that **clinicians who provide services for patients with the diagnosis of myelodysplastic syndromes or an acute leukemia (not in remission)** will submit this measure.

Measure Reporting via Registry:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

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

DENOMINATOR:
All patients aged 18 years and older with a diagnosis of myelodysplastic syndrome (MDS) or an acute leukemia

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Diagnosis for MDS or acute leukemia – not in remission (ICD-9-CM) [for use 1/1/2015-9/30/2015]: 204.00, 204.02, 205.00, 205.02, 206.00, 206.02, 207.00, 207.02, 207.20, 207.22, 208.00, 208.02, 238.72, 238.73, 238.74, 238.75
Diagnosis for MDS or acute leukemia – not in remission (ICD-10-CM) [for use 10/01/2015-12/31/2015]: C91.00, C91.02, C92.00, C92.02, C92.40, C92.42, C92.50, C92.52, C92.60, C92.62, C92.A0, C92.A2, C93.00, C93.02, C94.00, C94.02, C94.20, C94.22, C95.00, C95.02, D46.0, D46.1, D46.20, D46.21, D46.22, D46.4, D46.9, D46.A, D46.B, D46.C, D46.Z
AND
Patient encounter during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215

NUMERATOR:
Patients who had baseline cytogenetic testing performed on bone marrow

Definition:
Baseline Cytogenetic Testing – Testing that is performed at time of diagnosis or prior to initiating treatment (transfusion, growth factors, or antineoplastic therapy) for that diagnosis

Numerator Options:

	Performance Met:	Cytogenetic testing performed on bone marrow at time of diagnosis or prior to initiating treatment **(3155F)**
OR		
	Medical Performance Exclusion:	Documentation of medical reason(s) for not performing baseline cytogenetic testing on bone marrow (eg, no liquid bone marrow or fibrotic marrow) **(3155F *with* 1P)**
	Patient Performance Exclusion:	Documentation of patient reason(s) for not performing baseline cytogenetic testing on bone marrow (eg, at time of diagnosis receiving palliative care or not receiving treatment as defined above) **(3155F *with* 2P)**
	***System Performance Exclusion*:**	Documentation of system reason(s) for not performing baseline cytogenetic testing on bone marrow (eg, patient previously treated by another physician at the time cytogenetic testing performed) **(3155F *with* 3P)**
OR		
	Performance Not Met:	Cytogenetic testing **not** performed on bone marrow at time of diagnosis or prior to initiating treatment, reason not otherwise specified **(3155F *with* 8P)**

RATIONALE:

For MDS:

Cytogenetic testing is an integral component in calculating the International Prognostic Scoring System (IPSS) score. Cytogenetic testing should be performed on the bone marrow of patients with MDS in order to guide treatment options, determine prognosis, and predict the likelihood of disease evolution to leukemia.

For acute leukemias:

In addition to establishing the type of acute leukemia, cytogenetic testing is essential to detect chromosomal abnormalities that have diagnostic, prognostic, and therapeutic significance.

CLINICAL RECOMMENDATION STATEMENTS:

The following clinical recommendation statements are quoted verbatim from the referenced clinical guidelines:

For MDS:

Bone marrow aspiration with Prussian blue stain for iron and biopsy are needed to evaluate the degree of hematopoietic cell maturation abnormalities and relative proportions, percentage of marrow blasts, marrow cellularity, presence or absence of ringed sideroblasts (and presence of iron per se), and fibrosis. Cytogenetics for bone marrow samples (by standard karyotyping methods) should be obtained because they are of major importance for prognosis. (Category 2A Recommendation) (NCCN, 2014)

Acute Lymphoblastic Leukemia:

Hematopathology evaluations should include morphologic examination of malignant lymphocytes using Wright-Giemsa-stained slides and hemtoxylin and eosin (H&E)-stained core biopsy and clot sections, comprehensive immunophenotyping with flow cytometry, and assessment of cytogenetic or molecular abnormalities. Identification of specific recurrent genetic abnormalities is critical for disease evaluation, optimal risk stratification, and treatment planning. (Category 2A Recommendation) (NCCN, 2013)

Acute Myeloid Leukemia:

The initial evaluation of AML has two objectives. The first is to characterize the disease process based upon factors such as prior toxic exposure, antecedent myelodysplasia, and karyotypic or molecular abnormalities, which may provide prognostic information that can impact responsiveness to chemotherapy and risk of relapse. The second objective focuses on patient-specific factors including assessment of comorbid conditions, which may affect an individual's ability to tolerate chemotherapy. (Category 2A Recommendation) (NCCN, 2014)

♣ Measure #68 (NQF 0378): Hematology: Myelodysplastic Syndrome (MDS): Documentation of Iron Stores in Patients Receiving Erythropoietin Therapy – National Quality Strategy Domain: Effective Clincial Care

2015 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Percentage of patients aged 18 years and older with a diagnosis of myelodysplastic syndrome (MDS) who are receiving erythropoietin therapy with documentation of iron stores within 60 days prior to initiating erythropoietin therapy

INSTRUCTIONS:
This measure is to be reported a minimum of **once per reporting period** for **all** Myelodysplastic Syndrome (MDS) patients seen during the reporting period, regardless of when erythropoietin therapy is initiated; the quality action being measured is that iron stores were documented for each MDS patient receiving erythropoietin therapy within 60 days of starting erythropoietin therapy, regardless of how far back the erythropoietin therapy initiated. It is anticipated that **clinicians who provide services for patients with the diagnosis of myelodysplastic syndromes** will submit this measure.

Measure Reporting via Registry:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, QDC codes, and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

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

DENOMINATOR:
All patients aged 18 years and older with a diagnosis of myelodysplastic syndrome (MDS) who are receiving erythropoietin therapy

Definition:
Erythropoietin Therapy – Includes the following medications: epoetin and darbepoetin for the purpose of this measure.

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Diagnosis for MDS (ICD-9-CM) [for use 1/1/2015-9/30/2015]: 238.72, 238.73, 238.74, 238.75
Diagnosis for MDS (ICD-10-CM) [for use 10/01/2015-12/31/2015]: D46.0, D46.1, D46.20, D46.21, D46.22, D46.4, D46.9, D46.A, D46.B, D46.C, D46.Z
AND
Patient encounter during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215
AND
Patient receiving erythropoietin therapy: 4090F

NUMERATOR:
Patients with documentation of iron stores within 60 days prior to initiating erythropoietin therapy

Definition:

Documentation of Iron Stores – Includes either: **1)** bone marrow examination including iron stain OR **2)** serum iron measurement including ferritin, serum iron and total iron-binding capacity (TIBC).

Numerator Options:

Performance Met:	Documentation of iron stores prior to initiating erythropoietin therapy **(3160F)**
OR	
System Performance Exclusion:	Documentation of system reason(s) for not documenting iron stores prior to initiating erythropoietin therapy (3160F with 3P)
OR	
Performance Not Met:	Iron stores prior to initiating erythropoietin therapy **not** documented, reason not otherwise specified **(3160F with 8P)**

RATIONALE:
To be effective erythropoietin requires that adequate iron stores be present due to iron's importance in red-blood-cell synthesis. Iron deficiency presents a major limitation to the efficacy of erythropoietin therapy.

CLINICAL RECOMMENDATION STATEMENTS:
The following clinical recommendation statements are quoted verbatim from the referenced clinical guidelines:
Anemia related to MDS generally presents as a hypoproductive macrocytic anemia, often associated with suboptimal elevation of serum Epo levels. Iron repletion needs to be verified before instituting Epo or darbepoetin therapy. (Category 2A Recommendation) (NCCN, 2014)

♣ Measure #69 (NQF 0380): Hematology: Multiple Myeloma: Treatment with Bisphosphonates – National Quality Strategy Domain: Effective Clinical Care

2015 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Percentage of patients aged 18 years and older with a diagnosis of multiple myeloma, not in remission, who were prescribed or received intravenous bisphosphonate therapy within the 12 month reporting period

INSTRUCTIONS:
This measure is to be reported a minimum of **once per reporting period** for **all** multiple myeloma (not in remission) patients seen during the reporting period. It is anticipated that **clinicians who provide services for the patients with the diagnosis of multiple myeloma (not in remission)** will submit this measure.

Measure Reporting via Registry:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

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

DENOMINATOR:
All patients aged 18 years and older with a diagnosis of multiple myeloma, not in remission

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Diagnosis for multiple myeloma – not in remission (ICD-9-CM) [for use 1/1/2015-9/30/2015]: 203.00, 203.02
Diagnosis for multiple myeloma – not in remission (ICD-10-CM) [for use 10/01/2015-12/31/2015]: C90.00, C90.02
AND
Patient encounter during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215

NUMERATOR:
Patients who were prescribed or received intravenous bisphosphonate therapy within the 12 month reporting period

Definitions:
Bisphosphonate Therapy – Includes the following medications: pamidronate and zoledronate.
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 Options:

Performance Met:	Bisphosphonate therapy, intravenous, ordered or received **(4100F)**
OR	
Medical Performance Exclusion:	Documentation of medical reason(s) for not prescribing bisphosphonates (eg, patients who do not have bone

		disease, patients with dental disease, patients with renal insufficiency) **(4100F *with* 1P)**
	OR	
	Patient Performance Exclusion:	Documentation of patient reason(s) for not prescribing bisphosphonates **(4100F *with* 2P)**
OR		
	Performance Not Met:	Bisphosphonate therapy, intravenous, **not** ordered or received, reason not otherwise specified **(4100F *with* 8P)**

RATIONALE:
Multiple myeloma is a disease characterized by bone destruction, in the form of diffuse osteopenia and/or osteolytic lesions, which develop in a significant number of patients. Bisphosphonates can inhibit bone resorption by reducing the number and activity of osteoclasts.

Bisphosphonates have played an important palliative role in the care of patients with multiple myeloma. Use of these agents has demonstrated benefit in reducing painful bony complications.

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

Bony manifestations of myeloma, in the form of diffuse osteopenia and/or osteolytic lesions, develop in 85% of patients. Related complications are the major cause of limitations in quality of life and performance status in patients with MM. A recent meta-analysis of 20 randomized controlled trials of comparing bisphosphonates with either placebo or a different bisphosphonate as a comparator concluded that adding bisphosphonates to the treatment of MM reduces vertebral fractures and probably pain. The NCCN Guidelines for Multiple Myeloma recommend bisphosphonates for all patients receiving myeloma therapy for symptomatic disease regardless of documented bone disease. (Category 1 Recommendation) (NCCN, 2014)

In patients with smoldering or stage I MM, according to the NCCN Panel, bisphosphonates may be considered but preferably in a clinical trial. (Category 2A Recommendation) (NCCN, 2014)

♣ Measure #70 (NQF 0379): Hematology: Chronic Lymphocytic Leukemia (CLL): Baseline Flow Cytometry – National Quality Strategy Domain: Effective Clinical Care

2015 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Percentage of patients aged 18 years and older, seen within a 12 month reporting period, with a diagnosis of chronic lymphocytic leukemia (CLL) made at any time during or prior to the reporting period who had baseline flow cytometry studies performed and documented in the chart

INSTRUCTIONS:
This measure is to be reported a minimum of **once per reporting period** for **all** chronic lymphocytic leukemia (CLL) patients seen during the reporting period, regardless of when the diagnosis of CLL is made; the quality action being measured is that the baseline flow cytometry study occurred for each patient with CLL at the time of diagnosis or prior to initiating treatment. It is anticipated that **clinicians who provide services for patients with the diagnosis of chronic lymphocytic leukemia (not in remission)** will submit this measure.

Measure Reporting via Registry:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

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

DENOMINATOR:
All patients aged 18 years and older, seen within a 12 month reporting period, with a diagnosis of chronic lymphocytic leukemia (CLL) made at any time during or prior to the reporting period

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Diagnosis for CLL – not in remission (ICD-9-CM) [for use 1/1/2015-9/30/2015]: 204.10, 204.12
Diagnosis for CLL – not in remission (ICD-10-CM) [for use 10/01/2015-12/31/2015]: C91.10, C91.12
AND
Patient encounter during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215

NUMERATOR:
Patients who had baseline flow cytometry studies performed and documented in the chart

Definition:
Baseline Flow Cytometry Studies – Refer to testing that is performed at time of diagnosis or prior to initiating treatment for that diagnosis. Treatment may include anti-neoplastic therapy.

Numerator Options:

Performance Met:	Flow cytometry studies performed at time of diagnosis or prior to initiating treatment **(3170F)**
OR	
Medical Performance Exclusion:	Documentation of medical reason(s) for not performing baseline flow cytometry studies **(3170F *with* 1P)**

OR

Patient Performance Exclusion:	Documentation of patient reason(s) for not performing baseline flow cytometry studies (eg, receiving palliative care or not receiving treatment as defined above) **(3170F *with* 2P)**
OR	
System Performance Exclusion:	Documentation of system reason(s) for not performing baseline flow cytometry studies (eg, patient previously treated by another physician at the time baseline flow cytometry studies were performed) **(3170F *with* 3P)**

OR

Performance Not Met:	Flow cytometry studies **not** performed at time of diagnosis or prior to initiating treatment, reason not otherwise specified **(3170F *with* 8P)**

RATIONALE:

Due to the distinct pattern of protein antigens expressed in CLL, flow cytometry should be performed in order to confirm the diagnosis, correctly characterize the pathological cells, and determine prognosis. In some instances, flow cytometry may also offer additional therapeutically relevant information. (DiGiuseppe JA, Borowitz MJ. Clinical utility of flow cytometry studies in the chronic lymphoid leukemias. *Semin Oncol*. 1998:25(1):6-10.)

CLINICAL RECOMMENDATION STATEMENTS:

The following clinical recommendation statements are quoted verbatim from the referenced clinical guidelines:

Adequate immunophenotyping is required to establish the diagnosis of CLL/SLL. Flow cytometry of peripheral blood is adequate for the diagnosis of CLL, and a biopsy is generally not required. (Category 2A Recommendation) (NCCN, 2014)

¥ Measure #71 (NQF 0387): Breast Cancer: Hormonal Therapy for Stage IC - IIIC Estrogen Receptor/ Progesterone Receptor (ER/PR) Positive Breast Cancer – National Quality Domain: Effective Clinical Care

2015 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of female patients aged 18 years and older with Stage IC through IIIC, ER or PR positive breast cancer who were prescribed tamoxifen or aromatase inhibitor (AI) during the 12-month reporting period

INSTRUCTIONS:
This measure is to be reported a minimum of **once per reporting period** for **all** female patients with breast cancer seen during the reporting period. Review estrogen receptor (ER) or progesterone receptor (PR) AND breast cancer stage status AND tumor size to determine which quality-data codes should be submitted. It is anticipated that **clinicians who treat female breast cancer patients** will submit this measure.

Measure Reporting via Claims:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. CPT Category II codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and the appropriate CPT Category II codes **OR** the CPT Category II code(s) **with** the modifier. The modifiers allowed for this measure are: 1P- medical reasons, 2P- patient reasons, 3P- system reasons, 8P- reason not otherwise specified. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

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

DENOMINATOR:
All female patients aged 18 years and older with a diagnosis of breast cancer with Stage IC through IIIC, estrogen receptor (ER) or progesterone receptor (PR) positive breast cancer

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Diagnosis for breast cancer (ICD-9-CM) [for use 1/1/2015-9/30/2015]: 174.0, 174.1, 174.2, 174.3, 174.4, 174.5, 174.6, 174.8, 174.9
Diagnosis for breast cancer (ICD-10-CM) [for use 10/01/2015-12/31/2015]: C50.011, C50.012, C50.019, C50.111, C50.112, C50.119, C50.211, C50.212, C50.219 C50.311, C50.312, C50.319, C50.411, C50.412, C50.419, C50.511, C50.512, C50.519, C50.611, C50.612, C50.619, C50.811, C50.812, C50.819, C50.911, C50.912, C50.919
AND
Patient encounter during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215

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)*
Performance Met:

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.
Medical Performance Exclusion, Patient Performance Exclusion, or System Performance Exclusion:

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 currently receiving radiation or chemotherapy, patient's diagnosis date was ≥ 5 years from reporting date, patient's diagnosis date is within 120 days of the end of the 12-month reporting period, other medical reasons)
4179F *with* 2P:	Documentation of patient reason(s) for not prescribing tamoxifen or aromatase inhibitor (eg, patient refusal, other patient reasons)
4179F *with* 3P:	Documentation of system reason(s) for not prescribing tamoxifen or aromatase inhibitor (eg, patient is currently enrolled in a clinical trial, other system reasons)

AND

CPT II 3374F: AJCC Breast Cancer Stage I: T1C (tumor size > 1 cm to 2 cm), documented

OR

CPT II 3376F: AJCC Breast Cancer Stage II, documented

OR

CPT II 3378F: AJCC Breast Cancer Stage III, documented

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.*

Other Performance Exclusion: **CPT II 3370F:** AJCC Breast Cancer Stage 0, documented

OR

Other Performance Exclusion: **CPT II 3372F:** AJCC Breast Cancer Stage I: T1 mic, T1a or T1b (tumor size ≤ 1 cm), documented

OR

Other Performance Exclusion: **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.*

Other Performance Exclusion: **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.

Other Performance Exclusion: **3370F *with* 8P:** No documentation of cancer stage

OR

Other Performance Exclusion: **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.

Performance Not Met:

4179F *with* 8P:	Tamoxifen or aromatase inhibitor **not** prescribed, reason not otherwise specified
AND	
CPT II 3374F:	AJCC Breast Cancer Stage I: TIC (tumor size > 1 cm to 2 cm), documented
OR	
CPT II 3376F:	AJCC Breast Cancer Stage II, documented
OR	
CPT II 3378F:	AJCC Breast Cancer Stage III, documented
AND	
CPT II 3315F:	Estrogen receptor (ER) or progesterone receptor (PR) positive breast cancer

RATIONALE:

Despite evidence suggesting the role of adjuvant endocrine therapy in lowering the risk of tumor recurrence, many female patients who should be receiving this therapy are not. This measure assesses whether patients with a certain stage of breast cancer (IC through IIIC) and ER/PR+ are currently receiving the therapy. There are allowable medical, patient, and system reasons to document instances in which a woman with stage IC through IIIC, ER/PR+ may not be a candidate for the therapy.

Note: *The reporting/managing physician does not need to have actually written the prescription; however, the reporting/managing physician must verify that the patient already has been prescribed the hormonal therapy by another physician.*

CLINICAL RECOMMENDATION STATEMENTS:

Adjuvant therapy for postmenopausal women with hormone receptor–positive breast cancer should include an aromatase inhibitor in order to lower the risk of tumor recurrence. Aromatase inhibitors are appropriate as initial treatment for women with contraindications to tamoxifen. For all other postmenopausal women, treatment options include 5 years of aromatase inhibitors treatment or sequential therapy consisting of tamoxifen (for either 2 to 3 years or 5 years) followed by aromatase inhibitors for 2 to 3, or 5 years. (ASCO guidelines include narrative rankings) (ASCO, 2009)

Patients intolerant of aromatase inhibitors should receive tamoxifen. Women with hormone receptor–negative tumors should not receive adjuvant endocrine therapy. (ASCO guidelines include narrative rankings) (ASCO, 2009)

Patients with invasive breast cancers that are estrogen or progesterone receptor positive should be considered for adjuvant endocrine therapy regardless of patient age, lymph node status, or whether or not adjuvant chemotherapy is to be administered. (Category 2A) (NCCN, 2011)

The most firmly established adjuvant endocrine therapy is tamoxifen for both premenopausal and postmenopausal women. Prospective, randomized trials demonstrate that the optimal duration of tamoxifen appears to be five years. In patients receiving both tamoxifen and chemotherapy, chemotherapy should be given first, followed by sequential tamoxifen. A number of studies have evaluated aromatase inhibitors in the treatment of postmenopausal women with early-stage breast cancer. (Category 2A) (NCCN, 2011)

Patients with lymph node involvement or with tumors greater than 1 cm in diameter are appropriate candidates for adjuvant systemic therapy. (Category 1) For those with lymph node-negative, hormone receptor-positive breast cancer tumors greater than 1 cm, endocrine therapy with chemotherapy is recommended. (Category 1) (NCCN, 2011)

¥ Measure #72 (NQF 0385): Colon Cancer: Chemotherapy for AJCC Stage III Colon Cancer Patients – National Quality Domain: Effective Clinical Care

2015 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of patients aged 18 through 80 years with AJCC Stage III colon cancer who are referred for adjuvant chemotherapy, prescribed adjuvant chemotherapy, or have previously received adjuvant chemotherapy within the 12-month reporting period

INSTRUCTIONS:
This measure is to be reported a minimum of **once per reporting period** for **all** patients with colon cancer seen during the reporting period. It is anticipated that **clinicians who treat patients with colon cancer** will submit this measure.

Measure Reporting via Claims:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. CPT Category II codes and quality-data codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and the appropriate quality-data code **AND/OR** CPT Category II code **OR** the CPT Category II code **with** the modifier. The modifiers allowed for this measure are: 8P- reason not otherwise specified. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

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

DENOMINATOR:
All patients aged 18 through 80 years with AJCC Stage III colon cancer

> **Denominator Criteria (Eligible Cases):**
> Patients aged 18 through 80 years on date of encounter
> **AND**
> **Diagnosis for colon cancer (ICD-9-CM) [for use 1/1/2015-9/30/2015]:** 153.0, 153.1, 153.2, 153.3, 153.4, 153.6, 153.7, 153.8, 153.9
> **Diagnosis for colon cancer (ICD-10-CM) [for use 10/01/2015-12/31/2015]:** C18.0, C18.2, C18.3, C18.4, C18.5, C18.6, C18.7, C18.8, C18.9
> **AND**
> **Patient encounter during the reporting period (CPT):** 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215

NUMERATOR:
Patients who are referred for chemotherapy, prescribed 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, 2012). 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 quality-data code & one CPT II code [**G8927 & 3388F**] are required on the claim form to submit this numerator option)*

Performance Met:

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 quality-data code & one CPT II code [**G8928 & 3388F**] are required on the claim form to submit this numerator option)*

Other Performance Exclusion:

G8928:	Adjuvant chemotherapy not prescribed or previously received for documented reasons (eg, medical co-morbidities, diagnosis date more than 5 years prior to the current visit date, patient's diagnosis date is within 120 days of the end of the 12 month reporting period, patient's cancer has metastasized, medical contraindication/allergy, poor performance status, other medical reasons, patient refusal, other patient reasons, patient is currently enrolled in a clinical trial that precludes prescription of chemotherapy, other system reasons)
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)*

Other Performance Exclusion: **CPT II 3382F:**	AJCC Colon Cancer Stage 0, documented
OR	
Other Performance Exclusion: **CPT II 3384F:**	AJCC Colon Cancer Stage I, documented
OR	
Other Performance Exclusion: **CPT II 3386F:**	AJCC Colon Cancer Stage II, documented

OR

Other Performance Exclusion: **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.

Other Performance Exclusion: **3382F *with* 8P:** No documentation of cancer stage

OR

Adjuvant Chemotherapy not Referred, Prescribed or Previously Received, Reason not Given
*(One quality-data code & one CPT II code [**G8929 & 3388F**] are required on the claim form to submit this numerator option)*
Report **G8929** in circumstances when the action described in the numerator is not performed and the reason is not given.

Performance Not Met:

G8929: Adjuvant chemotherapy **not** prescribed or previously received, reason not given

AND

CPT II 3388F: AJCC Colon Cancer Stage III, documented

RATIONALE:
The receipt of adjuvant chemotherapy in AJCC Stage III colon cancer patients following primary surgical treatment is associated with a significant survival benefit.

CLINICAL RECOMMENDATION STATEMENTS:
For stage III patients (T1-4, N1-2, M0), the panel recommends 6 months of adjuvant chemotherapy following primary surgical treatment. The treatment options are: 5-FU/LV/oxaliplatin (mFOLFOX6) as the standard of care (category 1); bolus 5-FU/LV/oxaliplatin (FLOX, category 1), capecitabine/oxaliplatin (CapeOx, category 1); or single agent capecitabine (category 2A) or 5-FU/LV (category 2A) in patients felt to be inappropriate for oxaliplatin therapy. (NCCN, 2012)

There is currently a shortage of leucovorin in the United States. There are no specific data to guide management under these circumstances, and all proposed strategies are empiric. The panel recommends several possible options to help alleviate the problems associated with this shortage. One is the use of levo-leucovorin, which is commonly used in Europe. A dose of 200 mg/m^2 of levo–leucovorin is equivalent to 400 mg/m^2 of standard leucovorin. Another option is for practices or institutions to use lower doses of leucovorin for all doses in all patients, since the panel feels that lower doses are likely to be as efficacious as higher doses, based on several studies. Finally, if none of the above options are available, treatment without leucovorin would be reasonable. (NCCN, 2012)

Measure #76 (NQF 0464): Prevention of Central Venous Catheter (CVC) - Related Bloodstream Infections – National Quality Strategy Domain: Patient Safety

2015 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of patients, regardless of age, who undergo central venous catheter (CVC) insertion for whom CVC was inserted with all elements of maximal sterile barrier technique, hand hygiene, skin preparation and, if ultrasound is used, sterile ultrasound techniques followed

INSTRUCTIONS:
This measure is to be reported **each time** a CVC insertion is performed during the reporting period. There is no diagnosis associated with this measure. It is anticipated that **clinicians who perform CVC insertion** will submit this measure.

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

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

Measure Reporting via Registry:
CPT codes are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

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

DENOMINATOR:
All patients, regardless of age, who undergo CVC insertion

Denominator Criteria (Eligible Cases):
Patient encounter during the reporting period (CPT): 36555, 36556, 36557, 36558, 36560, 36561, 36563, 36565, 36566, 36568, 36569, 36570, 36571, 36578, 36580, 36581, 36582, 36583, 36584, 36585, 93503

NUMERATOR:
Patients for whom central venous catheter (CVC) was inserted with all elements of maximal sterile barrier technique, hand hygiene, skin preparation and, if ultrasound is used, sterile ultrasound techniques followed

Definition:
Maximal Sterile Barrier Technique – includes **all** of the following elements: Cap AND mask AND sterile gown AND sterile gloves AND sterile full body drape.
Sterile Ultrasound Techniques – require sterile gel and sterile probe covers.

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
All Elements of Maximal Sterile Barrier Technique Followed

***Performance Met:* CPT II 6030F:** All elements of maximal sterile barrier technique followed including: cap AND mask AND sterile gown AND sterile gloves AND a large sterile sheet AND hand hygiene AND 2% chlorhexidine for cutaneous antisepsis (or acceptable alternative antiseptics, per current guideline)

OR

All Elements of Maximal Sterile Barrier Technique not Followed for Medical Reasons
Append a modifier (**1P**) to CPT Category II code **6030F** to report documented circumstances that appropriately exclude patients from the denominator.

***Medical Performance Exclusion:* 6030F *with* 1P:** Documentation of medical reason(s) for not following all elements of maximal sterile barrier technique, hand hygiene, skin preparation and, if ultrasound is used, sterile ultrasound techniques during CVC insertion (including increased risk of harm to patient if adherence to aseptic technique would cause delay in CVC insertion)

OR

All Elements of Maximal Sterile Barrier Technique not Followed, Reason not Otherwise Specified
Append a reporting modifier (**8P**) to CPT Category II code **6030F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

***Performance Not Met:* 6030F *with* 8P:** All elements of maximal sterile barrier technique **not** followed including: cap AND mask AND sterile gown AND sterile gloves AND a large sterile sheet AND hand hygiene AND 2% chlorhexidine for cutaneous antisepsis (or acceptable alternative antiseptics, per current guideline), reason not otherwise specified

RATIONALE:
Catheter-related bloodstream infection is a costly complication of central venous catheter insertion, but may be avoided with routine use of aseptic technique during catheter insertion. This measure is constructed to require that *all* of the listed elements of aseptic technique are followed and documented.

CLINICAL RECOMMENDATION STATEMENTS:
Maximal sterile barrier precautions: Use maximal sterile barrier precautions, including the use of a cap, mask, sterile gown, sterile gloves, and a sterile full body drape, for the insertion of CVCs, PICCS, or guidewire exchange (CDC) (Category IB)

Hand hygiene: Perform hand hygiene procedures, either by washing hands with conventional soap and water or with alcohol-based hand rubs (ABHR) (Category IB)

Skin Preparation: Prepare clean skin with a >0.5% chlorhexidine preparation with alcohol before central venous catheter and peripheral arterial catheter insertion and during dressing changes. If there is a contraindication to chlorhexidine, tincture of iodine, an iodophor, or 70% alcohol can be used as alternatives (Category IB)

Sterile Ultrasound: The Food and Drug Administration recommends that policies and clinical practice standards be reviewed to ensure the use of sterile ultrasound gel. Once a container of sterile or non-sterile ultrasound gel is opened, it is no longer sterile and contamination during ongoing use is possible

Measure #81 (NQF 0323): Adult Kidney Disease: Hemodialysis Adequacy: Solute – National Quality Strategy Domain: Communication and Care Coordination

2015 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Percentage of calendar months within a 12-month period during which patients aged 18 years and older with a diagnosis of End Stage Renal Disease (ESRD) receiving hemodialysis three times a week for ≥ 90 days have a spKt/V ≥ 1.2

INSTRUCTIONS:
This measure is to be reported **each calendar month** the patient meets denominator criteria for End Stage Renal Disease (ESRD) patients seen during the reporting period. It is anticipated that **clinicians providing care for patients with ESRD** will submit this measure.

Measure Reporting via Registry:
ICD-9-CM/ICD-10-CM diagnosis codes CPT codes, quality-data code, and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

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

DENOMINATOR:
All calendar months during which patients aged 18 years and older with a diagnosis of ESRD are receiving hemodialysis three times a week for ≥ 90 days

> ***DENOMINATOR NOTE:*** *There should be documentation in the patient's chart that he/she is receiving hemodialysis three times per week for* ***≥ 90 days****.*
>
> **Denominator Criteria (Eligible Cases):**
> Patients aged ≥ 18 years on date of encounter
> **AND**
> **Diagnosis for ESRD (ICD-9-CM) [for use 1/1/2015-9/30/2015]:** 585.6
> **Diagnosis for ESRD (ICD-10-CM) [for use 10/01/2015-12/31/2015]:** N18.6
> **AND**
> **Encounter for Dialysis and Dialysis Catheter Care (ICD-9-CM) [for use 1/1/2015-9/30/2015]:** V56.0, V56.1, V56.32
> **Encounter for Dialysis and Dialysis Catheter Care (ICD-10-CM) [for use 10/01/2015-12/31/2015]:** Z49.01, Z49.31, Z49.32
> **AND**
> **Hemodialysis treatment performed exactly three times per week for ≥ 90 days:** G8714
> **AND**
> **Patient encounter during the reporting period (CPT):** 90957, 90958, 90959, 90960, 90961, 90962, 90965, 90966, 90969, 90970

NUMERATOR:
Calendar months during which patients have a spKt/V ≥ 1.2

NUMERATOR NOTE: *Urea kinetic modeling (UKM) or the second generation Daugirdas formula (simplified multivariable equation) are the most appropriate ways to calculate spKt/V, and the two accepted methods for calculating spKt/V per the KDOQI guidelines. For more information on these methods, please refer to National Kidney Foundation's KDOQI Clinical Practice Guidelines and Clinical Practice Recommendations for 2006 Updates: Hemodialysis Adequacy, Peritoneal Dialysis Adequacy and Vascular Access. Am J Kidney Dis 48:S1-S322, 2006 (suppl 1).*

Numerator Options:

Performance Met: spKt/V greater than or equal to 1.2 (single-pool clearance of urea [Kt] / volume [V]) **(G8713)**

OR

Performance Not Met: spKt/V less than 1.2 (single-pool clearance of urea [Kt] / volume [V]), reason not given **(G8717)**

RATIONALE:

Adequate dialysis dose (Kt/V ≥ 1.2), is strongly associated with better outcomes, including decreased mortality, fewer hospitalizations, decreased length of hospitalizations, and decreased hospital costs. (Plantinga et al, 2007 and Sehgal et al, 2001)

CLINICAL RECOMMENDATION STATEMENTS:

The following evidence statements are quoted verbatim from the referenced clinical guidelines. Only selected portions of the clinical guidelines are quoted here; for more details, please refer to the full guideline.

The minimally adequate dose of HD given 3 times per week to patients with Kr less than 2 mL/min/1.73m2 should be an spKt/V (excluding RKF) of 1.2 per dialysis. For treatment times less than 5 hours, an alternative minimum dose is a URR of 65% (A). The target dose for HD given 3 times per week with Kr less than 2mL/min/1.73m2 should be an spKt/V of 1.4 per dialysis not including RKF, or URR of 70% (A). (KDOQI, 2006)

Measure #82 (NQF 0321): Adult Kidney Disease: Peritoneal Dialysis Adequacy: Solute – National Quality Strategy Domain: Effective Clinical Care

2015 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Percentage of patients aged 18 years and older with a diagnosis of End Stage Renal Disease (ESRD) receiving peritoneal dialysis that have a total Kt/V ≥ 1.7 per week measured once every 4 months

INSTRUCTIONS:
This measure is to be reported **up to three times per reporting year for ESRD patients** receiving peritoneal dialysis during the entire reporting period and seen during the reporting period. This measure should be reported according to the following frequency depending on the number of months during the reporting period a patient is receiving peritoneal dialysis:

- 1 to 4 consecutive months of treatment – report once during the reporting year
- 5 to 8 consecutive months of treatment – report twice during the reporting year
- 9 to 12 consecutive months of treatment – report three times during the reporting year

It is anticipated that **clinicians providing care for patients with ESRD** will submit this measure.

Measure Reporting via Registry:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

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

DENOMINATOR:
All patients aged 18 years and older with a diagnosis of ESRD receiving peritoneal dialysis

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Diagnosis for ESRD (ICD-9-CM) [for use 1/1/2015-9/30/2015]: 585.6
Diagnosis for ESRD (ICD-10-CM) [for use 10/01/2015-12/31/2015]: N18.6
AND
Encounter for Dialysis and Dialysis Catheter Care (ICD-9-CM) [for use 1/1/2015-9/30/2015]: V56.2, V56.32, V56.8
Encounter for Dialysis and Dialysis Catheter Care (ICD-10-CM) [for use 10/01/2015-12/31/2015]: Z49.02, Z49.32
AND
Patient encounter during the reporting period (CPT): 90945, 90947, 90957, 90958, 90959, 90960, 90961, 90962, 90965, 90966, 90969, 90970

NUMERATOR:
Patients who have a total Kt/V ≥ 1.7 per week measured once every 4 months

Definition:

Total Kt/V – Total Kt/V includes residual kidney function and equals peritoneal dialysate Kt/V plus renal Kt/V.

Numerator Options:

Performance Met: Total Kt/V greater than or equal to 1.7 per week (Total clearance of urea [Kt]/volume [V]) **(G8718)**

OR

Performance Not Met: Total Kt/V less than 1.7 per week (Total clearance of urea [Kt]/volume [V] **(G8720)**

RATIONALE:

Adequate dialysis dose is strongly associated with better outcomes, including decreased mortality, fewer hospitalizations, fewer days in the hospital, and decreased hospital costs. (Plantinga et al, 2007)

CLINICAL RECOMMENDATION STATEMENTS:

The following evidence statements are quoted verbatim from the referenced clinical guidelines. Only selected portions of the clinical guidelines are quoted here; for more details, please refer to the full guideline.

Total solute clearance (residual kidney and peritoneal, in terms of Kt/V urea) should be measured within the first month after initiating dialysis therapy and at least once every 4 months thereafter (B). (KDOQI, 2006)

For patients with residual kidney function (considered to be significant when urine volume is > 100 mL/d): The minimal "delivered" dose of total small-solute clearance should be a total (peritoneal and kidney) Kt/V urea of at least 1.7 per week (B). For patients without RKF (considered insignificant when urine volume is ≤ 100 mL/d): The minimal "delivered" dose of total small-solute clearance should be a peritoneal Kt/V urea of at least 1.7 per week measured within the first month after starting dialysis therapy and at least once every 4 months thereafter (B). (KDOQI, 2006)

▣ Measure #91 (NQF 0653): Acute Otitis Externa (AOE): Topical Therapy – National Quality Strategy Domain: Effective Clinical Care

2015 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of patients aged 2 years and older with a diagnosis of AOE who were prescribed topical preparations

INSTRUCTIONS:
This measure is to be reported once for **each occurrence** of AOE during the reporting period. Each unique occurrence is defined as a 30-day period from onset of AOE. Claims data will be analyzed to determine unique occurrences. If multiple claims are submitted within that 30-day period, only one instance of reporting will be counted. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

Measure Reporting via Claims:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. CPT Category II codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the appropriate ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and the appropriate CPT Category II code **OR** the CPT Category II code **with** the modifier. The modifiers allowed for this measure are: 1P- medical reasons, 2P- patient reasons, 8P- reason not otherwise specified. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

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

DENOMINATOR:
All patients aged 2 years and older with a diagnosis of AOE

Denominator Criteria (Eligible Cases):
Patients aged ≥ 2 years on date of encounter
AND
Diagnosis for AOE (ICD-9-CM) [for use 1/1/2015-9/30/2015]: 380.10, 380.11, 380.12, 380.13, 380.22
Diagnosis for AOE (ICD-10-CM) [for use 10/01/2015-12/31/2015]: H60.00, H60.01, H60.02, H60.03, H60.10, H60.11, H60.12, H60.13, H60.311, H60.312, H60.313, H60.319, H60.321, H60.322, H60.323, H60.329, H60.331, H60.332, H60.333, H60.339, H60.391, H60.392, H60.393, H60.399, H60.501, H60.502, H60.503, H60.509, H60.511, H60.512, H60.513, H60.519, H60.521, H60.522, H60.523, H60.529, H60.531, H60.532, H60.533, H60.539, H60.541, H60.542, H60.543, H60.549, H60.551, H60.552, H60.553, H60.559, H60.591, H60.592, H60.593, H60.599, H61.90, H61.91, H61.92, H61.93, H62.40, H62.41, H62.42, H62.43, H62.8X1, H62.8X2, H62.8X3, H62.8X9
AND
Patient encounter during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99281, 99282, 99283, 99284, 99285,99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350

NUMERATOR:
Patients who were prescribed topical preparations

Definition:
Prescribed – May include prescription given to the patient for topical preparations at one or more visits during the episode of AOE OR patient already receiving topical preparations as documented in the current medication list.

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Performance Met:	Topical preparations (including OTC) prescribed for acute otitis externa **(4130F)**
OR	
Medical Performance Exclusion:	Documentation of medical reason(s) for not prescribing topical preparations (including OTC) for acute otitis externa (eg, coexisting acute otitis media, tympanic membrane perforation) **(4130F *with* 1P)**
OR	
Patient Performance Exclusion:	Documentation of patient reason(s) for not prescribing topical preparations (including OTC) for acute otitis externa **(4130F *with* 2P)**
OR	
Performance Not Met:	Topical preparations (including OTC) for acute otitis externa (AOE) **not** prescribed, reason not otherwise specified **(4130F *with* 8P)**

RATIONALE:
Topical preparations should be used to treat AOE as they are active against the most common bacterial pathogens in AOE, Pseudomonas aeruginosa and Staphylococcus aureus. Topical preparations have demonstrated efficacy in the treatment of AOE with resolution in about 65-90% of patients.

CLINICAL RECOMMENDATION STATEMENTS:
Clinicians should prescribe topical preparations for initial therapy of diffuse, uncomplicated AOE. (Recommendation based on randomized trials with some heterogeneity and a preponderance of benefit over harm. [Aggregate evidence quality – Grade B]) (AAO-HNSF, 2014)

◙ Measure #93 (NQF 0654): Acute Otitis Externa (AOE): Systemic Antimicrobial Therapy – Avoidance of Inappropriate Use – National Quality Strategy Domain: Efficiency and Cost Reduction

2015 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of patients aged 2 years and older with a diagnosis of AOE who were **not prescribed** systemic antimicrobial therapy

INSTRUCTIONS:
This measure is to be reported once for **each occurrence** of AOE during the reporting period. Each unique occurrence is defined as a 30-day period from onset of AOE. Claims data will be analyzed to determine unique occurrences. If multiple claims are submitted within that 30-day period, only one instance of reporting will be counted. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

Measure Reporting via Claims:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. CPT Category II codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the appropriate ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and the appropriate CPT Category II code **OR** the CPT Category II code **with** the modifier. The modifier allowed for this measure is: 1P- medical reasons. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

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

DENOMINATOR:
All patients aged 2 years and older with a diagnosis of AOE

Denominator Criteria (Eligible Cases):
Patients aged ≥ 2 years on date of encounter
AND
Diagnosis for AOE (ICD-9-CM) [for use 1/1/2015-9/30/2015]: 380.10, 380.11, 380.12, 380.13, 380.22
Diagnosis for AOE (ICD-10-CM) [for use 10/01/2015-12/31/2015]: H60.00, H60.01, H60.02, H60.03, H60.10, H60.11, H60.12, H60.13, H60.311, H60.312, H60.313, H60.319, H60.321, H60.322, H60.323, H60.329, H60.331, H60.332, H60.333, H60.339, H60.391, H60.392, H60.393, H60.399, H60.501, H60.502, H60.503, H60.509, H60.511, H60.512, H60.513, H60.519, H60.521, H60.522, H60.523, H60.529, H60.531, H60.532, H60.533, H60.539, H60.541, H60.542, H60.543, H60.549, H60.551, H60.552, H60.553, H60.559, H60.591, H60.592, H60.593, H60.599, H61.90, H61.91, H61.92, H61.93, H62.40, H62.41, H62.42, H62.43, H62.8X1, H62.8X2, H62.8X3, H62.8X9
AND
Patient encounter during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99281, 99282, 99283, 99284, 99285, 99304, 99305, 99306, 99307, 99308, 99309,

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

NUMERATOR:
Patients who were **not** prescribed systemic antimicrobial therapy

Numerator Instructions: For performance, the measure will be calculated as the number of patients for whom systemic antimicrobial therapy was not prescribed over the number of patients in the denominator (patients aged 2 years and older with acute otitis externa). A higher score indicates appropriate treatment of patients with AOE (eg, the proportion for whom systemic antimicrobials were not prescribed).

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Systemic Antimicrobial Therapy not Prescribed
***Performance Met:* CPT II 4132F:** Systemic antimicrobial therapy **not** prescribed

OR

Systemic Antimicrobial Therapy Prescribed for Medical Reasons
Append a modifier (**1P**) to CPT Category II code **4131F** to report documented circumstances that appropriately exclude patients from the denominator
***Medical Performance Exclusion:* 4131F *with* 1P:** Documentation of medical reason(s) for prescribing systemic antimicrobial therapy (eg, coexisting diabetes, immune deficiency)

OR

Systemic Antimicrobial Therapy Prescribed
***Performance Not Met:* CPT II 4131F:** Systemic antimicrobial therapy prescribed

RATIONALE:
Despite their limited utility, many patients with AOE receive systemic antimicrobial therapy, often in addition to topical therapy. “There are no data on the efficacy of systemic therapy with the use of appropriate antibacterials and stratified by severity of the infection. Moreover, orally administered antibiotics have significant adverse effects that include rashes, vomiting, diarrhea, allergic reactions, altered nasopharyngeal flora, and development of bacterial resistance”. The use of systemic antimicrobial therapy to treat AOE should be limited only to those clinical situations in which it is indicated.

CLINICAL RECOMMENDATION STATEMENTS:
Clinicians should not prescribe systemic antimicrobials as initial therapy for diffuse, uncomplicated AOE unless there is extension outside the ear canal or the presence of specific host factors that would indicate a need for systemic therapy. (Strong recommendation based on randomized controlled trials with minor limitations and a preponderance of benefit over harm. [Aggregate evidence quality – Grade B]) (AAO-HNSF, 2014)

Measure #99 (NQF 0391): Breast Cancer Resection Pathology Reporting: pT Category (Primary Tumor) and pN Category (Regional Lymph Nodes) with Histologic Grade – National Quality Clinical Strategy: Effective Clinical Care

2015 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of breast cancer resection pathology reports that include the pT category (primary tumor), the pN category (regional lymph nodes), and the histologic grade

INSTRUCTIONS:
This measure is to be reported **each time** a breast cancer resection surgical pathology examination is performed during the reporting period for breast cancer patients. Each unique CPT Category I code submitted on the claim will be counted for denominator inclusion. It is anticipated that **clinicians who examine breast tissue specimens following resection** in a laboratory or institution will submit this measure. Independent laboratories (ILs) and independent diagnostic testing facilities (IDTFs), using indicator Place of Service 81, are **not** included in PQRS. If the specimen is not primary breast tissue (eg, liver, lung), report only CPT II code **3250F**.

Measure Reporting via Claims:
ICD-9-CM/ICD-10-CM diagnosis codes and CPT codes are used to identify patients who are included in the measure's denominator. CPT Category II codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the appropriate ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and the appropriate CPT Category II code **OR** the CPT Category II code **with** the modifier. The modifiers allowed for this measure are: 1P- medical reasons, 8P- reason not otherwise specified. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
ICD-9-CM/ICD-10-CM diagnosis codes and CPT codes are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

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

DENOMINATOR:
All breast cancer resection pathology reports (excluding biopsies)

Denominator Criteria (Eligible Cases):
Diagnosis for breast cancer (ICD-9-CM) [for use 1/1/2015-9/30/2015]: 174.0, 174.1, 174.2, 174.3, 174.4, 174.5, 174.6, 174.8, 174.9, 175.0, 175.9
Diagnosis for breast cancer (ICD-10-CM) [for use 10/01/2015-12/31/2015]: C50.011, C50.012, C50.019, C50.021, C50.022, C50.029, C50.111, C50.112, C50.119, C50.121, C50.122, C50.129, C50.211, C50.212, C50.219, C50.221, C50.222, C50.229, C50.311, C50.312, C50.319, C50.321, C50.322, C50.329, C50.411, C50.412, C50.419, C50.421, C50.422, C50.429, C50.511, C50.512, C50.519, C50.521, C50.522, C50.529, C50.611, C50.612, C50.619, C50.621, C50.622, C50.629, C50.811, C50.812, C50.819, C50.821, C50.822, C50.829, C50.911, C50.912, C50.919, C50.921, C50.922, C50.929
AND
Patient encounter during the reporting period (CPT): 88307, 88309

NUMERATOR:
Reports that include the pT category, the pN category and the histologic grade

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

pT Category, pN Category and Histologic Grade Documented

***Performance Met:* CPT II 3260F:** pT category (primary tumor), pN category (regional lymph nodes), and histologic grade documented in pathology report

OR

pT Category, pN Category and Histologic Grade not Documented for Medical Reasons

Append a modifier (**1P**) to CPT Category II code **3260F** to report documented circumstances that appropriately exclude patients from the denominator.

***Medical Performance Exclusion:* 3260F *with* 1P:** Documentation of medical reason(s) for not including the pT category, the pN category, or the histologic grade in the pathology report (eg, re-excision without residual tumor, non-carcinomas)

OR

If patient is not eligible for this measure because the specimen is not primary breast tissue (eg, liver, lung) report:

***Other Performance Exclusion:* CPT II 3250F:** Specimen site other than anatomic location of primary tumor

OR

pT Category, pN Category and Histologic Grade not Documented, Reason not Otherwise Specified

Append a reporting modifier (**8P**) to CPT Category II code **3260F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

***Performance Not Met:* 3260F *with* 8P:** pT category, pN category, and histologic grade were **not** documented in pathology report, reason not otherwise specified

RATIONALE:

Therapeutic decisions for breast cancer management are stage driven and cannot be made without a complete set of pathology descriptors. Incomplete cancer resection pathology reports may result in misclassification of patients, rework and delays, and suboptimal management. The College of American Pathologists (CAP) has produced evidence-based checklists of essential pathologic parameters that are recommended to be included in cancer resection pathology reports. These checklists have been endorsed as a voluntary standard by National Quality Forum (NQF) and are considered the reporting standard by the Commission on Cancer (CoC) of the American College of Surgeons (ACS).

The CAP recently conducted a structured audit of breast cancer pathology report adequacy at 86 institutions. Overall, 35% of eligible reports were missing at least one of the ten CAP-recommended breast cancer elements. Cancer Care Ontario (CCO) conducted a similar study in 2005 and found that 25% of breast cancer pathology reports did not include all of the information required by the CAP standards. While the exact percentage of breast cancer resection pathology reports that are missing the pT category, the pN category and the histologic grade is unknown, these are essential elements in breast cancer treatment decisions and should be included in every pathology report when possible.

The CAP recently conducted a structured audit of breast cancer pathology report adequacy at 86 institutions. Overall, 32% of eligible reports were missing at least one of the ten CAP-recommended breast cancer elements (Idowu MO, et al).

CLINICAL RECOMMENDATION STATEMENTS:

All invasive breast carcinomas, with the exception of medullary carcinoma should be graded. The grading system used must be specified in the report; the Nottingham combined histologic grade (Elston-Ellis modification of Scarff-

Bloom-Richardson grading system) is recommended. Within each stage grouping there is a relation between histologic grade and outcome. (CAP, 2010)

All patients with breast cancer should be assigned a clinical stage of disease, and if appropriate evaluation is available, a pathologic stage of disease. The routine use of staging allows for efficient identification of local treatment options, assists in identifying systemic treatment options, allows the comparison of outcomes results across institutions and clinical trials, and provides baseline prognostic information. (NCCN, 2012)

Measure #100 (NQF 0392): Colorectal Cancer Resection Pathology Reporting: pT Category (Primary Tumor) and pN Category (Regional Lymph Nodes) with Histologic Grade – National Quality Strategy Domain: Effective Clinical Care

2015 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of colon and rectum cancer resection pathology reports that include the pT category (primary tumor), the pN category (regional lymph nodes) and the histologic grade

INSTRUCTIONS:
This measure is to be reported **each time** a colorectal cancer resection surgical pathology examination is performed during the reporting period for colorectal cancer patients. Each unique CPT Category I code submitted on the claim will be counted for denominator inclusion. It is anticipated that **clinicians who examine colorectal tissue specimens following resection** in a laboratory or institution will submit this measure. Independent Laboratories (ILs) and Independent Diagnostic Testing Facilities (IDTFs), using indicator Place of Service 81, are not included in PQRS. If the specimen is not primary colorectal tissue (eg, liver, lung), report only **G8723**.

Measure Reporting via Claims:
ICD-9-CM/ICD-10-CM diagnosis codes and CPT codes are used to identify patients who are included in the measure's denominator. Quality-data codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the appropriate ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and the appropriate quality-data code. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
ICD-9-CM/ICD-10-CM diagnosis codes and CPT codes are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

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

DENOMINATOR:
All colon and rectum cancer resection pathology reports

> **Denominator Criteria (Eligible Cases):**
> **Diagnosis for colon or rectum cancer (ICD-9-CM) [for use 1/1/2015-9/30/2015]:** 153.0, 153.1, 153.2, 153.3, 153.4, 153.5, 153.6, 153.7, 153.8, 153.9, 154.0, 154.1, 154.8
> **Diagnosis for colon or rectum cancer (ICD-10-CM) [for use 10/1/2015-12/31/2015]:** C18.0, C18.1, C18.2, C18.3, C18.4, C18.5, C18.6, C18.7, C18.8, C18.9, C19, C20, C21.2, C21.8
> **AND**
> **Patient encounter during the reporting period (CPT):** 88309

NUMERATOR:
Reports that include the pT category, the pN category and the histologic grade

> **Numerator Quality-Data Coding Options for Reporting Satisfactorily:**
> **pT Category, pN Category and Histologic Grade Documented**

***Performance Met:* G8721:** pT category (primary tumor), pN category (regional lymph nodes), and histologic grade were documented in pathology report

OR

pT Category, pN Category and Histologic Grade not Documented for Medical Reasons:

***Other Performance Exclusion:* G8722:** Documentation of medical reason(s) for not including the pT category, the pN category or the histologic grade in the pathology report (eg, re-excision without residual tumor; non-carcinomas, anal canal)

OR

If patient is not eligible for this measure because the specimen is not primary colorectal tissue (eg, liver, lung) report:

***Other Performance Exclusion:* G8723:** Specimen site is other than anatomic location of primary tumor

OR

pT Category, pN Category and Histologic Grade not Documented, Reason not Given

***Performance Not Met:* G8724:** pT category, pN category and histologic grade were **not** documented in the pathology report, reason not given

RATIONALE:

Therapeutic decisions for colorectal cancer management are stage driven and cannot be made without a complete set of pathology descriptors. Incomplete cancer resection pathology reports may result in misclassification of patients, rework and delays, and suboptimal management. The College of American Pathologists (CAP) has produced evidence-based checklists of essential pathologic parameters that are recommended to be included in cancer resection pathology reports. These checklists have been endorsed as a voluntary standard by National Quality Forum (NQF) and are considered the reporting standard by the Commission on Cancer (CoC) of the American College of Surgeons (ACS).

The CAP conducted a structured audit of colorectal cancer pathology report adequacy at 86 institutions. Overall, 21% of eligible reports were missing at least one of the ten CAP-recommended colorectal cancer elements. (Idowu MO, et al, 2010) Cancer Care Ontario (CCO) conducted a similar study in 2005 and found that 31% of colorectal cancer pathology reports did not include all of the information required by the CAP standards.

While the exact percentage of colorectal cancer resection pathology reports that are missing the pT category, the pN category and the histologic grade is unknown, these are essential elements in colorectal cancer treatment decisions and should be included in every pathology report when possible.

CLINICAL RECOMMENDATION STATEMENTS:

Surgical resection remains the most effective therapy for colorectal carcinoma, and the best estimation of prognosis is derived from the pathologic findings on the resection specimen. The anatomic extent of disease is by far the most important prognostic factor in colorectal cancer. The protocol recommends the TNM staging system of the American Joint Committee on Cancer (AJCC) and the International Union Against Cancer (UICC)1 but does not preclude the use of other staging systems. By AJCC/UICC convention, the designation “T” refers to a primary tumor that has not been previously treated. The symbol “p” refers to the pathologic classification of the TNM, as opposed to the clinical classification, and is based on gross and microscopic examination. pT entails a resection of the primary tumor or biopsy adequate to evaluate the highest pT category, pN entails removal or biopsy of nodes adequate to validate lymph node metastasis, and pM implies microscopic examination of distant lesions. (CAP, 2011)

Colorectal cancers are usually staged after surgical exploration of the abdomen and pathologic examination of the surgical specimen. Some of the criteria that should be included in the report of the pathologic evaluation include the

following: grade of the cancer; depth of penetration and extension to adjacent structures (T); number of regional lymph nodes evaluated; number of positive regional lymph nodes (N); an assessment of the presence of distant metastasis to other organs, the peritoneum of an abdominal structure, or in non-regional lymph nodes (M); the status of proximal, distal and radial margins; lymphovascular invasion, perineurial invasion and extra-nodal tumor deposits. (NCCN, 2012)

▲Measure #102 (NQF 0389): Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low Risk Prostate Cancer Patients – National Quality Strategy Domain: Efficiency and Cost Reduction

2015 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Percentage of patients, regardless of age, with a diagnosis of prostate cancer at low risk of recurrence receiving interstitial prostate brachytherapy, OR external beam radiotherapy to the prostate, OR radical prostatectomy, OR cryotherapy who did **not** have a bone scan performed at any time since diagnosis of prostate cancer

INSTRUCTIONS:
This measure is to be reported **once per episode** of treatment (ie, interstitial prostate brachytherapy, OR external beam radiotherapy to the prostate, OR radical prostatectomy, OR cryotherapy) for all male patients with prostate cancer who receive interstitial prostate brachytherapy, external beam radiotherapy to the prostate, radical prostatectomy, or cryotherapy during the reporting period. Each episode of radiation therapy in an eligible patient receiving external beam radiotherapy to the prostate occurring during the reporting period will be counted when calculating the reporting and performance rates. The PQRS quality-data code or equivalent needs to be submitted only once during the episode of radiation therapy (eg, 8 weeks of therapy). It is anticipated that **clinicians who perform the listed procedures** as specified in the denominator coding will submit this measure.

Measure Reporting via Registry:
ICD-9-CM/ICD-10-CM diagnosis codes and CPT codes and QDC code are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

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

DENOMINATOR:
All patients, regardless of age, with a diagnosis of prostate cancer at low risk of recurrence receiving interstitial prostate brachytherapy, OR external beam radiotherapy to the prostate, OR radical prostatectomy, OR cryotherapy

Definitions:
Risk Strata: Low, Intermediate, or High –
Low Risk – PSA ≤ 10 ng/mL; AND Gleason score 6 or less; AND clinical stage T1c or T2a. (AUA, 2007)
Intermediate Risk – PSA > 10 to 20 ng/mL; OR Gleason score 7; OR clinical stage T2b, and not qualifying for high risk. (AUA, 2007)
High Risk – PSA > 20 ng/mL; OR Gleason score 8 to 10; OR clinically localized stage T3a. (NCCN, 2011)

Denominator Criteria (Eligible Cases):
Any male patient, regardless of age
AND
Diagnosis for prostate cancer (ICD-9-CM) [for use 1/1/2015-9/30/2015]: 185
Diagnosis for prostate cancer (ICD-10-CM) [for use 10/01/2015-12/31/2015]: C61
AND
Patient encounter during the reporting period (CPT): 55810, 55812, 55815, 55840, 55842, 55845, 55866, 55873, 55875, 55876, 77427, 77776, 77777, 77778, 77787
AND
Low risk of recurrence, prostate cancer: 3271F

NUMERATOR:
Patients who did *not* have a bone scan performed at any time since diagnosis of prostate cancer

Numerator Instructions: A higher score indicates appropriate treatment of patients with prostate cancer at low risk of recurrence.

Numerator Options:

Performance Met: Bone scan not performed prior to initiation of treatment nor at any time since diagnosis of prostate cancer **(3270F)**

OR

Medical Performance Exclusion: Documentation of medical reason(s) for performing a bone scan (including documented pain, salvage therapy, other medical reasons) **(3269F *with* 1P)**

OR

System Performance Exclusion: Documentation of system reason(s) for performing a bone scan (including bone scan ordered by someone other than the reporting physician) **(3269F *with* 3P)**

OR

Performance Not Met: Bone scan performed prior to initiation of treatment or at any time since diagnosis of prostate cancer (**3269F)**

RATIONALE:

A bone scan is generally not required for staging prostate cancer in men with a low risk of recurrence and receiving primary therapy. This measure is written as a negative measure so that the performance goal is 100%, consistent with the other measures for this condition.

CLINICAL RECOMMENDATION STATEMENTS:

Routine use of a bone scan is not required for staging asymptomatic men with clinically localized prostate cancer when their PSA is equal to or less than 20.0 ng/mL. (AUA, 2009)

For symptomatic patients and/or those with a life expectancy of greater than 5 years, a bone scan is appropriate for patients with any of the following: 1) T1 disease with PSA over 20 ng/mL or T2 disease with PSA over 10 ng/mL; 2) a Gleason score of 8 or higher; 3) T3 to T4 tumors or symptomatic disease. (Category 2A) (NCCN, 2011)

& Measure #104 (NQF 0390): Prostate Cancer: Adjuvant Hormonal Therapy for High Risk Prostate Cancer Patients – National Quality Strategy Domain: Effective Clinical Care

2015 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Percentage of patients, regardless of age, with a diagnosis of prostate cancer at high or very high risk of recurrence receiving external beam radiotherapy to the prostate who were prescribed adjuvant hormonal therapy (GnRH [gonadotropin-releasing hormone] agonist or antagonist)

INSTRUCTIONS:
This measure is to be reported **once per episode** of radiation therapy for **all male** patients with prostate cancer who receive external beam radiotherapy to the prostate during the reporting period. Each episode of radiation therapy in an eligible patient receiving external beam radiotherapy to the prostate occurring during the reporting period will be counted when calculating the reporting and performance rates. The PQRS quality-data code or equivalent needs to be submitted only once during the episode of radiation therapy (eg, 8 weeks of therapy). It is anticipated that **clinicians who perform external beam radiotherapy to the prostate** will submit this measure.

Measure Reporting via Registry:
ICD-9-CM/ICD-10-CM diagnosis codes and CPT codes and QDC code are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

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

DENOMINATOR:
All patients, regardless of age, with a diagnosis of prostate cancer at high or very high risk of recurrence receiving external beam radiotherapy to the prostate

Definitions:
Risk Strata: Very Low, Low, Intermediate, High, or Very High–
Very Low Risk – PSA < 10 ng/mL; AND Gleason score 6 or less; AND clinical stage T1c; AND presence of disease in fewer than 3 biopsy cores; AND ≤ 50% prostate cancer involvement in any core; AND PSA density ≤ 0.15 ng/mL/cm^3.
Low Risk – PSA < 10 ng/mL; AND Gleason score 6 or less; AND clinical stage T1 to T2a.
Intermediate Risk – PSA 10 to 20 ng/mL; OR Gleason score 7; OR clinical stage T2b to T2c. *Note: patients with multiple adverse factors may be shifted into the high risk category.*
High Risk – PSA > 20 ng/mL; OR Gleason score 8 to 10; OR clinically localized stage T3a.
Very High Risk – Clinical stage T3b to T4. (NCCN, 2014)

External beam radiotherapy – external beam radiotherapy refers to 3D conformal radiation therapy (3D-CRT), intensity modulated radiation therapy (IMRT), stereotactic body radiotherapy (SBRT), and proton beam therapy.

Denominator Criteria (Eligible Cases):
Any male patient, regardless of age
AND
Diagnosis for prostate cancer (ICD-9-CM) [for use 1/1/2015-9/30/2015]: 185
Diagnosis for prostate cancer (ICD-10-CM) [for use 10/01/2015-12/31/2015]: C61
AND NOT

Diagnosis for metastatic cancer (ICD-9-CM) [for use 1/1/2015-9/30/2015]: 196.0, 196.1, 196.2, 196.3, 196.5, 196.6, 196.8, 196.9, 197.0, 197.1, 197.2, 197.3, 197.4, 197.5, 197.6, 197.7, 197.8, 198.0, 198.1, 198.2, 198.3, 198.4, 198.5, 198.6, 198.7, 198.81, 198.82, 198.89
Diagnosis for metastatic cancer (ICD-10-CM) [for use 10/01/2015-12/31/2015]: C77.0, C77.1, C77.2, C77.3, C77.4, C77.5, C77.8, C77.9, C78.00, C78.01, C78.02, C78.1, C78.2, C78.30, C78.39, C78.4, C78.5, C78.6, C78.7, C78.80, C78.89, C79.00, C79.01, C79.02, C79.10, C79.11, C79.19, C79.2, C79.31, C79.32, C79.40, C79.49, C79.51, C79.52, C79.60, C79.61, C79.62, C79.70, C79.71, C79.72, C79.81, C79.82, C79.89, C79.9
AND
Patient encounter during the reporting period (CPT): 77427, 77435
AND
High or very high risk of recurrence of prostate cancer: G8465

NUMERATOR:
Patients who were prescribed adjuvant hormonal therapy (GnRH [gonadotropin-releasing hormone] agonist or antagonist)

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 Options:

Performance Met:	Adjuvant (ie, in combination with external beam radiotherapy to the prostate for prostate cancer) hormonal therapy (GnRH [gonadotropin-releasing hormone] agonist or antagonist) prescribed/administered (**4164F)**
OR	
Medical Performance Exclusion:	Documentation of medical reason(s) for not prescribing/administering adjuvant hormonal therapy (eg, salvage therapy) **(416F *with* 1P)**
OR	
Patient Performance Exclusion:	Documentation of patient reason(s) for not prescribing/administering adjuvant hormonal therapy **(4164F *with* 2P)**
OR	
Performance Not Met:	Patients who were **not** prescribed/administered adjuvant hormonal therapy, reason not otherwise specified (**4164F *with* 8P)**

RATIONALE:
If receiving external beam radiotherapy as primary therapy, prostate cancer patients with a high risk of recurrence should also be prescribed hormonal therapy, which has been shown to increase the effectiveness of the radiotherapy and may also prolong survival.

CLINICAL RECOMMENDATION STATEMENTS:
When counseling patients regarding treatment options, physicians should consider the following:

Based on results of two randomized controlled clinical trials, the use of adjuvant and concurrent hormonal therapy may prolong survival in the patient who has opted for radiotherapy. (AUA, 2007)

High risk patients who are considering specific treatment options should be informed of findings of recent high quality clinical trials, including that:

For those considering external beam radiotherapy, use of hormonal therapy combined with conventional radiotherapy may prolong survival. (Standard) (AUA, 2007)

Men with prostate cancer that is clinically localized stage T3a, Gleason score 8 to 10, or PSA level greater than 20 ng/mL are categorized by the NCCN guidelines panel as high risk. Patients with multiple adverse factors may be shifted into the very high-risk category. The preferred treatment is RT [radiation therapy] in conjunction with 2 to 3 years of ADT [androgen deprivation therapy] (category 1); ADT alone is insufficient. In particular, patients with low-volume, high-grade tumor warrant aggressive local radiation combined with typically 2 or 3 years of ADT. The combination of EBRT [external beam radiation therapy] and brachytherapy, with or without ADT (typically 2 or 3 years), is another primary treatment option. However, the optimal duration of ADT in this setting remains unclear. (NCCN, 2014)

Patients at very high risk are defined by the NCCN guidelines as those with clinical stage T3b to T4 (locally advanced). The options for this group include: 1) RT and long-term ADT (category 1); 2) EBRT plus brachytherapy with or without long-term ADT; 3) radical prostatectomy plus [Pelvic lymph node dissection (PLND)] in selected patients with no fixation to adjacent organs; or 4) ADT for patient not eligible for definitive therapy. (NCCN, 2014)

Δ Measure #109: Osteoarthritis (OA): Function and Pain Assessment – National Quality Strategy Domain: Person and Caregiver-Centered Experience and Outcomes

2015 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of patient visits for patients aged 21 years and older with a diagnosis of osteoarthritis (OA) with assessment for function and pain

INSTRUCTIONS:
This measure is to be reported at **each visit** occurring during the reporting period for patients with osteoarthritis seen during the reporting period. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

Measure Reporting via Claims:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. CPT Category II codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and the appropriate CPT Category II code **OR** the CPT Category II code **with** the modifier. The reporting modifier allowed for this measure is: 8P- reason not otherwise specified. There are no allowable performance exclusions for this measure. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

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

DENOMINATOR:
All patient visits for patients aged 21 years and older with a diagnosis of OA

Denominator Criteria (Eligible Cases):
Patients aged ≥ 21 years on date of encounter
AND
Diagnosis for osteoarthritis (OA) (ICD-9-CM) [for use 1/1/2015-9/30/2015]: 715.00, 715.04, 715.09, 715.10, 715.11, 715.12, 715.13, 715.14, 715.15, 715.16, 715.17, 715.18, 715.20, 715.21, 715.22, 715.23, 715.24, 715.25, 715.26, 715.27, 715.28, 715.30, 715.31, 715.32, 715.33, 715.34, 715.35, 715.36, 715.37, 715.38, 715.80, 715.89, 715.90, 715.91, 715.92, 715.93, 715.94, 715.95, 715.96, 715.97, 715.98
Diagnosis for osteoarthritis (OA) (ICD-10-CM) [for use 10/01/2015-12/31/2015]: M15.0, M15.1, M15.2, M15.3, M15.4, M15.8, M15.9, M16.0, M16.10, M16.11, M16.12, M16.2, M16.30, M16.31, M16.32, M16.4, M16.50, M16.51, M16.52, M16.6, M16.7, M16.9, M17.0, M17.10, M17.11, M17.12, M17.2, M17.30, M17.31, M17.32, M17.4, M17.5, M17.9, M18.0, M18.10, M18.11, M18.12, M18.2, M18.30, M18.31, M18.32, M18.4, M18.50, M18.51, M18.52, M18.9, M19.011, M19.012, M19.019, M19.021, M19.022, M19.029, M19.031, M19.032, M19.039, M19.041, M19.042, M19.049, M19.071, M19.072, M19.079, M19.111, M19.112, M19.119, M19.121, M19.122, M19.129, M19.131, M19.132, M19.139, M19.141, M19.142, M19.149, M19.171, M19.172, M19.179, M19.211, M19.212, M19.219, M19.221, M19.222, M19.229, M19.231,

M19.232, M19.239, M19.241, M19.242, M19.249, M19.271, M19.272, M19.279, M19.90, M19.91, M19.92, M19.93

AND

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

NUMERATOR:

Patient visits with assessment for level of function and pain documented (may include the use of a standardized scale or the completion of an assessment questionnaire, such as an SF-36, AAOS Hip & Knee Questionnaire)

NUMERATOR NOTE: *For the purposes of this measure, the method for assessing function and pain is left up to the discretion of the individual clinician and based on the needs of the patient. The assessment may be done via a validated instrument (though one is not required) that measures pain and various functional elements including a patient's ability to perform activities of daily living (ADLs).*

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Osteoarthritis Symptoms and Functional Status Assessed

Performance Met: **CPT II 1006F:** Osteoarthritis symptoms and functional status assessed (may include the use of a standardized scale or the completion of an assessment questionnaire, such as the SF-36, AAOS Hip & Knee Questionnaire)

OR

Osteoarthritis Symptoms and Functional Status not Assessed, Reason not Otherwise Specified

Append a reporting modifier (**8P**) to CPT Category II code **1006F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

Performance Not Met: **1006F *with* 8P:** Osteoarthritis symptoms and functional status **not** assessed, reason not otherwise specified

RATIONALE:

Osteoarthritis can be a debilitating condition. An assessment of patient symptoms and functional status is important as it serves as the basis for making treatment modifications, which in turn, assists in improving the patient's quality of life.

CLINICAL RECOMMENDATION STATEMENTS:

Any persistent pain that has an impact on physical function, psychosocial function, or other aspects of quality of life should be recognized as a significant problem. (AGS; IIA Recommendation)

Control of pain and maintenance of activity correlate well with satisfactory quality of life. If the patient is not satisfied with the outcome due to continued pain and limitation of activity, more aggressive intervention may be warranted. (AAOS, 2003)

▲Measure #110 (NQF 0041): Preventive Care and Screening: Influenza Immunization – National Quality Strategy Domain: Community/Population Health

2015 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

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

INSTRUCTIONS:
This measure is to be reported a minimum of **once for visits for patients seen** between January and March for the 2014-2015 influenza season AND a minimum of **once for visits for patients seen** between October and December for the 2015-2016 influenza season. This measure is intended to determine whether or not all patients aged 6 months and older received (either from the reporting physician or from an alternate care provider) the influenza immunization during the flu season. There is no diagnosis associated with this measure. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

- If reporting this measure between January 1, 2015 and March 31, 2015, quality-data code **G8482** should be reported when the influenza immunization is administered to the patient during the months of August, September, October, November, and December of 2014 or January, February, and March of 2015 for the flu season ending March 31, 2015.
- If reporting this measure between October 1, 2015 and December 31, 2015, quality-data code **G8482** should be reported when the influenza immunization is administered to the patient during the months of August, September, October, November, and December of 2015 for the flu season ending March 31, 2016.
- Influenza immunizations administered during the month of August or September of a given flu season (either 2014-2015 flu season OR 2015-2016 flu season) can be reported when a visit occurs during the flu season (October 1 - March 31). In these cases, **G8482** should be reported.

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

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

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

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

DENOMINATOR:
All patients aged 6 months and older seen for a visit between October 1 and March 31

Denominator Criteria (Eligible Cases):
Patients aged ≥ 6 months seen for a visit between October 1 and March 31
AND
Patient encounter during the reporting period (CPT or HCPCS): 90945, 90947, 90951, 90952, 90953, 90954, 90955, 90956, 90957, 90958, 90959, 90960, 90961, 90962, 90963, 90964, 90965, 90966, 90967,

90968, 90969, 90970, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99315, 99316, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, G0438, G0439

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

Definition:
Previous Receipt – Receipt of the current season's influenza immunization from another provider OR from same provider prior to the visit to which the measure is applied (typically, prior vaccination would include influenza vaccine given since August 1st).

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Influenza Immunization Administered
Performance Met: **G8482:** Influenza immunization administered or previously received

OR

Influenza Immunization not Administered for Documented Reasons
Other Performance Exclusion: **G8483:** Influenza immunization was not administered for reasons documented by clinician (eg, patient allergy or other medical reasons, patient declined or other patient reasons, vaccine not available or other system reasons)

OR

Influenza Immunization not Administered, Reason not Given
Performance Not Met: **G8484:** Influenza immunization was **not** administered, reason not given

RATIONALE:
Annual influenza vaccination is the most effective method for preventing influenza virus infection and its complications. Influenza vaccine is recommended for all persons aged ≥ 6 months who do not have contraindications to vaccination.

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

Routine annual influenza vaccination is recommended for all persons aged ≥ 6 months. To permit time for production of protective antibody levels, vaccination should optimally occur before onset of influenza activity in the community, and providers should offer vaccination as soon as vaccine is available. Vaccination also should continue to be offered throughout the influenza season. (CDC/ACIP, 2011)

♦ Measure #111 (NQF 0043): Pneumonia Vaccination Status for Older Adults – National Quality Strategy Domain: Effective Clinical Care

2015 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of patients 65 years of age and older who have ever received a pneumococcal vaccine

INSTRUCTIONS:
This measure is to be reported a minimum of **once per reporting period** for patients seen during the reporting period. There is no diagnosis associated with this measure. Performance for this measure is not limited to the reporting period. This measure may be reported by clinicians who perform the quality actions described in the measure based on services provided and the measure-specific denominator coding.

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

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

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

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

DENOMINATOR:
Patients 65 years of age and older with a visit during the measurement period

> ***DENOMINATOR NOTE:*** *Pneumococcal vaccination is expected once ever for patients 65 years of age or older.*
>
> **Denominator Criteria (Eligible Cases):**
> Patients aged ≥ 65 years on date of encounter
> **AND**
> **Patient encounter during the reporting period (CPT or HCPCS):** 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, 99356, 99357, G0402

NUMERATOR:
Patients who have **ever** received a pneumococcal vaccination

> **Numerator Quality-Data Coding Options for Reporting Satisfactorily:**
> **Pneumococcal Vaccination Administered or Previously Received**
> ***Performance Met:***

CPT II 4040F: Pneumococcal vaccine administered or previously received

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.

Performance Not Met:

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

RATIONALE:

Pneumonia is a common cause of illness and death in the elderly and persons with certain underlying conditions such as heart failure, diabetes, cystic fibrosis, asthma, sickle cell anemia, or chronic obstructive pulmonary disease (NHLBI, 2011). In 1998, an estimated 3,400 adults aged > 65 years died as a result of invasive pneumococcal disease (IPD) (CDC, 2003).

Among the 91.5 million US adults aged > 50 years, 29,500 cases of IPD, 502,600 cases of nonbacteremic pneumococcal pneumonia and 25,400 pneumococcal-related deaths are estimated to occur yearly; annual direct and indirect costs are estimated to total $3.7 billion and $1.8 billion, respectively. Pneumococcal disease remains a substantial burden among older US adults, despite increased coverage with 23-valent pneumococcal polysaccharide vaccine, (PPV23) and indirect benefits afforded by PCV7 vaccination of young children (Weycker, et al., 2011).

Vaccination has been found to be effective against bacteremic cases (OR: 0.34; 95% CI: 0.27–0.66) as well as nonbacteremic cases (OR: 0.58; 95% CI: 0.39–0.86). Vaccine effectiveness was highest against bacteremic infections caused by vaccine types (OR: 0.24; 95% CI: 0.09–0.66) (Vila-Corcoles, et al., 2009).

CLINICAL RECOMMENDATION STATEMENTS:

The Advisory Committee on Immunization Practices' (ACIP) Updated Recommendations for Prevention of Invasive Pneumococcal Disease Among Adults Using the 23-Valent Pneumococcal Polysaccharide Vaccine recommends pneumococcal vaccine for all immunocompetent individuals who are 65 and older or otherwise at increased risk for pneumococcal disease. Routine revaccination is not recommended, but a second dose is appropriate for those who received PPV23 before age 65 years for any indication if at least 5 years have passed since their previous dose (USPSTF, 1989; ACIP, 2010).

The major updates for the 2010 update are: 1) the indications for which PPSV23 vaccination is recommended now include smoking and asthma, and 2) routine use of PPSV23 is no longer recommended for Alaska Natives or American Indians aged <65 years unless they have medical or other indications for PPV23.

♦Measure #112: Breast Cancer Screening – National Quality Strategy Domain: Effective Clinical Care

2015 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of women 50 through 74 years of age who had a mammogram to screen for breast cancer within 27 months

INSTRUCTIONS:
This measure is to be reported a minimum of **once per reporting period** for female patients seen during the reporting period. There is no diagnosis associated with this measure. The patient should either be screened for breast cancer on the date of service OR there should be documentation that the patient was screened for breast cancer at least once within 27 months prior to the date of service. Performance for this measure is not limited to the reporting period. This measure may be reported by clinicians who perform the quality actions described in the measure based on services provided and the measure-specific denominator coding.

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

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

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

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

DENOMINATOR:
Women 50 through 74 years of age with a visit during the measurement period

Definition:
The measure's 27-month look back period applies to women ages 52-74 (the numerator looks for a mammogram any time on or between October 1, 27 months prior to the measurement period, and December 31 of the measurement period in order to capture women who have had a mammogram every 24 months per clinical guidelines, with a 3-month grace period). Therefore, women ages 50-52 are included in the measure if they had a visit and a mammogram since age 50, but the 27-month look back period only applies to patients age 52-74. For patients that are 51 years of age during the measurement period look back only to age 50.

Denominator Criteria (Eligible Cases):
Patients 50 through 74 years of age on date of encounter
AND
Patient encounter during the reporting period (CPT or HCPCS): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, G0402

NUMERATOR:
Patients who had one or more mammograms any time on or between October 1, 27 months prior to December 31 of the measurement period, not to precede the patient's 50th birthday

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Mammogram Performed
***Performance Met:* 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.
***Medical Performance Exclusion:* 3014F *with* 1P:** Documentation of medical reason(s) for not performing a mammogram (ie, 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.
***Performance Not Met:* 3014F *with* 8P:** Screening mammography results were **not** documented and reviewed, reason not otherwise specified

RATIONALE:
Breast cancer is one of the most common types of cancers, accounting for a quarter of all new cancer diagnoses for women in the U.S. (BreastCancer.Org, 2011). It ranks as the second leading cause of cancer-related mortality in women, accounting for nearly 40,000 estimated deaths in 2013 (American Cancer Society, 2011).

According to the National Cancer Institute's Surveillance Epidemiology and End Results program, the chance of a woman being diagnosed with breast cancer in a given year increases with age. By age 30, it is one in 2,212. By age 40, the chances increase to one in 235, by age 50, it becomes one in 54, and, by age 60, it is one in 25. From 2004 to 2008, the median age at the time of breast cancer diagnosis was 61 years among adult women (Tangka et al, 2010).

In the U.S., costs associated with a diagnosis of breast cancer range from $451 to $2,520, factoring in continued testing, multiple office visits and varying procedures. The total costs related to breast cancer add up to nearly $7 billion per year in the U.S., including $2 billion spent on late-stage treatment (Lavigne et al, 2008; Boykoff et al, 2009).

CLINICAL RECOMMENDATION STATEMENTS:
The U.S. Preventive Services Task Force (USPSTF) recommends biennial screening mammography for women aged 50-74 years (B recommendation). The decision to start regular, biennial screening mammography before the age of 50 years should be an individual one and take patient context into account, including the patient's values regarding specific benefits and harms (C recommendation). (USPSTF, 2009) The Task Force concludes the evidence is insufficient to assess the additional benefits and harms of screening mammography in women 75 years and older (I statement).

U.S. Preventive Services Task Force (2009)

Grade: B recommendation. The USPSTF recommends biennial screening mammography for women aged 50 to 74 years.

Grade: C recommendation. The decision to start regular, biennial screening mammography before the age of 50 years should be an individual one and take patient context into account, including the patient's values regarding specific benefits and harms.

Grade: I Statement. The USPSTF concludes that the current evidence is insufficient to assess the additional benefits and harms of screening mammography in women 75 years or older.

Grade: D recommendation. The USPSTF recommends against teaching breast self-examination (BSE).

Grade: I Statement. The USPSTF concludes that the current evidence is insufficient to assess the additional benefits and harms of clinical breast examination (CBE) beyond screening mammography in women 40 years or older.

Grade: I Statement. The USPSTF concludes that the current evidence is insufficient to assess the additional benefits and harms of either digital mammography or magnetic resonance imaging (MRI) instead of film mammography as screening modalities for breast cancer.

♦Measure #113 (NQF 0034): Colorectal Cancer Screening – National Quality Strategy Domain: Effective Clinical Care

2015 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of patients 50 through 75 years of age who had appropriate screening for colorectal cancer

INSTRUCTIONS:
This measure is to be reported a minimum of **once per reporting period** for patients seen during the reporting period. There is no diagnosis associated with this measure. Performance for this measure is not limited to the reporting period. This measure may be reported by clinicians who perform the quality actions described in the measure based on services provided and the measure-specific denominator coding.

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

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

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

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

DENOMINATOR:
Patients 51 through 75 years of age with a visit during the measurement period

Definition:
The age ranges for the description (50 – 75), and the denominator (51 – 75) are different due to how the measure is calculated. The clinical guidelines supporting the three different screening approaches that state adults 50 years and older should be screened. The measure has a denominator of 51 to capture all adults at least 50 years of age and older who may have had a screening. For example, a patient who turns 51 in July of the measurement period was 50 when they had the appropriate screening in February; therefore, those patients who are 50 are included in the description.

Denominator Criteria (Eligible Cases):
Patients 51 through 75 years of age on date of encounter
AND
Patient encounter during the reporting period (CPT or HCPCS): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, G0402

NUMERATOR:
Patients who had at least one or more screenings for colorectal cancer during or prior to the measurement period. Appropriate screenings are defined by any one of the following criteria below:

- Fecal occult blood test (FOBT) during the measurement period
- Flexible sigmoidoscopy during the measurement period or the four years prior to the measurement period
- Colonoscopy during the measurement period or the nine years prior to the measurement period

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Colorectal Cancer Screening
***Performance Met:* 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.
***Medical Performance Exclusion:* 3017F *with* 1P:** Documentation of medical reason(s) for not performing a colorectal cancer screening (ie, diagnosis of colorectal cancer or total colectomy)

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

RATIONALE:
An estimated 142,570 men and women were diagnosed with colon cancer in 2010. In the same year, 51,370 were estimated to have died from the disease, making colorectal cancer the third leading cause of cancer death in the United States (American Cancer Society 2010).

Screening for colorectal cancer is extremely important as there are no signs or symptoms of the cancer in the early stages. If the disease is caught in its earliest stages, it has a five-year survival rate of 91%; however, the disease is often not caught this early. While screening is extremely effective in detecting colorectal cancer, it remains underutilized (American Cancer Society 2010).11

Fecal occult blood tests, colonoscopy, and flexible sigmoidoscopy are shown to be effective screening methods (United States Preventive Services Task Force, 2008). Colorectal screening of individuals with no symptoms can identify polyps whose removal can prevent more than 90% of colorectal cancers (Rozen, 2004).

Studies have shown that the cost-effectiveness of colorectal cancer screening is $40,000 per life year gained, which is similar to the cost-effectiveness of mammography for breast cancer screening (Hawk and Levin 2005).

CLINICAL RECOMMENDATION STATEMENTS:
The United States Preventive Services Task Force (2008):

1) The USPSTF recommends screening for colorectal cancer using fecal occult blood testing, sigmoidoscopy, or colonoscopy in adults, beginning at age 50 years and continuing until age 75 years (A recommendation).
2) The USPSTF concludes that the evidence is insufficient to assess the benefits and harms of computed tomographic (CT) colonography and fecal DNA testing as screening modalities for colorectal cancer (I statement).

The American Cancer Society, The American College of Radiology, and the U.S. Multi-Society Task Force on Colorectal Cancer (Levin et al. 2008):

Tests that Detect Adenomatous Polyps and Cancer

1) Colonoscopy (every 10 years)
2) Flexible sigmoidoscopy (every 5 years)
3) Double contrast barium enema (DCBE) (every 5 yrs)
4) Computed tomographic colonography (CTC) (every 5 years)

Tests that Primarily Detect Cancer:

1) guaiac fecal occult blood test (gFOBT) with high sensitivity for cancer (annually)
2) fecal immunochemical test (FIT) with high sensitivity for cancer (annually)
3) stool DNA (sDNA) with high sensitivity for cancer (interval uncertain)

Modalities not approved:

1) Single digital rectal examination fecal occult blood test (FOBT) has a poor sensitivity for CRC and should not be performed as a primary screening method
2) Studies evaluating virtual colonoscopy and fecal DNA testing for CRC screening have yielded conflicting results and therefore cannot be recommended

♦ Measure #116 (NQF 0058): Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis – National Quality Strategy Domain: Efficiency and Cost Reduction

2015 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Percentage of adults 18 through 64 years of age with a diagnosis of acute bronchitis who **were not prescribed or dispensed** an antibiotic prescription on or 3 days after the episode

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

Measure Reporting via Registry:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT or HCPCS codes, and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

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

DENOMINATOR:
All patients aged 18 through 64 years of age with an outpatient or emergency department (ED) visit with a diagnosis of acute bronchitis during the measurement period

Definition:
To determine eligibility, look for any of the listed antibiotic drugs below in the 30 days prior to the visit with the acute bronchitis diagnosis. As long as there are no prescriptions for the listed antibiotics during this time period, the patient is eligible for denominator inclusion.

Denominator Criteria (Eligible Cases):
Patients 18 through 64 years of age on date of encounter
AND
Diagnosis for acute bronchitis (ICD-9-CM) [for use 1/1/2015-9/30/2015]: 466.0
Diagnosis for acute bronchitis (ICD-10-CM) [for use 10/01/2015-12/31/2015]: J20.0, J20.1, J20.2, J20.3, J20.4, J20.5, J20.6, J20.7, J20.8, J20.9
AND
Patient encounter during the reporting period (CPT or HCPCS): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99217, 99218, 99219, 99220, 99281, 99282, 99283, 99284, 99285, G0402

Antibiotic Medications

Description	Prescription		
Aminoglycosides	• Amikacin • Gentamicin	• Kanamycin • Streptomycin	• Tobramycin
Aminopenicillins	• Amoxicillin	• Ampicillin	
Antipseudomonal penicillins	• Piperacillin		

Description	Prescription		
Beta-lactamase inhibitors	• Amoxicillin-clavulanate • Ampicillin-sulbactam	• Piperacillin-tazobactam	• Ticarcillin-clavulanate
First-generation cephalosporins	• Cefadroxil	• Cefazolin	• Cephalexin
Fourth-generation cephalosporins	• Cefepime		
Ketolides	• Telithromycin		
Lincomycin derivatives	• Clindamycin	• Lincomycin	
Macrolides	• Azithromycin • Clarithromycin	• Erythromycin • Erythromycin ethylsuccinate	• Erythromycin lactobionate • Erythromycin stearate
Miscellaneous antibiotics	• Aztreonam • Chloramphenicol • Dalfopristin-quinupristin	• Daptomycin • Erythromycin-sulfisoxazole • Linezolid	• Metronidazole • Vancomycin
Natural penicillins	• Penicillin G benzathine-procaine • Penicillin G potassium	• Penicillin G procaine • Penicillin G sodium	• Penicillin V potassium • Penicillin G benzathine
Penicillinase resistant penicillins	• Dicloxacillin	• Nafcillin	• Oxacillin
Quinolones	• Ciprofloxacin • Gemifloxacin	• Levofloxacin • Moxifloxacin	• Norfloxacin • Ofloxacin
Rifamycin derivatives	• Rifampin		
Second generation cephalosporin	• Cefaclor • Cefotetan	• Cefoxitin • Cefprozil	• Cefuroxime
Sulfonamides	• Sulfadiazine	• Sulfamethoxazole-trimethoprim	
Tetracyclines	• Doxycycline	• Minocycline	• Tetracycline
Third generation cephalosporins	• Cefdinir • Cefditoren • Cefixime	• Cefotaxime • Cefpodoxime • Ceftazidime	• Ceftibuten • Ceftriaxone
Urinary anti-infectives	• Fosfomycin • Nitrofurantoin • Nitrofurantoin macrocrystals	• Nitrofurantoin macrocrystals-monohydrate • Trimethoprim	

NUMERATOR:
Patients who were not prescribed or dispensed antibiotics on or within 3 days of the initial date of service

Numerator Instructions: For performance, the measure will be calculated as the number of patient encounters where antibiotics were neither prescribed nor dispensed on or within 3 days of the episode for acute bronchitis over the total number of encounters in the denominator (patients aged 18 through 64 years with an outpatient or ED visit for acute bronchitis). A higher score indicates appropriate treatment of patients with acute bronchitis (eg, the proportion for whom antibiotics were not prescribed or dispensed on or three days after the encounter).

Numerator Options:

Performance Met: Antibiotic neither prescribed nor dispensed **(4124F)**

OR

Medical Performance Exclusion: Documentation of medical reason(s) for prescribing or dispensing antibiotic (eg,intestinal infection, pertussis, bacterial infection, Lyme disease, otitis media, acute sinusitis, acute pharyngitis, acute tonsillitis, chronic sinusitis, infection of the pharynx/larynx/tonsils/adenoids, prostatitis, cellulitis/ mastoiditis/bone infections, acute lymphadenitis, impetigo, skin staph infections, pneumonia, gonococcal infections/venereal disease (syphilis, chlamydia, inflammatory diseases [female reproductive organs]), infections of the kidney, cystitis/UTI, acne, HIV disease/asymptomatic HIV, cystic fibrosis, disorders of the immune system, malignancy neoplasms, chronic bronchitis, emphysema, bronchiectasis, extrinsic allergic alveolitis, chronic airway obstruction, chronic obstructive asthma, pneumoconiosis and other lung disease due to external agents, other diseases of the respiratory system, and tuberculosis) **(4120F *with* 1P)**

OR

Performance Not Met: Antibiotic prescribed or dispensed **(4120F)**

RATIONALE:

Antibiotics are commonly misused and overused for a number of viral respiratory conditions where antibiotic treatment is not clinically indicated. (Scott J.G., D. Cohen, B. Dicicco-Bloom, 2001) About 80 percent of antibiotics prescribed for acute respiratory infections in adults are unnecessary, according to CDC prevention guidelines. In adults, antibiotics are most often (65–80 percent) prescribed for acute bronchitis, despite its viral origin. The misuse and overuse of antibiotics contributes to antibiotic drug resistance, which is of public health concern due to the diminished efficacy of antibiotics against bacterial infections, particularly in sick patients and the elderly. (Austin D.J., K.G. Kristinsson, R.M. Anderson, 1999, Patterson, JE, 2001, Cohen ML, 1992, Lipsitch M, 2001)

A HEDIS measure that highlights inappropriate antibiotic prescribing in adults for a common respiratory condition will help to raise awareness among clinicians and patients about inappropriate antibiotic use. Antibiotics are most often inappropriately prescribed in adults with acute bronchitis. This measure builds on an existing HEDIS measure targeting inappropriate antibiotic prescribing for children with upper respiratory infection (common cold), where antibiotics are also most often inappropriately prescribed. (Chandran R., 2001, Gonzales R., J.F. Steiner, et al, 1999)

CLINICAL RECOMMENDATION STATEMENTS:

Clinical guidelines do not support antibiotic treatment of otherwise healthy adults with acute bronchitis due to the viral origin of acute bronchitis. Patients with chronic bronchitis, COPD or other chronic comorbidity may be treated with antibiotics and are therefore excluded from the measure denominator. (Gonzales R., D.C. Malone, J.H. Maselli, et al, 2001)

♦ Measure #117 (NQF 0055): Diabetes: Eye Exam – National Quality Strategy Domain: Effective Clinical Care

2015 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of patients 18 through 75 years of age with a diagnosis of diabetes (type 1 and type 2) who had a retinal or dilated eye exam by an eye care professional in the measurement period or a negative retinal or dilated eye exam (negative for retinopathy) in the year prior to the measurement period

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

Measure Reporting via Claims:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT or HCPCS codes, and patient demographics are used to identify patients who are included in the measure's denominator. CPT Category II codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed ICD-9-CM/ICD-10-CM diagnosis codes, CPT or HCPCS codes, and the appropriate CPT Category II code **OR** the CPT Category II code **with** the modifier. The reporting modifier allowed for this measure is: 8P- reason not otherwise specified. There are no allowable performance exclusions for this measure. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT or HCPCS codes, and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

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

DENOMINATOR:
All patients aged 18 through 75 years of age who had a diagnosis of diabetes with a visit during the measurement period

Denominator Criteria (Eligible Cases):
Patients 18 through 75 years of age on date of encounter
AND
Diagnosis for diabetes (ICD-9-CM) [for use 1/1/2015-9/30/2015]: 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
77Diagnosis for diabetes (ICD-10-CM) [for use 10/01/2015-12/31/2015]: 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

AND

Patient encounter during the reporting period (CPT or HCPCS): 92002, 92004, 92012, 92014, 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99217, 99218, 99219, 99220, 99221, 99222, 99223, 99231, 99232, 99233, 99238, 99239, 99281, 99282, 99283, 99284, 99285, 99291, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99315, 99316, 99318, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, G0402, G0438, G0439

NUMERATOR:

Patients who had a retinal or dilated eye exam by an eye care professional (optometrist or ophthalmologist) in the measurement period or a negative retinal or dilated eye exam (negative for retinopathy) by an eye care professional (optometrist or ophthalmologist) in the year prior to the measurement period. For retinal or dilated eye exams performed 12 months prior to the measurement 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:

Retinal or Dilated Eye Exam Performed by an Eye Care Professional

***Performance Met:* CPT II 2022F:**	Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed
OR	
***Performance Met:* CPT II 2024F:**	Seven standard field stereoscopic photos with interpretation by an ophthalmologist or optometrist documented and reviewed
OR	
***Performance Met:* CPT II 2026F:**	Eye imaging validated to match diagnosis from seven standard field stereoscopic photos results documented and reviewed
OR	
***Performance Met:* CPT II 3072F:**	Low risk for retinopathy (no evidence of retinopathy in the prior year)*****

***Note:** *This code can only be used if the claim/encounter was during the measurement period because it indicates that the patient had "no evidence of retinopathy in the prior year". This code definition indicates results were negative; therefore an automated result is not required.*

OR

Retinal 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.

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

RATIONALE:

Diabetes mellitus (diabetes) is a group of diseases characterized by high blood glucose levels caused by the body's inability to correctly produce or utilize the hormone insulin. It is recognized as a leading cause of death and disability in the U.S. and is highly underreported as a cause of death. Diabetes of either type may cause life-threatening, life-ending or life-altering complications, including glaucoma and blindness. Diabetic retinopathy is the most common diabetic eye disease and causes 21,000–24,000 new cases of blindness annually. The consensus among established clinical guidelines is that patients with both types of diabetes should have an initial dilated and comprehensive eye exam soon after diagnosis. Guidelines also recommend consultation with an ophthalmologist for treatment options if a patient has any level of macular edema or diabetic retinopathy (proliferative and nonproliferative). (American Diabetes Association 2009)

CLINICAL RECOMMENDATION STATEMENTS:

American Diabetes Association (ADA) (2009):

- Adults and children aged 10 years or older with type 1 diabetes should have an initial dilated and comprehensive eye examination by an ophthalmologist or optometrist within 5 years after the onset of diabetes. (B recommendation)
- Patients with type 2 diabetes should have an initial dilated and comprehensive eye examination by an ophthalmologist or optometrist shortly after the diagnosis of diabetes. (B recommendation)
- Subsequent examinations for type 1 and type 2 diabetic patients should be repeated annually by an ophthalmologist or optometrist. Less frequent exams (every 2–3 years) may be considered following one or more normal eye exams. Examinations will be required more frequently if retinopathy is progressing. (B recommendation)
- Women with preexisting diabetes who are planning pregnancy or who have become pregnant should have a comprehensive eye examination and be counseled on the risk of development and/or progression of diabetic retinopathy. (B recommendation)
- Eye examination should occur in the first trimester with close follow-up throughout pregnancy and for 1 year postpartum. (B recommendation)
- Promptly refer patients with any level of macular edema, severe nonproliferative diabetic retinopathy (NPDR), or any proliferative diabetic retinopathy (PDR) to an ophthalmologist who is knowledgeable and experienced in the management and treatment of diabetic retinopathy. (A recommendation)
- Laser photocoagulation therapy is indicated to reduce the risk of vision loss in patients with high-risk PDR, clinically significant macular edema, and in some cases of severe NPDR. (A recommendation)
- The presence of retinopathy is not a contraindication to aspirin therapy for cardioprotection, as this therapy does not increase the risk of retinal hemorrhage. (A recommendation)

American Geriatric Society (AGS) (Brown et al. 2003): The older adult who has new-onset DM should have an initial screening dilated-eye examination performed by an eye-care specialist with funduscopy training. (Level I, Grade B)

➧ Measure #118 (NQF 0066): Coronary Artery Disease (CAD): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy - Diabetes or Left Ventricular Systolic Dysfunction (LVEF < 40%) – National Quality Strategy Domain: Effective Clinical Care

2015 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Percentage of patients aged 18 years and older with a diagnosis of coronary artery disease seen within a 12 month period who also have diabetes OR a current or prior Left Ventricular Ejection Fraction (LVEF) < 40% who were prescribed ACE inhibitor or ARB therapy

INSTRUCTIONS:
This measure is to be reported a minimum of **once per reporting period** for **all** patients with CAD seen during the reporting period. This measure may be reported by clinicians who perform the quality actions described in the measure for the primary management of patients with CAD based on the services provided and the measure-specific denominator coding. Only patients who had at least two denominator eligible visits during the reporting period will be counted for Reporting Criteria 1 and 2 of this measure.

Measure Reporting via Registry:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, quality-data code (Reporting Criteria 1), and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data. It is expected that a single performance rate will be calculated for this measure.

There are two reporting criteria for this measure:

1) **Patients who are 18 years and older with a diagnosis of CAD with LVEF < 40%**

OR

2) **Patients who are 18 years and older with a diagnosis of CAD who have diabetes**

The eligible professional should submit data on one of the reporting criteria, depending on the clinical findings. If the patient has CAD and LVSD (without a diagnosis of Diabetes), use Denominator Reporting Criteria 1. If the patient has CAD and Diabetes, use Denominator Reporting Criteria 2. If the patient has both diabetes and LVSD, the eligible professional may report quality data for Reporting Criteria 2 and this will count as appropriate reporting for this patient.

REPORTING CRITERIA 1: All patients with a diagnosis of CAD with LVEF < 40% (without a diagnosis of diabetes)

DENOMINATOR (REPORTING CRITERIA 1):
All patients aged 18 years and older with a diagnosis of coronary artery disease seen within a 12 month period who also have a current or prior LVEF < 40%

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

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter

AND

Diagnosis for coronary artery disease (ICD-9-CM) [for use 1/1/2015-9/30/2015]: 410.00, 410.01, 410.02, 410.10, 410.11, 410.12, 410.20, 410.21, 410.22, 410.30, 410.31, 410.32, 410.40, 410.41, 410.42, 410.50, 410.51, 410.52, 410.60, 410.61, 410.62, 410.70, 410.71, 410.72, 410.80, 410.81, 410.82, 410.90, 410.91, 410.92, 411.0, 411.1, 411.81, 411.89, 412, 413.0, 413.1, 413.9, 414.00, 414.01, 414.02, 414.03, 414.04, 414.05, 414.06, 414.07, 414.2, 414.3, 414.8, 414.9, V45.81, V45.82

Diagnosis for coronary artery disease(ICD-10-CM) [for use 10/01/2015-12/31/2015]: 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, I25.810, I25.811, I25.812, I25.82, I25.83, I25.89, I25.9, Z95.1, Z95.5, Z98.61

AND

Patient encounter during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350

AND

Two Denominator Eligible Visits

AND

Left Ventricular Ejection Fraction (LVEF) < 40% or documentation of moderately or severely depressed left ventricular systolic function: G8934

NUMERATOR (REPORTING CRITERIA 1):

Patients who were prescribed ACE inhibitor or ARB therapy

Definition:

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

Numerator Options:

Performance Met:	Clinician prescribed angiotensin converting enzyme (ACE) inhibitor or angiotensin receptor blocker (ARB) therapy **(G8935)**
OR	
Other Performance Exclusion:	Clinician documented that patient was not an eligible candidate for angiotensin converting enzyme (ACE) inhibitor or angiotensin receptor blocker (ARB) therapy (eg, allergy, intolerance, pregnancy, renal failure due to ACE inhibitor, diseases of the aortic or mitral valve, other medical reasons) or (eg, patient declined, other patient reasons) or (eg, lack of drug availability, other reasons attributable to the health care system) **(G8936)**
OR	
Performance Not Met:	Clinician did **not** prescribe angiotensin converting enzyme (ACE) inhibitor or angiotensin receptor blocker (ARB) therapy, reason not given **(G8937)**

OR

REPORTING CRITERIA 2: All patients with a diagnosis of CAD who have diabetes

DENOMINATOR (REPORTING CRITERIA 2):
All patients aged 18 years and older with a diagnosis of coronary artery disease seen within a 12 month period who also have diabetes

Definition:
If a patient has both diabetes and LVSD, reporting criteria #2 will count as appropriate reporting for this patient.

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Diagnosis for coronary artery disease (ICD-9-CM) [for use 1/1/2015-9/30/2015]: 410.00, 410.01, 410.02, 410.10, 410.11, 410.12, 410.20, 410.21, 410.22, 410.30, 410.31, 410.32, 410.40, 410.41, 410.42, 410.50, 410.51, 410.52, 410.60, 410.61, 410.62, 410.70, 410.71, 410.72, 410.80, 410.81, 410.82, 410.90, 410.91, 410.92, 411.0, 411.1, 411.81, 411.89, 412, 413.0, 413.1, 413.9, 414.00, 414.01, 414.02, 414.03, 414.04, 414.05, 414.06, 414.07, 414.2, 414.3, 414.8, 414.9, V45.81, V45.82
Diagnosis for coronary artery disease (ICD-10-CM) [for use 10/01/2015-12/31/2015]: 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, I25.810, I25.811, I25.812, I25.82, I25.83, I25.89, I25.9, Z95.1, Z95.5, Z98.61
AND
Diagnosis for diabetes (ICD-9-CM) [for use 1/1/2015-9/30/2015]: 250.00, 250.01, 250.02, 250.03, 250.10, 250.11, 250.12, 250.13, 250.20, 250.21, 250.22, 250.23, 250.30, 250.31, 250.32, 250.33, 250.40, 250.41, 250.42, 250.43, 250.50, 250.51, 250.52, 250.53, 250.60, 250.61, 250.62, 250.63, 250.70, 250.71, 250.72, 250.73, 250.80, 250.81, 250.82, 250.83, 250.90, 250.91, 250.92, 250.93
Diagnosis for diabetes (ICD-10-CM) [for use 10/01/2015-12/31/2015]: E10.10, E10.11, E10.21, E10.22, E10.29, E10.311, E10.319, E10.321, E10.329, E10.331, E10.339, E10.341, E10.349, E10.351, E10.359, E10.36, E10.39, E10.40, E10.41, E10.42, E10.43, E10.44, E10.49, E10.51, E10.52, E10.59, E10.610, E10.618, E10.620, E10.621, E10.622, E10.628, E10.630, E10.638, E10.641, E10.649, E10.65, E10.69, E10.8, E10.9, E11.00, E11.01, E11.21, E11.22, E11.29, E11.311, E11.319, E11.321, E11.329, E11.331, E11.339, E11.341, E11.349, E11.351, E11.359, E11.36, E11.39, E11.40, E11.41, E11.42, E11.43, E11.44, E11.49, E11.51, E11.52, E11.59, E11.610, E11.618, E11.620, E11.621, E11.622, E11.628, E11.630, E11.638, E11.641, E11.649, E11.65, E11.69, E11.8, E11.9, E13.00, E13.01, E13.10, E13.11, E13.21, E13.22, E13.29, E13.311, E13.319, E13.321, E13.329, E13.331, E13.339, E13.341, E13.349, E13.351, E13.359, E13.36, E13.39, E13.40, E13.41, E13.42, E13.43, E13.44, E13.49, E13.51, E13.52, E13.59, E13.610, E13.618, E13.620, E13.621, E13.622, E13.628, E13.630, E13.638, E13.641, E13.649, E13.65, E13.69, E13.8, E13.9
AND
Patient encounter during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350
AND
Two Denominator Eligible Visits

NUMERATOR (REPORTING CRITERIA 2):
Patients who were prescribed ACE inhibitor or ARB therapy

Definition:

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

Numerator Options:

Performance Met:	Angiotensin converting enzyme (ACE) inhibitor or angiotensin receptor blocker (ARB) therapy prescribed **(G8473)**
OR	
Other Performance Exclusion:	Angiotensin converting enzyme (ACE) inhibitor or angiotensin receptor blocker (ARB) therapy not prescribed for reasons documented by the clinician (eg, allergy, intolerance, pregnancy, renal failure due to ACE inhibitor, diseases of the aortic or mitral valve, other medical reasons) or (eg, patient declined, other patient reasons) or (eg, lack of drug availability, other reasons attributable to the health care system) **(G8474)**
OR	
Performance Not Met:	Angiotensin converting enzyme (ACE) inhibitor or angiotensin receptor blocker (ARB) therapy **not** prescribed, reason not given **(G8475)**

RATIONALE:

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

In the absence of contraindications, ACE inhibitors or ARBs are recommended for all patients with a diagnosis of coronary artery disease and diabetes or reduced left ventricular systolic function. ACE inhibitors remain the first choice, but ARBs can now be considered a reasonable alternative. Both pharmacologic agents have been shown to decrease the risk of death, myocardial infarction, and stroke. Additional benefits of ACE inhibitors include the reduction of diabetic symptoms and complications for patients with diabetes.

CLINICAL RECOMMENDATION STATEMENTS:

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

2012 ACCF/AHA/ACP/AATS/PCNA/SCAI/STS Guideline for the Diagnosis and Management of Patients With Stable Ischemic Heart Disease (SIHD)

RENIN-ANGIOTENSIN-ALDOSTERONE BLOCKER THERAPY

ACE inhibitors should be prescribed in all patients with SIHD who also have hypertension, diabetes mellitus, LVEF 40% or less, or CKD, unless contraindicated. (Class I Recommendation Level of Evidence: A)

ARBs are recommended for patients with SIHD who have hypertension, diabetes mellitus, LV systolic dysfunction, or CKD and have indications for, but are intolerant of, ACE inhibitors.(Class I Recommendation, Level of Evidence: A)

♦ Measure #119 (NQF 0062): Diabetes: Medical Attention for Nephropathy – National Quality Strategy Domain: Effective Clinical Care

2015 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
The percentage of patients 18-75 years of age with diabetes who had a nephropathy screening test or evidence of nephropathy during the measurement period

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

Measure Reporting via Claims:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT or HCPCS codes, and patient demographics are used to identify patients who are included in the measure's denominator. CPT Category II codes or quality-data codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed ICD-9-CM/ICD-10-CM diagnosis codes, CPT or HCPCS codes, and the appropriate CPT Category II code **OR** quality-data code **OR** the CPT Category II code **with** the modifier. The reporting modifier allowed for this measure is: 8P- reason not otherwise specified. There are no allowable performance exclusions for this measure. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT or HCPCS codes, and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

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

DENOMINATOR:
Patients 18 through 75 years of age who had a diagnosis of diabetes with a visit during the measurement period

Denominator Criteria (Eligible Cases):
Patients aged 18 years through 75 years on date of encounter
AND
Diagnosis for diabetes (ICD-9-CM) [for use 01/01/2015-09/30/2015]: 250.00, 250.01, 250.02, 250.03, 250.10, 250.11, 250.12, 250.13, 250.20, 250.21, 250.22, 250.23, 250.30, 250.31, 250.32, 250.33, 250.40, 250.41, 250.42, 250.43, 250.50, 250.51, 250.52, 250.53, 250.60, 250.61, 250.62, 250.63, 250.70, 250.71, 250.72, 250.73, 250.80, 250.81, 250.82, 250.83, 250.90, 250.91, 250.92, 250.93, 357.2, 362.01, 362.02, 362.03, 362.04, 362.05, 362.06, 362.07, 366.41, 648.00, 648.01, 648.02, 648.03, 648.04
Diagnosis for diabetes (ICD-10-CM) [for use 10/01/2015-12/31/2015]: 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

AND

Patient encounter during the reporting period (CPT or HCPCS): 99201, 99202, 99203, 99204, 99205, 99211,99212, 99213, 99214, 99215, 99217, 99218, 99219, 99220, 99221, 99222, 99223, 99231, 99232, 99233, 99238, 99239, 99281, 99282, 99283, 99284, 99285, 99291, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99315, 99316, 99318, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, G0402, G0438, G0439

NUMERATOR:

Patients with a screening for nephropathy or evidence of nephropathy during the measurement period

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

***Performance Met:* CPT II 3060F:**	Positive microalbuminuria test result documented and reviewed
OR	
***Performance Met:* CPT II 3061F:**	Negative microalbuminuria test result documented and reviewed
OR	
***Performance Met:* CPT II 3062F:**	Positive macroalbuminuria test result documented and reviewed
OR	
***Performance Met:* 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	
***Performance Met:* 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.

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

RATIONALE:

Diabetes mellitus (diabetes) is a group of diseases characterized by high blood glucose levels caused by the body's inability to correctly produce or utilize the hormone insulin (National Institute of Diabetes and Digestive and Kidney Diseases 2011). It is recognized as a leading cause of death and disability in the U.S. and is highly underreported as a cause of death (National Institute of Diabetes and Digestive and Kidney Diseases 2011). Diabetes may cause life-threatening, life-ending or life-altering complications, including end-stage kidney disease. Diabetes is the primary cause of kidney failure, accounting for 44 percent of newly diagnosed cases in 2005 (National Institute of Diabetes and Digestive and Kidney Diseases 2011). Clinical guidelines recommend regular testing to evaluate urine albumin excretions and serum creatinine and the estimated glomerular filtration rate derived from serum creatinine, in addition

to comparing measurements when screening for chronic kidney disease (American Diabetes Association 2009; American Association of Clinical Endocrinologists 2007).

CLINICAL RECOMMENDATION STATEMENTS:

American Diabetes Association (2009):

- Perform an annual test to assess urine albumin excretion in type 1 diabetic patients with diabetes duration of >=5 years and in all type 2 diabetic patients, starting at diagnosis. (Level of Evidence E)
- Measure serum creatinine at least annually in all adults with diabetes regardless of the degree of urine albumin excretion. The serum creatinine should be used to estimate GFR and stage the level of chronic kidney disease (CKD), if present. (Level of Evidence E)
- In the treatment of the nonpregnant patient with micro- or macroalbuminuria, either ACE inhibitors or ARBs should be used. (Level of Evidence A)

American Association of Clinical Endocrinologists (2007): Screen all patients with diabetes mellitus for chronic kidney disease annually; screening should begin 5 years after diagnosis in patients with Type 1 diabetes mellitus (T1DM) and at the time of diagnosis in patients with Type 2 diabetes mellitus (T2DM). Testing includes:

- Measurement of albumin-to-creatinine ratio in a spot urine specimen and measurement of the estimated glomerular filtration rate derived from serum creatinine
- The following are diagnostic criteria for chronic kidney disease:
    - Estimated glomerular filtration rate <60 mL/min/1.73 m2 or albumin-to-creatinine ratio >=30 mg albumin/g creatinine
    - Microalbuminuria >=30 mg albumin/g creatinine
    - Macroalbuminuria >=300 mg albumin/g creatinine (Grade A)
    - Prescribe an angiotensin-converting enzyme inhibitor or an angiotensin receptor blocker in the antihypertensive regimen in the absence of contraindications. (Grade A)

California Healthcare Foundation/American Geriatrics Society (2003): A test for the presence of microalbumin should be performed at diagnosis in patients with type 2 diabetes mellitus. After the initial screening and in the absence of previously demonstrated macro- or microalbuminuria, a test for the presence of microalbumin should be performed annually. (Level III, Grade A)

Measure #121 (NQF 1668): Adult Kidney Disease: Laboratory Testing (Lipid Profile) – National Quality Strategy Domain: Effective Clinical Care

2015 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

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

INSTRUCTIONS:
This measure is to be reported a minimum of **once per reporting period** for patients with a diagnosis of chronic kidney disease (CKD) (stage 3, 4, or 5, not receiving RRT) seen during the reporting period. It is anticipated that **clinicians providing care for patients with CKD** will submit this measure.

Measure Reporting via Registry:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

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

DENOMINATOR:
All patients aged 18 years and older with a diagnosis of CKD (stage 3, 4, or 5, not receiving RRT)

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

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Diagnosis for stage 3, 4, or 5 CKD (ICD-9-CM) [for use 1/1/2015-9/30/2015]: 585.3, 585.4, 585.5
Diagnosis for stage 3, 4, or 5 CKD (ICD-10-CM) [for use 10/01/2015-12/31/2015]: N18.3, N18.4, N18.5
AND
Patient encounter during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350

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

Numerator Options:
Fasting Lipid Profile Performed

Performance Met:	Fasting lipid profile performed (Triglycerides, LDL-C, HDL-C, and Total Cholesterol) (**G8725)**
OR	
Other Performance Exclusion:	Clinician has documented reason for not performing fasting lipid profile (eg, patient declined, other patient reasons) **(G8726)**

OR

Performance Not Met: Fasting lipid profile **not** performed, reason not given (**G8728)**

RATIONALE:

The principal reason to evaluate dyslipidemias in patients with CKD is to detect abnormalities that may be treated to reduce the incidence of ACVD. A number of observational studies have reported that various dyslipidemias are associated with decreased kidney function in the general population and in patients with CKD. (KDOQI)

Many factors influence the prevalence of dyslipidemias in CKD. Changes in proteinuria, GFR, and treatment of CKD may alter lipoprotein levels. Therefore, it is prudent to evaluate dyslipidemias more often than is recommended in the general population. (KDOQI)

CLINICAL RECOMMENDATION STATEMENTS:

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

Only selected portions of the clinical guidelines are quoted here; for more details, please refer to the full guideline.

All adults and adolescents with CKD should be evaluated for dyslipidemias. (Grade B) (KDOQI, 2003)

For adults and adolescents with CKD, the assessment of dyslipidemias should include a complete fasting lipid profile with total cholesterol, LDL, HDL, and triglycerides. (Grade B) (KDOQI, 2003)

If a patient has GFR ≤ 30 ml/min/1.73m2, then s/he should be monitored for dyslipidemias; measurements should include triglycerides, LDL, HDL, and total cholesterol. (B) (RPA, 2002)

Measure #122: Adult Kidney Disease: Blood Pressure Management – National Quality Strategy Domain: Effective Clinical Care

2015 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Percentage of patient visits for those patients aged 18 years and older with a diagnosis of chronic kidney disease (CKD) (stage 3, 4, or 5, not receiving Renal Replacement Therapy [RRT]) with a blood pressure < 140/90 mmHg OR ≥ 140/90 mmHg with a documented plan of care

INSTRUCTIONS:
This measure is to be reported at **each visit**, indicated within the denominator, for patients with a diagnosis of chronic kidney disease (CKD) (stage 3, 4, or 5, not receiving RRT) seen during the reporting period. It is anticipated that **clinicians providing care for patients with CKD** will submit this measure.

This measure will be calculated with 3 performance rates:

1) Percentage of patient visits with blood pressure results < 140/90 mmHg
2) Percentage of patient visits with blood pressure results ≥ 140/90 mmHg and plan of care
3) Overall percentage of patient visits with blood pressure results < 140/90 mmHg and ≥ 140/90 mmHg with a documented plan of care

Eligible professionals should continue to report the measure as specified, with no additional steps needed to account for multiple performance rates.

Measure Reporting via Registry:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

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

DENOMINATOR:
All patient visits for those patients aged 18 years and older with a diagnosis of CKD (stage 3, 4, or 5, not receiving RRT)

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

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Diagnosis for stage 3, 4, or 5 CKD (ICD-9-CM) [for use 1/1/2015-9/30/2015]: 585.3, 585.4, 585.5
Diagnosis for stage 3, 4, or 5 CKD (ICD-10-CM) [for use 10/01/2015-12/31/2015]: N18.3, N18.4, N18.5
AND
Patient encounter during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350

NUMERATOR:
Patient visits with blood pressure < 140/90 mmHg OR ≥ 140/90 mmHg with a documented plan of care

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

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

Numerator Options:
*(One quality-data code [**G8476**] is required on the claim form to submit this numerator option)*

Performance Met: Most recent blood pressure has a systolic measurement of < 140 mmHg and a diastolic measurement of < 90 mmHg (**G8476)**

OR

Performance Met:
Most recent blood pressure has a systolic measurement of ≥ 140 mmHg and/or a diastolic measurement of ≥ 90 mmHg (**G8477)**
AND
Elevated blood pressure plan of care documented (**0513F)**

OR

Performance Not Met: Blood pressure measurement **not** performed or documented, reason not given (**G8478)**

OR

Performance Not Met:
No documentation of elevated blood pressure plan of care, reason not otherwise specified (**0513F *with* 8P)**
AND
Most recent blood pressure has a systolic measurement of ≥140 mmHg and/or a diastolic measurement of ≥ 90 mmHg (**G8477)**

RATIONALE:
Accurate measurement in CKD is especially important, because hypertension is more common in CKD, and because JNC 8 identifies CKD as a "compelling indication" for more aggressive antihypertensive therapy because of the higher risk of CVD in CKD than in the general population.

CLINICAL RECOMMENDATION STATEMENTS:
Only selected portions of the clinical guidelines are quoted here; for more details, please refer to the full guideline.

Blood pressure should be measured at each health encounter (Grade A). (KDOQI, 2004)

If a patient has GFR ≤ 30 ml/min/1.73m^2, then his/her blood pressure should be checked with every clinic visit (Grade A). (RPA, 2002)

In the population aged ≥18 years with chronic kidney disease (CKD), initiate pharmacologic treatment to lower BP at SBP ≥140 mm Hg or DBP ≥90 mm Hg and treat to goal SBP <140 mm Hg and goal DBP <90 mm Hg. (Expert Opinion – Grade E). (JNC8, 2014)

Patients with CKD should be considered in the "highest-risk" group for CVD for implementing recommendations for pharmacological therapy, irrespective of cause of CKD (Grade A). (KDOQI, 2004)

All antihypertensive agents can be used to lower blood pressure in CKD. Multidrug regimens will be necessary in most patients with CKD to achieve therapeutic goals. Patients with specific causes of kidney disease and CVD will benefit from specific classes of agents. (KDOQI, 2004)

All classes of antihypertensive agents are effective in lowering blood pressure in CKD. Antihypertensive agents should be prescribed as follows, when possible: Preferred agents for CKD should be used first (Grade A); Diuretics should be included in the antihypertensive regimen in most patients (Grade A); Choose additional agents based on cardiovascular disease-specific indications to achieve therapeutic and preventive targets and to avoid side-effects and interactions (Grade B). (KDOQI, 2004)

Elevated blood pressure must be confirmed on repeated visits before characterizing an individual as having hypertension. Blood pressure can be determined by resting blood pressure measurement in the health-care provider's office (casual blood pressure [CBP]), self-measured blood pressure (SMBP), or ambulatory blood pressure monitoring (ABPM). Blood pressure should be measured according to the recommendations for indirect measurement of arterial blood pressure of the American Heart Association and Seventh Report of the Joint National Committee on the Prevention, Detection, Evaluation and Treatment of High Blood Pressure (JNC 7) (Grade A); Patients should be taught to measure and record their blood pressure, whenever possible (Grade C). (KDOQI, 2004)

High blood pressure is both a cause and a complication of chronic kidney disease. As a complication, high blood pressure may develop early during the course of chronic kidney disease and is associated with adverse outcomes—in particular, faster loss of kidney function and development of cardiovascular disease.

- Blood pressure should be closely monitored in all patients with chronic kidney disease.
- Treatment of high blood pressure in chronic kidney disease should include specification of target blood pressure levels, nonpharmacologic therapy, and specific antihypertensive agents for the prevention of progression of kidney disease (Guideline 13) and development of cardiovascular disease (Guideline 15). (KDOQI, 2002)
- Interventions to slow the progression of kidney disease should be considered in all patients with chronic kidney disease.
- Interventions that have been proven to be effective include:

1) Strict glucose control in diabetes;
2) Strict blood pressure control;
3) Angiotensin-converting enzyme inhibition or angiotensin-2 receptor blockade. (KDOQI, 2002)

♩ Measure #126 (NQF 0417): Diabetes Mellitus: Diabetic Foot and Ankle Care, Peripheral Neuropathy – Neurological Evaluation – National Quality Strategy Domain: Effective Clinical Care

2015 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Percentage of patients aged 18 years and older with a diagnosis of diabetes mellitus who had a neurological examination of their lower extremities within 12 months

INSTRUCTIONS:
This measure is to be reported a minimum of **once per reporting period** for patients with diabetes mellitus seen during the reporting period. Evaluation of neurological status in patients with diabetes to assign risk category and therefore have appropriate foot and ankle care to prevent ulcerations and infections ultimately reduces the number and severity of amputations that occur. Risk categorization and follow up treatment plan should be done according to the following table:

Risk Categorization System:

Category	Risk Profile	Evaluation Frequency
0	Normal	Annual
1	Peripheral Neuropathy (LOPS)	Semi-annual
2	Neuropathy, deformity, and/or PAD	Quarterly
3	Previous ulcer or amputation	Monthly to quarterly

This measure may be reported by non-MD/DO **clinicians who perform the quality actions described in the measure** based on the services provided and the measure-specific denominator coding.

Measure Reporting via Registry:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

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

DENOMINATOR:
All patients aged 18 years and older with a diagnosis of diabetes mellitus

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Diagnosis for diabetes (ICD-9-CM) [for use 1/1/2015-9/30/2015]: 250.00, 250.01, 250.02, 250.03, 250.10, 250.11, 250.12, 250.13, 250.20, 250.21, 250.22, 250.23, 250.30, 250.31, 250.32, 250.33, 250.40, 250.41, 250.42, 250.43, 250.50, 250.51, 250.52, 250.53, 250.60, 250.61, 250.62, 250.63, 250.70, 250.71, 250.72, 250.73, 250.80, 250.81, 250.82, 250.83, 250.90, 250.91, 250.92, 250.93
Diagnosis for diabetes (ICD-10-CM) [for use 10/01/2015-12/31/2015]: E10.10, E10.11, E10.21, E10.22, E10.29, E10.311, E10.319, E10.321, E10.329, E10.331, E10.339, E10.341, E10.349, E10.351, E10.359, E10.36, E10.39, E10.40, E10.41, E10.42, E10.43, E10.44, E10.49, E10.51, E10.52, E10.59, E10.610, E10.618, E10.620, E10.621, E10.622, E10.628, E10.630, E10.638, E10.641, E10.649, E10.65, E10.69, E10.8, E10.9, E11.00, E11.01, E11.21, E11.22, E11.29, E11.311, E11.319, E11.321, E11.329, E11.331,

E11.339, E11.341, E11.349, E11.351, E11.359, E11.36, E11.39, E11.40, E11.41, E11.42, E11.43, E11.44, E11.49, E11.51, E11.52, E11.59, E11.610, E11.618, E11.620, E11.621, E11.622, E11.628, E11.630, E11.638, E11.641, E11.649, E11.65, E11.69, E11.8, E11.9, E13.00, E13.01, E13.10, E13.11, E13.21, E13.22, E13.29, E13.311, E13.319, E13.321, E13.329, E13.331, E13.339, E13.341, E13.349, E13.351, E13.359, E13.36, E13.39, E13.40, E13.41, E13.42, E13.43, E13.44, E13.49, E13.51, E13.52, E13.59, E13.610, E13.618, E13.620, E13.621, E13.622, E13.628, E13.630, E13.638, E13.641, E13.649, E13.65, E13.69, E13.8, E13.9

AND

Patient encounter during the reporting period (CPT): 11042, 11043, 11044, 11055, 11056, 11057, 11719, 11720, 11721, 11730, 11740, 97001, 97002, 97597, 97598, 97802, 97803, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350

AND NOT

Clinician documented that patient was not an eligible candidate for lower extremity neurological exam measure, for example patient bilateral amputee, patient has condition that would not allow them to accurately respond to a neurological exam (dementia, Alzheimer´s, etc.), patient has previously documented diabetic peripheral neuropathy with loss of protective sensation

NUMERATOR:

Patients who had a lower extremity neurological exam performed at least once within 12 months

Definition:

Lower Extremity Neurological Exam – Consists of a documented evaluation of motor and sensory abilities and should include: 10-g monofilament plus testing any one of the following: vibration using 128-Hz tuning fork, pinprick sensation, ankle reflexes, or vibration perception threshold), however the clinician should perform all necessary tests to make the proper evaluation.

Numerator Options:

Performance Met:	Lower extremity neurological exam performed and documented (**G8404)**
OR	
Performance Not Met:	Lower extremity neurological exam **not** performed (**G8405)**

RATIONALE:

Foot ulceration is the most common single precursor to lower extremity amputations among persons with diabetes. Treatment of infected foot wounds accounts for up to one-quarter of all inpatient hospital admissions for people with diabetes in the United States. Peripheral sensory neuropathy in the absence of perceived trauma is the primary factor leading to diabetic foot ulcerations. Approximately 45-60% of all diabetic ulcerations are purely neuropathic. Other forms of neuropathy may also play a role in foot ulcerations. Motor neuropathy resulting in anterior crural muscle atrophy or intrinsic muscle wasting can lead to foot deformities such as foot drop, equinus, and hammertoes. In people with diabetes, 22.8% have foot problems – such as amputations and numbness – compared with 10% of nondiabetics. Over the age of 40 years old, 30% of people with diabetes have loss of sensation in their feet.

CLINICAL RECOMMENDATION STATEMENTS:

Recognizing important risk factors and making a logical, treatment-oriented assessment of the diabetic foot requires a consistent and thorough diagnostic approach using a common language. Without such a method, the practitioner is more likely to overlook vital information and to pay inordinate attention to less critical points in the evaluation. A useful examination will involve identification of key risk factors and assignment into appropriate risk category. Only then can an effective treatment plan be designed and implemented. (ACFAS/ACFAOM Clinical Practice Guidelines)

♪ Measure #127 (NQF 0416): Diabetes Mellitus: Diabetic Foot and Ankle Care, Ulcer Prevention – Evaluation of Footwear – National Quality Strategy Domain: Effective Clinical Care

2015 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Percentage of patients aged 18 years and older with a diagnosis of diabetes mellitus who were evaluated for proper footwear and sizing

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

Measure Reporting via Registry:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

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

DENOMINATOR:
All patients aged 18 years and older with a diagnosis of diabetes mellitus

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Diagnosis for diabetes (ICD-9-CM) [for use 1/1/2015-9/30/2015]: 250.00, 250.01, 250.02, 250.03, 250.10, 250.11, 250.12, 250.13, 250.20, 250.21, 250.22, 250.23, 250.30, 250.31, 250.32, 250.33, 250.40, 250.41, 250.42, 250.43, 250.50, 250.51, 250.52, 250.53, 250.60, 250.61, 250.62, 250.63, 250.70, 250.71, 250.72, 250.73, 250.80, 250.81, 250.82, 250.83, 250.90, 250.91, 250.92, 250.93
Diagnosis for diabetes (ICD-10-CM) [for use 10/01/2015-12/31/2015]: E10.10, E10.11, E10.21, E10.22, E10.29, E10.311, E10.319, E10.321, E10.329, E10.331, E10.339, E10.341, E10.349, E10.351, E10.359, E10.36, E10.39, E10.40, E10.41, E10.42, E10.43, E10.44, E10.49, E10.51, E10.52, E10.59, E10.610, E10.618, E10.620, E10.621, E10.622, E10.628, E10.630, E10.638, E10.641, E10.649, E10.65, E10.69, E10.8, E10.9, E11.00, E11.01, E11.21, E11.22, E11.29, E11.311, E11.319, E11.321, E11.329, E11.331, E11.339, E11.341, E11.349, E11.351, E11.359, E11.36, E11.39, E11.40, E11.41, E11.42, E11.43, E11.44, E11.49, E11.51, E11.52, E11.59, E11.610, E11.618, E11.620, E11.621, E11.622, E11.628, E11.630, E11.638, E11.641, E11.649, E11.65, E11.69, E11.8, E11.9, E13.00, E13.01, E13.10, E13.11, E13.21, E13.22, E13.29, E13.311, E13.319, E13.321, E13.329, E13.331, E13.339, E13.341, E13.349, E13.351, E13.359, E13.36, E13.39, E13.40, E13.41, E13.42, E13.43, E13.44, E13.49, E13.51, E13.52, E13.59, E13.610, E13.618, E13.620, E13.621, E13.622, E13.628, E13.630, E13.638, E13.641, E13.649, E13.65, E13.69, E13.8, E13.9
AND
Patient encounter during the reporting period (CPT): 11042, 11043, 11044, 11055, 11056, 11057, 11719, 11720, 11721, 11730, 11740, 97001, 97002, 97597, 97598, 97802, 97803, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350

NUMERATOR:
Patients who were evaluated for proper footwear and sizing at least once within 12 months

Definition:
Evaluation for Proper Footwear – Includes a foot examination documenting the vascular, neurological, dermatological, and structural/biomechanical findings. The foot should be measured using a standard measuring device, and counseling on appropriate footwear should be based on risk categorization.

Numerator Options:

Performance Met:	Footwear evaluation performed and documented(**G8410)**
OR	
Other Performance Exclusion:	Clinician documented that patient was not an eligible candidate for footwear evaluation measure(**G8416)**
OR	
Performance Not Met:	Footwear evaluation was **not** performed(**G8415)**

RATIONALE:
Foot ulceration is the most common single precursor to lower extremity amputations among persons with diabetes. Shoe trauma, in concert with loss of protective sensation and concomitant foot deformity, is the leading event precipitating foot ulceration in persons with diabetes. Treatment of infected foot wounds accounts for up to one-quarter of all inpatient hospital admissions for people with diabetes in the United States. Peripheral sensory neuropathy in the absence of perceived trauma is the primary factor leading to diabetic foot ulcerations. Approximately 45-60% of all diabetic ulcerations are purely neuropathic. In people with diabetes, 22.8% have foot problems – such as amputations and numbness – compared with 10% of non-diabetics. Over the age of 40 years old, 30% of people with diabetes have loss of sensation in their feet.

CLINICAL RECOMMENDATION STATEMENTS:
The multifactorial etiology of diabetic foot ulcers is evidenced by the numerous pathophysiologic pathways that can potentially lead to this disorder. Among these are two common mechanisms by which foot deformity and neuropathy may induce skin breakdown in persons with diabetes. The first mechanism of injury refers to prolonged low pressure over a bony prominence (ie, bunion or hammertoe deformity). This generally causes wounds over the medial, lateral, and dorsal aspects of the forefoot and is associated with tight or ill-fitting shoes. The other common mechanism of ulceration involves prolonged repetitive moderate stress. (ACFAS/ACFAOM Clinical Practice Guidelines)

♠ Measure #128 (NQF 0421): Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan – National Quality Strategy Domain: Community/Population Health

2015 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of patients aged 18 years and older with a BMI documented during the current encounter or during the previous six months AND with a BMI **outside of normal parameters**, a follow-up plan is documented during the encounter or during the previous six months of the current encounter

Normal Parameters: Age 65 years and older BMI ≥ 23 and < 30 kg/m^2
Age 18 – 64 years BMI ≥ 18.5 and < 25 kg/m^2

INSTRUCTIONS:
There is no diagnosis associated with this measure. This measure is to be reported a minimum of **once per reporting period** for patients seen during the reporting period. This measure may be reported by eligible professionals who perform the quality actions described in the measure based on the services provided at the time of the qualifying visit and the measure-specific denominator coding. The BMI may be documented in the medical record of the provider or in outside medical records obtained by the provider. If the most recent documented BMI is outside of normal parameters, then a follow-up plan must be documented during the encounter or during the previous six months of the current encounter. The documented follow-up plan must be based on the most recent document BMI outside of normal parameters, example: "Patient referred to nutrition counseling for BMI above normal parameters"(See Definitions for examples of a follow-up plan treatments). *If more than one BMI is reported during the measure period, the most recent BMI will be used to determine if the performance has been met.*

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

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

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

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

DENOMINATOR:
All patients aged 18 years and older

Denominator Criteria (Eligible Cases):
Patients aged ≥18 years on date of encounter
AND
Patient encounter during the reporting period (CPT or HCPCS): 90791, 90792, 90832, 90834, 90837, 90839, 96150, 96151, 96152, 97001, 97003, 97802, 97803, 98960, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, D7140, D7210, G0101, G0108, G0270, G0271, G0402, G0438, G0439, G0447

NUMERATOR:

Patients with a documented BMI during the encounter or during the previous six months, AND when the BMI is outside of normal parameters, a follow-up plan is documented during the encounter or during the previous six months of the current encounter

Numerator Instructions:

- Height and Weight - An eligible professional or their staff is required to measure both height and weight. Both height and weight must be measured within six months of the current encounter and may be obtained from separate encounters. Self-reported values cannot be used.
- Follow-Up Plan – If the most recent documented BMI is outside of normal parameters, then a follow-up plan is documented during the encounter or during the previous six months of the current encounter. The documented follow-up plan must be based on the most recent documented BMI outside of normal parameters, example: "Patient referred to nutrition counseling for BMI above normal parameters". (See Definitions for examples of a follow-up plan treatments)
- Performance Met for G8417 & G8418

    - If the provider documents a BMI and a follow-up plan at the current visit **OR**
    - If the patient has a documented BMI within the previous six months of the current encounter, the provider documents a follow-up plan at the current visit **OR**
    - If the patient has a documented BMI within the previous six months of the current encounter **AND** the patient has a documented follow-up plan for a BMI outside normal parameters within the previous six months of the current visit

Definitions:

BMI – Body mass index (BMI), is a number calculated using the Quetelet index: weight divided by height squared (W/H^2) and is commonly used to classify weight categories. BMI can be calculated using:

Metric Units: BMI = Weight (kg) / (Height (m) x Height (m))

OR

English Units: BMI = Weight (lbs) / (Height (in) x Height (in)) x 703

Follow-Up Plan – Proposed outline of treatment to be conducted as a result of a BMI out of normal parameters. A follow-up plan may include but is not limited to:

- Documentation of education
- Referral (eg, a registered dietitian/nutritionist, occupational therapist, physical therapist, primary care provider, exercise physiologist, mental health professional, or surgeon)
- Pharmacological interventions
- Dietary supplements
- Exercise counseling
- Nutrition counseling

Not Eligible for BMI Calculation or Follow-Up Plan – A patient is not eligible if one or more of the following reasons are documented:

- Patient is receiving palliative care
- Patient is pregnant
- Patient refuses BMI measurement (refuses height and/or weight)
- Any other reason documented in the medical record by the provider why BMI measurement was not appropriate
- Patient is in an urgent or emergent medical situation where time is of the essence, and to delay treatment would jeopardize the patient's health status

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

BMI Documented as Normal, No Follow-Up Plan Required

*(One quality-data code [**G8417, G8418 or G8420**] is required on the claim form to submit this numerator option)*

***Performance Met:* G8420:** BMI is documented within normal parameters and no follow-up plan is required

OR

BMI Documented as Above Normal Parameters, AND Follow-Up Documented

***Performance Met:* G8417:** BMI is documented above normal parameters and a follow-up plan is documented

OR

BMI Documented as Below Normal Parameters, AND Follow-Up Documented

***Performance Met:* G8418:** BMI is documented below normal parameters and a follow-up plan is documented

OR

BMI not Documented, Patient not Eligible

*(One quality-data code [**G8422 or G8938**] is required on the claim form to submit this numerator option)*

***Other Performance Exclusion:* G8422:** BMI not documented, documentation the patient is not eligible for BMI calculation

OR

BMI Documented Outside of Normal Limits, Follow-up Plan not Documented, Patient not Eligible

***Other Performance Exclusion:* G8938:** BMI is documented as being outside of normal limits, follow-up plan is not documented, documentation the patient is not eligible

OR

BMI not Documented, Reason not Given

*(One quality-data code [**G8419 or G8421**] is required on the claim form to submit this numerator option)*

***Performance Not Met:* G8421:** BMI **not** documented and no reason is given

OR

BMI Documented Outside of Normal Parameters, Follow-Up Plan not Documented, Reason not Given

***Performance Not Met:* G8419:** BMI documented outside normal parameters, **no** follow-up plan documented, no reason given

RATIONALE:

Normal Parameters for Age 65 Years and Older

Winter et al. (2014) performed a meta-analysis looking at the relationship between BMI and all-cause mortality among adults 65 and older. They identified a higher risk of mortality among those with a BMI <23 kg/m^2 and recommended monitoring weight status in this group to address any modifiable causes of weight loss promptly with due consideration of individual comorbidities. Dahl et al. (2013) reported that old persons (70-79) who were overweight had a lower mortality risk than old persons who were of normal weight, even after controlling for weight change and multimorbidity. The study also shows that persons who increased or decreased in BMI had a greater mortality risk than those who had a stable BMI, particularly those aged 70 to 79. Their results provide support to the belief that the World Health Organization guidelines for BMI are overly restrictive in old age.

BMI Above Upper Parameters

Obesity continues to be a costly public health concern in the United States. The Centers for Disease Control and Prevention (CDC, 2010) reported in 2009, no state met the Healthy People 2010 obesity target of 15 percent and the self-reported overall prevalence of obesity among adults had increased 1.1 percentage points in 2007 to 26.7 percent (2010).Ogden, Carroll, Kit and Flegal (2013) reported the prevalence of BMI-defined obesity in adults is high and continues to exceed 30% in most sex-age groups (34.9% overall). They also stated the overall prevalence of obesity

did not differ between men and women in 2011–2012; however, among non-Hispanic black adults, 56.6% of women were obese compared with 37.1% of men. In addition to the continued high prevalence rate for adults in general, Flegal, Carroll & Kit (2012) report a significant increase for men and for non-Hispanic black and Mexican American women over the 12-year period from 1999 through 2010 (2012). Moyer (2012) reported: Obesity is associated with such health problems as an increased risk for coronary artery disease, type 2 diabetes, various types of cancer, gallstones and disability. These comorbid medical conditions are associated with higher use of health care services and costs among obese patients (p. 373).

Obesity is also associated with an increased risk of death, particularly in adults younger than age 65 years and has been shown to reduce life expectancy by 6 to 20 years depending on age and race (LeBlanc et al., 2011). Masters, et al. (2013) also showed mortality due to obesity varied by race and gender. They estimated adult deaths between 1986 and 2006 associated with overweight and obesity was 5.0% and 15.6% for Black and White men, and 26.8% and 21.7% for Black and White women, respectively. They also found a stronger association than previous research demonstrated between obesity and mortality risk at older ages.

Finkelstein, Trogdon, Cohen and Dietz (2009) found that in 2006, across all payers, per capita medical spending for the obese is $1,429 higher per year, (42 percent) than for someone of normal weight. Using 2008 dollars, this was estimated to be equivalent to $147 billion dollars in medical care costs related to obesity.

Padula, Allen and Nair (2014) examined data from a commercial claims and encounters database to estimate the cost for obesity and associated comorbidities among working-age adults who had a claim with a primary or secondary diagnosis of obesity in 2006-2007. The mean net expenditure for inpatient and outpatient claims was $1,907 per patient per visit. The increases in cost for comorbidities ranged from $527 for obesity with CHF to $15,733 for the combination of obesity, diabetes mellitus, hypertension and depression.

In addition to a high prevalence rate of obesity, less than 50% of obese adults in 2010 received advice to exercise or perform physical activity (Barnes & Schoenborn, 2012).

BMI Below Normal Parameters
In the National Center for Health Statistics (NCHS) Health E-Stat, Fryer and Ogden (2012) reported that poor nutrition or underlying health conditions can result in underweight. Results from the 2007-2010 National Health and Nutrition Examination Survey (NHANES), using measured heights and weights, indicate an estimated 1.7% of U.S. adults are underweight with women more likely to be underweight than men (2012).

In a cohort study conducted by Borrell and Lalitha (2014), data from NHANES III (1988-1994) was linked to the National Death Index mortality file with follow-up to 2006, and showed that when compared to their normal weight counterparts (BMI 18.5-25 kg/m^2), underweight (BMI <18.5 kg/m^2) had significantly higher death rates (Hazard Ratio= 2.27; 95% confidence interval (CI) = 1.78, 2.90).

Ranhoff, Gjoen and Mowe (2005) recommended using BMI < 23 kg/m^2 for the elderly to identify positive results with malnutrition screens and poor nutritional status.

CLINICAL RECOMMENDATION STATEMENTS:
Although multiple clinical recommendations addressing obesity have been developed by professional organizations, societies and associations, two recommendations have been identified which exemplify the intent of the measure and address the numerator and denominator.

The US Preventive Health Services Task Force (USPSTF) recommends screening all adults (aged 18 years and older) for obesity. Clinicians should offer or refer patients with a BMI of 30 or higher to intensive, multicomponent behavioral interventions. This is a B recommendation (Moyer, 2012).

As cited in Wilkinson et al. (2013), Institute for Clinical Systems Improvement (ICSI) *Preventive Services for Adults, Obesity Screening* (Level II) Recommendation provides the following guidance:

- Record height, weight and calculate body mass index at least annually
    - Clinicians should consider waist circumference measurement to estimate disease risk for patients who have BMI scores indicative of overweight or obesity class I. For adult patients with a BMI of 25 to 34.9 kg/m^2, sex-specific waist circumference cutoffs should be used in conjunction with BMI to identify increased disease risk.
- A BMI greater or equal to 30 is defined as obese
- A BMI of 25-29 is defined as overweight
- Intensive intervention for obese individuals, based on BMI, is recommended by the U.S. Preventive Services to help control weight.

Similarly, the 2013 joint report/guideline from the American Heart Association, American College of Cardiology and The Obesity Society also recommend measuring height and weight and calculating BMI at annual visits or more frequently, using the current cutpoints for overweight (BMI>25.0-29.9 kg/m^2) and obesity (BMI ≥30 kg/m^2) to identify adults who may be at elevated risk of CVD and the current cutpoints for obesity to identify adults who may be at elevated risk of mortality from all causes. They also recommend counseling overweight and obese individuals on their increased risk for CVD, type 2 diabetes, all-cause mortality and need for lifestyle changes.

♠ Measure #130 (NQF 0419): Documentation of Current Medications in the Medical Record – National Quality Strategy Domain: Patient Safety

2015 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of visits for patients aged 18 years and older for which the eligible professional attests to documenting a list of current medications using all immediate resources available on the date of the encounter. This list ***must*** include ALL known prescriptions, over-the-counters, herbals, and vitamin/mineral/dietary (nutritional) supplements AND ***must*** contain the medications' name, dosage, frequency and route of administration

INSTRUCTIONS:
This measure is to be reported **each visit** during the 12 month reporting period. Eligible professionals meet the intent of this measure by making their best effort to document a current, complete and accurate medication list during each encounter. There is no diagnosis associated with this measure. This measure may be reported by eligible professionals who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

Measure Reporting via Claims:
CPT or HCPCS codes and patient demographics are used to identify visits that are included in the measure's denominator. Quality-data codes are used to report the numerator of the measure.

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

Measure Reporting via Registry:
CPT or HCPCS codes and patient demographics are used to identify visits that are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

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

DENOMINATOR:
All visits for patients aged 18 years and older

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Patient encounter during the reporting period (CPT or HCPCS): 90791, 90792, 90832, 90834, 90837, 90839, 90957, 90958, 90959, 90960, 90962, 90965, 90966, 92002, 92004, 92012, 92014, 92507, 92508, 92526, 92541, 92542, 92543, 92544, 92545, 92547, 92548, 92557, 92567, 92568, 92570, 92585, 92588, 92626, 96116, 96150, 96151, 96152, 97001, 97002, 97003, 97004, 97532, 97802, 97803, 97804, 98960, 98961, 98962, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99221, 99222, 99223, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, 99495, 99496, G0101, G0108, G0270, G0402, G0438, G0439

NUMERATOR:
Eligible professional attests to documenting, updating or reviewing a patient's current medications using all immediate resources available on the date of encounter. This list ***must*** include ALL known 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.

Route – Documentation of the way the medication enters the body (some examples include but are not limited to: oral, sublingual, subcutaneous injections, and/or topical)

Not Eligible – A patient is **not** eligible if the following reason is documented:

- 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 eligible professional must document in the medical record they obtained, updated, or reviewed a medication list on the date of the encounter. Eligible professionals reporting this measure may document medication information received from the patient, authorized representative(s), caregiver(s) or other available healthcare resources. G8427 should be reported if the eligible professional documented that the patient is not currently taking any medications*

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Current Medications Documented

Performance Met: **G8427:** Eligible professional attests to documenting in the medical record they obtained, updated, or reviewed the patient's current medications

OR

Current Medications not Documented, Patient not Eligible

Other Performance Exclusion: **G8430:** Eligible professional attests to documenting in the medical record the patient is not eligible for a current list of medications being obtained, updated, or reviewed by the eligible professional

OR

Current Medications with Name, Dosage, Frequency, or Route not Documented, Reason not Given

Performance Not Met: **G8428:** Current list of medications **not** documented as obtained, updated, or reviewed by the eligible professional, reason not given

RATIONALE:

In the American Medical Association's (AMA) *Physician's Role in Medication Reconciliation* (2007), critical patient information, including medical and medication histories, current medications the patient is receiving and taking, and sources of medications, is essential to the delivery of safe medical care. However, interruptions in the continuity of care and information gaps in patient health records are common and significantly affect patient outcomes. Consequently, clinical judgments may be based on incomplete, inaccurate, poorly documented or unavailable information about the patient and his or her medication.

Medication safety efforts have primarily focused on hospitals; however, the majority of health care services are provided in the outpatient setting where two-thirds of physician visits result in writing at least one prescription (Stock et al., 2009). Chronically ill patients are increasingly being treated as outpatients, many of whom take multiple medications requiring close monitoring (Nassaralla et al., 2007).

Adverse drug events (ADEs) prove to be more fatal in outpatient settings (1 of 131 outpatient deaths) than in hospitals (1 of 854 inpatient deaths) (Nassaralla et al., 2007). According to The Commonwealth Fund report (2010) about 11 to 15 of every 1,000 Americans visit a health care provider because of ADEs in a given year, representing about three to four of every 1,000 patient visits during 1995 to 2001. The total number of visits to treat ADEs increased from 2.9 million in 1995 to 4.3 million visits in 2001.

ADEs in the ambulatory setting substantially increased the healthcare costs of elderly persons and estimated costs were $1,983 per case. Further findings of The Commonwealth Fund studies additionally identified 11% to 28% of the 4.3 million visit related ADEs (VADEs) in 2001 might have been prevented with improved systems of care and better patient education, yielding an estimate of 473,000 to 1.2 million potentially preventable VADEs annually and potential cost-savings of $946 million to $2.4 billion.

In the Institute for Safe Medication Practices, *The White Paper on Medication Safety in the U.S. and the Roles of Community Pharmacists* (2007), the American Pharmaceutical Association identified that Americans spend more than $75 billion per year on prescription and nonprescription drugs. Unnecessary costs include: improper use of prescription medicines due to lack of knowledge costs the economy an estimated $20-100 billion per year; American businesses lose an estimated 20 million workdays per year due to incorrect use of medicines prescribed for heart and circulatory diseases alone; failure to have prescriptions dispensed and/or renewed has resulted in an estimated cost of $8.5 billion for increased hospital admissions and physician visits, nearly one percent of the country's total health care expenditures.

In 2005, the rate of medication errors during hospitalization was estimated to be 52 per 100 admissions, or 70 per 1,000 patient days. Emerging research suggests the scope of medication-related errors in ambulatory settings is as extensive as or more extensive than during hospitalization. Ambulatory visits result in a prescription for medication 50 to 70% of the time. One study estimated the rate of ADEs in the ambulatory setting to be 27 per 100 patients. It is estimated that between 2004 and 2005 in the United States, 701,547 patients were treated for ADEs in emergency departments, and 117,318 patients were hospitalized for injuries caused by an ADE. Individuals aged 65 years and older are more likely than any other population group to require treatment in the emergency department for ADEs (AMA, 2007).

A Systematic Review on "Prevalence of Adverse Drug Events in Ambulatory Care" finds that "The median ADE prevalence rate for retrospective studies was 3.3% (interquartile range [IQR] 2.3–7.1%) vs 9.65% (IQR 3.3–17.35%) for prospective studies. Median preventable ADE rates in ambulatory care-based studies were 16.5%, and 52.9% for hospital-based studies. Median prevalence rates by age group ranged from 2.45% for children to 5.27% for adults, 16.1% for elderly patients, and 3.45% for studies including all ages (Tache et al., 2011)".

The Agency for Healthcare Research and Quality's (AHRQ) The National Healthcare Disparities Report (2011) identified the rate of adverse drug events (ADE) among Medicare beneficiaries in ambulatory settings as 50 per 1,000 person-years. In 2005, AHRQ reported data on adults age 65 and over who received potentially inappropriate prescription medicines in the calendar year, by race, ethnicity, income, education, insurance status, and gender. The disparities were identified as follows**:** older Asians were more likely than older whites to have inappropriate drug use (20.3% compared with 17.3%); older Hispanics were less likely than older non-Hispanic Whites to have inappropriate drug use (13.5% compared with 17.6%); older women were more likely than older men to have inappropriate drug use (20.2% compared with 14.3%); there were no statistically significant differences by income or education.

Weeks et al. (2010) noted that fragmented medication records across the health care continuum, inaccurate reporting of medication regimens by patients, and provider failure to acquire all of the necessary elements of medication information from the patient or record, present significant obstacles to obtaining an accurate medication list in the ambulatory care setting. Because these obstacles require solutions demonstrating improvements in access to information and communication, the Institute of Medicine and others have encouraged the incorporation of IT solutions in the medication reconciliation process. In a survey administered to office-based physicians with high rates of EMR use, Weeks, et al found there is an opportunity for universal medication lists utilizing health IT.

CLINICAL RECOMMENDATION STATEMENTS:

The Joint Commission's 2014 Ambulatory Care National Patient Safety Goals guide providers to maintain and communicate accurate patient medication information. Specifically, the section "Use Medicines Safely NPSG.03.06.01" includes the following: "Record and pass along correct information about a patient's medicines. Find out what medicines the patient is taking. Compare those medicines to new medicines given to the patient. Make sure

the patient knows which medicines to take when they are at home. Tell the patient it is important to bring their up-to-date list of medicines every time they visit a doctor".

The National Quality Forum's 2010 update of the *Safe Practices for Better Healthcare*, states healthcare organizations must develop, reconcile, and communicate an accurate patient medication list throughout the continuum of care. Improving the safety of healthcare delivery saves lives, helps avoid unnecessary complications, and increases the confidence that receiving medical care actually makes patients better, not worse. Every healthcare stakeholder group should insist that provider organizations demonstrate their commitment to reducing healthcare error and improving safety by putting into place evidence-based safe practices.

The AMA's published report, *The Physician's Role in Medication Reconciliation*, identified the best practice medication reconciliation team as one that is multidisciplinary and—in all settings of care—will include physicians, pharmacists, nurses, ancillary health care professionals and clerical staff. The team's variable requisite knowledge, skills, experiences, and perspectives are needed to make medication reconciliation work as safely and smoothly as possible. Team members may have access to vital information or data needed to optimize medication safety. Because physicians are ultimately responsible for the medication reconciliation process and subsequently accountable for medication management, physician leadership and involvement in all phases of developing and initiating a medication reconciliation process or model is important to its success.

♠ Measure #131 (NQF 0420): Pain Assessment and Follow-Up – National Quality Strategy Domain: Community/Population Health*

*Please note that PQRS 131 is incorrectly listed under the Communication and Care Coordination domain in the CY 2015 PFS Final Rule. PQRS 131 was finalized in the CY 2013 PFS Final Rule under the Community and Population Health domain and will therefore remain under the Community and Population Health domain for 2015

2015 PQRS OPTIONS FOR INDIVIDUAL MEASURE:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of visits for patients aged 18 years and older with documentation of a pain assessment using a standardized tool(s) on each visit AND documentation of a follow-up plan when pain is present

INSTRUCTIONS:
This measure is to be reported **each visit** occurring during the reporting period for patients seen during the reporting period. There is no diagnosis associated with this measure. This measure may be reported by eligible professionals who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding. The documented follow-up plan must be related to the presence of pain, example: "Patient referred to pain management specialist for back pain" or "Return in two weeks for re-assessment of pain".

Measure Reporting via Claims:
CPT or HCPCS codes and patient demographics are used to identify visits included in the measure's denominator. Quality-data codes are used to report the numerator of the measure.

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

Measure Reporting via Registry:
CPT or HCPCS codes and patient demographics are used to identify visits included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

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

DENOMINATOR:
All visits for patients aged 18 years and older

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Patient encounter during the reporting period (CPT or HCPCS): 90791, 90792, 92002, 92004, 92012, 92014, 92507, 92508, 92526, 96116, 96118, 96150, 96151, 97001, 97002, 97003, 97004, 97532, 98940, 98941, 98942, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, D7140, D7210, G0101, G0402, G0438, G0439

NUMERATOR:
Patient visits with a documented pain assessment using a standardized tool(s) AND documentation of a follow-up plan when pain is present

Definitions:

Pain Assessment – Documentation of a clinical assessment for the presence or absence of pain using a standardized tool is required. A multi-dimensional clinical assessment of pain using a standardized tool may include characteristics of pain; such as: location, intensity, description, and onset/duration.
Standardized Tool – An assessment tool that has been appropriately normalized and validated for the population in which it is used. Examples of tools for pain assessment, include, but are not limited to: Brief Pain Inventory (BPI), Faces Pain Scale (FPS), McGill Pain Questionnaire (MPQ), Multidimensional Pain Inventory (MPI), Neuropathic Pain Scale (NPS), Numeric Rating Scale (NRS), Oswestry Disability Index (ODI), Roland Morris Disability Questionnaire (RMDQ), Verbal Descriptor Scale (VDS), Verbal Numeric Rating Scale (VNRS) and Visual Analog Scale (VAS).
Follow-Up Plan – A documented outline of care for a positive pain assessment is required. This **must** include a planned follow-up appointment or a referral, a notification to other care providers as applicable OR indicate the initial treatment plan is still in effect. These plans may include pharmacologic and/or educational interventions.
Not Eligible – A patient is **not** eligible if one or more of the following reason(s) is documented:

- Severe mental and/or physical incapacity where the person is unable to express himself/herself in a manner understood by others. For example, cases where pain cannot be accurately assessed through use of nationally recognized standardized pain assessment tools
- Patient is in an urgent or emergent situation where time is of the essence and to delay treatment would jeopardize the patient's health status

NUMERATOR NOTE: *The standardized tool used to assess the patient's pain must be documented in the medical record (exception: A provider may use a fraction such as 5/10 for Numeric Rating Scale without documenting this actual tool name when assessing pain for intensity)*

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Pain Assessment Documented as Positive AND Follow-Up Plan Documented
*(One quality-data code [**G8730 or G8731**] is required on the claim form to submit this numerator option)*
***Performance Met*: G8730:** Pain assessment documented as positive using a standardized tool AND a follow-up plan is documented

OR

Pain Assessment Documented as Negative, No Follow-Up Plan Required
***Performance Met*: G8731:** Pain assessment using a standardized tool is documented as negative, no follow-up plan required

OR

Pain Assessment not Documented Patient not Eligible
*(One quality-data code [**G8442 or G8939**] is required on the claim form to submit this numerator option)*
***Other Performance Exclusion*: G8442:** Pain assessment NOT documented as being performed, documentation the patient is not eligible for a pain assessment using a standardized tool

OR

Pain Assessment Documented as Positive, Follow-Up Plan not Documented, Patient not Eligible
***Other Performance Exclusion:* G8939:** Pain assessment documented as positive, follow-up plan not documented, documentation the patient is not eligible

OR

Pain Assessment not Documented, Reason not Given
*(One quality-data code [**G8732 or G8509**] is required on the claim form to submit this numerator option)*
***Performance Not Met*: G8732:** **No** documentation of pain assessment, reason not given

OR

Pain Assessment Documented as Positive, Follow-Up Plan not Documented, Reason not Given

***Performance Not Met**:* **G8509:**	Pain assessment documented as positive using a standardized tool, follow-up plan **not** documented, reason not given

RATIONALE:

Several provisions from the National Pain Care Policy Act (H.R. 756/S. 660) have been included in the Affordable Care Act (ACA) of 2010 to improve pain care. The legislation includes:

- Mandating an Institute of Medicine (IOM) conference on pain to address key medical and policy issues affecting the delivery of quality pain care.
- Establishing a training program to improve the skills of health care professionals to assess and treat pain.
- Enhancing the pain research agenda for the National Institute of Health (NIH).

The American Pain Foundation (2009) identified pertinent facts related to the impact of pain as follows:

- Approximately 76.5 million Americans suffer from pain.
- Pain affects more Americans than diabetes, heart disease and cancer combined. It is the number one reason people seek medical care.
- Uncontrolled pain is a leading cause of disability and diminishes quality of life for patients, survivors, and their loved ones. It interferes with all aspects of daily activity, including sleep, work, social and sexual relations.
- Under-treated pain drives up costs – estimated at $100 billion annually in healthcare expenses, lost income, and lost productivity– extending length of hospital stays, as well as increasing emergency room trips and unplanned clinic visits.
- Medically underserved populations endure a disproportionate pain burden in all health care settings.

Disparities exist among racial and ethnic minorities in pain perception, assessment, and treatment for all types of pain, whether chronic or acute.

The Institute Of Medicine's (IOM) *Relieving Pain in America: A Blueprint for Transforming Prevention, Care, Education and Research* (2011) report suggests that chronic pain rates will continue to increase as a result of:

- More Americans will experience a disease in which chronic pain is associated (diabetes, cardiovascular disease, etc.).
- Increase in obesity which is associated with chronic conditions that have painful symptoms.
- Progress in lifesaving techniques for catastrophic injuries for people who would have previously died leads to a group of young people at risk for lifelong chronic pain.
- Surgical patients are at risk for acute and chronic pain.
- The public has a better understanding of chronic pain syndromes and new treatments and therefore may seek help when they may not have sought help in the past.

Persistent chronic pain costs $560 to $635 billion in the USA. Additional healthcare costs due to pain range from

$261 to $300 billion. Lost productive time amounts to $299 to $334 billion. Productivity is affected by number of days missed, number of annual hours worked and hourly wages (Gaskin, 2012). Stewart et al. (2003) identified almost thirteen percent of the total workforce experienced a loss in productive time during a two-week period due to a common pain condition: 5.4% for headache; 3.2% for back pain; 2.0% for arthritis pain; 2.0% for other musculoskeletal pain.

There are no current estimates of the total cost of poorly controlled pain in today's dollars. Viewed from the perspective of health care inflation at levels of more than 40% during the past decade (President's Council of

Economic Advisors, 2009), the cost of health care due to pain is estimated to be between $261 to $300 billion. The value of lost productivity based on estimates of days of work missed is $11.6 to 12.7 billion, hours of work lost is

$95.2 to $96.5 billion and lower wages is $190.6 to $226.3 billion. Total financial cost of pain to society, combining healthcare cost estimates and productivity estimates, ranges from $560 to $635 billion in 2010 dollars (Relieving Pain in America: A Blueprint for Transforming Prevention, Care, Education and Research, Appendix C, 2011).

"Medical care, specifically specialty care, rather than primary care, chiropractic care, or physical therapy is responsible for the rising costs of ambulatory care for spine conditions" (Davis, 2012).

Medical Expenditures Panel (MEP) data from 2000-2007 show that prevalence of back pain has increased by 29% and chronic back pain has increased 64%. Inflation adjusted ($2010) biennial expenditures on ambulatory services for chronic back pain increased by 129% from $15.6 billion in 2000-2001 to $35.7 billion in 2006-2007 (Smith, 2013).

Chronic pain is defined as pain without biological values that has persisted beyond the normal time and despite the usual customary efforts to diagnose and treat the original condition and injury. If a patient's pain has persisted for six weeks (or longer than the anticipated healing time), a thorough evaluation for the course of the chronic pain is warranted (ICSI, 2013).

Chronic pain affects approximately 100 million adults in the USA. (Gaskin, 2012). It is clear the enormous pain-related costs represent both a great challenge and an opportunity in terms of improving the quality and cost-effectiveness of care (Mayday Fund, 2009).

Research also shows gender differences in the experience and treatment of pain. Most chronic pain conditions are more prevalent among women; however, women's pain complaints tend to be poorly assessed and undertreated (Green, 2003; Chronic Pain Research Alliance 2011, Weimer 2013). Although women may have higher baseline pain, differences in pain levels may not persist at one month (Peterson, 2012).

A growing body of research reveals even more extensive gaps in pain assessment and treatment among racial and ethnic populations, with minorities receiving less care for pain than non-Hispanic whites (Burgess, 2013; Green, 2003; Green, 2007; Green et al., 2011; Todd et al., 2004; Todd et al., 2007). Differences in pain care occur across all types of pain (eg, acute, chronic, cancer-related) and medical settings (eg, emergency departments and primary care) (Green, 2003; Green, 2007; Todd et al., 2007). Even when income, insurance status and access to health care are accounted for, minorities are still less likely than whites to receive necessary pain treatments (Green, 2003; Green, 2007; Paulson et al., 2007). Black race is associated with neighborhood socio-economic status (SES) and race plays a role in pain outcomes beyond SES (Green, 2012).

CLINICAL RECOMMENDATION STATEMENTS:

Chronic pain assessment should include determining the mechanisms of pain through documentation of pain location, intensity, quality and onset/duration; functional ability and goals; and psychological/social factors such as depression or substance abuse.

A patient-centered, multifactorial, comprehensive care plan is necessary; one that includes biopsychosocial factors, as well as spiritual and cultural issues. It is important to have an interdisciplinary team approach which includes the primary care physician and specialty areas of psychology and physical rehabilitation.

The Institute for Clinical Systems Improvement (ICSI, 2013) Assessment and Management of Chronic Pain Guideline, Sixth Edition is based on a very broad foundation of evidence addressing a wide range of clinical conditions. It was chosen because it addresses the key factors of the comprehensive plan of care which incorporates self-management and active input from the patient and primary care clinician, pain assessment outcomes and referral to a pain medicine specialist or pain medicine specialty clinic.

The Institute for Clinical Systems Improvement (ICSI, 2012) Adult Acute and Sub-acute Low Back Pain guideline provides guidelines for physical therapists for low back pain assessment criteria, reducing or eliminating imaging for diagnosis of non-specific low back pain in patients 18 years and older, first-line treatment which emphasizes patient education and a core treatment plan that includes encouraging activity, use of heat, no imaging, cautious and responsible use of opioids, anti-inflammatory and analgesic over-the-counter medications and return to work assessment, advising patients with acute or subacute low back pain to stay active and the use of opioids.

Low Back Pain: Clinical Guidelines Linked to the International Classification of Functioning, Disability, and Health from the Orthopedic Section of the American Physical Therapy Association (Delitto, 2012) provides evidence to classify musculoskeletal conditions, specify interventions and identify appropriate outcome measures.

"Initial physical therapy management was not associated with increased health care costs or utilization of specific services following a new primary care LBP consultation" (Fritz, 2013, p. 1).

♠ Measure #134 (NQF 0418): Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan – National Quality Strategy Domain: Community/Population Health

2015 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of patients aged 12 years and older screened for clinical depression on the date of the encounter using an age appropriate standardized depression screening tool AND if positive, a follow-up plan is documented on the date of the positive screen

INSTRUCTIONS:
This measure is to be reported a minimum of **once per reporting period** for patients seen during the reporting period. This measure may be reported by eligible professionals who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding. The follow up plan must be related to a positive depression screening, example: "Patient referred for psychiatric evaluation due to positive depression screening".

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

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

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

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

DENOMINATOR:
All patients aged 12 years and older

> **Denominator Criteria (Eligible Cases):**
> Patients aged ≥ 12 years on date of encounter
> **AND**
> **Patient encounter during the reporting period (CPT or HCPCS):** 90791, 90792, 90832, 90834, 90837, 90839, 92625, 96116, 96118, 96150, 96151, 97003, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, G0101, G0402, G0438, G0439, G0444

NUMERATOR:
Patients screened for clinical depression on the date of the encounter using an age appropriate standardized tool AND, if positive, a follow-up plan is documented on the date of the positive screen

> **Numerator Instructions:** The name of the age appropriate standardized depression screening tool utilized must be documented in the medical record. The depression screening must be reviewed and addressed in the office of the provider filing the code on the date of the encounter.
>
> **Definitions:**

Screening – Completion of a clinical or diagnostic tool used to identify people at risk of developing or having a certain disease or condition, even in the absence of symptoms.
Standardized Depression Screening Tool – A normalized and validated depression screening tool developed for the patient population in which it is being utilized. The name of the age appropriate standardized depression screening tool utilized must be documented in the medical record.
Examples of depression screening tools include but are not limited to:

- **Adolescent Screening Tools (12-17 years)**
  Patient Health Questionnaire for Adolescents (PHQ-A), Beck Depression Inventory-Primary Care Version (BDI-PC), Mood Feeling Questionnaire (MFQ), Center for Epidemiologic Studies Depression Scale (CES-D), and PRIME MD-PHQ2
- **Adult Screening Tools (18 years and older)**
  Patient Health Questionnaire (PHQ-9), Beck Depression Inventory (BDI or BDI-II), Center for Epidemiologic Studies Depression Scale (CES-D), Depression Scale (DEPS), Duke Anxiety-Depression Scale (DADS), Geriatric Depression Scale (GDS), Cornell Scale Screening, and PRIME MD-PHQ2

Follow-Up Plan – Documented follow-up for a positive depression screening ***must*** include one or more of the following:

- Additional evaluation for depression
- Suicide Risk Assessment
- Referral to a practitioner who is qualified to diagnose and treat depression
- Pharmacological interventions
- Other interventions or follow-up for the diagnosis or treatment of depression

Not Eligible – A patient is **not** eligible if one or more of the following conditions are documented:

- Patient refuses to participate
- Patient is in an urgent or emergent situation where time is of the essence and to delay treatment would jeopardize the patient's health status
- Situations where the patient's functional capacity or motivation to improve may impact the accuracy of results of standardized depression assessment tools. For example: certain court appointed cases or cases of delirium
- Patient has an active diagnosis of Depression
- Patient has a diagnosed Bipolar Disorder

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Screening for Clinical Depression Documented as Positive, AND Follow-Up Plan Documented
*(One quality-data code [**G8431or G8510**] is required on the claim form to submit this numerator option)*
Performance Met: **G8431:** Screening for clinical depression is documented as being positive AND a follow-up plan is documented

OR
Screening for Clinical Depression Documented as Negative, Follow-Up Plan not Required
Performance Met: **G8510:** Screening for clinical depression is documented as negative, a follow-up plan is not required

OR

Screening for Clinical Depression not Documented, Patient not Eligible
*(One quality-data code [**G8433 or G8940**] is required on the claim form to submit this numerator option)*
Other Performance Exclusion: **G8433:** Screening for clinical depression not documented, documentation stating the patient is not eligible

OR
Screening for Clinical Depression Documented as Positive, Follow-Up Plan not Documented, Patient not Eligible

***Other Performance Exclusion:* G8940:** Screening for clinical depression documented as positive, a follow-up plan not documented, documentation stating the patient is not eligible

OR

Screening for Clinical Depression not Documented, Reason not Given
*(One quality-data code [**G8432 or G8511**] is required on the claim form to submit this numerator option)*
***Performance Not Met:* G8432:** Clinical depression screening **not** documented, reason not given

OR

Screening for Clinical Depression Documented as Positive, Follow-Up Plan not Documented, Reason not Given
***Performance Not Met:* G8511:** Screening for clinical depression documented as positive, follow-up plan **not** documented, reason not given

RATIONALE:

The World Health Organization (WHO), as seen in Pratt & Brody (2008), found that major depression was the leading cause of disability worldwide. Depression causes suffering, decreases quality of life, and causes impairment in social and occupational functioning. It is associated with increased health care costs as well as with higher rates of many chronic medical conditions. Studies have shown that a higher number of depression symptoms are associated with poor health and impaired functioning, whether or not the criteria for a diagnosis of major depression are met. Persons 40-59 years of age had higher rates of depression than any other age group. Persons 12-17, 18-39 and 60 years of age and older had similar rates of depression. Depression was more common in females than in males. Non-Hispanic black persons had higher rates of depression than non-Hispanic white persons. In the 18-39 and 40-59 age groups, those with income below the federal poverty level had higher rates of depression than those with higher income. Among persons 12-17 and 60 years of age and older, raters of depression did not vary significantly by poverty status. Overall, approximately 80% of persons with depression reported some level of difficulty in functioning because of their depressive symptoms. In addition, 35% of males and 22% of females with depression reported that their depressive symptoms make it very or extremely difficult for them to work, get things done at home, or get along with other people. More than one-half of all persons with mild depressive symptoms also reported some difficulty in daily functioning attributable to their symptoms.

15–20 percent of adults older than age 65 in the United States have experienced depression (Geriatric Mental Health Foundation, 2008). 7 million adults aged 65 years and older are affected by depression (Steinman, 2007). Chronically ill Medicare beneficiaries with accompanying depression have significantly higher health care costs than those with chronic diseases alone (Unützer, 2009). People aged 65 years and older accounted for 16 percent of suicide deaths in 2004 (Centers for Disease Control and Prevention, 2007).

The negative outcomes associated with early onset depression, make it crucial to identify and treat depression in its early stages. As reported in Borner (2010), a study conducted by the World Health Organization (WHO) concluded that in North America, primary care and family physicians are likely to provide the first line of treatment for depressive disorders. Others consistently report a 10% prevalence rate of depression in primary care patients. But studies have shown that primary care physicians fail to recognize up to 50% of depressed patients, purportedly because of time constraints and a lack of brief, sensitive, easy-to administer psychiatric screening instruments. Coyle et al. (2003), suggested that the picture is more grim for adolescents, and that more than 70% of children and adolescents suffering from serious mood disorders go unrecognized or inadequately treated. Healthy People 2020 recommends routine screening for mental health problems as a part of primary care for both children and adults (U.S. Department of Health and Human Services, 2014).

Major depressive disorder (MDD) is a debilitating condition that has been increasingly recognized among youth, particularly adolescents. The prevalence of current or recent depression among children is 3% and among adolescents is 6%. The lifetime prevalence of MDD among adolescents may be as high as 20%. Adolescent-onset

MDD is associated with an increased risk of death by suicide, suicide attempts, and recurrence of major depression by young adulthood. MDD is also associated with early pregnancy, decreased school performance, and impaired work, social, and family functioning during young adulthood (Williams et al., 2009). Every fifth adolescent may have a history of depression by age 18. The increase in the onset of depression occurs around puberty. According to Zalsman et al., (2006) as reported in Borner et al. (2010), depression ranks among the most commonly reported mental health problems in adolescent girls.

The economic burden of depression is substantial for individuals as well as society. Costs to an individual may include suffering, possible side effects from treatment, fees for mental health and medical visits and medications, time away from work and lost wages, transportation, and reduced quality of personal relationships. Costs to society may include loss of life, reduced productivity (because of both diminished capacity while at work and absenteeism from work), and increased costs of mental health and medical care. In 2000, the United States spent an estimated $83.1 billion in direct and indirect costs of depression (USPSTF, 2009).

CLINICAL RECOMMENDATION STATEMENTS:

Adolescent Recommendation (12-18 years)
The USPSTF recommends screening of adolescents (12-18 years of age) for major depressive disorder (MDD) when systems are in place to ensure accurate diagnosis, psychotherapy (cognitive-behavioral or interpersonal), and follow-up (AHRQ, 2010, p.141).

Clinicians and health care systems should try to consistently screen adolescents ages 12-18 for major depressive disorder, but only when systems are in place to ensure accurate diagnosis, careful selection of treatment, and close follow-up (ICSI, 2013, p.16).

Adult Recommendation (18 years and older)
The USPSTF recommends screening adults for depression when staff-assisted depression care supports are in place to assure accurate diagnosis, effective treatment, and follow-up (AHRQ, 2010, p.136).

A system that has embedded the elements of best practice and has capacity to effectively manage the volume should consider routine screening of all patients, based on the recommendations of the U.S. Preventive Services Task Force (ICSI, 2013, p.7). Clinicians should use a standardized instrument to screen for depression if it is suspected based on risk factors or presentation. Clinicians should assess and treat for depression in patients with some comorbidities. Clinicians should acknowledge the impact of culture and cultural differences on physician and mental health. Clinicians should screen and monitor depression in pregnant and post-partum women (ICSI, 2013, p.4).

★Measure #137 (NQF 0650): Melanoma: Continuity of Care – Recall System – National Quality Strategy Domain: Communication and Care Coordination

2015 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Percentage of patients, regardless of age, with a current diagnosis of melanoma or a history of melanoma whose information was entered, at least once within a 12 month period, into a recall system that includes:

- A target date for the next complete physical skin exam, AND
- A process to follow up with patients who either did not make an appointment within the specified timeframe or who missed a scheduled appointment

INSTRUCTIONS:
This measure is to be reported a minimum of **once per reporting period** for patients with a current diagnosis of melanoma or a history of melanoma seen during the reporting period. It is anticipated that **clinicians providing care for patients with melanoma or a history of melanoma** will submit this measure.

Measure Reporting via Registry:
ICD-9-CM/ICD-10-CM diagnosis codes and CPT codes are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

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

DENOMINATOR:
All patients, regardless of age, with a current diagnosis of melanoma or a history of melanoma

Denominator Criteria (Eligible Cases):
Diagnosis for melanoma or history of melanoma (ICD-9-CM) [for use 1/1/2015-9/30/2015]: 172.0, 172.1, 172.2, 172.3, 172.4, 172.5, 172.6, 172.7, 172.8, 172.9, V10.82
Diagnosis for melanoma or history of melanoma (ICD-10-CM) [for use 10/01/2015-12/31/2015]: C43.0, C43.10, C43.11, C43.12, C43.20, C43.21, C43.22, C43.30, C43.31, C43.39, C43.4, C43.51, C43.52, C43.59, C43.60, C43.61, C43.62, C43.70, C43.71, C43.72, C43.8, C43.9, D03.0, D03.10, D03.11, D03.12, D03.20, D03.21, D03.22, D03.30, D03.39, D03.4, D03.51, D03.52, D03.59, D03.60, D03.61, D03.62, D03.70, D03.71, D03.72, D03.8, D03.9, Z85.820
AND
Patient encounter during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215

NUMERATOR:
Patients whose information is entered, at least once within a 12 month period, into a recall system that includes:

- A target date for the next complete physical exam **AND**
- A process to follow up with patients who either did not make an appointment within the specified timeframe or who missed a scheduled appointment

Numerator Instructions: To satisfy this measure, the recall system **must** be linked to a process to notify patients when their next physical exam is due, and to follow up with patients who either did not make an appointment within the specified timeframe or who missed a scheduled appointment and **must** include the

following elements at a minimum: patient identifier, patient contact information, cancer diagnosis(es), date(s) of initial cancer diagnosis (if known), and the target date for the next complete physical exam.

Numerator Options:

Performance Met:	Patient information entered into a recall system that includes: target date for the next exam specified AND a process to follow up with patients regarding missed or unscheduled appointments **(7010F)**
OR	
System Performance Exclusion:	Documentation of system reason(s) for not entering patient's information into a recall system (eg, melanoma being monitored by another physician provider) **(7010F *with* 3P)**
OR	
Performance Not Met:	Recall system **not** utilized, reason not otherwise specified **(7010F *with* 8P)**

RATIONALE:

Lack of follow-up with providers noted in the Institute of Medicine (IOM) report on patient errors. Follow-up for skin examination and surveillance is an important aspect in the management of patients with a current diagnosis or a history of melanoma. The presence of a recall system, whether it is electronic or paper based, enables providers to ensure that patients receive follow-up appointments in accordance with their individual needs.

CLINICAL RECOMMENDATION STATEMENTS:

Skin examination and surveillance at least once a year for life is recommended for all melanoma patients, including those with stage 0, in situ melanoma. Clinicians should educate all patients about post-treatment monthly self-exam of their skin and of their lymph nodes if they had stage 1A to IV melanoma. Specific signs or symptoms are indications for additional radiologic imaging. (NCCN, 2011)

No clear data regarding follow-up interval exists, but at least annual history and physical examination with attention to the skin and lymph nodes is recommended. (AAD, 2011)

Regular clinical follow-up and interval patient self-exam of skin and regional lymph nodes are the most important means of detecting recurrent disease or new primary melanoma; findings from history and physical exam should direct the need for further studies to detect local, regional, and distant metastasis. (AAD, 2011)

★Measure #138: Melanoma: Coordination of Care – National Quality Strategy Domain: Communication and Care Coordination

2015 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Percentage of patient visits, regardless of age, with a new occurrence of melanoma that have a treatment plan documented in the chart that was communicated to the physician(s) providing continuing care within one month of diagnosis

INSTRUCTIONS:
This measure is to be reported at **each visit** occurring during the reporting period for melanoma patients seen during the reporting period. It is anticipated that **clinicians providing care for patients with melanoma** will submit this measure.

Measure Reporting via Registry:
ICD-9-CM/ICD-10-CM diagnosis codes and CPT codes are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data. It is expected that a single performance rate will be calculated for this measure.

There are two reporting criteria for this measure:

1) **All visits for patients, regardless of age, diagnosed with a new occurrence of melanoma during excision of malignant lesion**

OR

2) **All visits for patients, regardless of age, diagnosed with a new occurrence of melanoma evaluated in an outpatient setting**

REPORTING CRITERIA 1: All visits for patients, regardless of age, diagnosed with a new occurrence of melanoma during excision of malignant lesion

DENOMINATOR (REPORTING CRITERIA 1)
All visits for patients, regardless of age, diagnosed with a new occurrence of melanoma

Denominator Criteria (Eligible Cases):
Diagnosis for melanoma (ICD-9-CM) [for use 1/1/2015-9/30/2015]: 172.0, 172.1, 172.2, 172.3, 172.4, 172.5, 172.6, 172.7, 172.8, 172.9
Diagnosis for melanoma (ICD-10-CM) [for use 10/01/2015-12/31/2015]: C43.0, C43.10, C43.11, C43.12, C43.20, C43.21, C43.22, C43.30, C43.31, C43.39, C43.4, C43.51, C43.52, C43.59, C43.60, C43.61, C43.62, C43.70, C43.71, C43.72, C43.8, C43.9, D03.0, D03.10, D03.11, D03.12, D03.20, D03.21, D03.22, D03.30, D03.39, D03.4, D03.51, D03.52, D03.59, D03.60, D03.61, D03.62, D03.70, D03.71, D03.72, D03.8, D03.9
AND
Patient encounter for excision of malignant melanoma (CPT): 11600, 11601, 11602, 11603, 11604, 11606, 11620, 11621, 11622, 11623, 11624, 11626, 11640, 11641, 11642, 11643, 11644, 11646, 14000, 14001, 14020, 14021, 14040, 14041, 14060, 14061, 14301, 17311, 17313

NUMERATOR (REPORTING CRITERIA 1):
Patient visits with a treatment plan documented in the chart that was communicated to the physician(s) providing continuing care within one month of diagnosis

Numerator Instructions: A treatment plan should include the following elements: diagnosis, tumor thickness, and plan for surgery or alternate care.

Definition:
Communication – Communication may include: documentation in the medical record that the physician(s) treating the melanoma communicated (eg, verbally, by letter, copy of treatment plan sent) with the physician(s) providing the continuing care OR a copy of a letter in the medical record outlining whether the patient was or should be treated for melanoma.

Numerator Options:

Performance Met: Treatment plan communicated to provider(s) managing continuing care within 1 month of diagnosis **(5050F)**

OR

Patient Performance Exclusion: Documentation of patient reason(s) for not communicating treatment plan to the Primary Care Physician(s) (PCP)(s) (eg, patient asks that treatment plan not be communicated to the physician(s) providing continuing care) **(5050F *with* 2P)**

OR

System Performance Exclusion: Documentation of system reason(s) for not communicating treatment plan to the PCP(s) (eg, patient does not have a primary care physician or referring physician) **(5050F *with* 3P)**

OR

Performance Not Met: Treatment plan **not** communicated, reason not otherwise specified **(5050F *with* 8P)**

OR

REPORTING CRITERIA 2: All visits for patients, regardless of age, diagnosed with a new occurrence of melanoma evaluated in an outpatient setting

DENOMINATOR: (REPORTING CRITERIA 2)
All visits for patients, regardless of age, diagnosed with a new occurrence of melanoma

Denominator Criteria (Eligible Cases):
Diagnosis for melanoma (ICD-9-CM) [for use 1/1/2015-9/30/2015]: 172.0, 172.1, 172.2, 172.3, 172.4, 172.5, 172.6, 172.7, 172.8, 172.9
Diagnosis for melanoma (ICD-10-CM) [for use 10/01/2015-12/31/2015]: C43.0, C43.10, C43.11, C43.12, C43.20, C43.21, C43.22, C43.30, C43.31, C43.39, C43.4, C43.51, C43.52, C43.59, C43.60, C43.61, C43.62, C43.70, C43.71, C43.72, C43.8, C43.9, D03.0, D03.10, D03.11, D03.12, D03.20, D03.21, D03.22, D03.30, D03.39, D03.4, D03.51, D03.52, D03.59, D03.60, D03.61, D03.62, D03.70, D03.71, D03.72, D03.8, D03.9
AND
Patient encounter during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215

NUMERATOR (REPORTING CRITERIA 2):

Patient visits with a treatment plan documented in the chart that was communicated to the physician(s) providing continuing care within one month of diagnosis

Numerator Instructions: A treatment plan should include the following elements: diagnosis, tumor thickness, and plan for surgery or alternate care.

Definition:
Communication – Communication may include: documentation in the medical record that the physician(s) treating the melanoma communicated (eg, verbally, by letter, copy of treatment plan sent) with the physician(s) providing the continuing care OR a copy of a letter in the medical record outlining whether the patient was or should be treated for melanoma.

Numerator Options:

Performance Met: Treatment plan communicated to provider(s) managing continuing care within 1 month of diagnosis **(5050F)**

OR

Patient Performance Exclusion: Documentation of patient reason(s) for not communicating treatment plan to the Primary Care Physician(s) (PCP)(s) (eg, patient asks that treatment plan not be communicated to the physician(s) providing continuing care) **(5050F *with* 2P)**

OR

System Performance Exclusion: Documentation of system reason(s) for not communicating treatment plan to the PCP(s) (eg, patient does not have a primary care physician or referring physician) **(5050F *with* 3P)**

OR

Performance Not Met: Treatment plan **not** communicated, reason not otherwise specified **(5050F *with* 8P)**

RATIONALE:
Perceived lack of follow-up with primary care providers which is reinforced in the Institute of Medicine (IOM) report on patient errors. The intention of this measure is to enable the primary care provider to support, facilitate, and coordinate the care of the patient.

Deficits in communication have clearly been shown to adversely affect post-discharge care transitions. A recent summary of the literature found that direct communication between hospital physicians and primary care physicians occurs infrequently (in 3%-20% of cases studied), the availability of a discharge summary at the first post-discharge visit is low (12%-34%) and did not improve greatly even after 4 weeks (51%-77%), affecting the quality of care in approximately 25% of follow-up visits. This systematic review of the literature also found that discharge summaries often lack important information such as diagnostic test results, treatment or hospital course, discharge medications, test results pending at discharge, patient or family counseling, and follow-up plans.

CLINICAL RECOMMENDATION STATEMENTS:
Each local skin cancer multi-disciplinary team (LSMDT) and specialist skin cancer multi-disciplinary team (SSMDT) should have at least one skin cancer clinical nurse specialist (CNS) who will play a leading role in supporting patients and caregivers. There should be equity of access to information and support regardless of where the care is delivered. A checklist may be used by healthcare professionals to remind them to give patients and caregivers the information they need in an appropriate format for pre-diagnosis, diagnosis, treatment, follow-up, and palliative care. This may also include a copy of the letter confirming the diagnosis and treatment plan sent by the consultant to the general practitioner (GP).

- Provide a rapid referral service for patients who require specialist management through the LSMDT/SSMDT.
- Be responsible for the provision of information, advice, and support for patients managed in primary care and their care givers.
- Maintain a register of all patients treated, whose care should be part of a regular audit presented to the LSMDT/SSMDT.
- Liaise and communicate with all members of the skin cancer site-specific network group.
- Ensure that referring GPs are given prompt and full information about their patients' diagnosis or treatment in line with national standards on communication to GPs of cancer diagnoses.
- Collect data for network-wide audit. (NICE, 2006)

Communication and information exchange between the medical home and the receiving provider should occur in an amount of time that will allow the receiving provider to effectively treat the patient. This communication and information exchange should ideally occur whenever patients are at a transition of care; eg, at discharge from the inpatient setting. The timeliness of this communication should be consistent with the patient´s clinical presentation and, in the case of a patient being discharged, the urgency of the follow-up required. Communication and information exchange between the MD and other physicians may be in the form of a call, voicemail, fax or other secure, private, and accessible means including mutual access to an EHR.

The TOCCC proposed a minimal set of data elements that should always be part of the transition record and be part of any initial implementation of this standard. That list includes the following:

- Principle diagnosis and problem list
- Medication list (reconciliation) including over the counter/ herbals, allergies and drug interactions
- Clearly identifies the medical home/transferring coordinating physician/institution and their contact information
- Patient's cognitive status
- Test results/pending results

The TOCCC recommended the following additional elements that should be included in an "ideal transition record" in addition to the above:

- Emergency plan and contact number and person
- Treatment and diagnostic plan
- Prognosis and goals of care
- Advance directives, power of attorney, consent
- Planned interventions, durable medical equipment, wound care, etc.
- Assessment of caregiver status
- Patients and/or their family/caregivers must receive, understand and be encouraged to participate in the development of their transition record which should take into consideration the patient's health literacy, insurance status and be culturally sensitive. (ACP, SGIMSHM, AGS, ACEP, SAEM, 2009) (Consensus Policy Statement)

Measure #140 (NQF 0566): Age-Related Macular Degeneration (AMD): Counseling on Antioxidant Supplement – National Quality Strategy Domain: Effective Clinical Care

2015 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of patients aged 50 years and older with a diagnosis of age-related macular degeneration (AMD) or their caregiver(s) who were counseled within 12 months on the benefits and/or risks of the Age-Related Eye Disease Study (AREDS) formulation for preventing progression of AMD

INSTRUCTIONS:
This measure is to be reported a minimum of **once per reporting period** for AMD patients seen during the reporting period. It is anticipated that **clinicians who provide the primary management of patients with AMD** will submit this measure.

Measure Reporting via Claims:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. CPT Category II codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the appropriate ICD-9-CM/ICD-10-CM diagnosis code, CPT codes, and the appropriate CPT Category II code **OR** the CPT Category II code **with** the modifier. The reporting modifier allowed for this measure is: 8P- reason not otherwise specified. There are no allowable performance exclusions for this measure. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

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

DENOMINATOR:
All patients aged 50 years and older with a diagnosis of AMD

Denominator Criteria (Eligible Cases):
Patients aged ≥ 50 years on date of encounter
AND
Diagnosis for AMD (ICD-9-CM) [for use 1/1/2015-9/30/2015]: 362.50, 362.51, 362.52
Diagnosis for AMD (ICD-10-CM) [for use 10/01/2015-12/31/2015]: H35.30, H35.31, H35.32
AND
Patient encounter during the reporting period (CPT): 92002, 92004, 92012, 92014, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337

NUMERATOR:
Patients with AMD or their caregiver(s) who were counseled within 12 months on the benefits and/or risks of the AREDS formulation for preventing progression of AMD

Definition:

Counseling – Documentation in the medical record should include a discussion of risk or benefits of the AREDS formulation. Counseling can be discussed with all patients with AMD, even those who do not meet the criteria for the AREDS formulation, or other reasons why the patient would not meet criteria for AREDS formulation as outlined in the AREDS. The ophthalmologist or optometrist can explain why these supplements are not appropriate for their particular situation. Also, given the purported risks associated with antioxidant use, patients would be informed of the risks and benefits and make their choice based on valuation of vision loss vs. other risks. As such, the measure seeks to educate patients about overuse as well as appropriate use.

NUMERATOR NOTE: *If patient is already receiving AREDS formulation, the assumption is that counseling about AREDS has already been performed.*

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

AREDS Counseling Performed

Performance Met: **CPT II 4177F:** Counseling about the benefits and/or risks of the Age-Related Eye Disease Study (AREDS) formulation for preventing progression of age-related macular degeneration (AMD) provided to patient and/or caregiver(s)

OR

AREDS Counseling not Performed, Reason not Otherwise Specified

Append a reporting modifier (**8P**) to CPT Category II code **4177F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

Performance Not Met: **4177F *with* 8P:** AREDS counseling **not** performed, reason not otherwise specified

RATIONALE:

1) Scientific basis for counseling regarding use of AREDS formulation for patients with AMD
   Antioxidant vitamins and mineral supplements help to reduce the rate of progression to advanced AMD for those patients with intermediate or advanced AMD in one eye. From the same AREDS study, there is no evidence that the use of antioxidant vitamin and mineral supplements for patients with mild AMD alters the natural history of mild AMD.
   At the same time, published meta-analyses have raised an issue as to the presence of an elevated mortality risk among patients taking elements similar to parts of the AREDS formulation (and elevated risk among smokers). As such, patients need to know of their individualized risk profile for taking the AREDS formula AND the potential benefits, so that they can make their OWN individual decision as to whether or not to take the AREDS formulation.
   This indicator thus seeks to directly enhance the provider-patient relationship to apply the results of level 1 randomized controlled trials (RCTs) in a manner that accommodates the needs of each individual patient in a patient-centered manner, rather than a paternalistic approach of either recommending or withholding treatment.
2) Evidence of gap in care.
   Antioxidant vitamins and mineral supplements help to reduce the rate of progression to advanced AMD for those patients with intermediate or advanced AMD in one eye. From the same AREDS study, there is no evidence that the use of antioxidant vitamin and mineral supplements for patients with mild AMD alters the natural history of mild AMD.

CLINICAL RECOMMENDATION STATEMENTS:

Patients with intermediate AMD or advanced AMD in one eye should be counseled on the use of antioxidant vitamin and mineral supplements as recommended in the Age-related Eye Disease Study (AREDS) reports. (A:I) (AAO, 2014)

Antioxidant Vitamin and Mineral Supplements Used in the Age-Related Eye Disease Study 2

Supplement	Daily Dose*
Vitamin C	500 mg
Vitamin E	400 IU
Lutein/zeaxanthin	10 mg/2 mg
Zinc oxide	80 mg or 25 mg
Cupric oxide	2 mg

Data from Age-Related Eye Disease Study 2 (AREDS2) Research Group. Lutein/zeaxanthin for the treatment of age-related cataract: AREDS2 randomized trial report number 4. JAMA Ophthalmol 2013;131:843-50.

* These doses are not those listed on the commercially available vitamin/mineral supplements because of a change in labeling rules by the U.S. Food and Drug Administration that specifies that the doses must reflect the amounts available at the end of the shelf life.

Measure #141 (NQF 0563): Primary Open-Angle Glaucoma (POAG): Reduction of Intraocular Pressure (IOP) by 15% OR Documentation of a Plan of Care – National Quality Strategy Domain: Communication and Care Coordination

2015 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Percentage of patients aged 18 years and older with a diagnosis of primary open-angle glaucoma (POAG) whose glaucoma treatment has not failed (the most recent IOP was reduced by at least 15% from the pre-intervention level) OR if the most recent IOP was not reduced by at least 15% from the pre-intervention level, a plan of care was documented within 12 months

INSTRUCTIONS:
This measure is to be reported a minimum of **once per reporting period** for glaucoma patients seen during the reporting period. It is anticipated that **clinicians who provide the primary management of patients with POAG** will submit this measure.

Measure Reporting via Registry:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

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

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

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Diagnosis for primary open-angle glaucoma (ICD-9-CM) [for use 1/1/2015-9/30/2015]: 365.10, 365.11, 365.12, 365.15
Diagnosis for primary open-angle glaucoma (ICD-10-CM) [for use 10/01/2015-12/31/2015]: 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, H40.151, H40.152, H40.153, H40.159
AND
Patient encounter during the reporting period (CPT): 92002, 92004, 92012, 92014, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337

NUMERATOR:
Patients whose glaucoma treatment has not failed (the most recent IOP was reduced by at least 15% from the pre-intervention level) OR if the most recent IOP was not reduced by at least 15% from the pre-intervention level, a plan of care was documented within 12 months

Definitions:

Plan of Care – May include: recheck of IOP at specified time, change in therapy, perform additional diagnostic evaluations, monitoring per patient decisions or health system reasons, and/or referral to a specialist.
Plan to Recheck – In the event certain factors do not allow for the IOP to be measured (eg, patient has an eye infection) but the physician has a plan to measure the IOP at the next visit; the plan of care code should be reported.
Glaucoma Treatment Not Failed – The most recent IOP was reduced by at least 15% in the affected eye or if both eyes were affected, the reduction of at least 15% occurred in both eyes.

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

Numerator Options:

Performance Met: Intraocular pressure (IOP) reduced by a value of greater than or equal to 15% from the pre-intervention level (**3284F)**

OR

Performance Met:

Glaucoma plan of care documented (**0517F)**

AND

Intraocular pressure (IOP) reduced by a value less than 15% from the pre-intervention level (**3285F)**

OR

Performance Not Met:

Glaucoma plan of care **not** documented, reason not otherwise specified (**0517F *with* 8P)**

AND

Intraocular pressure (IOP) reduced by a value less than 15% from the pre-intervention level (**3285F)**

OR

Performance Not Met: IOP measurement **not** documented, reason not otherwise specified (**3284F *with* 8P)**

RATIONALE:

1) Scientific basis for intraocular pressure (IOP) control as outcomes measure (intermediate)
Analyses of results of several randomized clinical trials all demonstrate that reduction of IOP of at least 18% (EMGT, CIGTS, AGIS, CNTGS) reduces the rate of worsening of visual fields by at least 40%. The various studies, however, achieved different levels of mean IOP lowering in realizing their benefit in patient outcomes, ranging from 18% in the "normal pressure" subpopulation of EMGT to 42% in the CIGTS study. (Level I studies) As such, an appropriate "failure" indicator is to NOT achieve at least a 15% IOP reduction. The rationales for a failure indicator are that 1) the results of different studies can lead experienced clinicians to believe that different levels of IOP reduction are appropriate; 2) to minimize the impact of adverse selection for those patients whose IOPs are more difficult to control; and 3) because each patient's clinical course may require IOP reduction that may vary from 18 to 40+%.
In addition, "…several population based studies have demonstrated that the prevalence of POAG as well as the incidence of POAG, increases as the level of IOP increases. These studies provide strong evidence that IOP plays an important role in the neuropathy of POAG. Furthermore, studies have demonstrated that

reduction in the level of IOP lessens the risk of visual field progression in open-angle glaucoma. In addition, treated eyes that have a greater IOP fluctuation are at increased risk of progression.
Intraocular pressure is the intermediate outcome of therapy used by the FDA for approval of new drugs and devices and, as noted above, has been shown to be directly related to ultimate patient outcomes of vision loss. As such, failure to achieve minimal pressure lowering, absent an appropriate plan of care to address the situation, would constitute performance whose improvement would directly benefit patients with POAG.

2) Evidence for gap in care
Based on studies in the literature reviewing documentation of IOP achieved under care, the gap could be as great as 50% or more in the community of ophthalmologists and optometrists treating patients with primary open-angle glaucoma. Based on loose criteria for control, IOP was controlled in 66% of follow-up visits for patients with mild glaucoma and 52% of visits for patients with moderate to severe glaucoma. Another study of a single comprehensive insurance plan suggested that a large proportion of individuals felt to require treatment for glaucoma or suspect glaucoma are falling out of care and are being monitored at rates lower than expected from recommendations of published guidelines.

CLINICAL RECOMMENDATION STATEMENTS:

When initiating therapy, the ophthalmologist assumes that the measured pretreatment pressure range contributed to optic nerve damage and is likely to cause additional damage in the future. Lowering the pretreatment IOP by 25% or more has been shown to inhibit progression of POAG. (A:II) (AAO, 2010)

Choosing an even lower target IOP can be justified if there is more severe optic nerve damage, if the damage is progressing rapidly, or if other risk factors such as family history, age, or disc hemorrhages are present.

Please note that the American Optometric Association's (AOA) 2002 guideline on Open-angle Glaucoma was not reviewed during the development of this measure prior to the public comment period and therefore is not presented here verbatim. Review of the AOA guideline subsequent to initial measure development indicates that the recommendations in the AOA guideline are consistent with the intent of the measure. This also applies to the 2010 guidelines. As such, the intent of this measure is to have this indicator apply to both optometrists and ophthalmologists (and any other physician who provides glaucoma care); the use of "ophthalmologists" only in the preceding verbatim section reflects the wording in the American Academy of Ophthalmology Preferred Practice pattern.

▲Measure #143 (NQF0384): Oncology: Medical and Radiation – Pain Intensity Quantified – National Quality Strategy Domain: Person and Caregiver-Centered Experience and Outcomes

2015 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Percentage of patient visits, regardless of patient age, with a diagnosis of cancer currently receiving chemotherapy or radiation therapy in which pain intensity is quantified

INSTRUCTIONS:
This measure is to be reported at **each visit** occurring during the measurement period for patients with a diagnosis of cancer who are seen during the measurement period. It is anticipated that **clinicians providing care for patients with cancer** will submit this measure.

For patients receiving radiation therapy, pain intensity should be quantified at each radiation treatment management encounter. For patients receiving chemotherapy, pain intensity should be quantified at each face-to-face encounter with the physician while the patient is receiving treatment. For purposes of calculating this measure, eligible encounters for patients receiving chemotherapy will include those encounters where the patient has been administered chemotherapy within 30 days prior to the encounter and also been administered chemotherapy within 30 days after the date of the encounter. For example, at every visit for patients with a diagnosis of cancer who are also receiving chemotherapy or radiation therapy, the patient should have pain intensity quantified.

Measure Reporting via Registry:
ICD-9-CM/ICD-10-CM diagnosis codes and CPT codes are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

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

DENOMINATOR:
All patient visits, regardless of patient age, with a diagnosis of cancer currently receiving chemotherapy or radiation therapy

Denominator Criteria (Eligible Cases):
Diagnosis for cancer (ICD-9-CM) [for use 1/1/2015-9/30/2015]: 140.0, 140.1, 140.3, 140.4, 140.5, 140.6, 140.8, 140.9, 141.0, 141.1, 141.2, 141.3, 141.4, 141.5, 141.6, 141.8, 141.9, 142.0, 142.1, 142.2, 142.8, 142.9, 143.0, 143.1, 143.8, 143.9, 144.0, 144.1, 144.8, 144.9, 145.0, 145.1, 145.2, 145.3, 145.4, 145.5, 145.6, 145.8, 145.9, 146.0, 146.1, 146.2, 146.3, 146.4, 146.5, 146.6, 146.7, 146.8, 146.9, 147.0, 147.1, 147.2, 147.3, 147.8, 147.9, 148.0, 148.1, 148.2, 148.3, 148.8, 148.9, 149.0, 149.1, 149.8, 149.9, 150.0, 150.1, 150.2, 150.3, 150.4, 150.5, 150.8, 150.9, 151.0, 151.1, 151.2, 151.3, 151.4, 151.5, 151.6, 151.8, 151.9, 152.0, 152.1, 152.2, 152.3, 152.8, 152.9, 153.0, 153.1, 153.2, 153.3, 153.4, 153.5, 153.6, 153.7, 153.8, 153.9, 154.0, 154.1, 154.2, 154.3, 154.8, 155.0, 155.1, 155.2, 156.0, 156.1, 156.2, 156.8, 156.9, 157.0, 157.1, 157.2, 157.3, 157.4, 157.8, 157.9, 158.0, 158.8, 158.9, 159.0, 159.1, 159.8, 159.9, 160.0, 160.1, 160.2, 160.3, 160.4, 160.5, 160.8, 160.9, 161.0, 161.1, 161.2, 161.3, 161.8, 161.9, 162.0, 162.2, 162.3, 162.4, 162.5, 162.8, 162.9, 163.0, 163.1, 163.8, 163.9, 164.0, 164.1, 164.2, 164.3, 164.8, 164.9, 165.0, 165.8, 165.9, 170.0, 170.1, 170.2, 170.3, 170.4, 170.5, 170.6, 170.7, 170.8, 170.9, 171.0, 171.2, 171.3, 171.4, 171.5, 171.6, 171.7, 171.8, 171.9, 172.0, 172.1, 172.2, 172.3, 172.4, 172.5, 172.6, 172.7, 172.8, 172.9, 173.00, 173.01, 173.02, 173.09, 173.10, 173.11, 173.12, 173.19, 173.20, 173.21, 173.22, 173.29, 173.30, 173.31, 173.32, 173.39, 173.40, 173.41, 173.42, 173.49, 173.50, 173.51, 173.52, 173.59, 173.60, 173.61, 173.62, 173.69, 173.70, 173.71, 173.72, 173.79, 173.80, 173.81, 173.82, 173.89, 173.90,

173.91, 173.92, 173.99, 174.0, 174.1, 174.2, 174.3, 174.4, 174.5, 174.6, 174.8, 174.9, 175.0, 175.9, 176.0, 176.1, 176.2, 176.3, 176.4, 176.5, 176.8, 176.9, 179, 180.0, 180.1, 180.8, 180.9, 181, 182.0, 182.1, 182.8, 183.0, 183.2, 183.3, 183.4, 183.5, 183.8, 183.9, 184.0, 184.1, 184.2, 184.3, 184.4, 184.8, 184.9, 185, 186.0, 186.9, 187.1, 187.2, 187.3, 187.4, 187.5, 187.6, 187.7, 187.8, 187.9, 188.0, 188.1, 188.2, 188.3, 188.4, 188.5, 188.6, 188.7, 188.8, 188.9, 189.0, 189.1, 189.2, 189.3, 189.4, 189.8, 189.9, 190.0, 190.1, 190.2, 190.3, 190.4, 190.5, 190.6, 190.7, 190.8, 190.9, 191.0, 191.1, 191.2, 191.3, 191.4, 191.5, 191.6, 191.7, 191.8, 191.9, 192.0, 192.1, 192.2, 192.3, 192.8, 192.9, 193, 194.0, 194.1, 194.3, 194.4, 194.5, 194.6, 194.8, 194.9, 195.0, 195.1, 195.2, 195.3, 195.4, 195.5, 195.8, 196.0, 196.1, 196.2, 196.3, 196.5, 196.6, 196.8, 196.9, 197.0, 197.1, 197.2, 197.3, 197.4, 197.5, 197.6, 197.7, 197.8, 198.0, 198.1, 198.2, 198.3, 198.4, 198.5, 198.6, 198.7, 198.81, 198.82, 198.89, 199.0, 199.1, 199.2, 200.00, 200.01, 200.02, 200.03, 200.04, 200.05, 200.06, 200.07, 200.08, 200.10, 200.11, 200.12, 200.13, 200.14, 200.15, 200.16, 200.17, 200.18, 200.20, 200.21, 200.22, 200.23, 200.24, 200.25, 200.26, 200.27, 200.28, 200.30, 200.31, 200.32, 200.33, 200.34, 200.35, 200.36, 200.37, 200.38, 200.40, 200.41, 200.42, 200.43, 200.44, 200.45, 200.46, 200.47, 200.48, 200.50, 200.51, 200.52, 200.53, 200.54, 200.55, 200.56, 200.57, 200.58, 200.60, 200.61, 200.62, 200.63, 200.64, 200.65, 200.66, 200.67, 200.68, 200.70, 200.71, 200.72, 200.73, 200.74, 200.75, 200.76, 200.77, 200.78, 200.80, 200.81, 200.82, 200.83, 200.84, 200.85, 200.86, 200.87, 200.88, 201.00, 201.01, 201.02, 201.03, 201.04, 201.05, 201.06, 201.07, 201.08, 201.10, 201.11, 201.12, 201.13, 201.14, 201.15, 201.16, 201.17, 201.18, 201.20, 201.21, 201.22, 201.23, 201.24, 201.25, 201.26, 201.27, 201.28, 201.40, 201.41, 201.42, 201.43, 201.44, 201.45, 201.46, 201.47, 201.48, 201.50, 201.51, 201.52, 201.53, 201.54, 201.55, 201.56, 201.57, 201.58, 201.60, 201.61, 201.62, 201.63, 201.64, 201.65, 201.66, 201.67, 201.68, 201.70, 201.71, 201.72, 201.73, 201.74, 201.75, 201.76, 201.77, 201.78, 201.90, 201.91, 201.92, 201.93, 201.94, 201.95, 201.96, 201.97, 201.98, 202.00, 202.01, 202.02, 202.03, 202.04, 202.05, 202.06, 202.07, 202.08, 202.10, 202.11, 202.12, 202.13, 202.14, 202.15, 202.16, 202.17, 202.18, 202.20, 202.21, 202.22, 202.23, 202.24, 202.25, 202.26, 202.27, 202.28, 202.30, 202.31, 202.32, 202.33, 202.34, 202.35, 202.36, 202.37, 202.38, 202.40, 202.41, 202.42, 202.43, 202.44, 202.45, 202.46, 202.47, 202.48, 202.50, 202.51, 202.52, 202.53, 202.54, 202.55, 202.56, 202.57, 202.58, 202.60, 202.61, 202.62, 202.63, 202.64, 202.65, 202.66, 202.67, 202.68, 202.70, 202.71, 202.72, 202.73, 202.74, 202.75, 202.76, 202.77, 202.78, 202.80, 202.81, 202.82, 202.83, 202.84, 202.85, 202.86, 202.87, 202.88, 202.90, 202.91, 202.92, 202.93, 202.94, 202.95, 202.96, 202.97, 202.98, 203.00, 203.01, 203.02, 203.10, 203.11, 203.12, 203.80, 203.81, 203.82, 204.00, 204.01, 204.02, 204.10, 204.11, 204.12, 204.20, 204.21, 204.22, 204.80, 204.81, 204.82, 204.90, 204.91, 204.92, 205.00, 205.01, 205.02, 205.10, 205.11, 205.12, 205.20, 205.21, 205.22, 205.30, 205.31, 205.32, 205.80, 205.81, 205.82, 205.90, 205.91, 205.92, 206.00, 206.01, 206.02, 206.10, 206.11, 206.12, 206.20, 206.21, 206.22, 206.80, 206.81, 206.82, 206.90, 206.91, 206.92, 207.00, 207.01, 207.02, 207.10, 207.11, 207.12, 207.20, 207.21, 207.22, 207.80, 207.81, 207.82, 208.00, 208.01, 208.02, 208.10, 208.11, 208.12, 208.20, 208.21, 208.22, 208.80, 208.81, 208.82, 208.90, 208.91, 208.92, 209.00, 209.01, 209.02, 209.03, 209.10, 209.11, 209.12, 209.13, 209.14, 209.15, 209.16, 209.17, 209.20, 209.21, 209.22, 209.23, 209.24, 209.25, 209.26, 209.27, 209.29, 209.30, 209.31, 209.32, 209.33, 209.34, 209.35, 209.36, 209.70, 209.71, 209.72, 209.73, 209.74, 209.75, 209.79, 235.0, 235.1, 235.2, 235.3, 235.4, 235.5, 235.6, 235.7, 235.8, 235.9, 236.0, 236.1, 236.2, 236.3, 236.4, 236.5, 236.6, 236.7, 236.90, 236.91, 236.99, 237.0, 237.1, 237.2, 237.3, 237.4, 237.5, 237.6, 237.70, 237.71, 237.72, 237.73, 237.79, 237.9, 238.0, 238.1, 238.2, 238.3, 238.4, 238.5, 238.6, 238.71, 238.72, 238.73, 238.74, 238.75, 238.76, 238.77, 238.79, 238.8, 238.9, 239.0, 239.1, 239.2, 239.3, 239.4, 239.5, 239.6, 239.7, 239.81, 239.89, 239.9

Diagnosis for cancer (ICD-10-CM) [for use 10/01/2015-12/31/2015]: C00.0, C00.1, C00.2, C00.3, C00.4, C00.5, C00.6, C00.8, C00.9, C01, C02.0, C02.1, C02.2, C02.3, C02.4, C02.8, C02.9, C03.0, C03.1, C03.9, C04.0, C04.1, C04.8, C04.9, C05.0, C05.1, C05.2, C05.8, C05.9, C06.0, C06.1, C06.2, C06.80, C06.89, C06.9, C07, C08.0, C08.1, C08.9, C09.0, C09.1, C09.8, C09.9, C10.0, C10.1, C10.2, C10.3, C10.4, C10.8, C10.9, C11.0, C11.1, C11.2, C11.3, C11.8, C11.9, C12, C13.0, C13.1, C13.2, C13.8, C13.9, C14.0, C14.2, C14.8, C15.3, C15.4, C15.5, C15.8, C15.9, C16.0, C16.1, C16.2, C16.3, C16.4, C16.5, C16.6, C16.8, C16.9, C17.0, C17.1, C17.2, C17.3, C17.8, C17.9, C18.0, C18.1, C18.2, C18.3, C18.4, C18.5, C18.6, C18.7, C18.8, C18.9, C19, C20, C21.0, C21.1, C21.2, C21.8, C22.0, C22.1, C22.2, C22.3, C22.4, C22.7, C22.8, C22.9, C23, C24.0, C24.1, C24.8, C24.9, C25.0, C25.1, C25.2, C25.3, C25.4, C25.7, C25.8, C25.9,

C26.0, C26.1, C26.9, C30.0, C30.1, C31.0, C31.1, C31.2, C31.3, C31.8, C31.9, C32.0, C32.1, C32.2, C32.3, C32.8, C32.9, C33, C34.00, C34.01, C34.02, C34.10, C34.11, C34.12, C34.2, C34.30, C34.31, C34.32, C34.80, C34.81, C34.82, C34.90, C34.91, C34.92, C37, C38.0, C38.1, C38.2, C38.3, C38.4, C38.8, C39.0, C39.9, C40.00, C40.01, C40.02, C40.10, C40.11, C40.12, C40.20, C40.21, C40.22, C40.30, C40.31, C40.32, C40.80, C40.81, C40.82, C40.90, C40.91, C40.92, C41.0, C41.1, C41.2, C41.3, C41.4, C41.9, C43.0, C43.10, C43.11, C43.12, C43.20, C43.21, C43.22, C43.30, C43.31, C43.39, C43.4, C43.51, C43.52, C43.59, C43.60, C43.61, C43.62, C43.70, C43.71, C43.72, C43.8, C43.9, C44.00, C44.01, C44.02, C44.09, C44.101, C44.102, C44.109, C44.111, C44.112, C44.119, C44.121, C44.122, C44.129, C44.191, C44.192, C44.199, C44.201, C44.202, C44.209, C44.211, C44.212, C44.219, C44.221, C44.222, C44.229, C44.291, C44.292, C44.299, C44.300, C44.301, C44.309, C44.310, C44.311, C44.319, C44.320, C44.321, C44.329, C44.390, C44.391, C44.399, C44.40, C44.41, C44.42, C44.49, C44.500, C44.501, C44.509, C44.510, C44.511, C44.519, C44.520, C44.521, C44.529, C44.590, C44.591, C44.599, C44.601, C44.602, C44.609, C44.611, C44.612, C44.619, C44.621, C44.622, C44.629, C44.691, C44.692, C44.699, C44.701, C44.702, C44.709, C44.711, C44.712, C44.719, C44.721, C44.722, C44.729, C44.791, C44.792, C44.799, C44.80, C44.81, C44.82, C44.89, C44.90, C44.91, C44.92, C44.99, C45.0, C45.1, C45.2, C45.7, C45.9, C46.0, C46.1, C46.2, C46.3, C46.4, C46.50, C46.51, C46.52, C46.7, C46.9, C47.0, C47.10, C47.11, C47.12, C47.20, C47.21, C47.22, C47.3, C47.4, C47.5, C47.6, C47.8, C47.9, C48.0, C48.1, C48.2, C48.8, C49.0, C49.10, C49.11, C49.12, C49.20, C49.21, C49.22, C49.3, C49.4, C49.5, C49.6, C49.8, C49.9, C4A.0, C4A.10, C4A.11, C4A.12, C4A.20, C4A.21, C4A.22, C4A.30, C4A.31, C4A.39, C4A.4, C4A.51, C4A.52, C4A.59, C4A.60, C4A.61, C4A.62, C4A.70, C4A.71, C4A.72, C4A.8, C4A.9, C50.011, C50.012, C50.019, C50.021, C50.022, C50.029, C50.111, C50.112, C50.119, C50.121, C50.122, C50.129, C50.211, C50.212, C50.219, C50.221, C50.222, C50.229, C50.311, C50.312, C50.319, C50.321, C50.322, C50.329, C50.411, C50.412, C50.419, C50.421, C50.422, C50.429, C50.511, C50.512, C50.519, C50.521, C50.522, C50.529, C50.611, C50.612, C50.619, C50.621, C50.622, C50.629, C50.811, C50.812, C50.819, C50.821, C50.822, C50.829, C50.911, C50.912, C50.919, C50.921, C50.922, C50.929, C51.0, C51.1, C51.2, C51.8, C51.9, C52, C53.0, C53.1, C53.8, C53.9, C54.0, C54.1, C54.2, C54.3, C54.8, C54.9, C55, C56.1, C56.2, C56.9, C57.00, C57.01, C57.02, C57.10, C57.11, C57.12, C57.20, C57.21, C57.22, C57.3, C57.4, C57.7, C57.8, C57.9, C58, C60.0, C60.1, C60.2, C60.8, C60.9, C61, C62.00, C62.01, C62.02, C62.10, C62.11, C62.12, C62.90, C62.91, C62.92, C63.00, C63.01, C63.02, C63.10, C63.11, C63.12, C63.2, C63.7, C63.8, C63.9, C64.1, C64.2, C64.9, C65.1, C65.2, C65.9, C66.1, C66.2, C66.9, C67.0, C67.1, C67.2, C67.3, C67.4, C67.5, C67.6, C67.7, C67.8, C67.9, C68.0, C68.1, C68.8, C68.9, C69.00, C69.01, C69.02, C69.10, C69.11, C69.12, C69.20, C69.21, C69.22, C69.30, C69.31, C69.32, C69.40, C69.41, C69.42, C69.50, C69.51, C69.52, C69.60, C69.61, C69.62, C69.80, C69.81, C69.82, C69.90, C69.91, C69.92, C70.0, C70.1, C70.9, C71.0, C71.1, C71.2, C71.3, C71.4, C71.5, C71.6, C71.7, C71.8, C71.9, C72.0, C72.1, C72.20, C72.21, C72.22, C72.30, C72.31, C72.32, C72.40, C72.41, C72.42, C72.50, C72.59, C72.9, C73, C74.00, C74.01, C74.02, C74.10, C74.11, C74.12, C74.90, C74.91, C74.92, C75.0, C75.1, C75.2, C75.3, C75.4, C75.5, C75.8, C75.9, C76.0, C76.1, C76.2, C76.3, C76.40, C76.41, C76.42, C76.50, C76.51, C76.52, C76.8, C77.0, C77.1, C77.2, C77.3, C77.4, C77.5, C77.8, C77.9, C78.00, C78.01, C78.02, C78.1, C78.2, C78.30, C78.39, C78.4, C78.5, C78.6, C78.7, C78.80, C78.89, C79.00, C79.01, C79.02, C79.10, C79.11, C79.19, C79.2, C79.31, C79.32, C79.40, C79.49, C79.51, C79.52, C79.60, C79.61, C79.62, C79.70, C79.71, C79.72, C79.81, C79.82, C79.89, C79.9, C7A.00, C7A.010, C7A.011, C7A.012, C7A.019, C7A.020, C7A.021, C7A.022, C7A.023, C7A.024, C7A.025, C7A.026, C7A.029, C7A.090, C7A.091, C7A.092, C7A.093, C7A.094, C7A.095, C7A.096, C7A.098, C7A.1, C7A.8, C7B.00, C7B.01, C7B.02, C7B.03, C7B.04, C7B.09, C7B.1, C7B.8, C80.0, C80.1, C80.2, C81.00, C81.01, C81.02, C81.03, C81.04, C81.05, C81.06, C81.07, C81.08, C81.09, C81.10, C81.11, C81.12, C81.13, C81.14, C81.15, C81.16, C81.17, C81.18, C81.19, C81.20, C81.21, C81.22, C81.23, C81.24, C81.25, C81.26, C81.27, C81.28, C81.29, C81.30, C81.31, C81.32, C81.33, C81.34, C81.35, C81.36, C81.37, C81.38, C81.39, C81.40, C81.41, C81.42, C81.43, C81.44, C81.45, C81.46, C81.47, C81.48, C81.49, C81.70, C81.71, C81.72, C81.73, C81.74, C81.75, C81.76, C81.77, C81.78, C81.79, C81.90, C81.91, C81.92, C81.93, C81.94, C81.95, C81.96, C81.97, C81.98, C81.99, C82.00, C82.01, C82.02, C82.03, C82.04, C82.05, C82.06, C82.07, C82.08, C82.09, C82.10, C82.11, C82.12, C82.13, C82.14, C82.15, C82.16, C82.17, C82.18,

C82.19, C82.20, C82.21, C82.22, C82.23, C82.24, C82.25, C82.26, C82.27, C82.28, C82.29, C82.30, C82.31, C82.32, C82.33, C82.34, C82.35, C82.36, C82.37, C82.38, C82.39, C82.40, C82.41, C82.42, C82.43, C82.44, C82.45, C82.46, C82.47, C82.48, C82.49, C82.50, C82.51, C82.52, C82.53, C82.54, C82.55, C82.56, C82.57, C82.58, C82.59, C82.60, C82.61, C82.62, C82.63, C82.64, C82.65, C82.66, C82.67, C82.68, C82.69, C82.80, C82.81, C82.82, C82.83, C82.84, C82.85, C82.86, C82.87, C82.88, C82.89, C82.90, C82.91, C82.92, C82.93, C82.94, C82.95, C82.96, C82.97, C82.98, C82.99, C83.00, C83.01, C83.02, C83.03, C83.04, C83.05, C83.06, C83.07, C83.08, C83.09, C83.10, C83.11, C83.12, C83.13, C83.14, C83.15, C83.16, C83.17, C83.18, C83.19, C83.30, C83.31, C83.32, C83.33, C83.34, C83.35, C83.36, C83.37, C83.38, C83.39, C83.50, C83.51, C83.52, C83.53, C83.54, C83.55, C83.56, C83.57, C83.58, C83.59, C83.70, C83.71, C83.72, C83.73, C83.74, C83.75, C83.76, C83.77, C83.78, C83.79, C83.80, C83.81, C83.82, C83.83, C83.84, C83.85, C83.86, C83.87, C83.88, C83.89, C83.90, C83.91, C83.92, C83.93, C83.94, C83.95, C83.96, C83.97, C83.98, C83.99, C84.00, C84.01, C84.02, C84.03, C84.04, C84.05, C84.06, C84.07, C84.08, C84.09, C84.10, C84.11, C84.12, C84.13, C84.14, C84.15, C84.16, C84.17, C84.18, C84.19, C84.40, C84.41, C84.42, C84.43, C84.44, C84.45, C84.46, C84.47, C84.48, C84.49, C84.60, C84.61, C84.62, C84.63, C84.64, C84.65, C84.66, C84.67, C84.68, C84.69, C84.70, C84.71, C84.72, C84.73, C84.74, C84.75, C84.76, C84.77, C84.78, C84.79, C84.90, C84.91, C84.92, C84.93, C84.94, C84.95, C84.96, C84.97, C84.98, C84.99, C84.A0, C84.A1, C84.A2, C84.A3, C84.A4, C84.A5, C84.A6, C84.A7, C84.A8, C84.A9, C84.Z0, C84.Z1, C84.Z2, C84.Z3, C84.Z4, C84.Z5, C84.Z6, C84.Z7, C84.Z8, C84.Z9, C85.10, C85.11, C85.12, C85.13, C85.14, C85.15, C85.16, C85.17, C85.18, C85.19, C85.20, C85.21, C85.22, C85.23, C85.24, C85.25, C85.26, C85.27, C85.28, C85.29, C85.80, C85.81, C85.82, C85.83, C85.84, C85.85, C85.86, C85.87, C85.88, C85.89, C85.90, C85.91, C85.92, C85.93, C85.94, C85.95, C85.96, C85.97, C85.98, C85.99, C86.0, C86.1, C86.2, C86.3, C86.4, C86.5, C86.6, C88.0, C88.2, C88.3, C88.4, C88.8, C88.9, C90.00, C90.01, C90.02, C90.10, C90.11, C90.12, C90.20, C90.21, C90.22, C90.30, C90.31, C90.32, C91.00, C91.01, C91.02, C91.10, C91.11, C91.12, C91.30, C91.31, C91.32, C91.40, C91.41, C91.42, C91.50, C91.51, C91.52, C91.60, C91.61, C91.62, C91.90, C91.91, C91.92, C91.A0, C91.A1, C91.A2, C91.Z0, C91.Z1, C91.Z2, C92.00, C92.01, C92.02, C92.10, C92.11, C92.12, C92.20, C92.21, C92.22, C92.30, C92.31, C92.32, C92.40, C92.41, C92.42, C92.50, C92.51, C92.52, C92.60, C92.61, C92.62, C92.90, C92.91, C92.92, C92.A0, C92.A1, C92.A2, C92.Z0, C92.Z1, C92.Z2, C93.00, C93.01, C93.02, C93.10, C93.11, C93.12, C93.30, C93.31, C93.32, C93.90, C93.91, C93.92, C93.Z0, C93.Z1, C93.Z2, C94.00, C94.01, C94.02, C94.20, C94.21, C94.22, C94.30, C94.31, C94.32, C94.40, C94.41, C94.42, C94.6, C94.80, C94.81, C94.82, C95.00, C95.01, C95.02, C95.10, C95.11, C95.12, C95.90, C95.91, C95.92, C96.0, C96.2, C96.4, C96.5, C96.6, C96.9, C96.A, C96.Z, D37.01, D37.02, D37.030, D37.031, D37.032, D37.039, D37.04, D37.05, D37.09, D37.1, D37.2, D37.3, D37.4, D37.5, D37.6, D37.8 D37.9, D38.0, D38.1, D38.2, D38.3, D38.4, D38.5, D38.6, D39.0, D39.10, D39.11, D39.12, D39.2, D39.8, D39.9, D40.0, D40.10, D40.11, D40.12, D40.8, D40.9, D41.00, D41.01, D41.02, D41.10, D41.11, D41.12, D41.20, D41.21, D41.22, D41.3, D41.4, D41.8, D41.9, D42.0, D42.1, D42.9, D43.0, D43.1, D43.2, D43.3, D43.4, D43.8, D43.9, D44.0, D44.10, D44.11, D44.12, D44.2, D44.3, D44.4, D44.5, D44.6, D44.7, D44.9, D45, D46.0, D46.1, D46.20, D46.21, D46.22, D46.4, D46.9, D46.A, D46.B, D46.C, D46.Z, D47.0, D47.1, D47.2, D47.3, D47.4, D47.9, D47.Z1, D47.Z9, D48.0, D48.1, D48.2, D48.3, D48.4, D48.5, D48.60, D48.61, D48.62, D48.7, D48.9, D49.0, D49.1, D49.2, D49.3, D49.4, D49.5, D49.6, D49.7, D49.81, D49.89, D49.9, Q85.00, Q85.01, Q85.02, Q85.03, Q85.09

AND

Patient encounter during the reporting period (CPT) – Procedure codes: 77427, 77431, 77432, 77435, 77470

OR

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

AND

Patient encounter during the reporting period (CPT) – Procedure codes: 51720, 96401, 96402, 96405, 96406, 96409, 96411, 96413, 96415, 96416, 96417, 96420, 96422, 96423, 96425, 96440, 96446, 96450, 96521, 96522, 96523, 96542, 96549

NUMERATOR:
Patient visits in which pain intensity is quantified

Numerator Instructions: Pain intensity should be quantified using a standard instrument, such as a 0-10 numerical rating scale, a categorical scale, or the pictorial scale.

Numerator Options:

Performance Met:	Pain severity quantified; pain present **(1125F)**
OR	
Performance Met:	Pain severity quantified; no pain present **(1126F)**
OR	
Performance Not Met:	Pain severity **not** documented, reason not otherwise specified **(1125F *with* 8P)**

RATIONALE:
Inadequate cancer pain management is widely prevalent, harmful to the patient and costly.

CLINICAL RECOMMENDATION STATEMENTS:
This algorithm begins with the premise that all patients with cancer should be screened for pain during the initial evaluation, at regular intervals, and whenever new therapy is initiated. If pain is present on a screening evaluation, the pain intensity must be quantified by the patient (whenever possible). Since pain is inherently subjective, patient's self report to pain is the current standard of care for assessment. Intensity of pain should be quantified using a 0-10 numerical rating scale, a categorical scale, or a pictorial scale (eg, The Faces Pain Rating Scale). The Faces Pain Rating Scale may be successful with patients who have difficulty with other scales, for example, children, the elderly, and patients with language or cultural differences or other communication barriers. (NCCN, 2011)

All patients should be routinely screened for pain, and when it is present, pain intensity should be recorded in highly visible ways that facilitate regular review by health care providers. A standard for pain assessment and documentation should be established in each setting to ensure that pain is recognized, documented, and treated promptly. (APS, 2005)

▲Measure #144 (NQF 0383): Oncology: Medical and Radiation – Plan of Care for Pain – National Quality Strategy Domain: Person and Caregiver-Centered Experience and Outcomes

2015 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Percentage of visits for patients, regardless of age, with a diagnosis of cancer currently receiving chemotherapy or radiation therapy who report having pain with a documented plan of care to address pain

INSTRUCTIONS:
This measure is to be reported at **each visit** occurring during the reporting period for patients with a diagnosis of cancer and in which pain is present who are seen during the reporting period. It is anticipated that **clinicians providing care for patients with cancer** will submit this measure.

Measure Reporting via Registry:
All eligible instances when patient reports pain for Measure #143 make up the denominator for this measure. The listed numerator options are used to report the numerator of the measure.

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

DENOMINATOR:
All visits for patients, regardless of age, with a diagnosis of cancer currently receiving chemotherapy or radiation therapy who report having pain

Denominator Criteria (Eligible Cases):
All eligible instances when pain severity quantified; pain present **(1125F)** is reported in the numerator for Measure #143
AND
Diagnosis for cancer (ICD-9-CM) [for use 1/1/2015-9/30/2015]: 140.0, 140.1, 140.3, 140.4, 140.5, 140.6, 140.8, 140.9, 141.0, 141.1, 141.2, 141.3, 141.4, 141.5, 141.6, 141.8, 141.9, 142.0, 142.1, 142.2, 142.8, 142.9, 143.0, 143.1, 143.8, 143.9, 144.0, 144.1, 144.8, 144.9, 145.0, 145.1, 145.2, 145.3, 145.4, 145.5, 145.6, 145.8, 145.9, 146.0, 146.1, 146.2, 146.3, 146.4, 146.5, 146.6, 146.7, 146.8, 146.9, 147.0, 147.1, 147.2, 147.3, 147.8, 147.9, 148.0, 148.1, 148.2, 148.3, 148.8, 148.9, 149.0, 149.1, 149.8, 149.9, 150.0, 150.1, 150.2, 150.3, 150.4, 150.5, 150.8, 150.9, 151.0, 151.1, 151.2, 151.3, 151.4, 151.5, 151.6, 151.8, 151.9, 152.0, 152.1, 152.2, 152.3, 152.8, 152.9, 153.0, 153.1, 153.2, 153.3, 153.4, 153.5, 153.6, 153.7, 153.8, 153.9, 154.0, 154.1, 154.2, 154.3, 154.8, 155.0, 155.1, 155.2, 156.0, 156.1, 156.2, 156.8, 156.9, 157.0, 157.1, 157.2, 157.3, 157.4, 157.8, 157.9, 158.0, 158.8, 158.9, 159.0, 159.1, 159.8, 159.9, 160.0, 160.1, 160.2, 160.3, 160.4, 160.5, 160.8, 160.9, 161.0, 161.1, 161.2, 161.3, 161.8, 161.9, 162.0, 162.2, 162.3, 162.4, 162.5, 162.8, 162.9, 163.0, 163.1, 163.8, 163.9, 164.0, 164.1, 164.2, 164.3, 164.8, 164.9, 165.0, 165.8, 165.9, 170.0, 170.1, 170.2, 170.3, 170.4, 170.5, 170.6, 170.7, 170.8, 170.9, 171.0, 171.2, 171.3, 171.4, 171.5, 171.6, 171.7, 171.8, 171.9, 172.0, 172.1, 172.2, 172.3, 172.4, 172.5, 172.6, 172.7, 172.8, 172.9, 173.00, 173.01, 173.02, 173.09, 173.10, 173.11, 173.12, 173.19, 173.20, 173.21, 173.22, 173.29, 173.30, 173.31, 173.32, 173.39, 173.40, 173.41, 173.42, 173.49, 173.50, 173.51, 173.52, 173.59, 173.60, 173.61, 173.62, 173.69, 173.70, 173.71, 173.72, 173.79, 173.80, 173.81, 173.82, 173.89, 173.90, 173.91, 173.92, 173.99, 174.0, 174.1, 174.2, 174.3, 174.4, 174.5, 174.6, 174.8, 174.9, 175.0, 175.9, 176.0, 176.1, 176.2, 176.3, 176.4, 176.5, 176.8, 176.9, 179, 180.0, 180.1, 180.8, 180.9, 181, 182.0, 182.1, 182.8, 183.0, 183.2, 183.3, 183.4, 183.5, 183.8, 183.9, 184.0, 184.1, 184.2, 184.3, 184.4, 184.8, 184.9, 185, 186.0, 186.9, 187.1, 187.2, 187.3, 187.4, 187.5, 187.6, 187.7, 187.8, 187.9, 188.0, 188.1, 188.2, 188.3, 188.4,

188.5, 188.6, 188.7, 188.8, 188.9, 189.0, 189.1, 189.2, 189.3, 189.4, 189.8, 189.9, 190.0, 190.1, 190.2, 190.3, 190.4, 190.5, 190.6, 190.7, 190.8, 190.9, 191.0, 191.1, 191.2, 191.3, 191.4, 191.5, 191.6, 191.7, 191.8, 191.9, 192.0, 192.1, 192.2, 192.3, 192.8, 192.9, 193, 194.0, 194.1, 194.3, 194.4, 194.5, 194.6, 194.8, 194.9, 195.0, 195.1, 195.2, 195.3, 195.4, 195.5, 195.8, 196.0, 196.1, 196.2, 196.3, 196.5, 196.6, 196.8, 196.9, 197.0, 197.1, 197.2, 197.3, 197.4, 197.5, 197.6, 197.7, 197.8, 198.0, 198.1, 198.2, 198.3, 198.4, 198.5, 198.6, 198.7, 198.81, 198.82, 198.89, 199.0, 199.1, 199.2, 200.00, 200.01, 200.02, 200.03, 200.04, 200.05, 200.06, 200.07, 200.08, 200.10, 200.11, 200.12, 200.13, 200.14, 200.15, 200.16, 200.17, 200.18, 200.20, 200.21, 200.22, 200.23, 200.24, 200.25, 200.26, 200.27, 200.28, 200.30, 200.31, 200.32, 200.33, 200.34, 200.35, 200.36, 200.37, 200.38, 200.40, 200.41, 200.42, 200.43, 200.44, 200.45, 200.46, 200.47, 200.48, 200.50, 200.51, 200.52, 200.53, 200.54, 200.55, 200.56, 200.57, 200.58, 200.60, 200.61, 200.62, 200.63, 200.64, 200.65, 200.66, 200.67, 200.68, 200.70, 200.71, 200.72, 200.73, 200.74, 200.75, 200.76, 200.77, 200.78, 200.80, 200.81, 200.82, 200.83, 200.84, 200.85, 200.86, 200.87, 200.88, 201.00, 201.01, 201.02, 201.03, 201.04, 201.05, 201.06, 201.07, 201.08, 201.10, 201.11, 201.12, 201.13, 201.14, 201.15, 201.16, 201.17, 201.18, 201.20, 201.21, 201.22, 201.23, 201.24, 201.25, 201.26, 201.27, 201.28, 201.40, 201.41, 201.42, 201.43, 201.44, 201.45, 201.46, 201.47, 201.48, 201.50, 201.51, 201.52, 201.53, 201.54, 201.55, 201.56, 201.57, 201.58, 201.60, 201.61, 201.62, 201.63, 201.64, 201.65, 201.66, 201.67, 201.68, 201.70, 201.71, 201.72, 201.73, 201.74, 201.75, 201.76, 201.77, 201.78, 201.90, 201.91, 201.92, 201.93, 201.94, 201.95, 201.96, 201.97, 201.98, 202.00, 202.01, 202.02, 202.03, 202.04, 202.05, 202.06, 202.07, 202.08, 202.10, 202.11, 202.12, 202.13, 202.14, 202.15, 202.16, 202.17, 202.18, 202.20, 202.21, 202.22, 202.23, 202.24, 202.25, 202.26, 202.27, 202.28, 202.30, 202.31, 202.32, 202.33, 202.34, 202.35, 202.36, 202.37, 202.38, 202.40, 202.41, 202.42, 202.43, 202.44, 202.45, 202.46, 202.47, 202.48, 202.50, 202.51, 202.52, 202.53, 202.54, 202.55, 202.56, 202.57, 202.58, 202.60, 202.61, 202.62, 202.63, 202.64, 202.65, 202.66, 202.67, 202.68, 202.70, 202.71, 202.72, 202.73, 202.74, 202.75, 202.76, 202.77, 202.78, 202.80, 202.81, 202.82, 202.83, 202.84, 202.85, 202.86, 202.87, 202.88, 202.90, 202.91, 202.92, 202.93, 202.94, 202.95, 202.96, 202.97, 202.98, 203.00, 203.01, 203.02, 203.10, 203.11, 203.12, 203.80, 203.81, 203.82, 204.00, 204.01, 204.02, 204.10, 204.11, 204.12, 204.20, 204.21, 204.22, 204.80, 204.81, 204.82, 204.90, 204.91, 204.92, 205.00, 205.01, 205.02, 205.10, 205.11, 205.12, 205.20, 205.21, 205.22, 205.30, 205.31, 205.32, 205.80, 205.81, 205.82, 205.90, 205.91, 205.92, 206.00, 206.01, 206.02, 206.10, 206.11, 206.12, 206.20, 206.21, 206.22, 206.80, 206.81, 206.82, 206.90, 206.91, 206.92, 207.00, 207.01, 207.02, 207.10, 207.11, 207.12, 207.20, 207.21, 207.22, 207.80, 207.81, 207.82, 208.00, 208.01, 208.02, 208.10, 208.11, 208.12, 208.20, 208.21, 208.22, 208.80, 208.81, 208.82, 208.90, 208.91, 208.92, 209.00, 209.01, 209.02, 209.03, 209.10, 209.11, 209.12, 209.13, 209.14, 209.15, 209.16, 209.17, 209.20, 209.21, 209.22, 209.23, 209.24, 209.25, 209.26, 209.27, 209.29, 209.30, 209.31, 209.32, 209.33, 209.34, 209.35, 209.36, 209.70, 209.71, 209.72, 209.73, 209.74, 209.75, 209.79, 235.0, 235.1, 235.2, 235.3, 235.4, 235.5, 235.6, 235.7, 235.8, 235.9, 236.0, 236.1, 236.2, 236.3, 236.4, 236.5, 236.6, 236.7, 236.90, 236.91, 236.99, 237.0, 237.1, 237.2, 237.3, 237.4, 237.5, 237.6, 237.70, 237.71, 237.72, 237.73, 237.79, 237.9, 238.0, 238.1, 238.2, 238.3, 238.4, 238.5, 238.6, 238.71, 238.72, 238.73, 238.74, 238.75, 238.76, 238.77, 238.79, 238.8, 238.9, 239.0, 239.1, 239.2, 239.3, 239.4, 239.5, 239.6, 239.7, 239.81, 239.89, 239.9

Diagnosis for cancer (ICD-10-CM) [for use 10/01/2015-12/31/2015]: C00.0, C00.1, C00.2, C00.3, C00.4, C00.5, C00.6, C00.8, C00.9, C01, C02.0, C02.1, C02.2, C02.3, C02.4, C02.8, C02.9, C03.0, C03.1, C03.9, C04.0, C04.1, C04.8, C04.9, C05.0, C05.1, C05.2, C05.8, C05.9, C06.0, C06.1, C06.2, C06.80, C06.89, C06.9, C07, C08.0, C08.1, C08.9, C09.0, C09.1, C09.8, C09.9, C10.0, C10.1, C10.2, C10.3, C10.4, C10.8, C10.9, C11.0, C11.1, C11.2, C11.3, C11.8, C11.9, C12, C13.0, C13.1, C13.2, C13.8, C13.9, C14.0, C14.2, C14.8, C15.3, C15.4, C15.5, C15.8, C15.9, C16.0, C16.1, C16.2, C16.3, C16.4, C16.5, C16.6, C16.8, C16.9, C17.0, C17.1, C17.2, C17.3, C17.8, C17.9, C18.0, C18.1, C18.2, C18.3, C18.4, C18.5, C18.6, C18.7, C18.8, C18.9, C19, C20, C21.0, C21.1, C21.2, C21.8, C22.0, C22.1, C22.2, C22.3, C22.4, C22.7, C22.8, C22.9, C23, C24.0, C24.1, C24.8, C24.9, C25.0, C25.1, C25.2, C25.3, C25.4, C25.7, C25.8, C25.9, C26.0, C26.1, C26.9, C30.0, C30.1, C31.0, C31.1, C31.2, C31.3, C31.8, C31.9, C32.0, C32.1, C32.2, C32.3, C32.8, C32.9, C33, C34.00, C34.01, C34.02, C34.10, C34.11, C34.12, C34.2, C34.30, C34.31, C34.32, C34.80, C34.81, C34.82, C34.90, C34.91, C34.92, C37, C38.0, C38.1, C38.2, C38.3, C38.4, C38.8, C39.0, C39.9, C40.00, C40.01, C40.02, C40.10, C40.11, C40.12, C40.20, C40.21, C40.22, C40.30,

C40.31, C40.32, C40.80, C40.81, C40.82, C40.90, C40.91, C40.92, C41.0, C41.1, C41.2, C41.3, C41.4, C41.9, C43.0, C43.10, C43.11, C43.12, C43.20, C43.21, C43.22, C43.30, C43.31, C43.39, C43.4, C43.51, C43.52, C43.59, C43.60, C43.61, C43.62, C43.70, C43.71, C43.72, C43.8, C43.9, C44.00, C44.01, C44.02, C44.09, C44.101, C44.102, C44.109, C44.111, C44.112, C44.119, C44.121, C44.122, C44.129, C44.191, C44.192, C44.199, C44.201, C44.202, C44.209, C44.211, C44.212, C44.219, C44.221, C44.222, C44.229, C44.291, C44.292, C44.299, C44.300, C44.301, C44.309, C44.310, C44.311, C44.319, C44.320, C44.321, C44.329, C44.390, C44.391, C44.399, C44.40, C44.41, C44.42, C44.49, C44.500, C44.501, C44.509, C44.510, C44.511, C44.519, C44.520, C44.521, C44.529, C44.590, C44.591, C44.599, C44.601, C44.602, C44.609, C44.611, C44.612, C44.619, C44.621, C44.622, C44.629, C44.691, C44.692, C44.699, C44.701, C44.702, C44.709, C44.711, C44.712, C44.719, C44.721, C44.722, C44.729, C44.791, C44.792, C44.799, C44.80, C44.81, C44.82, C44.89, C44.90, C44.91, C44.92, C44.99, C45.0, C45.1, C45.2, C45.7, C45.9, C46.0, C46.1, C46.2, C46.3, C46.4, C46.50, C46.51, C46.52, C46.7, C46.9, C47.0, C47.10, C47.11, C47.12, C47.20, C47.21, C47.22, C47.3, C47.4, C47.5, C47.6, C47.8, C47.9, C48.0, C48.1, C48.2, C48.8, C49.0, C49.10, C49.11, C49.12, C49.20, C49.21, C49.22, C49.3, C49.4, C49.5, C49.6, C49.8, C49.9, C4A.0, C4A.10, C4A.11, C4A.12, C4A.20, C4A.21, C4A.22, C4A.30, C4A.31, C4A.39, C4A.4, C4A.51, C4A.52, C4A.59, C4A.60, C4A.61, C4A.62, C4A.70, C4A.71, C4A.72, C4A.8, C4A.9, C50.011, C50.012, C50.019, C50.021, C50.022, C50.029, C50.111, C50.112, C50.119, C50.121, C50.122, C50.129, C50.211, C50.212, C50.219, C50.221, C50.222, C50.229, C50.311, C50.312, C50.319, C50.321, C50.322, C50.329, C50.411, C50.412, C50.419, C50.421, C50.422, C50.429, C50.511, C50.512, C50.519, C50.521, C50.522, C50.529, C50.611, C50.612, C50.619, C50.621, C50.622, C50.629, C50.811, C50.812, C50.819, C50.821, C50.822, C50.829, C50.911, C50.912, C50.919, C50.921, C50.922, C50.929, C51.0, C51.1, C51.2, C51.8, C51.9, C52, C53.0, C53.1, C53.8, C53.9, C54.0, C54.1, C54.2, C54.3, C54.8, C54.9, C55, C56.1, C56.2, C56.9, C57.00, C57.01, C57.02, C57.10, C57.11, C57.12, C57.20, C57.21, C57.22, C57.3, C57.4, C57.7, C57.8, C57.9, C58, C60.0, C60.1, C60.2, C60.8, C60.9, C61, C62.00, C62.01, C62.02, C62.10, C62.11, C62.12, C62.90, C62.91, C62.92, C63.00, C63.01, C63.02, C63.10, C63.11, C63.12, C63.2, C63.7, C63.8, C63.9, C64.1, C64.2, C64.9, C65.1, C65.2, C65.9, C66.1, C66.2, C66.9, C67.0, C67.1, C67.2, C67.3, C67.4, C67.5, C67.6, C67.7, C67.8, C67.9, C68.0, C68.1, C68.8, C68.9, C69.00, C69.01, C69.02, C69.10, C69.11, C69.12, C69.20, C69.21, C69.22, C69.30, C69.31, C69.32, C69.40, C69.41, C69.42, C69.50, C69.51, C69.52, C69.60, C69.61, C69.62, C69.80, C69.81, C69.82, C69.90, C69.91, C69.92, C70.0, C70.1, C70.9, C71.0, C71.1, C71.2, C71.3, C71.4, C71.5, C71.6, C71.7, C71.8, C71.9, C72.0, C72.1, C72.20, C72.21, C72.22, C72.30, C72.31, C72.32, C72.40, C72.41, C72.42, C72.50, C72.59, C72.9, C73, C74.00, C74.01, C74.02, C74.10, C74.11, C74.12, C74.90, C74.91, C74.92, C75.0, C75.1, C75.2, C75.3, C75.4, C75.5, C75.8, C75.9, C76.0, C76.1, C76.2, C76.3, C76.40, C76.41, C76.42, C76.50, C76.51, C76.52, C76.8, C77.0, C77.1, C77.2, C77.3, C77.4, C77.5, C77.8, C77.9, C78.00, C78.01, C78.02, C78.1, C78.2, C78.30, C78.39, C78.4, C78.5, C78.6, C78.7, C78.80, C78.89, C79.00, C79.01, C79.02, C79.10, C79.11, C79.19, C79.2, C79.31, C79.32, C79.40, C79.49, C79.51, C79.52, C79.60, C79.61, C79.62, C79.70, C79.71, C79.72, C79.81, C79.82, C79.89, C79.9, C7A.00, C7A.010, C7A.011, C7A.012, C7A.019, C7A.020, C7A.021, C7A.022, C7A.023, C7A.024, C7A.025, C7A.026, C7A.029, C7A.090, C7A.091, C7A.092, C7A.093, C7A.094, C7A.095, C7A.096, C7A.098, C7A.1, C7A.8, C7B.00, C7B.01, C7B.02, C7B.03, C7B.04, C7B.09, C7B.1, C7B.8, C80.0, C80.1, C80.2, C81.00, C81.01, C81.02, C81.03, C81.04, C81.05, C81.06, C81.07, C81.08, C81.09, C81.10, C81.11, C81.12, C81.13, C81.14, C81.15, C81.16, C81.17, C81.18, C81.19, C81.20, C81.21, C81.22, C81.23, C81.24, C81.25, C81.26, C81.27, C81.28, C81.29, C81.30, C81.31, C81.32, C81.33, C81.34, C81.35, C81.36, C81.37, C81.38, C81.39, C81.40, C81.41, C81.42, C81.43, C81.44, C81.45, C81.46, C81.47, C81.48, C81.49, C81.70, C81.71, C81.72, C81.73, C81.74, C81.75, C81.76, C81.77, C81.78, C81.79, C81.90, C81.91, C81.92, C81.93, C81.94, C81.95, C81.96, C81.97, C81.98, C81.99, C82.00, C82.01, C82.02, C82.03, C82.04, C82.05, C82.06, C82.07, C82.08, C82.09, C82.10, C82.11, C82.12, C82.13, C82.14, C82.15, C82.16, 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,

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AND

Patient encounter during the reporting period (CPT) – Procedure codes: 77427, 77431, 77432, 77435, 77470

OR

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

AND

Patient encounter during the reporting period (CPT) – Procedure codes: 51720, 96401, 96402, 96405, 96406, 96409, 96413, 96416, 96420, 96422, 96425, 96440, 96446, 96450, 96521, 96522, 96523, 96542, 96549

NUMERATOR:

Patient visits that included a documented plan of care to address pain

Numerator Instructions: A documented plan of care may include: use of opioids, nonopioid analgesics, psychological support, patient and/or family education, referral to a pain clinic, or reassessment of pain at an appropriate time interval.

Numerator Options:

Performance Met: Plan of care to address pain documented **(0521F)**

OR

Performance Not Met: Plan of care for pain **not** documented, reason not otherwise specified **(0521F *with* 8P)**

RATIONALE:

Inadequate cancer pain management is widely prevalent, harmful to the patient and costly.

CLINICAL RECOMMENDATION STATEMENTS:

If the Pain Rating Scale score is above 0, a comprehensive pain assessment is initiated. (NCCN, 2011)

For management of cancer related pain in adults, the algorithm distinguishes three levels of pain intensity, based on a 0-10 numerical value obtained using numerical or the pictorial rating scale (with 0 being no pain to 10 being the worst pain). The three levels of pain intensity listed in the algorithm are mild pain (1-3); moderate pain (4-6); and severe pain (7-10). (NCCN, 2011)

The [NCCN] guidelines acknowledge the range of complex decisions faced in caring for these patients. As a result, they provide dosing guidelines for opioids, non-opioid analgesics, and adjuvant analgesics. They also provide specific suggestions for titrating and rotating opioids, escalation of opioid dosage, management of opioid adverse effects, and when and how to proceed to other techniques/interventions for the management of cancer pain. (NCCN, 2011)

Treatment must be individualized based on clinical circumstances and patient wishes, with the goal of maximizing function and quality of life. (NCCN, 2011)

Clinicians must respond to pain reports in a manner appropriate to the type of pain (eg, acute vs. chronic) and setting (eg, inpatient vs. outpatient)… Appropriate responses may not always include more opioids but rather more detailed assessments, use of nonopioid analgesics or techniques, or non-pharmacologic interventions (eg, education, relaxation, and use of heat or cold). (APS, 2005)

Measure #145 (NQF 0510): Radiology: Exposure Time Reported for Procedures Using Fluoroscopy – National Quality Strategy Domain: Patient Safety

2015 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of final reports for procedures using fluoroscopy that include documentation of radiation exposure or exposure time

INSTRUCTIONS:
This measure is to be reported **each time** fluoroscopy is performed in a hospital or outpatient setting during the reporting period. There is no diagnosis associated with this measure. It is anticipated that **clinicians providing the services for procedures using fluoroscopy** will submit this measure.

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

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

Measure Reporting via Registry:
CPT or HCPCS codes are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

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

DENOMINATOR:
All final reports for procedures using fluoroscopy

Denominator Criteria (Eligible Cases):
Patient encounter during the reporting period (CPT or HCPCS): 0075T, 0234T, 0235T, 0236T, 0237T, 0238T, 0338T, 0339T, 25606, 25651, 26608, 26650, 26676, 26706, 26727, 27235, 27244, 27245, 27509, 27756, 27759, 28406, 28436, 28456, 28476, 36147, 36221, 36222, 36223, 36224, 36225, 36226, 36251, 36252, 36253, 36254, 36598, 37182, 37183, 37184, 37187, 37188, 37211, 37212, 37213, 37214, 37215, 37216, 37217, 37220, 37221, 37222, 37223, 37224, 37225, 37226, 37227, 37228, 37229, 37230, 37231, 37232, 37233, 37234, 37235, 37236, 37238, 37241, 37242, 37243, 37244, 43260, 43261, 43262, 43263, 43264, 43265, 43275, 43276, 43277, 43278, 43752, 44500, 49440, 49441, 49442, 49446, 49450, 49451, 49452, 49460, 49465, 50382, 50384, 50385, 50386, 50387, 50389, 50590, 61623, 61630, 61635, 61640, 62263, 62264, 62280, 62281, 62282, 63610, 64610, 64620, 70010, 70015, 70170, 70332, 70370, 70371, 70373, 70390, 71023, 71034, 72240, 72255, 72265, 72270, 72275, 72285, 72295, 73040, 73085, 73115, 73525, 73580, 73615, 74190, 74210, 74220, 74230, 74235, 74240, 74241, 74245, 74246, 74247, 74249, 74250, 74251, 74260, 74270, 74280, 74283, 74290, 74300, 74305, 74320, 74327, 74328, 74329, 74330, 74340, 74355, 74360, 74363, 74425, 74430, 74440, 74445, 74450, 74455, 74470, 74475, 74480, 74485, 74740, 74742, 75600, 75605, 75625, 75630, 75658, 75705, 75710, 75716, 75726, 75731, 75733, 75736, 75741, 75743, 75746, 75756, 75791, 75801, 75803, 75805, 75807, 75809, 75810, 75825, 75827, 75831, 75833, 75840, 75842, 75860, 75870, 75872, 75880, 75885, 75887, 75889, 75891, 75893, 75894, 75896,

75898, 75901, 75902, 75952, 75953, 75954, 75956, 75957, 75958, 75959, 75962, 75966, 75970, 75978, 75980, 75982, 75984, 76000, 76001, 76080, 76120, 76496, 77001, 77002, 77003, 92611, 93565, 93566, 93567, 93568, G0106, G0120, G0278

NUMERATOR:
Final reports for procedures using fluoroscopy that include documentation of radiation exposure or exposure time

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Radiation Exposure or Exposure Time Documented in Final Procedure Report
Performance Met: **CPT II 6045F:** Radiation exposure or exposure time in final report for procedure using fluoroscopy, documented

OR

Radiation Exposure or Exposure Time not Documented in Final Procedure Report, Reason not Otherwise Specified
Append a reporting modifier (**8P**) to CPT Category II code **6045F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.
Performance Not Met: **6045F *with* 8P:** Radiation exposure or exposure time **not** documented in final report for procedure using fluoroscopy, reason not otherwise specified

RATIONALE:
Increasing physician awareness of patient exposure to radiation is an important step towards reducing the potentially harmful effects of radiation as a result of imaging studies. One study by Darling et al found a significant correlation between documentation of fluoroscopy time by the radiologist in the dictated radiology report and reduced overall fluoroscopy time. Additional studies demonstrate that providing physicians with feedback regarding their fluoroscopy time leads to a reduction in average fluoroscopy times.

CLINICAL RECOMMENDATION STATEMENTS:
All available radiation dose data should be recorded in the patient's medical record. If cumulative air kerma or air kerma-area-product data are not available, the fluoroscopic exposure time and the number of acquired images (radiography, cine, or digital subtraction angiography) should be recorded in the patient's medical record. (ACR, 2013)

For the present, and for the purpose of this guideline, adequate recording of dose metrics is defined as documentation in the patient record of at least one of the following for all interventional procedures requiring fluoroscopy (in descending order of desirability): skin dose mapping, PSD, Ka,r, PKA, and fluoroscopic time/number of fluorographic images. Note, however, that this is adequate recording; this document recommends recording of all available dose metrics. (SIR, 2012)

[ACR] should now encourage practices to record actual fluoroscopy time for all fluoroscopic procedures. The fluoroscopy time for various procedures (eg, upper gastrointestinal, pediatric voiding cystourethrography, diagnostic angiography) should then be compared with benchmark figures…More complete patient radiation dose data should be recorded for all high-dose interventional procedures, such as embolizations, transjugular intrahepatic portosystemic shunts, and arterial angioplasty or stent placement anywhere in the abdomen and pelvis. (Amis et al., ACR, 2007)

Measure & record patient radiation dose:

- Record fluoroscopy time
- Record available measures - DAP (dose area product), cumulative dose, skin dose (NCI, 2005)

Measure #146 (NQF 0508): Radiology: Inappropriate Use of "Probably Benign" Assessment Category in Screening Mammograms – National Quality Strategy Domain: Efficiency and Cost Reduction

2015 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of final reports for screening mammograms that are classified as "probably benign"

INSTRUCTIONS:
This measure is to be reported **each time** a screening mammogram is performed during the reporting period. It is anticipated that **clinicians who provide the physician component of diagnostic imaging studies** for screening mammograms will submit this measure.

Measure Reporting via Claims:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT or HCPCS codes are used to identify patients who are included in the measure's denominator. CPT Category II codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed ICD-9-CM/ICD-10-CM diagnosis codes, CPT or HCPCS codes, and the appropriate CPT Category II codes. There are no allowable performance exclusions for this measure. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT or HCPCS codes, are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

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

DENOMINATOR:
All final reports for screening mammograms

> **Denominator Criteria (Eligible Cases):**
> **Diagnosis for screening mammogram (ICD-9-CM) [for use 1/1/2015-9/30/2015]:** V76.11, V76.12
> **Diagnosis for screening mammogram (ICD-10-CM) [for use 10/01/2015-12/31/2015]:** Z12.31
> **AND**
> **Patient encounter during the reporting period (CPT or HCPCS):** 77057, G0202

NUMERATOR:
Final reports classified as "probably benign"

> **Numerator Instructions:** A lower calculated performance rate for this measure indicates better clinical care or control. A lower percentage, with a definitional target approaching 0%, indicates appropriate assessment of screening mammograms. The mammogram assessment category (corresponding CPT Category II **33xxF** code for **Other than "Probably Benign"**) to be reported is the single overall final assessment for the mammographic study. Separate breast assessment categories should not be reported for this measure. Of note, the performance tags indicating 'Performance Met' and 'Performance Not Met' are included to highlight what is being measured and reported and not to encourage the use and documentation of "probably benign".

Definition:
"Probably Benign" Classification – Mammography Quality Standards Act (MQSA) assessment category of "probably benign"; BI-RADS® category 3; or Food and Drug Administration (FDA)-approved equivalent assessment category.

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Mammogram Assessment Category of "Probably Benign" Documented
Performance Met: **CPT II 3343F:** Mammogram assessment category of "probably benign," documented

OR

Mammogram Assessment Category Other than "Probably Benign" Documented
*(One CPT II code **[33xxF]** is required on the claim form to submit this numerator option)*
Performance Not Met: **CPT II 3340F:** Mammogram assessment category of "incomplete: need additional imaging evaluation," documented

OR
Performance Not Met: **CPT II 3341F:** Mammogram assessment category of "negative," documented

OR
Performance Not Met: **CPT II 3342F:** Mammogram assessment category of "benign," documented

OR
Performance Not Met: **CPT II 3344F:** Mammogram assessment category of "suspicious", documented

OR
Performance Not Met: **CPT II 3345F:** Mammogram assessment category "highly suggestive of malignancy", documented

OR
Performance Not Met: **CPT II 3350F:** Mammogram assessment category of "known biopsy proven malignancy", documented

RATIONALE:
The "probably benign" assessment category is reserved for findings that have a high probability (≥98%) chance of being benign and should not be used as a category for indeterminate findings. Inappropriate designation of findings as "probably benign" can result in unnecessary follow-up of lesions that could have been quickly classified or delayed diagnosis and treatment of cancerous lesions. Published guidance documents emphasize the need to conduct a complete diagnostic imaging evaluation before making a probably benign (Category 3) assessment; making it inadvisable to use the probably benign categorization when interpreting a screening mammogram. Immediate completion of a diagnostic imaging evaluation for abnormal screening mammograms eliminates potential anxiety that women would endure with the short interval follow-up that is recommended for "probably benign" findings.

CLINICAL RECOMMENDATION STATEMENTS:
A category 3, 4, or 5 assessment is not recommended for a screening mammogram, even though in some instances a highly suspicious abnormality may be identified that will warrant a recommendation for biopsy. Rather, all patients with screening abnormalities should be given a BI-RADS® category 0 assessment and recalled for further diagnostic studies. (ACR, 2013)

All the previously cited studies emphasize the need to conduct a complete diagnostic imaging evaluation before making a probably benign (category 3) assessment; hence it is recommended not to render such an assessment in interpreting a screening mammography examination. The practice of rendering category 3 assessments directly from screening examination also has been shown to result in adverse outcomes: 1) unnecessary follow-up of many lesions that could have been promptly assessed as benign, and 2) delayed diagnosis of a small number of cancers that otherwise may have been smaller in size and less likely to be advanced in stage (ACR, 2013)

The use of assessment category 3, probably benign, has been clarified in the lexicon of the 2013 edition. It is emphasized that this is ***not*** an indeterminate category used simply when the radiologist is unsure whether to render a benign (BI-RADS® category 2) or suspicious (BI-RADS® category 4) assessment, but one that is reserved for specific imaging findings known to have a greater than essentially 0% but ≤ 2% likelihood of representing malignancy. (ACR, 2013)

For mammography, there is robust literature describing three findings (noncalcified circumscribed solid mass, focal asymmetry and solitary group of punctate calcifications) that have likelihoods of malignancy in the defined (≤ 2%) probably benign range, for which short interval (6-month) follow-up mammography and then periodic mammographic surveillance represents appropriate management. Use of assessment category 3 for mammographic findings other than these three should be considered only if the radiologist has personal experience to justify a watchful-waiting approach, preferably involving observation of a sufficient number of cases of an additional mammographic finding to suggest a likelihood of malignancy within the defined (≤ 2%) probably-benign range. Two large-scale studies performed in the United States have validated that in the usual-care setting, category 3 assessments indeed are associated with a likelihood of malignancy of <2%. (ACR 2013)

Measure #147: Nuclear Medicine: Correlation with Existing Imaging Studies for All Patients Undergoing Bone Scintigraphy – National Quality Strategy Domain: Communication and Care Coordination

2015 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of final reports for all patients, regardless of age, undergoing bone scintigraphy that include physician documentation of correlation with existing relevant imaging studies (eg, x-ray, MRI, CT, etc.) that were performed

INSTRUCTIONS:
This measure is to be reported **each time** bone scintigraphy is performed during the reporting period. There is no diagnosis associated with this measure. It is anticipated **clinicians performing the bone scintigraphy study** will report on this measure.

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

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

Measure Reporting via Registry:
CPT codes are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

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

DENOMINATOR:
All final reports for patients, regardless of age, undergoing bone scintigraphy

Denominator Criteria (Eligible Cases):
Patient encounter during the reporting period (CPT): 78300, 78305, 78306, 78315, 78320

NUMERATOR:
Final reports that include physician documentation of correlation with existing relevant imaging studies (eg, x-ray, MRI, CT, etc.)

Definition:
Relevant Imaging Studies – Relevant imaging studies are defined as studies that correspond to the same anatomical region in question.

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Bone Scintigraphy Report Correlated with Existing Studies

Performance Met: **CPT II 3570F:**	Final report for bone scintigraphy study includes correlation with existing relevant imaging studies (eg, x-ray, MRI, CT) corresponding to the same anatomical region in question

OR

Bone Scintigraphy Report not Correlated for System Reasons
Append a modifier (**3P**) to CPT Category II code **3570F** to report documented circumstances that appropriately exclude patients from the denominator.

System Performance Exclusion: **3570F *with* 3P:** Documentation of system reason(s) for not documenting correlation with existing relevant imaging studies in final report (eg, no existing relevant imaging study available, patient did not have a previous relevant imaging study)

Note: *Correlative studies are considered to be unavailable if relevant studies (reports and/or actual examination material) from other imaging modalities exist but could not be obtained after reasonable efforts to retrieve the studies are made by the interpreting physician prior to the finalization of the bone scintigraphy report.*

OR

Bone Scintigraphy Report not Correlated, Reason not Otherwise Specified
Append a reporting modifier (**8P**) to CPT Category II code **3570F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

Performance Not Met: **3570F *with* 8P:** Bone scintigraphy report **not** correlated in the final report with existing relevant imaging studies, reason not otherwise specified

RATIONALE:

Radionuclide bone imaging plays an integral part in tumor staging and management; the majority of bone scans are performed in patients with a diagnosis of malignancy, especially carcinoma of the breast, prostate gland, and lung. This modality is extremely sensitive for detecting skeletal abnormalities, and numerous studies have confirmed that it is considerably more sensitive than conventional radiography for this purpose. However, the specificity of bone scan abnormalities can be low since many other conditions may mimic tumor; therefore, it is important that radionuclide bone scans are correlated with available, relevant imaging studies. Existing imaging studies that are available can help inform the diagnosis and treatment for the patient. Furthermore, correlation with existing radiographs is considered essential to insure that benign conditions are not interpreted as tumor. While there are no formal studies on variations in care in how often correlation with existing studies is not performed, there is significant anecdotal information from physicians practicing in the field that there is a gap in care and that correlation is not occurring frequently when images are available.

Literature suggests that as many as 30% of Radiology reports contain errors, regardless of the imaging modality, radiologists' experience, or time spent in interpretation. Evidence has also suggested that Radiology reports are largely non-standardized and commonly incomplete, vague, untimely, and error-prone and may not serve the needs of referring physicians. Therefore, it is imperative that existing imaging reports be correlated with the Nuclear Medicine bone scintigraphy procedure to ensure proper diagnosis and appropriate patient treatment.

CLINICAL RECOMMENDATION STATEMENTS:

Bone scintigraphic abnormalities should be correlated with appropriate physical examination and imaging studies to ascertain that osseous or soft-tissue abnormalities, which might cause cord or other nerve compression or pathologic fracture in an extremity, are not present. (SNM, 2003)

Interpretation criteria

Bone scans are very sensitive for disease, but specificity of findings is low and must be interpreted in light of other information

1) History
2) Physical exam
3) Other test results

4) Comparison with previous studies

(SNM, 2003)

Reporting

1) Description of technique
2) Description of abnormal tracer uptake
3) Correlation with other studies
4) Comparison with previous studies
5) Interpretation

(SNM, 2003)

Comparisons with previous examinations and reports, when possible, should be a part of the imaging consultation and report. Integrated PET/CT studies are more valuable when correlated with previous diagnostic CT, previous PET, previous PET/CT, previous MRI, and all appropriate imaging studies and clinical data that are relevant. (SNM, 2010)

*Measure #154 (NQF: 0101): Falls: Risk Assessment – National Quality Strategy Domain: Patient Safety

2015 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

This is a two-part measure which is paired with Measure #155: Falls: Plan of Care. If the falls risk assessment indicates the patient has documentation of two or more falls in the past year or any fall with injury in the past year (CPT II code 1100F is submitted), #155 *should* also be reported.

DESCRIPTION:
Percentage of patients aged 65 years and older with a history of falls that had a risk assessment for falls completed within 12 months

INSTRUCTIONS:
This measure is to be reported a minimum of **once per reporting period** for patients seen during the reporting period. There is no diagnosis associated with this measure. This measure is appropriate for use in all non-acute settings (excludes emergency departments and acute care hospitals). This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

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

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

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

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

DENOMINATOR:
All patients aged 65 years and older who have a history of falls (history of falls is defined as 2 or more falls in the past year or any fall with injury in the past year). Documentation of patient reported history of falls is sufficient.

Denominator Criteria (Eligible Cases):

Patients aged ≥ 65 years on date of encounter
AND
Patient encounter during the reporting period (CPT or HCPCS): 97001, 97002, 97003, 97004, 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, G0402, G0438, G0439

NUMERATOR:
Patients who had a risk assessment for falls completed within 12 months

Numerator Instructions: All components do not need to be completed during one patient visit, but should be documented in the medical record as having been performed within the past 12 months.

Definitions:
Fall – A sudden, unintentional change in position causing an individual to land at a lower level, on an object, the floor, or the ground, other than as a consequence of sudden onset of paralysis, epileptic seizure, or overwhelming external force.
Risk Assessment – Comprised of balance/gait AND one or more of the following: postural blood pressure, vision, home fall hazards, and documentation on whether medications are a contributing factor or not to falls within the past 12 months.

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

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Risk Assessment for Falls Completed
(Two CPT II codes [3288F & 1100F] are required on the claim form to submit this numerator option)
Performance Met:

CPT II 3288F:	Falls risk assessment documented
AND	
CPT II 1100F:	Patient screened for future fall risk; documentation of two or more falls in the past year or any fall with injury in the past year

OR

Risk Assessment for Falls not Completed for Medical Reasons
*(Two CPT II codes [**3288F-1P & 1100F**] are required on the claim form to submit this numerator option)*
Append a modifier (**1P**) to CPT Category II code **3288F** to report documented circumstances that appropriately exclude patients from the denominator.
Medical Performance Exclusion:

3288F *with* 1P:	Documentation of medical reason(s) for not completing a risk assessment for falls (ie, patient is not ambulatory, bed ridden, immobile, confined to chair, wheelchair bound, dependent on helper pushing wheelchair, independent in wheelchair or minimal help in wheelchair)
AND	
CPT II 1100F:	Patient screened for future fall risk; documentation of two or more falls in the past year or any fall with injury in the past year

OR

If patient is not eligible for this measure because patient has documentation of no falls or only one fall without injury the past year, report:
Patient not at Risk for Falls
*(One CPT II code [**1101F**] is required on the claim form to submit this numerator option)*

Other Performance Exclusion: CPT II 1101F:	Patient screened for future fall risk; documentation of no falls in the past year or only one fall without injury in the past year

OR

If patient is not eligible for this measure because falls status is not documented, report:
Falls Status not Documented
*(One CPT II code [**1101F-8P**] is required on the claim form to submit this numerator option)*
Append a reporting modifier (**8P**) to CPT Category II code **1101F** to report circumstances when the patient is not eligible for the measure.
Other Performance Exclusion: 1101F *with* 8P: No documentation of falls status

OR

Risk Assessment for Falls not Completed, Reason not Otherwise Specified
*(Two CPT II codes [**3288F-8P & 1100F**] are required on the claim form to submit this numerator option)*
Append a reporting modifier (8P) to CPT Category II code 3288F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified**.**
Performance Not Met:

3288F *with* 8P:	Falls risk assessment **not** completed, reason not otherwise specified
AND	
CPT II 1100F:	Patient screened for future fall risk; documentation of two or more falls in the past year or any fall with injury in the past year

RATIONALE:
Screening for specific medical conditions may direct the therapy. Although the clinical guidelines and supporting evidence calls for an evaluation of many factors, it was felt that for the purposes of measuring performance and facilitating implementation this initial measure must be limited in scope. For this reason, the work group defined an evaluation of balance and gait as a core component that must be completed on all patients with a history of falls as well as four additional evaluations – at least one of which must be completed within the 12 month period. Data elements required for the measure can be captured and the measure is actionable by the physician.

CLINICAL RECOMMENDATION STATEMENTS:
Older people who present for medical attention because of a fall, or report recurrent falls in the past year, or demonstrate abnormalities of gait and/or balance should be offered a multifactorial falls risk assessment. This assessment should be performed by a health care professional with appropriate skills and experience, normally in the setting of a specialist falls service. This assessment should be part of an individualized, multifactorial intervention. (NICE) (Grade C)

Multifactorial assessment may include the following:

- Identification of falls history
- Assessment of gait, balance and mobility, and muscle weakness
- Assessment of osteoporosis risk
- Assessment of the older person's perceived functional ability and fear relating to falling
- Assessment of visual impairment
- Assessment of cognitive impairment and neurological examination
- Assessment of urinary incontinence
- Assessment of home hazards
- Cardiovascular examination and medication review (nice) (grade c)

A falls risk assessment should be performed for older persons who present for medical attention because of a fall, report recurrent falls in the past year, report difficulties in walking or balance or fear of falling, or demonstrate unsteadiness or difficulty performing a gait and balance test.

The falls risk evaluation should be performed by a clinician with appropriate skills and experience. [C]

A falls risk assessment is a clinical evaluation that should include the following, but are not limited to:

- A history of fall circumstances
- Review of all medications and doses
- Evaluation of gait and balance, mobility levels and lower extremity joint function
- Examination of vision
- Examination of neurological function, muscle strength, proprioception, reflexes, and tests of cortical, extrapyramidal, and cerebellar function
- Cognitive evaluation
- Screening for depression
- Assessment of postural blood pressure
- Assessment of heart rate and rhythm
- Assessment of heart rate and rhythm, and blood pressure responses to carotid sinus stimulation if appropriate
- Assessment of home environment

The falls risks assessment should be followed by direct intervention on the identified risk. [A] (AGS)

*Measure #155 (NQF: 0101): Falls: Plan of Care – National Quality Strategy Domain: Communication and Care Coordination

2015 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

This is a two-part measure which is paired with Measure #154: Falls: Risk Assessment.

This measure *should* be reported if CPT II code 1100F "Patient screened for future falls risk; documentation of two or more falls in the past year or any fall with injury in the past year" is submitted for Measure #154.

DESCRIPTION:
Percentage of patients aged 65 years and older with a history of falls that had a plan of care for falls documented within 12 months

INSTRUCTIONS:
This measure is to be reported a minimum of **once per reporting period** for patients seen during the reporting period. There is no diagnosis associated with this measure. This measure is appropriate for use in all non-acute settings (excludes emergency departments and acute care hospitals). This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

Measure Reporting via Claims:
All eligible instances when CPT II code **1100F** (patient screened for future falls risk; documentation of two or more falls in the past year or any fall with injury in the past year) is reported in the numerator for Measure #154 make up the denominator for this measure. CPT Category II codes are used to report the numerator of the measure**.**

When CPT II code **1100F** is reported with Measure #154, add the appropriate CPT Category II codes **OR** the CPT Category II code(s) **with** the modifier. The modifiers allowed for this measure are: 1P- medical reasons, 8P- reason not otherwise specified. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
All eligible instances when patient is reported in the numerator for Measure #154 as screened for future falls risk; documentation of two or more falls in the past year or any fall with injury in the past year are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

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

DENOMINATOR:
All patients aged 65 years and older with a history of falls (history of falls is defined as 2 or more falls in the past year or any fall with injury in the past year). Documentation of patient reported history of falls is sufficient.

Denominator Criteria (Eligible Cases):
Patients aged ≥ 65 years on date of encounter
AND
All eligible instances when **CPT II code 1100F** (Patient screened for future fall risk; documentation of two or more falls in the past year or any fall with injury in the past year) is reported in the numerator for Measure #154.
AND

Patient encounter during the reporting period (CPT or HCPCS): 97001, 97002, 97003, 97004, 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, G0402, G0438, G0439

NUMERATOR:

Patients with a plan of care for falls documented within 12 months

Numerator Instructions: All components do not need to be completed during one patient visit, but should be documented in the medical record as having been performed within the past 12 months.

Definitions:

Plan of Care – Must include: **1)** consideration of vitamin D supplementation AND **2)** balance, strength, and gait training.

Consideration of Vitamin D Supplementation – Documentation that vitamin D supplementation was advised or considered or documentation that patient was referred to his/her physician for vitamin D supplementation advice.

Balance, Strength, and Gait Training – Medical record must include: documentation that balance, strength, and gait training/instructions were provided OR referral to an exercise program, which includes at least one of the three components: balance, strength or gait OR referral to physical therapy.

Fall – A sudden, unintentional change in position causing an individual to land at a lower level, on an object, the floor, or the ground, other than as a consequence of sudden onset of paralysis, epileptic seizure, or overwhelming external force.

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Plan of Care Documented
Performance Met:
CPT II 0518F: Falls plan of care documented

OR

Plan of Care not Documented for Medical Reasons

Append a modifier (1P) to CPT Category II code 0518F to report documented circumstances that appropriately exclude patients from the denominator.

Medical Performance Exclusion: **0518F *with* 1P:** Documentation of medical reason(s) for no plan of care for falls (ie, patient is not ambulatory, bed ridden, immobile, confined to chair, wheelchair bound, dependent on helper pushing wheelchair, independent in wheelchair or minimal help in wheelchair)

OR

Plan of Care not Documented, Reason not Otherwise Specified

Append a reporting modifier (**8P**) to CPT Category II code **0518F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

Performance Not Met: **0518F *with* 8P:** Plan of care **not** documented, reason not otherwise specified

RATIONALE:

Interventions to prevent future falls should be documented for the patient with 2 or more falls or injurious falls.

CLINICAL RECOMMENDATION STATEMENTS:

The USPSTF recommends exercise or physical therapy and vitamin D supplementation to prevent falls in community-dwelling adults aged 65 years or older who are at increased risk for falls.
Grade: B Recommendation.

The AGS 2010 Clinical Practice Guidelines Recommend:

Multifactorial/Multicomponent Interventions to Address Identified Risk(s) and Prevent Falls

1) A strategy to reduce the risk of falls should include multifactorial assessment of known fall risk factors and management of the risk factors identified.[A]
2) The components most commonly included in efficacious interventions were:

    a) Adaptation or modification of home environment [A]
    b) Withdrawal or minimization of psychoactive medications [B]
    c) Withdrawal or minimization of other medications [C]
    d) Management of postural hypotension [C]
    e) Management of foot problems and footwear [C]
    f) Exercise, particularly balance, strength, and gait training [A]

3) All older adults who are at risk of falling should be offered an exercise program incorporating balance, gait, and strength training. Flexibility and endurance training should also be offered, but not as sole components of the program. [A]
4) Multifactorial/multicomponent intervention should include an education component complementing and addressing issues specific to the intervention being provided, tailored to individual cognitive function and language. [C]
5) The health professional or team conducting the fall risk assessment should directly implement the interventions or should assure that the interventions are carried out by other qualified healthcare professionals. [A]

Measure #156 (NQF 0382): Oncology: Radiation Dose Limits to Normal Tissues – National Quality Strategy Domain: Patient Safety

2015 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of patients, regardless of age, with a diagnosis of breast, rectal, pancreatic or lung cancer receiving 3D conformal radiation therapy who had documentation in medical record that radiation dose limits to normal tissues were established prior to the initiation of a course of 3D conformal radiation for a minimum of two tissues

INSTRUCTIONS:
This measure is to be reported a minimum of **once per reporting period** for patients with a diagnosis of breast, rectal, pancreatic or lung cancer receiving 3D conformal radiation therapy seen during the reporting period. It is anticipated that **clinicians providing radiation therapy for patients with cancer** will submit this measure.

Measure Reporting via Claims:
ICD-9-CM/ICD-10-CM diagnosis codes and a CPT code are used to identify patients who are included in the measure's denominator. CPT Category II code(s) are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed ICD-9-CM/ICD-10-CM diagnosis codes, a CPT code, and the appropriate CPT Category II code **OR** the CPT Category II code **with** the modifier. The reporting modifier allowed for this measure is: 8P- reason not otherwise specified. There are no allowable performance exclusions for this measure. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
ICD-9-CM/ICD-10-CM diagnosis codes and a CPT code are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

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

DENOMINATOR:
All patients, regardless of age, with a diagnosis of breast, rectal, pancreatic or lung cancer receiving 3D conformal radiation therapy

Denominator Criteria (Eligible Cases):
Diagnosis for breast, rectal, pancreatic or lung cancer (ICD-9-CM) [for use 01/01/2015-09/30/2015]:
154.0, 154.1, 154.8, 157.0, 157.1, 157.2, 157.3, 157.4, 157.8, 157.9, 162.2, 162.3, 162.4, 162.5, 162.8, 162.9, 174.0, 174.1, 174.2, 174.3, 174.4, 174.5, 174.6, 174.8, 174.9, 175.0, 175.9
Diagnosis for breast, rectal, pancreatic or lung cancer (ICD-10-CM) [for use 10/01/2015-12/31/2015]:
C19, C20, C21.2, C21.8, C25.0, C25.1, C25.2, C25.3, C25.4, C25.7, C25.8, C25.9, C34.00, C34.01, C34.02, C34.10, C34.11, C34.12, C34.2, C34.30, C34.31, C34.32, C34.80, C34.81, C34.82, C34.90, C34.91, C34.92, C50.011, C50.012, C50.019, C50.021, C50.022, C50.029, C50.111, C50.112, C50.119, C50.121, C50.122, C50.129, C50.211, C50.212, C50.219, C50.221, C50.222, C50.229, C50.311, C50.312, C50.319, C50.321, C50.322, C50.329, C50.411, C50.412, C50.419, C50.421, C50.422, C50.429, C50.511, C50.512, C50.519, C50.521, C50.522, C50.529, C50.611, C50.612, C50.619, C50.621, C50.622, C50.629, C50.811, C50.812, C50.819, C50.821, C50.822, C50.829, C50.911, C50.912, C50.919, C50.921, C50.922, C50.929
AND NOT

Diagnosis for metastatic cancer (ICD-9-CM) [for use 01/01/2015-09/30/2015]: 196.0, 196.1, 196.2, 196.3, 196.5, 196.6, 196.8, 196.9, 197.0, 197.1, 197.2, 197.3, 197.4, 197.5, 197.6, 197.7, 197.8, 198.0, 198.1, 198.2, 198.3, 198.4, 198.5, 198.6, 198.7, 198.81, 198.82, 198.89
Diagnosis for metastatic cancer (ICD-10-CM) [for use 10/01/2015-12/31/2015]: C77.0, C77.1, C77.2, C77.3, C77.4, C77.5, C77.8, C77.9, C78.00, C78.01, C78.02, C78.1, C78.2, C78.30, C78.39, C78.4, C78.5, C78.6, C78.7, C78.80, C78.89, C79.00, C79.01, C79.02, C79.10, C79.11, C79.19, C79.2, C79.31, C79.32, C79.40, C79.49, C79.51, C79.52, C79.60, C79.61, C79.62, C79.70, C79.71, C79.72, C79.81, C79.82, C79.89, C79.9
AND
Patient encounter during the reporting period (CPT): 77295

NUMERATOR:
Patients who had documentation in medical record that radiation dose limits to normal tissues were established prior to the initiation of a course of 3D conformal radiation for a minimum of two tissues

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Radiation Dose Limits to Normal Tissues Established
***Performance Met:* CPT II 0520F:** Radiation dose limits to normal tissues established prior to the initiation of a course of 3D conformal radiation for a minimum of two tissue/organ

OR

Radiation Dose Limits to Normal Tissues not Established, Reason not Otherwise Specified
Append a reporting modifier (**8P**) to CPT Category II code **0520F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.
***Performance Not Met:* 0520F *with* 8P:** Radiation dose limits to normal tissues **not** established prior to the initiation of a course of 3D conformal radiation for a minimum of two tissue/organ, reason not otherwise specified

RATIONALE:
Identifying radiation dose limits to normal tissues is an important step in the process of care for patients receiving radiation therapy treatments. Although no specific data is available, in its practice accreditation reviews, the American College of Radiation Oncology has found that radiation dose limits to normal tissues are included in the patient chart less frequently than reviewers expected. While dose constraint specification is an integral part of IMRT, it is not required for 3D conformal radiation therapy. Patients treated with 3D conformal radiation therapy are often subjected to dose levels that exceed normal tissue tolerance, and precise specification of maximum doses to be received by normal tissues represent both an intellectual process for the physician during radiation treatment planning, and a fail-safe point for the treating therapists. In most circumstances where facilities require specification of radiation dose limits to normal tissues prior to initiation of therapy, policies and procedures exist that prohibit exceeding those limits in the absence of written physician approval.

CLINICAL RECOMMENDATION STATEMENTS:
Breast Cancer
Whole Breast Radiation: Target definition includes the majority of the breast tissue, and is best done by both clinical assessment and CT-based treatment planning. A uniform dose distribution and minimal normal tissue toxicity are the goals and can be accomplished using compensators such as wedges, forward planning using segments, intensity-modulated radiation therapy (IMRT), respiratory gating, or prone positioning. (NCCN, 2014)

Chest Wall Radiation (including breast reconstruction)
The target includes the ipsilateral chest wall, mastectomy scar, and drain sites where possible. Depending on whether the patient has been reconstructed or not, several techniques using photons and/or electrons are appropriate. CT-based treatment planning is encouraged in order to identify lung and heart volumes, and minimize

exposure of these organs. Special consideration should be given to the use of bolus material when photon fields are used, to ensure the skin dose is adequate. (NCCN, 2014)

Rectal Cancer
Radiation therapy fields should include the tumor or tumor bed, with a 2-5 cm margin, the presacral nodes, and the internal iliac nodes. The external iliac nodes should also be included for T4 tumors involving anterior structures. Multiple radiation therapy fields should be used (generally a 3- or 4- field technique). Positioning and other techniques to minimize the volume of small bowel in the fields should be encouraged. (NCCN, 2014)

Pancreatic Adenocarcinoma
It is imperative to evaluate the DVH [dose volume histogram] of the PTV [planning target volume] and critical normal structures such as liver, kidneys, spinal cord, liver and bowel. While these limits are empirical they differ based on dose per fraction, total dose delivered, and disease status (adjuvant vs. unresectable). Studies have shown that the tolerability of radiation is largely dependent on PTV size/elective nodal irradiation, types of concurrent systemic/ targeted therapy, and whether conformal (3-D, IMRT, SBRT) vs. conventional radiation is used. (NCCN, 2012)

Non-Small Cell Lung Cancer
It is essential to evaluate the dose volume histogram (DVH) of critical structures and to limit the doses to the spinal cord, lungs, heart, esophagus, and brachial plexus to minimize normal tissue toxicity. These limits are mainly empirical. For patients receiving postoperative RT, more strict DVH parameters should be considered for lung. (NCCN, 2012)

Small Cell Lung Cancer
Normal tissue doses will be dependent on tumor size and location. (NCCN, 2012)

♦ Measure #163 (NQF 0056): Diabetes: Foot Exam – National Quality Strategy Domain: Effective Clinical Care

2015 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of patients aged 18-75 years of age with diabetes who had a foot exam during the measurement period

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

Measure Reporting via Claims:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT or HCPCS codes, and patient demographics are used to identify patients who are included in the measure's denominator. CPT Category II codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed ICD-9-CM/ICD-10-CM diagnosis codes, CPT or HCPCS codes, and the appropriate quality-data code. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT or HCPCS codes, and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

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

DENOMINATOR:
Patients 18 through 75 years of age who had a diagnosis of diabetes with a visit during the measurement period

Denominator Criteria (Eligible Cases):
Patients aged 18 through 75 years on date of encounter
AND
Diagnosis for diabetes (ICD-9-CM) [for use 01/1/2015-09/30/2015]: 250.00, 250.01, 250.02, 250.03, 250.10, 250.11, 250.12, 250.13, 250.20, 250.21, 250.22, 250.23, 250.30, 250.31, 250.32, 250.33, 250.40, 250.41, 250.42, 250.43, 250.50, 250.51, 250.52, 250.53, 250.60, 250.61, 250.62, 250.63, 250.70, 250.71, 250.72, 250.73, 250.80, 250.81, 250.82, 250.83, 250.90, 250.91, 250.92, 250.93, 357.2, 362.01, 362.02, 362.03, 362.04, 362.05, 362.06, 362.07, 366.41, 648.00, 648.01, 648.02, 648.03, 648.04
Diagnosis for diabetes (ICD-10-CM) [for use 10/01/2015-12/31/2015]: E10.8, E10.9, E10.10, E10.11, E10.21, E10.22, E10.29, E10.311, E10.319, E10.321, E10.329, E10.331, E10.339, E10.341, E10.349, E10.351, E10.359, E10.36, E10.39, E10.40, E10.41, E10.42, E10.43, E10.44, E10.49, E10.51, E10.52, E10.59, E10.610, E10.618, E10.620, E10.621, E10.622, E10.628, E10.630, E10.638, E10.641, E10.649, E10.65, E10.69, E11.00, E11.01, E11.21, E11.22, E11.29, E11.311, E11.319, E11.321, E11.329, E11.331, E11.339, E11.341, E11.349, E11.351, E11.359, E11.36, E11.39, E11.40, E11.41, E11.42, E11.43, E11.44, E11.49, E11.51, E11.52, E11.59, E11.65, E11.69, E11.610, E11.618, E11.620, E11.621, E11.622, 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

AND

Patient encounter during the reporting period (CPT or HCPCS): 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99217, 99218, 99219, 99220, 99221, 99222, 99223, 99231, 99232, 99233, 99238, 99239, 99281, 99282, 99283, 99284, 99285, 99291, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99315, 99316, 99318, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, G0402, G0438, G0439

NUMERATOR:

Patients who received a foot exam (ie, visual inspection, sensory exam with monofilament **AND** pulse exam) during the measurement period

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Foot Exam Performed

***Performance Met:* G9226:**	Foot examination performed (includes examination through visual inspection, sensory exam with monofilament, and pulse exam – report when **all** of the 3 components are completed)

OR

Foot Exam not Performed, Reason not Given

***Performance Not Met:* G9225:**	Foot exam was **not** performed, reason not given

RATIONALE:

Diabetes mellitus (diabetes) is a group of diseases characterized by high blood glucose levels caused by the body's inability to correctly produce or utilize the hormone insulin. It is recognized as a leading cause of death and disability in the U.S. and is highly underreported as a cause of death. Diabetes may cause life-threatening, life-ending or life-altering complications, including poor circulation, nerve damage or neuropathy in the feet and eventual amputation. Nearly 60-70 percent of diabetics suffer from mild or severe nervous system damage. The consensus among established clinical guidelines is that patients with diabetes should have a foot exam soon after diagnosis and annually thereafter. Comprehensive foot care programs can lower amputation rates by 45-85 percent (American Diabetes Association 2009).

CLINICAL RECOMMENDATION STATEMENTS:

American Diabetes Association (2009) Guidelines/ Recommendations: Perform annual comprehensive foot examination to identify risk factors predictive of ulcers and amputations. The foot examination should include inspection, assessment of foot pulses, and testing for loss of protective sensation (10-g monofilament plus testing any one of: vibration using 128-Hz tuning fork, pinprick sensation, ankle reflexes, or vibration perception threshold).

Ω Measure #164 (NQF 0129): Coronary Artery Bypass Graft (CABG): Prolonged Intubation – National Quality Strategy Domain: Effective Clinical Care

2015 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

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

INSTRUCTIONS:
This measure is to be reported **each time** an isolated CABG procedure is performed during the reporting period. It is anticipated that **clinicians who provide services for isolated CABG** will submit this measure. This measure is intended to reflect the quality of surgical services provided for isolated CABG or isolated reoperation CABG patients. Isolated CABG refers to CABG using arterial and/or venous grafts only.

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

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

DENOMINATOR:
All patients undergoing isolated CABG surgery

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

OR

Patient encounter during the reporting period (CPT): 33510, 33511, 33512, 33513, 33514, 33516, 33517, 33518, 33519, 33521, 33522, 33523, 33533, 33534, 33535, 33536
AND
Patient encounter during the reporting period (CPT): 33530

NUMERATOR:
Patients undergoing isolated CABG who require intubation > 24 hours following exit from the operating room

Numerator Instructions: A lower calculated performance rate for this measure indicates better clinical care or control.

Numerator Options:

Performance Met:	Prolonged postoperative intubation (> 24 hrs) required **(G8569)**
OR	
Performance Not Met:	Prolonged postoperative intubation (> 24 hrs) **not** required **(G8570)**

RATIONALE:
Based on the STS coronary artery bypass graft (CABG) study population, the morbidity rate associated with prolonged intubation following CABG is 5.96%. Also, prolonged ventilation (defined as > 24 hours) was an independent predictor for readmission to the ICU following CABG surgery (OR=10.53; CI: 6.18 to 17.91). Shorter ventilation times are linked to high quality of care (ie, reduced in-hospital and operative mortality, as well as better long-term outcomes as compared to prolonged ventilation).

CLINICAL RECOMMENDATION STATEMENTS:
Extubation greater than (>) 24 hours postoperatively is considered a “pulmonary complication”. Patients who were extubated more than 24 hours after surgery had a longer duration of hospital stay and a greater incidence of postoperative complications.

Ω Measure #165 (NQF 0130): Coronary Artery Bypass Graft (CABG): Deep Sternal Wound Infection Rate – National Quality Strategy Domain: Effective Clinical Care

2015 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

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

INSTRUCTIONS:
This measure is to be reported **each time** an isolated CABG procedure is performed during the reporting period. It is anticipated that **clinicians who provide services for isolated CABG** will submit this measure. This measure is intended to reflect the quality of the surgical services provided for isolated CABG or isolated reoperation CABG patients. Isolated CABG refers to CABG using arterial and/or venous grafts only.

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

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

DENOMINATOR:
All patients undergoing isolated CABG surgery

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

OR

Patient encounter during the reporting period (CPT): 33510, 33511, 33512, 33513, 33514, 33516, 33517, 33518, 33519, 33521, 33522, 33523, 33533, 33534, 33535, 33536
AND
Patient encounter during the reporting period (CPT): 33530

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

Numerator Instructions: A lower calculated performance rate for this measure indicates better clinical care or control.

Numerator Options:

Performance Met: Development of deep sternal wound infection/mediastinitis within 30 days postoperatively **(G8571)**

OR

Performance Not Met: No deep sternal wound infection/mediastinitis **(G8572)**

RATIONALE:

The most serious hospital-acquired infection associated with coronary artery bypass graft (CABG) surgery is deep sternal wound or deep surgical site infection. The most common bacteria involved are *S. aureus* including increasingly more common methicillin resistant *Staph* (MRS). For CABG only outcomes 1997-1999 the STS dataset reported 0.63% deep sternal wound infection rate in 503,478 records. A report from an academic hospital reported 1.9% deep surgical site infections (Centers for Disease Control and Prevention National Nosocomial Infection Surveillance [CDC NNIS] criteria) in 1,980 patients undergoing isolated CABG or CABG+ procedures from 1996-1999. The Northern New England Cardiovascular Disease Study Group reported an incidence rate for mediastinitis of 1.25% and noted a marked increase in mortality during the first year post-CABG and a threefold increase during a 4-year follow-up period.

CLINICAL RECOMMENDATION STATEMENTS:

Several risk factors for sternal wound infection have been identified that can be optimized with good care practices: prophylactic antibiotics within 1 hour before incision time (odds ratio 5.3) [see antibiotic timing process measure] and avoiding elevated blood glucose levels (odds ratio 10.2). Surveillance for surgical site infections is a critical hospital function to monitor infection control practices and direct improvement activity.

Ω Measure #166 (NQF 0131): Coronary Artery Bypass Graft (CABG): Stroke – National Quality Strategy Domain: Effective Clinical Care

2015 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

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

INSTRUCTIONS:
This measure is to be reported **each time** an isolated CABG procedure is performed during the reporting period. It is anticipated that **clinicians who provide services for isolated CABG** will submit this measure. This measure is intended to reflect the quality of surgical services provided for isolated CABG or isolated reoperation CABG patients. Isolated CABG refers to CABG using arterial and/or venous grafts only.

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

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

DENOMINATOR:
All patients undergoing isolated CABG surgery

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

OR

Patient encounter during the reporting period (CPT): 33510, 33511, 33512, 33513, 33514, 33516, 33517, 33518, 33519, 33521, 33522, 33523, 33533, 33534, 33535, 33536
AND
Patient encounter during the reporting period (CPT): 33530

NUMERATOR:
Patients undergoing isolated CABG surgery who have a postoperative stroke (ie, 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: A lower calculated performance rate for this measure indicates better clinical care or control.

Numerator Options:
Performance Met: Stroke following isolated CABG surgery **(G8573)**

OR

Performance Not Met: No stroke following isolated CABG surgery **(G8574)**

RATIONALE:
Stroke is a devastating complication after coronary bypass surgery. The 1999 American College of Cardiology/American Heart Association (ACC/AHA) guidelines indicate that adverse cerebral outcomes are observed in ~6% of patients after bypass surgery equally divided between 2 types:

1) associated with major, focal neurological defects, stupor or coma and 2) evidence of deterioration in intellectual function. Type 1 deficits occur in ~3% of patients and are responsible for 21% mortality.

Reports in the literature on postoperative stroke incidence are difficult to compare because the conditions included in the term “stroke” vary. A standardized definition of stoke will provide common language to compare stroke incidence and evaluate management strategies for reducing this devastating complication.

Reported rates of postoperative cerebral dysfunction range from 0.4% to 13.8% following coronary operations. Complications for patients undergoing emergent CABG or valve surgery were greater than the complication rate for patients undergoing elective CABG or valve surgery. As bypass times increased, so did the incidence of stroke. When bypass time was 90 to 113 minutes, OR =1.59, p=0.022 and when bypass time was > 114 minutes, the OR =2.59, p < 0.001. Outcomes are better when patient age is younger and with beating-heart surgery rather than on-pump surgery.

CLINICAL RECOMMENDATION STATEMENTS:
The 1999 ACC/AHA guidelines describe strategies for reducing the risk of postoperative stroke such as an aggressive approach to the management of patients with severely diseased ascending aortas identified by intraoperative echocardiographic imaging, prevention or aggressive management of postoperative atrial fibrillation, delay of bypass surgery in the case of a left ventricular mural thrombus or a recent, preoperative CVA and preoperative carotid screening. Patients should carefully be screened for cerebrovascular disease to help prevent stroke and its associated morbidities.

Use of beta-adrenergic antagonists was associated with a lower incidence of stroke in patients undergoing elective CABG (OR=0.45; 95% CI 0.23 to 0.83; p=0.016). Use of antiplatelet agents within 48 hours of surgery is associated with a decreased risk of stroke (OR=0.51, p=0.01). Increased use of beating-heart surgery without cardiopulmonary bypass may lead to a lower prevalence of stroke following cardiac surgery and thus improve patient outcomes.

Ω Measure #167 (NQF 0114): Coronary Artery Bypass Graft (CABG): Postoperative Renal Failure – National Quality Strategy Domain: Effective Clinical Care

2015 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

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

INSTRUCTIONS:
This measure is to be reported **each time** an isolated CABG procedure is performed during the reporting period. It is anticipated that **clinicians who provide services for isolated CABG** will submit this measure. This measure is intended to reflect the quality of surgical services provided for isolated CABG or isolated reoperation CABG patients. Isolated CABG refers to CABG using arterial and/or venous grafts only.

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

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

DENOMINATOR:
All patients undergoing isolated CABG surgery

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

OR

Patient encounter during the reporting period (CPT): 33510, 33511, 33512, 33513, 33514, 33516, 33517, 33518, 33519, 33521, 33522, 33523, 33533, 33534, 33535, 33536
AND
Patient encounter during the reporting period (CPT): 33530

WITHOUT
Documented history of renal failure or baseline serum creatinine ≥ 4.0 mg/dL; renal transplant recipients are not considered to have preoperative renal failure, unless, since transplantation the Cr has been or is 4.0 or higher

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 (acute rise must be at least 0.5 mg/dL), or 2) a new requirement for dialysis postoperatively)

Numerator Instructions: A lower calculated performance rate for this measure indicates better clinical care or control.

Numerator Options:

Performance Met: Developed postoperative renal failure or required dialysis **(G8575)**

OR

Performance Not Met: No postoperative renal failure/dialysis not required **(G8576)**

RATIONALE:

In 2000, coronary artery bypass graft (CABG) surgery was performed on more than 350,000 patients at a cost of close to $20 billion. Some degree of Acute Renal Dysfunction (ARD) occurs in about 8% of patients following CABG, and dialysis-dependent renal failure occurs in 0.7% to 3.5% of patients receiving CABG. The latter is associated with substantial increases in morbidity, length of stay, and mortality (odds ratios for mortality range from 15 to 27). ARD is associated with increased morbidity, mortality and length of stay in an ICU following surgery. In addition, Acute Renal Failure occurs in 1.5% of patients undergoing any type of cardiac surgery. There has been a substantial increase in postoperative morbidity, mortality, and cost associated with this relatively common complication, regardless of whether or not this incidence varies much between providers, and there are implications of even a modest decrease in its incidence.

CLINICAL RECOMMENDATION STATEMENTS:

Acute renal failure following CABG is an intermediate outcome measure for mortality since this complication is independently associated (OR=27) with early mortality following cardiac surgery, even after adjustment for co-morbidity and postoperative complications.

Ω Measure #168 (NQF 0115): Coronary Artery Bypass Graft (CABG): Surgical Re-Exploration – National Quality Strategy Domain: Effective Clinical Care

2015 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

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

INSTRUCTIONS:
This measure is to be reported **each time** an isolated CABG procedure is performed during the reporting period. It is anticipated that **clinicians who provide services for isolated CABG** will submit this measure. This measure is intended to reflect the quality of the surgical services provided for isolated CABG or isolated reoperation CABG patients. Isolated CABG refers to CABG using arterial and/or venous grafts only.

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

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

DENOMINATOR:
All patients undergoing isolated CABG surgery

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

OR

Patient encounter during the reporting period (CPT): 33510, 33511, 33512, 33513, 33514, 33516, 33517, 33518, 33519, 33521, 33522, 33523, 33533, 33534, 33535, 33536
AND
Patient encounter during the reporting period (CPT): 33530

NUMERATOR:
Patients undergoing isolated CABG surgery 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: A lower calculated performance rate for this measure indicates better clinical care or control.

Numerator Options:

Performance Met:	Re-exploration required due to mediastinal bleeding with or without tamponade, graft occlusion, valve dysfunction, or other cardiac reason **(G8577)**

OR

Performance Not Met: Re-exploration **not** required due to mediastinal bleeding with or without tamponade, graft occlusion, valve dysfunction, or other cardiac reason **(G8578)**

RATIONALE:

In 2000, coronary artery bypass graft (CABG) surgery was performed on more than 350,000 patients at a cost of close to $20 billion. Re-exploration after surgery is a serious complication that impacts length of stay, efficient use of resources, and increases risk for additional complications and death. As one of several major complications of cardiac surgery, repeat surgery is particularly worrisome for consumers and is an inefficient use of resources.

CLINICAL RECOMMENDATION STATEMENTS:

Re-exploration after surgery is a serious complication that impacts length of stay, efficient use of resources, and increases risk for additional complications and death. This measure is currently in use by approximately 65% of providers in the United States who perform cardiac surgery and report data to the STS National Database.

✦ Measure #172 (NQF 0259): Hemodialysis Vascular Access Decision-Making by Surgeon to Maximize Placement of Autogenous Arterial Venous (AV) Fistula – National Quality Strategy Domain: Effective Clinical Care

2015 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of patients aged 18 years and older with a diagnosis of advanced Chronic Kidney Disease (CKD) (stage 3, 4, or 5) or End Stage Renal Disease (ESRD) requiring hemodialysis vascular access documented by surgeon to have received autogenous AV fistula

INSTRUCTIONS:
This measure is to be reported each time a procedure for hemodialysis access is performed during the reporting period. It is anticipated that **clinicians who perform the listed surgical procedures** as specified in the denominator coding will submit this measure.

Measure Reporting via Claims:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. Quality-data codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed ICD-9-CM/ICD-10-CM diagnosis codes, CPT code, and the appropriate numerator quality-data code. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

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

DENOMINATOR:
All patients with advanced CKD or ESRD who undergo open surgical placement of permanent hemodialysis access

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Diagnosis for stage 3, 4, or 5 CKD or ESRD (ICD-9-CM) [for use 1/1/2015-9/30/2015]: 585.3, 585.4, 585.5, 585.6, 996.73
Diagnosis for stage 3, 4, or 5 CKD or ESRD (ICD-10-CM) [for use 10/01/2015-12/31/2015]: N18.3, N18.4, N18.5, N18.6, T82.818A, T82.828A, T82.838A, T82.848A, T82.858A, T82.868A, T82.898A
AND
Patient encounter during the reporting period (CPT): 36818, 36819, 36820, 36821, 36825, 36830

NUMERATOR:
Patients diagnosed with advanced CKD or ESRD requiring hemodialysis vascular access as documented by the surgeon

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Autogenous AV Fistula Performed

***Performance Met:* G8530:** Autogenous AV fistula received

OR

Autogenous AV Fistula not Performed for Documented Reasons

***Other Performance Exclusion:* G8531:** Clinician documented that patient was not an eligible candidate for autogenous AV fistula

OR

Autogenous AV Fistula not Performed, Reason not Given

***Performance Not Met:* G8532:** Clinician documented that patient received vascular access other than autogenous AV fistula, reason not given

RATIONALE:

AV access complications account for more than 15% of hospital admissions among hemodialysis patients. As the number of patients in need of chronic hemodialysis increases - estimated at 10% per year starting at a base population of 345,000 in 2000 - the cost to the health care system of dialysis access-related complications will increase proportionally.

CLINICAL RECOMMENDATION STATEMENTS:

For the surgeon, the most directly measurable performance parameter is the percentage of autogenous accesses placed as a proportion of the total number of accesses, (autogenous and prosthetic) placed by the particular surgeon.

▲Measure #173: Preventive Care and Screening: Unhealthy Alcohol Use – Screening – National Quality Strategy Domain: Community/Population Health

20154 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

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

INSTRUCTIONS:
This measure is to be reported a minimum of **once per reporting period** for all patients seen during the reporting period. This measure is intended to determine whether or not all patients aged 18 years and older were screened for unhealthy alcohol use within 24 months. There is no diagnosis associated with this measure. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

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

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

DENOMINATOR:
All patients aged 18 years and older

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Patient encounter during the reporting period (CPT or HCPCS): 90791, 90792, 90832, 90834, 90837, 90845, 96150, 96151, 96152, 97003, 97004, 97802, 97803, 97804, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, G0270, G0271, G0438, G0439

NUMERATOR:
Patients who were screened for unhealthy alcohol use at least once within 24 months using a systematic screening method

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.
Systematic Screening Method – A systematic method of assessing for unhealthy alcohol use should be utilized. Systemic screening methods include but are not limited to:

- AUDIT Screening Instrument
- AUDIT-C Screening Instrument
- Single Question Screening

Alternative approaches may also include questions regarding quantity/frequency of consumption (ie, drinks per week or drinks per occasion).

Numerator Options:

Performance Met: Patient screened for unhealthy alcohol use using a systematic screening method **(3016F)**

OR

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

OR

Performance Not Met: Unhealthy alcohol use screening **not** performed, reason not otherwise specified **(3016F *with* 8P)**

RATIONALE:

Screening for unhealthy alcohol use can identify patients whose habits may put them at risk for adverse health outcomes due to their alcohol use. While this measure does not require counseling for those patients to be found at risk, brief counseling interventions for unhealthy alcohol use have shown to be effective in reducing alcohol use. It would be expected that if a provider found their patient to be at risk after screening that intervention would be provided.

A systematic method of assessing for unhealthy alcohol use should be utilized. Please refer to the National Institute on Alcohol Abuse and Alcoholism publication: *Helping Patients Who Drink Too Much: A Clinician's Guide* for additional information regarding systematic screening methods.

CLINICAL RECOMMENDATION STATEMENTS:

The USPSTF recommends that clinicians screen adults aged 18 years or older for alcohol misuse and provide persons engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce alcohol misuse. (B Recommendation) (USPSTF, 2013)

During new patient encounters and at least annually, patients in general and mental healthcare settings should be screened for at-risk drinking, alcohol use problems and illnesses, and any tobacco use. (NQF, 2007)

All patients identified with alcohol use in excess of National Institute on Alcohol Abuse and Alcoholism guidelines and/or any tobacco use should receive brief motivational counseling intervention by a healthcare worker trained in this technique. (NQF, 2007)

⌘Measure #178: Rheumatoid Arthritis (RA): Functional Status Assessment – National Quality Strategy Domain: Effective Clinical Care

2015 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

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

INSTRUCTIONS:
This measure is to be reported a minimum of **once per reporting period** for patients with RA seen during the reporting period. It is anticipated that **clinicians who provide care for patients with a diagnosis of RA** will submit this measure.

Measure Reporting via Registry:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT or HCPCS codes, and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

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

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

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Diagnosis for rheumatoid arthritis (RA) (ICD-9-CM) [for use 1/1/2015-9/30/2015]: 714.0, 714.1, 714.2, 714.81
Diagnosis for rheumatoid arthritis (RA) (ICD-10-CM) [for use 10/01/2015-12/31/2015]: 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, M05.10, 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, M06.80, M06.811, M06.812, M06.819, M06.821, M06.822, M06.829, M06.831, M06.832, M06.839, M06.841, M06.842, M06.849, M06.851, M06.852, M06.859, M06.861, M06.862, M06.869, M06.871, M06.872, M06.879, M06.88, M06.89, M06.9

AND

Patient encounter during the reporting period (CPT or HCPCS): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, G0402

NUMERATOR:

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

Definitions:

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

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

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Functional Status Assessed

Performance Met:	Functional status assessed(**1170F)**

OR

Performance Not Met:	Functional status **not** assessed, reason not otherwise specified (**1170F *with* 8P)**

RATIONALE:

Functional limitations are a significant and disruptive complication for patients living with RA. Assessments of functional limitations are used to assess prognosis and guide treatment and therapy decisions. Functional status should be assessed at the baseline and each follow-up visit, using questionnaires such as the ACR's Classification of Functional Status in RA or the Health Assessment Questionnaire or an assessment of activities of daily living. Regardless of the assessment tool used, it should indicate whether a functional decline is due to inflammation, mechanical damage, or both, as treatment strategies will vary accordingly.

CLINICAL RECOMMENDATION STATEMENTS:

The management of RA is an iterative process, and patients should be periodically reassessed for evidence of disease or limitation of function with significant alteration of joint anatomy. Baseline evaluation of disease activity and damage in patients with rheumatoid arthritis through evaluation of functional status or quality of life assessments using standardized questionnaires, a physician's global assessment of disease activity, or patient's global assessment of disease activity. The initial evaluation of the patient with RA should document symptoms of active disease (ie, presence of joint pain, duration of morning stiffness, degree of fatigue), functional status, objective evidence of disease activity (ie, synovitis, as assessed by tender and swollen joint counts, and the ESR or CRP level), and mechanical joint problems.

At each follow up visit, the physician must assess whether the disease is active or inactive. Symptoms of inflammatory (as contrasted with mechanical) joint disease, which include prolonged morning stiffness, duration of fatigue, and active synovitis on joint examination, indicate active disease and necessitate consideration of changing the treatment program. Occasionally, findings of the joint examination alone may not adequately reflect disease activity and structural damage; therefore, periodic measurements of the ESR or CRP level and functional status, as well as radiographic examinations of involved joints should be performed. It is important to determine whether a decline in function is the result of inflammation, mechanical damage, or both; treatment strategies will differ accordingly. (ACR, 2002)

♠ Measure #181: Elder Maltreatment Screen and Follow-Up Plan – National Quality Strategy Domain: Patient Safety

2015 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of patients aged 65 years and older with a documented elder maltreatment screen using an Elder Maltreatment Screening tool on the date of encounter AND a documented follow-up plan on the date of the positive screen

INSTRUCTIONS:
This measure is to be reported **once during the reporting period** for patients seen during the reporting period. This measure may be reported by eligible professionals who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding at the time of the qualifying visit. The documented follow up plan must be related to positive elder maltreatment screening, example: "Patient referred for protective services due to positive elder maltreatment screening". Cognitively impaired patients are included in the denominator of this measure and need to be screened using an elder maltreatment screening tool.

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

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

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

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

DENOMINATOR:
All patients aged 65 years and older

> **Denominator Criteria (Eligible Cases):**
> Patients aged ≥ 65 years on date of encounter
> **AND**
> **Patient encounter during the reporting period (CPT or HCPCS):** 90791, 90792, 90832, 90834, 90837, 96116, 96150, 96151, 97003, 97802, 97803, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99318, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, G0101, G0270, G0402, G0438, G0439

NUMERATOR:
Patients with a documented elder maltreatment screen using an Elder Maltreatment Screening tool on the date of the encounter and follow-up plan documented on the date of the positive screen

> **Definitions:**
> **Screen for Elder Maltreatment** – An elder maltreatment screen should include assessment and documentation of one or more of the following components: (1) physical abuse, (2) emotional or

psychological abuse, (3) neglect (active or passive), (4) sexual abuse, (5) abandonment, (6) financial or material exploitation and (7) unwarranted control.
Physical Abuse – Infliction of physical injury by punching, beating, kicking, biting, burning, shaking, or other actions that result in harm.
Emotional or Psychological Abuse – Involves psychological abuse, verbal abuse, or mental injury and includes acts or omissions by loved ones or caregivers that have caused or could cause serious behavioral, cognitive, emotional, or mental disorders.
Neglect – Involves attitudes of others or actions caused by others-such as family members, friends, or institutional caregivers-that have an extremely detrimental effect upon well-being.

- **Active** – Behavior that is willful or when the caregiver intentionally withholds care or necessities. The neglect may be motivated by financial gain or reflect interpersonal conflicts.
- **Passive** – Situations where the caregiver is unable to fulfill his or her care giving responsibilities as a result of illness, disability, stress, ignorance, lack of maturity, or lack of resources.

Sexual Abuse –Forcing of undesired sexual behavior by one person upon another against their will who are either competent or unable to fully comprehend and/or give consent. This may also be called molestation.
Elder Abandonment – Desertion of an elderly person by an individual who has assumed responsibility for providing care for an elder, or by a person with physical custody of an elder.
Financial or Material Exploitation – Taking advantage of a person for monetary gain or profit.
Unwarranted Control – Controlling a person's ability to make choices about living situations, household finances, and medical care.

Note: *Self-neglect is a prevalent form of abuse in the elderly population. Screening for self-neglect is not included in this measure. Resources for suspected self-neglect are listed below.*

Follow-Up Plan – Must include a documented report to state or local Adult Protective Services (APS) agency. Note: **APS does not have jurisdiction in all states to investigate maltreatment of patients in long-term care facilities. In those states where APS does not have jurisdiction, APS may refer the provider to another state agency - such as the state facility licensure agency – for appropriate reporting.** *Federal reporting: In addition to state requirements, some types of providers are required by federal law to report suspected maltreatment. For example, nursing facilities certified by Medicare and/or Medicaid are required to report suspected maltreatment to the applicable State Survey and Certification Agency.*
For state-specific information to report suspected elder maltreatment, including self-neglect, the following resources are available:

1) National Adult Protective Services Association - http://www.napsa-now.org/get-help/help-in-your-area/
2) Eldercare Locater - 1-800-677-1116 http://www.eldercare.gov
3) National Center on Elder Abuse

Disclaimer: The follow-up plan recommendations set forth in this quality measure are not intended to supersede any mandatory state, local or federal reporting requirements.

Not Eligible – A patient is not eligible if one or more of the following reasons is documented:

- Patient refuses to participate and has reasonable decisional capacity for self-protection
- Patient is in an urgent or emergent situation where time is of the essence and to delay treatment would jeopardize the patient's health status

NUMERATOR NOTE: *Documentation of an elder maltreatment screening must include identification of the tool used. Examples of screening tools for elder maltreatment include, but are not limited to: Elder Abuse Suspicion Index (EASI), Vulnerability to Abuse Screening Scale (VASS) and Hwalek-Sengstock Elder*

Abuse Screening Test (H-S/EAST). These tools are psychometrically sound instruments with demonstrated reliability and validity indices.

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Elder Maltreatment Screen Documented as Positive AND Follow-Up Plan Documented

*(One quality-data code [**G8733 or G8734**] is required on the claim form to submit this numerator option)*

Performance Met: **G8733:** Elder maltreatment screen documented as positive AND a follow-up plan is documented

OR

Elder Maltreatment Screen Documented as Negative, Follow-Up Plan not Required

Performance Met: **G8734:** Elder maltreatment screen documented as negative, follow-up is not required

OR

Elder Maltreatment Screen not Documented, Patient not Eligible

*(One quality-data code [**G8535 or G8941**] is required on the claim form to submit this numerator option)*

Other Performance Exclusion: **G8535:** Elder maltreatment screen not documented; documentation that patient is not eligible for the elder maltreatment screen

OR

Elder Maltreatment Screen Documented as Positive, Follow-Up Plan not Documented, Patient not Eligible for Follow-Up Plan

Other Performance Exclusion: **G8941:** Elder maltreatment screen documented as positive, follow-up plan not documented, documentation the patient is not eligible for follow-up plan

OR

Elder Maltreatment Screen not Documented, Reason not Given

*(One quality-data code [**G8536 or G8735**] is required on the claim form to submit this numerator option)*

Performance Not Met: **G8536:** No documentation of an elder maltreatment screen, reason not given

OR

Elder Maltreatment Screen Documented as Positive, Follow-Up Plan not Documented, Reason not Given

Performance Not Met: **G8735:** Elder maltreatment screen documented as positive, follow-up plan **not** documented, reason not given

RATIONALE:

The Institute of Medicine and the National Research Council of the National Academies: Elder abuse and its prevention: Workshop summary (2013) reports "The association of elder maltreatment with hospitalizations, hospital admissions, and mortality emphasizes the need to explore and expand appropriate measurement and assessment of maltreatment—across multiple settings and provider types" (Mosqueda & Dong, 2011; Dong et al., 2011d, 2012d; Dong, 2012). Research conducted by Bond and Butler (2013) reports "Elder abuse and neglect is estimated to affect approximately 700,000 to 1.2 million elderly people a year with an estimated annual cost of tens of billions of dollars".

"Most cases of elder abuse go unidentified and unreported (Cohen, 2011, p.261). Elder maltreatment is prevalent and occurs predominantly in the community, not in nursing care facilities. One in ten seniors reported being abused, neglected or exploited in the past twelve months; 5.2% for financial abuse, 4.6% for emotional, 1.6% for physical abuse and 0.6% for sexual abuse. Financial exploitation by family members and by strangers was increased among the more physically disabled adults (Aceirno et al., 2010). Elder Abuse and Neglect: In Search of Solutions (2013), reports that every year an estimated 4 million older Americans are victims of physical, psychological, or other forms of abuse and neglect, and for every reported case there may be as many as 23 unreported. Although less prevalent, patients in nursing homes do experience maltreatment.

There are many complex reasons for underreporting; minimal screening, a lack of knowledge and skills for interventions on the part of health care providers, (Cohen, 2011), a society's belief that family matters should not be discussed outside of the family and 'outsiders' should not interfere in a family matter, shame and embarrassment on the part of the victim, language barriers, and financial or emotional dependence on the abuser (APA, 2013). This lack of identifying victims of elder abuse leads to increased rates of emergency room use (Dong, 2013), hospitalization (Dong & Simon, 2013), morbidity (Cohen, 2011), mortality (Dong, et al., 2009) and admission into a nursing home (Lachs et al., 2011). These outcomes are costly. As cited in Dong and Simon (2011), the Government Accounting Office reported spending $11.9 million dollars in 2009 for all activities related to elder abuse and this amount was not enough to provide basic protection for older adults from abuse, neglect and exploitation. It is clear that additional screening, education of victims and health care providers and financial support is needed in order to unveil the depth of the problem and provide aid those who are being abused and neglected.

CLINICAL RECOMMENDATION STATEMENTS:

The United States Preventive Services Task Force (USPSTF) (2013) concludes that the current evidence is insufficient to assess the balance of benefits and harms of screening all elderly or vulnerable adults (physically or mentally dysfunctional) for abuse and neglect (I statement).

Though the USPSTF does not support elder maltreatment screening, it is important to remember that absence of hard evidence supporting screening is not evidence that it is not effective. There have been many qualitative reports that do support the benefits of screening. Expert consensus and public policy for mandatory reporting support the value of screening this vulnerable population.

Although there is a lack of evidence to support screening of all elderly, there is level I evidence (systematic review of the evidence) to support the use of screening tools for assessing the vulnerable elderly population for mistreatment. There is also a level I evidence for developing guidelines for responding to cases of elder maltreatment for the at risk or abuse population (Careces & Fulmer, 2013). Though this population is not harmonious with the denominator of this measure, those at risk are a subset of the total elder population, therefore these recommendations support the structure of this measure.

♠ Measure #182: Functional Outcome Assessment – National Quality Strategy Domain: Communication and Care Coordination

2015 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of visits for patients aged 18 years and older with documentation of a current functional outcome assessment using a standardized functional outcome assessment tool on the date of the encounter AND documentation of a care plan based on identified functional outcome deficiencies on the date of the identified deficiencies

INSTRUCTIONS:
This measure is to be reported **each visit** for patients seen during the 12 month reporting period. The functional outcome assessment is required to be **current** as defined in the definition section. This measure may be reported by eligible professionals who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

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

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

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

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

DENOMINATOR:
All visits for patients aged 18 years and older

> **Denominator Criteria (Eligible Cases):**
> Patients aged ≥ 18 years on date of encounter
> **AND**
> **Patient encounter during the reporting period (CPT):** 97001, 97002, 97003, 97004, 98940, 98941, 98942

NUMERATOR:
Patients with a documented current functional outcome assessment using a standardized tool AND a documented care plan based on the identified functional outcome deficiencies

> **Numerator Instructions:** Documentation of a current functional outcome assessment must include identification of the standardized tool used.
>
> **Definitions:**
> **Standardized Tool** – A tool that has been normalized and validated. Examples of tools for functional outcome assessment include, but are not limited to: Oswestry Disability Index (ODI), Roland Morris Disability/Activity Questionnaire (RM), Neck Disability Index (NDI), Patient-Reported Outcomes

Measurement Information System (PROMIS), Disabilities of the Arm, Shoulder and Hand (DASH), and Knee Outcome Survey Activities of Daily Living Scale (KOS-ADL).

Note: *A functional outcome assessment is multi-dimensional and quantifies pain and musculoskeletal/neuromusculoskeletal capacity; therefore the use of a standardized tool assessing pain alone, such as the visual analog scale (VAS), does **not** meet the criteria of a functional outcome assessment standardized tool.*

Functional Outcome Assessment – Patient completed questionnaires designed to measure a patient's physical limitations in performing the usual human tasks of living and to directly quantify functional and behavioral symptoms.
Current (Functional Outcome Assessment) – A patient having a documented functional outcome assessment utilizing a standardized tool and a care plan if indicated within the previous 30 days.
Functional Outcome Deficiencies – Impairment or loss of physical function related to musculoskeletal/neuromusculoskeletal capacity, may include but are not limited to: restricted flexion, extension and rotation, back pain, neck pain, pain in the joints of the arms or legs, and headaches.
Care Plan – A care plan is an ordered assembly of expected/planned activities or actionable elements based on identified deficiencies. These may include observations goals, services, appointments and procedures, usually organized in phases or sessions, which have the objective of organizing and managing health care activity for the patient, often focused on one or more of the patient's health care problems. Care plans may also be known as a treatment plan.
Not Eligible – A patient is not eligible if one or more of the following reasons(s) is documented:

- Patient refuses to participate
- Patient unable to complete questionnaire
- 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 intent of this measure is for a functional outcome assessment tool to be utilized at a minimum of every 30 days but reporting is required at each visit due to coding limitations. Therefore, for visits occurring within 30 days of a previously documented functional outcome assessment, the numerator quality-data code **G8942** should be used for reporting purposes.*

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Functional Outcome Assessment Documented as Positive AND Care Plan Documented
*(One quality-data code [**G8539 or G8542 or G8942**] is required on the claim form to submit this numerator option)*

Performance Met: **G8539:**	Functional outcome assessment documented as positive using a standardized tool **AND** a care plan based, on identified deficiencies on the date of the functional outcome assessment, is documented

OR
Functional Outcome Assessment Documented, No Functional Deficiencies Identified, Care Plan not Required

Performance Met: **G8542:**	Functional outcome assessment using a standardized tool is documented; no functional deficiencies identified, care plan not required

OR
Functional Outcome Assessment Documented AND Care Plan Documented, if Indicated, Within the Previous 30 Days

Performance Met: **G8942:**	Functional outcome assessment using a standardized tool is documented within the previous 30 days and

care plan, based on identified deficiencies on the date of the functional outcome assessment, is documented

OR

Functional Outcome Assessment not Documented, Patient not Eligible
*(One quality-data code [**G8540 or G9227**] is required on the claim form to submit this numerator option)*
Other Performance Exclusion: **G8540:** Functional Outcome Assessment NOT documented as being performed, documentation the patient is not eligible for a functional outcome assessment using a standardized tool

OR

Functional Outcome Assessment Documented, Care Plan not Documented, Patient not Eligible
Other Performance Exclusion: **G9227:** Functional outcome assessment documented, care plan not documented, documentation the patient is not eligible for a care plan

OR

Functional Outcome Assessment not Documented, Reason not Given
*(One quality-data code [**G8541 or G8543**] is required on the claim form to submit this numerator option)*
Performance Not Met: **G8541:** Functional outcome assessment using a standardized tool not documented, reason not given

OR

Functional Outcome Assessment Documented as Positive, Care Plan not Documented, Reason not Given
Performance Not Met: **G8543:** Documentation of a positive functional outcome assessment using a standardized tool; care plan **not** documented, reason not given

RATIONALE:
Standardized outcome assessments, questionnaires or tools are a vital part of evidence-based practice. Despite the recognition of the importance of outcomes assessments, questionnaires and tools, recent evidence suggests their use in clinical practice is limited. Selecting the most appropriate outcomes assessment, questionnaire or tool enhances clinical practice by (1) identifying and quantifying body function and structure limitations; (2) formulating the evaluation, diagnosis, and prognosis; (3) informing the plan of care; and (4) helping to evaluate the success of physical therapy interventions (Potter et al., 2011). "The use of standardized tests and measures early in an episode of care establishes the baseline status of the patient/client, providing a means to quantify change in the patient's/client's functioning. Outcome measures, along with other standardized tests and measures used throughout the episode of care, as part of periodic reexamination, provide information about whether predicted outcomes are being realized" (American Physical Therapy Association (APTA), 2011).

Early in the intervention process, occupational therapists should select outcomes that are valid, reliable, sensitive to change; congruent with client goals and based on their actual or purported ability to predict future outcomes. Outcomes are applied to measure progress and adjust goals and interventions. Results are used to make decisions about future direction of intervention (American Occupational Therapy Association (AOTA), 2014).

"Few outcome measures are routinely used to assess patients with neck pain other than a numeric pain rating scale. A comparison of practice patterns to current evidence suggests overutilization of some measures that have questionable reliability and underutilization of some with better supporting evidence. This practice analysis suggests that there is substantial need to implement more consistent outcome measurement" (MacDermid et al., 2013) (GRADE: Low).

Barriers to use of classification systems and outcome measures were lack of knowledge, too limiting and time. Classification systems are being used for decision-making in physical therapy practice for patients with lower back pain (LBP). Lack of knowledge and training seems to be the main barrier to the use of classification systems in

practice. The Oswestry Disability Index and Numerical Pain Scale were the most commonly used outcome measures. The main barrier to their use was lack of time. Continuing education and reading the literature were identified as important tools to teach evidence-based practice to physical therapists in practice (Davies et al., 2014) (GRADE: Low). Outcome use in occupational therapy indicated that some therapists used both biomechanical and self assessment of function measures in their practice to measure outcomes, but the majority use biomechanical outcomes (Bohnen, 2011).

Musculoskeletal disorders accounted for 6.8% of total Disability-adjusted life years (DALYs) as reported in the Global Burden of Disease Study 2010 (Hoy et al., 2014). Of this large total, low back pain accounted for nearly half, neck pain a fifth, and osteoarthritis about 10% (Murray, 2012). In 2010 the top 15 diseases and risk factors contributing to Disability-adjusted life years (DALYs) are a complex mix of cardiovascular diseases (ischemic heart disease and stroke), musculoskeletal disorder (low back pain, other musculoskeletal disorders, and neck pain), etc. (US Burden of Disease Collaborators, 2013).

In 2010, there were 777 million Years lived with disability (YLDs) from all causes, up from 583 million in 1990. The main contributors to global YLDs were mental and behavioral disorders, musculoskeletal disorders and diabetes or endocrine disorders (Vos et al., 2012). In 2010 the top 8 conditions were the same in 1990 and 2010 for Years lived with disability (YLDs) in the United States: low back pain, major depressive disorder, other musculoskeletal disorders, neck pain, anxiety disorders and diabetes (US Burden of Disease Collaborators, 2013).

One in two adults reports a musculoskeletal condition requiring medical attention. Annual direct and indirect costs for bone and joint health are 950 billion – 7.4% of the gross domestic product. Musculoskeletal disorders and diseases are the leading cause of disability in the United States. Between 1996-1998 and 2004-2006, the number of persons reporting a musculoskeletal disease increased nearly 14 million from 76 million reported in 1996. For the years 2004-2006 the sum of the direct expenditures in health care costs and indirect expenditures in lost wages has been estimated to be $950 billion dollars annually, or 7.4% of the national gross domestic product (Bone and Joint Initiative USA, 2011). Musculoskeletal disorder (MSD) cases (388,060) accounted for 34 percent of all injury and illness cases in 2012. Both the incidence rate and case count remained statistically unchanged from the previous year; however the median days away from work increased by 1 day to a median of 12 days (Bureau of Labor and Statistics, 2013).

Neck Pain is ranked as the 4th greatest contributor to global disability (Hoy et al., 2014). “The annual prevalence of nonspecific neck pain is estimated to range between 30% and 50%. Persistent or recurrent neck pain continues to be reported by 50% to 85% of patients 1 to 5 years after initial onset. Its course is usually episodic, and complete recovery is uncommon for most patients. Twenty-seven percent of patients seeking chiropractic treatment report neck or cervical problems (Bryans et al., 2014)”. “Neck disorders can cause pain and impairments in: joint motion, sensory function, proprioception, motor function, coordination, posture and balance. These can be associated with functional disability, loss of physical activity, loss of work capacity, psychological distress, and impaired quality of life” (MacDermid et al., 2013).

Low back pain is the leading cause of disability globally and was estimated to be responsible for 83 million years lived with a disability in 2010 (Buchbinder et al., 2013). “The majority of individuals with an episode of acute low back pain improve and return to work within the first two weeks. The probability of recurrence within the first year ranges from 30 to 60%. Most of these recurrences will recover in much the same pattern as the initial event. In as many as one-third of the cases, the initial episode of low back pain persists for the next year. Most of these individuals continue to function with only limited impairment” (ICSI, 2012). “ Low back pain symptoms peak between the ages of 40 and 69, are higher among females than males in all age groups, and are more common in affluent countries with high-income. Acute or chronic, LBP can lead to notable functional limitations and disability” (Learman et al., 2014).

“Most of the total cost for low back pain is dedicated to the small percentage of sufferers whose condition has progressed to the chronic disabling stage (pain for more than 12 weeks). The medical costs for low back pain in general were estimated at $26.3 billion in 1998 and now are one-third to one-fourth of the total cost of care. Lost production and disability account for other costs. Disability alone claims 80% of the total expense of this condition.

Expenditures for medical care and disability continue to increase. The human cost is equally significant; low back pain is currently the second most common cause of disability in the United States and is the most common cause of disability in those under age 45 *(Centers for Disease Control and Prevention, 2009)*" (ICSI, 2012).

"Visits to primary care clinicians for low back pain are equally split between chiropractors and allopathic clinicians, with low back pain the fifth most common reason for an office visit to all clinicians. The majority of these visits are not because of pain but rather due to the disability associated with the low back symptoms" (ICSI, 2012).

"Arthritis is considered the leading cause of disability among adults in the United States today and contributes substantially to the rising cost of health care. According to recent results from the 2007 to 2009 National Health Interview Survey, just over 20% of adults have been physician diagnosed with arthritis, and this estimate is projected to reach 25% of adults, or 67 million by 2030. Affected most is the growing aging population that currently represents about 13% of the total US population, with this figure expected to increase over the next 2 decades to 19%, or 72 million persons. In rural (nonmetropolitan) areas, the elderly, approximately 15% of the rural population or 7.5 million persons, are especially affected, with evidence suggesting that these individuals experience higher rates of arthritis and comorbid conditions, poorer health status, greater poverty, and less access to medical care. Total attributable costs for arthritis in 2003 were US $128 billion, with direct costs estimated at $81 billion and indirect costs at $47 billion. In addition, arthritis accounted for 3% of all hospitalizations and 5% of all ambulatory care visits in 2004 related to a primary diagnosis of arthritis. Costs related to pharmaceutical use for arthritis were estimated at more than $75 billion in 2003 compared with $33 billion in 1997" (Enyinnaya et al., 2012).

"Osteoarthritis (OA) is the most frequently diagnosed form of arthritis among the elderly and contributes substantially to their associated disability" (Enyinnaya et al., 2012). "Knee OA affects 28% of adults older than 45 years and 37% of adults older than 65 years in the United States. Osteoarthritis is a leading cause of disability among noninstitutionalized adults" (Wang et al., 2012).

Average expense per episode of ambulatory physical therapy was $1184 with an average of 9.6 visits (Machlin et al., 2011). Physical activity limitations are associated with worse economic outcomes across multiple economic metrics (Dall et al., 2013). Inflation-adjusted biennial expenditures on ambulatory services for chronic back pain increased by 129% over the same period, from $15.6 billion in 2000 to 2001 to $35.7 billion in 2006-2007 (Smith et al., 2013).

CLINICAL RECOMMENDATION STATEMENTS:

As a category, functional outcome assessments of everyday tasks are very suitable for evaluating treatment of dysfunctions of the neuromusculoskeletal system. Many questionnaires could be used; choice should depend upon the validity, reliability, responsiveness, and practicality demonstrated in the scientific literature. Functional questionnaires seek to directly quantify symptoms, function and behavior, rather than draw inferences from relevant physiological tests. Clinicians contemplating the use of functional instruments should be aware of differences between questionnaires and choose the most appropriate assessment tool for the specific purpose (Haldeman et al., 2005) (Evidence Class: I, II, III, Consensus Level: 1). Utilization of validated pain and function scales help to differentiate treatment approaches in order to improve the patient's ability to function (ICSI, 2012).

Outcome measures/standardized assessments are used by physical therapists to evaluate patient response to therapeutic interventions. In a 2006 Centers for Medicare & Medicaid Services report, *Uniform Patient Assessment for Post-Acute Care,* the Division of Health Care Policy and Research recommended there is a role for uniform outcome assessments to determine long term function for patients leaving the acute care hospital.

Clinicians should use validated functional outcome measures, such as the Disabilities of the Arm, Shoulder and Hand (DASH), the American Shoulder and Elbow Surgeons shoulder scale (ASES), or the Shoulder Pain and Disability Index (SPPADI). These should be utilized before and after interventions intended to alleviate the impairments of body function and structure, activity limitations, and participation restrictions associated with adhesive capsulitis (Kelley et al., 2013) (Guideline).

Clinicians should use validated self-report questionnaires, such as the Oswestry Disability Index and the Roland-Morris Disability Questionnaire. These tools are useful for identifying a patient's baseline status relative to pain, function, and disability and for monitoring a change in a patient's status throughout the course of treatment (Delitto et al., 2012) (Guideline).

"The Oswestry Disability Questionnaire is used to assess the patient's subjective rating of perceived disability related to his or her functional limitations, eg,work status, difficulty caring for oneself. The higher the score, the more perceived the disability. Using this test at the initial visit helps the examiner understand the patient's perception of how his or her back pain is affecting his or her life. There are two ways that this test aids in the treatment of back pain. A higher score is indicative of the need for more intensive treatment such as spinal manipulative therapy and education to help the patient understand the low likelihood of disability related to back pain. Understanding the low likelihood helps prevent the fear of disability from becoming a barrier to improvement. People with higher disability should be managed more aggressively, with a heightened sense of urgency to avoid the negative aspect of prolonged pain and disability. The use of anticipatory guidance and early return to work with appropriate restrictions are important aspects. By tracking these scores, improvement can be documented and monitored" (Goertz et al., 2012) (Guideline).

Tracking the outcomes of an implementation program is critical to evaluating its benefit to patients. (Kramer et al., 2013) Understanding the clinical course of a condition can help assessment of individual patient outcomes by providing a meaningful point of reference with which to compare an individual patient's progress (Leaver et al., 2013).

The Council on Chiropractic Education (2012) recommended keeping appropriate records of the patient's evaluation and case management needs to aptly respond to changes in patient status, or failure of the patient to respond to care. The Institute of Medicine's (2012) *Living Well with Chronic Illness: A Call for Public Health Action* stated the surveillance systems need to be improved to assess health-related quality of life and functional status of patients. Federal and state governments should expand surveillance systems which can be used to inform the planning, development, implementation, and evaluation of public health policies, programs and interventions relevant to individuals with chronic illness.

% Measure #185 (NQF 0659): Colonoscopy Interval for Patients with a History of Adenomatous Polyps – Avoidance of Inappropriate Use – National Quality Strategy Domain: Communication and Care Coordination

2015 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of patients aged 18 years and older receiving a surveillance colonoscopy, with a history of a prior adenomatous polyp(s) in previous colonoscopy findings, which had an interval of 3 or more years since their last colonoscopy

INSTRUCTIONS:
This measure is to be reported **each time** a surveillance colonoscopy is performed during the reporting period. It is anticipated the **clinician who performs the listed procedures**, as specified in the denominator coding, will report on this measure. Patients who have a coded colonoscopy procedure that has a modifier 52, 53, 73 or 74 will not qualify for inclusion into this measure.

Measure Reporting via Claims:
ICD-9-CM/ICD-10-CM diagnosis code, CPT or HCPCS codes, and patient demographics are used to identify patients who are included in the measure's denominator. CPT Category II codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed ICD-9-CM/ICD-10-CM diagnosis code, CPT or HCPCS codes, and the appropriate CPT Category II codes **OR** the CPT Category II code(s) **with** the modifier. The modifiers allowed for this measure are: 1P- medical reasons, 3P- system reasons, 8P- reason not otherwise specified. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
ICD-9-CM/ICD-10-CM diagnosis code, CPT or HCPCS codes and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

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

DENOMINATOR:
All patients aged 18 years and older receiving a surveillance colonoscopy, with a history of a prior adenomatous polyp(s) in previous colonoscopy findings

> **Denominator Instructions:** Clinicians who indicate that the colonoscopy procedure is incomplete or was discontinued should use the procedure number and the addition (as appropriate) of modifier 52, 53, 73, or 74. Patients who have a coded colonoscopy procedure that has a modifier 52, 53, 73, or 74 will **not** qualify for inclusion into this measure.
>
> **Denominator Criteria (Eligible Cases):**
> Patients aged ≥ 18 years on date of encounter
> **AND**
> **Diagnosis for history of adenomatous (colonic) polyp(s) (ICD-9-CM) [for use 1/1/2015-9/30/2015]:**
> V12.72
> **Diagnosis for history of adenomatous (colonic) polyp(s) (ICD-10-CM) [for use 10/01/2015-12/31/2015]:**
> Z86.010

AND
Patient encounter during the reporting period (CPT or HCPCS): 44388, 44389, 44392, 44394, 45378, 45380, 45381, 45384, 45385, G0105
WITHOUT
CPT Category I Modifiers: 52, 53, 73 or 74

NUMERATOR:
Patients who had an interval of 3 or more years since their last colonoscopy

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Interval of Three or More Years Since Patient's Last Colonoscopy
***Performance Met:* CPT II 0529F:** Interval of 3 or more years since patient's last colonoscopy, documented

OR

Interval of Less Than Three Years Since Patient's Last Colonoscopy for Medical or System Reasons
Append a modifier (**1P or 3P**) to CPT Category II code **0529F** to report documented circumstances that appropriately exclude patients from the denominator.
***Medical Performance Exclusion:* 0529F *with* 1P:** Documentation of medical reason(s) for an interval of less than 3 years since the last colonoscopy (eg, last colonoscopy incomplete, last colonoscopy had inadequate prep, piecemeal removal of adenomas, last colonoscopy found greater than 10 adenomas, or patient at high risk for colon cancer [Crohn's disease, ulcerative colitis, lower gastrointestinal bleeding, personal or family history of colon cancer])
***System Performance Exclusion:* 0529F *with* 3P:** Documentation of system reason(s) for an interval of less than 3 years since the last colonoscopy (eg, unable to locate previous colonoscopy report, previous colonoscopy report was incomplete)

OR

Interval of Less Than Three Years Since Patient's Last Colonoscopy, Reason not Otherwise Specified
Append a reporting modifier (**8P**) to CPT Category II code **0529F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.
***Performance Not Met:* 0529F *with* 8P:** Interval of less than 3 years since patient's last colonoscopy, reason not otherwise specified

RATIONALE:
Colorectal cancer is the 2nd leading cause of cancer death in the United States. Colonoscopy is the recommended method of surveillance after the removal of adenomatous polyps because it has been shown to significantly reduce subsequent colorectal cancer incidence. The time interval for the development of malignant changes in adenomatous polyps is estimated at 5 to 25 years. (ICSI, 2006) Inappropriate interval recommendations can result in overuse of resources and can lead to significant patient harm. Performing colonoscopy too often not only increases patients' exposure to procedural harm, but also drains resources that could be more effectively used to adequately screen those in need. (Lieberman et al, 2009)

CLINICAL RECOMMENDATION STATEMENTS:
Patients with only 1 or 2 small (< 1 cm) tubular adenomas with only low-grade dysplasia should have their next follow-up colonoscopy in 5–10 years; the precise timing within this interval should be based on other clinical factors (such as prior colonoscopy findings, family history, and the preferences of the patient and judgment of the physician). Patients with 3 to 10 adenomas, or any adenoma ≥ 1 cm, or any adenoma with villous features, or high-grade

dysplasia should have their next follow-up colonoscopy in 3 years providing that piecemeal removal has not been performed and the adenoma(s) are removed completely; if the follow-up colonoscopy is normal or shows only 1 or 2 small tubular adenomas with low-grade dysplasia, then the interval for the subsequent examination should be 5 years. (Winawer, et al, 2006)

Patients with > 10 adenomas are thought to be at particularly high risk, and current multi-society guidelines therefore recommend early surveillance colonoscopy in these individuals (< 3 years). (Lieberman, et al, 2012) However, it is important to note that risk is a continuum; an individual with 11 adenomas is not at dramatically higher risk than an individual with 9 or 10 adenomas. Thus, the optimal threshold at which early surveillance colonoscopy becomes worthwhile is subject to debate. For instance, in the United Kingdom, early surveillance colonoscopy is recommended for individuals with even fewer adenomas (≥ 5 adenomas of any size, or ≥ 3 adenomas with at least one large adenoma). A lower threshold is likely to result in higher colonoscopy utilization, but it may also provide greater clinical benefit. (Martinez, et al, 2012)

○Measure #187: Stroke and Stroke Rehabilitation: Thrombolytic Therapy – National Quality Strategy Domain: Effective Clinical Care

2015 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Percentage of patients aged 18 years and older with a diagnosis of acute ischemic stroke who arrive at the hospital within two hours of time last known well and for whom IV t-PA was initiated within three hours of time last known well

INSTRUCTIONS:
This measure is to be reported for **each episode** of acute ischemic stroke for patients who arrive at the hospital within two hours of time last known well and for whom IV t-PA was initiated within three hours of time last known well. It is anticipated that **clinicians providing care for patients with acute ischemic stroke in the hospital setting** will submit this measure.

Measure Reporting via Registry:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

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

DENOMINATOR:
All patients aged 18 years and older with a diagnosis of acute ischemic stroke whose time of arrival is within two hours (≤ 120 minutes) of time last known well

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter.
AND
Diagnosis for ischemic stroke (ICD-9-CM) [for use 1/1/2015-9/30/2015]: 433.01, 433.10, 433.11, 433.21, 433.31, 433.81, 433.91, 434.00, 434.01, 434.11, 434.91, 436
Diagnosis for ischemic stroke (ICD-10-CM) [for use 10/01/2015-12/31/2015]: I63.111, I63.112, I63.119, I63.139, I63.19, I63.20, I63.219, I63.22, I63.231, I63.232, I63.239, I63.30, I63.40, I63.50, I63.59, I65.29, I66.02, I66.03, I66.09, I66.19, I66.29
AND
Patient encounter during reporting period (CPT):99218, 99219, 99220, 99221, 99222, 99223, 99224, 99225, 99226, 99231, 99232, 99233, 99281, 99282, 99283, 99284, 99285, 99291
AND
Time last known well to arrival in the emergency department less than or equal to two hours (≤ 120 minutes)

NUMERATOR:
Patients for whom IV thrombolytic therapy was initiated at the hospital within three hours (≤ 180 minutes) of time last known well

Definition:
Last Known Well – The date and time prior to hospital arrival at which it was witnessed or reported that the patient was last known to be without the signs and symptoms of the current stroke or at his or her baseline state of health.

Numerator Options:

Performance Met: IV t-PA initiated within three hours (≤ 180 minutes) of time last known well **(G8600)**

OR

Other Performance Exclusion: IV t-PA not initiated within three hours (≤ 180 minutes) of time last known well for reasons documented by clinician (eg, patient enrolled in clinical trial for stroke, patient admitted for elective carotid intervention) **(G8601)**

OR

Performance Not Met: IV t-PA **not** initiated within three hours (≤ 180 minutes) of time last known well, reason not given **(G8602)**

RATIONALE:

The administration of thrombolytic agents to carefully screened, eligible patients with acute ischemic stroke has been shown to be beneficial in several clinical trials. These included two positive randomized controlled trials in the United States; The National Institute of Neurological Disorders and Stroke (NINDS) Studies, Part I and Part II. Based on the results of these studies, the Food and Drug Administration approved the use of intravenous recombinant tissue plasminogen activator (IV r-TPA or t-PA) for the treatment of acute ischemic stroke when given within 3 hours of stroke symptom onset. A large meta-analysis controlling for factors associated with stroke outcome confirmed the benefit of IV t-PA in patients treated within 3 hours of symptom onset. While controversy still exists among some specialists, the major society practice guidelines developed in the United States all recommend the use of IV t-PA for eligible patients. Physicians with experience and skill in stroke management and the interpretation of CT scans should supervise treatment.

CLINICAL RECOMMENDATION STATEMENTS:

Intravenous r-TPA (0.9 mg/kg, maximum dose 90 mg) is recommended for selected patients who may be treated within 3 hours of onset of ischemic stroke (Class 1, Level of Evidence A) (AHA/ASA).

For eligible patients (see inclusion and exclusion criteria listed below), we recommend administration of IV t-PA in a dose of 0.9 mg/kg (maximum of 90 mg), with 10% of the total dose given as an initial bolus and the remainder infused over 60 min, provided that treatment is initiated within 3 hours of clearly defined symptom onset (Class 1, Grade 1A) (ACP).

*Measure #191 (NQF 0565): Cataracts: 20/40 or Better Visual Acuity within 90 Days Following Cataract Surgery – National Quality Strategy Domain: Effective Clinical Care

2015 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

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

INSTRUCTIONS:
This measure is to be calculated **each time** a procedure for uncomplicated cataracts is performed during the reporting period. This measure is intended to reflect the quality of **services provided for the patients receiving uncomplicated cataract surgery**.

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

- *For patients who receive the cataract surgical procedures specified in the denominator coding, it should be reported whether or not the patient had best-corrected visual acuity of 20/40 or better achieved within 90 days following cataract surgery.*
- *Patients who have any of the listed significant ocular conditions [comorbid] 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 30th** of the reporting period. This will allow the post-operative period to occur within the reporting year.*

Measure Reporting via Registry:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes and patient demographics are used to determine patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

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

DENOMINATOR:
All patients aged 18 years and older who had cataract surgery and no significant ocular conditions impacting the visual outcome of surgery

> **Denominator Instructions:** Clinicians who indicate modifier 55, postoperative management only OR modifier 56, preoperative management only, will **not** qualify for this measure.
>
> **Denominator Criteria (Eligible Cases):**
> Patients aged ≥ 18 years on date of encounter
> **AND**
> **Patient encounter during the reporting period (CPT):** 66840, 66850, 66852, 66920, 66930, 66940, 66982, 66983, 66984
> **AND NOT**
> **Any of the following significant ocular conditions that impact the visual outcome of surgery**

(Patients with documentation of any of the following significant ocular conditions that impact the visual outcome of surgery prior to date of cataract surgery are excluded from the measure calculation)

Significant Ocular Condition	Corresponding ICD-9-CM Codes [for use 1/1/2015-9/30/2015]
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 Disorders366.32, 366.33Central Corneal Ulcer	370.03
Certain Types of Iridocyclitis	364.21, 364.22, 364.23, 364.24, 364.3
Choroidal Degenerations	363.43
Choroidal Detachment	363.72
Choroidal Hemorrhage and Rupture	363.61, 363.62, 363.63
Chorioretinal Scars	363.30, 363.31, 363.32, 363.33, 363.35
Chronic Iridocyclitis	364.10, 364.11
Cloudy Cornea	371.01, 371.02, 371.03, 371.04
Corneal Opacity and Other Disorders of Cornea	371.00, 371.03, 371.04
Corneal Edema	371.20, 371.21, 371.22, 371.23, 371.43, 371.44
Degeneration of Macula and Posterior Pole	362.50, 362.51, 362.52, 362.53, 362.54, 362.55, 362.56, 362.57
Degenerative Disorders of Globe	360.20, 360.21, 360.23, 360.24, 360.29
Diabetic Macular Edema	362.07
Diabetic Retinopathy	362.01, 362.02, 362.03, 362.04, 362.05, 362.06
Disorders of Optic Chiasm	377.51, 377.52, 377.53, 377.54
Disorders of Visual Cortex	377.75
Disseminated Chorioretinitis and Disseminated Retinochoroiditis	363.10, 363.11, 363.12, 363.13, 363.14, 363.15
Focal Chorioretinitis and Focal Retinochoroiditis	363.00, 363.01, 363.03, 363.04, 363.05, 363.06, 363.07, 363.08
Glaucoma	365.10, 365.11, 365.12, 365.13, 365.14, 365.15, 365.20, 365.21, 365.22, 365.23, 365.24, 365.31, 365.32, 365.51, 365.52, 365.59, 365.60, 365.61, 365.62, 365.63, 365.64, 365.65, 365.81, 365.82, 365.83, 365.89
Glaucoma Associated with Congenital Anomalies, Dystrophies, and Systemic Syndromes	365.41, 365.42, 365.43, 365.44, 365.60, 365.61, 365.62, 365.63, 365.64, 365.65, 365.81, 365.82, 365.83, 365.89, 365.9
Hereditary Choroidal Dystrophies	363.50, 363.51, 363.52, 363.53, 363.54, 363.55, 363.56, 363.57
Hereditary Corneal Dystrophies	371.50, 371.51, 371.52, 371.53, 371.54, 371.55, 371.56, 371.57, 371.58
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

Significant Ocular Condition	Corresponding ICD-9-CM Codes [for use 1/1/2015-9/30/2015]
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

Significant Ocular Condition	Corresponding ICD-10-CM Codes [for use 10/01/2015-12/31/2015]
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

Significant Ocular Condition	Corresponding ICD-10-CM Codes [for use 10/01/2015-12/31/2015]
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, H44.311, H44.312, H44.313, H44.319, H44.321, H44.322, H44.323, H44.329, H44.391, H44.392, H44.393, H44.399
Diabetic Macular Edema	E08.311, E08.321, E08.331, E08.341, E08.351, E09.311, E09.321, E09.331, E09.341, E09.351, E10.311, E10.321, E10.331, E10.341, E10.351, E11.311, E11.321, E11.331, E11.341, E11.351, E13.311, E13.321, E13.331, E13.341, E13.351
Diabetic Retinopathy	E08.311, E08.319, E08.321, E08.329, E08.331, E08.339, E08.341, E08.349, E08.351, E08.359, E09.311, E09.319, E09.321, E09.329, E09.331, E09.339, E09.341, E09.349, E09.351, E09.359, E10.311, E10.319, E10.321, E10.329, E10.331, E10.339, E10.341, E10.349, E10.351, E10.359, E11.311, E11.319, E11.321, E11.329, E11.331, E11.339, E11.341, E11.349, E11.351, E11.359, E13.311, E13.319, E13.321, E13.329, E13.331, E13.339, E13.341, E13.349, E13.351, E13.359
Disorders of Optic Chiasm	H47.41, H47.42, H47.43, H47.49
Disorders of Visual Cortex	H47.611, H47.612, H47.619
Disseminated Chorioretinitis and Disseminated Retinochoroiditis	A18.53, H30.101, H30.102, H30.103, H30.109, H30.111, H30.112, H30.113, H30.119, H30.121, H30.122, H30.123, H30.129, H30.131, H30.132, H30.133, H30.139, H30.141, H30.142, H30.143, H30.149
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

Significant Ocular Condition	Corresponding ICD-10-CM Codes [for use 10/01/2015-12/31/2015]
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, H40.1410, H40.1411, H40.1412, H40.1413, H40.1414, H40.1420, H40.1421, H40.1422, H40.1423, H40.1424, H40.1430, H40.1431, H40.1432, H40.1433, H40.1434, H40.1490, H40.1491, H40.1492, H40.1493, H40.1494, H40.151, H40.152, H40.153, H40.159, 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
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 Choroidal Dystrophies	H31.20, H31.21, H31.22, H31.23, H31.29
Hereditary Corneal Dystrophies	H18.50, H18.51, H18.52, H18.53, H18.54, H18.55, H18.59

Significant Ocular Condition	Corresponding ICD-10-CM Codes [for use 10/01/2015-12/31/2015]
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
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, H35.82, H35.89
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

Significant Ocular Condition	Corresponding ICD-10-CM Codes [for use 10/01/2015-12/31/2015]
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:

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

OR

Performance Not Met: 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)**

RATIONALE:

1) Scientific basis for measuring visual acuity outcomes after cataract surgery
   The only reason to perform cataract surgery (other than for a limited set of medical indications) is to improve a patient's vision and associated functioning. The use of a 20/40 visual acuity threshold is based on several considerations. First, it is the level for unrestricted operation of a motor vehicle in the US. Second, it has been consistently used by the FDA in its assessment for approval of intraocular lens (IOL) and other vision devices. Third, it is the literature standard to denote success in cataract surgery. Fourth, work by West et al in the Salisbury Eye Study suggests that 20/40 is a useful threshold for 50th percentile functioning for several vision-related tasks.
   Most patients achieve excellent visual acuity after cataract surgery (20/40 or better). This outcome is achieved consistently through careful attention through the accurate measurement of axial length and corneal power and the appropriate selection of an IOL power calculation formula. As such, it reflects the care and diligence with which the surgery is assessed, planned and executed. Failure to achieve this after surgery in eyes without comorbid ocular conditions that would impact the success of the surgery would reflect care that should be assessed for opportunities for improvement.
   The exclusion of patients with other ocular and systemic conditions known to increase the risk of an adverse outcome reflects the findings of the two published prediction rule papers for cataract surgery outcomes, by Mangione et al and Steinberg et al. In both papers, the presence of comorbid glaucoma and macular degeneration negatively impacted the likelihood of successful outcomes of surgery. Further, as noted in the prior indicator, exclusion of eyes with ocular conditions that could impact the success of the surgery would NOT eliminate the large majority of eyes undergoing surgery while also minimizing the potential adverse selection that might otherwise occur relative to those patients with the most complex situations who might benefit the most from having surgery to maximize their remaining vision.

2) Evidence of a gap in care

This is an outcome of surgery indicator of direct relevance to patients and referring providers. The available evidence suggests that cataract surgery achieves this in between 86 and 98% of surgeries in eyes without comorbid ocular conditions (this indicator). While small, the volume of cataract surgery in the US of over 2.8 million surgeries suggests that the impact could affect more than 100,000 patients per year. Because of the exclusion of comorbid ocular conditions, one would expect performance on this indicator to be as high as possible, with significantly lower rates suggestive of opportunities for improvement.

The ASCRS National Cataract Database reported that at 3 months postoperatively, 85.5% of all patients had a 20/40 or better best-corrected visual acuity, 57.2% of patients had 20/25 or better postoperative best-corrected visual acuity, and 74.6% of patients were within ± 1.0 D of target spherical equivalent. Based on 5,788 responses, the mean visual function index score at 3 months postoperatively was 70.3% compared with 55.0% preoperatively. (The score is based on a scale of 0 to 100, with 0 indicating an inability to perform any of the activities.) The European Cataract Outcome Study reported for 1999 that 89% of patients achieved a postoperative visual acuity of 0.5 or more (20/40 or better), the average induced astigmatism was 0.59 D, and 86% of patients had an induced astigmatism within ± 1.0 D.

The AAO National Eyecare Outcomes Network (NEON) database also found similar rates of success, with an improvement in visual acuity in 92.2% of patients and improvement in VF-14 in over 90% of patients. Best-corrected visual acuity (BCVA) of 20/40 was achieved by 89% of all NEON patients and 96% of NEON patients without preoperative ocular comorbid conditions. Seventy-eight percent of patients were within ± 1.0 D of target spherical equivalent. Ninety-five percent of patients reported being satisfied with the results of their surgery. Patients who were dissatisfied with the results of their surgery were slightly older and more likely to have ocular comorbidity.

In studies of phacoemulsification cataract surgery performed by ophthalmology residents, the reported range of patients with postoperative BCVA of 20/40 or better is 80% to 91%. If eyes with ocular comorbidities are excluded, the reported range of patients with postoperative BCVA of 20/40 or better is 86% to 98%. (AAO, 2011)

CLINICAL RECOMMENDATION STATEMENTS:

This is an outcome measure. As such, there is no statement in the guideline specific to this measurement topic.

*Measure #192 (NQF 0564): Cataracts: Complications within 30 Days Following Cataract Surgery Requiring Additional Surgical Procedures – National Quality Strategy Domain: Patient Safety

2015 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

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

INSTRUCTIONS:
This measure is to be calculated **each time** a procedure for non-complicated cataracts is performed during the reporting period. This measure is intended to reflect the quality of **services provided for the patients receiving uncomplicated cataract surgery**.

Note: This is an outcome 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 significant ocular conditions in the exclusion criteria should be removed from the denominator, and not considered as having a complication within 30 days following cataract surgery.*

Measure Reporting via Registry:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes and patient demographics are used to determine patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

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

DENOMINATOR:
All patients aged 18 years and older who had cataract surgery and no significant ocular conditions impacting the surgical complication rate

> **Denominator Instructions:** Clinicians who indicate modifier 55, postoperative management only OR modifier 56, preoperative management only, will **not** qualify for this measure.
>
> **Denominator Criteria (Eligible Cases):**
> Patients aged ≥ 18 years on date of encounter
> **AND**
> **Patient encounter during the reporting period (CPT):** 66840, 66850, 66852, 66920, 66930, 66940, 66982, 66983, 66984
> **AND NOT**
> **Any of the following significant ocular conditions that impact the visual outcome of surgery**
>
> *(Patients with documentation of one or more of the following significant ocular conditions prior to date of cataract surgery are excluded from the measure calculation)*

Significant Ocular Condition	Corresponding ICD-9-CM Codes [for use 1/1/2015-9/30/2015]
Acute and Subacute Iridocyclitis	364.00, 364.01, 364.02, 364.03, 364.04, 364.05
Adhesions and Disruptions of Iris and Ciliary Body	364.70, 364.71, 364.72, 364.73, 364.74, 364.75, 364.76, 364.77, 364.81, 364.82, 364.89
Anomalies of Pupillary Function	379.42
Aphakia and Other Disorders of Lens	379.32, 379.33, 379.34
Burn Confined to Eye and Adnexa	940.0, 940.1, 940.2, 940.3, 940.4, 940.5, 940.9
Cataract Secondary to Ocular Disorders	366.32, 366.33
Cataract, Congenital	743.30
Cataract, Mature or Hypermature	366.9
Cataract, Posterior Polar	743.31
Central Corneal Ulcer	370.03
Certain Types of Iridocyclitis	364.21, 364.22, 364.23, 364.24, 364.3
Chronic Iridocyclitis	364.10, 364.11
Cloudy Cornea	371.01, 371.02, 371.03, 371.04
Corneal Opacity and Other Disorders of Cornea	371.00, 371.03, 371.04
Corneal Edema	371.20, 371.21, 371.22, 371.23, 371.43, 371.44
Cysts of Iris, Ciliary Body, and Anterior Chamber	364.60, 364.61, 364.62, 364.63, 364.64
Enophthalmos	376.50, 376.51, 376.52
Glaucoma	365.10, 365.11, 365.12, 365.13, 365.14, 365.15, 365.20, 365.21, 365.22, 365.23, 365.24, 365.31, 365.32, 365.51, 365.52, 365.59, 365.60, 365.61, 365.62, 365.63, 365.64, 365.65, 365.81, 365.82, 365.83, 365.89
Hereditary Corneal Dystrophies	371.50, 371.51, 371.52, 371.53, 371.54, 371.55, 371.56, 371.57, 371.58
High Hyperopia	367.0
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

Significant Ocular Condition	Corresponding ICD-10-CM Codes [for use 10/01/2015-12/31/2015]
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 Pupillary Function	H57.03
Aphakia and Other Disorders of Lens	H27.10, H27.111, H27.112, H27.113, H27.119, H27.121, H27.122, H27.123, H27.129, H27.131, H27.132, H27.133, H27.139
Burn Confined to Eye and Adnexa	T26.00XA, T26.01XA, T26.02XA, T26.10XA, T26.11XA, T26.12XA, T26.20XA, T26.21XA, T26.22XA, T26.30XA, T26.31XA, T26.32XA, T26.40XA, T26.41XA, T26.42XA, T26.50XA, T26.51XA, T26.52XA, T26.60XA, T26.61XA, T26.62XA, T26.70XA, T26.71XA, T26.72XA, T26.80XA, T26.81XA, T26.82XA, T26.90XA, T26.91XA, T26.92XA
Cataract Secondary to Ocular Disorders	H26.211, H26.212, H26.213, H26.219, H26.221, H26.222, H26.223, H26.229
Cataract, Congenital	Q12.0
Cataract, Mature or Hypermature	H26.9
Cataract, Posterior Polar	Q12.0
Central Corneal Ulcer	H16.011, H16.012, H16.013, H16.019
Certain Types of Iridocyclitis	H20.20, H20.21, H20.22, H20.23, H20.811, H20.812, H20.813, H20.819, H20.821, H20.822, H20.823, H20.829, H20.9, H40.40X0
Chronic Iridocyclitis	A18.54, H20.10, H20.11, H20.12, H20.13, H20.9
Cloudy Cornea	H17.00, H17.01, H17.02, H17.03, H17.10, H17.11, H17.12, H17.13, H17.811, H17.812, H17.813, H17.819, H17.821, H17.822, H17.823, H17.829
Corneal Opacity and Other Disorders of Cornea	H17.00, H17.01, H17.02, H17.03, H17.10, H17.11, H17.12, H17.13, H17.89, H17.9
Corneal Edema	H18.10, H18.11, H18.12, H18.13, H18.20, H18.221, H18.222, H18.223, H18.229, H18.231, H18.232, H18.233, H18.239, H18.421, H18.422, H18.423, H18.429, H18.43
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

Significant Ocular Condition	Corresponding ICD-10-CM Codes [for use 10/01/2015-12/31/2015]
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, H40.1410, H40.1411, H40.1412, H40.1413, H40.1414, H40.1420, H40.1421, H40.1422, H40.1423, H40.1424, H40.1430, H40.1431, H40.1432, H40.1433, H40.1434, H40.1490, H40.1491, H40.1492, H40.1493, H40.1494, H40.151, H40.152, H40.153, H40.159, 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
Hypotony of Eye	H44.40, H44.411, H44.412, H44.413, H44.419, H44.421, H44.422, H44.423, H44.429, H44.431, H44.432, H44.433, H44.439, H44.441, H44.442, H44.443, H44.449
Injury to Optic Nerve and Pathways	S04.011A, S04.012A, S04.019A, S04.02XA, S04.031A, S04.032A, S04.039A, S04.041A, S04.042A, S04.049A
Open Wound of Eyeball	S05.10XA, S05.11XA, S05.12XA, S05.20XA, S05.21XA, S05.22XA, S05.30XA, S05.31XA, S05.32XA, S05.50XA, S05.51XA, S05.52XA, S05.60XA, S05.61XA, S05.62XA, S05.70XA, S05.71XA, S05.72XA, S05.8X1A, S05.8X2A, S05.8X9A, S05.90XA, S05.91XA, S05.92XA
Pathologic Myopia	H44.20, H44.21, H44.22, H44.23, H44.30
Posterior Lenticonus	Q12.2, Q12.4, Q12.8

Significant Ocular Condition	Corresponding ICD-10-CM Codes [for use 10/01/2015-12/31/2015]
Prior Pars Plana Vitrectomy	67036, 67039, 67040, 67041, 67042, 67043 (patient with history of this procedure)
Pseudoexfoliation Syndrome	H40.1410, H40.1411, H40.1412, H40.1413, H40.1414, H40.1420, H40.1421, H40.1422, H40.1423, H40.1424, H40.1430, H40.1431, H40.1432, H40.1433, H40.1434, H40.1490, H40.1491, H40.1492, H40.1493, H40.1494
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 (eg, retained nuclear fragments, endophthalmitis, dislocated or wrong power IOL, retinal detachment, or wound dehiscence): 65235, 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: *A lower calculated performance rate for this measure indicates better clinical care or control.*

Numerator Options:

Performance Met: Surgical procedure performed within 30 days following cataract surgery for major complications (eg, retained nuclear fragments, endophthalmitis, dislocated or wrong power IOL, retinal detachment or wound dehiscence) **(G8627)**

OR

Performance Not Met: Surgical procedure **not** performed within 30 days following cataract surgery for major complications (eg, retained nuclear fragments, endophthalmitis, dislocated or wrong power IOL, retinal detachment or wound dehiscence) **(G8628)**

RATIONALE:
1) Scientific basis for assessing short-term complications following cataract surgery

Complications that may result in a permanent loss of vision following cataract surgery are uncommon. This short-term outcome of surgery indicator seeks to identify those complications from surgery that can reasonably be attributed to the surgery and surgeon and which reflect situations which - if untreated - generally result in significant avoidable vision loss that would negatively impact patient functioning. Further, it seeks to reduce surgeon burden and enhance accuracy in reporting by focusing on those significant complications that can be assessed from administrative data alone and which can be captured by the care of another physician or the provision of additional, separately coded, post-operative services. Finally, it focuses on patient safety and monitoring for events that, while hopefully uncommon, can signify important issues in the care being provided. For example, the need to reposition or exchange an intraocular lens (IOL) reflects in part "wrong power" IOL placement, a major patient safety issue.

In order to achieve these ends, the indicator excludes patients with other known, pre-operative ocular conditions that could impact the likelihood of developing a complication. Based on the results of the Cataract Appropriateness Project at RAND, other published studies, and one analysis performed on a national MCO data base, the exclusion codes would preserve over 2/3 of all cataract surgery cases for analysis. Thus, this provides a "clean" indicator that captures care for the large majority of patients undergoing cataract surgery.

2) Evidence for gap in care

The advances in technology and surgical skills over the last 30 years have made cataract surgery much safer and more effective. An analysis of a single company's database (commercial age MCO) demonstrated that the rate of complications found for this indicator was approximately 1 to 2%. Nevertheless, as noted above, the occurrence of one of these events is associated with a significant potential for vision loss that is otherwise avoidable. Furthermore, with an annual volume of 2.8 million cataract surgeries in the US, a 2% rate would mean that over 36,000 surgeries are accompanied by these complications (2/3 of 56,000 surgeries).

A synthesis of the literature published prior to 1992 found weighted mean complication rates among all patients undergoing cataract surgery of 0.13% for endophthalmitis, 0.3% for bullous keratopathy, 1.4% clinically detectable CME, 3.5% for angiographically demonstrated CME, 0.7% for retinal detachment, and 1.1% for IOL dislocation. Bullous keratopathy and CME are not included in this indicator because they are conditions that are almost always temporary and resolve without additional intervention through additional procedures and associated care in this population of patients without prior known ocular conditions.

Additional studies similarly demonstrate the low occurrence of complications, including many that are temporary in nature and without a significant impact on patient outcomes. A national survey of over 100 hospitals from 1997 to 1998 found the following results on 18,454 patients 50 years old or older. Seventy-seven percent of these patients had surgery performed by phacoemulsification. Rates for events that occurred during surgery were 4.4% for posterior capsule rupture and vitreous loss, 1.0% for incomplete cortical cleanup, 1.0% for anterior chamber hemorrhage and or collapse, and 0.77% for iris damage. Short-term (within 48 hours) perioperative complications included corneal edema (9.5%), increased IOP (7.9%), uveitis (5.6%), wound leak (1.2%), hyphema (1.1%), and retained lens material (1.1%).

A retrospective study from New Zealand of 1,793 consecutive patients undergoing phacoemulsification reported a rate of 1.8% for posterior capsule rupture and a rate of 1.2% for rhegmatogenous retinal detachment. (AAO, 2006)

CLINICAL RECOMMENDATION STATEMENTS:

This is an outcome measure. As such, there are no statements in the guideline specific to this measurement topic.

Measure #193 (NQF 0454): Perioperative Temperature Management – National Quality Strategy Domain: Patient Safety

2015 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of patients, regardless of age, undergoing surgical or therapeutic procedures under general or neuraxial anesthesia of 60 minutes duration or longer, except patients undergoing cardiopulmonary bypass, for whom *either* active warming was used intraoperatively for the purpose of maintaining normothermia, OR at least one body temperature equal to or greater than 36 degrees Centigrade (or 96.8 degrees Fahrenheit) was recorded within the 30 minutes immediately before or the 15 minutes immediately after anesthesia end time

INSTRUCTIONS:
This measure is to be reported **each time** a surgical or therapeutic procedure not involving cardiopulmonary bypass is performed under general or neuraxial anesthesia during the reporting period. There is no diagnosis associated with this measure. It is anticipated that **clinicians who provide the listed anesthesia services** as specified in the denominator coding will submit this measure.

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

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

Measure Reporting via Registry:
CPT codes are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

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

DENOMINATOR:
All patients, regardless of age, undergoing surgical or therapeutic procedures under general or neuraxial anesthesia of 60 minutes duration or longer, except patients undergoing cardiopulmonary bypass

Denominator Criteria (Eligible Cases):
Patient encounter during the reporting period (CPT): Patient encounter during the reporting period (CPT): Anesthesia codes for surgical or therapeutic procedures under general or neuraxial anesthesia: 00100, 00102, 00103, 00104, 00120, 00124, 00126, 00140, 00142, 00144, 00145, 00147, 00148, 00160, 00162, 00164, 00170, 00172, 00174, 00176, 00190, 00192, 00210, 00211, 00212, 00214, 00215, 00216, 00218, 00220, 00222, 00300, 00320, 00322, 00326, 00350, 00352, 00400, 00402, 00404, 00406, 00410, 00450, 00454, 00470, 00472, 00474, 00500, 00520, 00522, 00524, 00528, 00529, 00530, 00532, 00534, 00537, 00539, 00540, 00541, 00542, 00546, 00548, 00550, 00560, 00566, 00580, 00600, 00604, 00620, 00625, 00626, 00630, 00632, 00635, 00640, 00670, 00700, 00702, 00730, 00740, 00750, 00752, 00754, 00756, 00770, 00790, 00792, 00794, 00796, 00797, 00800, 00802, 00810, 00820, 00830, 00832, 00834, 00836, 00840, 00842, 00844, 00846, 00848, 00851, 00860, 00862, 00864, 00865, 00866, 00868, 00870, 00872, 00873, 00880, 00882, 00902, 00904, 00906, 00908, 00910, 00912, 00914, 00916, 00918, 00920, 00921, 00922, 00924, 00926, 00928, 00930, 00932, 00934, 00936, 00938, 00940, 00942, 00944, 00948,

00950, 00952, 01112, 01120, 01130, 01140, 01150, 01160, 01170, 01173, 01180, 01190, 01200, 01202, 01210, 01212, 01214, 01215, 01220, 01230, 01232, 01234, 01250, 01260, 01270, 01272, 01274, 01320, 01340, 01360, 01380, 01382, 01390, 01392, 01400, 01402, 01404, 01420, 01430, 01432, 01440, 01442, 01444, 01462, 01464, 01470, 01472, 01474, 01480, 01482, 01484, 01486, 01490, 01500, 01502, 01520, 01522, 01610, 01620, 01622, 01630, 01634, 01636, 01638, 01650, 01652, 01654, 01656, 01670, 01680, 01682, 01710, 01712, 01714, 01716, 01730, 01732, 01740, 01742, 01744, 01756, 01758, 01760, 01770, 01772, 01780, 01782, 01810, 01820, 01829, 01830, 01832, 01840, 01842, 01844, 01850, 01852, 01860, 01924, 01925, 01926, 01930, 01931, 01932, 01933, 01935, 01936, 01951, 01952, 01961, 01962, 01963, 01965, 01966, 01968, 01969

NUMERATOR:
Patients for whom *either:*

- Active warming was used intraoperatively for the purpose of maintaining normothermia OR
- At least one body temperature equal to or greater than 36 degrees Centigrade (or 96.8 degrees Fahrenheit) was recorded within the 30 minutes immediately before or the 15 minutes immediately after anesthesia end time

Numerator Instructions: The anesthesia time used for this measure should be the time recorded in the anesthesia record.

Definition:
Active Warming – For purposes of this measure, active warming is limited to over-the-body active warming (eg, forced air, warm-water garments, and resistive heating blankets).

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Active Warming Used Intraoperatively OR At Least One Body Temperature Equal to or Greater than 36 Degrees Centigrade Recorded Within Designated Timeframe
*(Two CPT II codes [**4250F & 4255F**] are required on the claim form to submit this numerator option)*
Performance Met:

CPT II 4250F:	Active warming used intraoperatively for the purpose of maintaining normothermia, OR at least one body temperature equal to or greater than 36 degrees Centigrade (or 96.8 degrees Fahrenheit) recorded within the 30 minutes immediately before or the 15 minutes immediately after anesthesia end time
AND	
CPT II 4255F:	Duration of general or neuraxial anesthesia 60 minutes or longer, as documented in the anesthesia record

OR

Active Warming Not Performed OR at Least One Body Temperature Equal to or Greater than 36 Degrees Centigrade not Achieved Within Designated Timeframe for one of the following Medical Reasons:
*(One CPT II code [**4250F-1P] and one G-code[G9362**] are required on the claim form to submit this numerator option)*
Append a modifier (**1P**) to CPT Category II code **4250F** to report one of the following documented circumstances that appropriately exclude patients from the denominator.
Medical Performance Exclusion:

4250F *with* 1P:	Intentional hypothermia OR active warming not indicated due to anesthetic technique: peripheral nerve block without general anesthesia, OR monitored anesthesia care

AND

G9362: Duration of monitored anesthesia care (MAC) or peripheral nerve block (PNB) without the use of general anesthesia during an applicable procedure 60 minutes or longer, as documented in the anesthesia record

OR

If patient does not meet denominator inclusion because anesthesia time as indicated on the anesthesia record is less than 60 minutes duration

*(One G-code [**G9363**] is required on the claim form to submit this numerator option)*

***Other Performance Exclusion:* G9363:** Duration of monitored anesthesia care (MAC) or peripheral nerve block (PNB) without the use of general anesthesia during an applicable procedure or general or neuraxial anesthesia less than 60 minutes, as documented in the anesthesia record

OR

Active Warming Not Performed OR at Least One Body Temperature Equal to or Greater than 36 Degrees Centigrade Not Achieved Within Designated Timeframe, Reason Not Otherwise Specified

*(Two CPT II codes [**4250F-8P & 4255F**] are required on the claim form to submit this numerator option)*

Append a reporting modifier (**8P**) to CPT Category II code **4250F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

Performance Not Met:

4250F *with* 8P: Active warming **not performed** OR at least one body temperature equal to or greater than 36 degrees Centigrade **not achieved** within designated timeframe, reason not otherwise specified

AND

CPT II 4255F: Duration of general or neuraxial anesthesia 60 minutes or longer, as documented in the anesthesia record

RATIONALE:

Anesthetic-induced impairment of thermoregulatory control is the primary cause of perioperative hypothermia. Even mild hypothermia (1-2°C below normal) has been associated in randomized trials with a number of adverse consequences, including: increased susceptibility to infection, impaired coagulation and increased transfusion requirements, cardiovascular stress and cardiac complications, post-anesthetic shivering and thermal discomfort. Whether the benefits of avoiding hypothermia in patients undergoing cardiopulmonary bypass (CPB) outweigh potential harm is uncertain, because known complications of CPB include cerebral injury, which may be mitigated by mild hypothermia. Therefore, patients undergoing CPB are excluded from the denominator population for this measure. Several methods to maintain normothermia are available to the anesthesiologist in the perioperative period; various studies have demonstrated the superior efficacy of over-the-body active warming (eg, forced air, warm-water garments, and resistive heating blankets).

CLINICAL RECOMMENDATION STATEMENTS:

Preoperative patient management

Assessment: Identify patient's risk factors for unplanned perioperative hypothermia. Measure patient temperature on admission. Determine patient's thermal comfort level (ask the patients if they are cold). Assess for other signs and symptoms of hypothermia (shivering, piloerection, and/or cold extremities).

Interventions: Institute preventive warming measures for patients who are normothermic (normothermia is defined as a core temperature range from 36°C-38°C [96.8°F-100.4°F]). A variety of measures may be used, unless contraindicated. Passive insulation may include warmed cotton blankets, socks, head covering, limited skin

exposure, circulating water mattresses, and increase in ambient room temperature (minimum 68ºF- 75ºF). Institute active warming measures for patients who are hypothermic (defined as a core temperature less than 36°C). Active warming is the application of a forced air convection warming system. Apply appropriate passive insulation and increase the ambient room temperature (minimum 68ºF-75ºF). Consider warmed intravenous (IV) fluids. (ASPAN)

Intraoperative patient management
Assessment: Identify patient's risk factors for unplanned perioperative hypothermia. Determine patient's thermal comfort level (ask the patients if they are cold). Assess for other signs and symptoms of hypothermia (shivering, piloerection, and/or cold extremities). Monitor patient's temperature intraoperatively.

Intervention: Implement warming methods. (ASPAN)

Maintenance of body temperature in a normothermic range is recommended for most procedures other than during periods in which mild hypothermia is intended to provide organ protection (eg, during high aortic cross-clamping). (Class I Recommendation, Level of Evidence B) (ACC/AHA, 2007)

♥ Measure #194 (NQF 0386): Oncology: Cancer Stage Documented – National Quality Strategy Domain: Effective Clinical Care

2015 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Percentage of patients, regardless of age, with a diagnosis of cancer who are seen in the ambulatory setting 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 during the 12 month reporting period

INSTRUCTIONS:
This measure is to be reported a minimum of **once per reporting period** for patients with cancer seen during the reporting period. This measure is limited to cancer diagnoses for which AJCC staging or equivalent is available. This measure is intended to reflect the quality of **services provided for the primary management of patients with cancer who are seen in the ambulatory setting or receiving radiation treatment planning**.

Measure Reporting via Registry:
ICD-9-CM/ICD-10-CM diagnosis codes and CPT codes are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

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

DENOMINATOR:
All patients, regardless of age, with a diagnosis of cancer who are seen in the ambulatory setting

Denominator Criteria (Eligible Cases):
Diagnosis for cancer (ICD-9-CM) [for use 1/1/2015-9/30/2015]: 140.0, 140.1, 140.3, 140.4, 140.5, 140.6, 140.8, 140.9, 141.0, 141.1, 141.2, 141.3, 141.4, 141.5, 141.6, 141.8, 141.9, 142.0, 142.1, 142.2, 142.8, 142.9, 143.0, 143.1, 143.8, 143.9, 144.0, 144.1, 144.8, 144.9, 145.0, 145.1, 145.2, 145.3, 145.4, 145.5, 145.6, 145.8, 145.9, 146.0, 146.1, 146.2, 146.3, 146.4, 146.5, 146.6, 146.7, 146.8, 146.9, 147.0, 147.1, 147.2, 147.3, 147.8, 147.9, 148.0, 148.1, 148.2, 148.3, 148.8, 148.9, 150.0, 150.1, 150.2, 150.3, 150.4, 150.5, 150.8, 150.9, 151.0, 151.1, 151.2, 151.3, 151.4, 151.5, 151.6, 151.8, 151.9, 152.0, 152.1, 152.2, 152.3, 152.8, 152.9, 153.0, 153.1, 153.2, 153.3, 153.4, 153.5, 153.6, 153.7, 153.8, 153.9, 154.0, 154.1, 154.2, 154.3, 154.8, 155.0, 155.1, 155.2, 156.0, 156.1, 156.2, 157.0, 157.1, 157.2, 157.3, 157.4, 157.8, 157.9, 158.0, 158.8, 158.9, 160.0, 160.2, 160.3, 161.0, 161.1, 161.2, 161.3, 161.8, 161.9, 162.2, 162.3, 162.4, 162.5, 162.8, 162.9, 163.0, 163.1, 163.8, 163.9, 164.0, 164.1, 164.2, 164.3, 164.8, 164.9, 170.0, 170.1, 170.2, 170.3, 170.4, 170.5, 170.6, 170.7, 170.8, 170.9, 171.0, 171.2, 171.3, 171.4, 171.5, 171.6, 171.7, 171.8, 171.9, 172.0, 172.1, 172.2, 172.3, 172.4, 172.5, 172.6, 172.7, 172.8, 172.9, 173.00, 173.01, 173.02, 173.09, 173.10, 173.11, 173.12, 173.19, 173.20, 173.21, 173.22, 173.29, 173.30, 173.31, 173.32, 173.39, 173.40, 173.41, 173.42, 173.49, 173.50, 173.51, 173.52, 173.59, 173.60, 173.61, 173.62, 173.69, 173.70, 173.71, 173.72, 173.79, 173.80, 173.81, 173.82, 173.89, 173.90, 173.91, 173.92, 173.99 174.0, 174.1, 174.2, 174.3, 174.4, 174.5, 174.6, 174.8, 174.9, 175.0, 175.9, 179, 180.0, 180.1, 180.8, 180.9, 181, 182.0, 182.1, 182.8, 183.0, 183.2, 184.0, 184.1, 184.2, 184.3,185, 186.0, 187.1, 187.2, 187.3, 187.5, 187.6, 187.7, 188.0, 188.1, 188.2, 188.3, 188.4, 188.5, 188.6, 188.7, 188.8, 188.9, 189.0, 189.1, 189.2, 189.3, 190.1, 190.2, 190.3, 193, 200.20, 200.21, 200.22, 200.23, 200.24, 200.25, 200.26, 200.27, 200.28, 200.30, 200.31, 200.32, 200.33, 200.34, 200.35, 200.36, 200.37, 200.38, 200.40, 200.41, 200.42, 200.43, 200.44, 200.45, 200.46, 200.47, 200.48, 200.50, 200.51, 200.52, 200.53, 200.54, 200.55, 200.56, 200.57, 200.58, 200.60, 200.61, 200.62, 200.63, 200.64, 200.65, 200.66, 200.67, 200.68, 200.70, 200.71, 200.72, 200.73,

200.74, 200.75, 200.76, 200.77, 200.78, 201.00, 201.01, 201.02, 201.03, 201.04, 201.05, 201.06, 201.07, 201.08, 201.10, 201.11, 201.12, 201.13, 201.14, 201.15, 201.16, 201.17, 201.18, 201.20, 201.21, 201.22, 201.23, 201.24, 201.25, 201.26, 201.27, 201.28, 201.40, 201.41, 201.42, 201.43, 201.44, 201.45, 201.46, 201.47, 201.48, 201.50, 201.51, 201.52, 201.53, 201.54, 201.55, 201.56, 201.57, 201.58, 201.60, 201.61, 201.62, 201.63, 201.64, 201.65, 201.66, 201.67, 201.68, 201.70, 201.71, 201.72, 201.73, 201.74, 201.75, 201.76, 201.77, 201.78, 201.90, 201.91, 201.92, 201.93, 201.94, 201.95, 201.96, 201.97, 201.98, 202.00, 202.01, 202.02, 202.03, 202.04, 202.05, 202.06, 202.07, 202.08, 202.10, 202.11, 202.12, 202.13, 202.14, 202.15, 202.16, 202.17, 202.18, 202.20, 202.21, 202.22, 202.23, 202.24, 202.25, 202.26, 202.27, 202.28, 202.70, 202.71, 202.72, 202.73, 202.74, 202.75, 202.76, 202.77, 202.78, 202.80, 202.81, 202.82, 202.83, 202.84, 202.85, 202.86, 202.87, 202.88, 209.00, 209.01, 209.02, 209.03, 209.10, 209.11, 209.12, 209.13, 209.14, 209.15, 209.16, 209.17, 209.20, 209.21, 209.22, 209.23, 209.24, 209.25, 209.26, 209.27, 209.29, 209.30, 209.31, 209.32, 209.33, 209.34, 209.35, 209.36

Diagnosis for cancer (ICD-10-CM) [for use 10/01/2015-12/31/2015]: C00.0, C00.1, C00.2, C00.3, C00.4, C00.5, C00.6, C00.8, C00.9, C01, C02.0, C02.1, C02.2, C02.3, C02.4, C02.8, C02.9, C03.0, C03.1, C03.9, C04.0, C04.1, C04.8, C04.9, C05.0, C05.1, C05.2, C05.8, C05.9, C06.0, C06.1, C06.2, C06.80, C06.89, C06.9, C07, C08.0, C08.1, C08.9, C09.0, C09.1, C09.8, C09.9, C10.0, C10.1, C10.2, C10.3, C10.4, C10.8, C10.9, C11.0, C11.1, C11.2, C11.3, C11.8, C11.9, C12, C13.0, C13.1, C13.2, C13.8, C13.9, C15.3, C15.4, C15.5, C15.8, C15.9, C16.0, C16.1, C16.2, C16.3, C16.4, C16.5, C16.6, C16.8, C16.9, C17.0, C17.1, C17.2, C17.3, C17.8, C17.9, C18.0, C18.1, C18.2, C18.3, C18.4, C18.5, C18.6, C18.7, C18.8, C18.9, C19, C20, C21.0, C21.1, C21.2, C21.8, C22.0, C22.1, C22.2, C22.3, C22.4, C22.7, C22.8, C22.9, C23, C24.0, C24.1, C25.0, C25.1, C25.2, C25.3, C25.4, C25.7, C25.8, C25.9, C30.0, C31.0, C31.1, C32.0, C32.1, C32.2, C32.3, C32.8, C32.9, C34.00, C34.01, C34.02, C34.10, C34.11, C34.12, C34.2, C34.30, C34.31, C34.32, C34.80, C34.81, C34.82, C34.90, C34.91, C34.92, C37, C38.0, C38.1, C38.2, C38.3, C38.4, C38.8, C40.00, C40.01, C40.02, C40.10, C40.11, C40.12, C40.20, C40.21, C40.22, C40.30, C40.31, C40.32, C40.80, C40.81, C40.82, C40.90, C40.91, C40.92, C41.0, C41.1, C41.2, C41.3, C41.4, C41.9, C43.0, C43.10, C43.11, C43.12, C43.20, C43.21, C43.22, C43.30, C43.31, C43.39, C43.4, C43.51, C43.52, C43.59, C43.60, C43.61, C43.62, C43.70, C43.71, C43.72, C43.8, C43.9, C44.00, C44.01, C44.02, C44.09, C44.101, C44.102, C44.109, C44.111, C44.112, C44.119, C44.121, C44.122, C44.129, C44.191, C44.192, C44.199, C44.201, C44.202, C44.209, C44.211, C44.212, C44.219, C44.221, C44.222, C44.229, C44.291, C44.292, C44.299, C44.300, C44.301, C44.309, C44.310, C44.311, C44.319, C44.320, C44.321, C44.329, C44.390, C44.391, C44.399, C44.40, C44.41, C44.42, C44.49, C44.500, C44.501, C44.509, C44.510, C44.511, C44.519, C44.520, C44.521, C44.529, C44.590, C44.591, C44.599, C44.601, C44.602, C44.609, C44.611, C44.612, C44.619, C44.621, C44.622, C44.629, C44.691, C44.692, C44.699, C44.701, C44.702, C44.709, C44.711, C44.712, C44.719, C44.721, C44.722, C44.729, C44.791, C44.792, C44.799, C44.80, C44.81, C44.82, C44.89, C44.90, C44.91, C44.92, C44.99, C45.0, C45.1, C45.2, C47.0, C47.10, C47.11, C47.12, C47.20, C47.21, C47.22, C47.3, C47.4, C47.5, C47.6, C47.8, C47.9, C48.0, C48.1, C48.2, C48.8, C49.0, C49.10, C49.11, C49.12, C49.20, C49.21, C49.22, C49.3, C49.4, C49.5, C49.6, C49.8, C49.9, C4A.0, C4A.10, C4A.11, C4A.12, C4A.20, C4A.21, C4A.22, C4A.30, C4A.31, C4A.39, C4A.4, C4A.51, C4A.52, C4A.59, C4A.60, C4A.61, C4A.62, C4A.70, C4A.71, C4A.72, C4A.8, C4A.9, C50.011, C50.012, C50.019, C50.021, C50.022, C50.029, C50.111, C50.112, C50.119, C50.121, C50.122, C50.129, C50.211, C50.212, C50.219, C50.221, C50.222, C50.229, C50.311, C50.312, C50.319, C50.321, C50.322, C50.329, C50.411, C50.412, C50.419, C50.421, C50.422, C50.429, C50.511, C50.512, C50.519, C50.521, C50.522, C50.529, C50.611, C50.612, C50.619, C50.621, C50.622, C50.629, C50.811, C50.812, C50.819, C50.821, C50.822, C50.829, C50.911, C50.912, C50.919, C50.921, C50.922, C50.929, C51.0, C51.1, C51.2, C52, C53.0, C53.1, C53.8, C53.9, C54.0, C54.1, C54.2, C54.3, C54.8, C54.9, C55, C56.1, C56.2, C56.9, C57.00, C57.01, C57.02, C58, C60.0, C60.1, C60.2, C61, C62.00, C62.01, C62.02, C63.00, C63.01, C63.02, C63.10, C63.11, C63.12, C63.2, C64.1, C64.2, C64.9, C65.1, C65.2, C65.9, C66.1, C66.2, C66.9, C67.0, C67.1, C67.2, C67.3, C67.4, C67.5, C67.6, C67.7, C67.8, C67.9, C68.0, C69.00, C69.01, C69.02, C69.50, C69.51, C69.52, C69.60, C69.61, C69.62, C73, C7A.00, C7A.010, C7A.011, C7A.012, C7A.019, C7A.020, C7A.021, C7A.022, C7A.023, C7A.024, C7A.025, C7A.026, C7A.029, C7A.090, C7A.091, C7A.092, C7A.093, C7A.094, C7A.095, C7A.096, C7A.098, C7A.1, C7A.8, C81.00, C81.01, C81.02, C81.03, C81.04,

C81.05, C81.06, C81.07, C81.08, C81.09, C81.10, C81.11, C81.12, C81.13, C81.14, C81.15, C81.16, C81.17, C81.18, C81.19, C81.20, C81.21, C81.22, C81.23, C81.24, C81.25, C81.26, C81.27, C81.28, C81.29, C81.30, C81.31, C81.32, C81.33, C81.34, C81.35, C81.36, C81.37, C81.38, C81.39, C81.40, C81.41, C81.42, C81.43, C81.44, C81.45, C81.46, C81.47, C81.48, C81.49, C81.70, C81.71, C81.72, C81.73, C81.74, C81.75, C81.76, C81.77, C81.78, C81.79, C81.90, C81.91, C81.92, C81.93, C81.94, C81.95, C81.96, C81.97, C81.98, C81.99, C82.00, C82.01, C82.02, C82.03, C82.04, C82.05, C82.06, C82.07, C82.08, C82.09, C82.10, C82.11, C82.12, C82.13, C82.14, C82.15, C82.16, C82.17, C82.18, C82.19, C82.20, C82.21, C82.22, C82.23, C82.24, C82.25, C82.26, C82.27, C82.28, C82.29, C82.30, C82.31, C82.32, C82.33, C82.34, C82.35, C82.36, C82.37, C82.38, C82.39, C82.40, C82.41, C82.42, C82.43, C82.44, C82.45, C82.46, C82.47, C82.48, C82.49, C82.50, C82.51, C82.52, C82.53, C82.54, C82.55, C82.56, C82.57, C82.58, C82.59, C82.60, C82.61, C82.62, C82.63, C82.64, C82.65, C82.66, C82.67, C82.68, C82.69, C82.80, C82.81, C82.82, C82.83, C82.84, C82.85, C82.86, C82.87, C82.88, C82.89, C82.90, C82.91, C82.92, C82.93, C82.94, C82.95, C82.96, C82.97, C82.98, C82.99, C83.10, C83.11, C83.12, C83.13, C83.14, C83.15, C83.16, C83.17, C83.18, C83.19, C83.31, C83.32, C83.33, C83.34, C83.35, C83.36, C83.37, C83.38, C83.39, C83.70, C83.71, C83.72, C83.73, C83.74, C83.75, C83.76, C83.77, C83.78, C83.79, C83.80, C83.81, C83.82, C83.83, C83.84, C83.85, C83.86, C83.87, C83.88, C83.89, C84.00, C84.01, C84.02, C84.03, C84.04, C84.05, C84.06, C84.07, C84.08, C84.09, C84.10, C84.11, C84.12, C84.13, C84.14, C84.15, C84.16, C84.17, C84.18, C84.19, C84.40, C84.41, C84.42, C84.43, C84.44, C84.45, C84.46, C84.47, C84.48, C84.49, C84.60, C84.61, C84.62, C84.63, C84.64, C84.65, C84.66, C84.67, C84.68, C84.69, C84.70, C84.71, C84.72, C84.73, C84.74, C84.75, C84.76, C84.77, C84.78, C84.79, C84.90, C84.91, C84.92, C84.93, C84.94, C84.95, C84.96, C84.97, C84.98, C84.99, C84.A0, C84.A1, C84.A2, C84.A3, C84.A4, C84.A5, C84.A6, C84.A7, C84.A8, C84.A9, C84.Z0, C84.Z1, C84.Z2, C84.Z3, C84.Z4, C84.Z5, C84.Z6, C84.Z7, C84.Z8, C84.Z9, C85.10, C85.11, C85.12, C85.13, C85.14, C85.15, C85.16, C85.17, C85.18, C85.19, C85.20, C85.21, C85.22, C85.23, C85.24, C85.25, C85.26, C85.27, C85.28, C85.29, C85.80, C85.81, C85.82, C85.83, C85.84, C85.85, C85.86, C85.87, C85.88, C85.89, C85.90, C85.91, C85.92, C85.93, C85.94, C85.95, C85.96, C85.97, C85.98, C85.99, C86.0, C86.1, C86.2, C86.3, C86.4, C88.4, D03.0, D03.10, D03.11, D03.12, D03.20, D03.21, D03.22, D03.30, D03.39, D03.4, D03.51, D03.52, D03.59, D03.60, D03.61, D03.62, D03.70, D03.71, D03.72, D03.8, D03.9

AND

Patient encounter during reporting period (CPT): 77261, 77262, 77263, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215

NUMERATOR:

Patients who have a baseline American Joint Committee on Cancer (AJCC)***** cancer stage****** or documentation that the cancer is metastatic in the medical record at least once during 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 (eg, 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 Options:

Performance Met:	American Joint Committee on Cancer (AJCC) stage documented and reviewed (**3300F)**
OR	
Performance Met:	Cancer stage documented in medical record as metastatic and reviewed **(3301F)**

OR

Performance Not Met: Cancer stage **not** documented, reason not otherwise specified (**3301F *with* 8P)**

RATIONALE:
Cancer stage is a critical component in determining treatment options for patients with cancer. Though critically important, cancer stage is not always documented in the medical record. This measure is intended to be reported at least once per 12 month reporting period.

CLINICAL RECOMMENDATION STATEMENTS:
A simple classification scheme, which can be incorporated into a form for staging and can be universally applied, is the goal of the TNM system as proposed by the [American Joint Committee on Cancer (AJCC).] Thus, examination during the surgical procedure and histologic examination of the surgically removed tissues may identify significant additional indicators of the prognosis of the patient (T, N, and M) as different from what could be discerned clinically before therapy. Because this is that pathologic (pTNM) classification and stage grouping (based on examination of a surgically resected specimen with sufficient tissue to evaluate the highest T, N, or M classification), it is recorded in addition to the clinical classification. It does not replace the clinical classification. Both should be maintained in the patient's permanent medical record…It is intended to provide a means by which this information can readily be communicated to others, to assist in therapeutic decisions, and to help estimate prognosis. (American Joint Committee on Cancer, 2010)

The following represent a sample of guideline recommendation statements supporting the measure for a variety of cancers:

Breast Cancer
All patients with breast cancer should be assigned a clinical stage of disease, and if appropriate evaluation is available, a pathologic stage of disease. The routine use of staging allows for efficient identification of local treatment options, assists in identifying systemic treatment options, allows the comparison of outcome results across institutions and clinical trials, and provides baseline prognostic information….A central component of the treatment of breast cancer is full knowledge of extent of disease and biologic features. These factors contribute to the determination of the stage of disease, assist in the estimation of the risk that cancer will recur, and provide information that predicts response to therapy (eg, hormone receptors and human epidermal growth factor receptor 2 [HER2]). (NCCN, 2011)

Colon Cancer
Some of the criteria that should be included in the report of the pathologic evaluation include the following: grade of the cancer; depth of penetration and extension to adjacent structures (T); number of regional lymph nodes evaluated; number of positive regional lymph nodes (N); an assessment of the presence of distant metastases to other organs, the peritoneum of an abdominal structure, or in non-regional lymph nodes (M); the status of proximal, distal, and radial margins; lymphovascular invasion; perineural invasion; and extra-nodal tumor deposits. (NCCN, 2012)

Measure #195 (NQF 0507): Radiology: Stenosis Measurement in Carotid Imaging Reports – National Quality Strategy Domain: Effective Clinical Care

2015 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of final reports for carotid imaging studies (neck magnetic resonance angiography [MRA], neck computed tomography angiography [CTA], neck duplex ultrasound, carotid angiogram) performed that include direct or indirect reference to measurements of distal internal carotid diameter as the denominator for stenosis measurement

INSTRUCTIONS:
This measure is to be reported **each time** a carotid imaging study is performed during the reporting period for all patients, regardless of age. There is no diagnosis associated with this measure. **Clinicians who provide the professional component of diagnostic imaging studies of the carotids** will submit this measure.

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

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

Measure Reporting via Registry:
CPT codes are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

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

DENOMINATOR:
All final reports for carotid imaging studies (neck MR angiography [MRA], neck CT angiography [CTA], neck duplex ultrasound, carotid angiogram) performed

> **Denominator Criteria (Eligible Cases):**
> **Patient encounter during the reporting period (CPT):** 36222, 70498, 70547, 70548, 70549, 93880, 93882

NUMERATOR:
Final reports for carotid imaging studies that include direct or indirect reference to measurements of distal internal carotid diameter as the denominator for stenosis measurement

> **Numerator Instructions:** This measure requires that the estimate of stenosis included in the report of the imaging study employ a method such as the North American Symptomatic Carotid Endarterectomy Trial (NASCET) method for calculating the degree of stenosis. The NASCET method calculates the degree of stenosis with reference to the lumen of the carotid artery distal to the stenosis.
> For duplex imaging studies the reference is indirect, since the degree of stenosis is inferred from velocity parameters and cross referenced to published or self-generated correlations among velocity parameters and results of angiography or other imaging studies which serve as the gold standard. In Doppler

ultrasound, the degree of stenosis can be estimated using Doppler parameter of the peak systolic velocity (PSV) of the internal carotid artery (ICA), with concordance of the degree of narrowing of the ICA lumen. Additional Doppler parameters of ICA-to-common carotid artery (CCA) PSV ratio and ICA end-diastolic velocity (EDV) can be used when degree of stenosis is uncertain from ICA PSV. (Grant et al, 2003)
A short note can be made in the final report, such as:

- *"Severe left ICA stenosis of 70-80% by NASCET criteria" or*
- *"Severe left ICA stenosis of 70-80% by criteria similar to NASCET" or*
- *"70% stenosis derived by comparing the narrowest segment with the distal luminal diameter as related to the reported measure of arterial narrowing" or*
- *"Severe stenosis of 70-80% - validated velocity measurements with angiographic measurements, velocity criteria are extrapolated from diameter data as defined by the Society of Radiologists in Ultrasound Consensus Conference Radiology 2003; 229;340-346".*

DEFINITION:
"Direct or indirect reference to measurements of distal internal carotid diameter as the denominator for stenosis measurement" – includes direct angiographic stenosis calculation based on the distal lumen as the denominator for stenosis measurement OR an equivalent validated method referenced to the above method (eg, for duplex ultrasound studies, velocity parameters that **correlate** with anatomic measurements that use the distal internal carotid lumen as the denominator for stenosis measurement).

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Reference to Measurements of Distal Internal Carotid Diameter as the Denominator for Stenosis Measurement Referenced
***Performance Met:* CPT II 3100F:** Carotid imaging study report (includes direct or indirect reference to measurements of distal internal carotid diameter as the denominator for stenosis measurement)

OR

Measurements of Distal Internal Carotid Diameter not Referenced, Reason not Otherwise Specified
Append a reporting modifier (**8P**) to CPT Category II code **3100F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.
***Performance Not Met:* 3100F *with* 8P:** Carotid imaging study report did **not** include direct or indirect reference to measurements of distal internal carotid diameter as the denominator for stenosis measurement, reason not otherwise specified

RATIONALE:
Accurate assessment of the degree of carotid artery stenosis is essential to guiding proper treatment decisions for patients with carotid artery disease. Trials have demonstrated the ability of the degree of carotid artery stenosis to predict which patients will receive the greatest benefit from surgical intervention. To ensure accurate assessment of stenosis, it is important to use a standardized, validated approach. Rothwell et al demonstrated significant differences between measurements of stenosis made using different methods of measurement.

CLINICAL RECOMMENDATION STATEMENTS:
The panel recommended that the NASCET method of carotid stenosis measurement should be used when angiography is used to correlate the US findings. (USDSR, 2003)

When MRA techniques are used for determining carotid stenosis, the report should reflect the methodology and reference the criteria for percent stenosis outlined in the NASCET. Also, the percent stenosis must be calculated using the distal cervical ICA diameter, where the walls are parallel, for the denominator. Similar to CTA, MRA with attention to the acquisition parameters and post-processing techniques can provide cross sectional measurements of stenosis that correlate with properly performed NASCET estimates of percent stenosis obtained with catheter

angiography. In the setting of near occlusion, it may not be accurate to calculate percent stenosis ratios in the presence of post-stenotic arterial diameter decrease. Some MRA techniques may not be amenable to quantitative measurements, in which case qualitative assessment of stenosis should be provided. (ACR-ASNR-SNIS-SPR, 2010)

♦ Measure #204 (NQF 0068): Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic – National Quality Strategy Domain: Effective Clinical Care

2015 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of patients 18 years of age and older who were discharged alive for acute myocardial infarction (AMI), coronary artery bypass graft (CABG) or percutaneous coronary interventions (PCI) in the 12 months prior to the measurement period, or who had an active diagnosis of ischemic vascular disease (IVD) during the measurement period, and who had documentation of use of aspirin or another antithrombotic during the measurement period

INSTRUCTIONS:
This measure is to be reported a minimum of **once per reporting period** for patients with IVD seen during the reporting period. The performance period for this measure is 12 months from the date of service. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

Measure Reporting via Claims:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT or HCPCS codes, and patient demographics are used to identify patients who are included in the measure's denominator. Quality-data codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed ICD-9-CM/ICD-10-CM diagnosis codes, CPT or HCPCS codes, and the appropriate quality-data code. There are no allowable performance exclusions for this measure. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT or HCPCS codes, and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

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

DENOMINATOR:
Patients aged 18 years of age and older with the diagnosis of ischemic vascular disease (IVD) during the measurement period, OR who were discharged alive for acute myocardial infarction (AMI), coronary artery bypass graft (CABG) or percutaneous coronary interventions (PCI) in the 12 months prior to the measurement period

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Diagnosis for Ischemic Vascular Disease (ICD-9-CM) [for use 01/1/2015-09/30/2015]: 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, V45.81, V45.82
Diagnosis for Ischemic Vascular Disease (ICD-10-CM) [for use 10/01/2015-12/31/2015]: I20.0, I20.1, I20.8, I20.9, I21.11, I21.19, I21.21, I21.29, 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, Z95.1, Z95.5, Z98.61

OR

Diagnosis for acute myocardial infarction (ICD-9-CM) [for use 01/1/2015-09/30/2015]: 410.01, 410.11, 410.21, 410.31, 410.41, 410.51, 410.61, 410.71, 410.81, 410.91

Diagnosis for acute myocardial infarction (ICD-10-CM) [for use 10/01/2015-12/31/2015]: I21.01, I21.02, I21.09, I21.11, I21.19, I21.21, I21.29, I21.3, I21.4

AND

Patient encounter during reporting period (CPT or HCPCS): 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, G0402

OR

Patient encounter during the reporting period (CPT) – Procedure: 33510, 33511, 33512, 33513, 33514, 33516, 33517, 33518, 33519, 33521, 33522, 33523, 33533, 33534, 33535, 33536, 92920, 92924, 92928, 92933, 92937, 92941, 92943

NUMERATOR:

Patients who have documentation of use of aspirin or another antithrombotic therapy

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

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Aspirin or Another Antithrombotic Therapy Used

Performance Met: **G8598:** Aspirin or another antithrombotic therapy used

OR

Aspirin or Another Antithrombotic Therapy not Used, Reason not Given

Performance Not Met: **G8599:** Aspirin or another antithrombotic therapy **not** used, reason not given

RATIONALE:

Coronary heart disease (CHD) is a major cause of death in the United States – in 2004, it was an underlying or contributing cause of death for 451,300 people (1 of every 5 deaths). Acute myocardial infarction (AMI) was as an underlying or contributing cause of death for 156,000 people (American Heart Association 2008). In addition, nearly 16 million people (or 7.3 percent of the American population) had CHD in 2005 (American Heart Association 2008). The cost of cardiovascular diseases and stroke in the United States for 2008 was estimated at $448.5 billion

(American Heart Association 2008). This figure includes health expenditures (direct costs such as the cost of physicians and healthcare practitioners, hospital and nursing home services, medications, home health care and other medical durables) and lost productivity resulting from morbidity and mortality (indirect costs). AMI accounts for 18 percent of hospital discharges and 28 percent of deaths due to heart disease (National Heart, Lung, and Blood Institute 2000). Research has shown that costs associated with cardiovascular disease for hospitals are easily $156 billion (American Heart Association 2008).

Aspirin treatments reduce MI in men (127 events per 100,000 person-years) and women (17 events per 100,000 person-years) (Grieving et al. 2008). While studies have shown warfarin to be more effective, aspirin is a safer, more convenient, and less expensive form of therapy (Patrono et al. 2004). Aspirin therapy has been shown to directly reduce the odds of cardiovascular events among men by 14 percent and among women by 12 percent (Berger et al. 2006). Aspirin use has been shown to reduce the number of strokes by 20 percent, MI by 30 percent, and other vascular events by 30 percent (Weisman and Graham 2002).

CLINICAL RECOMMENDATION STATEMENTS:

U.S. Preventive Services Task Force (2009):
The U.S. Preventive Services Task Force (USPSTF) strongly recommends that clinicians discuss aspirin chemoprevention with adults who are at increased risk (5-year risk of greater than or equal to 3 percent) for coronary heart disease (CHD). Discussions with patients should address both the potential benefits and harms of aspirin therapy.

The USPSTF found good evidence that aspirin decreases the incidence of coronary heart disease in adults who are at increased risk for heart disease. They also found good evidence that aspirin increases the incidence of gastrointestinal bleeding and fair evidence that aspirin increases the incidence of hemorrhagic strokes. The USPSTF concluded that the balance of benefits and harms is most favorable in patients at high risk of CHD (5-year risk of greater than or equal to 3 percent) but is also influenced by patient preferences.

USPSTF encourages men age 45 to 79 years to use aspirin when the potential benefit of a reduction in myocardial infarctions outweighs the potential harm of an increase in gastrointestinal hemorrhage. They encourage women age 55 to 79 years to use aspirin when the potential benefit of a reduction in ischemic strokes outweighs the potential harm of an increase in gastrointestinal hemorrhage.

American Diabetes Association (2008):
Use aspirin therapy (75-162 mg/day) as a primary prevention strategy in those with type 1 or 2 diabetes at increased cardiovascular risk, including those who are 40 years of age or who have additional risk factors (family history of CVD, hypertension, smoking, dyslipidemia, or albuminuria).

American Heart Association/American Stroke Association (2006):
AHA/ASA: The use of aspirin is recommended for cardiovascular (including but not specific to stroke) prophylaxis among persons whose risk is sufficiently high for the benefits to outweigh the risks associated with treatment (a 10-year risk of cardiovascular events of 6% to 10%).

American College of Clinical Pharmacy (2004):
For long-term treatment after PCI, the guideline developers recommend aspirin, 75 to 162 mg/day. For long-term treatment after PCI in patients who receive antithrombotic agents such as clopidogrel or warfarin, the guideline developers recommend lower-dose aspirin, 75 to 100 mg/day. For patients with ischemic stroke who are not receiving thrombolysis, the guideline developers recommend early aspirin therapy, 160 to 325 mg/day.

❑ Measure #205 (NQF 0409): HIV/AIDS: Sexually Transmitted Disease Screening for Chlamydia, Gonorrhea, and Syphilis – National Quality Strategy Domain: Effective Clinical Care

2015 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

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

INSTRUCTIONS:
This measure is to be reported a minimum of **once per reporting period** for patients with HIV/AIDS seen during the reporting period. Only patients **who had at least two visits** during the reporting period, **with at least 90 days between** each visit will be counted in the denominator for this measure. This measure is intended to reflect the quality of services provided for the **primary management of patients with HIV/AIDS**.

Measure Reporting via Registry:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT or HCPCS codes, and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

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

DENOMINATOR:
Patients aged 13 and older with a diagnosis of HIV/AIDS who had at least two medical visits during the measurement year, with at least 90 days between each visit

Denominator Criteria (Eligible Cases):
Patients aged ≥ 13 years of age on date of encounter
AND
Diagnosis for HIV/AIDS (ICD-9-CM) [for use 1/1/2015-9/30/2015]: 042, V08
Diagnosis for HIV/AIDS (ICD-10-CM) [for use 10/01/2015-12/31/2015]: B20, Z21
AND
Patient encounters during the reporting period (CPT or HCPCS): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, G0402

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

NUMERATOR NOTE: *Report* ***G9228*** *when results are documented for all of the 3 screenings*

Numerator Options:

Performance Met:	Chlamydia, gonorrhea and syphilis screening results documented (report when results are present for **all** of the 3 screenings) **(G9228)**
OR	
Other Performance Exclusion:	Chlamydia, gonorrhea, and syphilis screening results not documented (Patient refusal is the only allowed exclusion) **(G9229)**

OR

Performance Not Met:	Chlamydia, gonorrhea, and syphilis screening results **not** documented as performed, reason not otherwise specified **(G9230)**

RATIONALE:

Sexually transmitted diseases that cause mucosal inflammation (such as gonorrhea and chlamydia) increase the risk for HIV-infection (as these diseases and other sexually transmitted diseases can increase the infectiousness of and a person's susceptibility to HIV) (Galvin, 2004).

CLINICAL RECOMMENDATION STATEMENTS:

All patients should be screened with laboratory tests for STDs at the initial encounter (A-II for syphilis, for trichomoniasis in women, and for chlamydial infection in women aged less than 25 years; B-II for gonorrhea and chlamydial infection in all men and women), and thereafter, depending on reported high-risk behavior, the presence of other STDs, and the prevalence of STDs in the community (B-III). (Aberg, 2004)

Consideration should be given to screening all HIV-infected men and women for gonorrhea and chlamydial infections. However, because of the cost of screening and the variability of prevalence of these infections, decisions about routine screening for these infections should be based on epidemiologic factors (including prevalence of infection in the community or the population being served), availability of tests, and cost. (Some HIV specialists also recommend type-specific serologic testing for herpes simplex virus type 2 for both men and women.) (B-II, for identifying STDs) (CDC, HRSA, NIH, HIVMA of IDSA, 2003)

☾Measure #217 (NQF 0422): Functional Deficit: Change in Risk-Adjusted Functional Status for Patients with Knee Impairments – National Quality Strategy Domain: Communication and Care Coordination

2015 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Percentage of patients aged 18 or older that receive treatment for a functional deficit secondary to a diagnosis that affects the knee in which the change in their Risk-Adjusted Functional Status is measured

INSTRUCTIONS:
This outcomes measure is to be reported **once per treatment episode** for all patients with a functional deficit related to the knee. This is an outcomes measure and its calculation requires reporting of the patient's functional status score, as a minimum, at admission to and again at discharge from an episode of rehabilitation. The admission score, estimated using patient self-report surveys, is recorded during the first rehabilitation treatment encounter and the discharge score is recorded at or near the conclusion of the final rehabilitation treatment encounter. It is anticipated that **physical and occupational therapists providing treatment for functional knee deficits** will report this measure.

Definitions:
Treatment Episode – A Treatment Episode is defined as beginning with an Admission for a functional knee deficit, progressing to development of a plan of care, including treatment, without interruption of care (for example a hospitalization or surgical intervention), and ending with Discharge from clinical care by the Eligible Professional. A patient currently under clinical care for a knee deficit remains in a single episode of care until the Discharge is conducted and documented by the Eligible Professional.
Admission – An Admission is the first encounter for a functional deficit involving the knee and includes an evaluation (CPT 97001 or 97003) and development of a plan of care by the Eligible Professional. A patient presenting with a knee impairment, who has had an interruption of a Treatment Episode for the same functional knee deficit secondary to an appropriate reason like hospitalization or surgical intervention, is a new Admission.
Discharge – Discharge is accompanied by a re-evaluation (CPT 97002 or 97004) or Functional Limitation Reporting Discharge Status G-Code (G8980, G8983, G8986, G8989 or G8992) identifying the close of a Treatment Episode for the same knee deficit identified at admission and documented by a discharge report by the Eligible Professional. An interruption in clinical care for an appropriate reason like hospitalization or surgical intervention requires a discharge from the current Treatment Episode.
Encounter – A face to face visit between the patient and the provider for the purpose of assessing and/or improving a functional deficit.
Patient Reported – The patient directly, or through a proxy, provides answers to functional status survey items using standardized, reliable and valid, computerized adaptive testing or paper and pencil survey methods.

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

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

DENOMINATOR:
All patients aged 18 years and older who receive a treatment episode for a functional deficit related to the knee

Option 1 – Physical Therapy Denominator Criteria (Eligible Cases):
All patients aged ≥ 18 years on date of encounter
AND
Patient encounter during the reporting period identifying evaluation: CPT 97001
AND
Patient encounter during the reporting period identifying discharge: CPT 97002 or Functional Limitation Reporting Discharge Status G-Code G8980, G8983, G8986, G8989 or G8992
AND
Functional deficit affecting knee

OR

Option 2 – Occupational Therapy Denominator Criteria (Eligible Cases):
All patients aged ≥ 18 years on date of encounter
AND
Patient encounter during the reporting period identifying evaluation: CPT 97003
AND
Patient encounter during the reporting period identifying discharge: CPT 97004 or Functional Limitation Reporting Discharge Status G-Code G8980, G8983, G8986, G8989 or G8992
AND
Functional deficit affecting knee

NUMERATOR:
Patients presented FOTO's Functional Intake Survey for the Knee at admission and FOTO's Functional Status Survey at discharge for the purpose of calculating the patient's Risk-adjusted Functional Status Change Residual Score

Definitions:
Patient's Functional Status Score – A functional status score is produced when the patient completes the FOTO functional status survey (either by paper and pencil or computerized adaptive testing administration). The functional status score is continuous and linear. Scores range from 0 (low function) to 100 (high function). The survey is standardized, and the scores are validated for the measurement of function for this population.
Patient's Functional Status Change Score – A functional status change score is calculated by subtracting the Patient's Functional Status Score at Admission from the Patient's Functional Status Score at Discharge.
Predicted Functional Status Change Score – Functional Status Change Scores for patients are risk adjusted using multiple linear regression methods that include the following independent variables: Patient's Functional Status Score at Admission, patient age, symptom acuity, surgical history, gender, number of co-morbidities and level of fear-avoidance. The Patient's Functional Status Change Score is the dependent variable. The statistical regression produces a Risk-Adjusted Predicted Functional Status Change Score.
Risk-Adjusted Functional Status Change Residual Score – The difference between the raw non-risk-adjusted Patient's Functional Status Change Score and the Risk-Adjusted Predicted Functional Status Change Score (raw minus predicted) is the Risk-Adjusted Functional Status Change Residual Score, which is in the same units as the Patient's Functional Status Scores, and should be interpreted as the unit of functional status change different than predicted given the risk-adjustment variables of the patient being treated. As such, the Risk-Adjusted Residual Change Score represents Risk-Adjusted Change corrected for the level of severity of the patient. Risk-Adjusted Residual Change Scores of zero (0) or greater (> 0) should be interpreted as functional status change scores that were predicted or better than predicted given the risk-adjustment variables of the patient and risk-adjusted residual change scores less than zero (< 0) should be interpreted as functional status change scores that were less than predicted given the risk-adjustment variables of the patient. Aggregated Risk-Adjusted Residual Scores allow meaningful comparisons amongst clinicians or clinics.
Not Eligible/Not Appropriate – A patient is **not** eligible if one or more of the following conditions exist:

- Patient refused to participate
- Patient unable to complete the questionnaire due to blindness, illiteracy, severe mental incapacity or language incompatibility and an adequate proxy is not available
- Prior to conclusion of Plan of Care, intervention was interrupted or discontinued for any reason including by the referring physician, the provider, the payer or the patient, and attempts by the provider to complete a follow-up functional status survey near Discharge were unsuccessful.

Numerator Options:

Performance Met: Risk-Adjusted Functional Status Change Residual Score for the knee successfully calculated and the score was equal to zero (0) or greater than zero (> 0) **(G8647)**

OR

Performance Met: Risk-Adjusted Functional Status Change Residual Score for the knee successfully calculated and the score was less than zero (< 0) **(G8648)**

OR

Other Performance Exclusion: Risk-Adjusted Functional Status Change Residual Scores for the knee not measured because the patient did not complete FOTO's Functional Intake on admission and/or follow up Status Survey near discharge, patient Not Eligible/Not Appropriate **(G8649)**

OR

Performance Not Met: Risk-Adjusted Functional Status Change Residual Scores for the knee **not** measured because the patient did **not** complete FOTO's Functional Intake on admission and/or follow up Status Survey near discharge, reason not given **(G8650)**

RATIONALE:

Functional deficits are common in the general population and are costly to the individual, their family and society. Improved functional status has been associated with greater quality of life, self-efficacy, improved financial well-being and lower future medical costs. Improving functional status in people seeking rehabilitation has become a goal of the American Physical Therapy Association. Therefore, measuring change in functional status is important for providers treating patients in rehabilitation and can be used to assess the success of treatment and direct modification of treatment.

Change in functional status represents the activity domain of the International Classification of Function. If treatment is designed to improve the functional deficit, it is logical to assess functional status at discharge using a standardized score to determine if treatment improved the functional status of the patient over the treatment episode.

The National Quality Measures Clearinghouse has approved the measurement of change in functional status, using this survey. (NQMC-1873)

CLINICAL RECOMMENDATION STATEMENTS:

The American Physical Therapy Association (APTA), in their *Guide to Physical Therapy Practice*, described five recommended elements of patient management: examination, evaluation, diagnosis, prognosis and intervention. The elements were intended to direct therapists in their approach to patient treatment for the purpose of optimizing patient outcomes. The APTA clearly identifies functional status data as one of the major forms of data to be collected for patients receiving rehabilitation. The functional status measures should be used to assist in the planning, implementation and modification of treatment interventions and should be used as measures of outcomes. The

current functional status scores can be used by therapists to fulfill the recommended methods of the APTA in the management of patients in rehabilitation.

☾Measure #218 (NQF 0423): Functional Deficit: Change in Risk-Adjusted Functional Status for Patients with Hip Impairments – National Quality Strategy Domain: Communication and Care Coordination

2015 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Percentage of patients aged 18 or older that receive treatment for a functional deficit secondary to a diagnosis that affects the hip in which the change in their Risk-Adjusted Functional Status is measured

INSTRUCTIONS:
This outcomes measure is to be reported **once per treatment episode** for all patients with a functional deficit related to the hip. This is an outcomes measure and its calculation requires reporting of the patient's functional status score, as a minimum, at admission to and again at discharge from an episode of rehabilitation. The admission score, estimated using patient self-report surveys, is recorded during the first rehabilitation treatment encounter and the discharge score is recorded at or near the conclusion of the final rehabilitation treatment encounter. It is anticipated that **physical and occupational therapists providing treatment for functional hip deficits** will report this measure.

Definitions:
Treatment Episode – A Treatment Episode is defined as beginning with an Admission for a functional hip deficit, progressing to development of a plan of care, including treatment, without interruption of care (for example, a hospitalization or surgical intervention), and ending with Discharge from clinical care by the Eligible Professional. A patient currently under clinical care for a hip deficit remains in a single episode of care until the Discharge is conducted and documented by the Eligible Professional.
Admission – An Admission is the first encounter for a functional deficit involving the hip and includes an evaluation (CPT 97001 or 97003) and development of a plan of care by the Eligible Professional. A patient presenting with a hip impairment, who has had an interruption of a Treatment Episode for the same functional hip deficit secondary to an appropriate reason like hospitalization or surgical intervention, is a new Admission.
Discharge – Discharge is accompanied by a re-evaluation (CPT 97002 or 97004) or Functional Limitation Reporting Discharge Status G-Code (G8980, G8983, G8986, G8989 or G8992) identifying the close of a Treatment Episode for the same hip deficit identified at admission and documented by a discharge report by the Eligible Professional. An interruption in clinical care for an appropriate reason like hospitalization or surgical intervention requires a discharge from the current Treatment Episode.
Encounter – A face to face visit between the patient and the provider for the purpose of assessing and/or improving a functional deficit.
Patient Reported – The patient directly, or through a proxy, provides answers to functional status survey items using standardized, reliable and valid, computerized adaptive testing or paper and pencil survey methods.

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

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

DENOMINATOR:
All patients aged 18 years and older who receive a treatment episode for a functional deficit related to the hip

Option 1 – Physical Therapy Denominator Criteria (Eligible Cases):
All patients aged ≥ 18 years on date of encounter
AND
Patient encounter during the reporting period identifying evaluation: CPT 97001
AND
Patient encounter during the reporting period identifying discharge: CPT 97002 or Functional Limitation Reporting Discharge Status G-Code G8980, G8983, G8986, G8989 or G8992
AND
Functional deficit affecting the hip

OR

Option 2 – Occupational Therapy Denominator Criteria (Eligible Cases):
All patients aged ≥ 18 years on date of encounter
AND
Patient encounter during the reporting period identifying evaluation: CPT 97003
AND
Patient encounter during the reporting period identifying discharge: CPT 97004 or Functional Limitation Reporting Discharge Status G-Code G8980, G8983, G8986, G8989 or G8992 AND
Functional deficit affecting the hip

NUMERATOR:
Patients presented FOTO's Functional Intake Survey for the Hip at admission and FOTO's Functional Status Survey at discharge for the purpose of calculating the patient's Risk-adjusted Functional Status Change Residual Score

Definitions:
Patient's Functional Status Score – A functional status score is produced when the patient completes the FOTO functional status survey (either by paper and pencil or computerized adaptive testing administration). The functional status score is continuous and linear. Scores range from 0 (low function) to 100 (high function). The survey is standardized, and the scores are validated for the measurement of function for this population.
Patient's Functional Status Change Score – A functional status change score is calculated by subtracting the Patient's Functional Status Score at Admission from the Patient's Functional Status Score at Discharge.
Predicted Functional Status Change Score – Functional Status Change Scores for patients are risk adjusted using multiple linear regression methods that include the following independent variables: Patient's Functional Status Score at Admission, patient age, symptom acuity, surgical history, gender, number of co-morbidities and level of fear-avoidance. The Patient's Functional Status Change Score is the dependent variable. The statistical regression produces a Risk-Adjusted Predicted Functional Status Change Score.
Risk-Adjusted Functional Status Change Residual Score – The difference between the raw non-risk-adjusted Patient's Functional Status Change Score and the Risk-Adjusted Predicted Functional Status Change Score (raw minus predicted) is the Risk-Adjusted Functional Status Change Residual Score, which is in the same units as the Patient's Functional Status Scores, and should be interpreted as the unit of functional status change different than predicted given the risk-adjustment variables of the patient being treated. As such, the Risk-Adjusted Residual Change Score represents Risk-Adjusted Change corrected for the level of severity of the patient. Risk-Adjusted Residual Change Scores of zero (0) or greater (> 0) should be interpreted as functional status change scores that were predicted or better than predicted given the risk-adjustment variables of the patient and risk-adjusted residual change scores less than zero (< 0) should be interpreted as functional status change scores that were less than predicted given the risk-adjustment variables of the patient. Aggregated Risk-Adjusted Residual Scores allow meaningful comparisons amongst clinicians or clinics.
Not Eligible/Not Appropriate – A patient is **not** eligible if one or more of the following conditions exist:

- Patient refused to participate

- Patient unable to complete the questionnaire due to blindness, illiteracy, severe mental incapacity or language incompatibility and an adequate proxy is not available
- Prior to conclusion of Plan of Care, intervention was interrupted or discontinued for any reason including by the referring physician, the provider, the payer or the patient, and attempts by the provider to complete a follow-up functional status survey near Discharge were unsuccessful.

Numerator Options:

Performance Met: Risk-Adjusted Functional Status Change Residual Score for the hip successfully calculated and the score was equal to zero (0) or greater than zero (> 0) **(G8651)**

OR

Performance Met: Risk-Adjusted Functional Status Change Residual Score for the hip successfully calculated and the score was less than zero (< 0) **(G8652)**

OR

Other Performance Exclusion: Risk-Adjusted Functional Status Change Residual Scores for the hip not measured because the patient did not complete FOTO's Functional Intake on admission and/or follow up Status Survey near discharge, patient Not Eligible/Not Appropriate **(G8653)**

OR

Performance Not Met: Risk-Adjusted Functional Status Change Residual Scores for the hip **not** measured because the patient did **not** complete FOTO's Functional Intake on admission and/or follow up Status Survey near discharge, reason not given **(G8654)**

RATIONALE:

Functional deficits are common in the general population and are costly to the individual, their family and society. Improved functional status has been associated with greater quality of life, self-efficacy, improved financial well-being and lower future medical costs. Improving functional status in people seeking rehabilitation has become a goal of the American Physical Therapy Association. Therefore, measuring change in functional status is important for providers treating patients in rehabilitation and can be used to assess the success of treatment and direct modification of treatment.

Change in functional status represents the activity domain of the International Classification of Function. If treatment is designed to improve the functional deficit, it is logical to assess functional status at discharge using a standardized score to determine if treatment improved the functional status of the patient over the treatment episode.

The National Quality Measures Clearinghouse has approved the measurement of change in functional status, using this survey. (NQMC-1872)

CLINICAL RECOMMENDATION STATEMENTS:

The American Physical Therapy Association (APTA), in their *Guide to Physical Therapy Practice*, described five recommended elements of patient management: examination, evaluation, diagnosis, prognosis and intervention. The elements were intended to direct therapists in their approach to patient treatment for the purpose of optimizing patient outcomes. The APTA clearly identifies functional status data as one of the major forms of data to be collected for patients receiving rehabilitation. The functional status measures should be used to assist in the planning, implementation and modification of treatment interventions and should be used as measures of outcomes. The current functional status scores can be used by therapists to fulfill the recommended methods of the APTA in the management of patients in rehabilitation.

☾Measure #219 (NQF 0424): Functional Deficit: Change in Risk-Adjusted Functional Status for Patients with Lower Leg, Foot or Ankle Impairments – National Quality Strategy Domain: Communication and Care Coordination

2015 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Percentage of patients aged 18 or older that receive treatment for a functional deficit secondary to a diagnosis that affects the lower leg, foot or ankle in which the change in their Risk-Adjusted Functional Status is measured

INSTRUCTIONS:
This outcomes measure is to be reported **once per treatment episode** for all patients with a functional deficit related to the lower leg, foot or ankle. This is an outcomes measure and its calculation requires reporting of the patient's functional status score, as a minimum, at admission to and again at discharge from an episode of rehabilitation. The admission score, estimated using patient self-report surveys, is recorded during the first rehabilitation treatment encounter and the discharge score is recorded at or near the conclusion of the final rehabilitation treatment encounter. It is anticipated that **physical and occupational therapists providing treatment for functional lower leg, foot or ankle deficits** will report this measure.

Definitions:
Treatment Episode – A Treatment Episode is defined as beginning with an Admission for a functional lower leg, foot or ankle deficit, progressing to development of a plan of care, including treatment, without interruption of care (for example, a hospitalization or surgical intervention), and ending with Discharge from clinical care by the Eligible Professional. A patient currently under clinical care for a lower leg, foot or ankle deficit remains in a single episode of care until the Discharge is conducted and documented by the Eligible Professional.
Admission – An Admission is the first encounter for a functional deficit involving the lower leg, foot or ankle and includes an evaluation (CPT 97001 or 97003) and development of a plan of care by the Eligible Professional. A patient presenting with a lower leg, foot or ankle impairment, who has had an interruption of a Treatment Episode for the same functional lower leg, foot or ankle deficit secondary to an appropriate reason like hospitalization or surgical intervention, is a new Admission.
Discharge – Discharge is accompanied by a re-evaluation (CPT 97002 or 97004) or Functional Limitation Reporting Discharge Status G-Code (G8980, G8983, G8986, G8989 or G8992)) identifying the close of a Treatment Episode for the same lower leg, foot or ankle deficit identified at admission and documented by a discharge report by the Eligible Professional. An interruption in clinical care for an appropriate reason like hospitalization or surgical intervention requires a discharge from the current Treatment Episode.
Encounter – A face to face visit between the patient and the provider for the purpose of assessing and/or improving a functional deficit.
Patient Reported – The patient directly, or through a proxy, provides answers to functional status survey items using standardized, reliable and valid, computerized adaptive testing or paper and pencil survey methods.

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

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

DENOMINATOR:

All patients aged 18 years and older who receive a treatment episode for a functional deficit related to the lower leg, foot or ankle

Option 1 – Physical Therapy Denominator Criteria (Eligible Cases):
All patients aged ≥ 18 years on date of encounter
AND
Patient encounter during the reporting period identifying evaluation: CPT 97001
AND
Patient encounter during the reporting period identifying discharge: CPT 97002 or Functional Limitation Reporting Discharge Status G-Code G8980, G8983, G8986, G8989 or G8992
AND
Functional deficit affecting the lower leg, foot or ankle

OR

Option 2 – Occupational Therapy Denominator Criteria (Eligible Cases):
All patients aged ≥ 18 years on date of encounter
AND
Patient encounter during the reporting period identifying evaluation: CPT 97003
AND
Patient encounter during the reporting period identifying discharge: CPT 97004 or Functional Limitation Reporting Discharge Status G-Code G8980, G8983, G8986, G8989 or G8992
AND
Functional deficit affecting the lower leg, foot or ankle

NUMERATOR:
Patients presented FOTO's Functional Intake Survey for the Lower Leg, Foot or Ankle at admission and FOTO's Functional Status Survey at discharge for the purpose of calculating the patient's Risk-adjusted Functional Status Change Residual Score

Definitions:
Patient's Functional Status Score – A functional status score is produced when the patient completes the FOTO functional status survey (either by paper and pencil or computerized adaptive testing administration). The functional status score is continuous and linear. Scores range from 0 (low function) to 100 (high function). The survey is standardized, and the scores are validated for the measurement of function for this population.
Patient's Functional Status Change Score – A functional status change score is calculated by subtracting the Patient's Functional Status Score at Admission from the Patient's Functional Status Score at Discharge.
Predicted Functional Status Change Score – Functional Status Change Scores for patients are risk adjusted using multiple linear regression methods that include the following independent variables: Patient's Functional Status Score at Admission, patient age, symptom acuity, surgical history, gender, number of co-morbidities, and level of fear-avoidance. The Patient's Functional Status Change Score is the dependent variable. The statistical regression produces a Risk-Adjusted Predicted Functional Status Change Score.
Risk-Adjusted Functional Status Change Residual Score – The difference between the raw non-risk-adjusted Patient's Functional Status Change Score and the Risk-Adjusted Predicted Functional Status Change Score (raw minus predicted) is the Risk-Adjusted Functional Status Change Residual Score, which is in the same units as the Patient's Functional Status Scores, and should be interpreted as the unit of functional status change different than predicted given the risk-adjustment variables of the patient being treated. As such, the Risk-Adjusted Residual Change Score represents Risk-Adjusted Change corrected for the level of severity of the patient. Risk-Adjusted Residual Change Scores of zero (0) or greater (> 0) should be interpreted as functional status change scores that were predicted or better than predicted given the risk-adjustment variables of the patient, and risk-adjusted residual change scores less than zero (< 0) should be interpreted as functional status change scores that were less than predicted given the risk-adjustment

variables of the patient. Aggregated Risk-Adjusted Residual Scores allow meaningful comparisons amongst clinicians or clinics.

Not Eligible/Not Appropriate – A patient is **not** eligible if one or more of the following conditions exist:

- Patient refused to participate
- Patient unable to complete the questionnaire due to blindness, illiteracy, severe mental incapacity or language incompatibility and an adequate proxy is not available
- Prior to conclusion of Plan of Care, intervention was interrupted or discontinued for any reason including by the referring physician, the provider, the payer or the patient, and attempts by the provider to complete a follow-up functional status survey near Discharge were unsuccessful.

Numerator Options:

Performance Met:	Risk-Adjusted Functional Status Change Residual Score for the lower leg, foot or ankle successfully calculated and the score was equal to zero (0) or greater than zero (> 0) **(G8655)**
OR	
Performance Met:	Risk-Adjusted Functional Status Change Residual Score for the lower leg, foot or ankle successfully calculated and the score was less than zero (< 0) **(G8656)**
OR	
Other Performance Exclusion:	Risk-Adjusted Functional Status Change Residual Scores for the lower leg, foot or ankle not measured because the patient did not complete FOTO's Functional Intake on admission and/or follow up Status Survey near discharge, patient Not Eligible/Not Appropriate **(G8657)**
OR	
Performance Not Met:	Risk-Adjusted Functional Status Change Residual Scores for the lower leg, foot or ankle **not** measured because the patient did **not** complete FOTO's Functional Intake on admission and/or follow up Status Survey near discharge, reason not given **(G8658)**

RATIONALE:

Functional deficits are common in the general population and are costly to the individual, their family and society. Improved functional status has been associated with greater quality of life, self-efficacy, improved financial well-being and lower future medical costs. Improving functional status in people seeking rehabilitation has become a goal of the American Physical Therapy Association. Therefore, measuring change in functional status is important for providers treating patients in rehabilitation and can be used to assess the success of treatment and direct modification of treatment.

Change in functional status represents the activity domain of the International Classification of Function. If treatment is designed to improve the functional deficit, it is logical to assess functional status at discharge using a standardized score to determine if treatment improved the functional status of the patient over the treatment episode.

The National Quality Measures Clearinghouse has approved the measurement of change in functional status, using this survey. (NQMC-1874)

CLINICAL RECOMMENDATION STATEMENTS:

The American Physical Therapy Association (APTA), in their *Guide to Physical Therapy Practice*, described five recommended elements of patient management: examination, evaluation, diagnosis, prognosis and intervention. The

elements were intended to direct therapists in their approach to patient treatment for the purpose of optimizing patient outcomes. The APTA clearly identifies functional status data as one of the major forms of data to be collected for patients receiving rehabilitation. The functional status measures should be used to assist in the planning, implementation and modification of treatment interventions and should be used as measures of outcomes. The current functional status scores can be used by therapists to fulfill the recommended methods of the APTA in the management of patients in rehabilitation.

☾Measure #220 (NQF 0425): Functional Deficit: Change in Risk-Adjusted Functional Status for Patients with Lumbar Spine Impairments – National Quality Stratgy Domain: Communication and Care Coordination

2015 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Percentage of patients aged 18 or older that receive treatment for a functional deficit secondary to a diagnosis that affects the lumbar spine in which the change in their Risk-Adjusted Functional Status is measured

INSTRUCTIONS:
This outcomes measure is to be reported **once per treatment episode** for all patients with a functional deficit related to the lumbar spine. This is an outcomes measure, and its calculation requires reporting of the patient's functional status score, as a minimum, at admission to and again at discharge from an episode of rehabilitation. The admission score, estimated using patient self-report surveys, is recorded during the first rehabilitation treatment encounter, and the discharge score is recorded at or near the conclusion of the final rehabilitation treatment encounter. It is anticipated that **physical and occupational therapists providing treatment for functional lumbar spine deficits** will report this measure.

Definitions:
Treatment Episode – A Treatment Episode is defined as beginning with an Admission for a functional lumbar spine deficit, progressing to development of a plan of care, including treatment, without interruption of care (for example, a hospitalization or surgical intervention), and ending with Discharge from clinical care by the Eligible Professional. A patient currently under clinical care for a lumbar spine deficit remains in a single episode of care until the Discharge is conducted and documented by the Eligible Professional.
Admission – An Admission is the first encounter for a functional deficit involving the lumbar spine and includes an evaluation (CPT 97001 or 97003) and development of a plan of care by the Eligible Professional. A patient presenting with a lumbar spine impairment, who has had an interruption of a Treatment Episode for the same functional lumbar spine deficit secondary to an appropriate reason like hospitalization or surgical intervention, is a new Admission.
Discharge – Discharge is accompanied by a re-evaluation (CPT 97002 or 97004) or Functional Limitation Reporting Discharge Status G-Code (G8980, G8983, G8986, G8989 or G8992) identifying the close of a Treatment Episode for the same lumbar spine deficit identified at admission and documented by a discharge report by the Eligible Professional. An interruption in clinical care for an appropriate reason like hospitalization or surgical intervention requires a discharge from the current Treatment Episode.
Encounter – A face to face visit between the patient and the provider for the purpose of assessing and/or improving a functional deficit.
Patient Reported – The patient directly, or through a proxy, provides answers to functional status survey items using standardized, reliable and valid, computerized adaptive testing or paper and pencil survey methods.

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

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

DENOMINATOR:

All patients aged 18 years and older who receive a treatment episode for a functional deficit related to the lumbar spine

Option 1 – Physical Therapy Denominator Criteria (Eligible Cases):
All patients aged ≥ 18 years on date of encounter
AND
Patient encounter during the reporting period identifying evaluation: CPT 97001
AND
Patient encounter during the reporting period identifying discharge: CPT 97002 or Functional Limitation Reporting Discharge Status G-Code G8980, G8983, G8986, G8989 or G8992
AND
Functional deficit affecting the lumbar spine

OR

Option 2 – Occupational Therapy Denominator Criteria (Eligible Cases):
All patients aged ≥ 18 years on date of encounter
AND
Patient encounter during the reporting period identifying evaluation: CPT 97003
AND
Patient encounter during the reporting period identifying discharge: CPT 97004 or Functional Limitation Reporting Discharge Status G-Code G8980, G8983, G8986, G8989 or G8992
AND
Functional deficit affecting the lumbar spine

NUMERATOR:
Patients presented FOTO's Functional Intake Survey for the Lumbar Spine at admission and FOTO's Functional Status Survey at discharge for the purpose of calculating the patient's Risk-adjusted Functional Status Change Residual Score

Definitions:
Patient's Functional Status Score – A functional status score is produced when the patient completes the FOTO functional status survey (either by paper and pencil or computerized adaptive testing administration). The functional status score is continuous and linear. Scores range from 0 (low function) to 100 (high function). The survey is standardized, and the scores are validated for the measurement of function for this population.
Patient's Functional Status Change Score – A functional status change score is calculated by subtracting the Patient's Functional Status Score at Admission from the Patient's Functional Status Score at Discharge.
Predicted Functional Status Change Score – Functional Status Change Scores for patients are risk adjusted using multiple linear regression methods that include the following independent variables: Patient's Functional Status Score at Admission, patient age, symptom acuity, surgical history, gender, number of co-morbidities and level of fear-avoidance. The Patient's Functional Status Change Score is the dependent variable. The statistical regression produces a Risk-Adjusted Predicted Functional Status Change Score.
Risk-Adjusted Functional Status Change Residual Score – The difference between the raw non-risk-adjusted Patient's Functional Status Change Score and the Risk-Adjusted Predicted Functional Status Change Score (raw minus predicted) is the Risk-Adjusted Functional Status Change Residual Score, which is in the same units as the Patient's Functional Status Scores, and should be interpreted as the unit of functional status change different than predicted given the risk-adjustment variables of the patient being treated. As such, the Risk-Adjusted Residual Change Score represents Risk-Adjusted Change corrected for the level of severity of the patient. Risk-Adjusted Residual Change Scores of zero (0) or greater (> 0) should be interpreted as functional status change scores that were predicted or better than predicted given the risk-adjustment variables of the patient and risk-adjusted residual change scores less than zero (< 0) should be interpreted as functional status change scores that were less than predicted given the risk-adjustment

variables of the patient. Aggregated Risk-Adjusted Residual Scores allow meaningful comparisons amongst clinicians or clinics.

Not Eligible/Not Appropriate – A patient is **not** eligible if one or more of the following conditions exist:

- Patient refused to participate
- Patient unable to complete the questionnaire due to blindness, illiteracy, severe mental incapacity or language incompatibility and an adequate proxy is not available
- Prior to conclusion of Plan of Care, intervention was interrupted or discontinued for any reason including by the referring physician, the provider, the payer or the patient, and attempts by the provider to complete a follow-up functional status survey near Discharge were unsuccessful.

Numerator Options:

Performance Met:	Risk-Adjusted Functional Status Change Residual Score for the lumbar spine successfully calculated and the score was equal to zero (0) or greater than zero (> 0) **(G8659)**
OR	
Performance Met:	Risk-Adjusted Functional Status Change Residual Score for the lumbar spine successfully calculated and the score was less than zero (< 0) **(G8660)**
OR	
Other Performance Exclusion:	Risk-Adjusted Functional Status Change Residual Scores for the lumbar spine not measured because the patient did not complete FOTO's Functional Intake on admission and/or follow up Status Survey near discharge, patient Not Eligible/Not Appropriate **(G8661)**
OR	
Performance Not Met:	Risk-Adjusted Functional Status Change Residual Scores for the lumbar spine **not** measured because the patient did **not** complete FOTO's Functional Intake on admission and/or follow up Status Survey near discharge, reason not given **(G8662)**

RATIONALE:

Functional deficits are common in the general population and are costly to the individual, their family and society. Improved functional status has been associated with greater quality of life, self-efficacy, improved financial well-being and lower future medical costs. Improving functional status in people seeking rehabilitation has become a goal of the American Physical Therapy Association. Therefore, measuring change in functional status is important for providers treating patients in rehabilitation and can be used to assess the success of treatment and direct modification of treatment.

Change in functional status represents the activity domain of the International Classification of Function. If treatment is designed to improve the functional deficit, it is logical to assess functional status at discharge using a standardized score to determine if treatment improved the functional status of the patient over the treatment episode.

The National Quality Measures Clearinghouse has approved the measurement of change in functional status, using this survey. (NQMC-2632)

CLINICAL RECOMMENDATION STATEMENTS:

The American Physical Therapy Association (APTA), in their *Guide to Physical Therapy Practice*, described five recommended elements of patient management: examination, evaluation, diagnosis, prognosis and intervention. The elements were intended to direct therapists in their approach to patient treatment for the purpose of optimizing patient outcomes. The APTA clearly identifies functional status data as one of the major forms of data to be collected for

patients receiving rehabilitation. The functional status measures should be used to assist in the planning, implementation and modification of treatment interventions and should be used as measures of outcomes. The current functional status scores can be used by therapists to fulfill the recommended methods of the APTA in the management of patients in rehabilitation.

☾Measure #221 (NQF 0426): Functional Deficit: Change in Risk-Adjusted Functional Status for Patients with Shoulder Impairments – National Quality Strategy Domain: Communication and Care Coordination

2015 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Percentage of patients aged 18 or older that receive treatment for a functional deficit secondary to a diagnosis that affects the shoulder in which the change in their Risk-Adjusted Functional Status is measured

INSTRUCTIONS:
This outcomes measure is to be reported **once per treatment episode** for all patients with a functional deficit related to the shoulder. This is an outcomes measure and its calculation requires reporting of the patient's functional status score, as a minimum, at admission to and again at discharge from an episode of rehabilitation. The admission score, estimated using patient self-report surveys, is recorded during the first rehabilitation treatment encounter and the discharge score is recorded at or near the conclusion of the final rehabilitation treatment encounter. It is anticipated that **physical and occupational therapists providing treatment for functional shoulder deficits** will report this measure.

Definitions:
Treatment Episode – A Treatment Episode is defined as beginning with an Admission for a functional shoulder deficit, progressing to development of a plan of care, including treatment, without interruption of care (for example, a hospitalization or surgical intervention), and ending with Discharge from clinical care by the Eligible Professional. A patient currently under clinical care for a shoulder deficit remains in a single episode of care until the Discharge is conducted and documented by the Eligible Professional.
Admission – An Admission is the first encounter for a functional deficit involving the shoulder and includes an evaluation (CPT 97001 or 97003) and development of a plan of care by the Eligible Professional. A patient presenting with a shoulder impairment, who has had an interruption of a Treatment Episode for the same functional shoulder deficit secondary to an appropriate reason like hospitalization or surgical intervention, is a new Admission.
Discharge – Discharge is accompanied by a re-evaluation (CPT 97002 or 97004) or Functional Limitation Reporting Discharge Status G-Code (G8980, G8983, G8986, G8989 or G8992) identifying the close of a Treatment Episode for the same shoulder deficit identified at admission and documented by a discharge report by the Eligible Professional. An interruption in clinical care for an appropriate reason like hospitalization or surgical intervention requires a discharge from the current Treatment Episode.
Encounter – A face to face visit between the patient and the provider for the purpose of assessing and/or improving a functional deficit.
Patient Reported – The patient directly, or through a proxy, provides answers to functional status survey items using standardized, reliable and valid, computerized adaptive testing or paper and pencil survey methods.

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

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

DENOMINATOR:
All patients aged 18 years and older who receive a treatment episode for a functional deficit related to the shoulder

Option 1 – Physical Therapy Denominator Criteria (Eligible Cases):
All patients aged ≥ 18 years on date of encounter
AND
Patient encounter during the reporting period identifying evaluation: CPT 97001
AND
Patient encounter during the reporting period identifying discharge: CPT 97002 or Functional Limitation Reporting Discharge Status G-Code G8980, G8983, G8986, G8989 or G8992
AND
Functional deficit affecting the shoulder

OR

Option 2 – Occupational Therapy Denominator Criteria (Eligible Cases):
All patients aged ≥ 18 years on date of encounter
AND
Patient encounter during the reporting period identifying evaluation: CPT 97003
AND
Patient encounter during the reporting period identifying discharge: CPT 97004 or Functional Limitation Reporting Discharge Status G-Code G8980, G8983, G8986, G8989 or G8992
AND
Functional deficit affecting the shoulder

NUMERATOR:
Patients presented FOTO's Functional Intake Survey for the Shoulder at admission and FOTO's Functional Status Survey at discharge for the purpose of calculating the patient's Risk-adjusted Functional Status Change Residual Score

Definitions:
Patient's Functional Status Score – A functional status score is produced when the patient completes the FOTO functional status survey (either by paper and pencil or computerized adaptive testing administration). The functional status score is continuous and linear. Scores range from 0 (low function) to 100 (high function). The survey is standardized, and the scores are validated for the measurement of function for this population.
Patient's Functional Status Change Score – A functional status change score is calculated by subtracting the Patient's Functional Status Score at Admission from the Patient's Functional Status Score at Discharge.
Predicted Functional Status Change Score – Functional Status Change Scores for patients are risk adjusted using multiple linear regression methods that include the following independent variables: Patient's Functional Status Score at Admission, patient age, symptom acuity, surgical history, gender, number of co-morbidities and level of fear-avoidance. The Patient's Functional Status Change Score is the dependent variable. The statistical regression produces a Risk-Adjusted Predicted Functional Status Change Score.
Risk-Adjusted Functional Status Change Residual Score – The difference between the raw non-risk-adjusted Patient's Functional Status Change Score and the Risk-Adjusted Predicted Functional Status Change Score (raw minus predicted) is the Risk-Adjusted Functional Status Change Residual Score, which is in the same units as the Patient's Functional Status Scores, and should be interpreted as the unit of functional status change different than predicted given the risk-adjustment variables of the patient being treated. As such, the Risk-Adjusted Residual Change Score represents Risk-Adjusted Change corrected for the level of severity of the patient. Risk-Adjusted Residual Change Scores of zero (0) or greater (> 0) should be interpreted as functional status change scores that were predicted or better than predicted given the risk-adjustment variables of the patient and risk-adjusted residual change scores less than zero (< 0) should be interpreted as functional status change scores that were less than predicted given the risk-adjustment variables of the patient. Aggregated Risk-Adjusted Residual Scores allow meaningful comparisons amongst clinicians or clinics.
Not Eligible/Not Appropriate – A patient is **not** eligible if one or more of the following conditions exist:

- Patient refused to participate
- Patient unable to complete the questionnaire due to blindness, illiteracy, severe mental incapacity or language incompatibility and an adequate proxy is not available
- Prior to conclusion of Plan of Care, intervention was interrupted or discontinued for any reason including by the referring physician, the provider, the payer or the patient, and attempts by the provider to complete a follow-up functional status survey near Discharge were unsuccessful.

Numerator Options:

Performance Met: Risk-Adjusted Functional Status Change Residual Score for the shoulder successfully calculated and the score was equal to zero (0) or greater than zero (> 0) **(G8663)**

OR

Performance Met: Risk-Adjusted Functional Status Change Residual Score for the shoulder successfully calculated and the score was less than zero (< 0) **(G8664)**

OR

Other Performance Exclusion: Risk-Adjusted Functional Status Change Residual Scores for the shoulder not measured because the patient did not complete FOTO's Functional Intake on admission and/or follow up Status Survey near discharge, patient Not Eligible/Not Appropriate **(G8665)**

OR

Performance Not Met: Risk-Adjusted Functional Status Change Residual Scores for the shoulder **not** measured because the patient did **not** complete FOTO's Functional Intake on admission and/or follow up Status Survey near discharge, reason not given **(G8666)**

RATIONALE:

Functional deficits are common in the general population and are costly to the individual, their family and society. Improved functional status has been associated with greater quality of life, self-efficacy, improved financial well-being and lower future medical costs. Improving functional status in people seeking rehabilitation has become a goal of the American Physical Therapy Association. Therefore, measuring change in functional status is important for providers treating patients in rehabilitation and can be used to assess the success of treatment and direct modification of treatment.

Change in functional status represents the activity domain of the International Classification of Function. If treatment is designed to improve the functional deficit, it is logical to assess functional status at discharge using a standardized score to determine if treatment improved the functional status of the patient over the treatment episode.

The National Quality Measures Clearinghouse has approved the measurement of change in functional status, using this survey. (NQMC-2633)

CLINICAL RECOMMENDATION STATEMENTS:

The American Physical Therapy Association (APTA), in their *Guide to Physical Therapy Practice*, described five recommended elements of patient management: examination, evaluation, diagnosis, prognosis and intervention. The elements were intended to direct therapists in their approach to patient treatment for the purpose of optimizing patient outcomes. The APTA clearly identifies functional status data as one of the major forms of data to be collected for patients receiving rehabilitation. The functional status measures should be used to assist in the planning, implementation and modification of treatment interventions and should be used as measures of outcomes. The

current functional status scores can be used by therapists to fulfill the recommended methods of the APTA in the management of patients in rehabilitation.

☾Measure #222 (NQF 0427): Functional Deficit: Change in Risk-Adjusted Functional Status for Patients with Elbow, Wrist or Hand Impairments – National Quality Strategy Domain: Communication and Care Coordination

2015 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Percentage of patients aged 18 or older that receive treatment for a functional deficit secondary to a diagnosis that affects the elbow, wrist or hand in which the change in their Risk-Adjusted Functional Status is measured

INSTRUCTIONS:
This outcomes measure is to be reported **once per treatment episode** for all patients with a functional deficit related to the elbow, wrist or hand. This is an outcomes measure and its calculation requires reporting of the patient's functional status score, as a minimum, at admission to and again at discharge from an episode of rehabilitation. The admission score, estimated using patient self-report surveys, is recorded during the first rehabilitation treatment encounter and the discharge score is recorded at or near the conclusion of the final rehabilitation treatment encounter. It is anticipated that **physical and occupational therapists providing treatment for functional elbow, wrist or hand deficits** will report this measure.

Definitions:
Treatment Episode – A Treatment Episode is defined as beginning with an Admission for a functional elbow, wrist or hand deficit, progressing to development of a plan of care, including treatment, without interruption of care (for example, a hospitalization or surgical intervention), and ending with Discharge from clinical care by the Eligible Professional. A patient currently under clinical care for an elbow, wrist or hand deficit remains in a single episode of care until the Discharge is conducted and documented by the Eligible Professional.
Admission – An Admission is the first encounter for a functional deficit involving the elbow, wrist or hand and includes an evaluation (CPT 97001 or 97003) and development of a plan of care by the Eligible Professional. A patient presenting with an elbow, wrist or hand impairment, who has had an interruption of a Treatment Episode for the same functional elbow, wrist or hand deficit secondary to an appropriate reason like hospitalization or surgical intervention, is a new Admission.
Discharge – Discharge is accompanied by a re-evaluation (CPT 97002 or 97004) or Functional Limitation Reporting Discharge Status G-Code (G8980, G8983, G8986, G8989 or G8992)identifying the close of a Treatment Episode for the same elbow, wrist or hand deficit identified at admission and documented by a discharge report by the Eligible Professional. An interruption in clinical care for an appropriate reason like hospitalization or surgical intervention requires a discharge from the current Treatment Episode.
Encounter – A face to face visit between the patient and the provider for the purpose of assessing and/or improving a functional deficit.
Patient Reported – The patient directly, or through a proxy, provides answers to functional status survey items using standardized, reliable and valid, computerized adaptive testing or paper and pencil survey methods.

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

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

DENOMINATOR:

All patients aged 18 years and older who receive a treatment episode for a functional deficit related to the elbow, wrist or hand

Option 1 – Physical Therapy Denominator Criteria (Eligible Cases):
All patients aged ≥ 18 years on date of encounter
AND
Patient encounter during the reporting period identifying evaluation: CPT 97001
AND
Patient encounter during the reporting period identifying discharge: CPT 97002 or Functional Limitation Reporting Discharge Status G-Code G8980, G8983, G8986, G8989 or G8992 AND
Functional deficit affecting elbow, wrist or hand

OR

Option 2 – Occupational Therapy Denominator Criteria (Eligible Cases):
All patients aged ≥ 18 years on date of encounter
AND
Patient encounter during the reporting period identifying evaluation: CPT 97003
AND
Patient encounter during the reporting period identifying discharge: CPT 97004 or Functional Limitation Reporting Discharge Status G-Code G8980, G8983, G8986, G8989 or G8992
AND
Functional deficit affecting elbow, wrist or hand

NUMERATOR:
Patients presented FOTO's Functional Intake Survey for the Elbow, Wrist or Hand at admission and FOTO's Functional Status Survey at discharge for the purpose of calculating the patient's Risk-adjusted Functional Status Change Residual Score

Definitions:
Patient's Functional Status Score – A functional status score is produced when the patient completes the FOTO functional status survey (either by paper and pencil or computerized adaptive testing administration). The functional status score is continuous and linear. Scores range from 0 (low function) to 100 (high function). The survey is standardized, and the scores are validated for the measurement of function for this population.
Patient's Functional Status Change Score – A functional status change score is calculated by subtracting the Patient's Functional Status Score at Admission from the Patient's Functional Status Score at Discharge.
Predicted Functional Status Change Score – Functional Status Change Scores for patients are risk adjusted using multiple linear regression methods that include the following independent variables: Patient's Functional Status Score at Admission, patient age, symptom acuity, surgical history, gender, number of co-morbidities and level of fear-avoidance. The Patient's Functional Status Change Score is the dependent variable. The statistical regression produces a Risk-Adjusted Predicted Functional Status Change Score.
Risk-Adjusted Functional Status Change Residual Score – The difference between the raw non-risk-adjusted Patient's Functional Status Change Score and the Risk-Adjusted Predicted Functional Status Change Score (raw minus predicted) is the Risk-Adjusted Functional Status Change Residual Score, which is in the same units as the Patient's Functional Status Scores, and should be interpreted as the unit of functional status change different than predicted given the risk-adjustment variables of the patient being treated. As such, the Risk-Adjusted Residual Change Score represents Risk-Adjusted Change corrected for the level of severity of the patient. Risk-Adjusted Residual Change Scores of zero (0) or greater (> 0) should be interpreted as functional status change scores that were predicted or better than predicted given the risk-adjustment variables of the patient and risk-adjusted residual change scores less than zero (< 0) should be interpreted as functional status change scores that were less than predicted given the risk-adjustment

variables of the patient. Aggregated Risk-Adjusted Residual Scores allow meaningful comparisons amongst clinicians or clinics.

Not Eligible/Not Appropriate – A patient is **not** eligible if one or more of the following conditions exist:

- Patient refused to participate
- Patient unable to complete the questionnaire due to blindness, illiteracy, severe mental incapacity or language incompatibility and an adequate proxy is not available
- Prior to conclusion of Plan of Care, intervention was interrupted or discontinued for any reason including by the referring physician, the provider, the payer or the patient, and attempts by the provider to complete a follow-up functional status survey near Discharge were unsuccessful.

Numerator Options:

Performance Met:	Risk-Adjusted Functional Status Change Residual Score for the elbow, wrist or hand successfully calculated and the score was equal to zero (0) or greater than zero (> 0) **(G8667)**
OR	
Performance Met:	Risk-Adjusted Functional Status Change Residual Score for the elbow, wrist or hand successfully calculated and the score was less than zero (< 0) **(G8668)**
OR	
Other Performance Exclusion:	Risk-Adjusted Functional Status Change Residual Scores for the elbow, wrist or hand not measured because the patient did not complete FOTO's Functional Intake on admission and/or follow up Status Survey near discharge, patient Not Eligible/Not Appropriate **(G8669)**
OR	
Performance Not Met:	Risk-Adjusted Functional Status Change Residual Scores for the elbow, wrist or hand **not** measured because the patient did **not** complete FOTO's Functional Intake on admission and/or follow up Status Survey near discharge, reason not given **(G8670)**

RATIONALE:

Functional deficits are common in the general population and are costly to the individual, their family and society. Improved functional status has been associated with greater quality of life, self-efficacy, improved financial well-being and lower future medical costs. Improving functional status in people seeking rehabilitation has become a goal of the American Physical Therapy Association. Therefore, measuring change in functional status is important for providers treating patients in rehabilitation and can be used to assess the success of treatment and direct modification of treatment.

Change in functional status represents the activity domain of the International Classification of Function. If treatment is designed to improve the functional deficit, it is logical to assess functional status at discharge using a standardized score to determine if treatment improved the functional status of the patient over the treatment episode.

The National Quality Measures Clearinghouse has approved the measurement of change in functional status, using this survey. (NQMC-1874)

CLINICAL RECOMMENDATION STATEMENTS:

The American Physical Therapy Association (APTA), in their *Guide to Physical Therapy Practice*, described five recommended elements of patient management: examination, evaluation, diagnosis, prognosis and intervention. The

elements were intended to direct therapists in their approach to patient treatment for the purpose of optimizing patient outcomes. The APTA clearly identifies functional status data as one of the major forms of data to be collected for patients receiving rehabilitation. The functional status measures should be used to assist in the planning, implementation and modification of treatment interventions and should be used as measures of outcomes. The current functional status scores can be used by therapists to fulfill the recommended methods of the APTA in the management of patients in rehabilitation.

☾Measure #223 (NQF 0428): Functional Deficit: Change in Risk-Adjusted Functional Status for Patients with Neck, Cranium, Mandible, Thoracic Spine, Ribs, or Other General Orthopedic Impairments – National Quality Strategy Domain: Communication and Care Coordination

2015 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Percentage of patients aged 18 or older that receive treatment for a functional deficit secondary to a diagnosis that affects the neck, cranium, mandible, thoracic spine, ribs, or other general orthopedic impairment in which the change in their Risk-Adjusted Functional Status is measured

INSTRUCTIONS:
This outcomes measure is to be reported **once per treatment episode** for all patients with a functional deficit related to the neck, cranium, mandible, thoracic spine, ribs or other general orthopedic impairment. This is an outcomes measure and its calculation requires reporting of the patient's functional status score, as a minimum, at admission to and again at discharge from an episode of rehabilitation. The admission score, estimated using patient self-report surveys, is recorded during the first rehabilitation treatment encounter and the discharge score is recorded at or near the conclusion of the final rehabilitation treatment encounter. It is anticipated that **physical and occupational therapists providing treatment for functional neck, cranium, mandible, thoracic spine, ribs or other general orthopedic deficits** will report this measure.

Definitions:

Treatment Episode – A Treatment Episode is defined as beginning with an Admission for a functional neck, cranium, mandible, thoracic spine, ribs or other general orthopedic deficit, progressing to development of a plan of care, including treatment, without interruption of care (for example, a hospitalization or surgical intervention), and ending with Discharge from clinical care by the Eligible Professional. A patient currently under clinical care for a neck, cranium, mandible, thoracic spine, ribs or other general orthopedic deficit remains in a single episode of care until the Discharge is conducted and documented by the Eligible Professional.

Admission – An Admission is the first encounter for a functional deficit involving the neck, cranium, mandible, thoracic spine, ribs or other general orthopedic impairment and includes an evaluation (CPT 97001 or 97003) and development of a plan of care by the Eligible Professional. A patient presenting with a neck, cranium, mandible, thoracic spine, ribs or other general orthopedic impairment, who has had an interruption of a Treatment Episode for the same functional neck, cranium, mandible, thoracic spine, ribs or other general orthopedic deficit secondary to an appropriate reason like hospitalization or surgical intervention, is a new Admission.

Discharge – Discharge is accompanied by a re-evaluation (CPT 97002 or 97004) or Functional Limitation Reporting Discharge Status G-Code (G8980, G8983, G8986, G8989 or G8992) identifying the close of a Treatment Episode for the same neck, cranium, mandible, thoracic spine, ribs or other general orthopedic deficit identified at admission and documented by a discharge report by the Eligible Professional. An interruption in clinical care for an appropriate reason like hospitalization or surgical intervention requires a discharge from the current Treatment Episode.

Encounter – A face to face visit between the patient and the provider for the purpose of assessing and/or improving a functional deficit.

Patient Reported – The patient directly, or through a proxy, provides answers to functional status survey items using standardized, reliable and valid, computerized adaptive testing or paper and pencil survey methods.

Measure Reporting via Registry:

CPT codes and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

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

DENOMINATOR:
All patients aged 18 years and older who receive a treatment episode for a functional deficit related to the neck, cranium, mandible, thoracic spine, ribs or other general orthopedic impairment

Option 1 – Physical Therapy Denominator Criteria (Eligible Cases):
All patients aged ≥ 18 years on date of encounter
AND
Patient encounter during the reporting period identifying evaluation: CPT 97001
AND
Patient encounter during the reporting period identifying discharge: CPT 97002 or Functional Limitation Reporting Discharge Status G-Code G8980, G8983, G8986, G8989 or G8992
AND
Functional deficit affecting neck, cranium, mandible, thoracic spine, ribs or other general orthopedic impairment

OR

Option 2 – Occupational Therapy Denominator Criteria (Eligible Cases):
All patients aged ≥ 18 years on date of encounter
AND
Patient encounter during the reporting period identifying evaluation: CPT 97003
AND
Patient encounter during the reporting period identifying discharge: CPT 97004 or Functional Limitation Reporting Discharge Status G-Code G8980, G8983, G8986, G8989 or G8992
AND
Functional deficit affecting neck, cranium, mandible, thoracic spine, ribs or other general orthopedic impairment

NUMERATOR:
Patients presented FOTO's Functional Intake Survey for the Neck, Cranium, Mandible, Thoracic Spine, Ribs, or Other General Orthopedic Impairment at admission and FOTO's Functional Status Survey at discharge for the purpose of calculating the patient's Risk-adjusted Functional Status Change Residual Score

Definitions:
Patient's Functional Status Score – A functional status score is produced when the patient completes the FOTO functional status survey (either by paper and pencil or computerized adaptive testing administration). The functional status score is continuous and linear. Scores range from 0 (low function) to 100 (high function). The survey is standardized, and the scores are validated for the measurement of function for this population.
Patient's Functional Status Change Score – A functional status change score is calculated by subtracting the Patient's Functional Status Score at Admission from the Patient's Functional Status Score at Discharge.
Predicted Functional Status Change Score – Functional Status Change Scores for patients are risk adjusted using multiple linear regression methods that include the following independent variables: Patient's Functional Status Score at Admission, patient age, symptom acuity, surgical history, gender, number of co-morbidities, and level of fear-avoidance. The Patient's Functional Status Change Score is the dependent variable. The statistical regression produces a Risk-Adjusted Predicted Functional Status Change Score.
Risk-Adjusted Functional Status Change Residual Score – The difference between the raw non-risk-adjusted Patient's Functional Status Change Score and the Risk-Adjusted Predicted Functional Status

Change Score (raw minus predicted) is the Risk-Adjusted Functional Status Change Residual Score, which is in the same units as the Patient's Functional Status Scores, and should be interpreted as the unit of functional status change different than predicted given the risk-adjustment variables of the patient being treated. As such, the Risk-Adjusted Residual Change Score represents Risk-Adjusted Change corrected for the level of severity of the patient. Risk-Adjusted Residual Change Scores of zero (0) or greater (> 0) should be interpreted as functional status change scores that were predicted or better than predicted given the risk-adjustment variables of the patient, and risk-adjusted residual change scores less than zero (< 0) should be interpreted as functional status change scores that were less than predicted given the risk-adjustment variables of the patient. Aggregated Risk-Adjusted Residual Scores allow meaningful comparisons amongst clinicians or clinics.

Not Eligible/Not Appropriate – A patient is **not** eligible if one or more of the following conditions exist:

- Patient refused to participate
- Patient unable to complete the questionnaire due to blindness, illiteracy, severe mental incapacity or language incompatibility and an adequate proxy is not available
- Prior to conclusion of Plan of Care, intervention was interrupted or discontinued for any reason including by the referring physician, the provider, the payer or the patient, and attempts by the provider to complete a follow-up functional status survey near Discharge were unsuccessful.

Numerator Options:

Performance Met:	Risk-Adjusted Functional Status Change Residual Score for the neck, cranium, mandible, thoracic spine, ribs or other general orthopedic impairment successfully calculated and the score was equal to zero (0) or greater than zero (> 0) **(G8671)**
OR	
Performance Met:	Risk-Adjusted Functional Status Change Residual Score for the neck, cranium, mandible, thoracic spine, ribs or other general orthopedic impairment successfully calculated and the score was less than zero (< 0) **(G8672)**
OR	
Other Performance Exclusion:	Risk-Adjusted Functional Status Change Residual Scores for the neck, cranium, mandible, thoracic spine, ribs or other general orthopedic impairment not measured because the patient did not complete FOTO's Functional Intake on admission and/or follow up Status Survey near discharge, patient Not Eligible/Not Appropriate **(G8673)**
OR	
Performance Not Met:	Risk-Adjusted Functional Status Change Residual Scores for the neck, cranium, mandible, thoracic spine, ribs or other general orthopedic impairment **not** measured because the patient did **not** complete FOTO's Functional Intake on admission and/or follow up Status Survey near discharge, reason not given **(G8674)**

RATIONALE:

Functional deficits are common in the general population and are costly to the individual, their family and society. Improved functional status has been associated with greater quality of life, self-efficacy, improved financial well-being and lower future medical costs. Improving functional status in people seeking rehabilitation has become a goal of the

American Physical Therapy Association. Therefore, measuring change in functional status is important for providers treating patients in rehabilitation and can be used to assess the success of treatment and direct modification of treatment.

Change in functional status represents the activity domain of the International Classification of Function. If treatment is designed to improve the functional deficit, it is logical to assess functional status at discharge using a standardized score to determine if treatment improved the functional status of the patient over the treatment episode.

The National Quality Measures Clearinghouse has approved the measurement of change in functional status, using this survey. (NQMC-0022)

CLINICAL RECOMMENDATION STATEMENTS:

The American Physical Therapy Association (APTA), in their *Guide to Physical Therapy Practice*, described five recommended elements of patient management: examination, evaluation, diagnosis, prognosis and intervention. The elements were intended to direct therapists in their approach to patient treatment for the purpose of optimizing patient outcomes. The APTA clearly identifies functional status data as one of the major forms of data to be collected for patients receiving rehabilitation. The functional status measures should be used to assist in the planning, implementation and modification of treatment interventions and should be used as measures of outcomes. The current functional status scores can be used by therapists to fulfill the recommended methods of the APTA in the management of patients in rehabilitation.

★Measure #224 (NQF 0562): Melanoma: Overutilization of Imaging Studies in Melanoma – National Quality Strategy Domain: Efficiency and Cost Reduction

2015 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Percentage of patients, regardless of age, with a current diagnosis of Stage 0 through IIC melanoma or a history of melanoma of any stage, without signs or symptoms suggesting systemic spread, seen for an office visit during the one-year measurement period, for whom no diagnostic imaging studies were ordered

INSTRUCTIONS:
This measure is to be reported **once per reporting period** for patients with a current diagnosis of stage 0 through IIC melanoma or a history of melanoma who are seen for an office visit during the reporting period. This measure is intended to reflect the quality of services provided for the primary management of patients with melanoma who have an office visit during the reporting period.

Measure Reporting via Registry
ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, HCPCS codes, and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

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

There are two reporting criteria for this measure:

1) **Patients with a diagnosis of Stage 0 through IIC melanoma without signs or symptoms suggesting systemic spread**

OR

2) **Patients with a history of any stage melanoma without signs or symptoms suggesting systemic spread**

REPORTING CRITERIA 1: Patients with a current diagnosis of Stage 0 through IIC melanoma without signs or symptoms suggesting systemic spread

DENOMINATOR (REPORTING CRITERIA 1):
All patients, regardless of age, with a current diagnosis of Stage 0 through IIC melanoma, without signs or symptoms suggesting systematic spread, seen for an office visit during the one-year measurement period

Definitions:
Signs – For the purposes of this measure, signs include tenderness, jaundice, localized neurologic signs such as weakness, or any other sign.
Symptoms – For the purposes of this measure, symptoms include cough, dyspnea, pain, paresthesia, or any other symptom suggesting the possibility of systemic spread.

Denominator Criteria (Eligible Cases) 1:
Diagnosis for melanoma (ICD-9-CM) [for use 1/1/2015-9/30/2015]: 172.0, 172.1, 172.2, 172.3, 172.4, 172.5, 172.6, 172.7, 172.8, 172.9
Diagnosis for melanoma (ICD-10-CM) [for use 10/01/2015-12/31/2015]: C43.0, C43.10, C43.11, C43.12, C43.20, C43.21, C43.22, C43.30, C43.31, C43.39, C43.4, C43.51, C43.52, C43.59, C43.60, C43.61,

C43.62, C43.70, C43.71, C43.72, C43.8, C43.9, D03.0, D03.10, D03.11, D03.12, D03.20, D03.21, D03.22, D03.30, D03.39, D03.4, D03.51, D03.52, D03.59, D03.60, D03.61, D03.62, D03.70, D03.71, D03.72, D03.8, D03.9

AND

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

AND

AJCC Melanoma Cancer Stage 0 through IIC Melanoma: G8944

AND

Absence of signs of melanoma (cough, dyspnea, tenderness, localized neurologic signs such as weakness, jaundice, or any other sign suggesting systemic spread) or absence of symptoms of melanoma (pain, paresthesia, or any other symptom suggesting the possibility of systemic spread of melanoma): G8749

NUMERATOR (REPORTING CRITERIA 1):

Patients for whom no diagnostic imaging studies were ordered

Numerator Instructions: A higher score indicates appropriate treatment of patients with melanoma without additional signs or symptoms.

Definition:

Diagnostic Imaging Studies – CXR, CT, Ultrasound, MRI, PET, and nuclear medicine scans. Ordering any of these imaging studies during the one year measurement period is considered a failure of the measure, unless a justified reason is documented through use of a medical or system reason for exception.

Numerator Options:

Performance Met: None of the following diagnostic imaging studies ordered: chest x-ray, CT, Ultrasound, MRI, PET, or nuclear medicine scans **(3320F)**

OR

Medical Performance Exclusion: Documentation of medical reason(s) for ordering diagnostic imaging studies (eg, patient has co-morbid condition that warrants imaging, other medical reasons) **(3319F *with* 1P)**

OR

System Performance Exclusion: Documentation of system reason(s) for ordering diagnostic imaging studies (eg, requirement for clinical trial enrollment, ordered by another provider, other system reasons) **(3319F *with* 3P)**

OR

Performance Not Met: One of the following diagnostic imaging studies ordered; chest x-ray, CT, Ultrasound, MRI, PET, or nuclear medicine scans **(3319F)**

OR

REPORTING CRITERIA 2: Patients with a history of any stage melanoma without signs or symptoms suggesting systemic spread

DENOMINATOR (REPORTING CRITERIA 2):

All patients, regardless of age, with a history of melanoma of any stage, without signs or symptoms suggesting systemic spread, seen for an office visit during the one-year measurement period

Definitions:
Signs – For the purposes of this measure, signs include tenderness, jaundice, localized neurologic signs such as weakness, or any other sign.
Symptoms – For the purposes of this measure, symptoms include cough, dyspnea, pain, paresthesia, or any other symptom suggesting the possibility of systemic spread.

Denominator Criteria (Eligible Cases) 2:
Diagnosis for history of melanoma (ICD-9-CM) [for use 1/1/2015-9/30/2015]: V10.82
Diagnosis for history of melanoma (ICD-10-CM) [for use 10/01/2015-12/31/2015]: Z85.820
AND
Patient encounter during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215
AND
Absence of signs of melanoma (cough, dyspnea, tenderness, localized neurologic signs such as weakness, jaundice or any other sign suggesting systemic spread) or absence of symptoms of melanoma (pain, paresthesia, or any other symptom suggesting the possibility of systemic spread of melanoma): G8749

NUMERATOR (REPORTING CRITERIA 2):
Patients for whom no diagnostic imaging studies were ordered

Numerator Instructions: A higher score indicates appropriate treatment of patients with melanoma without additional signs or symptoms.

Definition:
Diagnostic Imaging Studies – CXR, CT, Ultrasound, MRI, PET, and nuclear medicine scans. Ordering any of these imaging studies during the one year measurement period is considered a failure of the measure, unless a justified reason is documented through use of a medical or system reason for exception.

Numerator Options:

Performance Met:	None of the following diagnostic imaging studies ordered: chest x-ray, CT, Ultrasound, MRI, PET, or nuclear medicine scans **(3320F)**
OR	
Medical Performance Exclusion:	Documentation of medical reason(s) for ordering diagnostic imaging studies (eg, patient has co-morbid condition that warrants imaging, other medical reasons) **(3319F *with* 1P)**
OR	
System Performance Exclusion:	Documentation of system reason(s) for ordering diagnostic imaging studies (eg, requirement for clinical trial enrollment, ordered by another provider, other system reasons) **(3319F *with* 3P)**
OR	
Performance Not Met:	One of the following diagnostic imaging studies ordered; chest x-ray, CT, Ultrasound, MRI, PET, or nuclear medicine scans **(3319F)**

RATIONALE:
There is no valid indication for expensive imaging studies in early stage melanoma in the absence of signs or symptoms. There is a perception that radiologic studies are being administered for grade 0 and grade I melanoma that are clinically unnecessary and create economic burden to the patient and payer. While diagnostic imaging is also

inappropriate for patients with higher stages of melanoma as well, this measure is a first step in addressing the over-utilization of diagnostic imaging studies in patients with melanoma.

Diagnostic imaging is the fastest growing medical expenditure in the United States with an annual 9% growth rate - more than twice that of general medical expenditures. Studies have found overuse of diagnostic imaging and duplication of other types of scans add little or no value. Unnecessary or inappropriate tests not only incur excess expenditures, but may also expose patients to extra risk. For example, the radiation exposure of a CT scan can be several hundred times that of a chest X-ray. The advances in cardiac imaging have resulted in the inappropriate application of these imaging modalities resulting in substantial, unexplained regional variability and increased attendant costs.

CLINICAL RECOMMENDATION STATEMENTS:

In asymptomatic patients with localized cutaneous melanoma of any thickness, baseline blood tests and imaging studies are generally not recommended and should only be performed as clinically indicated for suspicious signs and symptoms. (AAD, 2011)

Routine cross-sectional imaging (CT, PET, MRI) is not recommended for patient with localized melanoma. For patients with stage IA melanoma, this is consistent with the National Institutes of Health guideline. For patients with stage IB to IIC, this recommendation is based on the very low yield of detection of subclinical disease. In patients with stage IIB-IIC, chest x-ray is optional. In any patient with localized melanoma, cross-sectional imaging should only be used to investigate specific signs or symptoms. (NCCN, 2011)

Measure #225 (NQF 0509): Radiology: Reminder System for Screening Mammograms – National Quality Strategy Domain: Communication and Care Coordination

2015 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of patients aged 40 years and older undergoing a screening mammogram whose information is entered into a reminder system with a target due date for the next mammogram

INSTRUCTIONS:
This measure is to be reported **each time** a screening mammogram is performed during the reporting period for patients seen during the reporting period. This measure is intended to reflect the quality of services provided for reminding patients when follow-up mammograms are due.

Measure Reporting via Claims:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT or HCPCS codes, and patient demographics are used to identify patients who are included in the measure's denominator. CPT Category II codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the appropriate ICD-9-CM/ICD-10-CM diagnosis codes, CPT or HCPCS codes, and the appropriate CPT Category II code **OR** the CPT Category II code **with** the modifier. The modifier allowed for this measure is: 8P- reasons not otherwise specified. There are no allowable performance exclusions for this measure. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT or HCPCS codes, and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

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

DENOMINATOR:
All patients aged 40 years and older undergoing a screening mammogram

> **Denominator Criteria (Eligible Cases):**
> Patients aged ≥ 40 years on date of encounter
> **AND**
> **Diagnosis for mammogram screening (ICD-9-CM) [for use 1/1/2015-9/30/2015]:** V76.11, V76.12
> **Diagnosis for mammogram screening (ICD-10-CM) [for use 10/01/2015-12/31/2015]:** Z12.31
> **AND**
> **Patient encounter during the reporting period (CPT or HCPCS):** 77057, G0202

NUMERATOR:
Patients whose information is entered into a reminder system with a target due date for the next mammogram

> **Numerator Instructions:** The reminder system should be linked to a process for notifying patients when their next mammogram is due and should include the following elements at a minimum: patient identifier,

patient contact information, dates(s) of prior screening mammogram(s) (if known), and the target due date for the next mammogram.

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Patient Information Entered into a Reminder System with Target Due Date for the Next Mammogram

***Performance Met:* CPT II 7025F:** Patient information entered into a reminder system with a target due date for the next mammogram

OR

Patient Information not Entered into a Reminder System, Reason Not Otherwise Specified

Append a reporting modifier (**8P**) to CPT Category II code **7025F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

***Performance Not Met:* 7025F *with* 8P:** Patient Information **not** entered into a reminder system, reason not otherwise specified

RATIONALE:

Although screening mammograms can reduce breast cancer mortality by 20-35% in women aged 40 years and older, recent evidence shows that only 72% of women are receiving mammograms based on current guideline recommendations. The use of patient reminders is associated with an increase in screening mammography. Encouraging the implementation of a reminder system could lead to an increase in mammography screening at appropriate intervals.

CLINICAL RECOMMENDATION STATEMENTS:

The Task Force [on Community Preventive Services] recommends client reminders to increase breast cancer screening on the basis of strong evidence of effectiveness. (TFCPS, 2010)

▲ Measure #226 (NQF 0028): Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention – National Quality Strategy Domain: Community / Population Health

2015 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

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

INSTRUCTIONS:
This measure is to be reported **once per reporting period** for patients seen during the reporting period. This measure is intended to reflect the quality of services provided for preventive screening for tobacco use.

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

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

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

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

DENOMINATOR:
All patients aged 18 years and older

> **Denominator Criteria (Eligible Cases):**
> Patients aged ≥ 18 years on date of encounter
> **AND**
> **Patient encounter during the reporting period (CPT or HCPCS):** 90791, 90792, 90832, 90834, 90837, 90845, 92002, 92004, 92012, 92014, 96150, 96151, 96152, 97003, 97004, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215**,** 99406, 99407**,** G0438, G0439

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

> **Definitions:**
> **Tobacco Use** – Includes use of any type of tobacco.
> **Cessation Counseling Intervention** – Includes brief counseling (3 minutes or less), and/or pharmacotherapy.
>
> ***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, Identified as a User and Received Intervention

***Performance Met:* 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

***Performance Met:* 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

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

OR

Tobacco Screening OR Tobacco Cessation Intervention not Performed, Reason Not Otherwise Specified

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

***Performance Not Met:* 4004F *with* 8P:** Tobacco screening OR tobacco cessation intervention **not** performed, reason not otherwise specified

RATIONALE:

This measure is intended to promote adult tobacco screening and tobacco cessation interventions for those who use tobacco products. There is good evidence that tobacco screening and brief cessation intervention (including counseling and/or pharmacotherapy) is successful in helping tobacco users quit. Tobacco users who are able to stop smoking lower their risk for heart disease, lung disease, and stroke.

CLINICAL RECOMMENDATION STATEMENTS:

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

All patients should be asked if they use tobacco and should have their tobacco use status documented on a regular basis. Evidence has shown that clinic screening systems, such as expanding the vital signs to include tobacco use status or the use of other reminder systems such as chart stickers or computer prompts, significantly increase rates of clinician intervention. (Strength of Evidence = A) (U.S. Department of Health and Human Services. Public Health Service, 2008)

All physicians should strongly advise every patient who smokes to quit because evidence shows that physician advice to quit smoking increases abstinence rates. (Strength of Evidence = A) (U.S. Department of Health and Human Services. Public Health Service, 2008)

Minimal interventions lasting less than 3 minutes increase overall tobacco abstinence rates. Every tobacco user should be offered at least a minimal intervention, whether or not he or she is referred to an intensive intervention. (Strength of Evidence = A) (U.S. Department of Health and Human Services. Public Health Service, 2008)

The combination of counseling and medication is more effective for smoking cessation than either medication or counseling alone. Therefore, whenever feasible and appropriate, both counseling and medication should be provided to patients trying to quit smoking. (Strength of Evidence = A) (U.S. Department of Health and Human Services. Public Health Service, 2008)

Clinicians should encourage all patients attempting to quit to use effective medications for tobacco dependence treatment, except where contraindicated or for specific populations for which there is insufficient evidence of effectiveness (ie, pregnant women, smokeless tobacco users, light smokers, and adolescents). (Strength of Evidence = A) (U.S. Department of Health and Human Services. Public Health Service, 2008)

The USPSTF recommends that clinicians ask all adults about tobacco use and provide tobacco cessation interventions for those who use tobacco products. (A Recommendation) (U.S. Preventive Services Task Force, 2009)

♦ Measure #236 (NQF 0018): Controlling High Blood Pressure – National Quality Strategy Domain: Effective Clinical Care

2015 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of patients 18 through 85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (< 140/90 mmHg) during the measurement period **INSTRUCTIONS:**

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

In reference to the numerator element, only blood pressure readings performed by a clinician in the provider office are acceptable for numerator compliance with this measure. Do not include blood pressure readings that meet the following criteria:

- Blood pressure readings from the patient's home (including readings directly from monitoring devices).
- Taken during an outpatient visit which was for the sole purpose of having a diagnostic test or surgical procedure performed (eg, sigmoidoscopy, removal of a mole).
- Obtained the same day as a major diagnostic or surgical procedure (eg, stress test, administration of IV contrast for a radiology procedure, endoscopy).

If no blood pressure is recorded during the measurement period, the patient's blood pressure is assumed "not controlled".

Measure Reporting via Claims:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT or HCPCS code and patient demographics are used to identify patients who are included in the measure's denominator. Quality-data codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed ICD-9-CM/ICD-10-CM diagnosis codes, CPT or HCPCS codes and the appropriate quality-data code. The reporting modifier allowed for this measure is: 8P- reason not otherwise specified. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT or HCPCS codes and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

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

DENOMINATOR:
Patients 18 through 85 years of age who had a diagnosis of essential hypertension within the first six months of the measurement period or any time prior to the measurement period

Denominator Criteria (Eligible Cases):
Patients 18 through 85 years of age on date of encounter
AND

Diagnosis for hypertension (ICD-9-CM) [for use 01/01/2015-09/30/2015]: 401.0, 401.1, 401.9
Diagnosis for hypertension (ICD-10-CM) [for use 10/01/2015-12/31/2015]: I10
AND
Patient encounter during reporting period (CPT or HCPCS): 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, G0402, G0438, G0439

NUMERATOR:
Patients whose most recent blood pressure is adequately controlled (systolic blood pressure < 140 mmHg and diastolic blood pressure < 90 mmHg) during the measurement period

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)****:*

Performance Met: **G8752:**	Most recent systolic blood pressure < 140 mmHg
OR	
Performance Not Met: **G8753:**	Most recent systolic blood pressure ≥ 140 mmHg

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

Performance Met**: G8754:**	Most recent diastolic blood pressure < 90 mmHg
OR	
Performance Not Met**: G8755:**	Most recent diastolic blood pressure ≥ 90 mmHg

OR
Patient not Eligible for Recommended Blood Pressure Parameters for Documented Reasons

Other Performance Exclusion: **G9231:**	Documentation of end stage renal disease (ESRD), dialysis, renal transplant or pregnancy.

OR
Blood Pressure Measurement not Documented, Reason not Given

Performance Not Met: **G8756:**	**No** documentation of blood pressure measurement, reason not given

RATIONALE:
Hypertension is a very significant health issue in the United States. Fifty million or more Americans have high blood pressure that warrants treatment, according to the National Health and Nutrition Examination Survey (NHANES) survey (Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure 2003). The United States Preventive Services Task Force (USPSTF) recommends that clinicians screen adults aged 18 and older for high blood pressure (United States Preventive Services Task Force 2007).

The most frequent and serious complications of uncontrolled hypertension include coronary heart disease, congestive heart failure, stroke, ruptured aortic aneurysm, renal disease, and retinopathy. The increased risks of hypertension are present in individuals ranging from 40 to 89 years of age. For every 20 mmHg systolic or 10 mmHg diastolic increase in blood pressure, there is a doubling of mortality from both ischemic heart disease and stroke (Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure 2003).

Better control of blood pressure has been shown to significantly reduce the probability that these undesirable and costly outcomes will occur. The relationship between the measure (control of hypertension) and the long-term clinical outcomes listed is well established. In clinical trials, antihypertensive therapy has been associated with reductions in stroke incidence (35-40 percent), myocardial infarction incidence (20-25 percent) and heart failure incidence (>50

percent) (Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure 2003).

CLINICAL RECOMMENDATION STATEMENTS:

The United States Preventive Services Task Force (2007) recommends screening for high blood pressure in adults age 18 years and older. This is a grade A recommendation.

Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure (2003): Treating systolic blood pressure and diastolic blood pressure to targets that are < 140/90 mmHg is associated with a decrease in cardiovascular disease complications.

♦ Measure #238 (NQF 0022): Use of High-Risk Medications in the Elderly – National Quality Strategy Domain: Patient Safety

2015 PHYSICIAN QUALITY REPORTING OPTIONS FOR INDIVIDUAL MEASURES
REGISTRY ONLY

DESCRIPTION:
Percentage of patients 66 years of age and older who were ordered high-risk medications. Two rates are reported.

1) Percentage of patients who were ordered at least one high-risk medication.
2) Percentage of patients who were ordered at least two different high-risk medications.

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

This measure will be calculated with 2 performance rates:

1) Percentage of patients who were ordered at least one high-risk medication
2) Percentage of patients who were ordered at least two different high-risk medications

Eligible professionals should continue to report the measure as specified, with no additional steps needed to account for multiple performance rates.

Measure Reporting via Registry:
CPT or HCPCS codes and patient demographics are used to identify visits that are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

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

There are two reporting criteria for this measure:

1) **Percentage of patients who were ordered at least one high-risk medication**

OR

2) **Percentage of patients who were ordered at least two different high-risk medications**

REPORTING CRITERIA 1: Percentage of patients who were ordered at least one high-risk medication

DENOMINATOR (REPORTING CRITERIA 1) :
Patients 66 years and older who had a visit during the measurement period

Denominator Criteria (Eligible Cases) 1:
Patients aged ≥ 66 years on date of encounter
AND
Patient encounter during reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, G0438, G0439

NUMERATOR (REPORTING CRITERIA 1):

Percentage of patients who were ordered at least one high-risk medication during the measurement period

Numerator Instructions: A lower calculated performance rate for this measure indicates better clinical care or control.

A high-risk medication is identified by either of the following:

- A prescription for medications classified as high risk at any dose and for any duration listed in Table 1
- Prescriptions for medications classified as high risk at any dose with greater than a 90 day cumulative medication duration listed in Table 2

Definition:

Cumulative Medication Duration - an individual's total number of medication days over a specific period; the period counts multiple prescriptions with gaps in between, but does not count the gaps during which a medication was not dispensed.

To determine the cumulative medication duration, determine first the number of the Medication Days for each prescription in the period: the number of doses divided by the dose frequency per day. Then add the Medication Days for each prescription without counting any days between the prescriptions.

High risk medication –

Table 1: High-Risk Medications at any dose or duration

Description	Prescription	
Anticholinergics (excludes TCAs), first-generation antihistamines	• Brompheniramine • Carbinoxamine • Chlorpheniramine • Clemastine • Cyproheptadine • Dexbrompheniramine	• Dexchlorpheniramine • Diphenhydramine (oral) • Doxylamine • Hydroxyzine • Promethazine • Triprolidine
Anticholinergics (excludes TCAs), anti-Parkinson agents	• Benztropine (oral)	• Trihexyphenidyl
Antithrombotics	• Dipyridamole, oral short-acting (does not apply to the extended-release combination with aspirin)	• Ticlopidine
Cardiovascular, alpha agonists, central	• Guanabenz • Guanfacine	• Methyldopa
Cardiovascular, other	• Disopyramide	• Nifedipine, immediate release
Central nervous system, tertiary TCAs	• Amitriptyline • Clomipramine	• Imipramine • Trimipramine
Central nervous system, barbiturates	• Amobarbital • Butabarbital • Butalbital • Mephobarbital	• Pentobarbital • Phenobarbital • Secobarbital
Central nervous system, vasodilators	• Ergot mesylates	• Isoxsuprine
Central nervous system, other	• Thioridazine • Chloral Hydrate	• Meprobamate

Description	Prescription	
Endocrine system, estrogens with or without progestins; include only oral and topical patch products	• Conjugated estrogen • Esterified estrogen	• Estradiol • Estropipate
Endocrine system, sulfonylureas, long-duration	• Chlorpropamide	• Glyburide
Endocrine system, other	• Desiccated thyroid	• Megestrol
Gastrointestinal system, other	• Trimethobenzamide	
Pain medications, skeletal muscle relaxants	• Carisoprodol • Chlorzoxazone • Cyclobenzaprine	• Metaxalone • Methocarbamol • Orphenadrine
Pain medications, other	• Indomethacin • Ketorolac, includes parenteral	• Meperidine • Pentazocine

Table 2: High-Risk Medications With Days Supply Criteria

Description	Prescription		Days Supply Criteria
Anti-Infectives, other	• Nitrofurantoin • Nitrofurantoin macrocrystals	• Nitrofurantoin macrocrystals-monohydrate	>90 days
Nonbenzodiazepine hypnotics	• Eszopiclone • Zaleplon	• Zolpidem	>90 days

NUMERATOR NOTE: *Some high-risk medications are not included in this specific measure but should be avoided above a specified average daily dose. These medications are listed in table DAE-C. To calculate an average daily dose multiply the quantity of pills ordered by the dose of each pill and divide by the days supply. For example, a prescription for a 30-days supply of digoxin containing 15 pills, 0.250 mg each pill, has an average daily dose of 0.125 mg.*

Table DAE-C: High-Risk Medications With Average Daily Dose Criteria

Description	Prescription	Average Daily Dose Criteria
Alpha agonists, central	• Reserpine	>0.1 mg/day
Cardiovascular, other	• Digoxin	>0.125 mg/day
Tertiary TCAs (as single agent or as part of combination products)	• Doexpin	>6 mg/day

Numerator Options:

Performance Met: One high-risk medication ordered **(G9365)**

OR

Performance Not Met: One high-risk medication **not** ordered **(G9366)**

OR

REPORTING CRITERIA 2: Percentage of patients who were ordered at least two different high-risk medications

DENOMINATOR (REPORTING CRITERIA 2):
Patients 66 years and older who had a visit during the measurement period

Denominator Criteria (Eligible Cases) 2:
Patients aged ≥ 66 years on date of encounter
AND
Patient encounter during reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, G0438, G0439

NUMERATOR (REPORTING CRITERIA 2):
Percentage of patients who were ordered at least two different high-risk medications during the measurement period

Numerator Instructions: A lower calculated performance rate for this measure indicates better clinical care or control.

A high-risk medication is identified by either of the following:

- A prescription for medications classified as high risk at any dose and for any duration listed in Table 1
- Prescriptions for medications classified as high risk at any dose with greater than a 90 day cumulative medication duration listed in Table 2

Definition:
Cumulative Medication Duration – an individual's total number of medication days over a specific period; the period counts multiple prescriptions with gaps in between, but does not count the gaps during which a medication was not dispensed.
To determine the cumulative medication duration, determine first the number of the Medication Days for each prescription in the period: the number of doses divided by the dose frequency per day. Then add the Medication Days for each prescription without counting any days between the prescriptions.
High risk medication –

Table 1: High-Risk Medications at any dose or duration

Description	Prescription	
Anticholinergics (excludes TCAs), first-generation antihistamines	• Brompheniramine • Carbinoxamine • Chlorpheniramine • Clemastine • Cyproheptadine • Dexbrompheniramine	• Dexchlorpheniramine • Diphenhydramine (oral) • Doxylamine • Hydroxyzine • Promethazine • Triprolidine
Anticholinergics (excludes TCAs), anti-Parkinson agents	• Benztropine (oral)	• Trihexyphenidyl
Antithrombotics	• Dipyridamole, oral short-acting (does not apply to the extended-release combination with aspirin)	• Ticlopidine
Cardiovascular, alpha agonists, central	• Guanabenz • Guanfacine	• Methyldopa

Description	Prescription	
Cardiovascular, other	• Disopyramide	• Nifedipine, immediate release
Central nervous system, tertiary TCAs	• Amitriptyline • Clomipramine	• Imipramine • Trimipramine
Central nervous system, barbiturates	• Amobarbital • Butabarbital • Butalbital • Mephobarbital	• Pentobarbital • Phenobarbital • Secobarbital
Central nervous system, vasodilators	• Ergot mesylates	• Isoxsuprine
Central nervous system, other	• Thioridazine • Chloral Hydrate	• Meprobamate
Endocrine system, estrogens with or without progestins; include only oral and topical patch products	• Conjugated estrogen • Esterified estrogen	• Estradiol • Estropipate
Endocrine system, sulfonylureas, long-duration	• Chlorpropamide	• Glyburide
Endocrine system, other	• Desiccated thyroid	• Megestrol
Gastrointestinal system, other	• Trimethobenzamide	
Pain medications, skeletal muscle relaxants	• Carisoprodol • Chlorzoxazone • Cyclobenzaprine	• Metaxalone • Methocarbamol • Orphenadrine
Pain medications, other	• Indomethacin • Ketorolac, includes parenteral	• Meperidine • Pentazocine

Table 2: High-Risk Medications With Days Supply Criteria

Description	Prescription		Days Supply Criteria
Anti-Infectives, other	• Nitrofurantoin • Nitrofurantoin macrocrystals	• Nitrofurantoin macrocrystals-monohydrate	>90 days
Nonbenzodiazepine hypnotics	• Eszopiclone • Zaleplon	• Zolpidem	>90 days

NUMERATOR NOTE: *Some high-risk medications are not included in this specific measure but should be avoided above a specified average daily dose. These medications are listed in table DAE-C. To calculate an average daily dose multiply the quantity of pills ordered by the dose of each pill and divide by the days supply. For example, a prescription for a 30-days supply of digoxin containing 15 pills, 0.250 mg each pill, has an average daily dose of 0.125 mg.*

Table DAE-C: High-Risk Medications With Average Daily Dose Criteria

Description	Prescription	Average Daily Dose Criteria
Alpha agonists, central	• Reserpine	>0.1 mg/day
Cardiovascular, other	• Digoxin	>0.125 mg/day
Tertiary TCAs (as single agent or as part of combination products)	• Doxepin	>6 mg/day

Numerator Options:

Performance Met: At least two different high-risk medications ordered **(G9367)**

OR

Performance Not Met: At least two different high-risk medications **not** ordered **(G9368)**

RATIONALE:

Seniors receiving inappropriate medications are more likely to report poorer health status at follow-up, compared to seniors who receive appropriate medications (Fu, Liu, and Christensen 2004). In 2005, rates of potentially inappropriate medication use in the elderly were as large or larger than in a 1996 national sample, highlighting the need for progress in this area (Simon et al. 2005). While some adverse drug events are not preventable, studies estimate that between 30 and 80 percent of adverse drug events in the elderly are preventable (MacKinnon and Hepler 2003).

Reducing the number of inappropriate prescriptions can lead to improved patient safety and significant cost savings. Conservative estimates of extra costs due to potentially inappropriate medications in the elderly average $7.2 billion a year (Fu, Liu, and Christensen 2004). Medication use by older adults will likely increase further as the U.S. population ages, new drugs are developed, and new therapeutic and preventive uses for medications are discovered (Rothberg et al. 2008). By the year 2030, nearly one in five U.S. residents is expected to be aged 65 years or older; this age group is projected to more than double in number from 38.7 million in 2008 to more than 88.5 million in 2050. Likewise, the population aged 85 years or older is expected to increase almost four-fold, from 5.4 million to 19 million between 2008 and 2050. As the elderly population continues to grow, the number of older adults who present with multiple medical conditions for which several medications are prescribed continues to increase, resulting in polypharmacy (Gray and Gardner 2009).

CLINICAL RECOMMENDATION STATEMENTS:

The measure is based on the literature and key clinical expert consensus processes by Beers in 1997, Zahn in 2001 and an updated process by Fick in 2003, which identified drugs of concern in the elderly based on various high-risk criteria. NCQA's Medication Management expert panel selected a subset of drugs that should be used with caution in the elderly for inclusion in the proposed measure based upon these two lists. NCQA analyzed the prevalence of drugs prescribed according to the Beers and Zhan classifications and determined that drugs identified by Zhan that are classified as never or rarely appropriate would form the basis for the list (Fick 2003).

Certain medications (MacKinnon 2003) are associated with increased risk of harms from drug side-effects and drug toxicity and pose a concern for patient safety. There is clinical consensus that these drugs pose increased risks in the elderly (Kaufman 2005). Studies link prescription drug use by the elderly with adverse drug events that contribute to hospitalization, increased length of hospital stay, increased duration of illness, nursing home placement and falls and fractures that are further associated with physical, functional and social decline in the elderly (AHRQ 2009).

➧ Measure #242: Coronary Artery Disease (CAD): Symptom Management – National Quality Strategy Domain: Effective Clincial Care

2015 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Percentage of patients aged 18 years and older with a diagnosis of coronary artery disease (CAD) seen within a 12 month period with results of an evaluation of level of activity and an assessment of whether anginal symptoms are present or absent with appropriate management of anginal symptoms within a 12 month period

INSTRUCTIONS:
This measure is to be reported a minimum of **once per reporting period** for all patients with a diagnosis of coronary artery disease seen during the reporting period. This measure may be reported by clinicians who perform the quality actions described in the measure for the primary management of patients with CAD based on the services provided and the measure-specific denominator coding. Only patients who had at least two denominator eligible visits during the reporting period will be counted into the denominator of this measure.

This measure will be calculated with 3 performance rates:

1) Evaluation of level of activity and evaluation of symptoms includes no report of anginal symptoms
2) Evaluation of level of activity and evaluation of symptoms includes report of anginal symptoms and a plan of care is documented to achieve control of anginal symptoms
3) Total comprising both 1) and 2)

Measure Reporting via Registry:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

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

DENOMINATOR:
All patients aged 18 years and older with a diagnosis of coronary artery disease seen within a 12 month period with results of an evaluation of level of activity and an assessment of whether anginal symptoms are present or absent

DENOMINATOR NOTE: *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 (eg, Seattle Angina Questionnaire or other validated questionnaire) to quantify angina and level of activity*

Definition:
Canadian Cardiovascular Society (CCS) Angina Classification:
Class 0: Asymptomatic
Class 1: Angina with strenuous exercise
Class 2: Angina with moderate exertion
Class 3: Angina with mild exertion

- Walking 1-2 level blocks at normal pace
- Climbing 1 flight of stairs at normal pace

Class 4: Angina at any level of physical exertion

Denominator Criteria (Eligible Cases):
Patient aged ≥ 18 years on date of encounter
AND
Diagnosis for coronary artery disease (ICD-9-CM) [for use 1/1/2015-9/30/2015]: 410.00, 410.01, 410.02, 410.10, 410.11, 410.12, 410.20, 410.21, 410.22, 410.30, 410.31, 410.32, 410.40, 410.41, 410.42, 410.50, 410.51, 410.52, 410.60, 410.61, 410.62, 410.70, 410.71, 410.72, 410.80, 410.81, 410.82, 410.90, 410.91, 410.92, 411.0, 411.1, 411.81, 411.89, 412, 413.0, 413.1, 413.9, 414.00, 414.01, 414.02, 414.03, 414.04, 414.05, 414.06, 414.07, 414.2, 414.3, 414.8, 414.9, V45.81, V45.82
Diagnosis for coronary artery disease (ICD-10-CM) [for use 10/01/2015-12/31/2015]: 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, I25.810, I25.811, I25.812, I25.82, I25.83, I25.89, I25.9, Z95.1, Z95.5, Z98.61
AND
Patient encounter during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350
AND
Two Denominator Eligible Visits
AND
Severity of angina assessed by level of activity: 1010F

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

Definition:
Appropriate Management of Anginal Symptoms Includes the Following:

1) Absence of anginal symptoms as determined by evaluation of level of activity and symptoms

OR

2) Presence of anginal symptoms as determined by evaluation of level of activity and symptoms and a plan of care is documented to achieve control of anginal symptoms
   Documented plan of care may include:

   a) 2 or more anti-anginal medications prescribed**, OR
   b) Referral for consideration for coronary revascularization, OR
   c) 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:
Performance Met: Angina absent **(1012F)**
OR
Performance Met: Angina present **(1011F)**
AND
Plan of care to manage anginal symptoms documented (**0557F)**

OR

Performance Met:	Angina Present ***(1011F)***
AND	
Medical Performance Exclusion:	Documentation of medical reason(s) for not providing any specified element of plan of care to achieve control of anginal symptoms (eg, allergy, intolerance, other medical reasons) **(0557F *with* 1P)**
OR	
Patient Performance Exclusion:	Documentation of patient reason(s) for not providing any specified element of plan of care to achieve control of angina symptoms (eg, patient declined, other patient reasons) **(0557F with 2P)**
OR	
System Performance Exclusion:	Documentation of system reason(s) for not providing any specified element of plan of care to achieve control of anginal symptoms (eg, financial reasons, other reasons attributable to the health care system) **(0557F *with* 3P)**

OR

Performance Not Met:	Angina present **(1011F)**
AND	
Plan of care to achieve control of angina symptoms was **not** performed, reason not otherwise specified **(0557F *with* 8P)**	

RATIONALE:

In order to effectively manage the symptoms of a patient with chronic stable coronary artery disease, an assessment of those symptoms needs to be performed. This assessment is the basis of any treatment modification that needs to be made. Effective management of the symptoms associated with chronic stable coronary artery disease (eg, chest pain, shortness of breath) through medication management or referral for consideration of revascularization or other additional treatment. This may lead to improved patient quality of life, an important patient-centered outcome.

CLINICAL RECOMMENDATION STATEMENTS:

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

2012 ACCF/AHA/ACP/AATS/PCNA/SCAI/STS Guideline for the Diagnosis and Management of Patients With Stable Ischemic Heart Disease (SIHD)

Medical Therapy for Relief of Symptoms

USE OF ANTI-ISCHEMIC MEDICATIONS: RECOMMENDATIONS

Beta blockers should be prescribed as initial therapy for relief of symptoms in patients with SIHD. (Class I Recommendation, Level of Evidence: B)

Calcium channel blockers or long-acting nitrates should be prescribed for relief of symptoms when beta blockers are contraindicated or cause unacceptable side effects in patients with SIHD. (Class I Recommendation, Level of Evidence: B)

Calcium channel blockers or long-acting nitrates, in combination with beta blockers, should be prescribed for relief of symptoms when initial treatment with beta blockers is unsuccessful in patients with SIHD. (Class I Recommendation, Level of Evidence: B)

Sublingual nitroglycerin or nitroglycerin spray is recommended for immediate relief of angina in patients with SIHD. (Class I Recommendation, Level of Evidence: B)

●Measure #243 (NQF 0643): Cardiac Rehabilitation Patient Referral from an Outpatient Setting – National Quality Strategy Domain: Effective Clinical Care

2015 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Percentage of patients evaluated in an outpatient setting who within the previous 12 months have experienced an acute myocardial infarction (MI), coronary artery bypass graft (CABG) surgery, a percutaneous coronary intervention (PCI), cardiac valve surgery, or cardiac transplantation, or who have chronic stable angina (CSA) and have not already participated in an early outpatient cardiac rehabilitation/secondary prevention (CR) program for the qualifying event/diagnosis who were referred to a CR program

Definition:
Referral - A referral is defined as an official communication between the health care provider and the patient to recommend and carry out a referral order to an outpatient CR program. This includes the provision of all necessary information to the patient that will allow the patient to enroll in an outpatient CR program. This also includes a written or electronic communication between the healthcare provider or healthcare system and the cardiac rehabilitation program that includes the patient's enrollment information for the program. A hospital discharge summary or office note may potentially be formatted to include the necessary patient information to communicate to the CR program (the patient's cardiovascular history, testing, and treatments, for instance). According to standards of practice for cardiac rehabilitation programs, care coordination communications are sent to the referring provider, including any issues regarding treatment changes, adverse treatment responses, or new non-emergency condition (new symptoms, patient care questions, etc.) that need attention by the referring provider. These communications also include a progress report once the patient has completed the program. All communications must maintain an appropriate level of confidentiality as outlined by the 1996 Health Insurance Portability and Accountability Act (HIPAA).

Note: *A patient with a qualifying diagnosis should have a referral to CR within the subsequent 12 months. In the event that the patient has a second (recurrent) qualifying event before the original 12 month "referral" period has ended, a new 12 month "referral" period for CR referral starts at the time of the second qualifying event, since the patient again becomes eligible for CR at that time.*

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for all patients seen during the reporting period who had a qualifying diagnosis within the previous 12 months and who have not already participated in an outpatient CR program. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

Measure Reporting via Registry:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT or HCPCS codes, and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

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

DENOMINATOR:
All patients age ≥ 18 years evaluated in the outpatient setting during the reporting period who have a qualifying event/diagnosis [chronic stable angina (CSA), or who **within the previous 12 months** have had an acute myocardial infarction (AMI) or have undergone coronary artery bypass graft (CABG) surgery, a percutaneous coronary

intervention (PCI), cardiac valve surgery, or cardiac transplantation] who do not meet any of the exclusion criteria (patient factors, medical factors, health care system factors) and who have not already participated in an early outpatient cardiac rehabilitation/secondary prevention (CR) program

Denominator Instructions: Coronary Artery Bypass Graft, Percutaneous Coronary Intervention, Cardiac Valve surgery, Cardiac Transplant or Acute Myocardial Infarction, in order to meet the criteria for inclusion of the measure, must have occurred or been performed within 12 months of date of encounter.

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Patient encounter during the reporting period (CPT or HCPCS): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, G0438, G0439
AND
Diagnosis of Chronic Stable Angina (ICD-9-CM) [for use 1/1/2015-9/30/2015]: 413.0, 413.1, 413.9
Diagnosis for Chronic Stable Angina (ICD-10-CM) [for use 10/01/2015-12/31/2015]: I20.1, I20.8, I20.9
OR
Diagnosis of Acute Myocardial Infarction (ICD-9-CM) [for use 1/1/2015-9/30/2015]: 410.00, 410.01, 410.02, 410.10, 410.11, 410.12, 410.20, 410.21, 410.22, 410.30, 410.31, 410.32, 410.40, 410.41, 410.42, 410.50, 410.51, 410.52, 410.60, 410.61, 410.62, 410.70, 410.71, 410.72, 410.80, 410.81, 410.82, 410.90, 410.91, 410.92, 412
Diagnosis of Acute Myocardial Infarction (ICD-10-CM) [for use 10/01/2015-12/31/2015]: I21.01, I21.02, I21.09, I21.11, I21.19, I21.21, I21.29, I21.3, I21.4, I22.0, I22.1, I22.2, I22.8, I22.9, I25.2
OR
Coronary Artery Bypass Graft Surgery (CPT): 33510, 33511, 33512, 33513, 33514, 33516, 33517, 33518, 33519, 33521, 33522, 33523, 33530, 33533, 33534, 33535, 33536, 33572, 33999, 35500, 35600
OR
Percutaneous Coronary Intervention (CPT): 92920, 92924, 92928, 92933, 92937, 92941, 92943
OR
Cardiac Valve Surgery (CPT): 33361, 33362, 33363, 33364, 33365, 33400, 33401, 33403, 33404, 33405, 33406, 33410, 33411, 33412, 33413, 33414, 33415, 33416, 33417, 33420, 33422, 33425, 33426, 33427, 33430, 33463, 33464, 33465, 33468, 33470, 33471, 33472, 33474, 33475, 33476, 33478, 33496, 33600, 33602
OR
Cardiac Transplantation (CPT): 33935, 33945
AND
Qualifying cardiac event/diagnosis in previous 12 months: 1460F

NUMERATOR:
Patients who have had a qualifying event/diagnosis **within the previous 12 months,** who have been referred to an outpatient cardiac rehabilitation/secondary prevention (CR) program

Numerator Instructions: CR programs may include a traditional CR program based on face-to-face interactions and training sessions or other options that include home-based approaches. If alternative CR approaches are used, they should be designed to meet appropriate safety standards.

Numerator Options:
Performance Met: Referral to an outpatient cardiac rehabilitation/secondary prevention program
Referred to an outpatient cardiac rehabilitation program **(4500F)**

OR

Medical Performance Exclusion:	Documentation of medical reason(s) for not referring to an outpatient CR program **(4500F *with* 1P)**
OR	
Patient Performance Exclusion:	Documentation of patient reason(s) for not referring to an outpatient CR program **(4500F *with* 2P)**
OR	
System Performance Exclusion:	Documentation of system reason(s) for not referring to an outpatient CR program **(4500F *with* 3P)**
OR	
Other Performance Exclusion:	Previous cardiac rehabilitation for qualifying cardiac event completed **(4510F)**
OR	
Performance Not Met:	Patient **not** referred to outpatient CR/secondary prevention program, reason not otherwise specified **(4500F *with* 8P)**

RATIONALE:

Cardiac rehabilitation services have been shown to help reduce morbidity and mortality in persons who have experienced a recent coronary artery disease event, but these services are used in less than 30% of eligible patients(1). A key component to CR utilization is the appropriate and timely referral of patients to an outpatient CR program. While referral takes place generally while the patient is hospitalized for a qualifying event (MI, CSA, CABG, PCI, cardiac valve surgery, or heart transplantation), there are many instances in which a patient can and should be referred from an outpatient clinical practice setting (eg, when a patient does not receive such a referral while in the hospital, or when the patient fails to follow through with the referral for whatever reason).

This performance measure has been developed to help health care systems implement effective steps in their systems of care that will optimize the appropriate referral of a patient to an outpatient CR program.

This measure is designed to serve as a stand-alone measure or, preferably, to be included within other performance measurement sets that involve disease states or other conditions for which CR services have been found to be appropriate and beneficial (eg, following MI, CABG surgery)(2, 3). This performance measure is provided in a format that is meant to allow easy and flexible inclusion into such performance measurement sets.

Referral of appropriate outpatients to a CR program is the responsibility of the health care provider within a health care system that is providing the primary cardiovascular care to the patient in the outpatient setting.

CLINICAL RECOMMENDATION STATEMENTS:

2011 ACCF/AHA Guideline for Coronary Artery Bypass Graft Surgery(4)

Class I

Cardiac rehabilitation is recommended for all eligible patients after CABG. (Level of Evidence: A)

ACC/AHA 2007 Update of the Guidelines for the Management of Patients with ST-Elevation Myocardial Infarction(5)

Class I

Advising medically supervised programs (cardiac rehabilitation) for high-risk patients (eg, recent acute coronary syndrome or revascularization, heart failure) is recommended. (Level of Evidence: B)

ACC/AHA 2007 Guidelines for the Management of Patients with Unstable Angina and Non–ST-Segment Elevation Myocardial Infarction(6)

Class I

Cardiac rehabilitation/secondary prevention programs are recommended for patients with UA/NSTEMI, particularly those with multiple modifiable risk factors and/or those moderate- to high-risk patients in whom supervised exercise training is particularly warranted. (Level of Evidence: B)

Cardiac rehabilitation/secondary prevention programs, when available, are recommended for patients with UA/NSTEMI, particularly those with multiple modifiable risk factors and those moderate- to high-risk patients in whom supervised or monitored exercise training is warranted. (Level of Evidence: B)

ACC/AHA 2007 Chronic Angina Focused Update of the Guidelines for the Management of Patients With Chronic Stable Angina (7)

Class I

Medically supervised programs (cardiac rehabilitation) are recommended for at-risk patients (eg, recent acute coronary syndrome or revascularization, heart failure). (Level of Evidence: B)

2009 Focused update incorporated into the ACC/AHA 2005 Guidelines for the Diagnosis and Management of Heart Failure in Adults (8)

Class I

Exercise training is beneficial as an adjunctive approach to improve clinical status in ambulatory patients with current or prior symptoms of HF and reduced LVEF. (Level of Evidence: B)

Effectiveness-based Guidelines for the Prevention of Cardiovascular Disease in Women—2011 update: A Guideline from the American Heart Association(9)*Class I*

A comprehensive CVD risk-reduction regimen such as cardiovascular or stroke rehabilitation or a physician-guided home- or community-based exercise training program should be recommended to women with a recent acute coronary syndrome or coronary revascularization, new-onset or chronic angina, recent cerebrovascular event, peripheral arterial disease (Class I; Level of Evidence A) or current/prior symptoms of heart failure and an LVEF ≤35%. (Class I; Level of Evidence B)

ACC/AHA/SCAI 2007 Focused Update of the Guidelines for Percutaneous Coronary Intervention(10)

Class I

Medically supervised exercise programs (cardiac rehabilitation) should be recommended to patients after PCI, particularly for patients at moderate to high risk, for whom supervised exercise training is warranted. (Class I; Level of Evidence A)

Measure #249: Barrett's Esophagus – National Quality Strategy Domain: Effective Clinical Care

2015 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of esophageal biopsy reports that document the presence of Barrett's mucosa that also include a statement about dysplasia

INSTRUCTIONS:
This measure is to be reported each time a patient's surgical pathology report demonstrates Barrett's Esophagus; however, only one QDC per date of service for a patient is required. This measure may be reported by eligible professionals who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

Measure Reporting via Claims:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. CPT Category II codes or quality-data codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and the appropriate CPT Category II code **OR** quality-data code **OR** the CPT Category II code **with** the modifier. The modifiers allowed for this measure are: 1P- medical reasons, 8P- reason not otherwise specified. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

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

DENOMINATOR:
All surgical pathology biopsy reports for Barrett's Esophagus

> **Denominator Criteria (Eligible Cases):**
> **Diagnosis for Barrett's esophagus (ICD-9-CM) [for use 1/1/2015-9/30/2015]:** 530.85
> **Diagnosis for Barrett's esophagus (ICD-10-CM) [for use 10/01/2015-12/31/2015]:** K22.70, K22.710, K22.711, K22.719
> **AND**
> **Patient encounter during the reporting period (CPT):** 88305

NUMERATOR:
Esophageal biopsy report documents the presence of Barrett's mucosa and includes a statement about dysplasia

> ***NUMERATOR NOTE****: Report quality data codes once per patient for each date-of-service.*
>
> **Numerator Quality-Data Coding Options for Reporting Satisfactorily:**
> **Esophageal Biopsy Reports with the Histological Finding of Barrett's Mucosa that Contains a Statement about Dysplasia (present, absent, or indefinite *and if present, contains appropriate grading*)**

Performance Met:* CPT II 3126F:** Esophageal biopsy reports with the histological finding of Barrett's mucosa that contains a statement about dysplasia (present, absent, or indefinite ***and if present, contains appropriate grading)

OR

Esophageal Biopsy Reports with the Histological Finding of Barrett's Mucosa that Contains a Statement about Dysplasia (present, absent, or indefinite) not Performed for Medical Reasons
Append a modifier **(1P)** to Category II code **3126F** to report documented circumstances that appropriately exclude patients from the denominator
***Medical Performance Exclusion:* 3126F *with* 1P:** Documentation of medical reason(s) for not reporting the histological finding of Barrett's mucosa (eg, malignant neoplasm or absence of intestinal metaplasia)

OR

If patient is not eligible for this measure because the specimen is not of esophageal origin report:
***Other Performance Exclusion:* G8797:** Specimen site other than anatomic location of esophagus

OR

Esophageal Biopsy Reports with the Histological Finding of Barrett's Mucosa that does not Contain a Statement about Dysplasia (present, absent, or indefinite), Reason not Otherwise Specified
Append a reporting modifier **(8P)** to CPT Category II code **3126F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified
***Performance Not Met:* 3126F *with* 8P:** Pathology report with the histological finding of Barrett's mucosa that does **not** contain a statement about dysplasia (present, absent, or indefinite, *and if present, contains appropriate grading*), reason not otherwise specified

RATIONALE:
Endoscopy is the technique of choice used to identify suspected Barrett's esophagus and to diagnose complications of GERD. Biopsy must be added to confirm the presence of Barrett's epithelium and to evaluate for dysplasia (ACG, 2005).

There is a rapidly rising incidence of adenocarcinoma of the esophagus in the United States. A diagnosis of Barrett's esophagus increases a patient's risk for esophageal adenocarcinoma by 30 to 125 times that of people without Barrett's esophagus (although this risk is still small 0.4% to 0.5% per year). Esophageal adenocarcinoma is often not curable, partly because the disease is frequently discovered at a late stage and because treatments are not effective. A diagnosis of Barrett's esophagus could allow for appropriate screening of at risk patients as recommended by the American College of Gastroenterology.

Standard endoscopy with biopsy currently is the most reliable means of establishing a diagnosis of Barrett's esophagus. The definitive diagnosis of Barrett's esophagus requires a pathologist's review of an esophageal biopsy. Dysplasia is the first step in the neoplastic process, and information about dysplasia is crucial for clinical decision-making directing therapy. The presence and grade of dysplasia cannot be determined by routine endoscopy, and pathologist's review of a biopsy is essential for recognition of dysplasia. Endoscopic surveillance detects curable neoplasia in patients with Barrett's esophagus.

CLINICAL RECOMMENDATION STATEMENTS:
The diagnosis of Barrett's esophagus requires systematic biopsy of the abnormal-appearing esophageal mucosa to document intestinal metaplasia and to detect dysplasia.

Measure #250: Radical Prostatectomy Pathology Reporting – National Quality Strategy Domain: Effective Clincial Care

2015 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of radical prostatectomy pathology reports that include the pT category, the pN category, the Gleason score and a statement about margin status

INSTRUCTIONS:
This measure is to be reported **each time** a radical prostatectomy surgical pathology examination is performed during the reporting period for prostate patients. Each unique CPT Category I code or quality-data code submitted on the claim will be counted for denominator inclusion. It is anticipated that **clinicians who examine prostate tissue specimens following resection** in a laboratory or institution will submit this measure. Independent Laboratories (ILs) and Independent Diagnostic Testing Facilities (IDTFs), using indicator Place of Service 81, are not included in PQRS. If the specimen is not primary prostate tissue (eg, breast, lung), report only **G8798**.

Measure Reporting via Claims:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. CPT Category II codes or quality-data codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed ICD-9-CM /ICD-10-CM diagnosis codes, CPT codes, and the appropriate CPT Category II code **OR** quality-data codes **OR** the CPT Category II code **with** the modifier. The modifiers allowed for this measure are: 1P- medical reasons, 8P- reason not otherwise specified. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

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

DENOMINATOR:
All radical prostatectomy surgical pathology examinations performed during the measurement period for prostate cancer patients

Denominator Criteria (Eligible Cases):
Diagnosis for malignant neoplasm of prostate (ICD-9-CM) [for use 1/1/2015-9/30/2015]: 185
Diagnosis for malignant neoplasm of prostate (ICD-10-CM) [for use 10/01/2015-12/31/2015]: C61
AND
Patient encounter during the reporting period (CPT): 88309

NUMERATOR:
Radical Prostatectomy reports that include the pT category, the pN category, Gleason score and a statement about margin status

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Radical Prostatectomy Report includes pT category, pN category, Gleason Score and Statement about Margin Status

***Performance Met:* CPT II 3267F:** Pathology report includes pT category, pN category, Gleason score and statement about margin status

OR

pT category, pN category, Gleason Score and Statement about Margin Status not Documented for Medical Reasons

Append a modifier (**1P**) to Category II code **3267F** to report documented circumstances that appropriately exclude patients from the denominator.

***Medical Performance Exclusion:* 3267F *with* 1P:** Documentation of medical reason(s) for not including pT category, pN category, Gleason score and statement about margin status in the pathology report (eg, specimen originated from other malignant neoplasms, transurethral resections of the prostate (TURP), or secondary site prostatic carcinomas)

OR

If patient is not eligible for this measure because the specimen is not primary prostate tissue from a radical resection report:

***Other Performance Exclusion:* G8798:** Specimen site other than anatomic location of prostate

OR

pT category, pN category, Gleason Score and Statement about Margin Status not Documented, Reason not Otherwise Specified

Append a reporting modifier (**8P**) to CPT Category II code **3267F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

***Performance Not Met:* 3267F *with* 8P:** pT category, pN category, Gleason score and statement about margin status were **not** documented in pathology report, reason not otherwise specified

RATIONALE:

Therapeutic decisions for prostate cancer management are stage driven and cannot be made without a complete set of pathology descriptors. Incomplete pathology reports for prostate cancer may result in misclassification of patients, rework and delays, and suboptimal management. The College of American Pathologists Cancer Committee has produced an evidence-based protocol/checklist of essential pathologic parameters that are recommended to be included in prostate cancer resection pathology reports. Conformance of pathology reports with the CAP checklist is a requirement for Cancer Center certification by the ACS.

The protocol recommends the use of the TNM Staging System for carcinoma of the prostate of the American Joint Committee on Cancer (AJCC) and the International Union Against Cancer (UICC). The radical prostatectomy checklist also includes extraprostatic extension.

In a study of cancer recurrence following radical prostatectomy, it was noted that "The relatively high proportion of patients who have biopsy-proven local recurrence who have organ-confined disease is probably inaccurate and, in large part, reflects under sampling and under recognition of extraprostatic extension".

The CAP Q probes data (2006) indicates that 11.6% of prostate pathology reports had missing elements. Extent of invasion (pTNM) was most frequently missing (52.1% of the reports missing elements), and extraprostatic extension was the second most frequently missing (41.7% of the reports missing elements). Margin status was missing in 8.3% of reports.

A sampling from prostate cancer cases in 2000 through 2001 from the College of Surgeons National Cancer Data Base found only 48.2% of surgical pathology reports for prostate cancer documented pathologic stage similar to the more recent data from the CAP Q probes study. The NCDB data showed the Gleason score was present 86.3% of

the time, slightly less than the 100% compliance found in the CAP Q probes study and that margin status was present in 84.9% of reports.

CLINICAL RECOMMENDATION STATEMENTS:

Patient management and treatment guidelines promote an organized approach to providing quality care. The (American College of Surgeons Committee on Cancer) CoC requires that 90% of pathology reports that include a cancer diagnosis contain the scientifically validated data elements outlined in the surgical case summary checklist of the College of American Pathologists (CAP) publication *Reporting on Cancer Specimens*. The College regards the reporting elements in the "Surgical Pathology Cancer Case Summary (Checklist)" portion of the protocols as essential elements of the pathology report. However, the manner in which these elements are reported is at the discretion of each specific pathologist, taking into account clinician preferences, institutional policies, and individual practice.

Pathologic staging is usually performed after surgical resection of the primary tumor. Pathologic staging depends on pathologic documentation of the anatomic extent of disease, whether or not the primary tumor has been completely removed.

Measure #251: Quantitative Immunohistochemical (IHC) Evaluation of Human Epidermal Growth Factor Receptor 2 Testing (HER2) for Breast Cancer Patients – National Quality Strategy Domain: Effective Clinical Care

2015 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
This is a measure based on whether quantitative evaluation of Human Epidermal Growth Factor Receptor 2 Testing (HER2) by immunohistochemistry (IHC) uses the system recommended in the current ASCO/CAP Guidelines for Human Epidermal Growth Factor Receptor 2 Testing in breast cancer

INSTRUCTIONS:
This measure should be reported each time a quantitative HER2 IHC pathology examination is performed during the reporting period for patients with breast cancer; however, only one QDC per date of service for a patient is required. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

Measure Reporting via Claims:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. CPT Category II codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and the appropriate CPT Category II code **OR** the CPT Category II code **with** the modifier. The modifiers allowed for this measure is: 8P- reason not otherwise specified. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

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

DENOMINATOR:
All breast cancer patients with quantitative breast tumor evaluation by HER2 IHC

Denominator Criteria (Eligible Cases):
Diagnosis for breast cancer (ICD-9-CM) [for use 1/1/2015-9/30/2015]: 174.0, 174.1, 174.2, 174.3, 174.4, 174.5, 174.6, 174.8, 174.9, 175.0, 175.9
Diagnosis for breast cancer (ICD-10-CM) [for use 10/01/2015-12/31/2015]: C50.011, C50.012, C50.019, C50.021, C50.022, C50.029, C50.111, C50.112, C50.119, C50.121, C50.122, C50.129, C50.211, C50.212, C50.219, C50.221, C50.222, C50.229, C50.311, C50.312, C50.319, C50.321, C50.322, C50.329, C50.411, C50.412, C50.419, C50.421, C50.422, C50.429, C50.511, C50.512, C50.519, C50.521, C50.522, C50.529, C50.611, C50.612, C50.619, C50.621, C50.622, C50.629, C50.811, C50.812, C50.819, C50.821, C50.822, C50.829, C50.911, C50.912, C50.919, C50.921, C50.922, C50.929
AND
Patient encounter during the reporting period (CPT): 88360, 88361

NUMERATOR:

Breast cancer patients receiving quantitative breast tumor HER2 IHC evaluation using the ASCO/CAP recommended manual system or a computer-assisted system consistent with the optimal algorithm for HER2 testing as described in the current ASCO/CAP guideline

NUMERATOR NOTE: *Report CPT II quality data codes once per patient for each date-of-service.*

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Quantitative Evaluation of HER2 by IHC Performed
Performance Met: **CPT II 3394F:** Quantitative HER2 by IHC evaluation consistent with scoring system defined in the ASCO/CAP guidelines1

OR

If patient is not eligible for this measure because quantitative non-HER2 IHC evaluation was performed (eg, testing for estrogen or progesterone, receptors, [ER/PR]) report:
Other Performance Exclusion: **CPT II 3395F:** Quantitative non-HER2 IHC evaluation (eg, testing for estrogen or progesterone receptors, [ER/PR]) performed

OR

Quantitative Evaluation of HER2 by IHC Performed but did not use the System Recommended in the ASCO/CAP Guidelines for Human Epidermal Growth Factor Receptor 2 Testing in Breast Cancer:
Append a reporting modifier (**8P**) to CPT Category II code **3394F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.
Performance Not Met: **3394F *with* 8P:** Quantitative evaluation of HER2 did **not** use the system recommended in the ASCO/CAP Guidelines for Human Epidermal Growth Factor Receptor 2 Testing in breast cancer, reason not otherwise specified

RATIONALE:
Through a cooperative effort with the American Society of Clinical Oncologists (ASCO) and the CAP, new guidelines for Human Epidermal Growth Factor 2 testing in breast cancer were published in January 2007 and then revised in 2013.

The ASCO/CAP Guideline recommendations for quantitative HER2 IHC evaluation were designed to enhance concordance with FISH assays for HER2 Amplified and Non-amplified tumor status. The recommendations are different from those provided by HER2 antibody manufacturers and compliance is likely to be considerably less than 100%. Implementation of Guideline scoring would promote uniformity and quality among interpreting pathologists.

1 Wolff, A.C., et al. American Society of Clinical Oncology/College of American Pathologists Clinical Practice Guideline Update Recommendations for Human Epidermal Growth Factor Receptor 2 Testing in Breast Cancer. *Arch Pathol Lab Med*. 2013; doi: 10.5858/arpa.2013-0953-SA)

- **Positive HER2 test. (p.2):** Must report a HER2 test result as positive if: (a) IHC 3þ positive or (b) ISH positive using either a single-probe ISH or dual-probeISH (Table 1; Figs 1 to 3). This assumes that there is no apparent histopathologic discordance observed by the pathologist (Table 2).
- **Equivocal HER2 test. (p.2):** Must report a HER2 test result as equivocal and order reflex test on the same specimen (unless the pathologist has concerns about the specimen) using the alternative test if: (a) IHC 2þ equivocal or (b) ISH equivocal using single-probe ISH or dual-probe ISH (Table 1; Figs 1 to 3). This assumes that there is no apparent histopathologic discordance observed by the pathologist (Table 2). Note that there are some rare breast cancers (eg, gland-forming tumors, micropapillary carcinomas) that show IHC 1þ staining that is intense but incomplete (basolateral or U shaped) and that are found to be HER2 amplified. The pathologist should consider also reporting these specimens equivocal and request reflex testing using the alternative test.
- **Negative HER2 test. (p.2):** Must report a HER2 test result as negative if a single test (or all tests) performed on a tumor specimen show: (a) IHC 1þ negative or IHC 0 negative or (b) ISH negative using single-probe ISH or dual-probe ISH (Table 1; Figs 1 to 3). This assumes that there is no apparent histopathologic discordance observed by the pathologist (Table 2).
- **Indeterminate HER2 test (p.2):** Must report a HER2 test result as indeterminate if technical issues prevent one or both tests (IHC and ISH) performed on a tumor specimen from being reported as positive, negative, or equivocal. This may occur if specimen handling was inadequate, if artifacts (crush or edge artifacts) make interpretation difficult, or if the analytic testing failed. Another specimen should be requested for testing, if possible, and a comment should be included in the pathology report documenting intended action.

CLINICAL RECOMMENDATION STATEMENTS:

"Positive HER2 test – Based on a literature review of clinical trials, international studies and protocols, expert consensus, and US Food and Drug Administration Panel findings, a positive HER2 test is defined as either … uniform intense membrane staining of > 30% of invasive tumor cells… or FISH result of amplified *HER2* gene copy number (average of > six gene copies/nucleus for test systems without internal control probe) or *HER2*/CEP 17 ratio of more than 2.2, where CEP 17 is a centromeric probe for chromosome 17 on which the *HER2* gene resides. The 30% [criterion] for a positive IHC is further discussed in Appendix G".

"For IHC assays of HER2 protein expression, the original US Food and Drug Administration-approved interpretation guidelines provide insufficient specificity. Several experts, including those serving as central reviewers on clinical trials, have specified that a threshold of more than 30% of tumor (rather than the originally specified 10%) should show strong circumferential membrane staining for a positive result. This means that according to this guideline, strong circumferential staining of 30% or less of cells would be considered equivocal and be subjected to confirmatory FISH testing.

Measure #254 (NQF 0651): Ultrasound Determination of Pregnancy Location for Pregnant Patients with Abdominal Pain – National Quality Strategy Domain: Effective Clinical Care

2015 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of pregnant female patients aged 14 to 50 who present to the emergency department (ED) with a chief complaint of abdominal pain or vaginal bleeding who receive a trans-abdominal or trans-vaginal ultrasound to determine pregnancy location

INSTRUCTIONS:
This measure is to be reported **each time** a patient who presents in the emergency department with a chief complaint of abdominal pain and/or vaginal bleeding who receive a trans-abdominal or trans-vaginal ultrasound during the reporting period. It is anticipated that **clinicians who provide care in the emergency department** will submit this measure. The Part B claim form place of service field must indicate that the encounter has taken place in the emergency department.

Measure Reporting via Claims:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, Place of Service Indicator, and patient demographics are used to identify patients who are included in the measure's denominator. Quality-data codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, Place of Service Indicator, and the appropriate numerator quality-data code. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, Place of Service Indicator, and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

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

DENOMINATOR:
All pregnant female patients aged 14 to 50 who present to the ED with a chief complaint of abdominal pain or vaginal bleeding

Denominator Criteria (Eligible Cases):
Pregnant females aged 14 to 50
AND
Diagnosis of Other Current Condition in the Mother Classifiable Elsewhere but Complicating Pregnancy, Childbirth, or the Puerperium (ICD-9-CM) [for use 1/1/2015-9/30/2015]: 648.90, 648.93
Diagnosis of Other Current Condition in the Mother Classifiable Elsewhere but Complicating Pregnancy, Childbirth, or the Puerperium (ICD-10-CM) [for use 10/01/2015-12/31/2015]: O26.899, O26.90, O26.91
AND
Diagnosis for Abdominal Pain (ICD-9-CM) [for use 1/1/2015-9/30/2015]: 789.00, 789.03, 789.04, 789.05, 789.06, 789.07, 789.09, 789.60, 789.63, 789.64, 789.65, 789.66, 789.67, 789.69

Diagnosis for Abdominal Pain (ICD-10-CM) [for use 10/01/2015-12/31/2015]: R10.0, R10.10, R10.13, R10.2, R10.30, R10.31, R10.32, R10.33, R10.813, R10.814, R10.815, R10.816, R10.817, R10.819, R10.823, R10.824, R10.825, R10.826, R10.827, R10.829, R10.84, R10.9

OR

Diagnosis for Vaginal Bleeding (ICD-9-CM) [for use 1/1/2015-9/30/2015]: 640.00, 640.03, 640.80, 640.83, 640.90, 640.93, 641.10, 641.13, 641.20, 641.23, 641.30, 641.33, 641.80, 641.83, 641.90, 641.93

Diagnosis for Vaginal Bleeding (ICD-10-CM) [for use 10/01/2015-12/31/2015]: O20.0, O20.8, O20.9, O44.10, O44.11, O45.001, O45.009, O45.011, O45.019, O45.021, O45.029, O45.091, O45.099, O45.8X1, O45.8X9, O45.90, O45.91, O46.001, O46.009, O46.011, O46.019, O46.021, O46.029, O46.8X1, O46.8X9, O46.90, O46.91, O46.091, O46.099

AND

Patient encounter during the reporting period (CPT): 99281, 99282, 99283, 99284, 99285, 99291

AND

Place of Service Indicator: 23

(The Part B claim form Place of Service field must indicate emergency department)

NUMERATOR:

Patients who receive a trans-abdominal or trans-vaginal ultrasound with documentation of pregnancy location in medical record

Numerator Instructions: This measure is to be reported **each time** a patient meets the requirements as indicated in the denominator. If the clinician documents that the clinical event surrounding the patient, with or without performance of trans-abdominal or trans-vaginal ultrasound, does not meet the intent of the measure report quality-data code **G8807**.

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Trans-Abdominal or Trans-Vaginal Ultrasound Performed and Pregnancy Location Documented During ED Visit

Performance Met: **G8806:** Performance of trans-abdominal or trans-vaginal ultrasound

OR

Trans-Abdominal or Trans-Vaginal Ultrasound not Performed for Documented Reasons

Other Performance Exclusion: **G8807:** Trans-abdominal or trans-vaginal ultrasound not performed for reasons documented by clinician (eg, patient has visited the ED multiple times within 72 hours, patient has a documented Intrauterine Pregnancy [IUP])

OR

Trans-Abdominal or Trans-Vaginal Ultrasound not Performed, Reason not Given

Performance Not Met: **G8808:** Performance of trans-abdominal or trans-vaginal ultrasound **not** ordered, reason not given (eg, patient has visited the ED multiple times with no documentation of a trans-abdominal or trans-vaginal ultrasound within ED or from referring eligible professional)

RATIONALE:

Ectopic Pregnancy is a relatively common condition which can result in morbidity or mortality if misdiagnosed resulting in a delay to appropriate treatment. Abdominal pain is a frequent presenting complaint of women with ruptured ectopic pregnancy. Pelvic ultrasound can establish a pregnancy as intrauterine and identify high risk features for ectopic pregnancy (pelvic free fluid, complex adnexal mass). Early ultrasound can shorten the time to diagnosis of ectopic pregnancy and can help risk stratify pregnant patients with the complaint of abdominal pain or vaginal bleeding for discharge with routine follow-up, discharge with early follow-up or admission.

CLINICAL RECOMMENDATION STATEMENTS:

Use of emergency ultrasound in pelvic disorders centers on the detection of intrauterine pregnancy (IUP), detection of ectopic pregnancy, detection of fetal heart rate in all stages of pregnancy, dating of the pregnancy, and detection of significant free fluid. Bedside pelvic ultrasound during the first trimester of pregnancy can be used to exclude ectopic pregnancy by demonstrating an intrauterine pregnancy. Studies of EP-performed ultrasound in this setting have demonstrated sensitivity of 76-90% and specificity of 88- 92% for the detection of ectopic pregnancy. In one study, EPs were able to detect an intrauterine pregnancy in 70% of patients with suspected ectopic pregnancy (first trimester pregnancy with abdominal pain or vaginal bleeding). When intrauterine fetal anatomy was visualized at the bedside, ectopic pregnancy was ruled out with a negative predictive value of essentially 100%. When bedside ultrasound evaluation was incorporated into a clinical algorithm for the evaluation of patients with suspected ectopic pregnancy, the incidence of discharged patients returning with ruptured ectopic pregnancy was significantly reduced.

Measure #255: Rh Immunoglobulin (Rhogam) for Rh-Negative Pregnant Women at Risk of Fetal Blood Exposure – National Quality Strategy Domain: Effective Clinical Care

2015 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of Rh-negative pregnant women aged 14-50 years at risk of fetal blood exposure who receive Rh-Immunoglobulin (Rhogam) in the emergency department (ED)

INSTRUCTIONS:
This measure is to be reported **each time** a pregnant patient presents to the emergency department with complaints including blunt abdominal trauma, vaginal bleeding, ectopic pregnancy, and threatened or spontaneous abortion. Claims data will be analyzed to determine the emergency department discharge. Patients who present to the emergency department with these complaints should have documentation in the medical record of receiving an order for Rh-Immunoglobulin (Rhogam). It is anticipated that **clinicians who provide care in the emergency department** will submit this measure. The Part B claim form place of service field must indicate that the encounter has taken place in the emergency department.

Measure Reporting via Claims:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, Place of Service Indicator, and patient demographics are used to identify patients who are included in the measure's denominator. Quality-data codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, Place of Service Indicator, and the appropriate numerator quality-data code. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, Place of Service Indicator, and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

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

DENOMINATOR:
All pregnant female patients aged 14 to 50 years who are Rh-negative and at significant risk of fetal blood exposure

Denominator Criteria (Eligible Cases):
Female patients aged 14 to 50 years on date of encounter
AND
Diagnosis for Rh-Negative (ICD-9-CM) [for use 1/1/2015-9/30/2015]: 656.10, 656.13
Diagnosis for Rh-Negative (ICD-10-CM) [for use 10/01/2015-12/31/2015]: O36.0110, O36.0111, O36.0190, O36.0191, O36.0910, O36.0911, O36.0990, O36.0991
AND
Diagnosis of High Risk Pregnancy Complications (ICD-9-CM) [for use 1/1/2015-9/30/2015]: 632, 633.80, 633.81, 633.90, 633.91, 634.10, 634.11, 634.12, 636.10, 636.11, 636.12, 637.10, 637.11, 637.12, 638.1, 639.1, 640.00, 640.03, 640.80, 640.83, 640.90, 640.93, 641.10, 641.13, 641.20, 641.23, 641.30, 641.33, 641.80, 641.83, 641.90, 641.93, 656.00, 656.03
Diagnosis of High Risk Pregnancy Complications (ICD-10-CM) [for use 10/01/2015-12/31/2015]: O00.8, O00.9, O02.1, O03.1, O03.6, O04.6, O07.1, O08.1, O20.0, O20.8, O20.9, O43.011, O43.019,

O44.10, O44.11, O45.001, O45.009, O45.011, O45.019, O45.021, O45.029, O45.091, O45.099, O45.8X1, O45.8X9, O45.90, O45.91, O46.001, O46.011, O46.021, O46.8X1, O46.8X9, O46.90, O46.91
AND
Patient encounter during the reporting period (CPT): 99281, 99282, 99283, 99284, 99285, 99291
AND
Place of Service Indicator: 23
(The Part B claim form Place of Service field must indicate emergency department)

NUMERATOR:
Patients who receive an order for Rh-Immunoglobulin (Rhogam) in the ED

Numerator Instructions: This measure is to be reported **each time** a patient meets the requirements as indicated in the denominator. In the clinical event a patient has documented receipt of Rhogam report quality-data code **G8810**.

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Documentation in Medical Record that Rh-immunoglobulin (Rhogam) Ordered
***Performance Met:* G8809:** Rh-immunoglobulin **(Rhogam)** ordered

OR

Rh-immunoglobulin (Rhogam) not Ordered for Documented Reasons
***Other Performance Exclusion:* G8810:** Rh-immunoglobulin (Rhogam) not ordered for reasons documented by clinician (eg, patient had prior documented receipt of Rhogam within 12 weeks, patient refusal)

OR

Rh-immunoglobulin (Rhogam) not Ordered, Reason not Given
***Performance Not Met:* G8811:** Documentation Rh-immunoglobulin (Rhogam) was **not** ordered, reason not given

RATIONALE:
The potential for maternal exposure to fetal blood is a concern among pregnant patients presenting to the emergency department with a number of common complaints or diagnoses including abdominal pain, blunt abdominal trauma, vaginal bleeding, ectopic pregnancy, threatened or spontaneous abortion, or pelvic instrumentation. This concern increases after the first trimester as fetal RBC mass increases.

CLINICAL RECOMMENDATION STATEMENTS:
Exposure to less than 0.1 ml of fetal blood of a different rhesus (Rh) antigenicity among Rh negative has been shown to increase the risk of maternal alloimmunization. Alloimmunization can result in hemolytic disease of the fetus or newborn including spontaneous abortion, fetal hemolytic anemia, hydrops fetalis and severe neonatal jaundice in subsequent pregnancies.

Anti-D-immunoglobulin reduces the likelihood of alloimmunization. Routine administration of antenatal anti-D-immunoglobulin has been demonstrated as an effective prophylaxis and is recommended by the American College of Obstetricians and Gynecologists (ACOG). Guidelines (UK) recommend administration of anti-D-immunogloblin after the first trimester for a number of sensitizing episodes including but not limited to uterine bleeding and for recurrent, painful or heavy uterine bleeding in the first trimester.

Routine use of anti-D prophylaxis is somewhat controversial as this is done to prevent so-called silent sensitization occurring in the absence of a clear hemorrhage, but this is generally performed in the UK and the US. As anti-D-immunoglobulin does cross the placenta, there are some concerns that this could cause fetal anemia, however, this was felt to be a minor concern relative to the benefits of administration.

✦ Measure #257: Statin Therapy at Discharge after Lower Extremity Bypass (LEB) – National Quality Strategy Domain: Effective Clinical Care

2015 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Percentage of patients aged 18 years and older undergoing infra-inguinal lower extremity bypass who are prescribed a statin medication at discharge

INSTRUCTIONS:
This measure is to be reported **each time** an infra-inguinal lower extremity is performed during the reporting period. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

ANY registry that includes anatomic details or CPT procedure codes and captures prescription of statin at hospital discharge as well as documented reasons for not prescribing statin medication is required to identify patients for numerator inclusion or denominator exclusion. The Society for Vascular Surgery Vascular Quality Initiative (SVS VQI) and the Vascular Study Group of New England (VSGNE) are examples of registries that capture detailed anatomic information, but the measure is not limited to these registries.

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

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

DENOMINATOR:
Patients who received an infra-inguinal lower extremity bypass

Denominator Criteria (Eligible Cases):
All patients aged 18 years and older
AND
Patient encounter during the reporting period (CPT): 35556, 35566, 35571, 35583, 35585, 35587, 35656, 35666, 35671

NUMERATOR:
Patients prescribed a statin medication at discharge

Numerator Options:

Performance Met:	Statin medication prescribed at discharge (G8816)
OR	
Other Performance Exclusion:	Statin therapy not prescribed for documented reasons (eg, medical intolerance to statin, death of patient prior to discharge, transfer of care to another acute care or federal hospital, hospice admission, left against medical advice) **(G8815)**
OR	
Performance Not Met:	Statin therapy **not** prescribed at discharge, reason not given **(G8817)**

RATIONALE:
Patients who require lower extremity revascularization procedures are at high risk of subsequent cardiovascular morbidity and mortality because of their widespread atherosclerotic disease. Statin therapy in this patient population has been associated with a significant decrease in cardiovascular events. Hospitalization for lower extremity revascularization provides an opportunity for initiating statin therapy on patients without contraindications who are not already on statin therapy.

CLINICAL RECOMMENDATION STATEMENTS:
Patients who present with lower extremity ischemia bear a large systemic burden of atherosclerotic disease, and therefore face not only the immediate risk of limb loss (Dormandy/Rutherford, TASC, 2000) but also an increased risk for cardiovascular events. (Criqui, et al., N Engl J Med, 1992; McKenna/Wolfson/Kuller, Atherosclerosis, 1991; Howell, et al., J Vasc Surg, 1989) The benefits of statin therapy for cardiovascular risk reduction in the PAD population have been demonstrated in several studies, most notably the Heart Protection Study.

(MRC/BHF, Lancet, 2002) The Heart Protection Study (HPS) is the largest trial to assess the effects of statins on major morbidity and mortality. The investigators enrolled over 20,000 patients deemed to be at high risk for cardiovascular events and randomized them to receive either 40mg of simvastatin or placebo. On survival analysis, they demonstrated that treatment with a statin was significantly associated with a decrease in all-cause mortality (12.9% vs. 14.7%, p=.0003) and that this effect was primarily driven by the reduction in death from vascular causes (7.6% vs. 9.1%, $p < .0001$). A recently published subgroup analysis (Randomized trial, J Vasc Surg, 2007) focusing specifically on patients with documented PAD (n=6748) did not include mortality data. However, the authors demonstrated a significant reduction in the rate of first major vascular event in the simvastatin treatment arm (relative reduction of 22%; $p < .0001$), when compared to placebo.

The PREVENT III trial was a prospective, randomized, double-blinded, multicenter trial designed to examine the efficacy of a novel pharmacologic agent (edifoligide) in preventing autogenous vein graft failure in 1404 patients who underwent infra-inguinal vein bypass at 83 hospitals exclusively for the treatment of critical limb ischemia. (Conte, et al., J Vasc Surg, 2006) This LEB trial, with its high-risk critical limb ischemia (CLI) population, provides another relevant database for examination of the role of statins. The salient finding from this study is that the use of statin drugs was associated with a significant one-year survival benefit in patients undergoing surgical bypass for CLI.(Schanzer, et al., J Vasc Surg, 2008) The Kaplan-Meier analysis also suggested that the benefit continues to increase with time, and might be even greater with longer term follow-up. In these 1404 patients, those not receiving statins experienced a 40% increase in the risk of death at one year. This effect was demonstrated both in the propensity score weighted analysis (HR 1.40, CI 1.02-1.92), and in the Cox proportional hazards model (HR 1.47, CI 1.11-1.96). These findings are consistent with prior observational studies that have examined the effects of statins, albeit, in heterogeneous PAD populations. (Feringa HH, et al., J Vasc Surg, 2007; Ward RP, et al., Int J Cardiol, 2005; Kertai MD, et al., Am J Med, 2004) The largest of these observational studies, conducted by Feringa and colleagues, enrolled 1374 patients with PAD and followed them for a mean duration of 6.4 years. The authors demonstrated a strong independent association between statin use and all-cause mortality (HR 1.41 for non-users, $p < 0.0001$). (Feringa HH, et al., J Vasc Surg, 2007)

The DECREASE study randomized 497 patients who had not previously been treated with a statin to receive either 80 mg of extended-release fluvastatin or placebo once daily before undergoing major non-cardiac vascular surgery. (Schouten O, et al., N Engl J Med, 2009) On evaluation of the primary endpoint, statin therapy conferred a 45% decreased hazard ratio (10.8% versus 19%, p=0.01) for peri-operative myocardial infarction. Furthermore, death from cardiovascular causes or myocardial infarction occurred in 4.8% of patients in the fluvastatin group and 10.1% of patients in the placebo group (hazard ratio, 0.47; 95% CI, 0.24 to 0.94; p= 0.03). Fluvastatin therapy was not associated with a significant increase in the rate of adverse events. Several additional studies in patients undergoing LEB have shown similar reductions in peri-operative morbidity and mortality associated with statin use. (Ward RP, et al., Int J Cardiol, 2005; Poldermans O, et al., Circulation, 2003; O'Neil-Callahan K, et al., J Am Coll Cardiol, 2005)

Recent studies have also demonstrated a specific benefit in graft patency after LEB in patients on statin therapy. (Christenson J, Cardiovasc Surg, 2001; Abbruzzese TA, et al., J Vasc Surg, 2004; Henke PK, et al., J Vasc Surg, 2004) Abbruzzese et al. observed that statin use was associated with improved secondary patency (3-fold increased risk compared to non-users) among 197 patients who had undergone lower extremity bypass using saphenous vein, in a single-center retrospective analysis. (Abbruzzese TA, et al., J Vasc Surg, 2004)

✦ Measure #258: Rate of Open Repair of Small or Moderate Non-Ruptured Abdominal Aortic Aneurysms (AAA) without Major Complications (Discharged to Home by Post-Operative Day #7) – National Quality Strategy Domain: Patient Safety

2015 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Percent of patients undergoing open repair of small or moderate sized non-ruptured abdominal aortic aneurysms who do not experience a major complication (discharge to home no later than post-operative day #7)

INSTRUCTIONS:
This measure is to be reported **each time** an open repair AAA is performed during the reporting period. It is anticipated that clinicians who provide services of AAA repair, as described in the measure, based on the services provided and the measure-specific denominator coding will report this measure. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

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

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

DENOMINATOR:
All open repairs of non-ruptured, infrarenal abdominal aortic aneurysms

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Patient encounter during the reporting period (CPT): 35081, 35102
AND NOT
For women:
Aortic aneurysm 5.5 - 5.9 cm maximum diameter on centerline formatted CT or minor diameter on axial formatted CT: 9003F
OR
Aortic aneurysm 6.0 cm or greater maximum diameter on centerline formatted CT or minor diameter on axial formatted CT: 9004F
OR
For men:
Aortic aneurysm 6.0 cm or greater maximum diameter on centerline formatted CT or minor diameter on axial formatted CT: 9004F

NUMERATOR:
Patients discharged to home no later than post-operative day #7

Definition:

Home – For purposes of reporting this measure, home is the point of origin prior to hospital admission prior to procedure of AAA. For example, if the patient comes from a skilled facility and returns to the skilled facility post AAA repair, this would meet criteria for discharged to home.

Numerator Options:

Performance Met: Patient discharge to home no later than post-operative day #7 (**G8818)**

OR

Performance Not Met: Patient **not** discharged to home by post-operative day #7 **(G8825)**

RATIONALE:

Elective repair of a small or moderate sized AAA is a prophylactic procedure and the mortality/morbidity of the procedure must be contrasted with the risk of rupture over time. Surgeons should select patients for intervention who have a reasonable life expectancy and who do not have a high surgical risk. Discharge to home within one week of open AAA repair is an indicator of patients who were not frail prior to the procedure and who did not experience a major complication. The proposed measure will therefore serve as an indicator of both appropriateness and overall outcome.

CLINICAL RECOMMENDATION STATEMENTS:

The Care of Patients with an Abdominal Aortic Aneurysm: The Society for Vascular Surgery Practice Guidelines. (Chaikof et al, J Vasc Surg, 50:4, supplement, 2009)

Elective repair is recommended for patients that present with a fusiform AAA ≥ 5.5 cm in maximum diameter, in the absence of significant co-morbidities.

Level of recommendation: Strong

Quality of evidence: High

Surveillance is recommended for most patients with a fusiform AAA in the range of 4.0 cm to 5.4 cm in maximum diameter.

Level of recommendation: Strong

Quality of evidence: Moderate

✦ Measure #259: Rate of Endovascular Aneurysm Repair (EVAR) of Small or Moderate Non-Ruptured Abdominal Aortic Aneurysms (AAA) without Major Complications (Discharged to Home by Post Operative Day #2) – National Quality Strategy Domain: Patient Safety

2015 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Percent of patients undergoing endovascular repair of small or moderate non-ruptured abdominal aortic aneurysms (AAA) that do not experience a major complication (discharged to home no later than post-operative day #2)

INSTRUCTIONS:
This measure is to be reported **each time** an open repair AAA is performed during the reporting period. It is anticipated that clinicians who provide services of AAA repair, as described in the measure, based on the services provided and the measure-specific denominator coding will report this measure. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

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

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

DENOMINATOR:
All endovascular repairs of non-ruptured, infrarenal abdominal aortic aneurysms

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Patient encounter during the reporting period (CPT): 34800, 34802, 34803, 34804, 34805
AND NOT
For women:
Aortic aneurysm 5.5 - 5.9 cm maximum diameter on centerline formatted CT or minor diameter on axial formatted CT: 9003F
OR
Aortic aneurysm 6.0 cm or greater maximum diameter on centerline formatted CT or minor diameter on axial formatted CT: 9004F
OR
For men:
Aortic aneurysm 6.0 cm or greater maximum diameter on centerline formatted CT or minor diameter on axial formatted CT: 9004F

NUMERATOR:
Patients discharged to home no later than post-operative day #2 following EVAR of AAA

Definition:

Home – For purposes of reporting this measure, home is the point of origin prior to hospital admission prior to procedure of AAA. For example, if the patient comes from a skilled facility and returns to the skilled facility post AAA repair, this would meet criteria for discharged to home.

Numerator Options:

Performance Met: Patient discharged to home no later than post-operative day #2 following EVAR **(G8826)**

OR

Performance Not Met: Patient **not** discharged to home by post-operative day #2 following EVAR **(G8833)**

RATIONALE:

Elective repair of a small or moderate sized AAA is a prophylactic procedure and the mortality/morbidity of the procedure must be contrasted with the risk of rupture over time. Surgeons should select patients for intervention who have a reasonable life expectancy and who do not have a high surgical risk. Discharge to home within two days of endovascular AAA repair is an indicator of patients who were not frail prior to the procedure and who did not experience a major complication. The proposed measure will therefore serve as an indicator of both appropriateness and overall outcome.

CLINICAL RECOMMENDATION STATEMENTS:

The Care of Patients with an Abdominal Aortic Aneurysm: The Society for Vascular Surgery practice Guidelines. (Chaikof et al, J Vasc Surg, 50:4, supplement, 2009)

Elective repair is recommended for patients that present with a fusiform AAA ≥ 5.5 cm in maximum diameter, in the absence of significant comorbidities.

Level of recommendation: Strong

Quality of evidence: High

Surveillance is recommended for most patients with a fusiform AAA in the range of 4.0 cm to 5.4 cm in maximum diameter.

Level of recommendation: Strong

Quality of evidence: Moderate

✦ Measure #260: Rate of Carotid Endarterectomy (CEA) for Asymptomatic Patients, without Major Complications (Discharged to Home by Post-Operative Day #2) – National Quality Strategy Domain: Patient Safety

2015 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Percent of asymptomatic patients undergoing CEA who are discharged to home no later than post-operative day #2

INSTRUCTIONS:
This measure is to be reported **each time** a CEA is performed during the reporting period. It is anticipated that clinicians who provide services of CEA, as described in the measure, based on the services provided and the measure-specific denominator coding will report this measure. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

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

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

DENOMINATOR:
All carotid endarterectomy procedures

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Patient encounter during the reporting period (CPT): 35301
AND NOT
Symptomatic carotid stenosis: Ipsilateral carotid territory TIA or stroke less than 120 days prior to procedure: 9006F
OR
Other carotid stenosis: Ipsilateral TIA or stroke 120 days or greater prior to procedure or any prior contralateral carotid territory or vertebrobasilar TIA or stroke: 9007F

NUMERATOR:
Patients that are asymptomatic neurologically who were discharged alive, to home no later than post-operative day #2 following CEA

Definition:
Home – For purposes of reporting this measure, home is the point of origin prior to hospital admission for procedure of CEA. For example, if the patient comes from a skilled facility and returns to the skilled facility post CEA, this would meet criteria for discharged to home.

Numerator Options:

Performance Met:	Patient discharged to home no later than post-operative day #2 following CEA (**G8834)**

OR

Performance Not Met: Patient **not** discharged to home by post-operative day #2 following CEA **(G8838)**

RATIONALE:

Surgeons performing CEA on asymptomatic patients must select patients at low risk for morbidity and perform the procedure with a very low complication rate in order to achieve benefit. Discharge to home within two days of the procedure is an indicator of patients who were not frail prior to the procedure and who did not experience a major complication (eg, disabling stroke, myocardial infarction). The proposed measure will therefore serve as an indicator of both appropriateness and overall outcome.

CLINICAL RECOMMENDATION STATEMENTS:

Updated Society for Vascular Surgery guidelines for management of extracranial carotid disease. (Ricotta et al, J Vasc Surg, 54:3, 2011)

Neurologically asymptomatic patients with ≥ 60% diameter stenosis should be considered for CEA for reduction of long-term risk of stroke, provided the patient has a 3- to 5-year life expectancy and perioperative stroke/death rates can be ≤ 3% (GRADE 1, Level of Evidence A).

Measure #261: Referral for Otologic Evaluation for Patients with Acute or Chronic Dizziness – National Quality Strategy Domain: Communication and Care Coordination

2015 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of patients aged birth and older referred to a physician (preferably a physician specially trained in disorders of the ear) for an otologic evaluation subsequent to an audiologic evaluation after presenting with acute or chronic dizziness

INSTRUCTIONS:
This measure is to be reported a minimum of **once per reporting period** for **all** patients seen during the reporting period who present with acute or chronic dizziness. This measure is intended to ensure that patients with acute or chronic dizziness receive a referral in order to receive appropriate care. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

Measure Reporting via Claims:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. Quality-data codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and the appropriate quality-data code. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

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

DENOMINATOR:
All patients aged birth and older presenting with acute or chronic dizziness

> **Denominator Criteria (Eligible Cases):**
> Patients aged birth and older
> **AND**
> **Diagnosis for Dizziness (ICD-9-CM) [for use 1/1/2015-9/30/2015]:** 386.11, 780.4
> **Diagnosis for Dizziness (ICD-10-CM) [for use 10/01/2015-12/31/2015]:** H81.10, H81.11, H81.12, H81.13, R42
> **AND**
> **Patient encounter during the reporting period (CPT):** 92540, 92541, 92542, 92543, 92544, 92545, 92546, 92547, 92548, 92550, 92557, 92567, 92568, 92570, 92575

NUMERATOR:
Patients referred to a physician for an otologic evaluation subsequent to an audiologic evaluation who present with acute or chronic dizziness

NUMERATOR NOTE: *The physician receiving the referral, or providing care currently, should preferably be specially trained in disorders of the ear.*

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Referral for Otologic Evaluation

Performance Met: **G8856:** Referral to a physician for an otologic evaluation performed

OR

Referral for Otologic Evaluation not Performed for Documented Reasons

Other Performance Exclusion: **G8857:** Patient is not eligible for the referral for otologic evaluation measure (eg, patients who are already under the care of a physician for acute or chronic dizziness)

OR

Referral for Otologic Evaluation not Performed, Reason not Given

Performance Not Met: **G8858:** Referral to a physician for an otologic evaluation **not** performed, reason not given

RATIONALE:

Studies demonstrate that patients who present with acute or chronic dizziness may suffer from underlying problems, so therefore referral is necessary. Without referral, patients may suffer consequences of the underlying problems.

CLINICAL RECOMMENDATION STATEMENTS:

The American Academy of Otolaryngology-Head and Neck Surgery policy statement (approved 9/12/2002):

Hearing loss and balance disorders are medical conditions. Only licensed physicians with medical training may diagnose and direct the management of disease and medical disorders. A full history and physical examination by a physician (preferably a physician specially trained in disorders of the ear) to determine the accurate medical diagnosis and appropriate medical/surgical treatment for hearing loss and balance disorders are indicated for patients with the following "red flags":

1) Hearing loss with a positive history of familial hearing loss, TB, syphilis, HIV, Meniere's disease, autoimmune disorder, otosclerosis, von Recklinghausen's neurofibromatosis, Paget's disease of bone, head trauma related to onset.
2) History of pain, active drainage, or bleeding from an ear.
3) Sudden onset or rapidly progressive hearing loss.
4) Acute, chronic, or recurrent episodes of dizziness.
5) Evidence of congenital or traumatic deformity of the ear.
6) Visualization of blood, pus, cerumen plug, or foreign body in the ear canal.
7) Conductive hearing loss or abnormal tympanogram.
8) Unilateral or asymmetric hearing loss; or bilateral hearing loss > 80 dB.
9) Unilateral or pulsatile tinnitus.
10) Unilateral or asymmetrically poor speech discrimination scores.

The red flags do not include all indications for a medical referral and are not intended to replace clinical judgment in determining the need for consultation with an otolaryngologist.

21 C.F.R. Section 801.420:

A hearing aid dispenser should advise a prospective hearing aid user to consult promptly with a licensed physician (preferably an ear specialist) before dispensing a hearing aid if the hearing aid dispenser determines through inquiry, actual observation, or review of any other available information concerning the prospective user, that the prospective user has any of the following conditions:

i) Visible congenital or traumatic deformity of the ear.
ii) History of active drainage from the ear within the previous 90 days.
iii) History of sudden or rapidly progressive hearing loss within the previous 90 days.
iv) Acute or chronic dizziness.
v) Unilateral hearing loss of sudden or recent onset within the previous 90 days.
vi) Audiometric air-bone gap equal to or greater than 15 decibels at 500 hertz (Hz), 1,000 Hz, and 2,000 Hz.
vii) Visible evidence of significant cerumen accumulation or a foreign body in the ear canal.
viii) Pain or discomfort in the ear.

✿Measure #262: Image Confirmation of Successful Excision of Image-Localized Breast Lesion – National Quality Strategy Domain: Patient Safety

2015 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Image confirmation of lesion(s) targeted for image guided excisional biopsy or image guided partial mastectomy in patients with nonpalpable, image-detected breast lesion(s). Lesions may include: microcalcifications, mammographic or sonographic mass or architectural distortion, focal suspicious abnormalities on magnetic resonance imaging (MRI) or other breast imaging amenable to localization such as positron emission tomography (PET) mammography, or a biopsy marker demarcating site of confirmed pathology as established by previous core biopsy

INSTRUCTIONS:
This measure is to be reported each time an image guided excisional biopsy or wire localized partial mastectomy is performed in patients with non-palpable, image-detected breast lesions. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

Measure Reporting via Claims:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. Quality-data codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and the appropriate numerator quality-data code. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

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

DENOMINATOR:
Number of patients aged 18 years and older on date of encounter with non-palpable, image-detected (by mammogram, ultrasound, or breast MRI, PET mammography or other imaging modality) breast lesion requiring localization of lesion (benign or malignant) for targeted resection (either excisional biopsy or partial mastectomy)

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date on encounter
AND
Diagnosis for Breast Lesion (ICD-9-CM) [for use 1/1/2015-9/30/2015]: 174.0, 174.1, 174.2, 174.3, 174.4, 174.5, 174.6, 174.8, 174.9, 175.0, 175.9, 198.81, 217, 239.3, 610.0, 610.1, 610.2, 610.3, 610.4, 610.8, 610.9, 611.0, 611.1, 611.2, 611.3, 611.4, 611.5, 611.6, 611.71, 611.72, 611.79, 611.81, 611.82, 611.83, 611.89, 611.9, 793.80, 793.81, 793.82, 793.89
Diagnosis for Breast Lesion (ICD-10-CM) [for use 10/01/2015-12/31/2015]: 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, C79.81, D24.1, D24.2, D24.9, D49.3, N60.01, N60.02, N60.09, N60.11, N60.12, N60.19, N60.21, N60.22, N60.29, N60.31, N60.32, N60.39, N60.41, N60.42, N60.49, N60.81, N60.82, N60.89, N60.91, N60.92, N60.99, N61, N62, N63, N64.0, N64.1, N64.2, N64.3, N64.4, N64.51, N64.52, N64.53, N64.59, N64.81, N64.82, N64.89, N64.9, R92.0, R92.1, R92.2, R92.8, T85.44XA, T85.44XD, T85.44XS

AND

Patient encounter during the reporting period (CPT): 19125, 19301, 19302

NUMERATOR:

Patients undergoing excisional biopsy or partial mastectomy of a non-palpable lesion whose excised breast tissue was evaluated by imaging (x-ray, ultrasound, MRI, PET mammography or other imaging modality) intraoperatively to confirm successful inclusion of targeted lesion

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Image Confirmation of Lesion(s) Targeted for Image Guided Excisional Biopsy or Image Guided Partial Mastectomy in Patients with Non-palpable, Image-detected Breast Lesion(s)

Performance Met: **G8872:** Excised tissue evaluated by imaging intraoperatively to confirm successful inclusion of targeted lesion

OR

Imaging Abnormality was Visible Only on an MRI of the Breast or Other Imaging Modality that does not Permit Direct Imaging of Excised Tissue (eg, PET mammography), Patient not Eligible

Other Performance Exclusion: **G8873:** Patients with needle localization specimens which are not amenable to intraoperative imaging such as MRI needle wire localization, or targets which are tentatively identified on mammogram or ultrasound which do not contain a biopsy marker but which can be verified on intraoperative inspection or pathology (eg, needle biopsy site where the biopsy marker is remote from the actual biopsy site)

OR

Image Confirmation of Lesion(s) Targeted for Image Guided Excisional Biopsy or Image Guided Partial Mastectomy in Patients with Non-palpable, Image-detected Breast Lesion(s) not Performed, Reason not Given

Performance Not Met: **G8874:** Excised tissue not evaluated by imaging intraoperatively to confirm successful inclusion of targeted lesion, reason not given

RATIONALE:

Many benign breast lesions and breast cancers are image-detected and will involve some form of image localization. Specimen radiography or specimen ultrasonography should routinely be performed for all excisions of image-detected abnormalities to document success of the procedure in excising the target.

CLINICAL RECOMMENDATION STATEMENTS:

Specimen radiography or specimen ultrasonography should be routinely performed for all excisions of image-detected abnormalities to help document the success of the procedure in finding the target. Specimen radiography should use two 90-degree orthogonal views. (The American Society of Breast Surgeons, 2001)

✿Measure #263: Preoperative Diagnosis of Breast Cancer – National Quality Strategy Domain: Effective Clinical Care

2015 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
The percent of patients undergoing breast cancer operations who obtained the diagnosis of breast cancer preoperatively by a minimally invasive biopsy method

INSTRUCTIONS:
This measure is to be reported each time a patient aged 18 and older undergoes a breast cancer operation. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

Measure Reporting via Claims:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. Quality-data codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed ICD-9-CM/ ICD-10-CM diagnosis codes, CPT codes, and the appropriate quality-data code. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

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

DENOMINATOR:
The number of patients aged 18 years and older on date of encounter undergoing breast cancer operations

> **Denominator Criteria (Eligible Cases):**
> Patients aged 18 and older on date of encounter
> **AND**
> **Diagnosis for Female/Male Breast Cancer (ICD-9-CM) [for use 1/1/2015-9/30/2015]:** 174.0, 174.1, 174.2, 174.3, 174.4, 174.5, 174.6, 174.8, 174.9, 175.0, 175.9, 198.81
> **Diagnosis for Female/Male Breast Cancer (ICD-10-CM) [for use 10/01/2015-12/31/2015]:** 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, C79.81
> **AND**
> **Patient encounter during the reporting period (CPT):** 19301, 19302, 19303, 19307

NUMERATOR:
The number of patients aged 18 and older undergoing breast cancer operations who had breast cancer diagnosed preoperatively by a minimally invasive biopsy

Definition:
Minimally invasive biopsy methods – Includes fine needle aspiration, percutaneous core needle biopsy, percutaneous automated vacuum assisted rotating biopsy device, skin biopsy, skin shave or punch biopsy

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Breast Cancer Preoperatively Diagnosed by a Minimally Invasive Biopsy Method
Performance Met: **G8875:** Clinician diagnosed breast cancer preoperatively by a minimally invasive biopsy method

OR

Clinician Determination that a Minimally Invasive Biopsy Method was not Indicated in this Instance, Patient not Eligible
Other Performance Exclusion: **G8876:** Documentation of reason(s) for not performing minimally invasive biopsy to diagnose breast cancer preoperatively (eg, lesion too close to skin, implant, chest wall, etc., lesion could not be adequately visualized for needle biopsy, patient condition prevents needle biopsy [weight, breast thickness, etc.], duct excision without imaging abnormality, prophylactic mastectomy, reduction mammoplasty, excisional biopsy performed by another physician)

OR
Minimally Invasive Biopsy Method was attempted but was not diagnostic of Breast Cancer
Other Performance Exclusion: **G8946**: Minimally Invasive Biopsy Method attempted but not diagnostic of Breast Cancer (eg, High Risk Lesion of Breast such as atypical ductal hyperplasia, lobular neoplasia, atypical lobular hyperplasia, lobular carcinoma in situ, atypical columnar hyperplasia, flat epithelial atypia, radial scar, complex sclerosing lesion, papillary lesion, or any lesion with spindle cells)

OR

Breast Cancer not Preoperatively Diagnosed by a Minimally Invasive Biopsy Method, Reason not Given
Performance Not Met: **G8877:** Clinician did **not** attempt to achieve the diagnosis of breast cancer preoperatively by a minimally invasive biopsy method, reason not given

RATIONALE:
The preoperative diagnosis of breast cancer by minimally invasive methods is recommended by the American Society of Breast Surgeons, the National Comprehensive Cancer Network, the European Society of Breast Cancer Specialists, the American College of Radiology, a recent consensus conference on image detected breast cancer, and a panel of experts who conducted a comparative effectiveness study of needle biopsy compared to open biopsy that was funded by Agency for Healthcare Research and Quality (AHRQ).

The policy of attempting to diagnose breast cancer by needle techniques has also been incorporated into quality measurement programs developed by the American Society of Breast Surgeons and the National Consortium of Breast Centers. (The American Society of Breast Surgeons, 2006)

The advantages of preoperative cancer diagnosis by minimally invasive method include the patient centered measures of a smaller scar, good cosmesis, timeliness, and good pain control. Other advantages include a greater likelihood of achieving negative lumpectomy surgical margins and allowing concurrent scheduling of axillary lymph node surgery, reducing the number of operations required to treat breast cancer.

CLINICAL RECOMMENDATION STATEMENTS:

A major goal of modern breast medicine is to minimize the number of patients with benign lesions who undergo open surgical breast biopsies for diagnosis. Image guided percutaneous needle biopsy is the diagnostic procedure of choice for image-detected breast abnormalities. Patients with a clearly palpable breast mass should also have a minimally invasive percutaneous biopsy with or without image guidance depending on the size of the mass. (The American Society of Breast Surgeons, 2006) It is not possible to achieve a 100% success rate for the diagnosis of breast cancer by a minimally invasive technique due to some technical issues described above or sampling issues with high risk lesions of the breast.

✿Measure #264: Sentinel Lymph Node Biopsy for Invasive Breast Cancer – National Quality Strategy Domain: Effective Clinical Care

2015 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
The percentage of clinically node negative (clinical stage T1N0M0 or T2N0M0) breast cancer patients who undergo a sentinel lymph node (SLN) procedure

INSTRUCTIONS:
This measure is to be reported each time a procedure is performed during the reporting period for patients age 18 years and older who are operated upon for invasive breast cancer that are clinically node negative (clinical stage T1N0M0 or T2N0M0). This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

Measure Reporting via Registry:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

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

DENOMINATOR:
Patients aged 18 and older with primary invasive breast cancer

Denominator Criteria (Eligible Cases):
Patients aged 18 and older at date of encounter
AND
Diagnosis for Female/Male Breast Cancer (ICD-9-CM) [for use 1/1/2015-9/30/2015]: 174.0, 174.1, 174.2, 174.3, 174.4, 174.5, 174.6, 174.8, 174.9, 175.0, 175.9
Diagnosis for Female/Male Breast Cancer (ICD-10-CM) [for use 10/01/2015-12/31/2015]: C50.011, C50.012, C50.019, C50.021, C50.022, C50.029, C50.111, C50.112, C50.119, C50.121, C50.122, C50.129, C50.211, C50.212, C50.219, C50.221, C50.222, C50.229, C50.311, C50.312, C50.319, C50.321, C50.322, C50.329, C50.411, C50.412, C50.419, C50.421, C50.422, C50.429, C50.511, C50.512, C50.519, C50.521, C50.522, C50.529, C50.611, C50.612, C50.619, C50.621, C50.622, C50.629, C50.811, C50.812, C50.819, C50.821, C50.822, C50.829, C50.911, C50.912, C50.919, C50.921, C50.922, C50.929
AND
Patient encounter during the reporting period (CPT): 19301, 19302, 19307, 38500, 38510, 38520, 38525, 38530, 38542, 38740, 38745, 38900
AND
Clinically Node Negative (T1N0M0 or T2N0M0) Invasive Breast Cancer: G8879

NUMERATOR:
Patients who undergo a SLN procedure

Numerator Options:

Performance Met:	Sentinel lymph node biopsy procedure performed **(G8878)**

OR

Other Performance Exclusion:	Documentation of reason(s) sentinel lymph node biopsy **not** performed (eg, reasons could include but not limited to; non-invasive cancer, incidental discovery of breast cancer on prophylactic mastectomy, incidental discovery of breast cancer on reduction mammoplasty, pre-operative biopsy proven lymph node (LN) metastases, inflammatory carcinoma, stage 3 locally advanced cancer, recurrent invasive breast cancer, patient refusal after informed consent) **(G8880)**
OR	
Performance Not Met:	Sentinel lymph node biopsy procedure **not** performed, reason not given **(G8882)**

RATIONALE:

A sentinel lymph node (SLN) procedure is defined as a method of axillary or other regional lymph node assessment that requires either a radioisotope and/or blue dye injection in the breast with subsequent identification of radioactive or blue stained node(s) in the axilla or other lymph node basin. There is level one evidence that breast cancer SLN biopsy is as accurate as axillary dissection for breast cancer staging and is associated with less morbidity than routine axillary dissection.

CLINICAL RECOMMENDATION STATEMENTS:

The current body of reported surgical experience shows that SLN biopsy is suitable for virtually all clinically node-negative T1-2 invasive breast cancers. (The American Society of Breast Surgeons, 2010)

★Measure #265 (NQF 0645): Biopsy Follow-Up – National Quality Strategy Domain: Communication and Care Coordination

2015 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Percentage of new patients whose biopsy results have been reviewed and communicated to the primary care/referring physician and patient by the performing physician

INSTRUCTIONS:
This measure is to be reported **once per reporting period** for patients who are seen for an office visit and have a biopsy performed during the reporting period. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

Note: *While this measure is only required to be reported once per eligible patient per reporting period, it is recommended that the eligible professional performing the biopsy communicates the results to the primary care/referring physician and patient each time a biopsy is done.*

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

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data. The listed denominator options are the codes used in practice for various biopsies.

DENOMINATOR:
All patients undergoing a biopsy

Denominator Criteria (Eligible Cases):
All patients regardless of age on date of encounter
AND
Patient procedure during the reporting period (CPT): 11100, 11755, 19081, 19083, 19085, 19100, 19101, 19125, 20200, 20205, 20206, 20220, 20225, 20240, 20245, 20250, 20251, 21550, 21920, 21925, 23065, 23066, 23100, 23101, 24065, 24066, 24100, 24101, 25065, 25066, 25100, 25101, 26100, 26105, 26110, 27040, 27041, 27050, 27052, 27323, 27324, 27330, 27331, 27613, 27614, 27620, 28050, 28052, 28054, 29800, 29805, 29830, 29840, 29860, 29870, 29900, 30100, 31050, 31051, 31237, 31510, 31576, 31625, 31628, 31629, 31632, 31633, 31717, 32096, 32097, 32098, 32400, 32405, 32604, 32606, 32607, 32608, 32609, 37200, 37609, 38221, 38500, 38505, 38510, 38520, 38525, 38530, 38570, 38572, 39400, 40490, 40808, 41100, 41105, 41108, 42100, 42400, 42405, 42800, 42804, 42806, 43193, 43197, 43198, 43202, 43239, 43261, 43605, 44010, 44020, 44025, 44100, 44322, 44361, 44377, 44382, 44386, 44389, 45100, 45305, 45331, 45380, 45392, 46606, 47000, 47001, 47100, 47553, 47561, 48100, 48102, 49000, 49010, 49180, 49321, 50200, 50205, 50555, 50557, 50574, 50576, 50955, 50957, 50974, 50976, 52007, 52204, 52224, 52250, 52354, 53200, 54100, 54105, 54500, 54505, 54800, 54865, 55700, 55705, 55706, 55812, 55842, 55862, 56605, 56821, 57100, 57105, 57421, 57454, 57455, 57460, 57500, 57520, 58100, 58558, 58900, 59015, 60100, 60540, 60545, 60650, 61140, 61575, 61576, 61750, 61751, 62269, 63275, 63276, 63277, 63278, 63280, 63281, 63282, 63283, 63285, 63286, 63287, 63290, 63615, 64795, 65410, 67346, 67400, 67450, 67810, 68100, 68510, 68525, 69100, 69105, 75970, 89290, 89291, 93505
AND
Patient encounter during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205

NUMERATOR:
Patients whose biopsy results have been reviewed and communicated to the primary care/referring physician and the patient by the physician performing the biopsy. The physician performing the biopsy must also acknowledge and/or document the communication in a biopsy tracking log and document in the patient's medical record.

Numerator Instructions: To satisfy this measure, the biopsying physician must:

- Review the biopsy results with the patient
- Communicate those results to the primary care/referring physician
- Track communication in a log
- Document tracking process in the patient's medical record

Definition:
The components of a **tracking log** incorporate the following:

- Initials of physician performing the biopsy
- Patient name
- Date of biopsy
- Type of biopsy
- Biopsy result
- Date of biopsy result

Numerator Options:

Performance Met:	Biopsy results reviewed, communicated, tracked, and documented **(G8883)**
OR	
Other Performance Exclusion:	Clinician documented reason that patient's biopsy results were not reviewed, [eg, patient asks that biopsy results not be communicated to the primary care/referring physician, patient does not have a primary care/referring physician or is a self-referred patient] **(G8884)**
OR	
Performance Not Met:	Biopsy results **not** reviewed, communicated, tracked, or documented **(G8885)**

RATIONALE:
The purpose of this measure is to ensure that biopsy results with potentially serious consequences for patient care are not lost or ignored. Large health plan/delivery systems have identified a prominent quality of care issue as involving missing or overlooked biopsy pathology reports. All biopsy results should be accounted for and the results communicated to the patient or patient's guardian/caregiver and to the patient's primary care physician and/or other physician/professional responsible for follow-up care. Failure of the medical team to take appropriate action based on the result of a biopsy may lead to significant delays in obtaining appropriate treatment with subsequent poor outcomes, complications and even death. This measure will facilitate physician quality assurance that all biopsies are read, recorded and the results communicated.

CLINICAL RECOMMENDATION STATEMENTS:
The measure does not directly address that follow-up care has been concluded, but rather addresses the critical **first** step in the treatment chain. Appropriate follow-up care must be specifically tailored to each clinical diagnosis. Biopsy results are not only essential to making a final diagnosis, but they are also essential to disease staging and treatment planning. The patient needs to be informed of the biopsy results so they can not only be completely aware of their condition, but also so they can make informed decisions about their care and treatment.

♮ Measure #268: Epilepsy: Counseling for Women of Childbearing Potential with Epilepsy – National Quality Strategy Domain: Effective Clinical Care

2015 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
All female patients of childbearing potential (12 - 44 years old) diagnosed with epilepsy who were counseled about epilepsy and how its treatment may affect contraception and pregnancy at least once a year

INSTRUCTIONS:
This measure is to be reported at **all visits** for patients with a diagnosis of epilepsy during the reporting period. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

Measure Reporting via Claims:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. CPT Category II codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and the appropriate CPT Category II code **OR** the CPT Category II code **with** the modifier. The modifiers allowed for this measure are: 1P- medical reasons, 8P- reason not otherwise specified. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

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

DENOMINATOR:
All females of childbearing potential (12-44 years old) with a diagnosis of epilepsy

Denominator Criteria (Eligible Cases):
All females age 12-44 years old
AND
Diagnosis for Epilepsy (ICD-9-CM) [for use 1/1/2015-9/30/2015]: 345.00, 345.01, 345.10, 345.11, 345.40, 345.41, 345.50, 345.51, 345.60, 345.61, 345.70, 345.71, 345.90, 345.91
Diagnosis for Epilepsy (ICD-10-CM) [for use 10/01/2015-12/31/2015]: G40.001, G40.009, G40.011, G40.019, G40.101, G40.109, G40.111, G40.119, G40.201, G40.209, G40.211, G40.219, G40.309, G40.311, G40.319, G40.401, G40.409, G40.411, G40.419, G40.901, G40.909, G40.911, G40.919
AND
Patient encounter during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309

NUMERATOR:
Female patients counseled about epilepsy and how its treatment may affect contraception and pregnancy and documented in the medical record at least once a year

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Counseling for Women of Childbearing Potential with Epilepsy
***Performance Met:* CPT II 4340F:** Counseling for women of childbearing potential with epilepsy

OR

Counseling for Women of Childbearing Potential with Epilepsy not Performed for Medical Reasons
Append a modifier (**1P**) to Category II code **4340F** to report documented circumstances that appropriately exclude patients from the denominator.
***Medical Performance Exclusion:* 4340F *with* 1P:** Documentation of medical reason(s) why counseling was not performed for women of childbearing potential with epilepsy

OR

Counseling for Women of Childbearing Potential with Epilepsy not Performed, Reason not Otherwise Specified
Append a reporting modifier (**8P**) to CPT Category II code **4340F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.
***Performance Not Met:* 4340F *with* 8P:** Counseling about epilepsy specific safety issues provided to patient or caregiver was **not** performed, reason not otherwise specified

RATIONALE:
Epilepsy is associated with sexual dysfunction, reduced fertility, increased pregnancy risks, and risks for malformations in the infant. Seizures can transiently disrupt pituitary hormone secretion. Treatment of seizures with antiepileptic drugs may alter hormone levels, render oral contraceptives less effective and may interfere with embryonic and fetal development. Certain antiepileptic mediations may have specific malformation risks. Since unplanned pregnancy is common, patients need to be informed about the risks of epilepsy and antiepileptic drug therapy prior to pregnancy. Folic acid supplementation, monotherapy for epilepsy, using lower doses of medication when possible and proper obstetrical, prenatal and pre-pregnancy care should all be discussed with the patient so they understand the risks involved and how to mitigate these risks.

CLINICAL RECOMMENDATION STATEMENTS:
Women (and, if appropriate, their family and/or caregivers or others closely involved) should be given information about contraception, conception, pregnancy and breastfeeding. Information should be given in advance of sexual activity or pregnancy. (Level C) NICE 2004

IF a woman with epilepsy is of childbearing potential and receives oral contraceptives in conjunction with an enzyme inducing AED, THEN decreased effectiveness of oral contraception should be addressed. (Higher doses of the oral contraceptive, alternative birth control methods, or change AED). (Level A 2++/Primary) (Pugh, 2007)

If AEDs are to be used in pregnancy the relative risks of seizures and fetal malformation should be discussed with the woman. (Level C) SIGN (April 2003)

Whenever possible, a woman should conceive on the lowest effective dose of one AED appropriate for her epilepsy syndrome. If she has good seizure control and presents already pregnant, there is probably little to be gained by altering her AEDs. (Level C) SIGN (April 2003)

Patients with epilepsy should receive an annual review of information including topics such as:

- Chronic effects of epilepsy and its treatment including drug side-effects, drug-drug interactions, effect on bone health
- Contraception, family planning, and how pregnancy and menopause may affect seizures (EVIDENCE GRADE C)
- Screening for mood disorders

- Triggers and lifestyle issues that may affect seizures
- Impact of epilepsy on other chronic and acute diseases
- Driving and safety issues (Level D/Secondary) (Pugh, 2007)

☐ Measure #270: Inflammatory Bowel Disease (IBD): Preventive Care: Corticosteroid Sparing Therapy – National Quality Strategy Domain: Effective Clinical Care

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

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 of prednisone equivalents for 60 or greater consecutive days or a single prescription equating to 600 mg prednisone or greater for all fills that have been prescribed corticosteroid sparing therapy in the last reporting year

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

Measure Reporting via Registry:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

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

DENOMINATOR:
All patients aged 18 and older with a diagnosis of inflammatory bowel disease

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.

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Diagnosis for inflammatory bowel disease (ICD-9-CM) [for use 1/1/2014-9/30/2014]: 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
Diagnosis for inflammatory bowel disease (ICD-10-CM) [for use 10/01/2014-12/31/2014]: 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
AND
Patient encounter during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99341, 99342, 99343, 99344, 99345, 99346, 99347, 99348, 99349, 99350, 99406, 99407

AND

Patient who has received or is receiving corticosteroids greater than or equal to 10 mg/day of prednisone equivalents for 60 or greater consecutive days or a single prescription equating to 600 mg prednisone or greater for all fills: **G9467**

NUMERATOR:

Patients managed with corticosteroids greater than or equal to 10 mg/day of prednisone equivalents for 60 or greater consecutive days or a single prescription equating to 600 mg prednisone or greater for all fills AND prescribed a corticosteroid sparing therapy (e.g., thiopurines, methotrexate, or biologic agents)

Numerator Options:

Performance Met:	Corticosteroid sparing therapy prescribed **(4142F)**
OR	
Medical Performance Exclusion:	Documentation of medical reason(s) for **not** treating with corticosteroid sparing therapy (eg, benefits of continuing steroid therapy outweigh the risk of continuing steroid therapy or initiating steroid sparing therapy, patient is receiving the first course of corticosteroids for the treatment of IBD) **(4142F with 1P)**
OR	
Patient Performance Exclusion:	Documentation of patient reason(s) for **not** treating with corticosteroid sparing therapy (eg, patient refuses to initiate steroid sparing therapy) **(4142F with 2P)**
OR	
Performance Not Met:	Corticosteroid sparing therapy **not** prescribed, reason not otherwise specified **(4142F with 8P)**

RATIONALE:

Thirty to forty percent of patients with moderate to severe IBD have steroid dependent disease. That means that they are unable to taper off steroids without experiencing a flare up. (Crohn's and Colitis Foundation of America, Corticosteroids, Special Considerations. www.ccfa.org, Jan. 16, 2009). A retrospective study examined whether the treatment of Crohn's disease (CD) and ulcerative colitis (UC) with immunosuppressant medications was associated with an increased risk of death prior to antitumor necrosis factor therapies. The authors found that patients with both CD and UC are at increased risk of death during periods of current corticosteroid use. In contrast, current treatment with thiopurines was not associated with an increased risk of death. (Lewis J et al. Immunosuppressant Medications and Mortality in Inflammatory Bowel Disease. Am J Gastro.2008; 103:1428-1435).

CLINICAL RECOMMENDATION STATEMENTS:

Long-term treatment with corticosteroids is undesirable. Patients with chronic active corticosteroid-dependent disease (either CD or UC) should be treated with AZA [azathioprine] 2.0 to 3.0 mg/kg/day or 6-MP [6-mercaptopurine] 1.0 to 1.5 mg/kg/day in an effort to lower or preferably eliminate corticosteroid use. Infliximab is another option in this situation, as is combination infliximab/antimetabolite therapy. (Grade A) (American Gastroenterological Association Institute. American Gastroenterological Association Institute Medical Position Statement on Corticosteroids, Immunomodulators, and Infliximab in Inflammatory Bowel Disease. Gastroenterology. 2006;130:935–939.)

Individual patients with either CD or UC who experience a severe flare of disease requiring corticosteroid treatment or require retreatment during the year with another course of corticosteroids should be considered for initiation of therapy with AZA 2.0 to 3.0 mg/kg/day or 6-MP 1.0 to 1.5 mg/kg/day in an effort to avoid future corticosteroid use. Infliximab is another option in this situation, as is combination infliximab/antimetabolite therapy. (Grade C) (American Gastroenterological Association Institute. American Gastroenterological Association Institute Medical Position

Statement on Corticosteroids, Immunomodulators, and Infliximab in Inflammatory Bowel Disease. Gastroenterology. 2006; 130:935–939.)

Conventional corticosteroids are not efficacious in maintenance treatment of patients with CD (Grade A) or patients with UC (Grade B). (American Gastroenterological Association Institute. American Gastroenterological Association Institute Medical Position Statement on Corticosteroids, Immunomodulators, and Infliximab in Inflammatory Bowel Disease. Gastroenterology,2006; 130:935–939.)

Corticosteroids should not be used to maintain remission (EL1a, RG A) (European Crohn's and Colitis Organization [ECCO, 2006]. European evidence based consensus on the diagnosis and management of Crohn's disease: current management. Gut. 2006 Mar; 55 Suppl 1:i16-35.)

Conventional corticosteroids should not be used as long-term agents to prevent relapse of CD (Grade A). Budesonide at a dose of 6 mg/day reduces the time to relapse in ileal and/or right colonic disease, but does not provide significant maintenance benefits after 6 months (Grade A). Azathioprine/6-mercaptopurine (Grade B) and methotrexate (Grade B) have demonstrable maintenance benefits after inductive therapy with corticosteroids. (Lichtenstein, GR et al. Management of Crohn's Disease in Adults. Am J Gastro. 2009.)

This is the first report from the TREAT Registry, a large, prospective, observational research program designed to address the long term safety of medications, including infliximab, for the treatment of CD. After adjustment for confounding factors including disease severity and the use of other medications, the risk for serious infection or death with infliximab use was similar to that observed with the use of conventional immunomodulators, and was not higher than the overall incidence of serious infections among all CD patients.

The use of prednisone was a strong independent risk factor for both serious infection and death. Likewise, the use of narcotic analgesics also was associated with a significantly increased risk for serious infection. (Lichtenstein GR, Feagan BG, Cohen RD, Salzberg BA, Diamond RH, Chen DM, Pritchard ML, Sandborn WJ. Serious infections and mortality in association with therapies for Crohn's disease: TREAT registry. Clin Gastroenterol Hepatol. 2006 May; ; 4 (5):621-30.)

◘Measure #271: Inflammatory Bowel Disease (IBD): Preventive Care: Corticosteroid Related Iatrogenic Injury – Bone Loss Assessment – National Quality Strategy Domain: Effective Clinical Care

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Percentage of patients aged 18 years and older with an inflammatory bowel disease encounter who were prescribed prednisone equivalents greater than or equal to 10 mg/day for 60 or greater consecutive days or a single prescription equating to 600 mg prednisone or greater for all fills and were documented for risk of bone loss once during the reporting year or the previous calendar year

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

Measure Reporting via Registry:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

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

DENOMINATOR:
All patients aged 18 and older with a diagnosis of inflammatory bowel disease

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.

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Diagnosis for inflammatory bowel disease (ICD-9-CM) [for use 1/1/2014-9/30/2014]: 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
Diagnosis for inflammatory bowel disease (ICD-10-CM) [for use 10/01/2014-12/31/2014]: 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
AND

Patient encounter during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99341, 99342, 99343, 99344, 99345, 99346, 99347, 99348, 99349, 99350, 99406, 99407

AND

Patients who have received or are receiving corticosteroids greater than or equal to 10 mg/day of prednisone equivalents for 60 or greater consecutive days or a single prescription equating to 600 mg prednisone or greater for all fills: **G9469**

NUMERATOR:

Patients who have received dose of corticosteroids greater than or equal to 10 mg/day of prednisone equivalents for 60 or greater consecutive days or a single prescription equating to 600 mg prednisone or greater for all fills and who were documented for risk of bone loss during the reporting year or the pervious calendar year.

Definition:

Documented – 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:

Performance Met:	Within the past 2 years, Central Dual-energy X-Ray Absorptiometry (DXA) ordered **and** documented review of systems and medication history or pharmacologic therapy (other than minerals/vitamins) for osteoporosis prescribed **(G8861)**

OR

Performance Not Met:	Within the past 2 years, Central Dual-energy X-Ray Absorptiometry (DXA) **not** ordered and documented, **no** review of systems and **no** medication history or pharmacologic therapy (other than minerals/vitamins) for osteoporosis prescribed **(G9472)**

RATIONALE:

Patients with inflammatory bowel disease (IBD) often rely on their gastroenterologist for healthcare maintenance. In addition, the gastroenterologist also provides guidance to the patient's primary care physician on a broad range of issues such as vaccinations, osteoporosis screening, and cancer/dysplasia surveillance. Screening for osteoporosis is based on a combination of individual risk factors, but a history of prolonged (>3 months) steroid use over 10 mg is reason enough to obtain dual-energy x-ray absorptiometry scanning. (Moscandrew M., Mahadevan U., Kane S. General Health Maintenance in IBD. Inflamm Bowel Dis. 2009; 15:1399–1409.)

Markers of greater osteoporosis and fracture risk include older age, hypogonadism, corticosteroid therapy, and established cirrhosis (American Gastroenterological Association. (2003). American Gastroenterological Association Medical Position Statement: Osteoporosis in Hepatic Disorders. Gastroenterology. 125: pp 937-940.)

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

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

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

(National Institutes of Health. Osteoporosis Prevention, Diagnosis and Therapy. NIH Consensus Statement. March 2000;17:1-45.)

CLINICAL RECOMMENDATION STATEMENTS:

IBD has only a modest effect on BMD, with a pooled Z score of - 0.5 (level A evidence). (AGA, American Gastroenterological Association Medical Position Statement: Guidelines on Osteoporosis in Gastrointestinal Diseases, 2003).

Corticosteroid use is the variable most strongly associated with osteoporosis (level A evidence). However, it is difficult to distinguish corticosteroid use from disease activity in terms of causal impact on bone density, because the two are closely linked. (AGA, American Gastroenterological Association Medical Position Statement: Guidelines on Osteoporosis in Gastrointestinal Diseases. 2003.)

However there is strong evidence that those on long-term steroids of greater than three months have a significant increase risk of fracture (Papaioannou A. et al. All Patients with Inflammatory Bowel Disease Should Have Bone Density Assessment: Pro. Inflammatory Bowel Diseases. 2001.7(2):158-162)

Data on the treatment of osteoporosis in Crohn's disease depend on studies that are not specific to IBD. The evidence levels and recommendation grades are accordingly marked down. Weight bearing, isotonic exercise [EL2b, RG B], stopping smoking [EL3b, RG C], avoiding alcohol excess [EL4, RG D], and maintaining adequate dietary calcium (>1 g/day) [EL2b, RG B] are beneficial. Hormone replacement treatment is no longer generally advised in post-menopausal women with osteoporosis [EL2b, RG B], but regular use of bisphosphonates, calcitonin and its derivatives, and raloxifene may reduce or prevent further bone loss [EL2b, RG C]. Data in men with osteoporosis are less secure but bisphosphonates are probably of value, [EL3b, RG C], and those with low testosterone may benefit from its therapeutic administration [EL3b, RG C]. Routine administration of vitamin D is not warranted [EL3b, RG C]. (Caprilli R. et al. European evidence based consensus on the diagnosis and management of Crohn's disease: special situations. Gut. 2006;55(Supplement 1):i36-i58.)

◘Measure #274: Inflammatory Bowel Disease (IBD): Testing for Latent Tuberculosis (TB) Before Initiating Anti-TNF (Tumor Necrosis Factor) Therapy – National Quality Strategy Domain: Effective Clinical Care

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

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 6 months prior to receiving a first course of anti-TNF (tumor necrosis factor) therapy

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

Measure Reporting via Registry:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

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

DENOMINATOR:
All patients aged 18 and older with a diagnosis of inflammatory bowel disease

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

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Diagnosis for inflammatory bowel disease (ICD-9-CM) [for use 1/1/2014-9/30/2014]: 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
Diagnosis for inflammatory bowel disease (ICD-10-CM) [for use 10/01/2014-12/31/2014]: 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
AND
Patient encounter during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99341, 99342, 99343, 99344, 99345, 99346, 99347, 99348, 99349, 99350, 99406, 99407
AND
Patients receiving a first course of anti-TNF therapy: **G8868**

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

Numerator Options:

Performance Met: Documentation that tuberculosis (TB) screening test performed and results interpreted **(3510F)**

OR

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

OR

Medical Performance Exclusion: 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

Patient Performance Exclusion: 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)**

OR

Performance Not Met: 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)**

RATIONALE:
Before initiating biologic anti-TNF therapy for a patient with IBD, it is essential to screen the patient for tuberculosis, as research has documented a higher incidence of TB after anti-TNF therapy. All patients being considered for biologic anti-TNF therapy should receive a tuberculin skin test, even if the patient has previously received the BCG vaccination. Test results, in addition to patient risk for TB and other tests, should be used to assess the patient's risk for latent TB infection. This is a patient safety measure.

Opportunity for improvement: While there are a limited number of studies that investigate gaps in care for patients with IBD, the research that does exist identifies opportunities for improvement in care areas: 1) there is a lack of adherence to tuberculosis screening, most noticeably in the use of disease-modifying anti-TNF drugs, and 2) variations in care by practice setting, geographic region and physician specialty.

Golimumab, certolizumab pegol, infliximab and adalimumab may all trigger latent TB. Also, all patients should be monitored during therapy for active TB even if the initial latent TB testing is negative. (See FDA package labeling for these anti-TNF biological agents).

Reactivation of hepatitis B virus has been reported in patients who are carriers of this virus and are taking TNF blocker medicines. (Kaiser T, Moessner J, McHutchison JG, Tillmann HG. Life threatening liver disease during treatment with monoclonal antibodies. BMJ 2009;338:b508.)

CLINICAL RECOMMENDATION STATEMENTS:
Prior to commencing treatment with anti-TNF, all patients should be screened for TB in accordance with the British Thoracic Society (BTS) guidelines. Active TB needs to be adequately treated before anti-TNF therapy can be started. Prior to commencing anti-TNF therapy, consideration of prophylactic anti-TB therapy (as directed by the BTS guidelines) should be given to patients with evidence of potential latent disease (past history of TB treatment or

abnormal chest X-ray raising the possibility of TB) after consultation with a local TB specialist. All patients commenced on anti-TNF therapies need to be closely monitored for TB. [Level of Evidence C) (J. Ledingham and C. Deighton, on behalf of the British Society for Rheumatology Standards, Guidelines and Audit Working Group (SGAWG). Update on the British Society for Rheumatology guidelines for prescribing TNFa blockers in adults with rheumatoid arthritis (update of previous guidelines of April 2001)Rheumatology. 2005; 44(2):157-163.]

In an immunocompromised person (adult or child), the tuberculin skin test (TST) should be the initial test used to detect LTBI. If the TST is positive, the person should be considered to have LTBI.

However, in light of the known problem with false-negative TST results in immunocompromised populations, a clinician still concerned about the possibility of LTBI in an immunocompromised person with a negative initial TST result may perform an IGRA test. If the IGRA (interferon-gamma release assay) result is positive, the person might be considered to have LTBI. If the IGRA result is indeterminate, the test should be repeated to rule out laboratory error. If the repeat test is also indeterminate, the clinician should suspect anergy and rely on the person's history, clinical features, and any other laboratory results to make a decision as to the likelihood of LTBI. Although both IGRAs may be used as described above, there is evidence that the T-SPOT.TB assay may be more sensitive than the QFT-GIT assay in active TB, and this characteristic might be especially relevant in immunocompromised populations. While the approach of accepting either test result (TST or IGRA) as positive will improve the sensitivity of detecting LTBI in immunocompromised populations, there are no data supporting the efficacy of preventive therapy in TST-negative but IGRA-positive individuals. Thus the Page 31 of 52 clinician must weigh the potential benefit of detecting more persons with positive test results against the lack of evidence for the benefit of preventive therapy in such persons. (Canada Communicable Disease Report, October 2008.)

Infliximab can reactivate latent HBV. (Esteve M, Saro C, González-Huix F, Suarez F, Forné M, Viver JM. Chronic hepatitis B reactivation following infliximab therapy in Crohn's disease patients: need for primary prophylaxis. Gut. 2004 Sep;53(9):1363-5.)

☐ Measure #275: Inflammatory Bowel Disease (IBD): Assessment of Hepatitis B Virus (HBV) Status Before Initiating Anti-TNF (Tumor Necrosis Factor) Therapy – National Quality Strategy Domain: Effective Clinical Care

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

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

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

Measure Reporting via Registry:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

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

DENOMINATOR:
All patients aged 18 and older with a diagnosis of inflammatory bowel disease

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Diagnosis for inflammatory bowel disease (ICD-9-CM) [for use 1/1/2014-9/30/2014]: 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
Diagnosis for inflammatory bowel disease (ICD-10-CM) [for use 10/01/2014-12/31/2014]: 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
AND
Patient encounter during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99341, 99342, 99343, 99344, 99345, 99346, 99347, 99348, 99349, 99350, 99406, 99407

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:

Performance Met:	Hepatitis B vaccine administered or previously received **(4149F)**
AND	
	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	
Performance Met:	Patient has documented immunity to hepatitis B and is receiving a first course of anti-TNF therapy **(G8869)**
OR	
Other Performance Exclusion:	Hepatitis B vaccine injection administered or previously received and is receiving a first course of anti-TNF therapy **(G8870)**
OR	
Other Performance Exclusion:	Patient not receiving a first course of anti-TNF therapy **(G8871)**
OR	
Patient Performance Exclusion:	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	
Performance Not Met:	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)**

RATIONALE:
Before initiating biologic anti-TNF therapy for a patient with IBD, it is essential to screen the patient for HBV, as research has documented reactivation of HBV after anti-TNF therapy. This is a patient safety measure.

Opportunity for improvement: While there are a limited number of studies that investigate gaps in care for patients with IBD, the research that does exist identifies opportunities for improvement in care areas: 1) there is a lack of adherence to documentation of HBV screening, most noticeably in the use of disease-modifying anti-TNF drugs, and 2) variations in care by practice setting, geographic region and physician specialty.

See FDA package labeling for anti-TNF biological agents — golimumab, certolizumab pegol, infliximab and adalimumab.

Reactivation of hepatitis B virus has been reported in patients who are carriers of this virus and are taking TNF blocker medicines. (Kaiser T, Moessner J, McHutchison JG, Tillmann HG. Life threatening liver disease during treatment with monoclonal antibodies. BMJ. 2009;338:b508)

CLINICAL RECOMMENDATION STATEMENTS:

Infliximab can reactivate latent HBV. (Esteve M, Saro C, González-Huix F, Suarez F, Forné M, Viver JM. Chronic hepatitis B reactivation following infliximab therapy in Crohn's disease patients: need for primary prophylaxis. Gut. 2004 Sep;53(9):1363-5.)

✣Measure #303 (NQF 1536): Cataracts: Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery – National Quality Strategy Domain: Person and Caregiver-Centered Experience and Outcomes

2015 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

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

INSTRUCTIONS:
This measure is to be calculated when a procedure for cataracts is performed in the sample during the reporting period. This measure is intended to reflect the quality of services provided for the patient receiving cataract surgery.

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

- *For patients who receive the cataract surgical procedures specified in the denominator coding in the sample, it should be reported whether or not the patient had improvement in visual function achieved within 90 days following the cataract surgery.*
- *Include only procedures performed through **September 30** of the reporting period. This will allow the post-operative period to occur before registries must submit data to CMS.*
- *It is the responsibility of a third party, which may be the registry or another third party designated by the eligible professional to administer, receive results, and review the surveys. Each registry must work directly with eligible professionals who wish to report these measures to determine who (a registry or another third party) will be administering, receiving and reviewing the surveys.*

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

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

DENOMINATOR:
All patients aged 18 years and older who had cataract surgery

> **Denominator Instructions:** Clinicians who indicate modifier 56 (pre-operative management) or modifier 55 (post-operative management) only, will **not** qualify for this measure.
>
> **Denominator Criteria (Eligible Cases):**
> Patients aged ≥ 18 years on date of encounter
> **AND**
> **Patient encounter during the reporting period (CPT):** 66840, 66850, 66852, 66920, 66930, 66940, 66983, 66984

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

> **Numerator Options:**

Performance Met: Improvement in visual function achieved within 90 days following cataract surgery **(G0913)**

OR

Other Performance Exclusion: Patient care survey was not completed by patient **(G0914)**

OR

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

RATIONALE:

1) Scientific Basis for Measuring Visual Function Outcomes after Cataract Surgery.
Visual function has been described as having multiple components, including central near, intermediate, and distance visual acuity; peripheral vision; visual search; binocular vision; depth perception; contrast sensitivity; perception of color; adaptation; and visual processing speed. Visual function also can be measured in terms of functional disability caused by visual impairment. Many activities are affected by more than one of these visual components.
Health services researchers have increasingly emphasized function and quality of life as the outcomes of treatment that are most critical and applicable to the patient. As previously stated, the primary purpose in managing a patient with cataract is to improve functional vision and the quality of life. In well-designed observational studies, cataract surgery consistently has been shown to have a significant impact on vision-dependent function. The Cataract Patient Outcomes Research Team (PORT) reported that 90% of patients under-going first-eye cataract surgery noted improvement in functional status and satisfaction with vision. The Activities of Daily Vision Study of elderly patients with a high prevalence of coexisting ocular and medical diseases reported improved visual function in 80% of patients at 12 months after surgery. A National Cataract Study conducted in England of 1,139 patients who had cataract surgery found that preoperative functional impairment varied in relation to gender, age, and visual acuity. Men were more likely to have trouble with driving, glare, and employment, and women were more likely to have difficulties with activities of daily living and recreational activities. Studies have found that regardless of the preoperative visual acuity in the better eye, most patients reported improvement in their ability to perform visually dependent tasks after undergoing cataract surgery.
Several studies have reported an association between improved visual function after cataract surgery and improved health-related quality of life. Visual function plays an important role in physical function, particularly in terms of mobility. The loss of visual function in the elderly is associated with a decline in physical and mental functioning as well as in independence in activities of daily living, including night-time driving, daytime driving, community activities, and home activities. Elderly patients with visual impairment only (and no other physical or mental impairments) were 2.5 times as likely to experience functional decline as elderly patients without visual impairment.
Improved visual function following cataract surgery can ameliorate the progressive deterioration of quality of life seen in elderly patients. In a cohort of 464 patients 65 years old and older, cataract extraction improved visual function and health-related quality of life. Patients with an improvement in their Activities of Daily Vision Scale (ADVS), a brief measure of vision-specific functional status, had from 10% to 59% less decline in nearly all Short Form (SF)-36 dimensions. The SF-36 is a generic global measure of multidimensional health-related quality of life. A nationally representative population of 7,114 persons who were 70 years old and older showed that limitations in vision correlated with decreased functional status. The unadjusted functional score of a person with reported poor vision was four times worse than the score for a person with excellent vision. This difference was comparable with the differences found in other chronic conditions such as arthritis. This relationship with vision persisted, even after adjustment for health, demographics, and economic status. Individuals who rated their vision as other than excellent reported worse functional status, even when controlled for the presence of other medical conditions, education, income, general health status, and other symptoms. By improving visual function, cataract surgery may play an important role in

preserving overall functional status, reducing associated injuries and accidents, and preventing disability in at-risk elderly patients.

An analysis of the Medical Outcomes Study found that having blurred vision more than once or twice a month has a significant impact on functional status and well-being, particularly on problems with work or other daily activities as a result of physical health. This impact was found to be greater than the impact of several other chronic conditions, such as hypertension, history of myocardial infarction, type 2 diabetes mellitus, indigestion, trouble urinating, and headache. In one study, patients planning to undergo cataract surgery assigned a mean preoperative preference value of 0.68 on a scale ranging from 0 to 1 (where 0 is death and 1 is excellent health), indicating that the visual impairment from cataracts had a substantial impact on their quality of life. Visual impairment is an important risk factor for falls and for hip fracture. Specifically, the Study for Osteoporotic Fractures Research Group found that poor depth perception and decreased contrast sensitivity independently increased the risk of hip fracture.

Visual impairment, in particular a decrease of visual acuity and contrast sensitivity, has been shown to be associated with difficulties in driving. In one study, older drivers with visually significant cataract were twice as likely as older drivers without cataract to report reduction in days driven and four times as likely to report difficulties in challenging driving situations. Drivers with visually significant cataract were 2.5 times more likely to have had an at-fault involvement in a motor vehicle crash in the past 5 years compared with drivers without cataract. This association was significant, even after accounting for other factors such as impaired general health, age, mental status deficit or depression. In this study, visually significant cataract was determined by reviewing the participant's medical record and most recent eye examination by an eye care specialist. The study required that cataract in both eyes was the cause of the visual impairment, based on the medical record; an additional inclusion criterion was best-corrected visual acuity in one eye of 20/40 or worse. A further study in the same group demonstrated that drivers with a history of crash involvement were eight times more likely to have a serious contrast sensitivity deficit (defined as a Pelli-Robson score of 1.25 or less) in the worse eye than those who had no history of crash involvement. A severe contrast sensitivity deficit in only one eye was still significantly associated with crash involvement.

Binocular vision is better than the vision of a single eye. The simultaneous use of the two eyes is complex and requires the integration of disparate images from each eye. A study demonstrated that binocular vision resulted in better perception of form, color, and the relationship of the body to the environment, which facilitated manipulation, reaching, and balance, particularly under dim illumination. However, if the vision of one eye is reduced due to cataract, visual performance can fall below the level of monocular vision by a mechanism known as binocular inhibition, which reduces patients' visual acuity and contrast sensitivity. A study of the Framingham Study Cohort found that poor vision in one or both eyes was associated with an increased risk of hip fracture. It also found that patients with good vision in one eye and moderately impaired vision in the other eye had a higher risk of fracture than those with similar visual impairment in both eyes. A study of 150 patients before and after cataract surgery found that poor binocular visual acuity was related to more problems in activities of daily living. Another study, based on patients who reported no beneficial outcomes after first-eye cataract surgery in the National Swedish Cataract Outcome register, found that anisometropia was the reason for the poor outcome in one-third of cases. These studies have shown that second-eye surgery is important to visual and physical function.

In summary, these studies demonstrate that physical function, emotional well-being, and overall quality of life can be enhanced when visual function is restored by cataract extraction.

Improved visual function as a result of cataract surgery includes the following:

- Better optically corrected vision.
- Better uncorrected vision with reduced spectacle dependence.
- Increased ability to read or do near work.
- Reduced glare.
- Improved ability to function in dim levels of light.
- Improved depth perception and binocular vision.
- Improved color vision.

Improved physical function as a critical outcome of cataract surgery includes the following:

- Increased ability to perform activities of daily living.
- Increased opportunity to continue or resume an occupation.
- Increased mobility (walking, driving).

Improved mental health and emotional well-being as a second critical outcome of cataract surgery includes the following benefits:

- Improved self-esteem and independence.
- Increased ability to avoid injury.
- Increased social contact and ability to participate in social activities.
- Relief from fear of blindness.

Most patients achieve improved visual function after cataract surgery. This outcome is achieved consistently through careful attention through the patient selection process, accurate measurement of axial length and corneal power, appropriate selection of an IOL power calculation formula, etc. As such, it reflects the care and diligence with which the surgery is assessed, planned and executed. Failure to achieve this after surgery would reflect patterns of patient selection or treatment that should be assessed for opportunities for improvement.

Sometimes cataract surgery is performed for other medical reasons other than to improve impaired visual function caused by cataract. These circumstances include the following: clinically significant anisometropia in the presence of a cataract; when the lens opacity interferes with optimal diagnosis or management of posterior segment conditions, when the lens causes inflammation (phacolysis, phacoanaphylaxis) and when the lens induces angle closure (phacomorphic or phacotopic). In these situations, improved visual function as a result of the removal of the cataract is not expected, because of the pre-existing comorbid conditions.

2) Evidence of a Gap in Care

This is an outcome of surgery indicator of direct relevance and import to patients, their families and referring providers. The available evidence suggests that cataract surgery achieves this in about 90% of patients. While the potential for improvement is seemingly small, the volume of cataract surgery in the U.S. of over 2.8 million surgeries means that the impact could affect more than 100,000 patients per year. Ideally, performance on this indicator would be as high as possible, with lower rates suggestive of opportunities for improvement.

3) Sampling Strategy

The survey methodology is described as follows. The survey could be administered by a third party or a registry for reporting of PQRS measures to prevent or minimize bias which might be introduced if it is an in-office paper survey with questions asked by the office staff. Options would be provided to the patient, either online survey, mail survey or phone survey (third party or registry only), depending on their preferences and abilities.

The survey would be of a sample of those individuals with cataract surgery. The sample size would be postulated at 20, because this is a well-accepted statistical sample and used by the CMS for reporting on measure groups in PQRS. Because visual function is reported at 90 days after surgery, this would allow physicians to identify 20 cases from January – September for reporting purposes.

4) Improvement in Visual Function

The strategy to identify improvement in visual function is as follows. The instrument proposed for visual function evaluation is the Rasch-scaled Short Version of the Visual Function-14, VF-8R. Reliability and validity testing have been performed on the VF-14 as well as the VF-8R. This instrument is scored on a scale of 0-100, with 0 indicating the lack of ability to perform functional activities and 100 indicating complete ability to perform functional activities. The difference between the pre-operative and post-operative scores on the VF-8R indicates a change in functional activities. Improvement in visual function would be defined as

an increase in the visual function score between pre-operative and post-operative assessment on the VF-8R in the range of 5 points or greater.

CLINICAL RECOMMENDATION STATEMENTS:

This is an outcomes measure. As such, there are no recommendation statements in the guideline specific to this measurement topic.

✣Measure #304: Cataracts: Patient Satisfaction within 90 Days Following Cataract Surgery – National Quality Strategy Domain: Person and Caregiver-Centered Experience and Outcomes

2015 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

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

INSTRUCTIONS:
This measure is to be calculated when a procedure for cataracts is performed in the sample during the reporting period. This measure is intended to reflect the quality of services provided for the patient receiving cataract surgery.

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

- *For patients who receive the cataract surgical procedures specified in the denominator coding in the sample, it should be reported whether or not the patient was satisfied with their care within 90 days following the cataract surgery.*
- *Include only procedures performed through **September 30** of the reporting period. This will allow the post-operative period to occur before registries must submit data to CMS.*
- *It is the responsibility of a third party, which may be the registry or another third party designated by the eligible professional to administer, receive results, and review the surveys. Each registry must work directly with eligible professionals who wish to report these measures to determine who (a registry or another third party) will be administering, receiving and reviewing the surveys.*

Measure Reporting via Registry:
CPT codes and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure. The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All patients aged 18 years and older in the sample who had cataract surgery

Denominator Instructions: Clinicians who indicate modifier 56 (pre-operative management) or modifier 55 (post-operative management) only, will **not** qualify for this measure.

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Patient encounter during the reporting period (CPT): 66840, 66850, 66852, 66920, 66930, 66940, 66983, 66984

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

Numerator Options:

***Performance Met**:* Satisfaction with care achieved within 90 days following cataract surgery **(G0916)**

OR

Other Performance Exclusion: Patient care survey was not completed by patient **(G0917)**

OR

Performance Not Met: Satisfaction with care **not** achieved within 90 days following cataract surgery (**G0918**)

RATIONALE:

1) Scientific Basis for Measuring Patient Satisfaction after Cataract Surgery

Patient satisfaction is a valuable performance indicator for measuring the quality of care delivered by ophthalmologists providing cataract surgery. In the broadest sense, patient satisfaction is an assessment of the patient's experience with the care process delivered by health plans, clinicians, health systems, hospitals, etc. This experience can cover domains as diverse as information/education, interpersonal manner, emotional support, accessibility, convenience, outcomes or results, environment, personalization, involvement in care, finances, etc.

In 1996, The American Academy of Ophthalmology launched the National Eyecare Outcomes Network (NEON) database. From January 1, 1996 through March 30, 2001, 249 ophthalmologists at 114 different practice sites submitted data to the NEON cataract surgery database. Post-operative patient satisfaction responses were collected for 6,154 patients, or about 34.5% of all patients who had pre-operative forms submitted. This assessment was performed at a median of 4.1 weeks postoperatively for all patients enrolled in the database. A 12-item questionnaire was used to assess patient satisfaction. Patient satisfaction was associated with younger age and absence of ocular comorbidity.

Other studies of patient satisfaction after cataract surgery were conducted in Austria and in Spain. The Austrian study found that patients with pre-existing eye disease, including those patients with improved visual acuity after surgery, were the least satisfied with the results of surgery. In these cases, improved patient education prior to surgery could be helpful in improving patient satisfaction. The Spanish study found that patient satisfaction was associated with expectations prior to surgery.

Most patients are satisfied with their care and results after cataract surgery. This outcome is achieved consistently through careful attention through the patient selection process, accurate measurement of axial length and corneal power, appropriate selection of an IOL power calculation formula, etc. As such, it reflects the care and diligence with which the surgery is assessed, planned and executed. Failure to achieve this satisfaction after surgery would reflect patterns of patient selection or treatment that should be assessed for opportunities for improvement.

Use of this indicator in PQRS claims-based reporting method would require some modification to the current reporting of post-operative care for patients undergoing cataract surgery, since this indicator would be operative during the 90 day global period. However, there is a strong and practical precedent for such modifications in that reporting arrangements have previously been made to accommodate co-management of care by different providers during the post-operative period. A similar adjustment to allow for filing of a claim of meeting this goal at one point in the 90 day global period would be sufficient, potentially drawing upon the methods to demarcate the onset of co-management transfer of post-operative care.

Various patient satisfaction instruments exist, but an instrument developed by the program, Consumer Assessment of Healthcare Providers and Systems (CAHPS), Agency for Healthcare Research and Quality develops and supports the use of a comprehensive and evolving family of standardized surveys that ask consumers and patients to report on and evaluate their experiences with health care. These surveys cover topics that are important to consumers, such as the communication skills of providers and the accessibility of services. AHRQ first launched the CAHPS program in October 1995 in response to concerns about the lack of good information about the quality of health plans from the enrollees' perspective. At that time, numerous public and private organizations collected information on enrollee and patient satisfaction, but the surveys varied from sponsor to sponsor and often changed from year to year.

The CAHPS Surgical Care Survey asks adult patients to report on surgical care, surgeons, their staff, and anesthesiologists. It was developed by the American College of Surgeons and the Surgical Quality Alliance to assess patients' experiences before, during, and after surgery. In early 2010, the CAHPS Consortium voted to adopt the Surgical Care Survey as an official CAHPS survey. The Surgical Care Survey expands on the current CAHPS Clinician & Group Survey, which focuses on primary and specialty care, by incorporating domains that are relevant to surgical care, such as informed consent, anesthesia care, and post-operative follow-up. The survey is unique in that it assesses patients' experiences with surgical care in both the inpatient and outpatient settings by asking respondents about their care before, during, and after surgery.

The main purpose of the CAHPS Surgical Care Survey is to address the need to assess and improve the experiences of surgical patients. Like other CAHPS surveys, this questionnaire focuses on aspects of surgical quality that are important to patients and for which patients are the best source of information. The survey results are expected to be useful to everyone with a need for information on the quality of surgeons and surgical care, including patients, practice groups, health plans, insurers, and specialty boards. Patients can use the information to help make better and more informed choices about their surgical care. Practices, health plans, and insurers can use the survey results for quality improvement initiatives and incentives. Specialty boards may use the survey for maintenance of certification.

The composite measures of surgical quality from the S-CAPHS that are most relevant and significant for this physician-level performance measure include:

- How well surgeon communicates with patients before surgery
- How well surgeon communicates with patients after surgery
- Rating of overall care from this surgeon

2) Evidence of a Gap in Care

This is an outcome of surgery indicator of direct relevance and importance to patients, their families and referring providers. The available evidence suggests that cataract surgery achieves this in about 90% of patients. While the potential for improvement appears seemingly small, the volume of cataract surgery in the U.S. of over 2.8 million surgeries means that the impact could affect more than 100,000 patients per year. Ideally performance on this indicator should be as high as possible, with rates lower than 95-100% suggestive of opportunities for improvement.

3) Sampling Strategy

The survey methodology is described as follows. The survey could be administered by a third party or a registry for reporting of PQRS measures to prevent or minimize bias which might be introduced if it is an in office paper survey with questions asked by the office staff. Options would be provided to the patient, either online survey, mail survey or phone survey (third party or registry only), depending on their preferences and abilities.

The survey would be of a sample of those individuals with cataract surgery. The sample size would be postulated at 20, because this is a well-accepted statistical sample and used by the CMS for reporting on measure groups in PQRS. Because patient satisfaction is reported at 90 days after surgery, this would allow physicians to identify 20 cases from January – September for reporting purposes.

4) Definition of Patient Satisfaction

The strategy for defining patient satisfaction is described as follows. CAHPS scores are actually normative scores, that is, they provide relative rankings rather than absolute rankings (where a score is compared with an 'objective criterion'). Patient satisfaction would be defined as a score above the lowest 5% of scores on the CAHPS.

CLINICAL RECOMMENDATION STATEMENTS:

This is an outcomes measure. As such, there are no recommendation statements in the guideline specific to this measurement topic.

♠ Measure #317: Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented – National Quality Strategy Domain: Community / Population Health

2015 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of patients aged 18 years and older seen during the reporting period who were screened for high blood pressure AND a recommended follow-up plan is documented based on the current blood pressure (BP) reading as indicated

INSTRUCTIONS:
This measure is to be reported a minimum of **once per reporting period** for patients seen during the reporting period. Eligible professionals who report the measure must perform the blood pressure screening at the time of a qualifying visit and may not obtain measurements from external sources.

This measure may be reported by eligible professionals who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding. The documented follow-up plan must be related to the current BP reading as indicated, example: "Patient referred to primary care provider for BP management".

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

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

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

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

DENOMINATOR:
All patients aged 18 years and older

> **Denominator Criteria (Eligible Cases):**
> Patients aged ≥ 18 years
> **AND**
> **Patient encounter during the reporting period (CPT or HCPCS):** 90791, 90792, 90832, 90834, 90837, 90839, 90845, 90880, 92002, 92004, 92012, 92014, 96118, 97532, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99218, 99219, 99220, 99224, 99225, 99226, 99234, 99235, 99236, 99281, 99282, 99283, 99284, 99285, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99318, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99340, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, D7140, D7210, G0101, G0402, G0438, G0439

NUMERATOR:
Patients who were screened for high blood pressure AND have a recommended follow-up plan documented, as indicated, if the blood pressure is pre-hypertensive or hypertensive

NUMERATOR NOTE: *Although the recommended screening interval for a normal BP reading is every 2 years, to meet the intent of this measure, BP screening and follow-up 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. Normal blood pressure follow-up is not recommended for patients with clinical or symptomatic hypotension.*

Definitions:

Blood Pressure (BP) Classification:

BP is defined by four (4) BP reading classifications: 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 the current BP reading as listed in the "Recommended Blood Pressure Follow-Up Interventions" listed below.

Recommended Lifestyle Modifications:

The current JNC report outlines lifestyle modifications which must include one or more of the following as indicated:

- Weight Reduction
- Dietary Approaches to Stop Hypertension (DASH) Eating Plan
- Dietary Sodium Restriction
- Increased Physical Activity
- Moderation in alcohol (ETOH) Consumption

Second Hypertensive Reading:

Requires 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 BP Reading Interventions:

The current JNC report outlines BP follow-up interventions for a second hypertensive BP reading and **must** include one or more of the following as indicated:

- Anti-Hypertensive Pharmacologic Therapy
- Laboratory Tests
- Electrocardiogram (ECG)

Recommended Blood Pressure Follow-up Interventions:

- Normal BP: No follow-up required for Systolic BP <120 mmHg AND Diastolic BP < 80 mmHg
- Pre-Hypertensive BP: Follow-up with rescreen every year with systolic BP of 120 – 139 mmHg OR diastolic BP of 80 – 89 mmHg AND recommended lifestyle modifications OR referral to Alternate/Primary Care Provider
- First Hypertensive BP Reading: Patients with one elevated reading of systolic BP >= 140 mmHg OR diastolic BP >= 90 mmHg:
    - Follow-up with rescreen ≥ 1 day and ≤ 4 weeks AND recommend lifestyle modifications OR referral to Alternative/Primary Care Provider
- Second Hypertensive BP Reading: Patients with second elevated reading of systolic BP >= 140 mmHg OR diastolic BP >= 90 mmHg:
    - Follow-up with Recommended lifestyle modifications AND one or more of the Second Hypertensive Reading Interventions OR referral to Alternative/Primary Care Provider

Recommended Blood Pressure Follow-Up Table

BP Classification	Systolic BP mmHg	Diastolic BP mmHg	Recommended Follow-Up *(must include all indicated actions for each BP Classification)*
Normal BP Reading	< 120	AND < 80	• No Follow-Up required
Pre-Hypertensive BP Reading	≥ 120 AND ≤ 139	OR ≥ 80 AND ≤ 89	• Rescreen BP within a minimum of 1 year **AND** Recommend Lifestyle Modifications **OR** • Referral to Alternative/Primary Care Provider
First Hypertensive BP Reading	≥ 140	OR ≥ 90	• Rescreen BP within a minimum of ≥ 1 day and ≤ 4 weeks *AND* Recommend Lifestyle Modifications **OR** • Referral to Alternative/Primary Care Provider
Second Hypertensive BP Reading	≥ 140	OR ≥ 90	• Recommend Lifestyle Modifications *AND* 1 or more of the Second Hypertensive Reading Interventions (see definitions) **OR** • Referral to Alternative/Prima*ry C*are Provider

Not Eligible – A patient is **not** eligible if one or more of the following reason(s) are documented:

- Patient has an active diagnosis of hypertension
- Patient refuses to participate (either BP measurement or follow-up)
- 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

Performance Met: **G8783:** Normal blood pressure reading documented, follow-up not required

OR

Pre-Hypertensive or Hypertensive Blood Pressure Reading Documented, AND Indicated Follow-Up Documented

Performance Met: **G8950:** Pre-Hypertensive or Hypertensive blood pressure reading documented, AND the indicated follow-up is documented

OR

Blood Pressure Reading <u>not</u> Documented, Patient <u>not</u> Eligible

Other Performance Exclusion: **G8784:** Blood pressure reading not documented, documentation the patient is not eligible

<u>OR</u>

Pre-Hypertensive or Hypertensive Blood Pressure Reading Documented, Indicated Follow-Up <u>not</u> Documented, Patient <u>not</u> Eligible

Other Performance Exclusion: **G8951:** Pre-Hypertensive or Hypertensive blood pressure reading documented, indicated follow-up not documented, documentation the patient is not eligible

<u>OR</u>

Blood Pressure Reading <u>not</u> Documented, Reason not Given

Performance Not Met: **G8785:** Blood pressure reading **<u>not</u>** documented, reason not given

<u>OR</u>

Pre-Hypertensive or Hypertensive Blood Pressure Reading Documented, Indicated Follow-Up <u>not</u> Documented, Reason not Given

Performance Not Met: **G8952:** Pre-Hypertensive or Hypertensive blood pressure reading documented, indicated follow-up **<u>not</u>** documented, reason not given

<u>RATIONALE:</u>

Hypertension is a prevalent condition that affects approximately 66.9 million people in the United States. It is estimated that about 20-40% of the adult population has hypertension; the majority of people over age 65 have a hypertension diagnosis (Appleton SL, et. al., 2012 and Luehr D, et. al., 2012). Winter (2013) noted that 1 in 3 American adults have hypertension and the lifetime risk of developing hypertension is 90% (Winter KH, et. al., 2013). The African American population or non-Hispanic Blacks, the elderly, diabetics and those with chronic kidney disease are at increased risk of stroke, myocardial infarction and renal disease. Non-Hispanic Blacks have the highest prevalence at 38.6% (Winter KH, et. al., 2013). Hypertension is a major risk factor for ischemic heart disease, left ventricular hypertrophy, renal failure, stroke and dementia (Luehr D, et. al., 2012).

Hypertension is the most common reason for adult office visits other than pregnancy. Garrison (2013) stated that in 2007, 42 million ambulatory visits were attributed to hypertension (Garrison GM and Oberhelman S, 2013). It also has the highest utilization of prescription drugs. Numerous resources and treatment options are available, yet only about 40-50% of the hypertensive patients have their blood pressure under control (<140/90) (Appleton SL, et. al., 2012, Luehr D, et. al., 2012). In addition to medication non-compliance, poor outcomes are also attributed to poor adherence to lifestyle changes such as a low-sodium diet, weight loss, increased exercise and limiting alcohol intake. Many adults find it difficult to continue medications and lifestyle changes when they are asymptomatic. Symptoms of elevated blood pressure usually do not occur until secondary problems arise such as with vascular diseases (myocardial infarction, stroke, heart failure and renal insufficiency) (Luehr D, et. al., 2012).

Appropriate follow-up after blood pressure measurement is a pivotal component in preventing the progression of hypertension and the development of heart disease. Detection of marginally or fully elevated blood pressure by a specialty clinician warrants referral to a provider familiar with the management of hypertension and prehypertension. The 2010 ACCF/AHA Guideline for the Assessment of Cardiovascular Risk in Asymptomatic Adults continues to support using a global risk score such as the Framingham Risk Score, to assess risk of coronary heart disease (CHD) in all asymptomatic adults (Greenland P, et. al., 2010). Lifestyle modifications have demonstrated effectiveness in lowering blood pressure (JNC 7, 2003). The synergistic effect of several lifestyle modifications results in greater benefits than a single modification alone. Baseline diagnostic/laboratory testing establishes if a co-existing underlying condition is the etiology of hypertension and evaluates if end organ damage from hypertension has already occurred. Landmark trials such as ALLHAT have repeatedly proven the efficacy of pharmacologic therapy to

control blood pressure and reduce the complications of hypertension. Follow-up intervals based on blood pressure control have been established by the JNC 7 and the USPSTF.

CLINICAL RECOMMENDATION STATEMENTS:

The U.S. Preventive Services Task Force (USPSTF) recommends screening for high blood pressure in adults age 18 years and older. This is a grade A recommendation.

% Measure #320 (NQF 0658): Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients – National Quality Strategy Domain: Communication and Care Coordination

2015 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of patients aged 50 years and older receiving a screening colonoscopy without biopsy or polypectomy who had a recommended follow-up interval of at least 10 years for repeat *colonoscopy documented in their colonoscopy report*

INSTRUCTIONS:
This measure is to be reported a minimum of **once per reporting period** for patients seen during the reporting period. There is no diagnosis associated with this measure. Performance for this measure is not limited to the reporting period. This measure may be reported by clinicians who perform the quality actions described in the measure based on services provided and the measure-specific denominator coding. Patients who have a coded colonoscopy procedure that has a modifier 52, 53, 73, or 74 will not qualify for inclusion into the measure.

Measure Reporting via Claims:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT or HCPCS codes, and patient demographics are used to identify patients who are included in the measure's denominator. CPT Category II codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed ICD-9-CM/ICD-10-CM diagnosis codes, CPT or HCPCS codes, and the appropriate CPT Category II code **OR** the CPT Category II code **with** the modifier. The modifiers allowed for this measure are: 1P- medical reasons, 8P- reason not otherwise specified. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT or HCPCS codes and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

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

DENOMINATOR:
All patients aged 50 years and older and receiving a screening colonoscopy **without** biopsy or polypectomy

> **Denominator Instructions:** Clinicians who indicate that the colonoscopy procedure is incomplete or was discontinued should use the procedure number and the addition (as appropriate) of modifier 52, 53, 73, or 74. Patients who have a coded colonoscopy procedure that has a modifier 52, 53, 73, or 74 will not qualify for inclusion into this measure.
>
> **Denominator Criteria (Eligible Cases):**
> Patients aged ≥ 50 on date of encounter
> **AND**
> **Patient undergoing screening for malignant neoplasm of colon (ICD-9-CM) [for use 1/1/2015-9/30/2015]:** V76.51
> **Patient undergoing screening for malignant neoplasm of colon (ICD-10-CM) [for use 10/01/2015-12/31/2015]:** Z12.11
> **AND**

Patient encounter during the reporting period (CPT or HCPCS): 44388, 45378, G0121
WITHOUT
CPT Category I Modifiers: 52, 53, 73, 74

NUMERATOR:
Patients who had recommended follow-up interval of at least 10 years for repeat colonoscopy documented in their colonoscopy report

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
At Least 10 Year Follow-Up Interval for Colonoscopy Recommended
Performance Met: **CPT II 0528F:** Recommended follow-up interval for repeat colonoscopy of at least 10 years documented in colonoscopy report

OR

At Least 10 Year Follow-Up Interval for Colonoscopy not Recommended for Medical Reasons
Append a modifier (**1P**) to CPT Category II code **0528F** to report documented circumstances that appropriately exclude patients from the denominator.
Medical Performance Exclusion: **0528F *with* 1P:** Documentation of medical reason(s) for not recommending at least a 10 year follow-up interval (eg, inadequate prep, other medical reasons)

OR

At Least 10 Year Follow-Up Interval for Colonoscopy not Recommended, Reason not Otherwise Specified
Append a reporting modifier (**8P**) to CPT Category II code **0528F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.
Performance Not Met: **0528F *with* 8P:** At least 10 year follow-up interval for colonoscopy **not** recommended, reason not otherwise specified

RATIONALE:
In the average-risk population, colonoscopy screening is recommended in all current guidelines at 10-year intervals. Inappropriate interval recommendations can result in overuse of resources and can lead to significant patient harm. Performing colonoscopy too often not only increases patients' exposure to procedural harm, but also drains resources that could be more effectively used to adequately screen those in need (Lieberman et al, 2008). The most common serious complication of colonoscopy is post-polypectomy bleeding (Levin et al, 2008).

Variations in the recommended time interval between colonoscopies exist for patients with normal colonoscopy findings. In a 2006 study of 1282 colonoscopy reports, recommendations were consistent with contemporaneous guidelines in only 39.2% of cases and with current guidelines in 36.7% of cases. Further, the adjusted mean number of years in which repeat colonoscopy was recommended was 7.8 years following normal colonoscopy(Krist et al, 2007)

CLINICAL RECOMMENDATION STATEMENTS:
At present, CSPY (colonoscopy) every 10 years is an acceptable option for CRC screening in average-risk adults beginning at age 50 years. (ACS/USMSTF/ACR, 2008)

The preferred CRC prevention test is colonoscopy every 10 years, beginning at age 50. (Grade 1B) (Rex, et al, 2009)

Measure #322 (NQF 0670): Cardiac Stress Imaging Not Meeting Appropriate Use Criteria: Preoperative Evaluation in Low Risk Surgery Patients – National Quality Strategy Domain: Efficiency and Cost Reduction

2015 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Percentage of stress single-photon emission computed tomography (SPECT) myocardial perfusion imaging (MPI), stress echocardiogram (ECHO), cardiac computed tomography angiography (CCTA), or cardiac magnetic resonance (CMR) performed in low risk surgery patients 18 years or older for preoperative evaluation during the 12-month reporting period

INSTRUCTIONS:
This measure is to be reported **once per procedure** of cardiac stress imaging (ie,SPECT, MPI, ECHO, CCTA, CMR) for patients seen during the reporting period. There is no diagnosis associated with this measure. It is anticipated that **clinicians who provide the physician component of diagnostic imaging studies for cardiac stress** will submit this measure.

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

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

DENOMINATOR:
All instances of stress single-photon emission computed tomography (SPECT) myocardial perfusion imaging (MPI), stress echocardiogram (ECHO), cardiac computed tomography angiography (CCTA), or cardiac magnetic resonance (CMR) performed on patients aged 18 years and older during the reporting period

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Cardiac Stress Imaging Performed – Procedure Codes (CPT): 75559, 75563, 75571, 75572, 75573, 75574, 78451, 78452, 78453, 78454, 78491, 78492, 78494, 93350, 93351

NUMERATOR:
Number of stress SPECT MPI, stress echo, CCTA, or CMR primarily performed in low risk surgery patients for preoperative evaluation within 30 days preceding low-risk non-cardiac surgery

Definition:
Low-Risk Surgery – Cardiac death or MI less than 1% including, but are not limited to, endoscopic procedures, superficial procedures, cataract surgery, and excisional breast surgery.

NUMERATOR NOTE:
- *A lower calculated performance rate for this measure indicates better clinical care or control. This measure is assessing overuse of cardiac stress imaging in low-risk surgery patients.*
- *Patients that did not have a surgery performed or had a surgery other than those defined as low-risk would report **G8962**.*

- *Clinical quality outcome is cardiac stress imaging NOT performed on patient who is a low risk surgery patient within 30 days preceding procedure.*

Numerator Options:

Performance Met: Cardiac Stress Imaging Test primarily performed on low-risk surgery patient for preoperative evaluation within 30 days preceding this surgery **(G8961)**

OR

Performance Not Met: Cardiac Stress Imaging Test performed on patient for any reason including those who did not have low-risk surgery or test that was performed more than 30 days preceding low-risk surgery **(G8962)**

RATIONALE:

Cardiac imaging is a mainstay in medical decision-making for patients with known or suspected heart disease. However, expenditures related to imaging comprise a significant portion of the health care budget. Much scrutiny has been focused on cardiovascular imaging with regard to the potential for overuse, especially in view of substantial geographic variation in ordering patterns and the limited amount of evidence-based data supporting the use of imaging as it relates to patient outcomes. Given the significant contribution of heart disease to morbidity and mortality and the prevalence of cardiovascular disease, it is important to determine the appropriate use of diagnostic tests such as stress echocardiography, stress SPECT MPI, CCTA, and CMR.

CLINICAL RECOMMENDATION STATEMENTS:

Diagnostic testing, such as stress SPECT MPI, stress echocardiography, CCTA, and CMR is used to detect disease and provide risk assessment used to modify treatment strategies and approaches. Information provided by such testing can initiate, modify and stop further treatments for coronary heart disease (medications and revascularization) which have an impact on patient outcomes.

In addition, false positives and false negatives can adversely impact the patient and their treatment outcomes. Lastly, radiation from stress SPECT MPI and CCTA poses a minimal but still important consideration for patient safety. Ensuring proper patient selection can avoid using resources in patients not expected to benefit from the testings and for which the associated risks would be unnecessary.

♦Measure #323 (NQF 0671): Cardiac Stress Imaging Not Meeting Appropriate Use Criteria: Routine Testing After Percutaneous Coronary Intervention (PCI) – National Quality Strategy Domain: Efficiency and Cost Reduction

2015 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Percentage of all stress single-photon emission computed tomography (SPECT) myocardial perfusion imaging (MPI), stress echocardiogram (ECHO), cardiac computed tomography angiography (CCTA), and cardiovascular magnetic resonance (CMR) performed in patients aged 18 years and older routinely after percutaneous coronary intervention (PCI), with reference to timing of test after PCI and symptom status

INSTRUCTIONS:
This measure is to be reported **once per procedure** of cardiac stress imaging (ie, SPECT, MPI, CCTA, and CMR) for patients seen during the reporting period. There is no diagnosis associated with this measure. It is anticipated that **clinicians who provide the physician component of diagnostic imaging studies for cardiac stress** will submit this measure.

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

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

DENOMINATOR:
All instances of stress single-photon emission computed tomography (SPECT) myocardial perfusion imaging (MPI), stress echocardiogram (ECHO), cardiac computed tomography angiography (CCTA), or cardiac magnetic resonance (CMR) performed on patients aged 18 years and older during the reporting period

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Cardiac Stress Imaging Performed – Procedure Codes (CPT): 75559, 75563, 75571, 75572, 75573, 75574, 78451, 78452, 78453, 78454, 78491, 78492, 78494, 93350, 93351

NUMERATOR:
Number of stress SPECT MPI, stress echo, CCTA and CMR performed in asymptomatic patients within 2 years of the most recent PCI

NUMERATOR NOTE: *A lower calculated performance rate for this measure indicates better clinical care or control. This measure is assessing overuse of cardiac stress imaging in asymptomatic patients that received PCI. Clinical quality outcome is cardiac stress imaging NOT performed on patient who is asymptomatic or low CHD risk.*

Numerator Options:

Performance Met:	Cardiac Stress Imaging performed primarily for monitoring of asymptomatic patient who had PCI within 2 years **(G8963)**

OR

Performance Not Met:	Cardiac Stress Imaging test performed primarily for any other reason than monitoring of asymptomatic patient who had PCI within 2 years (eg, symptomatic patient, patient greater than 2 years since PCI, initial evaluation, etc.) **(G8964)**

RATIONALE:

Diagnostic testing, such as stress SPECT MPI, stress echocardiography, CCTA and CMR, is used to detect disease and provide risk assessment used to modify treatment strategies and approaches. Information provided by such testing can initiate, modify and stop further treatments for coronary heart disease (medications and revascularization) which have an impact on patient outcomes.

In addition, false positives and false negatives can adversely impact the patient and their treatment outcomes. Lastly, radiation from stress SPECT MPI and CCTA poses a minimal but still important consideration for patient safety. Ensuring proper patient selection can avoid using resources in patients not expected to benefit from the testings and for which the associated risks would be unnecessary.

CLINICAL RECOMMENDATION STATEMENTS:

2005 PCI Guidelines

Text (No recommendations)

Neither exercise testing nor radionuclide imaging is indicated for the routine, periodic monitoring of asymptomatic patients after PCI without specific indications.

2011 ACCF/AHA/SCAI Guideline for Percutaneous Coronary Intervention A Report of the American College of Cardiology Foundation/American Heart Association Task Force on Practice Guidelines and the Society for Cardiovascular Angiography and Interventions (J Am Coll Cardiol, 2011)

AUC Indications

2008 Appropriateness Criteria for Stress Echocardiography Indication 39: Risk Assessment: Post-Revascularization (PCI or CABG): Asymptomatic: Asymptomatic (eg,silent ischemia) prior to previous revascularization AND less than 2 years after PCI - Inappropriate (3)

Indication 40: Risk Assessment: Post-Revascularization (PCI or CABG): Asymptomatic: Symptomatic prior to previous revascularization AND less than 2 years after PCI - Inappropriate (2)

ACCF/ASE/AHA/ASNC/HFSA/HRS/SCAI/SCCM/SCCT/SCMR 2011 Appropriate Use Criteria for Echocardiography (J Am Coll Cardiol, 2011)

2009 Appropriate Use Criteria for Cardiac Radionuclide Imaging

Indication 59: Risk Assessment: Post Revascularization (PCI or CABG): Asymptomatic: Less than 2 years after PCI – Inappropriate (3)

2006 Appropriateness Criteria for CCT and CMR Indication 27. Detection of CAD: Post-Revascularization (PCI or CABG) (Use of CCTA): Evaluation for in-stent restenosis and coronary anatomy after

PCI - Inappropriate (2)

2010 Appropriate Use Criteria for Cardiac Computed Tomography (J Am Coll Cardiol, 2010)

♦Measure #324 (NQF 0672): Cardiac Stress Imaging Not Meeting Appropriate Use Criteria: Testing in Asymptomatic, Low-Risk Patients – National Quality Strategy Domain: Efficiency and Cost Reduction

2015 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Percentage of all stress single-photon emission computed tomography (SPECT) myocardial perfusion imaging (MPI), **stress echocardiogram (ECHO)**, cardiac computed tomography angiography (CCTA), and cardiovascular magnetic resonance (CMR) performed in asymptomatic, low coronary heart disease (CHD) risk patients 18 years and older for initial detection and risk assessment

INSTRUCTIONS:
This measure is to be reported **once per procedure** of cardiac stress imaging (ie, SPECT, MPI, CCTA, and CMR) for patients seen during the reporting period. There is no diagnosis associated with this measure. It is anticipated that **clinicians who provide the physician component of diagnostic imaging studies for cardiac stress** will submit this measure.

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

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

DENOMINATOR:
All instances of stress single-photon emission computed tomography (SPECT) myocardial perfusion imaging (MPI), stress echocardiogram (ECHO), cardiac computed tomography angiography (CCTA), or cardiac magnetic resonance (CMR) performed on patients aged 18 years and older during the reporting period

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Cardiac Stress Imaging Performed – Procedure Codes (CPT): 75559, 75563, 75571, 75572, 75573, 75574, 78451, 78452, 78453, 78454, 78491, 78492, 78494, 93350, 93351

NUMERATOR:
Number of stress SPECT MPI, stress echo, CCTA, or CMR primarily performed for asymptomatic, low CHD risk patients for initial detection and risk assessment

Definition:
Low CHD risk – clinicians should consider the maximum number of available patient factors used to estimate risk based on Framingham (ATP III criteria), typically age, gender, diabetes, smoking status, and use of blood pressure medication, and integrate age appropriate estimates for missing elements, such as LDL or standard blood pressure.

NUMERATOR NOTE: *A lower calculated performance rate for this measure indicates better clinical care or control. This measure is assessing overuse of cardiac stress imaging in low-risk CHD patients.* ***Clinical quality outcome is cardiac stress imaging NOT performed on patient who is asymptomatic or low CHD risk.***

Numerator Options:

Performance Met: Cardiac Stress Imaging Test primarily performed on low CHD risk patient for initial detection and risk assessment **(G8965)**

OR

Performance Not Met: Cardiac Stress Imaging Test performed on symptomatic or higher than low CHD risk patient or for any reason other than initial detection and risk assessment **(G8966)**

RATIONALE:

Diagnostic testing, such as stress SPECT MPI, stress echocardiography, CCTA, and CMR, is used to detect disease and provide risk assessment used to modify treatment strategies and approaches. Information provided by such testing can initiate, modify and stop further treatments for coronary heart disease (medications and revascularization) which have an impact on patient outcomes. In addition, false positives and false negatives can adversely impact the patient and their treatment outcomes. Lastly, radiation from stress SPECT MPI poses a minimal but still important consideration for patient safety. Ensuring proper patient selection can avoid using resources in patients not expected to benefit from the testings and for which the associated risks would be unnecessary.

CLINICAL RECOMMENDATION STATEMENTS:

2002 Stable Angina Guideline

"Asymptomatic patients with abnormal findings on ambulatory ECG or EBCT who are able to exercise can be evaluated with exercise ECG testing, although the efficacy of exercise ECG testing in asymptomatic patients is not well established. Stress imaging procedures (ie, either stress myocardial perfusion imaging or stress echocardiography) are generally not indicated in most such patients".

AUC Indications

2008 Appropriateness Criteria for Stress Echocardiography Indication 11: Detection of CAD and Risk Assessment: Asymptomatic (without Chest Pain Syndrome or Anginal Equivalent): Low CHD risk (Framingham risk criteria) - Inappropriate (1)

2009 Appropriate Use Criteria for Cardiac Radionuclide Imaging Indication 12: Detection of CAD/Risk Assessment Without Ischemic Equivalent: Asymptomatic: Low CHD risk (ATP III risk criteria) - Inappropriate (1)

2006 Appropriateness Criteria for CCT and CMR Indication 10 - Detection of CAD: Asymptomatic (Use of CCTA) (Without Chest Pain Syndrome): Asymptomatic: Low CHD risk (Framingham risk criteria) - Inappropriate (1)

2002 Chronic Stable Angina Guideline

Class III

Recommendations for Cardiac Stress Imaging as the Initial Test for Diagnosis in Asymptomatic Patients

1. Exercise or dobutamine echocardiography in asymptomatic patients with left bundle-branch block. (Level of Evidence: C)

2. Exercise myocardial perfusion imaging, exercise echocardiography, adenosine or dipyridamole myocardial perfusion imaging, or dobutamine echocardiography as the initial stress test in an asymptomatic patient with a normal rest ECG who is not taking digoxin. (Level of Evidence: C)

3. Adenosine or dipyridamole myocardial perfusion imaging or dobutamine echocardiography in asymptomatic patients who are able to exercise and do not have left bundle-branch block or electronically paced ventricular rhythm. (Level of Evidence: C)

▶ Measure #325: Adult Major Depressive Disorder (MDD): Coordination of Care of Patients with Specific Comorbid Conditions – National Quality Strategy Domain: Communication and Care Coordination

2015 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Percentage of medical records of patients aged 18 years and older with a diagnosis of major depressive disorder (MDD) and a specific diagnosed comorbid condition (diabetes, coronary artery disease, ischemic stroke, intracranial hemorrhage, chronic kidney disease [stages 4 or 5], End Stage Renal Disease [ESRD] or congestive heart failure) being treated by another clinician with communication to the clinician treating the comorbid condition

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

Measure Reporting via Registry:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

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

DENOMINATOR:
All medical records of patients aged 18 years and older with a diagnosis of major depressive disorder (MDD) and a specific diagnosed comorbid condition (diabetes, coronary artery disease, ischemic stroke, intracranial hemorrhage, chronic kidney disease [stages 4 or 5], ESRD or congestive heart failure) being treated by another clinician

Definition:
Comorbid condition – For the purposes of this measure, only the following comorbid conditions will be included:

1) Diabetes
2) Coronary artery disease
3) Stroke, including ischemic stroke and intracranial hemorrhage
4) Chronic Kidney Disease (Stages 4 and 5) and End Stage Renal Disease
5) Congestive Heart Failure

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Diagnosis for MDD (ICD-9-CM) [for use 1/1/2015-9/30/2015]: 296.20, 296.21, 296.22, 296.23, 296.24, 296.30, 296.31, 296.32, 296.33, 296.34
Diagnosis for MDD (ICD-10-CM) [for use 10/01/2015-12/31/2015]: F32.0, F32.1, F32.2, F32.3, F32.9, F33.0, F33.1, F33.2, F33.3, F33.9
AND
Patient encounter during the reporting period (CPT): 90791, 90792, 90832, 90834, 90837, 90845, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215

AND

Diagnosis for Diabetes (ICD-9-CM) [for use 1/1/2015-9/30/2015]: 250.00, 250.01, 250.02, 250.03, 250.10, 250.11, 250.12, 250.13, 250.20, 250.21, 250.22, 250.23, 250.30, 250.31, 250.32, 250.33, 250.40, 250.41, 250.42, 250.43, 250.50, 250.51, 250.52, 250.53, 250.60, 250.61, 250.62, 250.63, 250.70, 250.71, 250.72, 250.73, 250.80, 250.81, 250.82, 250.83, 250.90, 250.91, 250.92, 250.93

Diagnosis for Diabetes (ICD-10-CM) [for use 10/01/2015-12/31/2015]: E10.10, E10.11, E10.21, E10.22, E10.29, E10.311, E10.319, E10.321, E10.329, E10.331, E10.339, E10.341, E10.349, E10.351, E10.359, E10.36, E10.39, E10.40, E10.41, E10.42, E10.43, E10.44, E10.49, E10.51, E10.52, E10.59, E10.610, E10.618, E10.620, E10.621, E10.622, E10.628, E10.630, E10.638, E10.641, E10.649, E10.65, E10.69, E10.8, E10.9, E11.00, E11.01, E11.21, E11.22, E11.29, E11.311, E11.319, E11.321, E11.329, E11.331, E11.339, E11.341, E11.349, E11.351, E11.359, E11.36, E11.39, E11.40, E11.41, E11.42, E11.43, E11.44, E11.49, E11.51, E11.52, E11.59, E11.610, E11.618, E11.620, E11.621, E11.622, E11.628, E11.630, E11.638, E11.641, E11.649, E11.65, E11.69, E11.8, E11.9, E13.00, E13.01, E13.10, E13.11, E13.21, E13.22, E13.29, E13.311, E13.319, E13.321, E13.329, E13.331, E13.339, E13.341, E13.349, E13.351, E13.359, E13.36, E13.39, E13.40, E13.41, E13.42, E13.43, E13.44, E13.49, E13.51, E13.52, E13.59, E13.610, E13.618, E13.620, E13.621, E13.622, E13.628, E13.630, E13.638, E13.641, E13.649, E13.65, E13.69, E13.8, E13.9

OR

Diagnosis for CAD (ICD-9-CM) [for use 1/1/2015-9/30/2015]: 410.00, 410.01, 410.02, 410.10, 410.11, 410.12, 410.20, 410.21, 410.22, 410.30, 410.31, 410.32, 410.40, 410.41, 410.42, 410.50, 410.51, 410.52, 410.60, 410.61, 410.62, 410.70, 410.71, 410.72, 410.80, 410.81, 410.82, 410.90, 410.91, 410.92, 411.0, 411.1, 411.81, 411.89, 412, 413.0, 413.1, 413.9, 414.00, 414.01, 414.02, 414.03, 414.04, 414.05, 414.06, 414.07, 414.2, 414.3, 414.8, 414.9, V45.81, V45.82

Diagnosis for CAD (ICD-10-CM) [for use 10/01/2015-12/31/2015]: 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, I25.810, I25.811, I25.812, I25.82, I25.83, I25.89, I25.9, Z95.1, Z95.5, Z98.61

OR

Diagnosis for Stroke, including ischemic stroke and intracranial hemorrhage (ICD-9-CM) [for use 1/1/2015-9/30/2015]: 430, 431, 432.0, 432.1, 432.9, 433.01, 433.11, 433.21, 433.31, 433.81, 433.91, 434.01, 434.11, 434.91

Diagnosis for Stroke, including ischemic stroke and intracranial hemorrhage (ICD-10-CM)[for use 10/01/2015-12/31/2015]: I60.00, I60.01, I60.02, I60.10, I60.11, I60.12, I60.20, I60.21, I60.22, I60.30, I60.31, I60.32, I60.4, I60.50, I60.51, I60.52, I60.6, I60.7, I60.8, I60.9, I61.0, I61.1, I61.2, I61.3, I61.4, I61.5, I61.6, I61.8, I61.9, I62.00, I62.01, I62.02, I62.03, I62.1, I62.9, I63.00, I63.011, I63.012, I63.019, I63.02, I63.031, I63.032, I63.039, I63.09, I63.10, I63.111, I63.112, I63.119, I63.12, I63.131, I63.132, I63.139, I63.19, I63.20, I63.211, I63.212, I63.219, I63.22, I63.231, I63.232, I63.239, I63.29, I63.30, I63.311, I63.312, I63.319, I63.321, I63.322, I63.329, I63.331, I63.332, I63.339, I63.341, I63.342, I63.349, I63.39, I63.40, I63.411, I63.412, I63.419, I63.421, I63.422, I63.429, I63.431, I63.432, I63.439, I63.441, I63.442, I63.449, I63.49, I63.50, I63.511, I63.512, I63.519, I63.521, I63.522, I63.529, I63.531, I63.532, I63.539, I63.541, I63.542, I63.549, I63.59, I63.6, I63.8, I63.9

OR

Diagnosis for Chronic Kidney Disease (Stages 4 and 5) and End Stage Renal Disease (ICD-9-CM) [for use 1/1/2015-9/30/2015]: 585.4, 585.5, 585.6

Diagnosis for Chronic Kidney Disease (Stages 4 and 5) and End Stage Renal Disease (ICD-10-CM) [for use 10/01/2015-12/31/2015]: N18.4, N18.5, N18.6

OR

Diagnosis for heart failure (ICD-9-CM) [for use 1/1/2015-9/30/2015]: 402.01, 402.11, 402.91, 404.01, 404.03, 404.11, 404.13, 404.91, 404.93, 428.0, 428.1, 428.20, 428.21, 428.22, 428.23, 428.30, 428.31, 428.32, 428.33, 428.40, 428.41, 428.42, 428.43, 428.9
Diagnosis for heart failure (ICD-10-CM) [for use 10/01/2015-12/31/2015]: I11.0, I13.0, I13.2, I50.1, I50.20, I50.21, I50.22, I50.23, I50.30, I50.31, I50.32, I50.33, I50.40, I50.41, I50.42, I50.43, I50.9

NUMERATOR:
Medical records of patients with communication to the clinician treating the comorbid condition

Definition:
Communication – Transmission of relevant clinical information which specifies that the patient has MDD.

Numerator Options:

Performance Met:	Clinician treating Major Depressive Disorder communicates to clinician treating comorbid condition **(G8959)**
OR	
Patient Performance Exclusion:	Clinician treating Major Depressive Disorder did **not** communicate to clinician treating comorbid condition for specified patient reason **(G9232)**
OR	
Performance Not Met:	Clinician treating Major Depressive Disorder did **not** communicate to clinician treating comorbid condition, reason not given **(G8960)**

RATIONALE:
Depressive disorders are more common among persons with chronic conditions (eg, obesity, cardiovascular disease, diabetes, asthma, arthritis, and cancer) and among those with unhealthy behaviors (eg, smoking, physical inactivity, and binge drinking). Comorbidities are more common in the elderly. The highest rates of depression are found in those with strokes (30% to 60%), coronary artery disease (up to 44%), cancer (up to 40%), Parkinson's disease (40%), and Alzheimer's disease (20% to 40%). The coordination of care for patients with depression and certain comorbid conditions is important for managing both the patient's depression and the other present medical condition. Improvements in the coordination of care between clinicians treating a patient with depression and other clinicians treating comorbid conditions can reduce the symptom exacerbation that depression and other conditions may cause to the other. Any [depression] treatment should be integrated with psychiatric management and any other treatments being provided for other diagnoses.

CLINICAL RECOMMENDATION STATEMENTS:
The following evidence statements are quoted verbatim from the referenced clinical guidelines. Only selected portions of the clinical guidelines are quoted here; for more details, please refer to the full guideline.

In patients with major depressive disorder, it is important to recognize and address the potential interplay between major depressive disorder and any co-occurring general medical conditions. (APA, 2010)

The clinical assessment should include identifying any potential interactions between medications used to treat depression and those used to treat general medical conditions. In addition, the psychiatrist (clinician) should consider the effects of prescribed psychotropic medications on the patient's general medical conditions, as well as the effects of interventions for such disorders on the patient's psychiatric condition. (APA, 2010)

Many patients with major depressive disorder will be evaluated by or receive treatment from other health care professionals in addition to the psychiatrist (clinician). If more than one clinician is involved in providing the care, all treating clinicians should have sufficient ongoing contact with the patient and with each other to ensure that care is

coordinated, relevant information is available to guide treatment decisions, and treatments are synchronized. (APA, 2010)

In ruling out general medical causes of depressive symptoms, it is important to ensure that a general medical evaluation has been done. (APA, 2010)

In patients with preexisting hypertension or cardiac conditions, treatment with specific antidepressant agents may suggest a need for monitoring of vital signs or cardiac rhythm (eg, electrocardiogram [ECG] with TCA treatment; heart rate and blood pressure assessment with SNRIs and TCAs). (APA, 2010)

In treating the depressive syndrome that commonly occurs following a stroke, consideration should be given to the potential for interactions between antidepressants and anticoagulating (including antiplatelet) medications. (APA, 2010)

The diagnostic work-up for MDD should include evaluation for existing or emerging medical conditions that may exacerbate the depression. These may include: Cardiovascular diseases, Chronic pain syndrome, Degenerative diseases, Immune disorders, Metabolic endocrine conditions (including kidney and lung diseases), Neoplasms, Trauma. Simultaneous treatment is often required for both the medical problem and psychiatric symptoms and can lead to overall improvement in function. (VA/DoD, 2009)

Indications for referral to a mental health specialist familiar with diabetes management may include gross noncompliance with medical regimen (by self or others), depression with the possibility of self-harm, debilitating anxiety (alone or with depression), indications of an eating disorder, or cognitive functioning that significantly impairs judgment. It is preferable to incorporate psychological assessment and treatment into routine care rather than waiting for identification of a specific problem or deterioration in psychological status. Although the clinician may not feel qualified to treat psychological problems, using the patient-provider relationship as a foundation for further treatment can increase the likelihood that the patient will accept referral for other services. It is important to establish that emotional well-being is part of diabetes management. (ADA, 2010)

Measure #326 (NQF 1525): Atrial Fibrillation and Atrial Flutter: Chronic Anticoagulation Therapy – National Quality Strategy Domain: Effective Clinical Care

2015 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of patients aged 18 years and older with a diagnosis of nonvalvular atrial fibrillation (AF) or atrial flutter whose assessment of the specified thromboembolic risk factors indicate one or more high-risk factors or more than one moderate risk factor, as determined by $CHADS_2$ risk stratification, who are prescribed warfarin OR another oral anticoagulant drug that is FDA approved for the prevention of thromboembolism

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

Measure Reporting via Claims:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. Quality-data codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and the appropriate quality-data code(s). All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

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

DENOMINATOR:
All patients aged 18 years and older with a diagnosis of nonvalvular AF or atrial flutter whose assessment of the specified thromboembolic risk factors indicate one or more high-risk factors or more than one moderate risk factor, as determined by $CHADS_2$ risk stratification

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Diagnosis for nonvalvular atrial fibrillation or atrial flutter (ICD-9-CM) [for use 1/1/2015-9/30/2015]: 427.31, 427.32
Diagnosis for nonvalvular atrial fibrillation or atrial flutter (ICD-10-CM) [for use 10/01/2015-12/31/2015]: I48.0, I48.1, I48.2, I48.3, I48.4, I48.91, I48.92
AND
Patient encounter during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99281, 99282, 99283, 99284, 99285, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350

NUMERATOR:

Patients who are prescribed warfarin OR another oral anticoagulant drug that is FDA approved for the prevention of thromboembolism

Definition:

Prescribed – May include prescription given to the patient for warfarin OR another oral anticoagulant that is FDA approved for the prevention of thromboembolism at one or more visits in the measurement period OR patient already taking warfarin OR another oral anticoagulant that is FDA approved for the prevention of thromboembolism as documented in current medication list.

The assessment of patients with nonvalvular AF or atrial flutter for thromboembolic risk factors should include the following criteria:

Risk Factors	Weighting
Prior stroke, TIA or systemic embolism	High risk
Age ≥ 75 years	Moderate risk
Hypertension	Moderate risk
Diabetes Mellitus	Moderate risk
Heart failure or impaired left ventricular systolic function	Moderate risk

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Warfarin OR Another Oral Anticoagulant that is FDA Approved Prescribed

*(Two quality-data codes [**G8967 & G8972**] are required on the claim form to submit this numerator option)*

Performance Met:

G8967: Warfarin OR another oral anticoagulant that is FDA approved prescribed

AND

G8972: One or more high risk factors for thromboembolism OR more than one moderate risk factor for thromboembolism

OR

Warfarin OR Another Oral Anticoagulant that is FDA Approved not Prescribed for Medical, or Patient Reasons

*(Two quality-data codes [**G896x & G8972**] are required on the claim form to submit this numerator option)*

Medical Performance Exclusion:

G8968: Documentation of medical reason(s) for not prescribing warfarin OR another oral anticoagulant that is FDA approved for the prevention of thromboembolism [eg, patients with mitral stenosis or prosthetic heart valves, patients with transient or reversible causes of AF (eg, pneumonia, hyperthyroidism, pregnancy, cardiac surgery), allergy, risk of bleeding, other medical reasons]

AND

G8972: One or more high risk factors for thromboembolism OR more than one moderate risk factor for thromboembolism

OR

Patient Performance Exclusion:

G8969: Documentation of patient reason(s) for not prescribing warfarin OR another oral anticoagulant that is FDA approved for the prevention of thromboembolism (eg,

economic, social, and/or religious impediments, noncompliance, patient refusal, other patient reasons)

AND

G8972: One or more high risk factors for thromboembolism OR more than one moderate risk factor for thromboembolism

OR

No Risk Factors or One Moderate Risk Factor for Thromboembolism, Patient not Eligible
*(One quality-data code [**G8970**] is required on the claim form to submit this numerator option)*
Other Performance Exclusion: **G8970:** No risk factors or one moderate risk factor for thromboembolism

OR

Warfarin OR Another Oral Anticoagulant that is FDA Approved not Prescribed, Reason not Given
*(Two quality-data codes [**G8971 & G8972**] are required on the claim form to submit this numerator option)*
Performance Not Met:
G8971: Warfarin OR another oral anticoagulant that is FDA approved **not** prescribed, reason not given

AND

G8972: One or more high risk factors for thromboembolism OR more than one moderate risk factor for thromboembolism

RATIONALE:
Anticoagulation should be prescribed for all high risk patients with AF or atrial flutter except those with contraindications to anticoagulation. Aspirin is preferred in patients without risk factors or in those with contraindications to anticoagulation, and is an alternative to anticoagulation in those with only one moderate risk factor.

CLINICAL RECOMMENDATION STATEMENTS:
2013 Guidelines for the Management of Patients with Atrial Fibrillation (compilation of 2006 ACCF/AHA/ESC and 2011 ACCF/AHA/HRS recommendations): a Report of the American College of Cardiology Foundation/American Heart Association Task Force on Practice Guidelines:

Class I

Antithrombotic therapy to prevent thromboembolism is recommended for all patients with AF, except those with lone AF or contraindications. (Level of Evidence: A)

The selection of the antithrombotic agent should be based upon the absolute risks of stroke and bleeding and the relative risk and benefit for a given patient. (Level of Evidence: A)

For patients without mechanical heart valves at high risk of stroke, chronic oral anticoagulant therapy with a vitamin K antagonist is recommended in a dose adjusted to achieve the target intensity international normalized ratio (INR) of 2.0 to 3.0, unless contraindicated. Factors associated with highest risk for stroke in patients with AF are prior thromboembolism (stroke, transient ischemic attack, or systemic embolism) and rheumatic mitral stenosis. (Level of Evidence: A)

Anticoagulation with a vitamin K antagonist is recommended for patients with more than 1 moderate risk factor. Such factors include age 75 y or greater, hypertension, HF, impaired LV systolic function (ejection fraction 35% or less or fractional shortening less than 25%), and diabetes mellitus. (Level of Evidence: A)

Aspirin, 81–325 mg daily, is recommended as an alternative to vitamin K antagonists in low-risk patients or in those with contraindications to oral anticoagulation. (Level of Evidence: A)

Antithrombotic therapy is recommended for patients with atrial flutter as for those with AF. (Level of Evidence: C)

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

Measure #327: Pediatric Kidney Disease: Adequacy of Volume Management – National Quality Strategy Domain: Effective Clinical Care

2015 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Percentage of calendar months within a 12-month period during which patients aged 17 years and younger with a diagnosis of End Stage Renal Disease (ESRD) undergoing maintenance hemodialysis in an outpatient dialysis facility have an assessment of the adequacy of volume management from a nephrologist

INSTRUCTIONS:
This measure is to be reported **each calendar month** patients are seen with a diagnosis of ESRD (who are undergoing maintenance hemodialysis in an outpatient dialysis facility) during the reporting period. The most recent quality code submitted will be used for performance calculation. It is anticipated that **clinicians providing care for patients with ESRD** will submit this measure.

Measure Reporting via Registry:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

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

DENOMINATOR:
All calendar months during which patients aged 17 years and younger with a diagnosis of ESRD are undergoing maintenance hemodialysis in an outpatient dialysis facility

Denominator Criteria (Eligible Cases):
Patients aged ≤ 17 years on date of encounter
AND
Diagnosis for ESRD (ICD-9-CM) [for use 1/1/2015-9/30/2015]: 585.6
Diagnosis for ESRD (ICD-10-CM) [for use 10/01/2015-12/31/2015]: N18.6
AND
Patient encounter during the reporting period (CPT): 90951, 90952, 90953, 90954, 90955, 90956, 90957, 90958, 90959, 90963, 90964, 90965, 90967, 90968, 90969
AND
Patient receiving maintenance hemodialysis in an outpatient dialysis facility: G8956

NUMERATOR:
Calendar months during which patients have an assessment of the adequacy of volume management from a nephrologist

Definition:
Adequacy of Volume Management – Adequacy of volume management for a patient on dialysis is determined by assessing whether or not the patient achieved a target end dialysis weight after receiving dialysis, by a comparison of the patient-specific target end dialysis weight and the actual post dialysis weight.

Numerator Options

Performance Met:	**Most recent** assessment of adequacy of volume management **(G8955)**

OR

Performance Not Met:	Assessment of adequacy of volume management **not** documented, reason not given **(G8958)**

RATIONALE:
Management of hypertension in dialysis patients includes the management of the fluid status. Poor extracellular volume control may exacerbate hypertension and so it is important to optimize ultrafiltration, volume status and dry weight to control blood pressure in an effort to improve patient outcomes. (KDOQI, 2006)

CLINICAL RECOMMENDATION STATEMENTS:
The following evidence statements are quoted verbatim from the referenced clinical guidelines. Only selected portions of the clinical guidelines are quoted here; for more details, please refer to the full guideline.

1.2 The following parameters of nutritional status and growth should be considered in combination for evaluation in children with CKD stages 2 to 5 and 5D. *(B)*

i) Dietary intake (3-day diet record or three 24-hour dietary recalls)
ii) Length- or height-for-age percentile or standard deviation score (SDS)
iii) Length or height velocity-for-age percentile or SDS
iv) Estimated dry weight and weight-forage percentile or SDS
v) BMI-for-height-age percentile or SDS
vi) Head circumference-for-age percentile or SDS (< 3 years old only)
vii) Normalized protein catabolic rate (nPCR) in hemodialyzed adolescents with CKD stage 5D. (KDOQI, 2009)

Measure #328 (NQF 1667): Pediatric Kidney Disease: ESRD Patients Receiving Dialysis: Hemoglobin Level < 10 g/dL – National Quality Strategy Domain: Effective Clinical Care

2015 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Percentage of calendar months within a 12-month period during which patients aged 17 years and younger with a diagnosis of End Stage Renal Disease (ESRD) receiving hemodialysis or peritoneal dialysis have a hemoglobin level < 10 g/dL

INSTRUCTIONS:
This measure is to be reported **each calendar month** patients are seen with a diagnosis of ESRD (who are on hemodialysis or peritoneal dialysis) during the reporting period. The most recent quality code submitted will be used for performance calculation. It is anticipated that **clinicians providing care for patients with ESRD** will submit this measure.

Measure Reporting via Registry:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

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

DENOMINATOR:
All calendar months during which patients aged 17 years and younger with a diagnosis of ESRD are receiving hemodialysis or peritoneal dialysis

Denominator Criteria (Eligible Cases):
Patients aged ≤ 17 years on date of encounter
AND
Diagnosis for ESRD (ICD-9-CM) [for use 1/1/2015-9/30/2015]: 585.6
Diagnosis for ESRD (ICD-10-CM) [for use 10/01/2015-12/31/2015]: N18.6
AND
Patient encounter during the reporting period (CPT): 90945, 90947, 90951, 90952, 90953, 90954, 90955, 90956, 90957, 90958, 90959, 90963, 90964, 90965, 90967, 90968, 90969

NUMERATOR:
Calendar months during which patients have a hemoglobin level < 10 g/dL

Numerator Instructions: The hemoglobin values used for this measure should be a most recent (last) hemoglobin value recorded for each calendar month.
A lower calculated performance rate for this measure indicates better clinical care or control.

Numerator Options:

Performance Met:	Most recent hemoglobin (Hgb) level < 10 g/dL **(G8973)**
OR	
Other Performance Exclusion:	Hemoglobin level measurement not documented, reason not given **(G8974)**
OR	

Medical Performance Exclusion:	Documentation of medical reason(s) for patient having a hemoglobin level < 10 g/dL (eg, patients who have non-renal etiologies of anemia (eg, sickle cell anemia or other hemoglobinopathies, hypersplenism, primary bone marrow disease, anemia related to chemotherapy for diagnosis of malignancy, postoperative bleeding, active bloodstream or peritoneal infection), other medical reasons) **(G8975)**

OR

Performance Not Met:	Most recent hemoglobin (Hgb) level ≥ 10 g/dL **(G8976)**

RATIONALE:

The clinical issues that impact achievement of the target hemoglobin in the pediatric population differ from the adult population. Normative, adult population data should not be used to assess performance in the pediatric population. Consideration(s) should be given to using age-specific normative data across the pediatric age range.

Anemia is a common complication of chronic kidney disease (CKD). The prevalence of anemia varies with the degree of renal impairment in predialysis patients with CKD, but once end-stage kidney failure occurs, all patients are eventually affected. Anemia develops once renal function decreases to < 50% because of a deficiency in endogenous erythropoietin (EPO) production by the kidney, decreased red cell survival, blood losses, and increased red blood cell destruction once the patient begins dialysis treatment, particularly hemodialysis. Anemia reduces physical capacity, well-being, neurocognitive function, and energy level and worsens quality of life both in predialysis and dialysis patients. Anemia also induces adaptive cardiovascular mechanisms to maintain tissue oxygen supply. This leads to left ventricular hypertrophy, left ventricular dilation, and myocardial ischemia, which are risk factors for cardiovascular disease and death. It is plausible that reversing anemia may reduce this risk. (Strippoli et al., 2004)

CLINICAL RECOMMENDATION STATEMENTS:

The following evidence statements are quoted verbatim from the referenced clinical guidelines. Only selected portions of the clinical guidelines are quoted here; for more details, please refer to the full guideline.

CLINICAL PRACTICE RECOMMENDATIONS FOR ANEMIA IN CHRONIC KIDNEY DISEASE IN CHILDREN:

2.1.2 *(FULLY APPLICABLE TO CHILDREN)* In the opinion of the [KDOQI] Work Group, in pediatric dialysis and nondialysis patients with CKD receiving ESA therapy, the selected Hb target should generally be in the range of 11.0 to 12.0 g/dL. *(Clinical Practice RECOMMENDATION)* (KDOQI, 2007)

Measure #329: Adult Kidney Disease: Catheter Use at Initiation of Hemodialysis – National Quality Strategy Domain: Effective Clinical Care

2015 PQRS OPTIONS FOR INDIVIDUAL MEASURES
REGISTRY ONLY

This is a two part measure which is paired with Measure #330: Adult Kidney Disease: Catheter Use for Greater Than or Equal to 90 Days. If there is documentation that the patient initiated hemodialysis with a catheter, then Measure #330 *should* also be reported.

DESCRIPTION:
Percentage of patients aged 18 years and older with a diagnosis of End Stage Renal Disease (ESRD) who initiate maintenance hemodialysis during the measurement period, whose mode of vascular access is a catheter at the time maintenance hemodialysis is initiated

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

Measure Reporting via Registry:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, quality-data code and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

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

DENOMINATOR:
All patients aged 18 years and older with a diagnosis of ESRD who initiate maintenance hemodialysis during the measurement period

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Diagnosis for ESRD (ICD-9-CM) [for use 1/1/2015-9/30/2015]: 585.6, V56.0
Diagnosis for ESRD (ICD-10-CM) [for use 10/01/2015-12/31/2015]: N18.6, Z49.31
AND
Patient encounter during reporting period (CPT): 90957, 90958, 90959, 90960, 90961, 90962, 90966, 90970
AND
Initiation of maintenance hemodialysis during the reporting/maintenance period

NUMERATOR:
Patients whose mode of vascular access is a catheter at the time maintenance hemodialysis is initiated

Numerator Instructions: A lower calculated performance rate for this measure indicates better clinical care or control. Of note, the performance tags indicating 'Performance Met' and 'Performance Not Met' are included to highlight what is being measured and reported and not to encourage catheter use.

Numerator Options:

Performance Met:	Patient whose mode of vascular access is a catheter at the time maintenance hemodialysis is initiated **(G9240)**
OR	
Other Performance Exclusion:	Documentation of reasons for patient initiating maintenance hemodialysis with a catheter as the mode of vascular access (eg, patient has a maturing AVF/AVG, time-limited trial of hemodialysis, patients undergoing palliative dialysis, other medical reasons, patient declined AVF/AVG, other patient reasons, patient followed by reporting nephrologist for fewer than 90 days, other system reasons) **(G9239)**
OR	
Performance Not Met:	Patient whose mode of vascular access is **not** a catheter at the time maintenance hemodialysis is initiated **(G9241)**

RATIONALE:

Cuffed tunneled central venous catheters should be discouraged as permanent vascular access.

Among vascular access modalities, catheters have the highest rates of infectious complications, thrombosis, risk of permanent central venous stenosis or occlusion.

Patients receiving catheters and grafts have greater mortality risk than patients dialyzed with fistulae.

CLINICAL RECOMMENDATION STATEMENTS:

The following evidence statements are quoted verbatim from the referenced clinical guidelines. Only selected portions of the clinical guidelines are quoted here; for more details, please refer to the full guideline.

A structured approach to the type and location of long-term HD accesses should help optimize access survival and minimize complications. The access should be placed distally and in the upper extremities whenever possible. Options for fistula placement should be considered first, followed by prosthetic grafts if fistula placement is not possible. Catheters should be avoided for HD and used only when other options listed are not available. (KDOQI, 2006) 2.1 The order of preference for placement of fistulae in patients with kidney failure who choose HD as their initial mode of KRT should be (in descending order of preference):

2.1.1 Preferred: Fistulae (B)

2.1.1.1 A wrist (radiocephalic) primary fistula (A)

2.1.1.2 An elbow (brachiocephalic) primary fistula (a)

2.1.1.3 A transposed brachial basilic vein fistula (B)

2.1.2 Acceptable: AVG of synthetic or biological material, such as: (B)

2.1.2.1 A forearm loop graft, preferable to a straight configuration

2.1.2.2 Upper-arm graft

2.1.2.3 Chest wall or “necklace” prosthetic graft or lower-extremity fistula or graft; all upper-arm sites should be exhausted. (KDOQI, 2006)

Measure #330: Adult Kidney Disease: Catheter Use for Greater Than or Equal to 90 Days – National Quality Strategy Domain: Effective Clinical Care

2015 PQRS OPTIONS FOR INDIVIDUAL MEASURES
REGISTRY ONLY

This is a two part measure which is paired with Measure #329: Adult Kidney Disease: Catheter Use at Initiation of Hemodialysis.

This measure *should* be reported if quality-data code G9240 "Documentation of patient with a catheter at the time maintenance hemodialysis is initiated" is submitted for Measure #329.

DESCRIPTION:
Percentage of patients aged 18 years and older with a diagnosis of End Stage Renal Disease (ESRD) receiving maintenance hemodialysis for greater than or equal to 90 days whose mode of vascular access is a catheter

INSTRUCTIONS:
This measure is to be reported a minimum of **once per reporting period** for patients with ESRD seen during the reporting period. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding. **NOTE:** Include only patients that have catheters at the time of initiation of hemodialysis through September 30 of the reporting period. This will allow the evaluation of at least 90 days of catheter use for hemodialysis within the reporting year.

Measure Reporting via Registry:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, quality-data code and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

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

DENOMINATOR:
All patients aged 18 years and older with a diagnosis of ESRD receiving maintenance hemodialysis for greater than or equal to 90 days

> **Denominator Criteria (Eligible Cases):**
> Patients aged ≥ 18 years on date of encounter
> **AND**
> **Diagnosis for ESRD (ICD-9-CM) [for use 1/1/2015-9/30/2015]:** 585.6, V56.0
> **Diagnosis for ESRD (ICD-10-CM) [for use 10/01/2015-12/31/2015]:** N18.6, Z49.31
> **AND**
> **Patient encounter during reporting period (CPT):** 90957, 90958, 90959, 90960, 90961, 90962, 90966, 90970
> **AND**
> **All eligible instances of quality-data code G9240 (Documentation of patient with a catheter at the time maintenance hemodialysis is initiated as applied in the numerator for Measure #329 Adult Kidney Disease: Catheter Use at Initiation of Hemodialysis)**

NUMERATOR:
Patients whose mode of vascular access is a catheter

Numerator Instructions: A lower calculated performance rate for this measure indicates better clinical care or control. Of note, the performance tags indicating 'Performance Met' and 'Performance Not Met' are included to highlight what is being measured and reported and not to encourage extended use of catheters for vascular access.

Numerator Options:

Performance Met: Patient receiving maintenance hemodialysis for greater than or equal to 90 days with a catheter as the mode of vascular access **(G9265)**

OR

Other Performance Exclusion: Documentation of patient receiving maintenance hemodialysis for greater than or equal to 90 days with a catheter for documented reasons (eg, patient is undergoing palliative dialysis with a catheter, patient approved by a qualified transplant program and scheduled to receive a living donor kidney transplant, other medical reasons, patient declined AVF/AVG, other patient reasons) **(G9264)**

OR

Performance Not Met: Patient receiving maintenance hemodialysis for greater than or equal to 90 days **without** a catheter as the mode of vascular access **(G9266)**

RATIONALE:

Long-term catheter use without appropriate adjustments in treatment duration can compromise dialysis adequacy. Compromise of dialysis adequacy is associated with increased morbidity and mortality. Long-term catheter access is associated with a risk for central venous stenosis development, which can preclude the establishment of a permanent vascular access for HD.

Data suggest that a change from non-cuffed to long-term cuffed catheters, and the reduction in catheter placement rates, may reflect longer duration of catheter use and longer exposure to potential infections.

The infection rate for long-term cuffed catheters is one episode per 252 catheter days, and their use is associated with lower blood flows, less hemodialysis, and an increased risk of sepsis, endocarditis, and metastatic infections.

CLINICAL RECOMMENDATION STATEMENTS:

The following evidence statements are quoted verbatim from the referenced clinical guidelines. Only selected portions of the clinical guidelines are quoted here; for more details, please refer to the full guideline. A structured approach to the type and location of long-term HD accesses should help optimize access survival and minimize complications. The access should be placed distally and in the upper extremities whenever possible. Options for fistula placement should be considered first, followed by prosthetic grafts if fistula placement is not possible. Catheters should be avoided for HD and used only when other options listed are not available. (KDOQI, 2006)

2.1 The order of preference for placement of fistulae in patients with kidney failure who choose HD as their initial mode of KRT should be (in descending order of preference):

2.1.1 Preferred: Fistulae (B)

2.1.1.1 A wrist (radiocephalic) primary fistula (A)

2.1.1.2 An elbow (brachiocephalic) primary fistula (a)

2.1.1.3 A transposed brachial basilic vein fistula (B)

2.1.2 Acceptable: AVG of synthetic or biological material, such as: (B)

2.1.2.1 A forearm loop graft, preferable to a straight configuration

2.1.2.2 Upper-arm graft

2.1.2.3 Chest wall or “necklace” prosthetic graft or lower-extremity fistula or graft; all upper-arm sites should be exhausted.

2.1.3 Avoid if possible: Long-term catheters. (B)

2.1.3.1 Short-term catheters should be used for acute dialysis and for a limited duration in hospitalized patients. Noncuffed femoral catheters should be used in bed-bound patients only. (B)

2.1.3.2 Long-term catheters or dialysis port catheter systems should be used in conjunction with a plan for permanent access. Catheters capable of rapid flow rates are preferred. Catheter choice should be based on local experience, goals for use, and cost. (B)

2.1.3.3 Long-term catheters should not be placed on the same side as a maturing AV access, if possible. (B)

Special attention should be paid to consideration of avoiding femoral catheter access in HD patients who are current or future kidney transplant candidates. MRA imaging of both arteries and veins is the diagnostic procedure of choice for evaluating central vessels for possible chest wall construction. (KDOQI, 2006)

◙ Measure #331: Adult Sinusitis: Antibiotic Prescribed for Acute Sinusitis (Appropriate Use) – National Quality Strategy Domain: Efficiency and Cost Reduction

2015 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Percentage of patients, aged 18 years and older, with a diagnosis of acute sinusitis who were prescribed an antibiotic within 7 days of diagnosis or within 10 days after onset of symptoms

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

Measure Reporting via Registry:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

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

DENOMINATOR:
All patients aged 18 years and older with a diagnosis of acute sinusitis

Definitions:
Acute Sinusitis/Rhinosinusitis: Up to 4 weeks of purulent nasal drainage (anterior, posterior, or both) accompanied by nasal obstruction, facial pain-pressure-fullness, or both:
Purulent nasal discharge is cloudy or colored, in contrast to the clear secretions that typically accompany viral upper respiratory infection, and may be reported by the patient or observed on physical examination
Nasal obstruction may be reported by the patient as nasal obstruction, congestion, blockage, or stuffiness, or may be diagnosed by physical examination
Facial pain-pressure-fullness may involve the anterior face, periorbital region, or manifest with headache that is localized or diffuse

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Diagnosis for acute sinusitis (ICD-9-CM) [for use 1/1/2015-9/30/2015]: 461.0, 461.1, 461.2, 461.3, 461.8, 461.9
Diagnosis for acute sinusitis (ICD-10-CM) [for use 10/01/2015-12/31/2015]: J01.00, J01.10, J01.20, J01.30, J01.40, J01.80, J01.90
AND
Patient encounter during reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99281, 99282, 99283, 99284, 99285, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350

NUMERATOR:
Patients prescribed any antibiotic within 7 days of diagnosis or within 10 days after onset of symptoms

Numerator Instructions: The desired performance goal is not an antibiotic prescribing rate of zero. This measure is an overall rate of all patients receiving an antibiotic.
A lower calculated performance rate for this measure indicates better clinical care or control.

Numerator Options:

Performance Met: Antibiotic regimen prescribed within 7 days of diagnosis or within 10 days after onset of symptoms **(G9286)**

OR

Performance Not Met: Antibiotic regimen **not** prescribed within 7 days of diagnosis or within 10 days after onset of symptoms **(G9287)**

RATIONALE:

Antibiotic treatment for sinusitis is indicated for some patients, but overtreatment of acute sinusitis with antibiotics is common and often not indicated. Further, treatment with antibiotics may increase patient harm and can lead to antibiotic resistance.

A Cochrane systematic review was undertaken to quantify the effectiveness of antibiotic therapy for patients diagnosed with acute sinusitis and treated in ambulatory settings. The authors concluded that antibiotics have a small benefit for improving clinical outcomes in patients with uncomplicated acute sinusitis and symptoms lasting more than seven days in a primary care setting. However, 80% of patients treated with a placebo also improved within two weeks.

CLINICAL RECOMMENDATION STATEMENTS:

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

AAO-HNS Sinusitis Guideline (2007)

Observation without use of antibiotics is an option for selected adults with uncomplicated ABRS who have mild illness (mild pain and temperature < 38.3°C or 101°F) and assurance of follow-up.

Option based on double-blind randomized controlled trials with heterogeneity in diagnostic criteria and illness severity, and a relative balance of benefit and risk.

Antibiotics are not recommended for treating viral rhinosinusitis (VRS) because they are ineffective and do not relieve symptoms directly.

◙ Measure #332: Adult Sinusitis: Appropriate Choice of Antibiotic: Amoxicillin Prescribed for Patients with Acute Bacterial Sinusitis (Appropriate Use) – National Quality Strategy Domain: Efficiency and Cost Reduction

2015 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Percentage of patients aged 18 years and older with a diagnosis of acute bacterial sinusitis that were prescribed amoxicillin, with or without clavulanate, as a first line antibiotic at the time of diagnosis

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

Measure Reporting via Registry
ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

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

DENOMINATOR:
All patients aged 18 years and older with a diagnosis of acute bacterial sinusitis

Definitions:
Acute Bacterial Rhinosinusitis (ABRS):
Acute rhinosinusitis that is caused by, or is presumed to be caused by, bacterial infection. A clinician should diagnose ABRS when: (a) symptoms or signs of acute rhinosinusitis are present 10 days or more beyond the onset of upper respiratory symptoms, or (b) symptoms or signs of acute rhinosinusitis worsen within 10 days after an initial improvement (double worsening)

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Diagnosis for acute sinusitis (ICD-9-CM) [for use 1/1/2015-9/30/2015]: 461.0, 461.1, 461.2, 461.3, 461.8, 461.9
Diagnosis for acute sinusitis (ICD-10-CM) [for use 10/01/2015-12/31/2015]: J01.00, J01.10, J01.20, J01.30, J01.40, J01.80, J01.90
AND
Patient encounter during reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99281, 99282, 99283, 99284, 99285, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350
AND
Sinusitis caused by, or presumed to be caused by, bacterial infection: G9364

NUMERATOR:
Patients who were prescribed amoxicillin, with or without clavulanate, as a first line antibiotic at the time of diagnosis

Numerator Options:

Performance Met: Amoxicillin, with or without clavulanate, prescribed as a first line antibiotic at the time of diagnosis **(G9315)**

OR

Other Performance Exclusion: Amoxicillin, with or without clavulanate, not prescribed as first line antibiotic at the time of diagnosis for documented reason (eg, cystic fibrosis, immotile cilia disorders, ciliary dyskinesia, immune deficiency, prior history of sinus surgery within the past 12 months, and anatomic abnormalities, such as deviated nasal septum, resistant organisms, allergy to medication, recurrent sinusitis, chronic sinusitis, or other reasons) **(G9313)**

OR

Performance Not Met: Amoxicillin, with or without clavulanate, **not** prescribed as first line antibiotic at the time of diagnosis, reason not given **(G9314)**

RATIONALE:

The use of broad-spectrum antibiotics as first line treatment have contributed to the rising incidence of drug-resistant strains of bacteria and to increased costs.

Once antibiotics therapy is initiated due to severity and/or duration of symptoms, the goal is to choose a first-line antibiotic treatment that is efficacious, cost-effective and that results in minimal side effects. The justification for amoxicillin as first-line therapy for most patients with ABRS relates to its favorable adverse effect profile, efficacy, low cost, and narrow microbiologic spectrum.

CLINICAL RECOMMENDATION STATEMENTS:

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

AAO-HNS Sinusitis Guideline (2007)

If a decision is made to treat ABRS with an antibiotic agent, the clinician should prescribe amoxicillin as first-line therapy for most adults.

Recommendation based on randomized controlled trials with heterogeneity and noninferiority design with a preponderance of benefit over harm.

IDSA Clinical Practice Guideline for Acute Bacterial Rhinosinusitis in Children and Adults (2012)

Amoxicillin-clavulanate rather than amoxicillin alone is recommended as empiric antimicrobial therapy for ABRS in adults (weak, low).

Evidence for at least 1 critical outcome from observational studies, from RCTs with serious flaws or indirect evidence.

◙ Measure #333: Adult Sinusitis: Computerized Tomography (CT) for Acute Sinusitis (Overuse) – National Quality Strategy Domain: Efficiency and Cost Reduction

2015 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Percentage of patients aged 18 years and older, with a diagnosis of acute sinusitis who had a computerized tomography (CT) scan of the paranasal sinuses ordered at the time of diagnosis or received within 28 days after date of diagnosis

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

Measure Reporting via Registry
ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

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

DENOMINATOR:
All patients aged 18 years and older with a diagnosis of acute sinusitis

Definitions:
Acute Sinusitis/Rhinosinusitis: Up to 4 weeks of purulent nasal drainage (anterior, posterior, or both) accompanied by nasal obstruction, facial pain-pressure-fullness, or both:
Purulent nasal discharge is cloudy or colored, in contrast to the clear secretions that typically accompany viral upper respiratory infection, and may be reported by the patient or observed on physical examination
Nasal obstruction may be reported by the patient as nasal obstruction, congestion, blockage, or stuffiness, or may be diagnosed by physical examination
Facial pain-pressure-fullness may involve the anterior face, periorbital region, or manifest with headache that is localized or diffuse

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Diagnosis for acute sinusitis (ICD-9-CM) [for use 1/1/2015-9/30/2015]: 461.0, 461.1, 461.2, 461.3, 461.8, 461.9
Diagnosis for acute sinusitis (ICD-10-CM) [for use 10/01/2015-12/31/2015]: J01.00, J01.10, J01.20, J01.30, J01.40, J01.80, J01.90
AND
Patient encounter during reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99281, 99282, 99283, 99284, 99285, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350

NUMERATOR:

Patients who had a computerized tomography (CT) scan of the paranasal sinuses ordered at the time of diagnosis or received within 28 days after date of diagnosis

Numerator Options:

Performance Met:	CT scan of the paranasal sinuses ordered at the time of diagnosis or received within 28 days after date of diagnosis **(G9349)**
OR	
Other Performance Exclusion:	CT scan of the paranasal sinuses ordered at the time of diagnosis for documented reasons (eg, persons with sinusitis symptoms lasting at least 7 to 10 days, antibiotic resistance, immunocompromised, recurrent sinusitis, acute frontal sinusitis, acute sphenoid sinusitis, periorbital cellulitis, or other medical) **(G9348)**
OR	
Performance Not Met:	CT scan of the paranasal sinuses **not** ordered at the time of diagnosis or received within 28 days after date of diagnosis **(G9350)**

RATIONALE:

Most cases of uncomplicated acute and subacute sinusitis are diagnosed clinically and should not require any imaging procedure. Sinus CT scanning is of limited value in the routine evaluation of sinusitis due to the high prevalence of abnormal imaging findings. Forty percent of asymptomatic patients and 87 percent of patients with community-acquired colds have sinus abnormalities on sinus CT. Additionally, sinus CT imaging has a high sensitivity but a low specificity for demonstrating acute sinusitis. Furthermore, CT imaging is not recommended for the diagnosis of uncomplicated sinusitis because it is not cost-effective and exposes patients to unnecessary radiation.

Sinusitis cannot be diagnosed on the basis of imaging findings alone. Findings on CT scans should be interpreted in conjunction with clinical and endoscopic findings. Up to 40% of asymptomatic adults have abnormalities on sinus CT scans, as do more than 80% of those with minor upper respiratory tract infections.

CLINICAL RECOMMENDATION STATEMENTS:

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

AAO-HNS Sinusitis Guideline (2007)

Clinicians should not obtain radiographic imaging for patients who meet diagnostic criteria for acute rhinosinusitis, unless a complication or alternative diagnosis is suspected. Recommendation against based on diagnostic studies with minor limitations and a preponderance of benefit over harm.

Radiographic imaging of the paranasal sinuses is unnecessary for diagnosis in patients who already meet clinical diagnostic criteria (Table 5) for acute Rhinosinusitis Imaging modalities for the paranasal sinuses include plain film radiography, computed tomography (CT), and magnetic resonance (MR) imaging. The utility of ultrasound for diagnosis is inconclusive.

Imaging should only be considered for persons with rhinosinusitis symptoms lasting at least 7 to 10 days who have a history of recurrent symptoms or nonresponse to multiple courses of antibiotics in the past.

American College of Radiology ACR Appropriateness Criteria® For Sinonasal Disease (ACR, 2012)
Clinical Condition: Sinonasal Disease
Variant 1: Acute (<4 weeks) or subacute (4-12 weeks) uncomplicated rhinosinusitis.
Radiologic Procedure: CT paranasal sinuses without contrast

Rating: 5
Comments: Most episodes are managed without imaging, as this is primarily a clinical diagnosis. Imaging may be indicated if acute frontal sphenoid sinusitis is suspected, or if there are atypical symptoms, or if the diagnosis is uncertain.
RRL*: 0.1-1 mSv
Radiologic Procedure: MRI head and paranasal sinuses without contrast
Rating: 4
Comments: May be useful as part of a general workup for headache.
RRL*: 0 mSv
Radiologic Procedure: MRI head and paranasal sinuses without and with contrast
Rating: 2
Comments: May be useful as part of a general workup for headache.
RRL*: 0 mSv
Radiologic Procedure: CT paranasal sinuses with contrast
Rating: 2
RRL*: 0.1-1 mSv
Radiologic Procedure: CT paranasal sinuses without and with contrast
Rating: 1
RRL*: 1-10 mSv
Radiologic Procedure: X-ray paranasal sinuses
Rating: 1
RRL*: <0.1 mSv
Rating Scale: 1,2,3 Usually not appropriate; 4,5,6 May be appropriate; 7,8,9 Usually appropriate *Relative Radiation Level

◙ Measure #334: Adult Sinusitis: More than One Computerized Tomography (CT) Scan Within 90 Days for Chronic Sinusitis (Overuse) – National Quality Strategy Domain: Efficiency and Cost Reduction

2015 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Percentage of patients aged 18 years and older with a diagnosis of chronic sinusitis who had more than one CT scan of the paranasal sinuses ordered or received within 90 days after date of diagnosis

INSTRUCTIONS:
This measure is to be reported at **each visit** for patients with chronic sinusitis during the reporting period. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

Measure Reporting via Registry
ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

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

DENOMINATOR:
All patients aged 18 years and older with a diagnosis of chronic sinusitis

Definition:
Chronic Sinusitis/Rhinosinusitis - is defined as twelve (12) weeks or longer of two or more of the following signs and symptoms: mucopurulent drainage (anterior, posterior, or both), nasal obstruction (congestion), facial pain-pressure-fullness, or decreased sense of smell AND inflammation is documented by one or more of the following findings: purulent (not clear) mucus or edema in the middle meatus or ethmoid region, polyps in nasal cavity or the middle meatus, and/or radiographic imaging showing inflammation of the paranasal sinuses.

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Diagnosis for chronic sinusitis (ICD-9-CM) [for use 1/1/2015-9/30/2015]: 473.0, 473.1, 473.2, 473.3, 473.8, 473.9
Diagnosis for chronic sinusitis (ICD-10-CM) [for use 10/01/2015-12/31/2015]: J32.0, J32.1, J32.2, J32.3, J32.4, J32.8, J32.9
AND
Patient encounter during reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350

NUMERATOR:
Patients who had more than one CT scan of the paranasal sinuses ordered or received within 90 days after date of diagnosis

Numerator Instructions: A lower calculated performance rate for this measure indicates better clinical care or control. A lower percentage, with a definitional target approaching 0%, indicates appropriate use of CT in cases of chronic sinusitis (eg, not ordering more than one CT scan within 90 days after the date of diagnosis).

Numerator Options:

Performance Met:	More than one CT scan of the paranasal sinuses ordered or received within 90 days after the date of diagnosis, reason not given **(G9352)**
OR	
Other Performance Exclusion:	More than one CT scan of the paranasal sinuses ordered or received within 90 days after the date of diagnosis for documented reasons (eg, patients with complications, second CT obtained prior to surgery, other medical reasons) **(G9353)**
OR	
Performance Not Met:	One CT scan or no CT scan of the paranasal sinuses ordered within 90 days after the date of diagnosis **(G9354)**

RATIONALE:
In contrast to acute or isolated cases of sinusitis, chronic or recurrent sinusitis may benefit from additional diagnostic evaluation (eg, CT scan, nasal endoscopy) and management to corroborate a diagnosis and/or investigate for underlying causes. When endoscopic sinus surgery is considered in patients with recurrent or chronic sinusitis, a CT of the paranasal sinuses should be obtained to provide the anatomic detail necessary to guide the surgery. Multiple CT scans, however, are not indicated for chronic sinusitis patients due to risk of radiation overexposure and the fact that sinusitis cannot be diagnosed on the basis of imaging findings alone.

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

AAO-HNS Sinusitis Guideline (2007)

Diagnostic Testing
The clinician should corroborate a diagnosis and/or investigate for underlying causes of chronic Rhinosinusitis and recurrent acute rhinosinusitis.

Recommendation based on observational studies with a preponderance of benefit over harm.

Radiographic Imaging
The clinician should obtain computed tomography (CT) of the paranasal sinuses in diagnosing or evaluating a patient with chronic rhinosinusitis or recurrent acute Rhinosinusitis (AAO-HNS, 2007).

Recommendation based on diagnostic and observational studies and a preponderance of benefit over harm.

American College of Radiology ACR Appropriateness Criteria®: Sinonasal Disease (ACR, 2012):
Recurrent acute or chronic rhinosinusitis (possible surgical candidate)
Radiologic Procedure: CT paranasal sinuses without contrast
Rating: 9
Comments: Consider using as a surgical planning protocol.
RRL*: 0.1-1 mSv
Radiologic Procedure: CT paranasal sinuses with contrast

Rating: 4
RRL*: 0.1-1 mSv
Radiologic Procedure: CT paranasal sinuses without and with contrast
Rating: 3
RRL*: 1-10mSv
Radiologic Procedure: MRI head and paranasal sinuses without and with contrast
Rating: 3
RRL*: 0 mSv
Radiologic Procedure: MRI head and paranasal sinuses without contrast
Rating: 2
RRL*: 0 mSv
Radiologic Procedure: X-ray paranasal sinuses
Rating: 1
Comments: May be indicated for planning frontal sinus obliteration.
RRL*: <0.1 mSv
Radiologic Procedure: SPECT paranasal sinuses
Rating: 1
RRL*: 1-10 mSv
Rating Scale: 1,2,3 Usually not appropriate; 4,5,6 May be appropriate; 7,8,9 Usually appropriate *Relative Radiation Level

▲ Measure #335: Maternity Care: Elective Delivery or Early Induction Without Medical Indication at ≥ 37 and < 39 Weeks (Overuse) – National Quality Strategy Domain: Patient Safety

2015 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Percentage of patients, regardless of age, who gave birth during a 12-month period who delivered a live singleton at ≥ 37 and < 39 weeks of gestation completed who had elective deliveries or early inductions without medical indication

INSTRUCTIONS:
This measure is to be reported **each time** a procedure is performed for patients undergoing delivery or induction at 37 or 38 weeks gestation during the reporting period. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

Measure Reporting via Registry
ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

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

DENOMINATOR:
All patients, regardless of age, who gave birth during a 12-month period delivering a live singleton at ≥ 37 and < 39 weeks of gestation completed without medical indication for induction

Denominator Criteria (Eligible Cases):
All patients, regardless of age
AND
Live Singleton (ICD-9-CM) [for use 1/1/2015-9/30/2015]: V27.0
Live Singleton (ICD-10-CM) [for use 10/01/2015-12/31/2015]: Z37.0
AND
Patient encounter during reporting period (CPT): 59400, 59409, 59410, 59510, 59514, 59515, 59610, 59612, 59614, 59618, 59620, 59622
AND
Delivery between ≥ 37 and < 39 weeks gestation

NUMERATOR:
Patients who had elective deliveries or early inductions

Numerator Options:

Performance Met:	Early elective delivery or early elective induction not performed (≥ 37 and < 39 weeks gestation) **(G9355)**
OR	
Medical Performance Exclusion:	Medical indication for induction [Documentation of reason(s) for elective delivery or early induction (eg, hemorrhage and placental complications, hypertension, preeclampsia and eclampsia, rupture of membranes-

premature or prolonged, maternal conditions complicating pregnancy/delivery, fetal conditions complicating pregnancy/delivery, malposition and malpresentation of fetus, late pregnancy, prior uterine surgery, or participation in clinical trial)] **(G9361)**

OR

Performance Not Met: Early elective delivery or early elective induction performed (≥ 37 and < 39 weeks gestation) **(G9356)**

RATIONALE:

Elective delivery or early induction often leads to prematurity, increased costs, and an increased incidence of cesarean section. Studies have determined that elective delivery or elective cesarean section prior to the gestational age of 39 weeks may result in significant short term neonatal morbidity (neonatal intensive care unit admission rates of 13-21%). Among women undergoing induction, women with their first pregnancies have a higher rate of cesarean delivery than women with prior vaginal births. Recent research shows that infants born prior to 39 weeks face a higher risk of breathing disorders and other problems than those who remain in the womb longer.

CLINICAL RECOMMENDATION STATEMENTS:

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

ACOG induction of labor guidelines (ACOG, 2009)

The goal of induction of labor is to achieve vaginal delivery by stimulating uterine contractions before the spontaneous onset of labor. Generally, induction of labor has merit as a therapeutic option when the benefits of expeditious delivery outweigh the risks of continuing the pregnancy. The benefits of labor induction must be weighed against the potential maternal and fetal risks associated with this procedure.

"Labor may also be induced for logistic reasons, eg, rapid labor, distance, or psychosocial reasons. In such circumstances, at least 1 of the criteria (for being > 39 weeks) should be met or fetal lung maturity should be established".

Indications for induction of labor are not absolute but should take into account maternal and fetal conditions, gestational age, cervical status, and other factors. Following are examples of maternal or fetal conditions that may be indications for induction of labor:

- Placental abruption
- Chorioamnionitis
- Fetal demise
- Gestational hypertension
- Preeclampsia, eclampsia
- Premature rupture of membranes
- Postterm pregnancy
- Maternal medical conditions (eg, diabetes mellitus, renal disease, chronic pulmonary disease, chronic hypertension, antiphospholipid syndrome)
- Fetal compromise (eg, severe fetal growth restriction, isoimmunization, oligohydramnios)

The individual patient and clinical situation should be considered in determining when induction of labor is contraindicated. Generally, the contraindications to labor induction are the same as those for spontaneous labor and vaginal delivery. They include, but are not limited to, the following situations:

- Vasa previa or complete placenta previa
- Transverse fetal lie

- Umbilical cord prolapse
- Previous classical cesarean delivery
- Active genital herpes infection
- Previous myomectomy entering the endometrial cavity

▲ Measure #336: Maternity Care: Post-Partum Follow-Up and Care Coordination – National Quality Strategy Domain: Communication and Care Coordination

2015 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Percentage of patients, regardless of age, who gave birth during a 12-month period who were seen for post-partum care within 8 weeks of giving birth who received a breast feeding evaluation and education, post-partum depression screening, post-partum glucose screening for gestational diabetes patients, and family and contraceptive planning

INSTRUCTIONS:
This measure is to be reported a minimum of **once per reporting period** for all patients seen for post-partum care within 8 weeks of giving birth during the reporting period. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

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

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

DENOMINATOR:
All patients, regardless of age, who gave birth during a 12-month period seen for post-partum care visit before or at 8 weeks of giving birth

Denominator Criteria (Eligible Cases):
All patients, regardless of age
AND
Patient encounter during reporting period (CPT): 59400, 59410, 59430, 59510, 59515, 59610, 59614, 59618, 59622
AND
Post-partum Care Visit before or at 8 weeks post-delivery

NUMERATOR:
Patients receiving the following at a post-partum visit:

- Breast feeding evaluation and education, including patient-reported breast feeding
- Post-partum depression screening
- Post-partum glucose screening for gestational diabetes patients and
- Family and contraceptive planning

Definitions:
Breast Feeding Evaluation and Education – Patients who were evaluated for breast feeding before or at 8 weeks post-partum.
Post-Partum Depression Screening – Patients who were screened for post-partum depression before or at 8 weeks post-partum. Questions may be asked either directly by a health care provider or in the form of self-completed paper- or computer administered questionnaires and results should be documented in the medical record. Depression screening may include a self-reported validated depression screening tool (eg,

PHQ-2, Beck Depression Inventory, Beck Depression Inventory for Primary Care, Edinburgh Postnatal Depression Scale (EPDS).
Post-Partum Glucose Screening for Gestational Diabetes – Patients who were diagnosed with gestational diabetes during pregnancy who were screened with a glucose screen before or at 8 weeks post-partum.
Family and Contraceptive Planning – Patients who were provided family and contraceptive planning and education *(including contraception, if necessary)* before or at 8 weeks post-partum.

Numerator Instruction: To satisfactorily meet the numerator ALL components (breast feeding evaluation and education, post-partum depression screening, family and contraceptive planning and post-partum glucose screening for patients with gestational diabetes) must be performed.

Numerator Options:

Performance Met:	Post-partum screenings, evaluations and education performed **(G9357)**
OR	
Performance Not Met:	Post-partum screenings, evaluations and education **not** performed **(G9358)**

RATIONALE:
Managing and ensuring concrete post-partum follow-up after delivery is a critical challenge to the health care system impacting the quality of care mothers receive. Post-partum follow-up for depression screening, breast feeding evaluation, family planning, and glucose screening are important risk factors to evaluate after childbirth. Maternal depression is one of the most common perinatal complications; however, the disorder remains unrecognized, undiagnosed, and untreated. The various maternal depression disorders are defined by the severity of the depression and the timing and length of the episode. Studies report that three to 25 percent of women experience major depression during the year following childbirth. Establishing the diagnosis of gestational diabetes mellitus offers an opportunity not only to improve pregnancy outcome, but also to decrease risk factors associated with the subsequent development of type 2 diabetes. The American College of Obstetricians and Gynecologists' Committee on Obstetric Practice recommends that all women with gestational diabetes mellitus be screened at 6-12 weeks postpartum and managed appropriately.

This measure is a measure of the adequacy of the care provided for those that come for postpartum care, as patients who do not have post-partum visits are excluded from this measure.

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

The following should be included in the postpartum visit (VA/DoD Clinical Practice Guideline for Pregnancy Management, 2009):

- Pelvic and breast examinations.
- Cervical smear should be completed as indicated by cervical cancer screening guidelines. [A]
- Initiate or continue the HPV vaccine series for women age < 26 years [C]
- Screening for postpartum depression
- Screening for domestic violence [B]
- Diabetes testing for patients with pregnancies complicated by gestational diabetes. The two-hour 75g oral glucose tolerance test (GTT) is recommended but a fasting glucose can also be done. [B]
- Education about contraception, infant feeding method, sexual activity, weight, exercise and the woman's assessment of her adaptation to motherhood. Pre-existing or chronic medical conditions should be addressed with referral for appropriate follow-up as indicated. [I]

Breast Feeding
The USPSTF recommends interventions during pregnancy and after birth to promote and support breastfeeding.

This recommendation applies to pregnant women, new mothers, and young children. In rare circumstances involving health issues in mothers or infants, such as human immunodeficiency virus (HIV) infection or galactosemia, breastfeeding may be contraindicated and interventions to promote breastfeeding may not be appropriate. Interventions to promote and support breastfeeding may also involve a woman's partner, other family members, and friends.

Depression Screening
Edinburgh Postnatal Depression Scale (EPDS): The 10-question Edinburgh Postnatal Depression Scale (EPDS) is a valuable and efficient way of identifying patients at risk for “perinatal” depression. The EPDS is easy to administer and has proven to be an effective screening tool. Mothers who score above 13 are likely to be suffering from a depressive illness of varying severity. The EPDS score should not override clinical judgment. A careful clinical assessment should be carried out to confirm the diagnosis. The scale indicates how the mother has felt during the previous week. In doubtful cases it may be useful to repeat the tool after 2 weeks.

★ Measure #337: Tuberculosis Prevention for Psoriasis,Psoriatic Arthritis and Rheumatoid Arthritis Patients on a Biological Immune Response Modifier – National Quality Strategy Domain: Effecitve Clincal Care

2015 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Percentage of patients whose providers are ensuring active tuberculosis prevention either through yearly negative standard tuberculosis screening tests or are reviewing the patient's history to determine if they have had appropriate management for a recent or prior positive test

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

Measure Reporting via Registry
ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes or HCPCS codes and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

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

DENOMINATOR:
All patients with a diagnosis of psoriasis and/or psoriatic arthritis or rheumatoid arthritis who are on a biologic immune response modifier

> ***DENOMINATOR NOTE:*** *A patient would be considered denominator eligible for Measure #337 for reporting purposes, if the patient meets the denominator criteria with diagnosis of psoriasis or psoriatic arthritis or rheumatoid arthritis AND is on a biologic immune response modifier PRESCRIBED BY THE PROVIDER BEING EVALUATED FOR THE MEASURE.*
>
> **Definition:**
> **Biologic Immune Response Modifier –**
> 1) TNF-alpha inhibitors, to include, but not limited toInfliximab (Remicade), Adalimumab (Humira), Etanercept (Enbrel), or Golimumab (Simponi), Certolizumab (Cimzia).
> 2) Inhibitors of IL-12 and/or IL-23 or their receptors to include but not limited to Ustekinumab (Stelara).
> 3) B7 inhibitors, to include but not limited to Abatacept (Orencia).
> 4) Inhibitors of IL-17 family members or their receptors.
>
> **Denominator Criteria (Eligible Cases):**
> All patients seen within reporting year that are on a biologic immune response modifier prescribed by the provider being evaluated for the measure
> **AND**
> **Diagnosis for psoriasis (ICD-9-CM) [for use 1/1/2015-9/30/2015]:** 696.1
> **Diagnosis for psoriasis (ICD-10-CM) [for use 10/01/2015-12/31/2015]:** L40.0, L40.1, L40.2, L40.3, L40.4, L40.8, L40.9
> **AND/OR**
> **Diagnosis for psoriatic arthritis (ICD-9-CM) [for use 1/1/2015-9/30/2015]:** 696.0

Diagnosis for psoriatic arthritis (ICD-10-CM) [for use 10/01/2015-12/31/2015]: L40.50, L40.51, L40.52, L40.53, L40.54, L40.59

OR

Diagnosis for rheumatoid arthritis (ICD-9-CM) [for use 1/1/2015-9/30/2015]: 714.0, 714.2, 714.81

Diagnosis for rheumatoid arthritis (ICD-10-CM) [for use 10/01/2015-12/31/2015]: M05.10, 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, M05.621, 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, M06.20, M06.211, M06.212, M06.219, M06.221, M06.222, M06.229, M06.231, M06.232, M06.239, M06.241, M06.242, M06.249, M06.251, M06.252, M06.259, M06.261, M06.262, M06.269, M06.271, M06.272, M06.279, M06.28, M06.29, 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, M06.80, M06.811, M06.812, M06.819, M06.821, M06.822, M06.829, M06.831, M06.832, M06.839, M06.841, M06.842, M06.849, M06.851, M06.852, M06.859, M06.861, M06.862, M06.869, M06.871, M06.872, M06.879, M06.88, M06.89, M06.9

AND

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

NUMERATOR:

Patients who have a documented negative annual TB screening or have documentation of the management of a positive TB screening test with no evidence of active tuberculosis, confirmed through use of radiographic imaging (ie, chest x-ray, CT)

Numerator Options:

Performance Met:	Documentation of negative or managed positive TB screen with further evidence that TB is not active **(G9359)**
OR	
Performance Not Met:	**No** documentation of negative or managed positive TB screen **(G9360)**

RATIONALE:

The safety of biologics in terms of their long-term adverse events and their use in different types of psoriasis and in different patient populations is important for clinicians to understand and monitor. Biologics have been associated with a variety of serious and "routine" opportunistic infections, particularly tuberculosis. For this reason, anti-tuberculosis testing both prior to the initiation of a biologic therapy and annually during treatment is pertinent.

CLINICAL RECOMMENDATION STATEMENTS:

When planning to initiate treatment of a patient with psoriasis with a biologic it is important to obtain an age appropriate history and physical examination along with an updated medication list. In addition, it is also important to obtain a reliable set of baseline laboratory studies that will allow the clinician to detect and be aware of any underlying conditions or risk factors. This is particularly important because after patients have been initiated on a biologic treatment, they are likely to be treated with other biologics or systemic therapies and it may be useful to have reliable baseline laboratory studies. Tuberculosis testing (PPD) should be performed on all patients who will be treated with TNF inhibitors as there are reports of tuberculosis reactivation in patients treated with this class of drug. (AAD)

ΦMeasure #342 (NQF 0209): Pain Brought Under Control Within 48 Hours – National Quality Strategy Domain: Person and Caregiver-Centered Experience and Outcomes

2015 PHYSICIAN QUALITY REPORTING OPTIONS FOR INDIVIDUAL MEASURES
REGISTRY ONLY

DESCRIPTION:
Patients aged 18 and older who report being uncomfortable because of pain at the initial assessment (after admission to palliative care services) that report pain was brought to a comfortable level within 48 hours

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

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

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

DENOMINATOR:
Patients aged 18 and older admitted to palliative care services who communicated and self reported that they were uncomfortable due to pain at the initial assessment (by responding "yes" when asked if they were uncomfortable because of pain)

Denominator Criteria (Eligible Cases):
Patients aged 18 and older
AND
Patient encounter during reporting period (CPT or HCPCS): 99324, 99325, 99326, 99337, 99377 G0182
AND
Patient able to Communicate and Understand the Language of the Person Asking
AND
Patient Self Reported Uncomfortable due to Pain at the Initial Assessment

NUMERATOR:
Patients whose pain was brought to a comfortable level within 48 hours of initial assessment (after admission to palliative care services)

Definition:
Comfortable Level – For the purpose of reporting this measure, achievement of comfort should be assessed as defined by the patient's response (of "yes" or "no" when asked if their pain was brought to a comfortable level within 48 hours after the initial assessment).
Within 48 Hours – The lookback window for the pain management measure question is 48 hours. The follow up measure question should be asked between 48 to 72 hours from the initial evaluation. The follow up question should not be asked prior to 48 hours.

Numerator Options:

Performance Met:	Documentation of patient pain brought to a comfortable level within 48 hours from initial assessment (**G9250)**

OR

Performance Not Met:	Documentation of patient with pain **not** brought to a comfortable level within 48 hours from initial assessment (**G9251)**

RATIONALE:

Poorly controlled pain diminishes patient quality of life and functional status, and causes suffering for patients and family caregivers. Pain is highly prevalent in the palliative care population, so the timely evaluation and treatment of pain at the start of palliative services is a priority. This measure is particularly important because it ensures integration of patient choice for desired level of treatment with the care process by incorporating the patient's own pain goals and perception of his or her own degree of comfort. If pain is an individual experience with an individual response, then the decision of what is comfortable should be left up to the individual, not determined arbitrarily by a clinician. It's more consistent with patient-centered care to care to ask the patient to decide how comfortable he/she wants to be, rather than aim for a specific numeric pain intensity rating, even if that rating can be linked to functionality. The Comfortable Dying measure also allows for a broader conceptualization of pain than use of a measure that relies solely on a numeric intensity rating.

CLINICAL RECOMMENDATION STATEMENTS:

This measure is designed to evaluate the effectiveness and timeliness of initial pain management after the start of palliative care services. Pain control may be immediate but pain management occurs over time. Therefore, the look-back window for follow-up after the initial pain assessment is 48 hours. The clinician should contact the patient the number of times and at intervals as clinically appropriate for good pain management practice. But the patient should not be asked the follow-up question for the purpose of data collection to inform the measure numerator until at least 48 hours after the initial assessment.

■ Measure #343: Screening Colonoscopy Adenoma Detection Rate – National Quality Strategy Domain: Effective Clincal Care

2015 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
The percentage of patients age 50 years or older with at least one adenoma or other colorectal cancer precursor or colorectal cancer detected during screening colonoscopy

INSTRUCTIONS:
This measure is to be reported **each time** a screening colonoscopy for colorectal cancer is performed during the reporting period. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

Measure Reporting via Registry:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes or HCPCS codes and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

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

DENOMINATOR:
Patients age 50 years or older undergoing a screening colonoscopy

Definitions:
Colorectal Cancer Precursor Lesions: Based on pathologic diagnosis, colorectal cancer precursor lesions include: adenomatous polyps [tubular, tubulovillous, villous] and traditional serrated adenomas, sessile serrated polyps and sessile serrated adenomas.

Denominator Criteria (Eligible Cases):
Patients 50 years of age or older on date of encounter
AND
Risk factors for colorectal cancer (ICD-9-CM) [for use 1/1/2015-9/30/2015]: V16.0, V18.51, V76.51
Risk factors for colorectal cancer (ICD-10-CM) [for use 10/01/2015-12/31/2015]: Z12.11, Z80.0, Z83.71
AND
Patient encounter during reporting period (CPT or HCPCS): 45378, 45380, 45381, 45384, 45385, G0121
WITHOUT
CPT Category I Modifiers: 52, 53, 73, 74

NUMERATOR:
Number of patients age 50 years or older with at least one adenoma or other colorectal cancer precursor or colorectal cancer detected during screening colonoscopy

Numerator Options:

Performance Met:	Adenoma(s) or other neoplasm detected during screening colonoscopy **(3775F)**

OR

Performance Not Met:	Adenoma(s) or other neoplasm **not** detected during screening colonoscopy **(3776F)**

RATIONALE:
The removal of adenomatous polyps during a screening colonoscopy is associated with a lower risk of subsequent colorectal cancer incidence and mortality. Higher adenoma detection rates (> 20% in a mixed gender population) are associated with significant protection against incident colorectal cancer in the five years following screening colonoscopy. Up to 30% of colorectal cancers arise from serrated neoplasms including sessile serrated polyps, sessile serrated adenomas and traditional serrated adenomas.

CLINICAL RECOMMENDATION STATEMENTS:
The United States Preventive Services Task Force has recommended screening colonoscopy for adults, beginning at age 50 and continuing until age 75 (Grade A recommendation) Screening exams are those performed to detect lesions in the absence of signs, symptoms, or personal history of colon neoplasia. The adenoma detection rate is an independent predictor of risk of developing colorectal cancer between screening colonoscopies. However, studies have documented wide variation in adenoma detection rates, illustrating the need for measuring and monitoring this metric for endoscopists. Some studies have identified variation due to the location of adenomas (lesions in the colon's right side are more difficult to detect). Procedure length has also been found in some, but not all, studies to correlate with adenoma detection rate. The adenoma detection rate varies between genders, with a lower rate demonstrated in women. Multi-specialty and stakeholder guidelines support the importance of measuring the adenoma detection rate in the prevention of colorectal cancer. Guidelines and the supporting literature support performance targets for adenoma detection rate of 25% for a mixed gender population (20% in women and 30% in men). Multi-specialty guidelines support the detection and complete removal of serrated colorectal neoplasms and surveillance of individuals with these lesions.

✦ Measure #344: Rate of Carotid Artery Stenting (CAS) for Asymptomatic Patients, Without Major Complications (Discharged to Home by Post-Operative Day #2) – National Quality Strategy Domain: Effective Clinical Care

2015 PHYSICIAN QUALITY REPORTING OPTIONS FOR INDIVIDUAL MEASURES
REGISTRY ONLY

DESCRIPTION:
Percent of asymptomatic patients undergoing CAS who are discharged to home no later than post-operative day #2

INSTRUCTIONS:
This measure is to be reported **each time** a CAS is performed during the reporting period. It is anticipated that clinicians who provide services of CAS, as described in the measure, based on the services provided and the measure-specific denominator coding will report this measure. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

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

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

DENOMINATOR:
Patients aged 18 and older who are asymptomatic undergoing CAS

Denominator Criteria (Eligible Cases):
Patients aged 18 and older
AND
Patient encounter during reporting period (CPT or HCPCS): 37215
AND NOT
Symptomatic carotid stenosis: Ipsilateral carotid territory TIA or stroke less than 120 days prior to procedure: 9006F
OR
Other carotid stenosis: Ipsilateral TIA or stroke 120 days or greater prior to procedure or any prior contralateral carotid territory or vertebrobasilar TIA or stroke: 9007F

NUMERATOR:
Patients discharged to home no later than post-operative day 2 following CAS

Definition:
Home – For purposes of reporting this measure, home is the point of origin prior to hospital admission prior to procedure. For example, if the patient comes from a skilled facility and returns to the skilled facility, this would meet criteria for discharged to home.

Numerator Options:
Performance Met: Documentation of patient discharged to home no later than post-operative day 2 following CAS **(G9255)**

OR

Performance Not Met: Documentation of patient discharged to home later than post-operative day 2 following CAS **(G9254)**

RATIONALE:
Surgeons performing CAS on asymptomatic patients must select patients at low risk for morbidity and perform the procedure with a very low complication rate in order to achieve benefit. Discharge to home within two days of the procedure is an indicator of patients who were not frail prior to the procedure and who did not experience a major complication (eg, disabling stroke, myocardial infarction). The proposed measure will therefore serve as an indicator of both appropriateness and overall outcome.

CLINICAL RECOMMENDATIONS STATEMENTS:
Percutaneous carotid intervention is a rapidly emerging field. Published trial results have established carotid stenting (CAS) in high risk surgical patients to be an effective alternative to carotid endarterectomy (CEA). It is well established that CEA benefits patients with asymptomatic >60% stenosis only if performed with a high degree of technical proficiency on appropriately selected patients. The same is proposed to hold true for CAS. This is particularly important when considering an asymptomatic population where the relative risk reduction with intervention is narrow when compared to medical management. Numerous publications have noted variation in the combined endpoint of stroke and death following carotid angioplasty and stent placement with embolic protection (Percutaneous Transluminal Angioplasty, Cochrane Database Syst Rev 2007)**.** Adoption of this outcome measure in the United States would likely disclose disparate results between hospitals and between providers, and lead to quality improvement when this information was provided to individual providers and participating centers. The SVS Vascular Registry has shown that outcome results are good for CAS, but variations exist between interventionalists and centers. Postoperative stroke or death is the accepted outcome parameter for this procedure, and its measurement and reporting would demonstrate variation and opportunity for improvement. CAS is an elective procedure in nearly all cases. Patients can be referred or transferred to a center with the personnel and experience to perform this procedure with a high level of competence and any procedure that has "stroke" as a potential risk should be performed only by individuals with appropriate training and experience. (Carotid Artery Angioplasty, J Vasc Interv Radiol 2003)

✦ Measure #345: Rate of Postoperative Stroke or Death in Asymptomatic Patients Undergoing Carotid Artery Stenting (CAS) – National Quality Strategy Domain: Effective Clinical Care

2015 PHYSICIAN QUALITY REPORTING OPTIONS FOR INDIVIDUAL MEASURES
REGISTRY ONLY

DESCRIPTION:
Percent of asymptomatic patients undergoing CAS who experience stroke or death following surgery while in the hospital

INSTRUCTIONS:
This measure is to be reported **each time** a CAS is performed during the reporting period. It is anticipated that clinicians who provide services of CAS, as described in the measure, based on the services provided and the measure-specific denominator coding will report this measure. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

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

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

DENOMINATOR:
Patients aged 18 and older who are asymptomatic undergoing CAS

Denominator Criteria (Eligible Cases):
Patients aged 18 and older
AND
Patient encounter during reporting period (CPT): 37215
AND NOT
Symptomatic carotid stenosis: Ipsilateral carotid territory TIA or stroke less than 120 days prior to procedure: 9006F
OR
Other carotid stenosis: Ipsilateral TIA or stroke 120 days or greater prior to procedure or any prior contralateral carotid territory or vertebrobasilar TIA or stroke: 9007F

NUMERATOR:
Patients who experience stroke or death in the hospital following CAS

Numerator Instructions: A lower calculated performance rate for this measure indicates better clinical care or control.

Numerator Options:
Performance Met: Documentation of patient stroke following CAS **(G9257)**
OR
Performance Met: Documentation of patient death following CAS **(G9256)**

OR

Performance Not Met:	Documentation of patient survival and absence of stroke following CAS **(G9259)**

RATIONALE:
Surgeons performing CAS on asymptomatic patients must select patients at low risk for morbidity and perform the procedure with a very low complication rate in order to achieve benefit. The proposed measure will therefore serve as an indicator of both appropriateness and overall outcome.

CLINICAL RECOMMENDATION STATEMENTS:
Updated Society for Vascular Surgery guidelines for management of extracranial carotid disease. Ricotta et al, J Vasc Surg, 54:3, 2011

Neurologically asymptomatic patients with ≥ 60% diameter stenosis should be considered for CAS for reduction of long-term risk of stroke, provided the patient has a 3- to 5-year life expectancy and perioperative stroke/death rates can be ≤ 3% (GRADE 1, Level of Evidence A).

✦ Measure #346: Rate of Postoperative Stroke or Death in Asymptomatic Patients Undergoing Carotid Endarterectomy (CEA) -- Clinical Quality Strategy Domain: Effective Clinical Care

2015 PHYSICIAN QUALITY REPORTING OPTIONS FOR INDIVIDUAL MEASURES
REGISTRY ONLY

DESCRIPTION:
Percent of asymptomatic patients undergoing CEA who experience stroke or death following surgery while in the hospital

INSTRUCTIONS:
This measure is to be reported **each time** a CEA is performed during the reporting period. It is anticipated that clinicians who provide services of CEA, as described in the measure, based on the services provided and the measure-specific denominator coding will report this measure. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

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

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

DENOMINATOR:
Patients aged 18 and older who are asymptomatic undergoing CEA

Denominator Criteria (Eligible Cases):
Patients aged 18 and older
AND
Patient encounter during reporting period (CPT): 35301
AND NOT
Symptomatic carotid stenosis: Ipsilateral carotid territory TIA or stroke less than 120 days prior to procedure: 9006F
OR
Other carotid stenosis: Ipsilateral TIA or stroke 120 days or greater prior to procedure or any prior contralateral carotid territory or vertebrobasilar TIA or stroke: 9007F

NUMERATOR:
Patients who experience stroke or death in the hospital following CEA

Numerator Instructions: A lower calculated performance rate for this measure indicates better clinical care or control.

Numerator Options:

Performance Met:	Documentation of patient stroke following CEA **(G9258)**
OR	
Performance Met:	Documentation of patient death following CEA **(G9260)**
OR	

Performance Not Met: Documentation of patient survival and absence of stroke following CEA **(G9261)**

RATIONALE:
Surgeons performing CEA on asymptomatic patients must select patients at low risk for morbidity and perform the procedure with a very low complication rate in order to achieve benefit. The proposed measure will therefore serve as an indicator of both appropriateness and overall outcome.

CLINICAL RECOMMENDATION STATEMENTS:
Updated Society for Vascular Surgery guidelines for management of extracranial carotid disease. Ricotta et al, J Vasc Surg, 54:3, 2011

Neurologically asymptomatic patients with ≥ 60% diameter stenosis should be considered for CEA for reduction of long-term risk of stroke, provided the patient has a 3- to 5-year life expectancy and perioperative stroke/death rates can be ≤ 3% (GRADE 1, Level of Evidence A).

✦ Measure #347: Rate of Endovascular Aneurysm Repair (EVAR) of Small or Moderate Non-Ruptured Abdominal Aortic Aneurysms (AAA) Who Die While in Hospital – National Quality Strategy Domain: Patient Safety

2015 PHYSICIAN QUALITY REPORTING OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Percent of patients undergoing endovascular repair of small or moderate abdominal aortic aneurysms (AAA) that die while in the hospital

INSTRUCTIONS:
This measure is to be reported **each time** an EVAR is performed during the reporting period. It is anticipated that clinicians who provide services of EVAR, as described in the measure, based on the services provided and the measure-specific denominator coding will report this measure. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

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

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

DENOMINATOR:
Patients aged 18 and older with infrarenal non-ruptured endovascular AAA repairs

Denominator Criteria (Eligible Cases):
Patients aged 18 and older
AND
Patient encounter during reporting period (CPT): 34800, 34802
AND NOT
For women:
Aortic aneurysm 5.5 - 5.9 cm maximum diameter on centerline formatted CT or minor diameter on axial formatted CT: 9003F
OR
Aortic aneurysm 6.0 cm or greater maximum diameter on centerline formatted CT or minor diameter on axial formatted CT: 9004F
OR
For men:
Aortic aneurysm 6.0 cm or greater maximum diameter on centerline formatted CT or minor diameter on axial formatted CT: 9004F

NUMERATOR:
Patients who die in the hospital following endovascular AAA repair

Numerator Instructions: A lower calculated performance rate for this measure indicates better clinical care or control.

Numerator Options:

Performance Met: Documentation of patient death in the hospital following endovascular AAA repair **(G9262)**

OR

Performance Not Met: Documentation of patient survival in the hospital following endovascular AAA repair **(G9263)**

RATIONALE:

Elective repair of a small or moderate sized AAA is a prophylactic procedure and the mortality/morbidity of the procedure must be contrasted with the risk of rupture over time. Surgeons should select patients for intervention who have a reasonable life expectancy and who do not have a high surgical risk.

CLINICAL RECOMMENDATION STATEMENTS:

The care of patients with an abdominal aortic aneurysm: The Society for Vascular Surgery practice guidelines. Chaikof et al, J Vasc Surg, 50:4, supplement, 2009.

Elective repair is recommended for patients that present with a fusiform AAA ≥5.5 cm in maximum diameter, in the absence of significant co-morbidities.

Surveillance is recommended for most patients with a fusiform AAA in the range of 4.0 cm to 5.4 cm in maximum diameter.

£Measure #348: HRS-3 Implantable Cardioverter-Defibrillator (ICD) Complications Rate – National Quality Strategy Domain: Patient Safety

2015 PHYSICIAN QUALITY REPORTING OPTIONS FOR INDIVIDUAL MEASURES
REGISTRY ONLY

DESCRIPTION:
Patients with physician-specific risk-standardized rates of procedural complications following the first time implantation of an ICD

INSTRUCTIONS:
This measure is to be reported a minimum of **once per reporting period** for patients with a first time implantation of an ICD during the reporting period. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding. **NOTE:** Include only patients that have had first time implantation through November 30 for evaluation of complications for 30 days and September 30 for evaluation of complications for 90 days post procedure within the reporting period. This will allow the evaluation of ICD implant complications within the reporting year.

This is a risk adjusted measure. Please refer to the "**Hierarchical logistic regression"** at the end of this specification.

There are 2 rates to be calculated for this measure:

1) Complications or mortality at 30 days

OR

2) Complications at 90 days

Measure Reporting via Registry:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

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

There are two reporting criteria for this measure:

1) **Patients with first time implants with one or more complications or mortality within 30 days**

OR

2) **Patients with first time implants with one or more complications within 90 days**

The eligible professional should submit data on both reporting criteria 1 and 2 for a patient that meets the denominator.

REPORTING CRITERIA 1: All patients with first time implants with one or more of the identified complications or mortality within 30 days

DENOMINATOR (REPORTING CRITERIA 1):
Patients with a first time implantation of an ICD

Denominator Instructions: Include patients with procedures that are performed ≥ 31 days prior to the end of the reporting period. Denominator patients can be identified using the following ICD-9 or ICD-10 codes.

Denominator Criteria (Eligible Cases):
Patient aged ≥ 65 years on date of encounter
AND
Implantation of ICD (ICD-9-CM) [for use 1/1/2015-9/30/2015]: 00.50, 00.51, 00.52, 00.53, 00.54, 37.94
Implantation of ICD (ICD-10-CM) [for use 10/01/2015-12/31/2015]: OJH607Z, OJH637Z, OJH807Z, OJH837Z, OJH608Z, OJH638Z, OJH808Z, OJH838Z, OJH609Z, OJH639Z, OJH809Z, OJH839Z
AND/OR
Patient encounter during reporting period (CPT): 33216, 33217, 33218, 33220, 33223, 33240, 33241, 33249
AND NOT
OJPT0PZ, OJPT3PZ

NUMERATOR (REPORTING CRITERIA 1):
Number of patients with one or more of the following complications or mortality within 30 days (depending on the complication) following ICD implantation

Numerator Instructions: A lower calculated performance rate for this measure indicates better clinical care or control.

Definitions:
Complications measured for 30 days:
1) Death
2) Pneumothorax or hemothorax plus a chest tube
3) Hematoma plus a blood transfusion or evacuation
4) Cardiac tamponade or pericardiocentesis

Numerator Options:

Performance Met:	Documentation of patient with one or more complications or mortality within 30 days **(G9267).**
OR	
Performance Not Met:	Documentation of patient without one or more complications and without mortality within 30 days **(G9269).**

OR

REPORTING CRITERIA 2: All patients with first time implants with one or more of the identified complications within 90 days

DENOMINATOR (REPORTING CRITERIA 2):
Patients with a first time implantation of an ICD

Denominator Instructions: Include patients with procedures that are performed ≥ 91 days prior to the end of the reporting period. Denominator patients can be identified using the following ICD-9 or ICD-10 codes.

Denominator Criteria (Eligible Cases):
Patient aged ≥ 65 years on date of encounter
AND
Implantation of ICD (ICD-9-CM) [for use 1/1/2015-9/30/2015]: 00.50, 00.51, 00.52, 00.53, 00.54, 37.94

Implantation of ICD (ICD-10-CM) [for use 10/01/2015-12/31/2015]: OJH607Z, OJH637Z, OJH807Z, OJH837Z, OJH608Z, OJH638Z, OJH808Z, OJH838Z, OJH609Z, OJH639Z, OJH809Z, OJH839Z
AND/OR
Patient encounter during reporting period (CPT): 33216, 33217, 33218, 33220, 33223, 33240, 33241, 33249
AND NOT
OJPT0PZ, OJPT3PZ

NUMERATOR (REPORTING CRITERIA 2):
Number of patients with one or more of the following complications within 90 days (depending on the complication) following ICD implantation

Numerator Instructions: A lower calculated performance rate for this measure indicates better clinical care or control.

Definitions:
Complications measured for 90 days:
1) Mechanical complications requiring a system revision
2) Device related infection
3) Additional ICD implantation

Numerator Options:

Performance Met:	Documentation of patient with one or more complications within 90 days **(G9268)**
OR	
Performance Not Met:	Documentation of patient without one or more complications within 90 days **(G9270)**

RATIONALE:
The proposed measure of ICD complications has the potential to significantly improve the quality of care delivered to patients with advanced heart disease. The model used for risk adjustment meets recognized standards for outcomes measurement and was developed with extensive input from stakeholders with a broad range of expertise and perspectives. The study sample is appropriately defined, consisting of an ICD population that has distinct outcomes that will allow for valid comparisons of physician quality. The definition of the complications, the complication-specific period of assessment, and the risk-adjustment variables all have strong face validity, which may facilitate physician acceptance. We excluded covariates that we would not want to adjust for in a quality measure.

In summary, we present an ICD complications measure that is suitable for public reporting. The proposed measure capitalizes on the National Cardiovascular Data Registry (NCDR) ICD Registry data already collected as part of an ongoing collaboration between CMS and NCDR. Accordingly, the incremental burden of data collection on physicians would be minimal and the proposed measure could be implemented by using the direct patient identifiers already being collected by CMS.

CLINICAL RECOMMENDATION STATEMENTS:
ICD implantation is an expensive procedure performed on patients with advanced cardiovascular disease and, often, significant comorbidities. Despite improvements in technology and increasing experience with device implantation, the procedure carries a significant risk of complications (Hammill, Curtis, 2008).

- Roughly 150,000 ICDs are implanted each year and approximately two thirds of implantations are performed on Medicare patients.
- Direct total medical cost per device (2005) (Sanders, Hlatky et al. 2005) is $68,000-$100,000. The total national costs range from $10-$15 billion, of which $7-$10 billion represents fee-for-service Medicare.

- Complications are expensive and, in one study (Reynolds et al, 2006), associated with increased length of stay (1-10 days) and costs $5,000 – 20,000 (mean $7,251), adding roughly $80 million in Medicare costs.
- Reported complication rates following ICD implantation vary from 4% to 30%, depending largely on how complications are defined and the period of assessment. In the NCDR ICD Registry, the incidence of in-hospital complications is approximately 4%. However, complications such as device infection, malfunction, or cardiac tamponade are not fully captured by the registry since they may only become evident following hospital discharge.
- Al-Khatib et al (2008) analyzed administrative claims data and found overall rates of complication within 90 days of ICD implantation ranged from 18.8% in 2002 to 14.2% in 2005 (Al-Khatib et al, 2005).

We analyzed Medicare FFS administrative claims to assess complications rates following ICD implantation. From 2006 through 2009, a total of 105,575 implants performed by 3,488 physicians met inclusion/exclusion criteria and were included in the analysis. The number of eligible implants increased over time from 22,931 in 2006 to 28,383. The overall complication rate decreased modestly over this time period, from 8.60% to 7.55%. The rate of mechanical complications requiring system revision had the largest decrease over time (0.78%), but similar relative declines were seen across all complications. As expected, the characteristics of patients with and without adverse events differed significantly. Most notably, patients receiving a CRT-D device had a significantly higher complication rate than patients receiving a single and dual chamber device (8.09%, 6.30%, and 5.33% respectively). These results demonstrate an opportunity to improve physician-level performance.

Hierarchical logistic regression
The specification is designed to align with the NQF-endorsed *Hospital Risk-Standardized Complication Rate following Implantation of Implantable Cardioverter-Defibrillator* performance measure (NQF #0694).

The variables apply to both the 30 and 90 day outcomes, but how the variables are to be utilized within the performance calculation is part of a risk model developed by Yale.

𝄞Measure #349 (NQF 0076): Optimal Vascular Care Composite – National Quality Strategy Domain: Effective Clinical Care

2015 PHYSICIAN QUALITY REPORTING OPTIONS FOR INDIVIDUAL MEASURES
REGISTRY ONLY

DESCRIPTION:
Percent of patients aged 18 to 75 with ischemic vascular disease (IVD) who have optimally managed modifiable risk factors demonstrated by meeting all of the numerator targets of this patient level all-or-none composite measure: blood pressure less than 140/90, tobacco-free status, and daily aspirin use.

INSTRUCTIONS:
This measure is to be reported a minimum of **once per reporting period** for patients with IVD during the reporting period. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding. All components of this composite must be documented with the specified outcomes in order to meet performance of the measure.

Each component within this composite measure should be reported in order to calculate the reporting rate and performance rate for the overall percentage of patients that meet performance for ALL targets indicated. Reporting and performance rates will be required for each component of this composite measure.

Measure Reporting via Registry:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT or HCPCS codes, and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

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

This measure will be calculated with 4 performance rates:
1) Overall percentage for patients that meet performance for ALL targets indicated
2) Percentage of patients with most recent blood pressure in the measurement period that have a systolic value of <140 and a diastolic value of <90 (**BOTH** values must be less than)
3) Percentage of patients with documentation in the chart that the patient is currently a non-tobacco user
4) Percentage of patients with documentation in the measurement period that the patient is on daily oral aspirin or antiplatelet medication or has documentation of a valid contraindication to aspirin/ antiplatelet.

DENOMINATOR:
Patients aged 18 through 75 with the diagnosis of IVD. Eligible patients are those that have two or more face-to-face visits for IVD in the last two years and at least one visit for any reason in the last 12 months.

> ***DENOMINATOR NOTE:*** *In order for the patient to be included in the denominator criteria, the patient must have two denominator eligible encounters within the current measurement period and prior measurement period AND at least one visit for any reason in the current measurement period.*
>
> **Denominator Criteria (Eligible Cases):**
> Patients aged 18 through 75
> **AND**
> **Diagnosis for IVD (ICD-9-CM) [for use 1/1/2015-9/30/2015]**: 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, 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, 440.0, 440.1, 440.20, 440.21, 440.22, 440.23, 440.24, 440.29, 440.30, 440.31, 440.32, 440.4, 444.0, 444.01, 444.09, 444.1, 444.21, 444.22, 444.81, 444.89, 444.9, 445.01, 445.02, 445.81, 445.89

Diagnosis for IVD (ICD-10-CM) [for use 10/01/2015-12/31/2015]: 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, I23.0, I23.1, I23.2, I23.3, I23.4, I23.5, I23.6, I23.7, I23.8, I24.0, I24.1, I24.8, I24.9, I25.10, I25.110, I25.111, I25.118, I25.119, I25.2, I25.3, I25.41, I25.42, 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, I25.83, I25.89, I25.9, I63.20, I63.211, I63.212, I63.219, I63.22, I63.231, I63.232, I63.239, I63.29, 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, 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, I67.2, I70.0, 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, I70.301, I70.302, I70.303, I70.308, I70.309, I70.311, I70.312, I70.313, I70.318, I70.319, I70.321, I70.322, I70.323, I70.328, I70.329, I70.331, I70.332, I70.333, I70.334, I70.335, I70.338, I70.339, I70.341, I70.342, I70.343, I70.344, I70.345, I70.348, I70.349, I70.35, I70.361, I70.362, I70.363, I70.368, I70.369, I70.391, I70.392, I70.393, I70.398, I70.399, I70.401, I70.402, I70.403, I70.408, I70.409, I70.411, I70.412, I70.413, I70.418, I70.419, I70.421, I70.422, I70.423, I70.428, I70.429, I70.431, I70.432, I70.433, I70.434, I70.435, I70.438, I70.439, I70.441, I70.442, I70.443, I70.444, I70.445, I70.448, I70.449, I70.45, I70.461, I70.462, I70.463, I70.468, I70.469, I70.491, I70.492, I70.493, I70.498, I70.499, I70.501, I70.502, I70.503, I70.508, I70.509, I70.511, I70.512, I70.513, I70.518, I70.519, I70.521, I70.522, I70.523, I70.528, I70.529, I70.531, I70.532, I70.533, I70.534, I70.535, I70.538, I70.539, I70.541, I70.542, I70.543, I70.544, I70.545, I70.548, I70.549, I70.55, I70.561, I70.562, I70.563, I70.568, I70.569, I70.591, I70.592, I70.593, I70.598, I70.599, I70.601, I70.602, I70.603, I70.608, I70.609, I70.611, I70.612, I70.613, I70.618, I70.619, I70.621, I70.622, I70.623, I70.628, I70.629, I70.631, I70.632, I70.633, I70.634, I70.635, I70.638, I70.639, I70.641, I70.642, I70.643, I70.644, I70.645, I70.648, I70.649, I70.65, I70.661, I70.662, I70.663, I70.668, I70.669, I70.691, I70.692, I70.693, I70.698, I70.699, I70.701, I70.702, I70.703, I70.708, I70.709, I70.711, I70.712, I70.713, I70.718, I70.719, I70.721, I70.722, I70.723, I70.728, I70.729, I70.731, I70.732, I70.733, I70.734, I70.735, I70.738, I70.739, I70.741, I70.742, I70.743, I70.744, I70.745, I70.748, I70.749, I70.75, I70.761, I70.762, I70.763, I70.768, I70.769, I70.791, I70.792, I70.793, I70.798, I70.799, I70.8, I70.90, I70.91, 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; I76

AND

Patient encounter during reporting period (CPT or HCPCS): 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99455, 99456, G0402

AND

Two Denominator Eligible Visits and at Least One Visit for Any Reason

AND NOT

Patient Died Prior to the End of the Measurement Period

OR

Patient was a Permanent Nursing Home Resident

OR

Patient was in Palliative Care Services at any time During the Measurement Period

NUMERATOR (All or Nothing):

The number of IVD patients aged 18 to 75 years who met **ALL** of the following targets:

- The most recent Blood Pressure in the measurement period has a systolic value of <140 and a diastolic value of <90 (**BOTH** values must be less than)
- There is documentation in the chart that the patient is currently a non-tobacco user
- There is documentation in the measurement period that the patient is on daily oral aspirin or antiplatelet medication or has documentation of a valid contraindication to aspirin/ antiplatelet.

Numerator Options:
Each component should be reported in order to determine the reporting and performance rate for the overall percentage of patients that meet ALL targets represented as the numerator.

COMPONENT 1:
Patients with most recent blood pressure in the measurement period that have a systolic value of <140 and a diastolic value of <90 (BOTH values must be less than)
Component Options:

Performance Met:	Blood Pressure has a systolic value of <140 and a diastolic value of < 90 **(G9273)**
OR	
Performance Not Met:	Blood Pressure has a systolic value of ≥140 and a diastolic value of ≥ 90 OR systolic value < 140 and diastolic value ≥ 90 OR systolic value ≥ 140 and diastolic value < 90 **(G9274)**

AND
COMPONENT 2:
Documentation in the chart that the patient is currently a non-tobacco user
Component Options:

Performance Met:	Documentation that patient is a current non-tobacco user **(G9275)**
OR	
Performance Not Met:	Documentation that patient is a current tobacco user **(G9276)**

AND
COMPONENT 3:
Documentation in the measurement period that the patient is on daily oral aspirin or antiplatelet medication or has documentation of a valid contraindication to aspirin/ antiplatelet.
Component Options:

Performance Met:	Documentation that the patient is on daily aspirin or anti-platelet or has documentation of a valid contraindication to aspirin/anti-platelet. Automatic contraindications include anti-coagulant use, allergy, and history of gastrointestinal bleed. Additionally, any reason documented by the physician as a reason for not taking daily aspirin or anti-platelet is acceptable (examples include non-steroidal anti-inflammatory agents, risk for drug interaction, or uncontrolled hypertension defined as > 180 systolic or > 110 diastolic) **(G9277)**
OR	
Performance Not Met:	Documentation that the patient is **not** on daily aspirin or anti-platelet regimen **(G9278)**

RATIONALE:
According to the Minnesota Department of Health, vascular disease is a high impact clinical condition in Minnesota. Approximately 20% of all deaths in Minnesota are due to heart disease and approximately 5% are due to stroke, making them the second and fourth leading causes of death, respectively, in the state behind cancer. Inpatient hospitalization charges alone in Minnesota were $1.79 billion for heart disease patients and $367 million for stroke patients in 2009. Prevalence of risk factors reported by Minnesotans include 34% high cholesterol, 22% high blood pressure, 17% cigarette smoke, 5% diabetes, 63% overweight or obese, and 16% physical inactivity. According to the American Heart Association (2013) Heart Disease and Stoke Statistics, nearly 84 million Americans have one or more types of cardiovascular disease. In 2009 the overall death rate attributable to CVD was 236.1 per 100,000. From 1999 to 2009, the relative rate of death attributable to CVD declined by 32.7%, yet still accounted for 32.3% or one of every three deaths in the United States.

CLINICAL RECOMMENDATION STATEMENTS:
Guidelines referenced include the American College of Cardiology/ American Heart Association, ICSI Institute for Clinical Systems Improvement and ACCF/AHA/AATS/PCNA/SCAI/ STS: Guideline for the Diagnosis and Management of Patients with Stable Ischemic Heart Disease

American College of Cardiology/ American Heart Association
Guideline for Treatment of Blood Cholesterol to Reduce Atherosclerotic Cardiovascular Disease (ASCVD) November 12, 2013

For patients age ≥ 21

Four statin benefit groups

1) Clinical ASCVD; high intensity age ≤ 75
2) Primary LDL > 190 [B; moderate]
3) Diabetes age 40 to 75 years with LDL 70 to 189 without clinical ASCVD

    a) Moderate intensity statin should be initiated or continued
    b) High intensity statin therapy is reasonable with estimated 10 year ASCVD risk ≥ 7.5%

4) Without clinical ASCVD or diabetes, LDL 70 to 189 and estimated 10 year ASCVD risk ≥ 7.5%

ICSI Lipid Management in Adults [November 2013]

Initiate Statin Treatment
Recommendation: Clinicians should initiate statin therapy regardless of LDL, in patients with established ASCVD *(Strong Recommendation, High Quality Evidence) (Cannon, 2004; Heart Protection Study Collaborative Group, 2002; Shepard, 2002; La Rosa, 1999; LIPID Study Group, 1998; Goldberg, 1998; Scandinavian Simvastatin Survival Study Group, 1994)*.

ICSI Stable Coronary Artery Disease [May 2013]

Hyperlipidemia
Section to be updated reflecting new ACC/AHA Nov 2013 guidelines in next revision.

Hypertension
General health measures include the treatment of hypertension, which is not only a risk factor for development and progression of atherosclerosis, but also causes cardiac hypertrophy, augments myocardial oxygen requirements, and thereby intensifies myocardial ischemia in patients with obstructive coronary disease.

Please refer to the ICSI Hypertension Diagnosis and Treatment guideline for recommendations regarding blood pressure management. The recommended target blood pressure is 140/90 mmHg or less. Based on current evidence, pursuing blood pressure goals lower than < 140/90 should be considered on an individual patient basis based on clinical judgment and patient preference *(ACCORD Study Group, 2010 [High Quality Evidence], Cooper-DeHoff, 2010 [Meta-analysis]).* Please see ICSI Hypertension Diagnosis and Treatment guideline for more information.

Smoking
Cigarette smoking may cause an acute cardiac ischemic event and may interfere with the efficacy of medications to relieve angina.

Aspirin and Anti-platelet Therapy
Recommendation: The use of one aspirin tablet daily (81 mg) is strongly recommended unless there are medical contraindications.

Antiplatelet Therapy
The use of one aspirin tablet daily (81 mg) is strongly recommended unless there are medical contraindications *(Kurth, 2003 [High Quality Evidence]; CAPRI, 1996 [High Quality Evidence]; Antiplatelet Trialists' Collaboration, 1994 [High Quality Evidence]; Fuster, 1993 [Low Quality Evidence]; Juul-Möller, 1992 [High Quality Evidence]; Ridker, 1991 [High Quality Evidence])*.

The Antithrombotic Trialists' Collaboration is a meta-analysis that analyzed 287 studies involving 135,000 patients for different aspects of antiplatelet therapy. When comparing the 500-1,500 mg versus 160-325 mg versus 75-150 mg daily regimens of aspirin in multiple trials, there was a trend of reduction in vascular events with decreased dose (odds reduction: 19% versus 26% versus 32%, respectively) *(Antithrombotic Trialists Collaboration, 2002 [Meta-analysis])*. Although the meta-analysis concludes that risk of gastrointestinal bleed was similar among doses 325 mg or less, other studies such as the CURE study showed increased bleeding risk with increasing the dose, without any increase in efficiency (*Peters, 2003 [High Quality Evidence]*

ACCF/AHA/AATS/PCNA/SCAI/ STS: Guideline for the Diagnosis and Management of Patients With Stable Ischemic Heart Disease 2012

Blood Pressure Management
1) All patients should be counseled about the need for lifestyle modification: weight control; increased physical activity; alcohol moderation; sodium reduction; and emphasis on increased consumption of fresh fruits, vegetables, and low-fat dairy products.(Level of Evidence: B)
2) In patients with SIHD with BP 140/90 mm Hg or higher, antihypertensive drug therapy should be instituted in addition to or after a trial of lifestyle modifications.538–543 (Level of Evidence: A)
3) The specific medications used for treatment of high BP should be based on specific patient characteristics and may include ACE inhibitors and/or beta blockers, with addition of other drugs, such as thiazide diuretics or calcium channel blockers, if needed to achieve a goal BP of less than 140/90 mm Hg.544,545 (Level of Evidence: B)

Smoking Cessation Counseling
Smoking cessation and avoidance of exposure to environmental tobacco smoke at work and home should be encouraged for all patients with SIHD. Follow-up, referral to special programs, and pharmacotherapy are recommended, as is a stepwise strategy for smoking cessation (Ask, Advise, Assess, Assist, Arrange, Avoid).650–652 (Level of Evidence: B)

Antiplatelet Therapy
1) Treatment with aspirin 75 to 162 mg daily should be continued indefinitely in the absence of contraindications in patients with SIHD. (*Level of Evidence: A*)

2) Treatment with clopidogrel is reasonable when aspirin is contraindicated in patients with SIHD. (*Level of Evidence: B*)

Measure #358: Patient-centered Surgical Risk Assessment and Communication – National Quality Strategy Domain: Person and Caregiver-Centered Experience and Outcomes

2015 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Percentage of patients who underwent a non-emergency surgery who had their personalized risks of postoperative complications assessed by their surgical team prior to surgery using a clinical data-based, patient-specific risk calculator and who received personal discussion of those risks with the surgeon

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

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

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

DENOMINATOR:
The total number of adult patients (age 18 and over) having had non-emergency surgery

> **Denominator Instructions:** CPT Category I procedure codes billed by surgeons performing surgery on the same patient, submitted with modifier 62 (indicating two surgeons, ie, dual procedures) will be included in the denominator population. Both surgeons participating in PQRS will be fully accountable for the clinical action described in the measure.
>
> **Denominator Criteria (Eligible Cases):**
> Patients aged ≥ 18 years on date of encounter
> **AND**
> **Non-emergency surgery**
> **AND**
> **Patient encounter during the reporting period (CPT):** Listed below are surgical procedures.

List of Eligible CPT Codes for This Measure

Specialty	Surgical Procedure	CPT code
General Surgery	Abdomen, Peritoneum & Omentum	20102, 44111, 49000, 49002, 49010, 49020, 49040, 49060, 49062, 49203, 49204, 49205, 49215, 49220, 49250, 49255, 49321, 49322, 49323, 49324, 49325, 49329, 49402, 49418, 49419, 49421, 49422, 49425, 49426, 49505, 49507, 49520, 49521, 49525, 49540, 49550, 49553, 49555, 49557, 49560, 49561, 49565, 49566, 49570, 49572, 49580, 49582, 49585, 49587, 49590, 49600, 49606, 49650, 49651, 49652, 49653, 49654, 49655, 49656, 49657, 49659, 49900, 49904, 49905, 49906, 49999

Specialty	Surgical Procedure	CPT code
	Anorectal	0184T, 45000, 45005, 45020, 45108, 45110, 45111, 45112, 45113, 45114, 45116, 45119, 45120, 45121, 45123, 45126, 45130, 45135, 45136, 45150, 45160, 45190, 45395, 45397, 45400, 45402, 45499, 45500, 45505, 45540, 45541, 45550, 45560, 45562, 45563, 45800, 45805, 45820, 45825, 45905, 45910, 45999, 46020, 46030, 46040, 46045, 46060, 46080, 46250, 46255, 46257, 46258, 46260, 46261, 46262, 46270, 46275, 46280, 46285, 46288, 46700, 46705, 46706, 46710, 46712, 46715, 46730, 46735, 46740, 46744, 46748, 46750, 46753, 46760, 46761, 46762, 46924, 46930, 46940, 46942, 46945, 46946, 46947, 46999
	Appendix and Meckel's Diverticulum	44800, 44820, 44850, 44899, 44900, 44950, 44960, 44970, 44979
	Bariatric	43644, 43645, 43770, 43771, 43772, 43773, 43774, 43775, 43843, 43845, 43846, 43847, 43848, 43886, 43887, 43888
	Biliary	47420, 47425, 47460, 47480, 47490, 47560, 47561, 47562, 47563, 47564, 47570, 47579, 47600, 47605, 47610, 47612, 47620, 47630, 47700, 47711, 47712, 47715, 47720, 47721, 47740, 47741, 47760, 47765, 47780, 47785, 47800, 47802, 47900, 47999
	Breast	11960, 19020, 19101, 19110, 19120, 19125, 19296, 19297, 19298, 19300, 19301, 19302, 19303, 19304, 19305, 19306, 19307, 19316, 19318, 19324, 19325, 19328, 19330, 19340, 19342, 19350, 19355, 19357, 19361, 19364, 19366, 19367, 19368, 19369, 19370, 19371, 19380, 19499
General Surgery	Colon	44025, 44110, 44140, 44141, 44143, 44144, 44145, 44146, 44147, 44150, 44151, 44155, 44156, 44157, 44158, 44160, 44180, 44188, 44204, 44205, 44206, 44207, 44208, 44210, 44211, 44212, 44227, 44238, 44320, 44322, 44340,44345, 44346, 44604, 44605, 44620, 44625, 44626, 44660, 44661, 44680, 44799
	Endocrine	60200, 60210, 60212, 60220, 60225, 60240, 60252, 60254, 60260, 60270, 60271, 60500, 60502, 60505, 60540, 60545, 60650, 60659, 60699
	Esophagus	43020, 43030, 43045, 43100, 43101, 43107, 43108, 43112, 43113, 43116, 43117, 43118, 43121, 43122, 43123, 43124, 43130, 43135, 43279, 43280, 43281, 43282, 43289, 43300, 43305, 43310, 43312, 43313, 43320, 43325, 43327, 43328, 43330, 43331, 43332, 43333, 43334, 43335, 43336, 43337, 43340, 43341, 43351, 43352, 43360, 43361, 43400, 43401, 43405, 43410, 43415, 43420, 43425, 43496

Specialty	Surgical Procedure	CPT code
	Integumentary	10121, 10140, 10160, 10180, 11000, 11001, 11004, 11005, 11006, 11010, 11011, 11042, 11043, 11044, 11401, 11402, 11403, 11404, 11406, 11420, 11421, 11422, 11423, 11424, 11426, 11440, 11441, 11442, 11443, 11444, 11446, 11601, 11602, 11603, 14301, 15040, 15150, 15155, 15200, 15220, 15240, 15260, 15570, 15572, 15574, 15576, 15600, 15610, 15620, 15630, 15650, 15731, 15732, 15734, 15736, 15738, 15740, 15750, 15756, 15757, 15758, 15760, 15770, 15830, 15920, 15922, 15931, 15933, 15934, 15935, 15936, 15937, 15940, 15941, 15944, 15945, 15946, 15950, 15951, 15953, 15956, 15958, 20005, 20922, 20926, 20938, 21011, 21012, 21013, 21014, 21015, 21016, 21501, 21502, 21510, 21552, 21554, 21555, 21556, 21557, 21558, 21920, 21925, 21930, 21931, 21932, 21933, 21935, 21936, 22900, 22901, 22902, 22903, 22904, 22905, 22999, 23030, 23071, 23073, 23075, 23076, 23077, 23078, 24065, 24066, 24071, 24073, 24075, 24076, 24077, 24079, 25065, 25066, 25071, 25073, 25075, 25076, 25077, 25078, 26111, 26113, 26115, 26116, 26117, 26118, 26990, 27040, 27041, 27043, 27045, 27047, 27048, 27049, 27059, 27301, 27327, 27328, 27329, 27337, 27339, 27364, 27365, 27603, 27615, 27616, 27618, 27619, 27632, 27634, 28039, 28041, 28043, 28045, 28046, 28047
General Surgery	Liver	47010, 47015, 47100, 47120, 47122, 47125, 47130, 47300, 47350, 47360, 47361, 47362, 47370, 47371, 47379, 47380, 47381, 47382, 47399, 47400
	Mediastinum and Diaphragm	39501, 39503, 39540, 39541, 39545, 39560, 39561, 39599
	Pancreas	48000, 48020, 48100, 48105, 48120, 48140, 48145, 48146, 48148, 48150, 48152, 48153, 48154, 48155, 48500, 48510, 48520, 48540, 48545, 48548, 48999
	Small intestine	44005, 44010, 44020, 44021, 44050, 44055, 44120, 44125, 44126, 44127, 44130, 44186, 44187, 44202, 44310, 44312, 44314, 44316, 44602, 44603, 44615, 44640, 44650, 44700, 48547
	Spleen & Lymph nodes	38100, 38101, 38115, 38120, 38129, 38305, 38308, 38380, 38381, 38382, 38542, 38550, 38555, 38562, 38564, 38570, 38571, 38572, 38589, 38700, 38720, 38724, 38740, 38745, 38760, 38765, 38770, 38780, 38999
	Stomach	43500, 43501, 43502, 43510, 43520, 43605, 43610, 43611, 43620, 43621, 43622, 43631, 43632, 43633, 43634, 43640, 43641, 43651, 43652, 43659, 43800, 43810, 43820, 43825, 43832, 43840, 43850, 43855, 43860, 43865, 43870, 43880, 43999, 64755, 64760
ENT	Laryngectomy	31360, 31365, 31367, 31370, 31375, 31380, 31382, 31390, 31395

Specialty	Surgical Procedure	CPT code
	ENT - other	20100, 21025, 21026, 21034, 21040, 21044, 21045, 21046, 21047, 21048, 21049, 21139, 21154, 21235, 21299, 21360, 21395, 21462, 21465, 21499, 31300, 31320, 31400, 31420, 31580, 31587, 31590, 31599, 31611, 31614, 40812, 40814, 40816, 41000, 41005, 41007, 41008, 41009, 41016, 41017, 41018, 41110, 41112, 41113, 41114, 41116, 41120, 41130, 41135, 41140, 41145, 41150, 41153, 41155, 41599, 41806, 41820, 41822, 41823, 41825, 41826, 41830, 41850, 42104, 42106, 42107, 42120, 42140, 42145, 42160, 42300, 42305, 42330, 42335, 42340, 42408, 42409, 42410, 42415, 42420, 42425, 42426, 42440, 42450, 42500, 42505, 42507, 42665, 42699, 42700, 42720, 42725, 42808, 42810, 42815, 42821, 42826, 42831, 42836, 42842, 42844, 42845, 42870, 42890, 42892, 42894, 42950, 42953, 42955, 42960, 42961, 42962, 42972, 42999, 60280, 60281, 60520, 69511, 69530, 69601, 69602, 69603, 69604, 69610, 69631, 69632, 69633, 69635, 69636, 69637, 69642, 69644, 69645, 69646, 69801
Gynecologic Surgery	Hyst/Myomectomy	58140, 58145, 58146, 58150, 58152, 58180, 58200, 58210, 58240, 58260, 58262, 58263, 58267, 58270, 58275, 58280, 58285, 58290, 58291, 58292, 58293, 58294, 58541, 58542, 58543, 58544, 58545, 58546, 58548, 58550, 58552, 58553, 58554, 58570, 58571, 58572, 58573, 58940, 58943, 58950, 58951, 58952, 58953, 58954, 58956
	Gynecologic reconstruction	57260, 57265, 57268, 57270, 57280, 57282, 57283, 57291, 57292
	Gynecology - other	56405, 56420, 56440, 56501, 56515, 56620, 56625, 56630, 56631, 56632, 56633, 56634, 56637, 56640, 56740, 56800, 56810, 57000, 57010, 57065, 57106, 57107, 57109, 57110, 57120, 57130, 57135, 57200, 57210, 57240, 57250, 57284, 57285, 57295, 57296, 57300, 57305, 57307, 57308, 57335, 57423, 57425, 57522, 57530, 57531, 57540, 57550, 57555, 57556, 57720, 58120, 58356, 58400, 58520, 58540, 58578, 58579, 58700, 58720, 58740, 58750, 58752, 58760, 58770, 58800, 58805, 58820, 58822, 58825, 58920, 58925, 58957, 58958, 58960, 59120, 59121, 59130, 59136, 59140, 59150, 59151, 59350
Urology	Urogynecology	51990, 51992, 57288, 57289, 57310, 57311, 57320, 57330
	Cystectomy	51550, 51555, 51565, 51570, 51575, 51580, 51585, 51590, 51595, 51596, 51597
	Nephrectomy	50220, 50225, 50230, 50234, 50236, 50240, 50543, 50545, 50546, 50548
	Prostatectomy	55801, 55810, 55812, 55815, 55821, 55831, 55840, 55842, 55845, 55866
	TURP	52601, 52630, 52647, 52648, 52649
	Urogynecology	51990, 51992, 57288, 57289, 57310, 57311, 57320, 57330

Specialty	Surgical Procedure	CPT code
	Urology - other	50010, 50020, 50060, 50065, 50075, 50120, 50130, 50135, 50205, 50250, 50280, 50290, 50389, 50400, 50405, 50500, 50540, 50541, 50542, 50544, 50549, 50610, 50630, 50650, 50660, 50700, 50715, 50725, 50727, 50728, 50740, 50750, 50760, 50770, 50780, 50782, 50783, 50785, 50800, 50810, 50815, 50820, 50825, 50830, 50840, 50845, 50860, 50900, 50940, 50945, 50947, 50948, 50949, 51040, 51045, 51050, 51060, 51065, 51080, 51500, 51525, 51530, 51535, 51800, 51820, 51840, 51841, 51845, 51860, 51865, 51880, 51900, 51920, 51960, 51980, 51999, 52234, 52235, 52240, 52320, 52341, 52342, 52344, 52345, 52346, 52400, 52402, 52450, 52500, 52640, 52700, 53000, 53010, 53040, 53210, 53220, 53215, 53230, 53235, 53240, 53260, 53265, 53400, 53405, 53410, 53415, 53420, 53425, 53431, 53440, 53442, 53444, 53445, 53446, 53447, 53449, 53450, 53460, 53505, 53510, 53520, 53852, 53899, 54015, 54050, 54057, 54065, 54110, 54111, 54112, 54115, 54120, 54125, 54130, 54135, 54300, 54308, 54324, 54326, 54340, 54344, 54348, 54352, 54360, 54420, 54430, 54435, 54440, 54520, 54522, 54530, 54535, 54550, 54600, 54620, 54640, 54650, 54660, 54670, 54680, 54690, 54692, 54840, 54860, 54861, 54901, 55040, 55041, 55060, 55100, 55110, 55120, 55150, 55175, 55180, 55200, 55530, 55535, 55540, 55550, 55600, 55680, 55862, 55873, 55876, 55899
Hand	Hand	25000, 25001, 25040, 25085, 25101, 25105, 25107, 25110, 25111, 25112, 25115, 25116, 25118, 25130, 25135, 25136, 25145, 25210, 25215, 25240, 25260, 25263, 25265, 25270, 25274, 25275, 25280, 25290, 25295, 25301, 25310, 25312, 25320, 25332, 25337, 25430, 25431, 25440, 25442, 25445, 25446, 25447, 25449, 25607, 25608, 25609, 25628, 25645, 25652, 25670, 25676, 25685, 25695, 26350, 26352, 26356, 26357, 26358, 26370, 26372, 26373, 26390, 26392, 26410, 26415, 26418, 26420, 26426, 26433, 26434, 26437, 26440, 26442, 26445, 26449, 26450, 26455, 26460, 26471, 26477, 26478, 26480, 26483, 26485, 26489, 26490, 26492, 26496, 26497, 26498, 26500, 26502, 26510, 26520, 26525, 26530, 26531, 26535, 26536, 26540, 26541, 26542, 26545, 26546, 26548, 26561, 26565, 26567, 26568, 26587, 26591, 26593, 26615, 26650, 26665, 26676, 26685, 26686, 26715, 26727, 26735, 26746, 26765, 26776, 26785, 26989, 29844, 29846, 29847, 29904, 35207
Neurological Surgery	Brain tumor	61510, 61512, 61518, 61519, 61520, 61521, 61526, 61530, 61545, 61546
	Neurosurgery – other	61304, 61305, 61312, 61313, 61314, 61315, 61320, 61321, 61322, 61323, 61330, 61332, 61333, 61340, 61343, 61345, 61450, 61458, 61460, 61500, 61501, 61514, 61516, 61522, 61524, 61531, 61533, 61534, 61535, 61536, 61537, 61538, 61539, 61540, 61541, 61548, 61556, 61557, 61566, 61570, 61575, 61590, 61680, 61682, 61684, 61686, 61690, 61692, 61697, 61698, 61700, 61702, 61703, 61705, 61710, 61711, 61860, 61880, 61885, 61886, 61888, 62000, 62005, 62010, 62100, 63700, 63707, 63709, 64702, 64704, 64708, 64713, 64722, 64727, 64804, 64809, 64818, 64856, 64862
Orthopaedics	Amputation of lower extremity	27295, 27590, 27591, 27592, 27594, 27596, 27598, 27880, 27881, 27882, 27884, 27886, 27888, 27889, 28800, 28805, 28810, 28820, 28825
	Foot and Ankle	27702, 27703, 27704, 28192, 28193, 28293, 28415, 28420, 28445, 28465, 28485, 28505, 28525, 28531, 28555, 28585, 28615, 28645, 28675, 28705, 28715, 28725, 28730, 28735, 28737

Specialty	Surgical Procedure	CPT code
	Hip Reconstruction	27125, 27130, 27132, 27134, 27137, 27138
	Knee Reconstruction	27440, 27441, 27442, 27443, 27445, 27446, 27447, 27486, 27487
	Trauma (Fractures)	27202, 27226, 27227, 27228, 27235, 27236, 27244, 27245, 27248, 27254, 27269, 27758, 27759, 27766, 27769, 27792, 27814
Orthopaedics	Orthopaedics - other	20103, 20150, 20696, 20900, 20902, 20910, 20955, 20956, 20999, 23000, 23020, 23031, 23035, 23040, 23044, 23101, 23106, 23107, 23120, 23125, 23130, 23140, 23146, 23150, 23156, 23170, 23180, 23182, 23184, 23190, 23195, 23200, 23210, 23220, 23395, 23397, 23400, 23405, 23410, 23412, 23415, 23420, 23430, 23440, 23450, 23455, 23460, 23462, 23465, 23466, 23470, 23472, 23480, 23485, 23491, 23515, 23530, 23532, 23550, 23552, 23585, 23615, 23616, 23630, 23660, 23670, 23680, 23800, 23802, 23900, 23920, 23929, 23935, 24000, 24006, 24102, 24105, 24116, 24120, 24125, 24130, 24134, 24136, 24140, 24145, 24149, 24150, 24152, 24201, 24301, 24310, 24320, 24330, 24332, 24340, 24341, 24342, 24344, 24345, 24346, 24358, 24359, 24360, 24361, 24363, 24365, 24366, 24400, 24430, 24435, 24495, 24498, 24515, 24516, 24538, 24545, 24546, 24575, 24579, 24586, 24587, 24615, 24635, 24665, 24666, 24685, 24800, 24802, 24900, 24920, 24925, 24999, 25020, 25023, 25024, 25025, 25120, 25125, 25150, 25151, 25170, 25230, 25248, 25315, 25350, 25355, 25360, 25375, 25390, 25391, 25392, 25400, 25405, 25415, 25420, 25443, 25490, 25515, 25525, 25526, 25545, 25574, 25575, 25900, 25905, 25909, 25920, 25927, 25999, 26117, 26121, 26123, 26130, 26145, 26180, 26952, 26991, 26992, 27000, 27001, 27005, 27006, 27025, 27027, 27030, 27033, 27035, 27036, 27054, 27057, 27060, 27062, 27065, 27066, 27070, 27071, 27075, 27076, 27077, 27078, 27080, 27086, 27087, 27097, 27110, 27120, 27122, 27140, 27146, 27147, 27151, 27156, 27158, 27161, 27165, 27170, 27176, 27177, 27179, 27181, 27187, 27238, 27253, 27258, 27259, 27267, 27280, 27290, 27299, 27303, 27305, 27307, 27310, 27331, 27332, 27333, 27334, 27335, 27340, 27345, 27347, 27350, 27355, 27356, 27357, 27360, 27365, 27372, 27380, 27381, 27385, 27386, 27390, 27392, 27403, 27405, 27407, 27409, 27412, 27415, 27416, 27418, 27420, 27422, 27424, 27425, 27427, 27428, 27429, 27430, 27435, 27437, 27438, 27448, 27450, 27454, 27455, 27457, 27465, 27466, 27468, 27470, 27472, 27477, 27485, 27488, 27495, 27496, 27497, 27498, 27499, 27506, 27507, 27509, 27511, 27513, 27514, 27519, 27524, 27535, 27536, 27540, 27556, 27557, 27566, 27580, 27599, 27600, 27601, 27602, 27604, 27605, 27606, 27607, 27610, 27612, 27620, 27625, 27626, 27630, 27635, 27637

Specialty	Surgical Procedure	CPT code
Orthopaedics	Orthopaedics - other	27638, 27640, 27641, 27645, 27646, 27647, 27650, 27652, 27654, 27656, 27658, 27659, 27664, 27665, 27675, 27676, 27680, 27681, 27685, 27686, 27687, 27695, 27696, 27698, 27700, 27705, 27707, 27709, 27715, 27720, 27722, 27724, 27725, 27726, 27745, 27756, 27784, 27822, 27823, 27826, 27827, 27828, 27829, 27832, 27846, 27848, 27892, 27893, 27894, 27899, 28002, 28003, 28446, 29806, 29807, 29819, 29820, 29821, 29822, 29823, 29824, 29825, 29827, 29828, 29834, 29835, 29837, 29838, 29850, 29855, 29862, 29866, 29867, 29868, 29871, 29873, 29874, 29875, 29876, 29877, 29879, 29880, 29881, 29882, 29883, 29884, 29885, 29886, 29887, 29888, 29889, 29891, 29893, 29895, 29897, 29898, 29905, 29906, 29907, 29914, 29915, 29916, 29999, 38230
Spine	Spine	0202T, 22010, 22015, 22100, 22101, 22102, 22110, 22112, 22114, 22206, 22207, 22210, 22212, 22214, 22220, 22222, 22224, 22318, 22319, 22325, 22326, 22327, 22532, 22533, 22548, 22551, 22554, 22556, 22558, 22586, 22590, 22595, 22600, 22610, 22612, 22630, 22800, 22802, 22804, 22808, 22810, 22812, 22818, 22819, 22830, 22841, 22849, 22850, 22852, 22855, 22856, 22857, 22861, 22862, 22864, 22865, 22899, 63001, 63003, 63005, 63011, 63012, 63015, 63016, 63017, 63020, 63030, 63040, 63042, 63045, 63046, 63047, 63050, 63051, 63055, 63056, 63064, 63075, 63077, 63081, 63085, 63087, 63088, 63090, 63101, 63102, 63170, 63172, 63173, 63180, 63182, 63185, 63190, 63191, 63194, 63195, 63196, 63197, 63198, 63199, 63200, 63250, 63251, 63252, 63265, 63266, 63267, 63268, 63270, 63271, 63272, 63273, 63275, 63276, 63277, 63278, 63280, 63281, 63282, 63283, 63285, 63286, 63287, 63290, 63300, 63301, 63302, 63303, 63304, 63305, 63306, 63307
Thoracic	Lung resection	32440, 32442, 32445, 32480, 32482, 32484, 32486, 32488, 32491, 32503, 32504, 32505, 32663, 32666, 32669, 32670, 32671, 32672
	Thoracic - other	19260, 19271, 19272, 20101, 21620, 21627, 21630, 21632, 21685, 21740, 21742, 21743, 21750, 21805, 21825, 21899, 31750, 31755, 31760, 31775, 31780, 31781, 31785, 31786, 31800, 31820, 31825, 31899, 32035, 32036, 32100, 32110, 32120, 32124, 32140, 32141, 32150, 32151, 32160, 32200, 32215, 32220, 32225, 32310, 32320, 32540, 32560, 32650, 32651, 32652, 32653, 32654, 32655, 32656, 32658, 32659, 32661, 32662, 32664, 32665, 32800, 32810, 32815, 32820, 32900, 32905, 32906, 32940, 32999, 33020, 33025, 33030, 33031, 33050, 33300, 33310, 33320, 39000, 39010, 39200, 39220, 39400, 39499, 40510, 40520, 40525, 40530, 40650, 40652, 40800, 40801, 40810, 41006, 42210, 60521, 60522
Vascular	Abdominal aortic aneurysm	34800, 34802, 34803, 34804, 34805, 34825, 34830, 34831, 34832, 35081, 35082, 35091, 35092, 35102, 35103,
	Aortoiliac	0236T, 0238T 35331, 35351, 35355, 35361, 35363, 35472, 35521, 35533, 35537, 35538, 35539, 35540, 35558, 35563, 35565, 35621, 35623, 35637, 35638, 35646, 35647, 35654, 35661, 35663, 35665, 37220, 37221
	Carotid artery	35301, 37215
	Lower extremity	35556, 35566, 35571, 35583, 35585, 35587, 35656, 35666, 35671, 37224, 37225, 37226, 37227, 37228, 37229, 37230, 37231
	Varicose veins	36475, 36478, 37700, 37718, 37722, 37735, 37760, 37761, 37765, 37766, 37785

Specialty	Surgical Procedure	CPT code
Vascular	Vascular - other	21600, 21615, 21616, 21700, 21705, 33875, 33877, 33880, 33881, 33883, 33886, 33889, 33891, 34001, 34051, 34101, 34111, 34151, 34201, 34203, 34401, 34421, 34451, 34471, 34490, 34501, 34502, 34510, 34520, 34530, 34812, 34820, 34833, 34834, 34900, 35001, 35002, 35005, 35011, 35013, 35021, 35045, 35111, 35112, 35121, 35122, 35131, 35132, 35141, 35142, 35151, 35152, 35184, 35189, 35190, 35201, 35206, 35211, 35216, 35221, 35226, 35231, 35236, 35246, 35251, 35256, 35261, 35266, 35271, 35281, 35286, 35302, 35303, 35304, 35305, 35311, 35321, 35341, 35371, 35372, 35471, 35501, 35506, 35508, 35509, 35510, 35512, 35515, 35516, 35518, 35522, 35523, 35525, 35526, 35531, 35535, 35536, 35560, 35570, 35601, 35606, 35612, 35616, 35626, 35631, 35632, 35633, 35634, 35636, 35642, 35645, 35650, 35691, 35693, 35694, 35695, 35701, 35721, 35741, 35761, 35800, 35820, 35840, 35860, 35870, 35875, 35876, 35879, 35881, 35883, 35884, 35901, 35903, 35905, 35907, 36818, 36819, 36820, 36821, 36825, 36830, 36838, 37140, 37160, 37180, 37181, 37500, 37565, 37605, 37607, 37615, 37616, 37617, 37618, 37650, 37660, 37718, 37780, 37799, 60600, 60605, 61613

NUMERATOR:

Documentation of empirical, personalized risk assessment based on the patient's risk factors with a validated risk calculator using multi-institutional clinical data, the specific risk calculator used, and communication of risk assessment from risk calculator with the patient and/or family

Numerator Instructions: The number of adult patients (age 18 and over) having had non-emergency surgery as defined by CPT codes during the reporting period who had their personalized risk of procedure-specific, 30-day postoperative complications assessed and documented by their surgeon prior to surgery using a clinical data-based, patient-specific risk-calculator* and who had a documented personal discussion with their surgeon about these risks.

The procedure-specific, patient-specific, data-based risk calculator should be based on a validated, risk-adjusted statistical model predicting 30-day postoperative complications (detailed below) for the procedure that the patient is to undergo. Risk calculations should be based on preoperative patient-specific clinical data, and should include the following groups of variables: patient demographic characteristics (eg, age, gender); relevant lifestyle and clinical risk factors (eg, smoking status, American Society of Anesthesiologists class, body mass index); patient comorbidities (eg, diabetes; neurologic event/disease; disseminated cancer); and procedure type.

Postoperative complications should include 30-day risk-adjusted mortality, 30-day risk-adjusted overall morbidity (superficial surgical site infection, deep incisional surgical site infection, wound dehiscence, pneumonia, deep venous thrombosis; pneumonia; renal failure; urinary tract infection; prolonged ventilator dependence; bleeding complications; sepsis; and pulmonary embolism), serious complications (cardiac arrest; myocardial infarction, pneumonia; progressive renal insufficiency; acute renal failure; pulmonary embolism; deep venous thrombosis; return to the operating room deep incisional surgical site infection; organ space surgical site infection; systemic sepsis; unplanned intubation; urinary tract infection; and wound dehiscence), surgical site infection, and average length of stay.

Risk calculators based on multi-institutional, validated clinical data are acceptable for this measure. ACS NSQIP now offers a risk calculator which can be used for operations in many surgical subspecialty (http://www.riskcalculator.facs.org). Other risk calculators are available and acceptable for this measure, including but not limited to the risk calculator from the Society of Thoracic Surgeons.

Numerator Options:

Performance Met:	Documentation of patient-specific risk assessment with a risk calculator based on multi-institutional clinical data, the specific risk calculator used, and communication of risk assessment from risk calculator with the patient or family **(G9316)**
OR	
Performance Not Met:	Documentation of patient-specific risk assessment with a risk calculator based on multi-institutional clinical data, the specific risk calculator used, and communication of risk assessment from risk calculator with the patient or family **not** completed **(G9317)**

RATIONALE:

Preoperative risk assessment and communication between surgeons and patients is critical for effective informed consent and shared decision making in surgical care. Shared decision-making is considered an integral component of patient-centered care, especially for preference-sensitive issues. Evidence suggests that there is room for improving communication and the informed consent/shared decision-making processes between physicians and patients. Use of a risk calculator helps improve the quality of the informed consent/shared decision-making process by providing a personalized, customized, empirically-based estimate of a patient's risk of post-operative complications. Moreover, evidence suggests that sharing numeric estimates of patient-specific risk may enhance patient trust in providers.

CLINICAL RECOMMENDATION STATEMENTS:

Preoperative risk assessment and communication between surgeons and patients is critical for effective informed consent and shared decision making in surgical care. Shared decision-making is considered an integral component of patient-centered care, especially for preference-sensitive issues. Evidence suggests that there is room for improving communication and the informed consent/shared decision-making processes between physicians and patients. Use of a risk calculator helps improve the quality of the informed consent/shared decision-making process by providing a personalized, customized, empirically-based estimate of a patient's risk of post-operative complications. Moreover, evidence suggests that sharing numeric estimates of patient-specific risk may enhance patient trust in providers.

♠ Measure #383 (NQF 1879): Adherence to Antipsychotic Medications For Individuals with Schizophrenia – National Quality Strategy Domain: Patient Safety

2015 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
The measure calculates the percentage of individuals aged 18 years and older as of the beginning of the measurement period with schizophrenia or schizoaffective disorder who are prescribed an antipsychotic medication, with adherence to the antipsychotic medication [defined as a Proportion of Days Covered (PDC)] of at least 0.8 during the measurement period (12 consecutive months).

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

Measure Reporting via Registry:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, HCPCS codes, and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

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

DENOMINATOR:
Individuals aged 18 years and older as of the beginning of the measurement period with schizophrenia or schizoaffective disorder with at least two claims for any antipsychotic medication during the measurement period (12 consecutive months)

> ***DENOMINATOR NOTE:*** *The following are the oral antipsychotic medications by class for the denominator. The route of administration includes all oral formulations of the medications listed below.*
>
> **TYPICAL ANTIPSYCHOTIC MEDICATIONS:**
> - chlorpromazine
> - fluphenazine
> - haloperidol
> - loxapine
> - molindone
> - perphenazine
> - perphenazine-amitriptyline
> - pimozide
> - prochlorperazine
> - thioridazine
> - thiothixene
> - trifluoperazine
>
> **ATYPICAL ANTIPSYCHOTIC MEDICATIONS:**
> - aripiprazole

- asenapine
- clozapine
- olanzapine
- olanzapine-fluoxetine
- iloperidone
- lurasidone
- paliperidone
- quetiapine
- risperidone
- ziprasidone

The following are the long-acting (depot) injectable antipsychotic medications by class for the denominator. The route of administration includes all injectable and intramuscular formulations of the medications listed below.

TYPICAL ANTIPSYCHOTIC MEDICATIONS:

- fluphenazine decanoate (J2680)
- haloperidol decanoate (J1631)

ATYPICAL ANTIPSYCHOTIC MEDICATIONS:

- olanzapine pamoate (J2358)
- paliperidone palmitate (J2426)
- risperidone microspheres (J2794)

NOTE: *Since the days' supply variable is not reliable for long-acting injections in administrative data, the days' supply is imputed as listed below for the long-acting (depot) injectable antipsychotic medications billed under Part D and Part B:*

- *fluphenazine decanoate (J2680) – 28 days' supply*
- *haloperidol decanoate (J1631) – 28 days' supply*
- *olanzapine pamoate (J2358) – 28 days' supply*
- *paliperidone palmitate (J2426) – 28 days' supply*
- *risperidone microspheres (J2794) – 14 days' supply*

Denominator Criteria (Eligible Cases):

Patients aged ≥ 18 years at the beginning of the measurement year

AND

Diagnosis for schizophrenia or schizoaffective disorder (ICD-9-CM) [for use 1/1/2015-9/30/2015]: 295.00, 295.01, 295.02, 295.03, 295.04, 295.05, 295.10, 295.11, 295.12, 295.13, 295.14, 295.15, 295.20, 295.21, 295.22, 295.23, 295.24, 295.25, 295.30, 295.31, 295.32, 295.33, 295.34, 295.35, 295.40, 295.41, 295.42, 295.43, 295.44, 295.45, 295.50, 295.51, 295.52, 259.53, 295.54, 295.55, 295.60, 295.61, 295.62, 295.63, 295.64, 295.65, 295.70, 295.71, 295.72, 295.73, 295.74, 295.75,295.80, 295.81, 295.82, 295.83, 295.84, 295.85, 295.90, 295.91, 295.92, 295.93, 295.94, 295.95, V11.0

Diagnosis for schizophrenia or schizoaffective disorder (ICD-10-CM) [for use 10/1/2015-12/31/2015]: F20.0, F20.1, F20.2, F20.3, F20.5, F20.81, F20.89, F20.9, F21 F25.0, F25.1, F25.8, F25.9

AND

Patient encounter during the reporting period (CPT or HCPCS): 90785, 90791, 90792, 90832, 90833, 90834, 90836, 90837,90838 98960, 98961,98962, 99078, 99201, 99202, 99203, 99204,99205, 99211, 99212, 99213, 99214,99215, 99217, 99218, 99219, 99220,99224, 99225, 99226, 99281, 99282, 99283, 99284, 99285, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99315, 99316, 99318, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, 99401, 99402, 99403,99404, 99411, 99412, 99429, G0155, G0176, G0177, G0409, G0410,

G0411, G0463, H0002, H0004, H0017, H0018, H0019, H0031, H0034, H0035, H0036, H0037, H0039, H0040, H2000, H2001, H2010,H2011, H2012, H2013, H2014, H2015, H2016, H2017, H2018, H2019,H2020, M0064, S0201, S9480, S9484, S9485, T2048

OR

90845, 90847, 90849, 90853, 90862, 90870, 90875, 90876, 90880, 99291, 99292

WITH

Place of Service (POS): 03, 05, 07, 09, 11, 12, 13, 14, 15, 20, 22, 24, 26, 33, 49, 50, 52, 53, 54, 55, 57, 62, 71, 72

OR

90791, 90792, 90832, 90833, 90834, 90836, 90837, 90838, 90845, 90847, 90849, 90853, 90862, 90870, 90875, 90876, 99291, 99292

WITH

Place of Service (POS): 23

OR

90791, 90792, 90832, 90833, 90834, 90836, 90837, 90838, 90845, 90847, 90849, 90853, 90862, 90870, 90875, 90876, 99291, 99292

WITH

Place of Service (POS): 31, 32, 55, 56, 57, 62

OR

90791, 90792, 90832, 90833, 90834, 90837, 90838, 90845, 90847, 90849, 90853, 90862, 90870, 90875, 90876, 99221, 99222, 99223, 99231, 99232, 99233, 99238, 99239, 99291, 99292

WITH

Place of Service (POS): 21, 51, 61

AND

At least two encounters with a diagnosis of schizophrenia with different dates of service in an outpatient setting, emergency department setting, or nonacute inpatient setting during the measurement period

OR

At least one encounter with a diagnosis of schizophrenia in an acute inpatient setting during the measurement period

AND NOT

Diagnosis for dementia (ICD-9-CM) [for use 1/1/2015-9/30/2015]: 290.0, 290.10, 290.11, 290.12, 290.13, 290.20, 290.21, 290.3, 290.40, 290.41, 290.42, 290.43, 291.2, 294.10, 294.11, 294.20, 294.21, 331.0, 331.19, 331.82

Diagnosis for dementia (ICD-10-CM) [for use 10/1/2015-12/31/2015]: E75.00, E75.01, E75.02, E75.09, E75.10, E75.11, E75.19, E75.4, F01.50, F01.51, F02.80, F02.81, F03, F03.90, F03.91, F05, F10.27, F10.97, F13.27, F13.97, G30.0, G30.1, G30.8, G30.9, G31.09, G31.83

NUMERATOR:

Individuals with schizophrenia or schizoaffective disorder who filled at least two prescriptions for any antipsychotic medication and have a Proportion of Days Covered (PDC) for antipsychotic medications of at least 0.8

NUMERATOR NOTE: *The PDC is calculated as follows:*

PDC NUMERATOR:

The PDC numerator is the sum of the days covered by the days' supply of all antipsychotic prescriptions. The period covered by the PDC starts on the day the first prescription is filled (index date) and lasts through the end of the measurement period, or death, whichever comes first. For prescriptions with a days' supply that extends beyond the end of the measurement period, count only the days for which the drug was available to the individual during the measurement period. If there are prescriptions for the same drug (generic name or 10-digit generic product identifier [GPI]) on the same date of service, keep the prescription

with the largest days' supply. If prescriptions for the same drug (generic name or GPI) overlap, then adjust the latest prescription start date to be the day after the previous fill has ended.

PDC DENOMINATOR:
The PDC denominator is the number of days from the first prescription date through the end of the measurement period, or death date, whichever comes first.

Numerator Options:

Performance Met:	Individual filled at least two prescriptions for any antipsychotic medication and had a PDC of 0.8 or greater **(G9369)**
OR	
Performance Not Met:	Individual who did **not** fill at least two prescriptions for any antipsychotic medication or did not have a PDC of 0.8 or greater **(G9370)**

RATIONALE:
A large body of evidence has shown that antipsychotic medications are effective in treating acute psychotic exacerbations of schizophrenia and in reducing the likelihood of relapse. The Schizophrenia Patient Outcomes Research Team (PORT) recommends that "persons who experience acute symptom relief with an antipsychotic medication should continue to receive this medication for at least 1 year" (Lehman & Steinwachs, 1998), and according to an American Psychiatric Association Clinical Practice Guideline, "antipsychotic medications substantially reduce the risk of relapse in the stable phase of illness and are strongly recommended" (Lehman et al., 2004). This measure will describe the degree of compliance or non-compliance with these recommendations. By providing information on the percentage of schizophrenic individuals with appropriate long-term use of antipsychotic medications, this measure has the potential to improve management of schizophrenia.

This measure relates to mental disorders that have been identified by AHRQ as a priority area for future effectiveness metrics (2009) and by the Institute of Medicine as a priority area (2003).

Approximately 1.1% of the adult American population has schizophrenia (Regier et al., 1993). Individuals suffering from schizophrenia have service utilization rates above 60% (Regier et al.), and the overall U.S. cost of schizophrenia has been estimated at $11.6 to $19.5 billion annually (Andrews et al., 1985). Antipsychotic medications have proven to be effective in treating this disease, and this measure will help to capture the extent of utilization of this treatment.

CLINICAL RECOMMENDATION STATEMENTS:
The 2009 PORT Schizophrenia Psychopharmacological Treatment Recommendations state the following about "Maintenance Antipsychotic Medication Treatment": "People with treatment-responsive, multi-episode schizophrenia who experience acute and sustained symptom relief with an antipsychotic medication should be offered continued antipsychotic treatment in order to maintain symptom relief and to reduce the risk of relapse or worsening of positive symptoms". This recommendation is found on page 76 of the 2009 PORT Treatment Recommendations in the section entitled "Maintenance Pharmacotherapy in Treatment-Responsive People with Schizophrenia" (Buchanan et al., 2010).

¢ Measure #384: Adult Primary Rhegmatogenous Retinal Detachment Repair Success Rate – National Quality Strategy Domain: Effective Clinical Care

2015 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Percentage of surgeries for primary rhegmatogenous retinal detachment where the retina remains attached after only one surgery

INSTRUCTIONS:
This measure is to be calculated when a procedure for primary rhegmatogenous retinal detachment is performed in the sample during the reporting period. This measure is intended to reflect the quality of services provided for the patient receiving primary rhegmatogenous retinal detachment surgery.

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

- *For patients who receive the surgical procedures specified in the denominator coding in the sample, it should be reported whether or not the patient continued to have the retina attached after 6 months following only one surgery.*
- *Include only procedures performed through **June 30** of the reporting period. This will allow the post-operative period to occur before registries must submit data to CMS.*

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

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

DENOMINATOR:
Number of adult primary rhegmatogenous retinal detachment cases with 6 month follow up

> ***DENOMINATOR NOTE:*** Include patients with history of Yag capsulotomy or laser surgery for diabetic or macular edema.
>
> **Denominator Criteria (Eligible Cases):**
> Patients aged ≥ 18 years on the date of the procedure
> **AND**
> **Patient encounter during the reporting period (CPT):** 67113
> **AND NOT**
> Patients with a history of prior retinal surgery, or non-rhematogenous retinal detachments, or retinal detachments of an unclear mechanism, or rhegmatogenous retinal detachments in the setting of traumatic eye injuries, or eyes with early or severe proliferative vitreoretinopathy, or patients with laser retinopexy or cryopexy for a retinal hole or tear, patients with giant retinal tears, or eyes with prior macular hole procedures.

NUMERATOR:
Number of patients with rhegmatogenous retinal detachment surgery success with only one retinal detachment surgery

> **Numerator Options:**

Performance Met:	Patient continued to have the retina attached at the 6 months follow up visit (+/- 1 month following only one surgery **(G9376)**

OR

Performance Not Met:	Patient did not have the retina attached after 6 months following only one surgery **(G9377)**

RATIONALE:

Achieving success with the initial surgery is the most favorable outcome. In a study published in 2011, Schall and colleagues studied the success rate with 4 surgical techniques. Initial success rate for retinal reattachment was 86% for scleral buckling only, 90% for vitrectomy only, 94% for the combination of scleral buckling and vitrectomy, and 63% for pneumatic retinopexy surgery. Patients undergoing pneumatic retinopexy had a lower initial success rate, however there was no statistically significant difference in initial reattachment rates between the other three groups. In a 2002 study Ling and colleagues reported an 85% success rate with a single procedure. Of the 15% that initially failed 97 % were successful with one additional surgery. References: 1. Schall S, Sherman MP, Barr CC, Kaplan HJ, Primary retinal detachment repair: comparison of 1-year outcomes of four surgical techniques. Retina 2011 Sep;31(8):1500-4. 2. Ling, et al, Retinal detachment surgery in district general hospitals: An Audit of Changing Practice, Br J Ophthalmology 2002; 86:827-833, Sullivan PM, Luff AJ, Aylward GW. Results of primary retinal reattachment surgery: a prospective audit. Eye 1997; 11:869-71., Day S, Grossman DS, Mruthyunjaya P, Sloan FA, Lee PP. One year outcomes after retinal detachment surgery among Medicare beneficiaries. Am J Ophthalmol 2010; 150(3):338-45, Massachusetts Eye and Ear Infirmary, Harvard Medical School. Ophthalmology Quality & Outcomes Report 2012.

CLINICAL RECOMMENDATION STATEMENTS:

This is an outcome measure. As such, no clinical recommendations are included.

¢ Measure #385: Adult Primary Rhegmatogenous Retinal Detachment Surgery Success Rate – National Quality Strategy Domain: Effective Clinical Care

2015 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Percentage of retinal detachment cases achieving flat retinas six months post surgery

INSTRUCTIONS:
This measure is to be calculated when a procedure for primary rhegmatogenous retinal detachment is performed in the sample during the reporting period. This measure is intended to reflect the quality of services provided for the patient receiving primary rhegmatogenous retinal detachment surgery.

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

- *For patients who receive the surgical procedures specified in the denominator coding in the sample, it should be reported whether or not the patient achieved flat retinas after 6 months following surgery.*
- *Include only procedures performed through **June 30** of the reporting period. This will allow the post-operative period to occur before registries must submit data to CMS.*

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

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

DENOMINATOR:
Number of adult primary rhegmatogenous retinal detachment cases with 6 month follow up

> ***DENOMINATOR NOTE:*** *Include patients with a history of Yag laser capsulotomy or laser surgery for diabetic or macular edema.*
>
> **Denominator Criteria (Eligible Cases):**
> Patients aged ≥ 18 years on the date of the procedure
> **AND**
> **Patient encounter during the reporting period (CPT):** 67113
> **AND NOT**
> Patients with a history of prior retinal surgery, or non-rhematogenous retinal detachments, or retinal detachments of an unclear mechanism, or rhegmatogenous retinal detachments in the setting of traumatic eye injuries, or eyes with early or severe proliferative vitreoretinopathy, or patients with laser retinopexy or cryopexy for a retinal hole or tear, patients with giant retinal tears, or eyes with prior macular hole procedures.

NUMERATOR:
Number of adult primary rhegmatogenous retinal detachment cases achieving flat retinas six months post surgery

> **Numerator Options:**
> ***Performance Met:*** Patient continued to have the retina attached at the 6 months follow up visit (+/- 1 month) **(G9378)**

OR

Performance Not Met:	Patient did **not** achieve flat retinas six months post surgery **(G9379)**

RATIONALE:
Studies demonstrate that the success rate increases with the recognition of risk factors and the practice of retina subspecialization. International studies report primary rhegmatogenous retinal surgery success rates ranging from 64 to 91%. References: 1. MEEI Quality and Outcomes Report 2011, 2. Wickham, BC, Wong, D, Charteris, DG, Retinal detachment repair by vitrectomy: simplified formulae to estimate the risk of failure, Br J Ophthalmology 2011 Feb 16, Sullivan PM, Luff AJ, Aylward GW. Results of primary retinal reattachment surgery: a prospective audit. Eye 1997; 11:869-71., Day S, Grossman DS, Mruthyunjaya P, Sloan FA, Lee PP. One year outcomes after retinal detachment surgery among Medicare beneficiaries. Am J Ophthalmol 2010; 150(3):338-45, Massachusetts Eye and Ear Infirmary, Harvard Medical School. Ophthalmology Quality & Outcomes Report 2012

CLINICAL RECOMMENDATION STATEMENTS:
This is an outcome measure. As such, no clinical recommendations are included.

Measure #386: Amyotrophic Lateral Sclerosis (ALS) Patient Care Preferences – National Quality Strategy Domain: Person and Caregiver-Centered Experience and Outcomes

2015 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Percentage of patients diagnosed with Amyotrophic Lateral Sclerosis (ALS) who were offered assistance in planning for end of life issues (eg,advance directives, invasive ventilation, hospice) at least once annually

INSTRUCTIONS:
This measure is to be reported a minimum of **once per reporting period** for patients with a diagnosis of ALS during the reporting period. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding. This measure is appropriate for use in outpatient and long term care (eg, nursing home, ambulatory). For each of these settings, there should be documentation in the medical record(s) that advance care planning was discussed or documented.

Measure Reporting via Registry:
ICD-9-CM/ICD-10-CM diagnosis codes and CPT codes are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure.

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

DENOMINATOR:
All patients with a diagnosis of Amyotrophic Lateral Sclerosis (ALS)

Denominator Criteria (Eligible Cases):
Diagnosis of Amyotrophic Lateral Sclerosis (ICD-9-CM) [for use 1/1/2015-9/30/2015]: 335.20
Diagnosis for Amyotrophic Lateral Sclerosis (ICD-10-CM) [for use 10/01/2015-12/31/2015]: G12.21
AND
Patient encounter during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99318, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99354, 99355

NUMERATOR:
Patients who were offered assistance in planning for end of life issues (eg,advance directives, invasive ventilation, or hospice) at least once annually

Definition:
Assistance with end of life issues – assessment of patient concerns, desires and needs relating to end of life issues. Bases on patient's disease progression this may include discussions regarding invasive ventilation, advance directives and hospice.

Numerator Options:

Performance Met:	Patient offered assistance with end of life issues during the measurement period **(G9380)**
OR	
Medical Performance Exclusion:	Documentation of medical reason(s) for **not** offering assistance with end of life issues (eg, patient in hospice

and in terminal phase) during the measurement period **(G9381)**

OR

Performance Not Met: Patient **not** offered assistance with end of life issues during the measurement period **(G9382)**

RATIONALE:

Palliative care should be adopted from the time of diagnosis. Many patients are not adequately informed about advance directives and end of life decision making and many hospice workers are not familiar with ALS. Management of the terminal phase of ALS is unsatisfactory in 33% - 61% of cases in Europe and only 8% of palliative care units are involved from the time of diagnosis.[6] The current system of palliative care in the USA is highly decentralized. Between 60-88% of patients die in a medical facility in some countries and not at home, while over 58% of seriously ill ALS patients do not have hospice care. Approaches to end of life care vary widely and are not standardized either in timing or content.

J Neurol Neurosurg Psychiatry 2011; 82(4):413-8

Neuron Disord 2001; 2(4):203–208

Ann Neurol 2009; 65:S1:S24-8

Amyotroph Lateral Scler Other Motor Neuron Disord 2004; 5:240 –244

Amyotroph Lateral Scler 2001; 2:159

Palliat Med 2000; 14:42

National Hospice and Palliative Care Organization (NHPCO). Facts and Figures: Hospice Care in America. National Hospice and Palliative Care Organization (NHPCO), 2009. Available online at: http://www.nhpco.org/files/public/

Acta Neurol Scand 2010; 122(3):217-23. Epub 2010 Jan 15

Eur J Neurol 2008 Nov;15(11):1245-51

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CLINICAL RECOMMENDATION STATEMENTS:

No clinical recommendation statements provided.

☺Measure #387: Annual Hepatitis C Virus (HCV) Screening for Patients who are Active Injection Drug Users – National Quality Strategy Domain: Effective Clinical Care

2015 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Percentage of patients regardless of age who are active injection drug users who received screening for HCV infection within the 12 month reporting period

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

Measure Reporting via Registry:
ICD-9-CM/ICD-10-CM diagnosis codes and CPT or HCPCS codes are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure.

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

DENOMINATOR:
All patients, regardless of age, who were seen twice for any visit or who had at least one preventive care visit within the 12 month reporting period who are active* injection drug users

Definition:
Active injection drug users: Those who have injected any drug(s) within the past 12 months.

Denominator Criteria (Eligible Cases):
Documentation of active injection drug use
AND
At least one preventive care visit: (CPT or HCPCS): G0438, G0439
OR
At least two visits during the reporting period: (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350
AND NOT
Diagnosis for Chronic Hepatitis C (ICD-9-CM) [for use 1/1/2015-9/30/2015]: 070.44, 070.54
Diagnosis for Chronic Hepatitis C (ICD-10-CM) [for use 10/01/2015-12/31/2015]: B18.2

NUMERATOR:
Patients who received screening for HCV infection within the 12 month reporting period

Definition:
Screening for HCV infection includes HCV antibody test or HCV RNA test

Numerator Options:

Performance Met:	Patient received screening for HCV infection within the 12 month reporting period (**G9383**)

OR

Medical Performance Exclusion:	Documentation of medical reason(s) for not receiving screening for HCV infection within the 12 month reporting period (eg, decompensated cirrhosis indicating advanced disease [ie, ascites, esophageal variceal bleeding, hepatic encephalopathy], hepatocellular carcinoma, or waitlist for organ transplant, limited life expectancy, other medical reasons) (**G9384**)
OR	
Patient Performance Exclusion:	Documentation of patient reason(s) for not receiving screening for HCV infection within the 12 month reporting period (eg, patient declined, other patient reasons) (**G9385**)
OR	
Performance Not Met:	Screening for HCV infection **not** received within the 12 month reporting period, reason not given (**G9386**)

RATIONALE:

In the United States, an estimated 2.7–3.9 million persons (1.0%–1.5%) are living with hepatitis C virus (HCV) infection, and an estimated 17,000 persons were newly infected in 2010, the most recent year that data are available. With an HCV antibody prevalence of 3.25%, persons born during 1945–1965 account for approximately three fourths of all chronic HCV infections among adults in the United States. Although effective treatments are available to clear HCV infection from the body, most persons with HCV do not know they are infected, do not receive needed care (eg, education, counseling, and medical monitoring), and are not evaluated for treatment. Since 1998, routine HCV testing has been recommended by CDC for persons most likely to be infected with HCV. These recommendations were made on the basis of a known epidemiologic association between a risk factor and acquiring HCV infection. HCV testing is the first step toward improving health outcomes for persons infected with HCV.

CLINICAL RECOMMENDATION STATEMENTS:

Verbatim from AASLD and IDSA Recommendations for Testing, Managing, and Treating Hepatitis C, January 2014:
HCV testing is recommended at least once for persons born between 1945 and 1965.
Rating: Class I, Level B
Other persons should be screened for risk factors for HCV infection, and one-time testing should be performed for all persons with behaviors, exposures, and conditions associated with an increased risk of HCV infection.

1) *Risk behaviors*

    a) Injection drug use (current or ever, including those who injected once)
    b) Intranasal illicit drug use

2) *Risk exposures*

    a) Long-term hemodialysis (ever)
    b) Getting a tattoo in an unregulated setting
    c) Healthcare, emergency medical, and public safety workers after needle sticks, sharps, or mucosal exposures to HCV-infected blood
    d) Children born to HCV-infected women
    e) Prior recipients of transfusions or organ transplants, including persons who:

        i) Were notified that they received blood from a donor who later tested positive for HCV infection
        ii) Received a transfusion of blood or blood components, or underwent an organ transplant before July 1992
        iii) Received clotting factor concentrates produced before 1987

iv) Were ever incarcerated

3) Other medical conditions

a) HIV infection
b) Unexplained chronic liver disease and chronic hepatitis including elevated alanine aminotransferase levels

Rating: Class I, Level B
Annual HCV testing is recommended for persons who inject drugs and for HIV-seropositive men who have unprotected sex with men. Periodic testing should be offered to other persons with ongoing risk factors for exposure to HCV.
Rating: Class IIA, Level C
An anti-HCV test is recommended for HCV testing, and if the result is positive, current infection should be confirmed by a sensitive RNA test.
Rating: Class I, Level A
Among persons with a negative anti-HCV test who are suspected of having liver disease, testing for HCV RNA or follow-up testing for HCV antibody is recommended if exposure to HCV occurred within the past 6 months; testing for HCV RNA can also be considered in persons who are immunocompromised.
Rating: Class I, Level C
Among persons suspected of reinfection after previous spontaneous or treatment-related viral clearance, initial HCV-RNA testing is recommended because an anti-HCV test is expected to be positive.
Rating: Class I, Level C
Quantitative HCV RNA testing is recommended prior to the initiation of antiviral therapy to document the baseline level of viremia (ie, baseline viral load).
Rating: Class I, Level A
Testing for HCV genotype is recommended to guide selection of the most appropriate antiviral regimen.
Rating: Class I, Level A
If found to have positive results for anti-HCV test and negative results for HCV RNA by PCR, persons should be informed that they do not have evidence of current (active) HCV infection.
Rating: Class I, Level A
Persons with current (active) HCV infection should receive education and interventions aimed at reducing progression of liver disease and preventing transmission of HCV.
Rating: Class IIa, Level B
Abstinence from alcohol and, when appropriate, interventions to facilitate cessation of alcohol consumption should be advised for all persons with HCV infection.
Rating: Class IIa, level B
Evaluation for other conditions that may accelerate liver fibrosis, including HBV and HIV infections, is recommended for all persons with HCV infection.
Rating: Class IIb, level B
Evaluation for advanced fibrosis is recommended using liver biopsy, imaging, or non-invasive markers in all persons with HCV infection to facilitate an appropriate decision regarding HCV treatment strategy and to determine the need for initiating additional screening measures (eg, hepatocellular carcinoma [HCC] screening).
Rating: Class I, Level B
Vaccination against hepatitis A and hepatitis B is recommended for all persons with HCV infection who are susceptible to these types of viral hepatitis.
Rating: Class IIa, Level C
All persons with HCV infection should be provided education on how to avoid HCV transmission to others.
Rating: Class I, level C
Evaluation by a practitioner who is prepared to provide comprehensive management, including consideration of antiviral therapy, is recommended for all persons with current (active) HCV infection.

Rating: Class IIa, level C
The USPSTF recommends screening for hepatitis C virus (HCV) infection in persons at high risk for infection. The USPSTF also recommends offering 1-time screening for HCV infection to adults born between 1945 and 1965. (Grade B recommendation) (USPSTF, 2013) Assessment of Risk
The most important risk factor for HCV infection is past or current injection drug use. Another established risk factor for HCV infection is receipt of a blood transfusion before 1992. Because of the implementation of screening programs for donated blood, blood transfusions are no longer an important source of HCV infection. In contrast, 60% of new HCV infections occur in persons who report injection drug use within the past 6 months. Additional risk factors include long-term hemodialysis, being born to an HCV-infected mother, incarceration, intranasal drug use, getting an unregulated tattoo, and other percutaneous exposures (such as in health care workers or from having surgery before the implementation of universal precautions). Evidence on tattoos and other percutaneous exposures as risk factors for HCV infection is limited. The relative importance of these additional risk factors may differ on the basis of geographic location and other factors. (USPSTF, 2013)

Measure #388: Cataract Surgery with Intra-Operative Complications (Unplanned Rupture of Posterior Capsule requiring unplanned vitrectomy) – National Quality Strategy Domain: Patient Safety

2015 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Rupture of the posterior capsule during anterior segment surgery requiring vitrectomy

INSTRUCTIONS:
This measure is to be calculated when a procedure for cataracts is performed in the sample during the reporting period. This measure is intended to reflect the quality of services provided for the patient receiving cataract surgery.

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

- *For patients who receive the surgical procedures specified in the denominator coding in the sample, it should be reported whether or not the patient had a rupture of the posterior capsule during anterior segment surgery requiring vitrectomy.*

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

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

DENOMINATOR:
Total number of cataract surgery cases

Denominator Criteria (Eligible Cases):
Patients of any age
AND
Patient encounter during the reporting period (CPT): 66840, 66850, 66852, 66920, 66930, 66940, 66982, 66983, 66984
WITHOUT
Modifier 55 (postoperative management only) OR Modifier 56 (preoperative management only)
AND NOT
Cases with preoperative posterior capsule rupture

NUMERATOR:
Number of cataract surgery cases with unplanned rupture of the posterior capsule requiring vitrectomy

Numerator Instructions: A lower calculated performance rate for this measure indicates better clinical care or control.

Numerator Options:

Performance Met:	Unplanned rupture of the posterior capsule requiring vitrectomy **(G9389)**
OR	
Performance Not Met:	**No** unplanned rupture of the posterior capsule requiring vitrectomy **(G9390)**

RATIONALE:
Unplanned anterior vitrectomies are performed following cataract surgery when vitreous inadvertently prolapses into the anterior segment of the eye. This may result in poor visual outcome and additional complications, including retinal detachment. Studies have shown unplanned Vitrectomy Rates ranging from 1% to 4%. The literature states that this complication occurs more commonly for inexperienced surgeons. References: 1. D.F Chang, Cataract Surgery Complication Rates, How are we doing? Cataract and Refractive Surgery Feb 2012 2. Australasian Clinical Indicator Report 2004-2011, Summary of Results; Ophthalmology; 3. Chan, FM, Au Eong, KG, Phacoemulsification Cataract Surgery and Unplanned Anterior Vitrectomy - it can be bad news, Eye (2003)17, 679

CLINICAL RECOMMENDATION STATEMENTS:
This is an outcome measure. As such, no clinical recommendations are included.

¢ Measure #389: Cataract Surgery: Difference Between Planned and Final Refraction -- National Quality Stategy Domain: Effective Clinical Care

2015 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Percentage of patients who achieve planned refraction within +-1,0 D

INSTRUCTIONS:
This measure is to be calculated when a procedure for cataracts is performed in the sample during the reporting period. This measure is intended to reflect the quality of services provided for the patient receiving cataract surgery.

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

- *For patients who receive the surgical procedures specified in the denominator coding in the sample, it should be reported whether or not the patient had a difference between planned and final refraction.*
- *Include only procedures performed through **November 30** of the reporting period. This will allow the post-operative period to occur before registries must submit data to CMS.*

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

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

DENOMINATOR:
Total number of uncomplicated cataract surgeries with one month follow up

Denominator Criteria (Eligible Cases):
Patients > or = 18 years on date of encounter
AND
Patient encounter during the reporting period (CPT): 66840, 66850, 66852, 66920, 66930, 66940, 66982, 66983, 66984
WITHOUT
Modifier 55 (postoperative management only) OR Modifier 56 (preoperative management only)
AND
One month follow-up visit at least 21 days after cataract procedure
AND
Patient has received his or her corrective lens prescription
AND NOT
Patients with eye diseases other than cataract for the eye that underwent the cataract procedure.

Significant Ocular Condition	Corresponding ICD-9-CM Codes [for use 01/01/2015-09/30/2015]
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

Significant Ocular Condition	Corresponding ICD-9-CM Codes [for use 01/01/2015-09/30/2015]
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	362.50, 362.51, 362.52, 362.53, 362.54, 362.55, 362.56
Posterior Pole	362.57
Degenerative Disorders of Globe	360.20, 360.21, 360.23, 360.24, 360.29
Diabetic Macular Edema	362.07
Diabetic Retinopathy	362.01, 362.02, 362.03, 362.04, 362.05, 362.06
Disorders of Optic Chiasm	377.51, 377.52, 377.53, 377.54
Disorders of Visual Cortex	377.75
Disseminated Chorioretinitis and Disseminated Retinochoroiditis	363.10, 363.11, 363.12, 363.13, 363.14, 363.15
Focal Chorioretinitis and Focal	363.00, 363.01, 363.03, 363.04, 363.05, 363.06, 363.07
Retinochoroiditis	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, 365.9, 365.64, 365.65, 365.81, 365.82, 365.83, 365.89
Hereditary Choroidal Dystrophies	363.50, 363.51, 363.52, 363.53, 363.54, 363.55, 363.56, 363.57
Hereditary Corneal Dystrophies	371.50, 371.51, 371.52, 371.53, 371.54, 371.55, 371.56, 371.57, 371.58
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

Significant Ocular Condition	Corresponding ICD-9-CM Codes [for use 01/01/2015-09/30/2015]
Moderate or Severe Impairment, Better Eye, Profound Impairment Lesser Eye	369.10, 369.17, 369.11, 369.18, 369.12, 369.13, 369.14, 369.15, 369.16
Nystagmus and Other Irregular Eye Movements	379.51
Open Wound of Eyeball	871.0, 871.1, 871.9, 921.3, 871.2, 871.3, 871.4, 871.5, 871.6, 871.7
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, 362,27 362.21, 362.22, 362.23, 362.24, 362.25, 362.26
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, 369.07, 369.01, 369.08 369.02, 369.03, 369.04, 369.05, 369.06
Purulent Endophthalmitis	360.00, 360.01, 360.02, 360.03, 360.04
Retinal Detachment with Retinal Defect	361.00, 361.07 361.01, 361.02, 361.03, 361.04, 361.05, 361.06
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

Significant Ocular Condition	Corresponding ICD-10-CM Codes [for use 10/01/2015-12/31/2015]
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

Significant Ocular Condition	Corresponding ICD-10-CM Codes [for use 10/01/2015-12/31/2015]
Burn Confined to Eye and Adnexa	T26.00XA, T26.01XA, 126.02XA, T26.10XA, T26.11XA, T26.12XA, T26.20XA, T26.21XA, T26.22XA, T26.30XA, T26.31XA, T26.32XA, T26.40XA, T26.41XA, T26.42M, T26.50M, T26.51XA, T26.52XA, T26.60XA, T26.61XA, T26.62M, T26.70XA, T26.71XA, T26.72XA, T26.80XA, T26.81XA, T26.82XA, 126.90XA, 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, H44.311, H44.312, H44.313, H44.319, H44.321, H44.322, H44.323, H44.329, H44.391, H44.392, H44.393, H44.399
Diabetic Macular Edema	E08.311, E08.321, E08.331, E08.341, E08.351, E09.311, E09.321, E09.331, E09.341, E09.351, E10.311, E10.321, E10.331, E10.341, E10.351, E11.311, E11.321, E11.331, E11.341, E11.351, E13.311, E13.321, E13.331, E13.341, E13.351
Diabetic Retinopathy	E08.311, E08.319, E08.321, E08.329, E08.331, E08.339, E08.341, E08.349, E08.351, E08.359, E09.311, E09.319, E09.321, E09.329, E09.331, E09.339, E09.341, E09.349, E09.351, E09.359, E10.311, E10.319, E10.321, E10.329, E10.331, E10.339, E10.341, E10.349, E10.351, E10.359, E11.311, E11.319, E11.321, E11.329, E11.331, E11.339, E11.341, E11.349, E11.351, E11.359, E13.311, El 3.319, 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

Significant Ocular Condition	Corresponding ICD-10-CM Codes [for use 10/01/2015-12/31/2015]
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, H30.013,1130.019, H30.021, H30.022, H30.023, H30.029, H30.031, H30.032, 1130.033, H30.039, H30.041, H30.042, H30.043, H30.049
Glaucoma	H40.10X0, H40.10X1, H40.10X2, H40.10X3, H40.10X4, H40.11X0, H40.11X1, H40.11X2, H40.11X3, H40.11X4, H40.1210, H40.1211, H40.1212, H40.1213, H40.1214, H40.1220, H40.1221, H40.1222, H40.1223, H40.1224, H40.1230, H40.1231, H40.1232, H40.1233, H40.1234, H40.1290, H40.1291, H40.1292, H40.1293, H40.1294, H40.1310, H40.1311, H40.1312, H40.1313, H40.1314, H40.1320, H40.1321, H40.1322, H40.1323, H40.1324, H40.1330, H40.1331, H40.1332, H40.1333, H40.1334, H40.1390, H40.1391, H40.1392, H40.1393, H40.1394, H40.1410, H40.1411, H40.1412, H40.1413, H40.1414, H40.1420, H40.1421, H40.1422, H40.1423, H40.1424, H40.1430, H40.1431, H40.1432, H40.1433, H40.1434, H40.1490, H40.1491, H40.1492, H40.1493, H40.1494, H40.151, H40.152, H40.153, H40.159, 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, 1140.2223, 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
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

Significant Ocular Condition	Corresponding ICD-10-CM Codes [for use 10/01/2015-12/31/2015]
Hereditary Choroidal Dystrophies	H31.20, H31.21, H31.22, H31.23, H31.29
Hereditary Comeal Dystrophies	H18.50, H18.51, H18.52, H18.53, H18.54, H18.55, H18.59
Hereditary Retinal Dystrophies	H35.50, H35.51, H35.52, H35.53, H35.54, H36
Injury to Optic Nerve and Pathways	SO4.01 1A, SO4.012A, SO4.019A, SO4.02M, SO4.031A, SO4.032A, SO4.039A, SO4.041A, SO4.042A, SO4.049A
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, S05.22M, S05.30XA, S05.31XA, S05.32XA, S05.50XA, S05.51XA, S05.52M, S05.60XA, S05.61XA, S05.62XA, S05.70XA, S05.71XA, S05.72M, 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
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, H35.82, H35.89
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

Significant Ocular Condition	Corresponding ICD-10-CM Codes [for use 10/01/2015-12/31/2015]
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:
Number of uncomplicated cataracts in patients without other eye diseases who achieve refraction +-1 D, measured at the one month follow up visit

Numerator Options:

Performance Met: Patient achieves refraction +-1 D for the eye that underwent cataract surgery measured at the one month follow up visit **(G9391)**

OR

Performance Not Met: Patient does **not** achieve refraction +-1 D for the eye that underwent cataract surgery, measured at the one month follow up visit **(G9392)**

RATIONALE
Refractive Outcome is important to the patient and to the surgeon. Planned refraction is something the surgeon and patient discuss at the time of assessment for cataract surgery and is a way to align patient and surgeon expectations of the outcome. Comparing actual outcome to predicted outcome is a valuable measure of success. Kugelberg and Lundstrom published outcomes data from the Swedish registry and found in routine cataract surgeries 75% to 90% of patients ended up with refraction within 1 Diopter of the target refraction. The study describes factors that influenced refractive outcome as older age and use of a clear corneal incision. High volume ophthalmology departments showed a significant difference in absolute prediction error. Another 2009 study by Gale and colleagues reported outcomes improving from 79.7% to 87% within 3 measurement cycles and the authors suggested that a benchmark standard of 85% be established. References: 1. Kugelberg, M.A. and Lundstrom, M, Refractive Outcome After Cataract Surgery, Cataract & Refractive Surgery Today Europe, May 2009: 2. Gale, RP, Johnston, RL, Zuberbuhler, B, McKibbin, M, Benchmark Standards for refractive Outcomes After Cataract Surgery, Eye (London) 2009 Jan;23 (1) 149-52, Kugelberg M, Lundstrom M. Factors related to the degree of success in achieving target refraction in cataract surgery. J Cat Refr Surg 2008;34(11):1935-39., Massachusetts Eye and Ear Infirmary, Harvard Medical School.

Ophthalmology Quality & Outcomes Report 2013., Lum F, Schein O, Schachat AP, Abbott RL, Hoskins HD, Steinberg EP. Initial two years of experience with the AAO Nation Eyecare Outcomes Network (NEON) cataract surgery database. Ophthalmology 2000;107:691-97

CLINICAL RECOMMENDATION STATEMENTS:

This is an outcome measure. As such, no clinical recommendations are included.

☐ Measure #390: Discussion and Shared Decision Making Surrounding Treatment Options – National Quality Strategy Domain: Person and Caregiver-Centered Experience and Outcomes

2015 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Percentage of patients aged 18 years and older with a diagnosis of hepatitis C with whom a physician or other qualified healthcare professional reviewed the range of treatment options appropriate to their genotype and demonstrated a shared decision making approach with the patient. To meet the measure, there must be documentation in the patient record of a discussion between the physician or other qualified healthcare professional and the patient that includes all of the following: treatment choices appropriate to genotype, risks and benefits, evidence of effectiveness, and patient preferences toward treatment

INSTRUCTIONS:
This measure is to be reported a minimum of **once per reporting period** for **all** patients with a diagnosis of chronic hepatitis C seen during the reporting period. This measure is intended to reflect the quality of services provided for patients with chronic hepatitis C who are undergoing evaluation for antiviral treatment. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

Measure Reporting via Registry:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

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

DENOMINATOR:
All patients aged 18 years and older with a diagnosis of chronic hepatitis C

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Diagnosis for chronic hepatitis C (ICD-9-CM) [for use 1/1/2015-9/30/2015]: 070.44, 070.54, 070.70, 070.71
Diagnosis for chronic hepatitis C (ICD-10-CM) [for use 10/1/2015-12/31/2015]: B18.2, B19.20, B19.21
AND
Patient encounter during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215

NUMERATOR:
Patients with whom a physician or other clinician reviewed the range of treatment options appropriate to their genotype and demonstrated a shared decision making approach with the patient

Numerator Options:

Performance Met:	Documentation in the patient record of a discussion between the physician/clinician and the patient that includes all of the following: treatment choices appropriate to genotype, risks and benefits, evidence of

		effectiveness, and patient preferences toward the outcome of the treatment **(G9399)**
OR		
	Other Performance Exclusion:	Documentation of medical or patient reason(s) for not discussing treatment options. Medical reasons: Patient is not a candidate for treatment due to advanced physical or mental health comorbidity (including active substance use); currently receiving antiviral treatment; successful antiviral treatment (with sustained virologic response) prior to reporting period; other documented medical reasons. Patient reasons: Patient unable or unwilling to participate in the discussion or other patient reasons **(G9400)**
OR		
	Performance Not Met:	**No** documentation of a discussion in the patient record of a discussion between the physician or other qualified healthcare professional and the patient that includes all of the following: treatment choices appropriate to genotype, risks and benefits, evidence of effectiveness, and patient preferences toward treatment **(G9401)**

RATIONALE:

Shared decision making has the potential to provide numerous benefits for patients, clinicians, and the health care system, including increased patient knowledge, less anxiety over the care process, improved health outcomes, reductions in unwarranted variation in care and costs, and greater alignment of care with patients' values (Lee, E., & Emanuel, E., 2013). In hepatitis C, the decision about whether to initiate treatment is sensitive to patient preferences about achieving cure and limiting symptoms versus tolerating side effects of medications (Colter, et. al., 2001). It is also intuitive that patients are more likely to be adherent to treatment if they are engaged in the decision to start. Numerous studies have documented problems with patient-physician communication in this population (Zickmund, et. al., 2004), and patient misperceptions and lack of education have been implicated as barriers to treatment (Zickmund & Bielefeldt, 2007; Richmond, et. al., 2007; McNally's, et. al., 2006). For these reasons, it is likely that shared decision making would improve decision quality, result in more effective antiviral therapy, and better patient health outcomes.

CLINICAL RECOMMENDATION STATEMENTS:

The decision to defer treatment for a specific patient should consider the patient's preferences and priorities, the natural history and risk of progression, the presence of co-morbidities, and the patient's age. (EASL, 2014).

Treatment decisions should be individualized based on the severity of liver disease, the potential for serious side effects, the likelihood of treatment response, the presence of comorbid conditions, and the patient's readiness for treatment (Class IIa, Level C). (AASLD, 2009)

The Institute of Medicine endorses shared decision-making and the strongly recommends use of decision aids as a way to foster patient-centered care (Committee on Quality of Health Care in American Institute of Medicine. Crossing the Quality Chasm: A New Health System for the 21st Century. Washington, DC: National Academies Press; 2001)

♦ Measure #391 (NQF 0576): Follow-Up After Hospitalization for Mental Illness (FUH) – National Quality Strategy Domain: Communication and Care Coordination

2015 PHYSICIAN QUALITY REPORTING OPTIONS FOR INDIVIDUAL MEASURES
REGISTRY ONLY

DESCRIPTION:
The percentage of discharges for patients 6 years of age and older who were hospitalized for treatment of selected mental illness diagnoses and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner. Two rates are reported:

- The percentage of discharges for which the patient received follow-up within 30 days of discharge.
- The percentage of discharges for which the patient received follow-up within 7 days of discharge.

INSTRUCTIONS:
This measure is to be reported at each outpatient visit, intensive outpatient visit, or partial hospitalization occurring within 30 and 7 days of each inpatient setting discharge with a principal diagnosis of mental illness. **This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.**

NOTE: *Discharged from an acute inpatient setting (including acute care psychiatric facilities) with a principal diagnosis of mental illness on or between January 1 and December 1 of the measurement period. The denominator for this measure is based on discharges, not on patients. If patients have more than one discharge, include all discharges on or between January 1 and December 1 of the measurement period.*

Use only discharges from the facility to identify denominator events (including readmissions or direct transfers). Do not use professional claims.

If the discharge is followed by readmission or direct transfer to an *acute facility* for a principal diagnosis of mental health within the 30-day follow-up period, count only the readmission discharge or the discharge from the facility to which the patient was transferred.

This measure will be calculated with 2 performance rates:

1) **The percentage of discharges for which the patient received follow-up within 30 days of discharge**

AND

2) **The percentage of discharges for which the patient received follow-up within 7 days of discharge**

Measure Reporting via Registry:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT or HCPCS codes, and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

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

There are two reporting criteria for this measure:

1) **The percentage of discharges for which the patient received follow-up within 30 days of discharge**

AND

2) **The percentage of discharges for which the patient received follow-up within 7 days of discharge**

REPORTING CRITERIA 1: The percentage of discharges for which the patient received follow-up within 30 days of discharge

DENOMINATOR (REPORTING CRITERIA 1):
Patients 6 years of age and older who were discharged from an acute inpatient setting (including acute care psychiatric facilities) with a principal diagnosis of mental illness on or between January 1 and December 1 of the measurement period.

Denominator Criteria (Eligible Cases) 1:
Patients aged 6 years and older as of the date of discharge
AND
Diagnosis for mental illness (ICD-9-CM) [for use 1/1/2014-9/30/2014]:, 295.00, 295.01, 295.02, 295.03, 295.04, 295.05, 295.10, 295.11, 295.12, 295.13, 295.14, 295.15, 295.20, 295.21, 295.22, 295.23, 295.24, 295.25, 295.30, 295.31, 295.32, 295.33, 295.34, 295.35, 295.40, 295.41, 295.42, 295.43, 295.44, 295.45, 295.50, 295.51, 295.52, 295.53, 295.54, 295.55, 295.60, 295.61, 295.62, 295.63, 295.64, 295.65, 295.70, 295.71, 295.72, 295.73, 295.74, 295.75, 295.80, 295.81, 295.82, 295.83, 295.84, 295.85, 295.90, 295.91, 295.92, 295.93, 295.94, 295.95, 296.00, 296.01, 296.02, 296.03, 296.04, 296.05, 296.06, 296.10, 296.11, 296.12, 296.13, 296.14, 296.15, 296.16, 296.20, 296.21, 296.22, 296.23, 296.24, 296.25, 296.26, 296.30, 296.31, 296.32, 296.33, 296.34, 296.35, 296.36, 296.40, 296.41, 296.42, 296.43, 296.44, 296.45, 296.46, 296.50, 296.51, 296.52, 296.53, 296.54, 296.55, 296.56, 296.60, 296.61, 296.62, 296.63, 296.64, 296.65, 296.66, 296.7, 296.80, 296.81, 296.82, 296.89, 296.90, 296.99, 297.0, 297.1, 297.2, 297.3, 297.8, 297.9, 298.0, 298.1, 298.2, 298.3, 298.4, 298.8, 298.9, 299.00, 299.01, 299.10, 299.11, 299.80, 299.81, 299.90, 299.91, 300.3, 300.4, 301.0, 301.10, 301.11, 301.12, 301.13, 301.20, 301.21, 301.22, 301.3, 301.4, 301.50, 301.51, 301.59, 301.6, 301.7, 301.81, 301.82, 301.83, 301.84, 301.89, 301.9, 308.0, 308.1, 308.2, 308.3, 308.4, 308.9, 309.0, 309.1, 309.21, 309.22, 309.23, 309.24, 309.28, 309.29, 309.3, 309.4, 309.81, 309.82, 309.83, 309.89,309.9, 311, 312.00, 312.01, 312.02, 312.03, 312.10, 312.11, 312.12, 312.13, 312.20, 312.21, 312.22, 312.23, 312.30, 312.31, 312.32, 312.33, 312.34, 312.35, 312.39, 312.4, 312.81, 312.82, 312.89, 312.9, 313.0, 313.1, 313.21, 313.22, 313.23, 313.3, 313.81, 313.82, 313.83, 313.89, 313.9, 314.00, 314.01, 314.1, 314.2, 314.8, 314.9, 648.44.
Diagnosis for mental illness (ICD-10-CM) [for use 10/01/2014-12/31/2014 REFERENCE ONLY/Not Reportable: F20.0, F20.1, F20.2, F20.3, F20.5, F20.81, F20.89, F20.9, F21, F22, F23, F24, F25.0, F25.1, F25.8, F25.9, F28, F29, F30.10, F30.11, F30.12, F30.13, F30.2, F30.3, F30.4, F30.8, F30.9, F31.0, F31.10, F31.11, F31.12, F31.13, F31.2, F31.30, F31.31, F31.32, F31.4, F31.5, F31.60, F31.61, F31.62, F31.63, F31.64, F31.70, F31.71, F31.72, F31.73, F31.74, F31.75, F31.76, F31.77, F31.78, F31.81, F31.89, F31.9, F32.0, F32.1, F32.2, F32.3, F32.4, F32.5, F32.8, F32.9, F33.0, F33.1, F33.2, F33.3, F33.40, F33.41, F33.42, F33.8, F33.9, F34.0, F34.1, F34.8, F34.9, F39, F42, F43.0, F43.10, F43.11, F43.12, F43.20, F43.21, F43.22, F43.23, F43.24, F43.25, F43.29, F43.8, F43.9, F44.89, F53, F60.0, F60.1, F60.2, F60.3, F60.4, F60.5, F60.6, F60.7, F60.81, F60.89, F60.9, F63.0, F63.1, F63.2, F63.3, F63.81, F63.89, F63.9, F68.10, F68.11, F68.12, F68.13, F68.8, F84.0, F84.2, F84.3, F84.5, F84.8, F84.9, F90.0, F90.1, F90.2, F90.8, F90.9, F91.0, F91.1, F91.2, F91.3, F91.8, F91.9, F93.0, F93.8, F93.9, F94.0, F94.1, F94.2, F94.8, F94.9
AND
Patient encounter during the reporting period (CPT or HCPCS): 99221, 99222, 99223, 99231, 99232, 99233, 99238, 99239, 99291
AND
Patient alive at time of acute inpatient setting discharge
AND
Patient is discharged from an acute inpatient setting on or between January 1 and December 1 of the measurement period.

AND

Exclude discharges followed by readmission or direct transfer to a nonacute facility within the 30-day follow-up period, regardless of principal diagnosis for the readmission.
Exclude discharges followed by readmission or direct transfer to an acute facility within the 30-day follow-up period if the principal diagnosis was for non-mental health.

NOTE: *These discharges are excluded from the measure because readmission or transfer may prevent an outpatient follow-up visit from taking place.*

NUMERATOR (REPORTING CRITERIA 1): Patient Received Follow-Up within 30 Days from Discharge
An outpatient visit, intensive outpatient visit or partial hospitalization with a mental health practitioner within 30 days after acute inpatient discharge. Include outpatient visits, intensive outpatient visits or partial hospitalizations that occur on the date of discharge.

Numerator Options:

***Performance Met*:**	Patient received follow-up on the date of discharge or within 30 days after discharge **(G9402)**
OR	
Medical Performance Exclusion:	Clinician documented reason patient was not able to complete 30 day follow-up from acute inpatient setting discharge (eg, patient death prior to follow-up visit, patient non-compliant for visit follow-up) **(G9403)**
OR	
Performance Not Met:	Patient did not receive follow-up on the date of discharge or within 30 days after discharge **(G9404)**

OR

REPORTING CRITERIA 2: The percentage of discharges for which the patient received follow-up within 7 days of discharge

DENOMINATOR (REPORTING CRITERIA 2):
Patients 6 years of age and older who were discharged from an acute inpatient setting (including acute care psychiatric facilities) with a principal diagnosis of mental illness on or between January 1 and December 1 of the measurement period.

Denominator Criteria (Eligible Cases) 2:
Patients aged 6 years and older as of the date of discharge
AND
Diagnosis for mental illness (ICD-9-CM) [for use 1/1/2014-9/30/2014]:, 295.00, 295.01, 295.02, 295.03, 295.04, 295.05, 295.10, 295.11, 295.12, 295.13, 295.14, 295.15, 295.20, 295.21, 295.22, 295.23, 295.24, 295.25, 295.30, 295.31, 295.32, 295.33, 295.34, 295.35, 295.40, 295.41, 295.42, 295.43, 295.44, 295.45, 295.50, 295.51, 295.52, 295.53, 295.54, 295.55, 295.60, 295.61, 295.62, 295.63, 295.64, 295.65, 295.70, 295.71, 295.72, 295.73, 295.74, 295.75, 295.80, 295.81, 295.82, 295.83, 295.84, 295.85, 295.90, 295.91, 295.92, 295.93, 295.94, 295.95, 296.00, 296.01, 296.02, 296.03, 296.04, 296.05, 296.06, 296.10, 296.11, 296.12, 296.13, 296.14, 296.15, 296.16, 296.20, 296.21, 296.22, 296.23, 296.24, 296.25, 296.26, 296.30, 296.31, 296.32, 296.33, 296.34, 296.35, 296.36, 296.40, 296.41, 296.42, 296.43, 296.44, 296.45, 296.46, 296.50, 296.51, 296.52, 296.53, 296.54, 296.55, 296.56, 296.60, 296.61, 296.62, 296.63, 296.64, 296.65, 296.66, 296.7, 296.80, 296.81, 296.82, 296.89, 296.90, 296.99, 297.0, 297.1, 297.2, 297.3, 297.8, 297.9298.0, 298.1, 298.2, 298.3, 298.4, 298.8, 298.9, 299.00, 299.01, 299.10, 299.11, 299.80, 299.81, 299.9, 299.90, 299.91, 300.3, 300.4, 301.0, 301.10, 301.11, 301.12, 301.13, 301.20, 301.21, 301.22, 301.3, 301.4, 301.50, 301.51, 301.59, 301.6, 301.7, 301.81, 301.82, 301.83, 301.84, 301.89, 301.9, 308.0, 308.1,

308.2, 308.3, 308.4, 308.9, 309.0, 309.1, 309.21, 309.22, 309.23,309.24, 309.28, 309.29, 309.3, 309.4, 309.81, 309.82, 309.83, 309.89,309.9, 311, 312.0, 312.00, 312.01, 312.02, 312.03, 312.10, 312.11, 312.12, 312.13, 312.20, 312.21, 312.22, 312.23, 312.30, 312.31, 312.32, 312.33, 312.34, 312.35, 312.39, 312.4, 312.81, 312.82, 312.89, 312.9, 313.0, 313.1, 313.21, 313.22, 313.23, 313.3, 313.81, 313.82, 313.83, 313.89, 313.9, 314.0, 314.00, 314.01, 314.1, 314.2, 314.8, 314.9, 648.44

Diagnosis for mental illness (ICD-10-CM) [for use 10/01/2014-12/31/2014 REFERENCE ONLY/Not Reportable: F20.0, F20.1, F20.2, F20.3, F20.5, F20.81, F20.89, F20.9, F21, F22, F23, F24, F25.0, F25.1, F25.8, F25.9, F28, F29, F30.10, F30.11, F30.12, F30.13, F30.2, F30.3, F30.4, F30.8, F30.9, F31.0, F31.10, F31.11, F31.12, F31.13, F31.2, F31.30, F31.31, F31.32, F31.4, F31.5, F31.60, F31.61, F31.62, F31.63, F31.64, F31.70, F31.71, F31.72, F31.73, F31.74, F31.75, F31.76, F31.77, F31.78, F31.81, F31.89, F31.9, F32.0, F32.1, F32.2, F32.3, F32.4, F32.5, F32.8, F32.9, F33.0, F33.1, F33.2, F33.3, F33.40, F33.41, F33.42, F33.8, F33.9, F34.0, F34.1, F34.8, F34.9, F39, F42, F43.0, F43.10, F43.11, F43.12, F43.20, F43.21, F43.22, F43.23, F43.24, F43.25, F43.29, F43.8, F43.9, F44.89, F53, F60.0, F60.1, F60.2, F60.3, F60.4, F60.5, F60.6, F60.7, F60.81, F60.89, F60.9, F63.0, F63.1, F63.2, F63.3, F63.81, F63.89, F63.9, F68.10, F68.11, F68.12, F68.13, F68.8, F84.0, F84.2, F84.3, F84.5, F84.8, F84.9, F90.0, F90.1, F90.2, F90.8, F90.9, F91.0, F91.1, F91.2, F91.3, F91.8, F91.9, F93.0, F93.8, F93.9, F94.0, F94.1, F94.2, F94.8, F94.9

AND

Patient encounter during the reporting period (CPT or HCPCS): 99221, 99222, 99223, 99231, 99232, 99233, 99238, 99239, 99291

AND

Patient alive at time of acute inpatient setting discharge

AND

Patient is discharged from an acute inpatient setting on or between January 1 and December 1 of the measurement period.

AND

Exclude discharges followed by readmission or direct transfer to a nonacute facility within the 30-day follow-up period, regardless of principal diagnosis for the readmission.

AND

Exclude discharges followed by readmission or direct transfer to an acute facility within the 30-day follow-up period if the principal diagnosis was for non-mental health.

NOTE: *These discharges are excluded from the measure because readmission or transfer may prevent an outpatient follow-up visit from taking place.*

NUMERATOR (REPORTING CRITERIA 2): Patient Received Follow-Up within 7 Days from Discharge

An outpatient visit, intensive outpatient visit or partial hospitalization with a mental health practitioner within 7 days after acute inpatient discharge. Include outpatient visits, intensive outpatient visits or partial hospitalizations that occur on the date of discharge.

Numerator Options:

Performance Met:	Patient received follow-up within 7 days from discharge **(G9405)**
OR	
Medical Performance Exclusion:	Clinician documented reason patient was not able to complete 7 day follow-up from acute inpatient setting discharge (ie,patient death prior to follow-up visit, patient non-compliance for visit follow-up) **(G9406)**
OR	
Performance Not Met:	Patient did not receive follow-up on or within 7 days after discharge **(G9407)**

RATIONALE:
It is important to provide regular follow-up therapy to patients after they have been hospitalized for mental illness. An outpatient visit with a mental health practitioner after discharge is recommended to make sure that the patient's transition to the home or work environment is supported and that gains made during hospitalization are not lost. It also helps health care providers detect early post-hospitalization reactions or medication problems and provide continuing care.

This measure is consistent with guidelines of the National Institute of Mental Health and the Centers for Mental Health Services.

CLINICAL RECOMMENDATION STATEMENTS:
According to a guideline developed by the American Academy of Child and Adolescent Psychiatry and the American Psychiatric Association, there is a need for regular and timely assessments and documentation of the patient's response to all treatments.

The organization should make a practice of helping schedule follow-up appointments when a patient is discharged, as part of the treatment or case management plan, and should educate patients and practitioners about the importance of follow-up visits. Systems should be established to generate reminder or "reschedule" notices that are mailed to patients in the event that a follow-up visit is missed or canceled. In many cases, it may also be necessary to develop outreach systems or assign case managers to encourage recently released patients to keep follow-up appointments or reschedule missed appointments.

£Measure #392: HRS-12: Cardiac Tamponade and/or Pericardiocentesis Following Atrial Fibrillation Ablation – National Quality Strategy Domain: Patient Safety

2015 PHYSICIAN QUALITY REPORTING OPTIONS FOR INDIVIDUAL MEASURES
REGISTRY ONLY

DESCRIPTION:
Rate of cardiac tamponade and/or pericardiocentesis following atrial fibrillation ablation

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

NOTE: *Include only patients that have had atrial fibrillation ablation performed by November 30, 2015, for evaluation of cardiac tamponade and/or pericardiocentesis occurring within 30 days within the reporting period. This will allow the evaluation of cardiac tamponade and/or pericardiocentesis complications within the reporting year. A minimum of 30 cases is recommended by the measure owner to ensure a volume of data that accurately reflects provider performance; however, this minimum number is **not required** for purposes of PQRS reporting.*

This measure will be calculated with 5 performance rates:

1) **Females less than 65 years of age**
2) **Males less than 65 years of age**
3) **Females 65 years of age and older**
4) **Males 65 years of age and older**
5) **Overall percentage of patients with cardiac tamponade and/or pericardiocentesis occurring within 30 days**

Eligible professionals should continue to report the measure as specified, with no additional steps needed to account for multiple performance rates.

Measure Reporting via Registry:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

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

DENOMINATOR:
All patients age 18 years and older with atrial fibrillation ablation performed during the reporting period.

Denominator Criteria (Eligible Cases):
Patient aged ≥ 18 years on date of encounter
AND
Diagnosis for atrial fibrillation or ablation (ICD-9-CM) [for use 1/1/2014-9/30/2014]: 37.33, 37.34, 427.31
Diagnosis for atrial fibrillation or ablation (ICD-10-CM, ICD-10-PCS) [for use 10/01/2014-12/31/2014]: I48.0, I48.1, I48.2, I48.91, 02563ZZ, 02573ZZ, 02583ZZ, 025S3ZZ, 025T3ZZ, 02560ZZ, 02564ZZ, 02570ZZ, 02574ZZ, 02580ZZ, 02584ZZ, 025S4ZZ, 025T4ZZ

AND

Patient encounter during reporting period (CPT): 33250, 33251, 33254, 33255, 33256, 33265, 33266, 93650, 93653, 93656, C1886

AND

Ablation procedures that have been performed by November 30 of current reporting year

NUMERATOR:

The number of patients from the denominator with cardiac tamponade and/or pericardiocentesis occurring within 30 days following atrial fibrillation ablation

Numerator Instructions: A lower calculated performance rate for this measure indicates better clinical care or control.

Numerator Options:

Performance Met:	Patients with cardiac tamponade and/or pericardiocentesis occurring within 30 days **(G9408)**
OR	
Performance Not Met:	Patients **without** cardiac tamponade and/or pericardiocentesis occurring within 30 days **(G9409)**

RATIONALE:

Cardiac tamponade is one of the most serious complications of atrial fibrillation ablation that can lead to substantial morbidity due to a significant drop in the cardiac output and blood pressure leading to hypo-perfusion of important organs such as the brain, heart and kidneys. In many cases, cardiac tamponade has to be treated surgically, and it invariably prolongs hospital stay. If not treated promptly, cardiac tamponade can lead to death. The risk of this dreaded complication has been reported to range from 2 to 6%; however, these rates were observed in tertiary referral centers where the procedure was performed by experienced and skillful operators. Given that the occurrence of cardiac tamponade is largely dependent on the operator's level of experience and, therefore, is in most cases preventable, higher rates are expected to occur when less experienced operators perform the procedure. These issues prove the need to measure performance in this area.

CLINICAL RECOMMENDATION STATEMENTS:

In recognition that there is an absence of applicable physician-level performance measures for the profession of cardiac electrophysiology, the Heart Rhythm Society (the international professional society focused on the care of patients with heart rhythm disorders) convened a Performance Measures Development Task Force to consider and develop potential physician-level measures cardiac electrophysiologists. The task force consisted of thought leaders in atrial fibrillation ablation, cardiovascular health policy, performance measures development, clinical outcomes, and population science. The process for consideration of the evidence included review of multi-stakeholder professional society clinical expert consensus statements on the topic, such as the 2012 Heart Rhythm Society/European Heart Rhythm Association/European Cardiac Arrhythmia Society Expert Consensus Statement on Catheter and Surgical Ablation of Atrial Fibrillation (Calkins et al, 2012), and the relevant literature both referenced within this document and in the knowledge of the members of the task force (Cappato et al, 2005; Hsu et al, 2005; Andrade et al, 2011; Bunch et al, 2005; Cappato et al, 2009; Cappato et al, 2010; Cappato et al, 2011; Fisher et al, 2000; Hsu et al, 2003; Latchamsetty et al, 2011; O'Neill et al, 2008; Tsang et al, 2002).

The expert consensus statement does not provide a specific recommendation related to this proposed outcome measure, but rather summarizes that in high-volume and high-quality programs, the incidence of complications in general should be comparable to the low rates of complications observed in published studies, including the world-wide survey of atrial fibrillation ablation (Cappato et al, 2005; Cappato et al, 2009; Cappato et al, 2010; Cappato et al, 2011). Collectively, the incidence of this complication has in general ranged from between 1.2 and 2.4% across the literature evaluated ((Cappato et al, 2005; Hsu et al, 2005; Calkins et al, 2012; Andrade et al, 2011; Bunch et al,

2005; Cappato et al, 2009; Cappato et al, 2010; Cappato et al, 2011; Fisher et al, 2000; Hsu et al, 2003; Latchamsetty et al, 2011; O'Neill et al, 2008; Tsang et al, 2002).

£Measure #393: HRS-9: Infection within 180 Days of Cardiac Implantable Electronic Device (CIED) Implantation, Replacement, or Revision – National Quality Strategy Domain: Patient Safety

2015 PHYSICIAN QUALITY REPORTING OPTIONS FOR INDIVIDUAL MEASURES
REGISTRY ONLY

DESCRIPTION:
Infection rate following CIED device implantation, replacement, or revision

INSTRUCTIONS:
This measure is to be reported a minimum of **once per reporting period** for patients with a CIED device implantation, replacement, or revision performed from January 1, 2015 through June 30, 2015 of the reporting period. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

NOTE: *Include only patients that have had CIED implantation, replacement, or revision performed by June 30. This timeframe allows for evaluation of infection requiring within 180 days within the reporting period. This will allow the evaluation of infection status post CIED implantation, replacement, or revision within the reporting year.*

Infection rates for new implants shall be calculated and reported separately from device replacements and revisions.

Additional reporting stratification categories **may** be useful; however, these stratifications are **not required** for purposes of PQRS reporting:

- Device class (eg, pacemaker, ICD) and type (eg, single chamber, dual chamber);
- Advanced renal disease (CKD stages 4 and 5, ESRD);
- Diabetes;
- CIED infection requiring device removal within 180 days prior to index CIED procedures; and
- CIED-related surgical procedure within 180 days prior to current CIED procedure.

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

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data. There are no allowable performance exclusions for this measure. **Note:** Since the measure is only capturing procedures from January 1, 2015, through June 30, 2015, ICD-10 codes are not included in the measure.

There are two reporting criteria for this measure:

1) **Patients, regardless of age, with a new CIED**

OR

2) **Patients, regardless of age, with a replaced or revised CIED**

REPORTING CRITERIA 1: Patients with a new CIED

DENOMINATOR (REPORTING CRITERIA 1):
All patients with a new CIED from January 1, 2015 through June 30, 2015 of the reporting period

Definition:

CIEDs encompassed for this measure are the following devices:

- Pacemaker devices (single or dual chamber);
- Implantable cardioverter-defibrillators (ICDs, single or dual chamber);
- Cardiac resynchronization devices (pacemaker or ICD); and
- Implantable loop recorders (ILRs)

Denominator Criteria (Eligible Cases) 1:
All patients, regardless of age
AND
Codes for CIED implantation, replacement, or revision (ICD-9-CM procedure codes) [for use 1/1/2015-9/30/2015]: 00.50, 00.51, 00.52, 00.53, 00.54, 37.74, 37.75, 37.76, 37.77, 37.79, 37.80, 37.81, 37.82, 37.83, 37.85, 37.86, 37.87, 37.89, 37.94, 37.96, 37.98
AND
Patient encounter during reporting period (CPT): 33202, 33203, 33206, 33207, 33208, 33212, 33213, 33214, 33215, 33216, 33217, 33218, 33220, 33221, 33222, 33223, 33224, 33225, 33226, 33227, 33228, 33229, 33233, 33234, 33240, 33241, 33249, 33262, 33263, 33264, 33282
AND
New CIED

NUMERATOR (REPORTING CRITERIA 1):
The number of patients from the denominator admitted with an infection requiring device removal or surgical revision within 180 days following CIED implantation, replacement, or revision.

Numerator Instructions: A lower calculated performance rate for this measure indicates better clinical care or control.

Numerator Options:

Performance Met:	Patient admitted within 180 days, status post CIED implantation, replacement, or revision with an infection requiring device removal or surgical revision **(G9410)**
OR	
Performance Not Met:	Patient **not** admitted within 180 days, status post CIED implantation, replacement, or revision with an infection requiring device removal or surgical revision **(G9411)**

OR

REPORTING CRITERIA 2: Patients with a replaced or revised CIED

DENOMINATOR (REPORTING CRITERIA 2):
All patients with replacement or revision of a CIED from January 1, 2015 through June 30, 2015 of the reporting period

Definition:
CIEDs encompassed for this measure are the following devices:

- Pacemaker devices (single or dual chamber);
- Implantable cardioverter-defibrillators (ICDs, single or dual chamber);
- Cardiac resynchronization devices (pacemaker or ICD); and
- Implantable loop recorders (ILRs)

Denominator Criteria (Eligible Cases) 2:
All patients, regardless of age

AND

Codes for CIED implantation, replacement, or revision (ICD-9-CM procedure codes) [for use 1/1/2015-9/30/2015]: 00.50, 00.51, 00.52, 00.53, 00.54, 37.74, 37.75, 37.76, 37.77, 37.79, 37.80, 37.81, 37.82, 37.83, 37.85, 37.86, 37.87, 37.89, 37.94, 37.96, 37.98

AND

Patient encounter during reporting period (CPT): 33202, 33203, 33206, 33207, 33208, 33212, 33213, 33214, 33215, 33216, 33217, 33218, 33220, 33221, 33222, 33223, 33224, 33225, 33226, 33227, 33228, 33229, 33233, 33234, 33240, 33241, 33249, 33262, 33263, 33264, 33282

AND

Replaced or revised CIED

NUMERATOR (REPORTING CRITERIA 2):

The number of patients from the denominator admitted with an infection requiring device removal or surgical revision within 180 days following CIED implantation, replacement, or revision.

Numerator Instructions: A lower calculated performance rate for this measure indicates better clinical care or control.

Numerator Options:

Performance Met:	Patient admitted within 180 days, status post CIED implantation, replacement, or revision with an infection requiring device removal or surgical revision **(G9412)**
OR	
Performance Not Met:	Patient **not** admitted within 180 days, status post CIED implantation, replacement, or revision with an infection requiring device removal or surgical revision **(G9413)**

RATIONALE:

The rate of implantable cardioverter-defibrillator (ICD) infections has been increasing faster than that of device implantation and is associated with substantial morbidity, mortality, and financial cost. A recent study including over 200,000 ICD implant patients found 2 percent of patients undergoing ICD implantation experienced a device-related infection. Patients who developed an ICD infection were likely to have more comorbidity burden, warfarin use, and coronary sinus lead, device upgrade/malfunction as the last surgery, peri-ICD implant complications, and non-EP trained operator. The evidence demonstrates the need to measure performance in this area.

CLINICAL RECOMMENDATION STATEMENTS:

In recognition that there is an absence of applicable physician-level performance measures for the profession of cardiac electrophysiology, the Heart Rhythm Society (the international professional society focused on the care of patients with heart rhythm disorders) convened a Performance Measures Development Task Force to consider and develop potential physician-level measures for cardiac electrophysiologists. The task force consisted of thought leaders in 1) implantation of cardiac implantable electronic devices (CIEDs) including pacemakers, implantable cardioverter defibrillators (ICDs), cardiac resynchronization devices (pacemaker or ICD); and implantable loop recorders (ILRs), 2) cardiovascular health policy, 3) performance measures development, 4) clinical outcomes, and 4) population science. The process for consideration of the evidence included review of the relevant literature referenced within this document and in the knowledge of the members of the task force (Voigt et al, 2006; Cabell et al, 2004; Voigt et al, 2010; Greenspon et al, 2011; Sohail et al, 2011; Nery et al, 2010; Ferguson et al, 1996; Uslan et al, 2007; Lee et al, 2010; Klug et al, 2007; Alter et al, 2005; Al-Khatib et al, 2008; de Oliveira et al, 2009; Uslan et al, 2011; Borleffs et al, 2010; Sohail et al, 2007; Bloom et al, 2006; Baddour et al, 2010; Le KY et al, 2011; Johansen et al, 2011; Al-Khatib et al, 2005; Tarakji et al, 2010).

The number of CIED-related infections in the United States continues to increase out of proportion to the increase in the CIED implantation rates (Voigt et al, 2006; Cabell et al, 2004; Voigt et al, 2010). This infection burden is

associated with increased mortality, prolonged hospital stays and high financial costs (Greenspon et al, 2011; Sohail et al, 2011; Ferguson et al, 1996). Collectively, the incidence of CIED infection has ranged from 0.3 to 2.9% across the literature evaluated (Greenspon et al, 2011; Sohail et al, 2011; Nery et al, 2010; Uslan et al, 2007; Lee et al, 2010; Klug et al, 2007; Alter et al, 2005; Al-Khatib et al, 2008; Uslan et al, 2011; Bloom et al, 2006; Baddour et al, 2010; Johansen et al, 2011). In the vast majority of patients, CIED infection is preventable, and an association between a higher volume of ICD implants and a lower rate of infections has been demonstrated (Tarakji et al, 2010). This is why a performance measure that could lower the risk of CIED infection is critically needed.

♦ Measure #394 (NQF 1407): Immunizations for Adolescents – National Quality Strategy Domain: Community/Population Health

2015 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
The percentage of adolescents 13 years of age who had the recommended immunizations by their 13th birthday

INSTRUCTIONS:
This measure is to be reported a minimum of **once per reporting period** for patients seen during the reporting period. There is no diagnosis associated with this measure. Performance for this measure is not limited to the reporting period. This measure may be reported by clinicians who perform the quality actions described in the measure based on services provided and the measure-specific denominator coding.

This measure will be calculated with 3 performance rates:

1) **Patients who had one dose of meningococcal vaccine on or between the patient's 11th and 13th birthdays**
2) **Patients who had one tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap) or one tetanus, diphtheria toxoids vaccine (Td) on or between the patient's 10th and 13th birthdays**
3) **All patients who are compliant for both Meningococcal and Td/Tdap during the specified timeframes.**

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

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

DENOMINATOR (Reporting criteria for all rates):
Adolescents who turn 13 years of age during the measurement period.

DENOMINATOR NOTE: *The same denominator is used for all rates.*

Denominator Criteria (Eligible Cases):
Patients who turn 13 years of age during the measurement period.
AND
Patient encounter during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, G0402
AND NOT
Meningococcal, Tdap and/or Td vaccine contraindicated OR patient allergic to the meningococcal, Tdap, and/or Td vaccine

NUMERATOR (Reporting Criteria for Rate 1):
Adolescents who had one dose of meningococcal vaccine on or between the patient's 11th and 13th birthdays.

Numerator Options:

Performance Met: Patient had one dose of meningococcal vaccine on or between the patient's 11th and 13th birthdays. **(G9414)**

OR

Performance Not Met: Patient did not have one dose of meningococcal vaccine on or between the patient's 11th and 13th birthdays. **(G9415)**

OR

NUMERATOR (Reporting Criteria for Rate 2):
Adolescents who had one tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap) **OR** one tetanus, diphtheria toxoids vaccine (Td) on or between the patient's 10th and 13th birthdays **OR** one tetanus and one diphtheria vaccine on or between the patient's 10th and 13th birthdays.

Numerator Options:

Performance Met: Patient had one tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap) **OR** one tetanus, diphtheria toxoids vaccine (Td) on or between the patient's 10th and 13th birthdays **OR** one tetanus and one diphtheria vaccine on or between the patient's 10th and 13th birthdays. **(G9416)**

OR

Performance Not Met: Patient did **not** have one tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap) **OR** one tetanus, diphtheria toxoids vaccine (Td) on or between the patient's 10th and 13th birthdays **OR** one tetanus and one diphtheria vaccine on or between the patient's 10th and 13th birthdays. **(G9417)**

OR

NUMERATOR (Reporting Criteria for Rate 3):
Adolescents who are numerator compliant for Rates 1 and 2.

RATIONALE:
Adolescent immunization rates have historically lagged behind early childhood immunization rates in the United States. In 2000, the American Academy of Pediatrics (AAP) reported that 3 million adolescents failed to receive at least one recommended vaccination. Low immunization rates among adolescents have the potential to cause outbreaks of preventable diseases and to establish reservoirs of disease in adolescents that can affect other populations including infants, the elderly, and individuals with chronic conditions. Immunization recommendations for adolescents have changed in recent years. In addition to assessing for immunizations that may have been missed, there are new vaccines targeted specifically to adolescents.

This measure follows the Centers for Disease Control and Prevention (CDC) Advisory Committee on Immunization Practices (ACIP) guidelines for immunizations.

CLINICAL RECOMMENDATION STATEMENTS:
Receiving recommended vaccinations is the best defense against vaccine-preventable diseases. However, as children get older, the protection they received from some of their childhood vaccinations begins to wear off and they need booster shots. Adolescents are also at risk for vaccine-preventable diseases (eg, meningococcal meningitis) they are not typically vaccinated against as children.

The tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine is given to adolescents as a booster shot to increase the protection they received in childhood vaccinations.

Diphtheria, tetanus and pertussis are serious diseases that can cause life-threatening illnesses. Diphtheria can cause breathing difficulties, heart problems, nerve damage, pneumonia and even death. Tetanus can cause seizures and severe muscle spasms that can be strong enough to cause bone fractures of the spine, and causes death in 30 to 40 percent of cases. Pertussis can cause severe coughing spells that can interfere with breathing, as well as pneumonia, long-lasting bronchitis, seizures, brain damage and death.

Meningococcal disease occurs when the protective membranes covering the brain and spinal cord become infected and swell, and can cause serious complications, such as brain damage, hearing loss or learning disabilities. Meningococcal disease is caused by the bacterium *Neisseria meningitides*, or meningococcus, and is the leading cause of bacterial meningitis in the United States (U.S.).

A meningococcal infection can spread quickly, killing an otherwise healthy adolescent in 48 hours. Although not all cases of meningococcal disease progress into meningitis, 15 percent of the cases that do progress, result in death.

Each year, many adolescents miss their recommended vaccinations, leaving them needlessly vulnerable to disease, suffering and death.

Vaccine-preventable diseases are expensive for society as a whole, costing more than $10 billion in direct medical costs and indirect societal costs.

In 2012, pertussis outbreaks were reported in a majority of states, with more than 32,000 cases and 16 deaths.

Outbreaks can occur in workplaces, schools and homes, and can result in physical, economic and social costs.

Bacterial meningitis remains a major global health threat, with an estimated 500,000 cases reported worldwide each year, accounting for at least 50,000 deaths. According to preliminary data, meningitis was responsible for 606 deaths in the U.S. in 2011.

Vaccines are a safe and effective way to protect adolescents against potentially deadly diseases and help them develop into healthy adults. Vaccines can protect their family and their community as well.

Measure #395: Lung Cancer Reporting (Biopsy/Cytology Specimens) – National Quality Strategy Domain: Communication and Care Coordination

2015 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Pathology reports based on biopsy and/or cytology specimens with a diagnosis of primary nonsmall cell lung cancer classified into specific histologic type or classified as NSCLC-NOS with an explanation included in the pathology report

INSTRUCTIONS:
This measure is to be reported **each time** a patient's pathology report addresses specimens with a diagnosis of non-small cell lung cancer; however, only one QDC per date of service for a patient is required. This measure may be reported by eligible professionals who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

Measure Reporting via Claims:
ICD-9-CM/ICD-10-CM diagnosis codes, and CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. Quality-data codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed ICD-9-CM/ICD-10-CM diagnosis codes, and CPT codes, and the appropriate quality-data code.

Measure Reporting via Registry:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure.

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

DENOMINATOR:
Biopsy and cytology specimen reports with a diagnosis of primary non-small cell lung cancer

Denominator Criteria (Eligible Cases):
Patients 18 through 75 years of age on date of encounter
AND
Diagnosis for lung cancer (ICD-9-CM) [for use 1/1/2015-9/30/2015]: 162.3, 162.4, 162.5, 162.8, 162.9
Diagnosis for lung cancer (ICD-10-CM) [for use 10/01/2015-12/31/2015]: C34.00, C34.01, C34.02, C34.10, C34.11, C34.12, C34.2, C34.30, C34.31, C34.32, C34.80, C34.81, C34.82, C34.90, C34.91, C34.92
AND
Patient encounter during reporting period (CPT): 88305, 88307

NUMERATOR:
Biopsy and cytology specimen reports with a diagnosis of primary non-small cell lung cancer classified into specific histologic type (squamous cell carcinoma, adenocarcinoma) OR classified as NSCLC-NOS with an explanation included in the pathology report

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Non-Small Cell Lung Cancer Biopsy and Cytology Specimen Reports Classified

***Performance Met:* (G9418):** Primary non-small cell lung cancer biopsy and cytology specimen report documents classification into specific histologic type OR classified as NSCLC-NOS with an explanation

OR

Medical Performance Exclusion: Non-Small Cell Lung Cancer Biopsy and Cytology Specimen Reports not Classified for Medical Reasons

(G9419): Documentation of medical reason(s) for not reporting the histological type OR NSCLC-NOS classification with an explanation (eg, biopsy taken for other purposes in a patient with a history of primary non-small cell lung cancer or other documented medical reasons)

OR

If patient is not eligible for this measure because the specimen is not of lung origin or is not classified as non-small cell lung cancer report:

***Other Performance Exclusion:* (G9420):** Specimen site other than anatomic location of lung or is not classified as primary non-small cell lung cancer

OR

Non-Small Cell Lung Cancer Biopsy and Cytology Specimen Reports *not* Classified, Reason *not* given

***Performance Not Met:* (G9421):** Primary non-small cell lung cancer biopsy and cytology specimen report does **not** document classification into specific histologic type OR classified as NSCLC-NOS with an explanation

RATIONALE:

Lung cancer is the most frequent cause of major cancer incidence and mortality worldwide. The classifications of lung cancer published by the World Health Organization (WHO) in 1967, 1981, and 1999 were written primarily by pathologists for pathologists. Only in the 2004 revision, relevant genetics and clinical information were introduced. Nevertheless, because of remarkable advances over the last 6 years in our understanding of lung adenocarcinoma, particularly in area of medical oncology, molecular biology, and radiology, there is a pressing need for a revised classification, based not on pathology alone, but rather on an integrated multidisciplinary platform.

For the first time, this classification addresses an approach to small biopsies and cytology in lung cancer diagnosis. Recent data regarding *EGFR* mutation predicting responsiveness to EGFR-TKIs, toxicities, and therapeutic efficacy have established the importance of distinguishing squamous cell carcinoma from adenocarcinoma and non-small cell lung carcinoma (NSCLC) not otherwise specified (NOS) in patients with advanced lung cancer. Approximately 70% of lung cancers are diagnosed and staged by small biopsies or cytology rather than surgical resection specimens, with increasing use of transbronchial needle aspiration (TBNA), endobronchial ultrasound-guided TBNA and esophageal ultrasound-guided needle aspiration. Within the NSCLC group, most pathologists can identify well- or moderately-differentiated squamous cell carcinomas or adenocarcinomas, but specific diagnoses are more difficult with poorly differentiated tumors. Nevertheless, in small biopsies and/or cytology specimens, 10 to 30% of specimens continue to be diagnosed as NSCLC-NOS.

CLINICAL RECOMMENDATION STATEMENTS:

To address advances in oncology, molecular biology, pathology, radiology, and surgery of lung adenocarcinoma, an international multidisciplinary classification was sponsored by the International Association for the Study of Lung Cancer, American Thoracic Society, and European Respiratory Society. This new adenocarcinoma classification is needed to provide uniform terminology and diagnostic criteria, especially for bronchioloalveolar carcinoma (BAC), the overall approach to small non-resection cancer specimens, and for multidisciplinary strategic management of tissue for molecular and immunohistochemical studies.

For small biopsies and cytology, we recommend that NSCLC be further classified into a more specific histologic type, such as adenocarcinoma or squamous cell carcinoma, whenever possible (strong recommendation, moderate quality evidence).

We recommend that the term NSCLC-NOS be used as little as possible and we recommend it be applied only when a more specific diagnosis is not possible by morphology and/or special stains (strong recommendation, moderate quality evidence).

The above strategy for classification of adenocarcinoma versus other histologies and the terminology should be used in routine diagnosis and future research and clinical trials so that there is uniform classification of disease cohorts in relationship to tumor subtypes.

Travis WD, Brambilla E, Noguchi M, et al. International Association for the Study of Lung Cancer/American Thoracic Society/European Respiratory Society International Multidisciplinary Classification of Lung Adenocarcinoma. *Journal of Thoracic Oncology* 2011;6:244-285.

Measure #396: Lung Cancer Reporting (Resection Specimens) – National Quality Strategy Domain: Communication and Care Coordination

2015 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Pathology reports based on resection specimens with a diagnosis of primary lung carcinoma that include the pT category, pN category and for non-small cell lung cancer, histologic type.

INSTRUCTIONS:
This measure is to be reported **each time** a patient's pathology report addresses specimens with a diagnosis of non-small cell lung cancer; however, only one QDC per date of service for a patient is required. This measure may be reported by eligible professionals who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

Measure Reporting via Claims:
ICD-9-CM/ICD-10-CM diagnosis codes, and CPT odes, and patient demographics are used to identify patients who are included in the measure's denominator. Quality-data codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed ICD-9-CM/ICD-10-CM diagnosis codes, and CPT codes, and the appropriate quality-data code.

Measure Reporting via Registry:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure.

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

DENOMINATOR:
Pathology reports for resection specimens for primary lung carcinoma

> **Denominator Criteria (Eligible Cases):**
> Patients 18 through 75 years of age on date of encounter
> **AND**
> **Diagnosis for lung cancer (ICD-9-CM) [for use 1/1/2015-9/30/2015]:** 162.3, 162.4, 162.5, 162.8, 162.9
> **Diagnosis for lung cancer (ICD-10-CM) [for use 10/01/2015-12/31/2015]:** C34.00, C34.01, C34.02, C34.10, C34.11, C34.12, C34.2, C34.30, C34.31, C34.32, C34.80, C34.81, C34.82, C34.90, C34.91, C34.92
> **AND**
> **Patient encounter during reporting period (CPT):** 88309

NUMERATOR:
Pathology reports based on resection specimens with a diagnosis of primary lung carcinoma that include the pT category, pN category and for non-small cell lung cancer, histologic type (squamous cell carcinoma, adenocarcinoma and NOT NSCLC-NOS)

> **Numerator Quality-Data Coding Options for Reporting Satisfactorily:**
> **Primary Lung Carcinoma that Include the pT category, pN category and for Non-Small Cell Lung Cancer, Histologic Type (Squamous Cell Carcinoma, Adenocarcinoma)**

***Performance Met:* (G9422):** Non-small cell lung cancer biopsy and cytology specimen report documents classification into specific histologic type OR classified as NSCLC-NOS with an explanation

OR

Primary Lung Carcinoma that Include the pT category, pN category and for Non Small Cell Lung Cancer, Histologic Type (Squamous Cell Carcinoma, Adenocarcinoma) not Documented for Medical Reasons

***Medical Performance Exclusion:* (G9423):** Documentation of medical reason(s) for not reporting the histological type OR NSCLC-NOS classification with an explanation (eg, a solitary fibrous tumor in a person with a history of non-small cell carcinoma or other documented medical reasons)

OR

If patient is not eligible for this measure because the specimen is not of lung origin, is not classified as non-small cell lung cancer, or is classified as NSCLC-NOS report:

***Other Performance Exclusion:* (G9424):** Specimen site other than anatomic location of lung, is not classified as non-small cell lung cancer OR classified as NSCLC-NOS

OR

Primary Lung Carcinoma that Include the pT category, pN category and for Non Small Cell Lung Cancer, Histologic Type (Squamous Cell Carcinoma, Adenocarcinoma) not Documented, Reason not Given

***Performance Not Met:* (G9425):** Non small cell lung cancer biopsy and cytology specimen report does **not** document classification into specific histologic type OR classified as NSCLC-NOS with an explanation

RATIONALE:

The TNM staging revisions (AJCC 7th edition) became effective for all new cases diagnosed after January 1, 2010. The new staging system is applicable to both NSCLC and, for the first time, SCLC. There are significant changes in staging, particularly in T3 for NSCLC. For these reasons, we believe a gap exists in the appropriate and consistent use of the new pT standards for lung cancer. (CAP Performance Measures Working Group)

CLINICAL RECOMMENDATION STATEMENTS:

The TNM staging system of the American Joint Committee on Cancer (AJCC) and the International Union Against Cancer (UICC) is recommended for non-small cell lung cancer. Small cell lung cancer has been more commonly classified according to a separate staging system as either “limited” or “extensive” disease, but based on analysis of the International Association for the Study of Lung Cancer (IASLC) database, TNM staging is also recommended for small cell lung cancer.

The purpose of pathologic evaluation is to precisely classify the histologic type of lung cancer and to determine all staging parameters as recommended by the AJCC including tumor size, the extent of invasion (pleural and bronchial), adequacy of surgical margins, and presence or absence of lymph node metastasis.

Pathologic evaluation is performed to classify the histologic type of the lung cancer, determine the extent of invasion, determine whether it is primary lung cancer or metastatic cancer, establish the cancer involvement status of the surgical margins (ie, positive or negative margins), and do molecular diagnostic studies to determine whether certain gene mutations are present.

A new lung cancer TMN staging system was developed by the International Association of the Study of Lung Cancer (IASLC) and adopted by the American Joint Commission for Cancer (AJCC) (7th edition, 2010). This new staging

system is applicable to both NSCLC and SCLC based on studies by the IASLC which demonstrated the prognostic significance of the various stage designations in both diseases… application of the TNM system will not change how patients are treated; however, clinical research studies should begin to utilize the TNM system, because it will allow for more precise assessments of prognosis and specific therapy in the future. Therefore, the SCLC algorithm was revised in 2011 to include the TNM staging information.

College of American Pathologists. Protocol for the Examination of Specimens from Patients with Primary Non-Small Cell Carcinoma, Small Cell Carcinoma, or Carcinoid Tumor of the Lung. http://www.cap.org/apps/docs/committees/cancer/cancer_protocols/2011/Lung_11protocol.pdf.

The NCCN. Non-Small Cell Lung Cancer: Clinical Practice Guidelines in Oncology. http://www.nccn.org/professionals/physician_gls/pdf/nscl.pdf. Updated April 11, 2012. Accessed May 9, 2012. To view the most recent and complete version of the guideline, go online to http://www.nccn.org.

The NCCN. Small Cell Lung Cancer: Clinical Practice Guidelines in Oncology. http://www.nccn.org/professionals/physician_gls/pdf/sclc.pdf. Updated June 23, 2012. Accessed May 9, 2012. To view the most recent and complete version of the guideline, go online to http://www.nccn.org.

Measure #397: Melanoma Reporting – National Quality Strategy Domain: Communication and Care Coordination

2015 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Pathology reports for primary malignant cutaneous melanoma that include the pT category and a statement on thickness and ulceration and for pT1, mitotic rate

INSTRUCTIONS:
This measure is to be reported **each time** a patient's pathology report addresses specimens with a diagnosis of malignant cutaneous melanoma; however, only one QDC per date of service for a patient is required. This measure may be reported by eligible professionals who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

Measure Reporting via Claims:
ICD-9-CM/ICD-10-CM diagnosis codes, and CPT odes, and patient demographics are used to identify patients who are included in the measure's denominator. Quality-data codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed ICD-9-CM/ICD-10-CM diagnosis codes, and CPT codes, and the appropriate quality-data code.

Measure Reporting via Registry:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure.

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

DENOMINATOR:
All melanoma pathology reports for primary malignant cutaneous melanoma

Denominator Criteria (Eligible Cases):
Patients 18 through 75 years of age on date of encounter
AND
Diagnosis for malignant cutaneous melanoma (ICD-9-CM) [for use 1/1/2015-9/30/2015]: 172.0, 172.1, 172.2, 172.3, 172.4, 172.5, 172.6, 172.7, 172.8, 172.9
Diagnosis for malignant cutaneous melanoma (ICD-10-CM) [for use 10/01/2015-12/31/2015]: C43.0, C43.20, C43.21, C43.22, C43.30, C43.31, C43.39, C43.4, C43.51, C43.52, C43.59, C43.60, C43.61, C43.62, C43.70, C43.71, C43.72, C43.8, C43.9
AND
Patient encounter during reporting period (CPT): 88305

NUMERATOR:
Pathology reports for primary malignant cutaneous melanoma that include the pT category and a statement on thickness and ulceration and for pT1, mitotic rate

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Pathology Reports that Include the pT Category and a Statement on Thickness and Ulceration and for pT1, mitotic rate

***Performance Met:* (G9428):** Pathology report includes the pT Category and a statement on thickness and ulceration and for pT1, mitotic rate

OR

Pathology Reports that does not Include the pT Category and a Statement on Thickness and Ulceration and for pT1, mitotic rate, not Documented for Medical Reasons

***Medical Exclusion:* (G9429):** Documentation of medical reason(s) for not reporting pT Category and a statement on thickness and ulceration and for pT1, mitotic rate (eg, negative skin biopsies in a patient with a history of melanoma or other documented medical reasons)

OR

If patient is not eligible for this measure because the specimen is not of cutaneous origin

***Other Performance Exclusion:* (G9430):** Specimen site other than anatomic cutaneouslocation

OR

Pathology Reports that does not Include the pT Category and a Statement on Thickness and Ulceration and for pT1, mitotic rate, Reason not Given

***Performance Not Met:* (G9431):** Pathology report does **not** include the pT Category and a statement on thickness and ulceration and for pT1, mitotic rate

RATIONALE:

In the evidence-based derivation of the 2010 AJCC staging system, mitotic rate greater than or equal to 1 per mm^2 was independently associated with worse disease-specific survival, especially in patients with melanoma less than or equal to 1.0 mm thick. As such, mitotic rate has replaced Clark level as a criterion for upstaging patients with melanomas less than or equal to 1.0 mm in thicknesses from IA to IB.

Until now, routine histopathologic reporting of primary melanomas has infrequently included an assessment of mitotic rate. Even in a geographic area with a high melanoma incidence, such as Queensland, Australia, fewer than 50% of pathology reports on primary melanomas documented mitotic rate in a recent study assessing the completeness of histopathologic reporting of melanoma. Similarly, in another recently published study undertaken at the H. Lee Moffitt Cancer Center in Florida, 47% of outside pathology reports for patients with thin (<=1 mm) or in situ melanoma did not mention mitotic rate. Moreover, clinicians involved in the care of patients with primary melanomas have not generally considered mitotic rate as an important factor to be considered when discussing prognosis with patients and planning their treatment.

In addition to the specific gap noted above, recent research and the publication of new guidelines in 2012 indicate newer tumor characteristics for more precise staging with implications for treatment outcomes. For these reasons, we believe there is a gap in reporting of these new characteristics in melanoma pathology reports. (CAP Performance Measures Working Group)

Travis WD, Brambilla E, Noguchi M, et al. International Association for the Study of Lung Cancer/American Thoracic Society/European Respiratory Society International Multidisciplinary Classification of Lung Adenocarcinoma. *Journal of Thoracic Oncology* 2011;6:244-285.

Thompson JF, Soong SJ, Balch CM, et al. Prognostic Significance of Mitotic Rate in Localized Primary Cutaneous Melanoma: An Analysis of Patients in the Multi-Institutional American Joint Committee on Cancer Melanoma Staging Database. *Journal of Clinical Oncology* 2011;29(18):2199-2205.

CLINICAL RECOMMENDATION STATEMENTS:

In patients with localized melanoma (Stage I or II), Breslow tumor thickness, ulceration and mitotic rate are the three most important characteristics of the primary tumor predicting outcome.

Measure #398: Optimal Asthma Control – National Quality Strategy Domain: Person and Caregiver-Centered Experience and Outcomes

2015 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Patients ages 5-50 (pediatrics ages 5-17) whose asthma is well-controlled as demonstrated by one of three age appropriate patient reported outcome tools

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

Measure Reporting via Registry:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

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

DENOMINATOR:
Patients ages 5 to 50 with asthma

Denominator Criteria (Eligible Cases):
Patients aged 5-50 years
AND
Diagnosis for asthma (ICD-9-CM) [for use 1/1/2015-9/30/2015]: 493.00, 493.01, 493.02, 493.10, 493.11, 493.12, 493.81, 493.82, 493.90, 493.91, 493.92
Diagnosis for asthma (ICD-10-CM) [for use 10/1/2015-12/31/2015]: J45.20, J45.21, J45.22, J45.30, J45.31, J45.32, J45.40, J45.41, J45.42, J45.50, J45.51, J45.52, J45.901, J45.902, J45.909, J45.990, J45.991, J45.998
AND
Patient encounter during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, 99354, 99355
AND
At least two visits for asthma over the last two years with at least one visit for any reason in the last 12 months
AND NOT
Diagnosis for chronic obstructive pulmonary disease, emphysema, cystic fibrosis, or acute respiratory failure (ICD-9-CM) [for use 1/1/2015-9/30/2015]: 277.00, 277.01, 277.02, 277.03, 277.09, 491.20, 491.21, 491.22, 492.0, 492.8, 493.20, 493.21, 493.22, 496, 506.4, 518.1, 518.2, 518.81
Diagnosis for chronic obstructive pulmonary disease, emphysema, cystic fibrosis, or acute respiratory failure (ICD-10-CM) [for use 10/1/2015-12/31/2015]: E84.0, E84.11, E84.19, E84.8, E84.9, J43.0, J43.1, J43.2, J43.8, J43.9, J44.0, J44.1, J44.9, J68.4, J96.00, J96.01, J96.02, J96.10, J96.11, J96.12, J96.20, J96.21, J96.22, J98.2, J98.3
AND NOT

Death, permanent nursing home resident or receiving hospice or palliative care any time during the measurement period

NUMERATOR:
Asthma well-controlled (use the most recent asthma control result available) using any of the following tools below:

- Asthma Control Test™ (ACT) score of 20 or above - ages 12 and older
- Childhood Asthma Control Test (C-ACT) score of 20 or above - ages 11 and younger
- Asthma Control Questionnaire (ACQ) score of 0.75 or lower - ages 17 and older
- Asthma Therapy Assessment Questionnaire (ATAQ) score of 0 – Pediatric (ages 5 – 17) or Adult (ages 18 and older)

Numerator Options:

Performance Met:	Asthma well-controlled based on the ACT, C-ACT, ACQ, or ATAQ score and results documented **(G9432)**
OR	
***Other Performance Exclusion*:**	Death, permanent nursing home resident or receiving hospice or palliative care any time during the measurement period **(G9433)**
OR	
Performance Not Met:	Asthma **not** well-controlled based on the ACT, C-ACT, ACQ, or ATAQ score, OR specified asthma control tool not used, reason not given **(G9434)**

RATIONALE:
Roughly 7% of adults and children in Minnesota are currently living with asthma. Asthma is a chronic disease associated with familial, infectious, allergenic, socioeconomic, psychosocial and environmental factors. It is not curable but is treatable. Despite improvements in diagnosis and management, and an increased understanding of the epidemiology, immunology, and biology of the disease, asthma prevalence has progressively increased over the past 15 years. In addition, variation in practice from recommended clinical guidelines is evident with only 33% of adult asthma patients in Minnesota reporting in 2005 to having an action plan and 75% reporting instruction on what to do when having an asthma attack. It is up to providers to assess patients, prescribe medications, educate about self-management, help patients identify and mitigate triggers so patients can prevent their exacerbations.

CLINICAL RECOMMENDATION STATEMENTS:
From the National Quality Forum's 2013 report, Patient Reported Outcomes (PROs) in Performance Measurement:

Patient and family engagement is increasingly acknowledged as a key component of a comprehensive strategy, (along with performance improvement and accountability), to achieve a high quality, affordable health system. Emerging evidence affirms that patients who are engaged in their care tend to experience better outcomes and choose less costly but effective interventions.

Historically, with the exception of collecting feedback on satisfaction or experience with care, patients remain an untapped resource in assessing the quality of healthcare and of long-term support services. Patients are a valuable and, arguably, the authoritative source of information on outcomes beyond experience with care. These include health-related quality of life, functional status, symptom and symptom burden, and health behaviors.

Patient Reported Outcome Measures (PROMs) are standardized instruments that capture patients' self-assessment of their health and can provide timely information on patient health status, function and symptoms over time that can be used to improve patient-centered care and inform clinical decision-making.

The Asthma Control Test™ (ACT) is a validated self-administered survey utilizing 5 questions to assess asthma control on a scale from 0 (poor control) to 5 (total control) in individuals 12 years and older. © 2002 by QualityMetric Incorporated. Asthma Control Test is a trademark of QualityMetric Incorporated.

The Childhood Asthma Control Test (C-ACT) is a caregiver-assisted, child-completed tool that can be used with or without lung function assessment to assess pediatric asthma control at home or in clinical practice for children ages 4-11 years. It consists of 7 questions of which 4 are child-reported and 3 are caregiver-reported questions. ©2011 The GlaxoSmithKline Group of Companies.

The Asthma Control Questionnaire (ACQ) is a validated, self-administered survey available in various formats from the developer, Elizabeth F. Juniper, MCSP, MSc. http://www.goltech.co.uk/acq.html

The Asthma Therapy Assessment Questionnaire (ATAQ) is available in a version for adults (18 and over) and a version for children and adolescents (5 – 17). © 2011 Merck Sharp & Dohme Corp., a subsidiary of Merck & Co., Inc.

● Measure #399: Post-Procedural Optimal Medical Therapy Composite (Percutaneous Coronary Intervention) – National Quality Strategy Domain: Effective Clinical Care

2015 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Percentage of patients aged 18 years and older for whom PCI is performed who are prescribed optimal medical therapy at discharge

INSTRUCTIONS:
This measure is to be reported **each time** a patient is seen during the reporting period. There is no diagnosis associated with this measure. This measure may be reported by clinicians who perform the quality actions described in the measure based on services provided and the measure-specific denominator coding.

Measure Reporting via Registry:
CPT codes, Place of Service Indicator, and patient demographics are used to identify patients who are included in the measure's denominator. Quality-data codes are used to report the numerator of the measure.

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

This measure will be calculated with 4 performance rates:

1) Overall percentage for patients prescribed all of the following medications for which they are eligible at discharge: aspirin, P2Y inhibitor, statin
2) Patients prescribed aspirin if eligible at discharge
3) Patients prescribed P2Y inhibitor if eligible at discharge
4) Patients prescribed statin if eligible at discharge

DENOMINATOR:
All patients aged 18 years and older for whom PCI is performed

Denominator Criteria (Eligible Cases):
Patients aged 18 and older on date of encounter
AND
Patient encounter during the reporting period (CPT or HCPCS): 92920, 92924, 92928, 92933
AND NOT
Patient Died Prior to the End of the Measurement Period
OR
Patient Left Against Medical Advice (AMA)
OR
Patient Discharged to Palliative Care Services or other Acute Care Hospital at any time During the Measurement Period

NUMERATOR:
Patients who are prescribed all of the following medications for which they are eligible at discharge: aspirin, P2Y inhibitor, statin

Numerator Options:
Each component should be reported in order to determine the reporting and performance rate for the overall percentage of patients that meet ALL targets represented as the numerator.

COMPONENT 1:
Patients prescribed aspirin at discharge
Component Options:

Performance Met:	Aspirin prescribed at discharge **(G9435)**
OR	
Other Performance Exclusion:	Aspirin not prescribed for documented reasons (eg, allergy, medical intolerance, history of bleed) **(G9436)**
OR	
Performance Not Met:	Aspirin **not** prescribed at discharge **(G9437)**

AND
COMPONENT 2:
Patients prescribed P2Y inhibitor at discharge
Component Options:

Performance Met:	P2Y inhibitor prescribed at discharge **(G9438)**
OR	
Other Performance Exclusion:	P2Y inhibitor not prescribed for documented reasons (eg, allergy, medical intolerance, history of bleed) **(G9439)**
OR	
Performance Not Met:	P2Y inhibitor **not** prescribed at discharge **(G9440)**

AND
COMPONENT 3:
Patients prescribed statin at discharge
Component Options:

Performance Met:	Statin prescribed at discharge **(G9441)**
OR	
Other Performance Exclusion:	Statin not prescribed for documented reasons (eg, allergy, medical intolerance) **(G9442)**
OR	
Performance Not Met:	Statin **not** prescribed at discharge **(G9443)**

RATIONALE:
The rate of prescribed optimal medical statin therapy after PCI is suboptimal. Only 84% of patients are prescribed a statin upon discharge after PCI. Additionally, only 86% of patients with a prior diagnosis of cardiovascular disease are prescribed statin therapy after PCI.

CLINICAL RECOMMENDATION STATEMENTS:
No clinical recommendation statements provided.

☺Measure #400: Hepatitis C: One-Time Screening for Hepatitis C Virus (HCV) for Patients at Risk – National Quality Strategy Domain: Community / Population Health

2015 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Percentage of patients aged 18 years and older with one or more of the following: a history of injection drug use, receipt of a blood transfusion prior to 1992, receiving maintenance hemodialysis OR birthdate in the years 1945-1965 who received a one-time screening for HCV infection

INSTRUCTIONS:
This measure is to be reported a minimum of **once per reporting period** for **all** patients with one or more of the following: a history of injection drug use, receipt of a blood transfusion prior to 1992, receiving maintenance hemodialysis OR birthdate in the years 1945–1965 seen during the reporting period AND who were seen twice for any visits or who had at least one preventive care visit within the 12 month reporting period. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

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

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

DENOMINATOR:
All patients aged 18 years and older who were seen twice for any visit or who had at least one preventive care visit within the 12 month reporting period with one or more of the following: a history of injection drug use, receipt of a blood transfusion prior to 1992, receiving maintenance hemodialysis, OR birthdate in the years 1945–1965

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
At least one preventive care visit (CPT and HCPCS): G0438, G0439
OR
At least two visits during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350
AND
Patients who were born in the years 1945–1965: **(G9448)**
OR
History of receiving blood transfusions prior to 1992: **(G9449)**
OR
Receiving maintenance hemodialysis (CPT): 90951, 90952, 90953, 90954, 90955, 90956, 90957, 90958, 90959, 90960, 90961, 90962, 90963, 90964, 90965, 90966, 90967, 90968, 90969, 90970, 99512
OR
History of injection drug use: (G9450)
AND NOT
Diagnosis for Chronic Hepatitis C (ICD-9-CM) [for use 1/1/2015-9/30/2015]: 070.44, 070.54

Diagnosis for Chronic Hepatitis C (ICD-10-CM) [for use 10/01/2015-12/31/2015]: B18.2

NUMERATOR:
Patients who received a one-time screening for HCV infection*

Definition:
Screening for HCV Infection includes current or prior receipt of:
1) HCV antibody test
2) HCV RNA test
3) Recombinant immunoblot assay (RIBA) test (if performed at any time in the past)

Numerator Options:

Performance Met:	Patient received one-time screening for HCV infection **(G9451)**
OR	
Medical Performance Exclusion:	Documentation of medical reason(s) for **not** receiving one-time screening for HCV infection (eg, decompensated cirrhosis indicating advanced disease [ie, ascites, esophageal variceal bleeding, hepatic encephalopathy], hepatocellular carcinoma, waitlist for organ transplant, limited life expectancy, other medical reasons) **(G9452)**
OR	
Patient Performance Exclusion:	Documentation of patient reason(s) for **not** receiving one-time screening for HCV infection (eg, patient declined, other patient reasons) **(G9453)**
OR	
Performance Not Met:	One-time screening for HCV infection **not** received within 12 month reporting period **and** no documentation of prior screening for HCV infection, reason not given **(G9454)**

RATIONALE:
In the United States, an estimated 2.7–3.9 million persons (1.0%–1.5%) are living with hepatitis C virus (HCV) infection, and an estimated 17,000 persons were newly infected in 2010, the most recent year that data are available. With an HCV antibody prevalence of 3.25%, persons born during 1945–1965 account for approximately three fourths of all chronic HCV infections among adults in the United States. Although effective treatments are available to clear HCV infection from the body, most persons with HCV do not know they are infected, do not receive needed care (eg, education, counseling, and medical monitoring), and are not evaluated for treatment. HCV causes acute infection, which can be characterized by mild to severe illness but is usually asymptomatic. In approximately 75%–85% of persons, HCV persists as a chronic infection, placing infected persons at risk for liver cirrhosis, hepatocellular carcinoma (HCC), and extrahepatic complications that develop over the decades following onset of infection. HCV testing is the first step toward improving health outcomes for persons infected with HCV.

CLINICAL RECOMMENDATION STATEMENTS:
In addition to testing adults of all ages at risk for HCV infection, CDC recommends that:

- Adults born during 1945–1965 should receive one-time testing for HCV without prior ascertainment of HCV risk (Strong Recommendation, Moderate Quality of Evidence), and
- All persons identified with HCV infection should receive a brief alcohol screening and intervention as clinically indicated, followed by referral to appropriate care and treatment services for HCV infection and related conditions (Strong Recommendation, Moderate Quality of Evidence).

Providers and patients can discuss HCV testing as part of an individual's preventive health care. For persons identified with HCV infection, CDC recommends that they receive appropriate care, including HCV-directed clinical preventive services (eg, screening for alcohol use, hepatitis A and hepatitis B vaccination as appropriate, and medical monitoring of disease). Recommendations are available to guide treatment decisions. Treatment decisions should be made by the patient and provider after several factors are considered, including stage of disease, hepatitis C genotype, comorbidities, therapy-related adverse events, and benefits of treatment. (CDC, 2012)

The USPSTF recommends screening for hepatitis C virus (HCV) infection in persons at high risk for infection. The USPSTF also recommends offering 1-time screening for HCV infection to adults born between 1945 and 1965. (Grade B recommendation) (USPSTF, 2013)

Assessment of Risk

The most important risk factor for HCV infection is past or current injection drug use. Another established risk factor for HCV infection is receipt of a blood transfusion before 1992. Because of the implementation of screening programs for donated blood, blood transfusions are no longer an important source of HCV infection. In contrast, 60% of new HCV infections occur in persons who report injection drug use within the past 6 months. Additional risk factors include long-term hemodialysis, being born to an HCV-infected mother, incarceration, intranasal drug use, getting an unregulated tattoo, and other percutaneous exposures (such as in health care workers or from having surgery before the implementation of universal precautions). Evidence on tattoos and other percutaneous exposures as risk factors for HCV infection is limited. The relative importance of these additional risk factors may differ on the basis of geographic location and other factors. (USPSTF, 2013)

Verbatim from AASLD and IDSA Recommendations for Testing, Managing, and Treating Hepatitis C**,** January 2014:

HCV testing is recommended at least once for persons born between 1945 and 1965.

Rating: Class I, Level B

Other persons should be screened for risk factors for HCV infection, and one-time testing should be performed for all persons with behaviors, exposures, and conditions associated with an increased risk of HCV infection.

1) *Risk behaviors*

    a) Injection drug use (current or ever, including those who injected once)
    b) Intranasal illicit drug use

2) *Risk exposures*

    a) Long-term hemodialysis (ever)
    b) Getting a tattoo in an unregulated setting
    c) Healthcare, emergency medical, and public safety workers after needle sticks, sharps, or mucosal exposures to HCV-infected blood
    d) Children born to HCV-infected women
    e) Prior recipients of transfusions or organ transplants, including persons who:

        i) Were notified that they received blood from a donor who later tested positive for HCV infection
        ii) Received a transfusion of blood or blood components, or underwent an organ transplant before July 1992
        iii) Received clotting factor concentrates produced before 1987
        iv) Were ever incarcerated

3) *Other medical conditions*

a) HIV infection
b) Unexplained chronic liver disease and chronic hepatitis including elevated alanine aminotransferase levels

Rating: Class I, Level B
Annual HCV testing is recommended for persons who inject drugs and for HIV-seropositive men who have unprotected sex with men. Periodic testing should be offered to other persons with ongoing risk factors for exposure to HCV.
Rating: Class IIA, Level C
An anti-HCV test is recommended for HCV testing, and if the result is positive, current infection should be confirmed by a sensitive RNA test.
Rating: Class I, Level A
Among persons with a negative anti-HCV test who are suspected of having liver disease, testing for HCV RNA or follow-up testing for HCV antibody is recommended if exposure to HCV occurred within the past 6 months; testing for HCV RNA can also be considered in persons who are immunocompromised.
Rating: Class I, Level C
Among persons suspected of reinfection after previous spontaneous or treatment-related viral clearance, initial HCV-RNA testing is recommended because an anti-HCV test is expected to be positive.
Rating: Class I, Level C
Quantitative HCV RNA testing is recommended prior to the initiation of antiviral therapy to document the baseline level of viremia (ie, baseline viral load).
Rating: Class I, Level A
Testing for HCV genotype is recommended to guide selection of the most appropriate antiviral regimen.
Rating: Class I, Level A
If found to have positive results for anti-HCV test and negative results for HCV RNA by PCR, persons should be informed that they do not have evidence of current (active) HCV infection.
Rating: Class I, Level A
Persons with current (active) HCV infection should receive education and interventions aimed at reducing progression of liver disease and preventing transmission of HCV.
Rating: Class IIa, Level B
Abstinence from alcohol and, when appropriate, interventions to facilitate cessation of alcohol consumption should be advised for all persons with HCV infection.
Rating: Class IIa, level B
Evaluation for other conditions that may accelerate liver fibrosis, including HBV and HIV infections, is recommended for all persons with HCV infection.
Rating: Class IIb, level B
Evaluation for advanced fibrosis is recommended using liver biopsy, imaging, or non-invasive markers in all persons with HCV infection to facilitate an appropriate decision regarding HCV treatment strategy and to determine the need for initiating additional screening measures (eg, hepatocellular carcinoma [HCC] screening).
Rating: Class I, Level B
Vaccination against hepatitis A and hepatitis B is recommended for all persons with HCV infection who are susceptible to these types of viral hepatitis.
Rating: Class IIa, Level C
All persons with HCV infection should be provided education on how to avoid HCV transmission to others.
Rating: Class I, level C
Evaluation by a practitioner who is prepared to provide comprehensive management, including consideration of antiviral therapy, is recommended for all persons with current (active) HCV infection.
Rating: Class IIa, level CBottom of Form

◘ Measure #401: Screening for Hepatocellular Carcinoma (HCC) in Patients with Hepatitis C Cirrhosis – National Quality Strategy Domain: Effective Clinical Care

2015 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Percentage of patients aged 18 years and older with a diagnosis of chronic hepatitis C cirrhosis who underwent imaging with either ultrasound, contrast enhanced CT or MRI for hepatocellular carcinoma (HCC) at least once within the 12 month reporting period

INSTRUCTIONS:
This measure is to be reported a minimum of **once per reporting period** for **all** patients with a diagnosis of chronic hepatitis C cirrhosis seen during the reporting period. This measure is intended to reflect the quality of services provided for patients with chronic hepatitis C cirrhosis. This measure may be reported by physicians or other qualified healthcare professionals who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

Measure Reporting via Registry:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

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

DENOMINATOR:
All patients aged 18 years and older with a diagnosis of chronic hepatitis C cirrhosis

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Diagnosis for chronic hepatitis C (ICD-9-CM) [for use 1/1/2015-9/30/2015]: 070.41, 070.44, 070.51, 070.54, 070.70, 070.71
Diagnosis for chronic hepatitis C (ICD-10-CM) [for use 10/1/2015-12/31/2015]: B18.2, B19.20, B19.21
AND
Diagnosis for cirrhosis (ICD-9-CM) [for use 1/1/2015-9/30/2015]: 571.2, 571.5
Diagnosis for cirrhosis (ICD-10-CM) [for use 10/1/2015-12/31/2015]: K70.30, K70.31, K74.60, K74.69
AND
Patient encounter during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215

NUMERATOR:
Patients who underwent abdominal imaging with either ultrasound, contrast enhanced CT or MRI

Numerator Options:

Performance Met:	Patient underwent abdominal imaging with ultrasound, contrast enhanced CT or contrast MRI for HCC **(G9455)**
OR	
Other Performance Exclusion:	Documentation of medical or patient reason(s) for not ordering or performing screening for HCC.

Medical reason: Comorbid medical conditions with expected survival <5 years, hepatic decompensation and not a candidate for liver transplantation, or other medical reasons. Patient reasons: Patient declined or other patient reasons (eg, cost of tests, time related to accessing testing equipment) **(G9456)**

OR

Performance Not Met: Patient did not undergo abdominal imaging and did **not** have a documented reason for not undergoing abdominal imaging in the reporting period **(G9457)**

RATIONALE:

HCC (hepatocellular carcinoma) is the fourth most common cancer in the world and is the fastest rising cause of cancer-related deaths in the United States. HCV is the leading cause of HCC and the risk of developing HCC is highest in patients with established HCV cirrhosis.

Several potentially curative treatments are available for patients with early-stage HCC. These include surgical resection, liver transplantation, and local ablation. Long-term survival of patients who have liver resection or transplantation for HCC can be high (40% to 70% for resection and 52% to 81% for transplant patients after 5 years) (Kansagara 2014).

A recent systematic review of 18 nonrandomized studies found that screened patients had early-stage HCC than clinically diagnosed patients. More screened patients received potentially curative treatment. However, these studies were limited by their observational nature (including lead time bias) and thus the effect on overall mortality was unclear. There are no randomized controlled trials that evaluated the impact of HCC screening versus no screening on survival in patients with cirrhosis. A randomized trial of HCC screening is not forthcoming because, even in the absence of high quality data, most informed patients and their clinicians consider randomization unethical and prefer surveillance (Poustchi 2011). In a recent modeling based study (that corrected for lead time bias), US based screening for HCC in compensated HCV cirrhosis patients reduced mortality compared to no screening (Mourad 2014).

Collectively, these data suggest that screening has a potential to produce benefits in the highest-risk patients, such as those with HCV cirrhosis who are good candidates for potentially curative treatment (Atkins AIM 2014).

CLINICAL RECOMMENDATION STATEMENTS:

Patients at high risk for developing HCC, including patients with hepatitis C cirrhosis, should be entered into surveillance programs. (Level I). Surveillance for HCC should be performed using ultrasonography (Level II). Patients should be screened at 6-month intervals (level II) (AASLD, 2011).

HCC surveillance must be continued indefinitely in patients with cirrhosis (A1). Patients with cirrhosis should undergo regular surveillance for HCC, irrespective of SVR (B1) (EASL, 2014)

While current guidelines only specify using ultrasound, evidence suggests that using multiple screening methods, including incorporating the alpha fetoprotein biomarker into surveillance plans, may be more effective in identifying early stages of HCC.

♦ Measure #402: Tobacco Use and Help with Quitting Among Adolescents – National Quality Strategy Domain: Community / Population Health

2015 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
The percentage of adolescents 12 to 20 years of age with a primary care visit during the measurement year for whom tobacco use status was documented and received help with quitting if identified as a tobacco user

INSTRUCTIONS:
This measure is to be reported **once per reporting period** for patients seen during the reporting period. This measure is intended to reflect the quality of services provided for preventive screening for tobacco use.

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

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

DENOMINATOR:
All patients aged 12-20 years with a visit during the measurement period.

Denominator Criteria (Eligible Cases):
Patients aged 12-20 years on date of encounter
AND
Patient encounter during the reporting period (CPT): 90791, 90792, 90832, 90834, 90837, 90839, 90845, 92002, 92004, 92012, 92014, 96150, 96151, 96152, 97003, 97004, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99406, 99407, G0438, G0439

NUMERATOR:
Patients who were screened for tobacco use at least once within 18 months (during the measurement period or the six months prior to the measurement period) **AND** who received tobacco cessation counseling intervention if identified as a tobacco user

Definitions:
Tobacco Use Status – Any documentation of smoking or tobacco use status, including 'never' or 'non-use'.
Tobacco User – Any documentation of active or current use of tobacco products, including smoking.

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* ***G9460****.*

Numerator Options:

Performance Met:	Patient documented as tobacco user AND received tobacco cessation intervention (**must** include at least one of the following: advice given to quit smoking or tobacco use, counseling on the benefits of quitting smoking or tobacco use, assistance with or referral to external smoking or tobacco cessation support programs, or current enrollment in smoking or tobacco

	use cessation program) if identified as a tobacco user **(G9458)**
OR	
Performance Met:	Currently a tobacco non-user **(G9459)**
OR	
Performance Not Met:	Tobacco assessment OR tobacco cessation intervention **not** performed, reason not otherwise specified **(G9460)**

RATIONALE:
This measure is intended to promote adolescent tobacco screening and tobacco cessation interventions for those who use tobacco products. There is good evidence that tobacco screening and brief cessation intervention (including counseling and/or pharmacotherapy) is successful in helping tobacco users quit. Tobacco users who are able to stop smoking lower their risk for heart disease, lung disease, and stroke.

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

The U.S. Preventive Services Task Force recommends that primary care clinicians provide interventions, including education or brief counseling, to prevent initiation of tobacco use in school-aged children and adolescents. (Strength of Recommendation = B) (U.S. Preventive Services Task Force, 2013)

All patients should be asked if they use tobacco and should have their tobacco use status documented on a regular basis. Evidence has shown that clinic screening systems, such as expanding the vital signs to include tobacco use status or the use of other reminder systems such as chart stickers or computer prompts, significantly increase rates of clinician intervention. (Strength of Evidence = A) (U.S. Department of Health and Human Services. Public Health Service, 2008)

All physicians should strongly advise every patient who smokes to quit because evidence shows that physician advice to quit smoking increases abstinence rates. (Strength of Evidence = A) (U.S. Department of Health and Human Services. Public Health Service, 2008)

Minimal interventions lasting less than 3 minutes increase overall tobacco abstinence rates. Every tobacco user should be offered at least a minimal intervention, whether or not he or she is referred to an intensive intervention. (Strength of Evidence = A) (U.S. Department of Health and Human Services. Public Health Service, 2008)

The combination of counseling and medication is more effective for smoking cessation than either medication or counseling alone. Therefore, whenever feasible and appropriate, both counseling and medication should be provided to patients trying to quit smoking. (Strength of Evidence = A) (U.S. Department of Health and Human Services. Public Health Service, 2008)

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These Measures are intended to assist physicians in enhancing quality of care. Measures are designed for use by any physician who manages the care of a patient for a specific condition or for prevention. These performance Measures are not clinical guidelines and do not establish a standard of medical care. The PCPI has not tested its Measures for all potential applications. The PCPI encourages the testing and evaluation of its Measures.

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