2011 Physician Quality Reporting System (Physician Quality Reporting) Measure Specifications Manual for Claims and Registry Reporting of Individual Measures

The measure specifications contained in this manual are intended for claims-based and registry reporting of individual measures for the 2011 Physician Quality Reporting System ("Physician Quality Reporting," formerly known as Physician Quality Reporting Initiative or PQRI). Each measure is assigned a unique number. Measure numbers for 2011 Physician Quality Reporting represent a continuation in numbering from the 2010 measures. For 2010 PQRI measures that are continuing forward in the 2011 Physician Quality Reporting System, measure specifications have been updated. In addition to the measure specifications manual, please refer to the "2011 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/PQRS/15_MeasuresCodes.asp. Measure specifications for measures groups reporting are included in a separate manual, "2011 Physician Quality Reporting System Measures Groups Specifications Manual," which can be accessed at: http://www.cms.gov/PQRS/15_MeasuresCodes.asp.

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 Physician Quality Reporting 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 Physician Quality Reporting. A list of eligible professionals can be found on the Physician Quality Reporting website at: http://www.cms.gov/PQRS/03_How_To_Get_Started.asp.

Frequency and Performance Timeframes

The measure instructions limit the frequency of reporting necessary in certain circumstances, such as for patients with chronic illness for whom a particular process of care is provided only periodically. Each individual eligible professional participating in 2011 Physician Quality Reporting should report according to the frequency and timeframe listed within each measure specification.

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

Quality measures consist of a numerator and a denominator that permit the calculation of the percentage of a defined patient population that receive a particular process of care or achieve a particular outcome. The denominator population is defined by demographic information, certain International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) diagnosis, Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) codes specified in the measure that are submitted by individual eligible professionals as part of a claim for covered services under the PFS. 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 Physician Quality Reporting measure does not apply to the patient. Some measure specifications are adapted as needed for implementation in Physician Quality Reporting in agreement with the measure developer. For example, CPT codes for non-covered services such as preventive visits are not included in the denominator. Also, the denominators for measures groups have been modified to provide common denominator codes for all measures within the group.

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

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

Measure Specification Format

Measure title
Reporting option available for each measure (claims-based 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

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2011 Physician Quality Reporting System (Physician Quality Reporting)
Measure Specifications Manual for Claims and Registry
Reporting of Individual Measures

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2011 Physician Quality Reporting Initiative
Measure Specifications Manual for Claims and Registry
Reporting of Individual Measures

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2011 Physician Quality Reporting Initiative
Measure Specifications Manual for Claims and Registry
Reporting of Individual Measures

Measure Number	Measure Title	Reporting Options	Page
112	Preventive Care and Screening: Screening Mammography	C, R	244
113	Preventive Care and Screening: Colorectal Cancer Screening	C, R	247
116	Antibiotic Treatment for Adults with Acute Bronchitis: Avoidance of Inappropriate Use	C, R	250
117	Diabetes Mellitus: Dilated Eye Exam in Diabetic Patient	C, R	254
118	Coronary Artery Disease (CAD): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Patients with CAD and Diabetes and/or Left Ventricular Systolic Dysfunction (LVSD)	R	257
119	Diabetes Mellitus: Urine Screening for Microalbumin or Medical Attention for Nephropathy in Diabetic Patients	C, R	261
121	Chronic Kidney Disease (CKD): Laboratory Testing (Calcium, Phosphorus, Intact Parathyroid Hormone (iPTH) and Lipid Profile)	C, R	264
122	Chronic Kidney Disease (CKD): Blood Pressure Management	C, R	267
123	Chronic Kidney Disease (CKD): Plan of Care – Elevated Hemoglobin for Patients Receiving Erythropoiesis-Stimulating Agents (ESA)	C, R	270
124	Health Information Technology (HIT): Adoption/Use of Electronic Health Records (EHR)	C, R	274
126	Diabetes Mellitus: Diabetic Foot and Ankle Care, Peripheral Neuropathy - Neurological Evaluation	C, R	277
127	Diabetes Mellitus: Diabetic Foot and Ankle Care, Ulcer Prevention – Evaluation of Footwear	C, R	280
128	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up	C, R	282
130	Documentation and Verification of Current Medications in the Medical Record	C, R	287
131	Pain Assessment Prior to Initiation of Patient Therapy and Follow-Up	C, R	292
134	Screening for Clinical Depression and Follow-Up Plan	C, R	297
135	Chronic Kidney Disease (CKD): Influenza Immunization	C, R	301
137	Melanoma: Continuity of Care – Recall System	R	304
138	Melanoma: Coordination of Care	R	307
140	Age-Related Macular Degeneration (AMD): Counseling on Antioxidant Supplement	C, R	310
141	Primary Open-Angle Glaucoma (POAG): Reduction of Intraocular Pressure (IOP) by 15% OR Documentation of a Plan of Care	C, R	313
142	Osteoarthritis (OA): Assessment for Use of Anti-Inflammatory or Analgesic Over-the-Counter (OTC) Medications	C, R	317
143	Oncology: Medical and Radiation – Pain Intensity Quantified	R	319
144	Oncology: Medical and Radiation – Plan of Care for Pain	R	323
145	Radiology: Exposure Time Reported for Procedures Using Fluoroscopy	C, R	327
146	Radiology: Inappropriate Use of “Probably Benign” Assessment Category in Mammography Screening	C, R	330
147	Nuclear Medicine: Correlation with Existing Imaging Studies for All Patients	C, R	333

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List of Retired PQRI Measure Specifications		
Measure #	Measure Title	Retirement Effective Date
4	Screening for Future Fall Risk	January 1, 2009
11	Stroke and Stroke Rehabilitation: Carotid Imaging Reports	January 1, 2010
13	Age-Related Macular Degeneration: Age-Related Eye Disease Study (AREDS) Prescribed/Recommended	January 1, 2008
15	Cataracts: Assessment of Visual Functional Status	January 1, 2008
16	Cataracts: Documentation of Pre-Surgical Axial Length, Corneal Power Measurement and Method of Intraocular Lens Power Calculation	January 1, 2008
17	Cataracts: Pre-Surgical Dilated Fundus Evaluation	January 1, 2008
25	Melanoma: Patient Medical History	January 1, 2008
26	Melanoma: Complete Physical Skin Examination	January 1, 2008
27	Melanoma: Counseling on Self-Examination	January 1, 2008
29	Beta-Blocker at Time of Arrival for Acute Myocardial Infarction (AMI)	January 1, 2008
34	Stroke and Stroke Rehabilitation: Tissue Plasminogen Activator (t-PA) Considered	January 1, 2010
37	Dialysis Dose in End Stage Renal Disease (ESRD) Patients	January 1, 2008
38	Hematocrit Level in End Stage Renal Disease (ESRD) Patients	January 1, 2008
42	Osteoporosis: Counseling for Vitamin D, Calcium Intake, and Exercise	January 1, 2008
60	Gastroesophageal Reflux Disease (GERD): Assessment for Alarm Symptoms	January 1, 2008
61	Gastroesophageal Reflux Disease (GERD): Upper Endoscopy for Patients with Alarm Symptoms	January 1, 2008
62	Gastroesophageal Reflux Disease (GERD): Biopsy for Barrett's Esophagus	January 1, 2008
63	Gastroesophageal Reflux Disease (GERD): Barium Swallow-Inappropriate Use	January 1, 2008
73	Plan for Chemotherapy Documented Before Chemotherapy Administered	January 1, 2009
74	Radiation Therapy Recommended for Invasive Breast Cancer Patients who Have undergone Breast Conserving Surgery	January 1, 2009

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List of Retired PQRI Measure Specifications		
Measure #	Measure Title	Retirement Effective Date
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
80	End Stage Renal Disease (ESRD): Plan of Care for ESRD Patients with Anemia	January 1, 2009
88	Hepatitis C: Hepatitis A and B Vaccination in Patients with HCV	January 1, 2009
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
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
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

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List of Retired PQRI Measure Specifications		
Measure #	Measure Title	Retirement Effective Date
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
152	Coronary Artery Disease (CAD): Lipid Profile in Patients with CAD	January 1, 2010
174	Pediatric End Stage Renal Disease (ESRD): Plan of Care for Inadequate Hemodialysis	January 1, 2011

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

2011 PHYSICIAN QUALITY REPORTING OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

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

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

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

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

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT codes, G-codes, and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure. The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data. There are no allowable performance exclusions for this measure.

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

Denominator Criteria (Eligible Cases):
Patients aged 18 through 75 years on date of encounter
AND

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Diagnosis for diabetes (ICD-9-CM): 250.00, 250.01, 250.02, 250.03, 250.10, 250.11, 250.12, 250.13, 250.20, 250.21, 250.22, 250.23, 250.30, 250.31, 250.32, 250.33, 250.40, 250.41, 250.42, 250.43, 250.50, 250.51, 250.52, 250.53, 250.60, 250.61, 250.62, 250.63, 250.70, 250.71, 250.72, 250.73, 250.80, 250.81, 250.82, 250.83, 250.90, 250.91, 250.92, 250.93, 357.2, 362.01, 362.02, 362.03, 362.04, 362.05, 362.06, 362.07, 366.41, 648.00, 648.01, 648.02, 648.03, 648.04

AND

Patient encounter during reporting period (CPT or HCPCS): 97802, 97803, 97804, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, G0270, G0271

NUMERATOR:

Patients with most recent hemoglobin A1c level > 9.0%

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

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Most Recent Hemoglobin A1c Level > 9.0%

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

OR

Hemoglobin A1c not Performed, Reason not Specified

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

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

OR

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

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

OR

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

RATIONALE:

Intensive therapy of glycosylated hemoglobin (A1c) reduces the risk of microvascular complications.

CLINICAL RECOMMENDATION STATEMENTS:

A glycosylated hemoglobin should be performed during an initial assessment and during follow-up assessments, which should occur at no longer than three-month intervals. (AACE/ACE)

The A1c should be universally adopted as the primary method of assessment of glycemic control. On the basis of data from multiple interventional trials, the target for attainment of glycemic control should be A1c values ≤6.5%. (AACE/ACE)

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Obtain a glycosylated hemoglobin during an initial assessment and then routinely as part of continuing care. In the absence of well-controlled studies that suggest a definite testing protocol, expert opinion recommends glycosylated hemoglobin be obtained at least twice a year in patients who are meeting treatment goals and who have stable glycemic control and more frequently (quarterly assessment) in patients whose therapy was changed or who are not meeting glycemic goals. (Level of Evidence: E) (ADA)

Because different assays can give varying glycated hemoglobin values, the ADA recommends that laboratories only use assay methods that are certified as traceable to the Diabetes Control and Complications Trial A1c reference method. The ADA's goal for glycemic control is A1c <7%. (Level of Evidence: B) (ADA)

Monitor and treat hyperglycemia, with a target A1c of 7%, but less stringent goals for therapy may be appropriate once patient preferences, diabetes severity, life expectancy and functional status have been considered. (AGS)

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

2011 PHYSICIAN QUALITY REPORTING OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

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

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

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

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

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT codes, G-codes, and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure. The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data. There are no allowable performance exclusions for this measure.

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

Denominator Criteria (Eligible Cases):
Patients aged 18 through 75 years on date of encounter
AND

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Diagnosis for diabetes (ICD-9-CM): 250.00, 250.01, 250.02, 250.03, 250.10, 250.11, 250.12, 250.13, 250.20, 250.21, 250.22, 250.23, 250.30, 250.31, 250.32, 250.33, 250.40, 250.41, 250.42, 250.43, 250.50, 250.51, 250.52, 250.53, 250.60, 250.61, 250.62, 250.63, 250.70, 250.71, 250.72, 250.73, 250.80, 250.81, 250.82, 250.83, 250.90, 250.91, 250.92, 250.93, 357.2, 362.01, 362.02, 362.03, 362.04, 362.05, 362.06, 362.07, 366.41, 648.00, 648.01, 648.02, 648.03, 648.04

AND

Patient encounter during reporting period (CPT or HCPCS): 97802, 97803, 97804, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, G0270, G0271

NUMERATOR:

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

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Most Recent LDL-C Level < 100 mg/dL

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

OR

Most Recent LDL-C Level **≥ 100 mg/dL**

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

OR

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

OR

LDL-C Level not Performed, Reason not Specified

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

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

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

RATIONALE:

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

CLINICAL RECOMMENDATION STATEMENTS:

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

A fasting lipid profile should be obtained as part of an initial assessment. Adult patients with diabetes should be tested annually for lipid disorders with fasting serum cholesterol, triglycerides, HDL cholesterol, and calculated LDL cholesterol measurements. If values fall in lower-risk levels, assessments may be repeated every two years. (Level of Evidence: E) (ADA)

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Patients who do not achieve lipid goals with lifestyle modifications require pharmacological therapy. Lowering LDL cholesterol with a statin is associated with a reduction in cardiovascular events. (Level of Evidence: A)

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

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

Once lipid-lowering therapy is initiated, patients with type 2 diabetes mellitus should be taking at least moderate doses of a statin.

Older persons with diabetes are likely to benefit greatly from cardiovascular risk reduction, therefore monitor and treat hypertension and dyslipidemias. (AGS)

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

2011 PHYSICIAN QUALITY REPORTING OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

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

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

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

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

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT codes, G-codes, and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure. The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data. There are no allowable performance exclusions for this measure.

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

> Denominator Criteria (Eligible Cases):
> Patients aged 18 through 75 years on date of encounter
> AND

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Diagnosis for diabetes (ICD-9-CM): 250.00, 250.01, 250.02, 250.03, 250.10, 250.11, 250.12, 250.13, 250.20, 250.21, 250.22, 250.23, 250.30, 250.31, 250.32, 250.33, 250.40, 250.41, 250.42, 250.43, 250.50, 250.51, 250.52, 250.53, 250.60, 250.61, 250.62, 250.63, 250.70, 250.71, 250.72, 250.73, 250.80, 250.81, 250.82, 250.83, 250.90, 250.91, 250.92, 250.93, 357.2, 362.01, 362.02, 362.03, 362.04, 362.05, 362.06, 362.07, 366.41, 648.00, 648.01, 648.02, 648.03, 648.04

AND

Patient encounter during reporting period (CPT or HCPCS): 97802, 97803, 97804, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, G0270, G0271

NUMERATOR:

Patients whose most recent blood pressure < 140/90 mmHg

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

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Most Recent Blood Pressure Measurement Performed

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

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

OR

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

OR

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

AND

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

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

OR

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

OR

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

OR

Blood Pressure Measurement not Performed, Reason not Specified

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

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

RATIONALE:

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

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CLINICAL RECOMMENDATION STATEMENTS:

Recommends that a blood pressure determination during the initial evaluation, including orthostatic evaluation, be included in the initial and every interim physical examination. (AACE/ACE)

Blood pressure control must be a priority in the management of persons with hypertension and type 2 diabetes. (ACP)

Blood pressure should be measured at every routine diabetes visit. Patients found to have systolic blood pressure >130 mmHg or diastolic >80 mmHg should have blood pressure confirmed on a separate day. Orthostatic measurement of blood pressure should be performed to assess for the presence of autonomic neuropathy. (Level of Evidence: E) (ADA)

Older persons with diabetes are likely to benefit greatly from cardiovascular risk reduction, therefore monitor and treat hypertension and dyslipidemias. (AGS)

Measurement of blood pressure in the standing position is indicated periodically, especially in those at risk for postural hypotension. At least two measurements should be made and the average recorded. After BP is at goal and stable, follow-up visits can usually be at 3- to 6-month intervals. Comorbidities such as heart failure, associated diseases such as diabetes, and the need for laboratory tests influence the frequency of visits. (JNC)

All individuals should be evaluated during health encounters to determine whether they are at increased risk of having or of developing chronic kidney disease. This evaluation of risk factors should include blood pressure measurement. (NKF)

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

2011 PHYSICIAN QUALITY REPORTING OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Percentage of patients aged 18 years and older with a diagnosis of HF and LVSD (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 HF patients seen during the reporting period. This measure is intended to reflect the quality of services provided for patients with HF and decreased left ventricular systolic function. The LVSD may be determined by quantitative or qualitative assessment, which may be current or historical. Examples of a quantitative or qualitative assessment may include an echocardiogram: 1) that provides a numerical value of LVSD or 2) that uses descriptive terms such as moderately or severely depressed left ventricular systolic function. Any current or prior ejection fraction study documenting LVSD can be used to identify patients. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT codes, 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 have been provided for registry only measures for use by registries that utilize claims data. It is not necessary to submit these codes for registry-based submissions. Do not report this measure via claims.

DENOMINATOR:
Heart failure patients aged 18 years and older with LVEF < 40% or with moderately or severely depressed left ventricular systolic function

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Diagnosis for HF (ICD-9-CM): 402.01, 402.11, 402.91, 404.01, 404.03, 404.11, 404.13, 404.91, 404.93, 428.0, 428.1, 428.20, 428.21, 428.22, 428.23, 428.30, 428.31, 428.32, 428.33, 428.40, 428.41, 428.42, 428.43, 428.9
AND
Patient encounter during reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99238, 99239, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350

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NUMERATOR:
Patients who were prescribed ACE inhibitor or ARB therapy

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

Numerator Options:
Angiotensin converting enzyme (ACE) inhibitor or angiotensin receptor blocker (ARB) therapy prescribed (4009F)
AND
Left ventricular ejection fraction (LVEF) <40% or documentation of moderately or severely depressed left ventricular systolic function (3021F)

OR

Documentation of medical reason(s) for not prescribing angiotensin converting enzyme (ACE) inhibitor or angiotensin receptor blocker (ARB) therapy (4009F *with* 1P)
OR
Documentation of patient reason(s) for not prescribing angiotensin converting enzyme (ACE) inhibitor or angiotensin receptor blocker (ARB) therapy (4009F *with* 2P)
OR
Documentation of system reason(s) for not prescribing angiotensin converting enzyme (ACE) inhibitor or angiotensin receptor blocker (ARB) therapy (4009F *with* 3P)

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

OR

Left ventricular ejection fraction (LVEF) ≥ 40% or documentation as normal or mildly depressed left ventricular systolic function (3022F)
OR
Left ventricular ejection fraction (LVEF) was not performed or documented (3021F *with* 8P)

OR

Angiotensin converting enzyme (ACE) inhibitor or angiotensin receptor blocker (ARB) therapy was not prescribed, reason not otherwise specified (4009F *with* 8P)
AND
Left ventricular ejection fraction < 40% or documentation of moderately or severely depressed left ventricular systolic function (3021F)

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, as measured by left

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ventricular ejection fraction (LVEF). Both drugs have been shown to decrease mortality and hospitalizations.

CLINICAL RECOMMENDATION STATEMENTS:

Angiotensin converting enzyme inhibitors are recommended for all patients with current or prior symptoms of HF and reduced LVEF, unless contraindicated. (Class I Recommendation, Level of Evidence: A) (ACC/AHA)

Angiotensin II receptor blockers approved for the treatment of HF are recommended in patients with current or prior symptoms of HF and reduced LVEF who are ACEI-intolerant. (Class I Recommendation, Level of Evidence: A) (ACC/AHA)

Angiotensin II receptor blockers are reasonable to use as alternatives to ACEIs as first-line therapy for patients with mild to moderate HF and reduced LVEF, especially for patients already taking ARBs for other indications. (Class IIa Recommendation, Level of Evidence: A) (ACC/AHA)

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▲ Measure #6: Coronary Artery Disease (CAD): Oral Antiplatelet Therapy Prescribed for Patients with CAD

2011 PHYSICIAN QUALITY REPORTING OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of patients aged 18 years and older with a diagnosis of CAD who were prescribed oral antiplatelet therapy

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

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

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

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure. The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All patients aged 18 years and older with a diagnosis of coronary artery disease

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Diagnosis for CAD (ICD-9-CM): 410.00, 410.01, 410.02, 410.10, 410.11, 410.12, 410.20, 410.21, 410.22, 410.30, 410.31, 410.32, 410.40, 410.41, 410.42, 410.50, 410.51, 410.52, 410.60, 410.61, 410.62, 410.70, 410.71, 410.72, 410.80, 410.81, 410.82, 410.90, 410.91, 410.92, 411.0, 411.1, 411.81, 411.89, 412, 413.0, 413.1, 413.9, 414.00, 414.01, 414.02, 414.03, 414.04, 414.05, 414.06, 414.07, 414.8, 414.9, V45.81, V45.82

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AND

Patient encounter during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99238, 99239, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350

NUMERATOR:

Patients who were prescribed oral antiplatelet therapy

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

Definition:

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

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Oral Antiplatelet Therapy Prescribed

CPT II 4011F: Oral antiplatelet therapy prescribed

OR

Oral Antiplatelet Therapy not Prescribed for Medical, Patient, or System Reasons

Append a modifier (1P, 2P or 3P) to Category II code 4011F to report documented circumstances that appropriately exclude patients from the denominator.

4011F *with* 1P: Documentation of medical reason(s) for not prescribing oral antiplatelet therapy

4011F *with* 2P: Documentation of patient reason(s) for not prescribing oral antiplatelet therapy

4011F *with* 3P: Documentation of system reason(s) for not prescribing oral antiplatelet therapy

OR

Oral Antiplatelet Therapy not Prescribed, Reason not Specified

Append a reporting modifier (8P) to CPT Category II code 4011F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

4011F *with* 8P: Oral antiplatelet therapy was not prescribed, reason not otherwise specified

RATIONALE:

Oral antiplatelet therapy, preferably aspirin unless contraindicated, is recommended for all patients with coronary artery disease. By limiting the ability of clots to form in the arteries, antiplatelet agents have proven benefits in reducing the risk of non-fatal myocardial infarction, non-fatal stroke and death.

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CLINICAL RECOMMENDATION STATEMENTS:

Chronic Stable Angina: Class I – Aspirin 75-325 mg daily should be used routinely in all patients with acute and chronic ischemic heart disease with or without manifest symptoms in the absence of contraindications. Class IIa – Clopidogrel is recommended when aspirin is absolutely contraindicated. Class III – Dipyridamole. Because even the usual oral doses of dipyridamole can enhance exercise-induced myocardial ischemia in patients with stable angina, it should not be used as an antiplatelet agent. (ACC/AHA/ACP-ASIM)

Unstable Angina and Non-ST-Segment Elevation Myocardial Infarction: Class I – Aspirin 75 to 325 mg/dl in the absence of contraindications. Class I – Clopidogrel 75 qd for patients with a contraindication to ASA. (ACC/AHA)

Acute Myocardial Infarction (AMI): Class I – A dose of aspirin, 160 to 325 mg, should be given on day one of AMI and continued indefinitely on a daily basis thereafter. Trials suggest long-term use of aspirin in the postinfarction patient in a dose as low as 75 mg per day can be effective, with the likelihood that side effects can be reduced. Class IIb – Other antiplatelet agents such as dipyridamole, ticlopidine or clopidogrel may be substituted if true aspirin allergy is present or if the patient is unresponsive to aspirin. (ACC/AHA)

Coronary Artery Bypass Graft Surgery: Aspirin is the drug of choice for prophylaxis against early saphenous graft thrombotic closure and should be considered a standard of care for the first postoperative year. In general, patients are continued on aspirin indefinitely, given its benefit in the secondary prevention of AMI. Ticlopidine is efficacious but offers no advantage over aspirin except as an alternative in the truly aspirin-allergic patient. Clopidogrel offers the potential of fewer side effects compared with ticlopidine as an alternative to aspirin for platelet inhibition. Indobufen appears to be as effective as aspirin for saphenous graft patency over the first postoperative year but with fewer gastrointestinal side effects. Current evidence suggests that dipyridamole adds nothing to the aspirin effect for saphenous graft patency. (ACC/AHA)

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▲ Measure #7: Coronary Artery Disease (CAD): Beta-Blocker Therapy for CAD Patients with Prior Myocardial Infarction (MI)

2011 PHYSICIAN QUALITY REPORTING OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Percentage of patients aged 18 years and older with a diagnosis of CAD and prior MI who were prescribed beta-blocker therapy

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

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure. The quality-data codes have been provided for registry only measures for use by registries that utilize claims data. It is not necessary to submit these codes for registry-based submissions. Do not report this measure via claims.

DENOMINATOR:
Patients aged 18 years and older with a diagnosis of coronary artery disease who also have prior myocardial infarction (MI) at any time

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Diagnosis for CAD* (ICD-9-CM): 410.00*, 410.01*, 410.02*, 410.10*, 410.11*, 410.12*, 410.20*, 410.21*, 410.22*, 410.30*, 410.31*, 410.32*, 410.40*, 410.41*, 410.42*, 410.50*, 410.51*, 410.52*, 410.60*, 410.61*, 410.62*, 410.70*, 410.71*, 410.72*, 410.80*, 410.81*, 410.82*, 410.90*, 410.91*, 410.92*, 411.0, 411.1, 411.81, 411.89, 412*, 413.0, 413.1, 413.9, 414.00, 414.01, 414.02, 414.03, 414.04, 414.05, 414.06, 414.07, 414.8, 414.9, V45.81, V45.82
AND
Diagnosis for MI – includes patient that had a prior MI at any time: (ICD-9-CM): 410.00, 410.01, 410.02, 410.10, 410.11, 410.12, 410.20, 410.21, 410.22, 410.30, 410.31, 410.32, 410.40, 410.41, 410.42, 410.50, 410.51, 410.52, 410.60, 410.61, 410.62, 410.70, 410.71, 410.72, 410.80, 410.81, 410.82, 410.90, 410.91, 410.92, 412
AND

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Patient encounter during reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99238, 99239, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350

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

NUMERATOR:
Patients who were prescribed beta-blocker therapy

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

Numerator Options:
Beta-blocker therapy prescribed (4006F)
OR
Beta-blocker therapy not prescribed for medical reason (4006F *with* 1P)
OR
Beta-blocker therapy not prescribed for patient reason (4006F *with* 2P)
OR
Beta-blocker therapy not prescribed for system reason (4006F *with* 3P)
OR
Beta-blocker therapy not prescribed, reason not specified (4006F *with* 8P)

RATIONALE:
In the absence of contraindications, beta-blocker therapy has been shown to reduce the risk of a recurrent MI and decrease mortality for those patients with a prior MI.

CLINICAL RECOMMENDATION STATEMENTS:
Chronic Stable Angina: Class I – Beta-blockers as initial therapy in the absence of contraindications in patients with prior MI. Class I – Beta-blockers as initial therapy in the absence of contraindications in patients without prior MI. (ACC/AHA/ACP-ASIM)

Unstable Angina and Non-ST-Segment Elevation Myocardial Infarction: Class I – Drugs required in the hospital to control ischemia should be continued after hospital discharge in patients who do not undergo coronary revascularization, patients with unsuccessful revascularization, or patients with recurrent symptoms after revascularization. Upward or downward titration of the doses may be required. Class I – Beta-blockers in the absence of contraindications. (ACC/AHA)

Acute Myocardial Infarction: Class I – All but low-risk patients without a clear contraindication to ß-adrenoceptor blocker therapy. Treatment should begin within a few days of the event (if not initiated acutely) and continue indefinitely.

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Class IIa – Low-risk patients without a clear contraindication to ß-adrenoceptor blocker therapy. Survivors of non-ST-elevation MI. Class IIb – Patients with moderate or severe LV failure or other relative contraindications to ß-adrenoceptor blocker therapy, provided they can be monitored closely. (ACC/AHA)

Although no study has determined if long-term ß-adrenoceptor blocker therapy should be administered to survivors of MI who subsequently have satisfactorily undergone revascularization, there is no reason to believe that these agents act differently in coronary patients who have undergone revascularization. (ACC/AHA)

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

2011 PHYSICIAN QUALITY REPORTING OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Percentage of patients aged 18 years and older with a diagnosis of heart failure who also have LVSD (LVEF < 40%) and who were prescribed beta-blocker therapy

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for all heart failure patients seen during the reporting period. This measure is intended to reflect the quality of services provided for patients with heart failure and decreased left ventricular systolic function. The left ventricular systolic dysfunction may be determined by quantitative or qualitative assessment, which may be current or historical. Examples of a quantitative or qualitative assessment may include an echocardiogram: 1) that provides a numerical value of left ventricular systolic dysfunction or 2) that uses descriptive terms such as moderately or severely depressed left ventricular systolic function. Any current or prior ejection fraction study documenting LVSD can be used to identify patients. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure. The quality-data codes have been provided for registry only measures for use by registries that utilize claims data. It is not necessary to submit these codes for registry-based submissions. Do not report this measure via claims.

DENOMINATOR:
Patients aged 18 years and older with a diagnosis of heart failure with left ventricular ejection fraction (LVEF) < 40% or with moderately or severely depressed left ventricular systolic function

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Diagnosis for HF (ICD-9-CM): 402.01, 402.11, 402.91, 404.01, 404.03, 404.11, 404.13, 404.91, 404.93, 428.0, 428.1, 428.20, 428.21, 428.22, 428.23, 428.30, 428.31, 428.32, 428.33, 428.40, 428.41, 428.42, 428.43, 428.9
AND
Patient encounter during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350

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NUMERATOR:
Patients who were prescribed beta-blocker therapy

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

Numerator Options:
Beta-blocker therapy prescribed for patients with left ventricular ejection fraction (LVEF) <40% or documentation as moderately or severely depressed left ventricular systolic function (G8450)

OR

Clinician documented patient with left ventricular ejection fraction (LVEF) <40% or documentation as moderately or severely depressed left ventricular systolic function was not eligible candidate for beta-blocker therapy (G8451)

OR

Left ventricular ejection fraction (LVEF) ≥ 40% or documentation as normal or mildly depressed left ventricular systolic function (G8395)
OR
Left ventricular ejection fraction (LVEF) not performed or documented (G8396)

OR

Beta-blocker therapy not prescribed for patients with left ventricular ejection fraction (LVEF) <40% or documentation as moderately or severely depressed left ventricular systolic function (G8452)

RATIONALE:
Beta-blockers are recommended for all patients with symptoms of heart failure and left ventricular systolic dysfunction, unless contraindicated. Treatment with beta-blockers has been shown to provide multiple benefits to the patient, including reducing the symptoms of heart failure, improving the clinical status of patients, and decreasing the risk of mortality and hospitalizations.

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

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

2011 PHYSICIAN QUALITY REPORTING OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

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

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

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

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

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure. The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

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

> Denominator Criteria (Eligible Cases):
> Patients aged ≥ 18 years on date of encounter
> AND
> Diagnosis for MDD (ICD-9-CM): 296.20, 296.21, 296.22, 296.23, 296.24, 296.25, 296.30, 296.31, 296.32, 296.33, 296.34, 296.35, 298.0, 300.4, 309.0, 309.1, 311
> AND

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Patient encounter during the reporting period (CPT): 90801, 90802, 90804, 90805, 90806, 90807, 90808, 90809, 90810, 90811, 90812, 90813, 90814, 90815, 90821, 90822, 90823, 90824, 90829, 90845, 90849, 90853, 90857, 90862, 99078, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350

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

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

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

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

OR

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

OR

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

RATIONALE:
The consequences of untreated, or inadequately treated, depression are significant; therefore, adherence to antidepressant medication is very important. Clinical guidelines for depression stress the importance of effective clinical management in increasing patients' medication compliance, monitoring treatment effectiveness, and identifying and managing side effects. If pharmacological treatment is initiated, appropriate dosing and continuation of therapy through the acute and continuation phases decreases recurrence of depression. Thus, evaluation of length of treatment serves as an important indicator of success in promoting patient compliance with the establishment and maintenance of an effective medication regimen.

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CLINICAL RECOMMENDATION STATEMENTS:

Successful treatment of patients with major depressive disorder is promoted by a thorough assessment of the patient and close adherence to treatment plans. Treatment consists of an acute phase, during which remission is induced; a continuation phase, during which remission is preserved; and a maintenance phase, during which the susceptible patient is protected against the recurrence of a subsequent major depressive episode. Patients who have been treated with antidepressant medications in the acute phase should be maintained on these agents to prevent relapse. *American Psychiatric Association (APA) Practice Guideline for the Treatment of Patients with Major Depressive Disorder, 2000*

Antidepressants should be continued for at least 6 months after remission of an episode of depression, because this greatly reduces the risk of relapse. (A: At least one randomized controlled trial as part of a body of literature of overall good quality and consistency addressing the specific recommendation (evidence level-I) without extrapolation) *National Institute for Clinical Excellence (UK), Management of Depression in Primary and Secondary Care, 2004*

In recent years, major depression has come to be considered a chronic and/or recurrent, rather than an acute illness. This reevaluation of the disorder has inherent treatment implications because patients with major depression tend to exhibit episodic recurrence and/or chronic residual symptoms. Considering this, the management of depression can be divided into the acute phase (suppression of symptoms to achieve clinical remission), lasting 8 to 12 weeks, and the maintenance phase (prevention of relapse/recurrence), lasting 6 months or longer. Clinical management is an important component of pharmacotherapy; and includes a brief session of psychoeducation and supportive strategies. During the maintenance phase after remission of acute symptoms, all patients should continue the antidepressant dose that induced remission for at least 6 months. The relapse rate is 35% to 60% if antidepressants are discontinued in the first 6 months, compared with 10% to 25% in patients who continue medications. The risk of relapse is particularly high if drug discontinuation occurs in the first few months of response/remission. *Canadian Psychiatric Association, 2001*

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*Measure #10: Stroke and Stroke Rehabilitation: Computed Tomography (CT) or Magnetic Resonance Imaging (MRI) Reports

2011 PHYSICIAN QUALITY REPORTING OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of final reports for CT or MRI studies of the brain performed either:

- In the hospital within 24 hours of arrival, OR
- In an outpatient imaging center to confirm initial diagnosis of stroke, transient ischemic attack (TIA) or intracranial hemorrhage.

For patients aged 18 years and older with either a diagnosis of ischemic stroke, TIA or intracranial hemorrhage OR at least one documented symptom consistent with ischemic stroke ,TIA or intracranial hemorrhage that includes documentation of the presence or absence of each of the following: hemorrhage, mass lesion and acute infarction

INSTRUCTIONS:
This measure is to be reported each time a CT or MRI study of the brain is performed in a hospital or outpatient setting during the reporting period for patients with a diagnosis or symptom of ischemic stroke, TIA, or intracranial hemorrhage. The "within 24 hours of arrival" requirement does not apply to CT or MRI studies performed in an outpatient imaging center because it is the intent of the measure to include these outpatient studies regardless of whether the patient is subsequently referred to the hospital. It is anticipated that clinicians who provide the physician component of diagnostic imaging studies for patients with stroke, TIA, or intracranial hemorrhage in the hospital or outpatient setting will submit this measure. Note: Use of symptom codes is limited to those specified in the denominator coding.

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

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

Measure Reporting via Registry:
ICD-9-CM diagnosis codes (includes symptom 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.

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DENOMINATOR:
All final reports for CT or MRI studies of the brain performed either

- In the hospital within 24 hours of arrival OR
- In an outpatient imaging center to confirm initial diagnosis of stroke, TIA or intracranial hemorrhage*

For patients aged 18 years and older with either a diagnosis of ischemic stroke, TIA or intracranial hemorrhage OR at least one documented symptom consistent with ischemic stroke, TIA or intracranial hemorrhage

* Final reports for outpatient imaging studies of the brain performed to confirm initial diagnosis are eligible for this measure whether or not patient is subsequently referred to the hospital.

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
For purposes of this measure, the listed symptoms will be considered "documented symptoms consistent" with ischemic stroke, TIA or intracranial hemorrhage. Each of the listed symptoms corresponds to a specific ICD-9-CM code in the code table below.
Note: Use of symptom codes is limited to the following:

• Transient visual loss (368.12) • Diplopia (double vision) (368.2) • Vertigo of central origin (386.2) • Transient global amnesia (437.7) • Transient alteration of awareness (780.02) • Lack of coordination (781.3)	• Transient paralysis of limb (781.4) • Facial weakness (781.94) • Disturbance of skin sensation (782.0) • Aphasia (784.3) • Slurred speech (784.51, 784.59)

Diagnosis for ischemic stroke, TIA or intracranial hemorrhage – including symptom codes (ICD-9-CM): 368.12, 368.2, 386.2, 431, 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, 437.7, 780.02, 781.3, 781.4, 781.94, 782.0, 784.3, 784.51, 784.59
AND
Patient encounter during the reporting period (CPT): 0042T, 70450, 70460, 70470, 70551, 70552, 70553

NUMERATOR:
Final reports of the initial CT or MRI that include documentation of the presence or absence of each of the following: hemorrhage and mass lesion and acute infarction

Numerator Instructions: Equivalent terms or synonyms for hemorrhage, mass lesion, or infarction, if documented in the CT or MRI report, would meet the measure.

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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:
Presence/Absence of Hemorrhage, Mass Lesion, and Acute Infarction Documented
(Two CPT II codes [3110F & 3111F] are required on the claim form to submit this numerator option)
CPT II 3110F: Documentation in the final CT or MRI report of presence or absence of hemorrhage and mass lesion and acute infarction
AND
CPT II 3111F: CT or MRI of the brain performed in the hospital within 24 hours of arrival OR performed in an outpatient imaging center to confirm initial diagnosis of stroke, TIA or intracranial hemorrhage.

OR

If patient is not eligible for this measure because CT or MRI of the brain was performed in the hospital greater than 24 hours after arrival or performed in an outpatient imaging center for the purpose other than confirmation of initial diagnosis, report:
(One CPT II code [3112F] is required on the claim form to submit this numerator option)
CPT II 3112F: CT or MRI of the brain performed in the hospital greater than 24 hours after arrival OR performed in an outpatient imaging center for purpose other than confirmation of initial diagnosis of stroke, TIA or intracranial hemorrhage.

OR

Presence/Absence of Hemorrhage, Mass Lesion, and Acute Infarction not Documented, Reason not Specified
(Two CPT II codes [3110F-8P & 3111F] are required on the claim form to submit this numerator option)
Append a reporting modifier (8P) to CPT Category II code 3110F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.
3110F *with* 8P: No documentation in final CT or MRI report of presence or absence of hemorrhage and mass lesion and acute infarction, reason not otherwise specified
AND
CPT II 3111F: CT or MRI of the brain performed in the hospital within 24 hours of arrival OR performed in an outpatient imaging center to confirm initial diagnosis of stroke, TIA or intracranial hemorrhage.

RATIONALE:
The CT and MRI findings are critical to initiating care for the patient with stroke. All CT and MRI reports should address the presence or absence of these three important findings. This documentation is particularly vital in the report of the first imaging study performed after arrival at the hospital (whether or not the patient is admitted), on which initial treatment decisions will be based.

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The denominator language and specifications also allow for inclusion of CT or MRI studies performed in an outpatient imaging center to confirm initial diagnosis of stroke, TIA or intracranial hemorrhage (i.e., *not* including follow-up studies performed after acute treatment for these diagnoses), regardless of whether the patient is subsequently referred to the hospital.

CLINICAL RECOMMENDATION STATEMENTS:

Brain imaging is required to guide acute intervention. (Grade A) There is a uniform agreement that CT accurately identifies most cases of intracranial hemorrhage and helps discriminate nonvascular causes of neurological symptoms, e.g., brain tumor. (Grade B) With the advent of rtPA treatment, interest has grown in using CT to identify subtle, early signs of ischemic brain injury (early infarct signs) or arterial occlusion that might affect decisions about treatment. The presence of these signs is associated with poor outcomes. (Adams, ASA, 2003) (Class A)

A technically adequate head CT scan is required prior to administration of thrombolytic therapy to exclude brain hemorrhage and nonischemic diagnoses. The baseline CT scan is also sensitive for detection of early signs of cerebral infarction. Subtle or limited signs of early infarction on the CT scan are common even within the first 3 h of stroke evolution.

Preliminary data suggest that specific MRI profiles may identify patients who are particularly likely to benefit from thrombolytic therapy. New MRI techniques including perfusion-weighted and diffusion-weighted may detect ischemic injury in the first hour and may reveal the extent of reversible and irreversible injury. In addition, MRI appears to be highly sensitive for identification of acute brain hemorrhage. (Albers, ACCP, 2004)

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

2011 PHYSICIAN QUALITY REPORTING OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

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

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

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

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

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure. The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

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

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Diagnosis for primary open-angle glaucoma (ICD-9-CM): 365.10, 365.11, 365.12, 365.15
AND
Patient encounter during the reporting period (CPT): 92002, 92004, 92012, 92014, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337

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

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

OR

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

OR

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

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

CLINICAL RECOMMENDATION STATEMENTS:
The physical exam focuses on nine elements: visual acuity, pupils, slit-lamp biomicroscopy of the anterior segment, measurement of intraocular pressure (IOP), determination of central corneal thickness, gonioscopy, evaluation of optic nerve head and retinal nerve fiber layer, documentation of optic nerve head appearance, evaluation of fundus (through dilated pupil), and evaluation of the visual field. (Level A: II Recommendation for optic nerve head evaluation) (AAO, 2005)

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

2011 PHYSICIAN QUALITY REPORTING OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

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

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

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

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

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure. The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

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

Denominator Criteria (Eligible Cases):
Patients aged ≥ 50 years on date of encounter
AND
Diagnosis for age-related macular degeneration (ICD-9-CM): 362.50, 362.51, 362.52
AND

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

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

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

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

OR

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

OR

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

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

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CLINICAL RECOMMENDATION STATEMENTS:

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

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

2011 PHYSICIAN QUALITY REPORTING OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

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

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

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

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

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure. The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

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

> Denominator Criteria (Eligible Cases):
> Patients aged ≥ 18 years on date of encounter
> AND
> Diagnosis for diabetic retinopathy (ICD-9-CM): 362.01, 362.02, 362.03, 362.04, 362.05, 362.06
> AND

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

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

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

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

OR

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

OR

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

RATIONALE:
Several level 1 RCT studies demonstrate the ability of timely treatment to reduce the rate and severity of vision loss from diabetes (Diabetic Retinopathy Study – DRS, Early Treatment Diabetic Retinopathy Study – ETDRS). Necessary examination prerequisites to applying the study results are that the presence and severity of both peripheral diabetic retinopathy and macular edema be accurately documented. In the RAND chronic disease quality project, while administrative data

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indicated that roughly half of the patients had an eye exam in the recommended time period, chart review data indicated that only 19% had documented evidence of a dilated examination. (McGlynn, 2003). Thus, ensuring timely treatment that could prevent 95% of the blindness due to diabetes requires the performance and documentation of key examination parameters. The documented level of severity of retinopathy and the documented presence or absence of macular edema assists with the on-going plan of care for the patient with diabetic retinopathy.

CLINICAL RECOMMENDATION STATEMENTS:

Since treatment is effective in reducing the risk of visual loss, detailed examination is indicated to assess for the following features that often lead to visual impairment: presence of macular edema, optic nerve neovascularization and/or neovascularization elsewhere, signs of severe NPDR and vitreous or preretinal hemorrhage. (Level A:III Recommendation) (AAO, 2003)

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*Measure #19: Diabetic Retinopathy: Communication with the Physician Managing On-going Diabetes Care

2011 PHYSICIAN QUALITY REPORTING 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 on-going care of the patient with diabetes mellitus regarding the findings of the macular or fundus exam at least once within 12 months

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

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

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

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure. The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

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

> Denominator Criteria (Eligible Cases):
> Patients aged ≥ 18 years on date of encounter
> AND
> Diagnosis for diabetic retinopathy (ICD-9-CM): 362.01, 362.02, 362.03, 362.04, 362.05, 362.06

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AND

Patient encounter during the reporting period (CPT): 92002, 92004, 92012, 92014, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 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

Definition:

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

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

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Dilated Macular or Fundus Exam Findings Communicated

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

CPT II 5010F: Findings of dilated macular or fundus exam communicated to the physician managing the diabetes care

AND

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

OR

Dilated Macular or Fundus Exam Findings not Communicated for Medical Reasons

(One CPT II code & one G-code [5010F-1P & G8397] are required on the claim form to submit this numerator option)

Append a modifier (1P) to CPT Category II code 5010F to report documented circumstances that appropriately exclude patients from the denominator.

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

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

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

AND

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

OR

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

OR

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

AND

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

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

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

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

2011 PHYSICIAN QUALITY REPORTING OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

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

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

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

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

Measure Reporting via Registry:
CPT codes and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure. The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

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

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

Denominator Criteria (Eligible Cases):

Patients aged ≥ 18 years on date of encounter

AND

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

SURGICAL PROCEDURE	CPT CODE
Integumentary	15734, 15738, 19260, 19271, 19272, 19301, 19302, 19303, 19304, 19305, 19306, 19307, 19361, 19364, 19366, 19367, 19368, 19369
Le Fort Fractures	21346, 21347, 21348, 21422, 21423, 21432, 21433, 21435, 21436
Mandibular Fracture	21454, 21461, 21462, 21465, 21470
Spine	22325, 22612, 22630, 22800, 22802, 22804, 63030, 63042
Hip Reconstruction	27125, 27130, 27132, 27134, 27137, 27138
Trauma (Fractures)	27235, 27236, 27244, 27245, 27269, 27758, 27759, 27766, 27769, 27792, 27814
Knee Reconstruction	27440, 27441, 27442, 27443, 27445, 27446, 27447
Laryngectomy	31360, 31365, 31367, 31368, 31370, 31375, 31380, 31382, 31390, 31395
Vascular	33877, 33880, 33881, 33883, 33886, 33891, 34800, 34802, 34803, 34804, 34805, 34825, 34830, 34831, 34832, 34900, 35081, 35091, 35102, 35131, 35141, 35151, 35601, 35606, 35612, 35616, 35621, 35623, 35626, 35631, 35632, 35633, 35634, 35636, 35637, 35638, 35642, 35645, 35646, 35647, 35650, 35651, 35654, 35656, 35661, 35663, 35665, 35666, 35671, 36830
Spleen and Lymph Nodes	38115
Glossectomy	41130, 41135, 41140, 41145, 41150, 41153, 41155
Esophagus	43045, 43100, 43101, 43107, 43108, 43112, 43113, 43116, 43117, 43118, 43121, 43122, 43123, 43124, 43130, 43135, 43300, 43305, 43310, 43312, 43313, 43320, 43325, 43327, 43328, 43330, 43331, 43332, 43333, 43334, 43335, 43336, 43337, 43340, 43341, 43350, 43351, 43352, 43360, 43361, 43400, 43401, 43405, 43410, 43415, 43420, 43425, 43496
Stomach	43500, 43501, 43502, 43510, 43520, 43605, 43610, 43611, 43620, 43621, 43622, 43631, 43632, 43633, 43634, 43640, 43641, 43653, 43800, 43810, 43820,

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SURGICAL PROCEDURE	CPT CODE
	43825, 43830, 43831, 43832, 43840, 43843, 43845, 43846, 43847, 43848, 43850, 43855, 43860, 43865, 43870
Small Intestine	44005, 44010, 44020, 44021, 44050, 44055, 44100, 44120, 44125, 44126, 44127, 44130, 44132, 44133, 44135, 44136
Colon and Rectum	43880, 44025, 44110, 44111, 44140, 44141, 44143, 44144, 44145, 44146, 44147, 44150, 44151, 44155, 44156, 44157, 44158, 44160, 44202, 44204, 44205, 44206, 44207, 44208, 44210, 44211, 44212, 44300, 44310, 44312, 44314, 44316, 44320, 44322, 44340, 44345, 44346, 44602, 44603, 44604, 44605, 44615, 44620, 44625, 44626, 44640, 44650, 44660, 44661, 44700, 44950, 51597
Anus and Rectum	45108, 45110, 45111, 45112, 45113, 45114, 45116, 45119, 45120, 45121, 45123, 45126, 45130, 45135, 45136, 45150, 45160, 45171, 45172, 45190, 45500, 45505, 45520, 45540, 45541, 45550, 45560, 45562, 45563, 45800, 45805, 45820, 45825
Hepatic Surgery	47135, 47136, 47140, 47141, 47142
Biliary Surgery	47420, 47425, 47460, 47480, 47560, 47561, 47570, 47600, 47605, 47610, 47612, 47620, 47700, 47701, 47711, 47712, 47715, 47720, 47721, 47740, 47741, 47760, 47765, 47780, 47785, 47800, 47802, 47900
Pancreas	48020, 48100, 48120, 48140, 48145, 48146, 48148, 48150, 48152, 48153, 48154, 48155, 48500, 48510, 48511, 48520, 48540, 48545, 48547, 48548, 48554, 48556
Abdomen, Peritoneum, & Omentum	49215, 49568
Renal Transplant	50320, 50340, 50360, 50365, 50370, 50380
Gynecologic Surgery	58150, 58152, 58180, 58200, 58210, 58260, 58262, 58263, 58267, 58270, 58275, 58280, 58285, 58290, 58291, 58292, 58293, 58294
Acoustic Neuroma	61520, 61526, 61530, 61591, 61595, 61596, 61598, 61606, 61616, 61618, 61619, 69720, 69955, 69960, 69970
Cochlear Implants	69930
Neurological Surgery	22524, 22554, 22558, 22600, 22612, 22630, 35301, 61154, 61312, 61313, 61315, 61510, 61512, 61518, 61548, 61697, 61700, 61750, 61751, 61867, 62223, 62230, 63015, 63020, 63030, 63042, 63045, 63047, 63056, 63075, 63081, 63267, 63276
Cardiothoracic Surgery	33120, 33130, 33140, 33141, 33202, 33250, 33251, 33256, 33261, 33305, 33315, 33321, 33322, 33332, 33335, 33400, 33401, 33403, 33404, 33405, 33406,

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SURGICAL PROCEDURE	CPT CODE
	33410, 33411, 33413, 33416, 33422, 33425, 33426, 33427, 33430, 33460, 33463, 33464, 33465, 33475, 33496, 33510, 33511, 33512, 33513, 33514, 33516, 33517, 33518, 33519, 33521, 33522, 33523, 33530, 33533, 33534, 33535, 33536, 33542, 33545, 33548, 33572, 35211, 35241, 35271
Cardiothoracic (Pacemaker)	33203, 33206, 33207, 33208, 33212, 33213, 33214, 33215, 33216, 33217, 33218, 33220, 33222, 33223, 33224, 33225, 33226, 33233, 33234, 33235, 33236, 33237, 33238, 33240, 33241, 33243, 33244, 33249, 33254, 33255
Genitourinary Surgery	51550, 51555, 51565, 51570, 51575, 51580, 51585, 51590, 51595, 51596, 51920, 51925, 52450, 52601, 52630, 52647, 52648, 52649, 54401, 54405, 54406, 54408, 54410, 54415, 54416, 55801, 55810, 55812, 55815, 55821, 55831, 55840, 55842, 55845
General Thoracic Surgery	0236T, 19272, 21627, 21632, 21740, 21750, 21805, 21825, 31760, 31766, 31770, 31775, 31786, 31805, 32095, 32100, 32110, 32120, 32124, 32140, 32141, 32150, 32215, 32220, 32225, 32310, 32320, 32402, 32440, 32442, 32445, 32480, 32482, 32484, 32486, 32488, 32491, 32500, 32501, 32800, 32810, 32815, 32900, 32905, 32906, 32940, 33020, 33025, 33030, 33031, 33050, 33300, 33310, 33320, 34051, 35021, 35216, 35246, 35276, 35311, 35526, 37616, 38381, 38746, 39000, 39010, 39200, 39220, 39545, 39561, 60521, 60522, 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

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

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

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

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

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

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

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

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

OR

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

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

OR

Order for Prophylactic Parenteral Antibiotic not Given for Documented Reasons

G8631: Clinician documented that patient was not an eligible candidate for ordering prophylactic parenteral antibiotics to be given within one hour (if fluoroquinolone or vancomycin, two hours) prior to the surgical incision (or start of procedure when no incision is required)

OR

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

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

RATIONALE:

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

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CLINICAL RECOMMENDATION STATEMENTS:

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

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

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

2011 PHYSICIAN QUALITY REPORTING OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

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

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

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

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

Measure Reporting via Registry:
CPT codes and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure. The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

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

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Denominator Instructions: CPT Category I procedure codes billed by surgeons performing surgery on the same patient, submitted with modifier 62 (indicating two surgeons, i.e., dual procedures) will be included in the denominator population. Both surgeons participating in the Physician Quality Reporting System 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	15734, 15738, 19260, 19271, 19272, 19301, 19302, 19303, 19304, 19305, 19306, 19307, 19361, 19364, 19366, 19367, 19368, 19369
Spine	22325, 22612, 22630, 22800, 22802, 22804, 63030, 63042
Hip Reconstruction	27125, 27130, 27132, 27134, 27137, 27138
Trauma (Fractures)	27235, 27236, 27244, 27245, 27269, 27758, 27759, 27766, 27769, 27792, 27814
Knee Reconstruction	27440, 27441, 27442, 27443, 27445, 27446, 27447
Vascular	33877, 33880, 33881, 33883, 33886, 33891, 34800, 34802, 34803, 34804, 34805, 34825, 34830, 34831, 34832, 34900, 35081, 35091, 35102, 35131, 35141, 35151, 35601, 35606, 35612, 35616, 35621, 35623, 35626, 35631, 35632, 35633, 35634, 35636, 35637, 35638, 35642, 35645, 35646, 35647, 35650, 35651, 35654, 35656, 35661, 35663, 35665, 35666, 35671, 36830
Spleen and Lymph Nodes	38115
Esophagus	43045, 43100, 43101, 43107, 43108, 43112, 43113, 43116, 43117, 43118, 43121, 43122, 43123, 43124, 43130, 43135, 43300, 43305, 43310, 43312, 43313, 43320, 43325, 43327, 43328, 43330, 43331, 43332, 43333, 43334, 43335, 43336, 43337, 43340, 43341, 43350, 43351, 43352, 43360, 43361, 43400, 43401, 43405, 43410, 43415, 43420, 43425, 43496
Stomach	43500, 43501, 43502, 43510, 43520, 43605, 43610, 43611, 43620, 43621, 43622, 43631, 43632, 43633, 43634, 43640, 43641, 43653, 43800, 43810, 43820, 43825, 43830, 43831, 43832, 43840, 43843, 43845, 43846, 43847, 43848, 43850, 43855, 43860, 43865, 43870
Small Intestine	44005, 44010, 44020, 44021, 44050, 44055, 44100,

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SURGICAL PROCEDURE	CPT CODE
	44120, 44125, 44126, 44127, 44130, 44132, 44133, 44135, 44136
Biliary Surgery	47420, 47425, 47460, 47480, 47560, 47561, 47570, 47600, 47605, 47610, 47612, 47620, 47700, 47701, 47711, 47712, 47715, 47720, 47721, 47740, 47741, 47760, 47765, 47780, 47785, 47800, 47802, 47900
Pancreas	48020, 48100, 48120, 48140, 48145, 48146, 48148, 48150, 48152, 48153, 48154, 48155, 48500, 48510, 48511, 48520, 48540, 48545, 48547, 48548, 48554, 48556
Abdomen, Peritoneum & Omentum	49215, 49568
Renal Transplant	50320, 50340, 50360, 50365, 50370, 50380
Neurological Surgery	22524, 22554, 22558, 22600, 22612, 22630, 35301, 61154, 61312, 61313, 61315, 61510, 61512, 61518, 61548, 61697, 61700, 61750, 61751, 61867, 62223, 62230, 63015, 63020, 63030, 63042, 63045, 63047, 63056, 63075, 63081, 63267, 63276
Cardiothoracic Surgery	33120, 33130, 33140, 33141, 33202, 33250, 33251, 33256, 33261, 33305, 33315, 33321, 33322, 33332, 33335, 33400, 33401, 33403, 33404, 33405, 33406, 33410, 33411, 33413, 33416, 33422, 33425, 33426, 33427, 33430, 33460, 33463, 33464, 33465, 33475, 33496, 33510, 33511, 33512, 33513, 33514, 33516, 33517, 33518, 33519, 33521, 33522, 33523, 33530, 33533, 33534, 33535, 33536, 33542, 33545, 33548, 33572, 35211, 35241, 35271
General Thoracic Surgery	0236T, 19272, 21627, 21632, 21740, 21750, 21805, 21825, 31760, 31766, 31770, 31775, 31786, 31805, 32095, 32100, 32110, 32120, 32124, 32140, 32141, 32150, 32215, 32220, 32225, 32310, 32320, 32402, 32440, 32442, 32445, 32480, 32482, 32484, 32486, 32488, 32491, 32500, 32501, 32800, 32810, 32815, 32900, 32905, 32906, 32940, 33020, 33025, 33030, 33031, 33050, 33300, 33310, 33320, 34051, 35021, 35216, 35246, 35276, 35311, 35526, 37616, 38381, 38746, 39000, 39010, 39200, 39220, 39545, 39561, 60521, 60522, 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

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

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

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

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Acceptable First and Second Generation Cephalosporin Prophylactic Antibiotics
First generation cephalosporin: cefazolin
Second generation cephalosporin: cefuroxime

Documentation of order for cefazolin OR cefuroxime for antimicrobial prophylaxis (written order, verbal order, or standing order/protocol)
CPT II 4041F: Documentation of order for cefazolin OR cefuroxime for antimicrobial prophylaxis
Note: *CPT Category II code* 4041F *is provided for antibiotic* ordered *or antibiotic* given*. Report CPT Category II code* 4041F *if cefazolin OR cefuroxime was given for antimicrobial prophylaxis.*

OR

Order for First or Second Generation Cephalosporin not Ordered for Medical Reasons
Append a modifier (1P) to CPT Category II code 4041F to report documented circumstances that appropriately exclude patients from the denominator.
4041F *with* 1P: Documentation of medical reason(s) for not ordering cefazolin OR cefuroxime for antimicrobial prophylaxis

OR

Order for First or Second Generation Cephalosporin not Ordered, Reason not Specified
Append a reporting modifier (8P) to CPT Category II code 4041F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.
4041F *with* 8P: Order for cefazolin OR cefuroxime for antimicrobial prophylaxis was not documented, reason not otherwise specified

RATIONALE:
Current published evidence supports the use of either cefazolin, a first generation cephalosporin, or cefuroxime, a second generation cephalosporin, for many surgical procedures, in the absence of β-lactam allergy. An alternative antimicrobial regimen may be appropriate depending on the antimicrobial susceptibility pattern in an individual institution (potentially a medical reason for excluding patients treated at that institution from this measure.)

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CLINICAL RECOMMENDATION STATEMENTS:

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

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

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

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

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

2011 PHYSICIAN QUALITY REPORTING OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

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

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

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

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

Measure Reporting via Registry:
CPT codes and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure. The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

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

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Denominator Instructions:

- CPT Category I procedure codes billed by surgeons performing surgery on the same patient, submitted with modifier 62 (indicating two surgeons, i.e., dual procedures) will be included in the denominator population. Both surgeons participating in the Physician Quality Reporting System 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	15734, 15738, 19260, 19271, 19272, 19301, 19302, 19303, 19304, 19305, 19306, 19307, 19361, 19364, 19366, 19367, 19368, 19369
Le Fort Fractures	21346, 21347, 21348, 21422, 21423, 21432, 21433, 21435, 21436
Mandibular Fracture	21454, 21461, 21462, 21465, 21470
Spine	22325, 22612, 22630, 22800, 22802, 22804, 63030, 63042
Hip Reconstruction	27125, 27130, 27132, 27134, 27137, 27138
Trauma (Fractures)	27235, 27236, 27244, 27245, 27269, 27758, 27759, 27766, 27769, 27792, 27814
Knee Reconstruction	27440, 27441, 27442, 27443, 27445, 27446, 27447
Laryngectomy	31360, 31365, 31367, 31368, 31370, 31375, 31380, 31382, 31390, 31395
Vascular	33877, 33880, 33881, 33883, 33886, 33891, 34800, 34802, 34803, 34804, 34805, 34825, 34830, 34831, 34832, 34900, 35081, 35091, 35102, 35131, 35141, 35151, 35601, 35606, 35612, 35616, 35621, 35623, 35626, 35631, 35632, 35633, 35634, 35636, 35637, 35638, 35642, 35645, 35646, 35647, 35650, 35651, 35654, 35656, 35661, 35663, 35665, 35666, 35671, 36830
Glossectomy	41130, 41135, 41140, 41145, 41150, 41153, 41155
Esophagus	43045, 43100, 43101, 43107, 43108, 43112, 43113, 43116, 43117, 43118, 43121, 43122, 43123, 43124, 43130, 43135, 43300, 43305, 43310, 43312, 43313, 43320, 43325, 43327, 43328, 43330, 43331, 43332, 43333, 43334, 43335, 43336, 43337, 43340, 43341,

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SURGICAL PROCEDURE	CPT CODE
	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, 43653, 43800, 43810, 43820, 43825, 43830, 43831, 43832, 43840, 43843, 43845, 43846, 43847, 43848, 43850, 43855, 43860, 43865, 43870
Small Intestine	44005, 44010, 44020, 44021, 44050, 44055, 44100, 44120, 44125, 44126, 44127, 44130, 44132, 44133, 44135, 44136
Colon and Rectum	43880, 44025, 44110, 44111, 44140, 44141, 44143, 44144, 44145, 44146, 44147, 44150, 44151, 44155, 44156, 44157, 44158, 44160, 44202, 44204, 44205, 44206, 44207, 44208, 44210, 44211, 44212, 44300, 44310, 44312, 44314, 44316, 44320, 44322, 44340, 44345, 44346, 44615, 44620, 44625, 44626, 44640, 44650, 44660, 44661, 44700, 44950, 51597
Anus and Rectum	45108, 45110, 45111, 45112, 45113, 45114, 45116, 45119, 45120, 45121, 45123, 45126, 45130, 45135, 45136, 45150, 45160, 45171, 45172, 45190, 45500, 45505, 45520, 45540, 45541, 45550, 45560, 45562, 45563, 45800, 45805, 45820, 45825
Biliary Surgery	47420, 47425, 47460, 47480, 47560, 47561, 47570, 47600, 47605, 47610, 47612, 47620, 47700, 47701, 47711, 47712, 47715, 47720, 47721, 47740, 47741, 47760, 47765, 47780, 47785, 47800, 47802, 47900
Pancreas	48020, 48100, 48120, 48140, 48145, 48146, 48148, 48150, 48152, 48153, 48154, 48155, 48500, 48510, 48511, 48520, 48540, 48545, 48547, 48548, 48554, 48556
Abdomen, Peritoneum, & Omentum	49215, 49568
Renal Transplant	50320, 50340, 50360, 50365, 50370, 50380
Gynecologic Surgery	58150, 58152, 58180, 58200, 58210, 58260, 58262, 58263, 58267, 58270, 58275, 58280, 58285, 58290, 58291, 58292, 58293, 58294
Acoustic Neuroma	61520, 61526, 61530, 61591, 61595, 61596, 61598, 61606, 61616, 61618, 61619, 69720, 69955, 69960, 69970
Cochlear Implants	69930
Neurological Surgery	22524, 22554, 22558, 22600, 22612, 22630, 35301, 61154, 61312, 61313, 61315, 61510, 61512, 61518, 61548, 61697, 61700, 61750, 61751, 61867, 62223, 62230, 63015, 63020, 63030, 63042, 63045, 63047,

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SURGICAL PROCEDURE	CPT CODE
	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, 19272, 21627, 21632, 21740, 21750, 21805, 21825, 31760, 31766, 31770, 31775, 31786, 31805, 32095, 32100, 32110, 32120, 32124, 32140, 32141, 32150, 32215, 32220, 32225, 32310, 32320, 32402, 32440, 32442, 32445, 32480, 32482, 32484, 32486, 32488, 32491, 32500, 32501, 32800, 32810, 32815, 32900, 32905, 32906, 32940, 33020, 33025, 33030, 33031, 33050, 33202, 33300, 33310, 33320, 33321, 33322, 34051, 35021, 35211, 35216, 35241, 35246, 35271, 35276, 35311, 35526, 37616, 38381, 38746, 39000, 39010, 39200, 39220, 39545, 39561, 60521, 60522, 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

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

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

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

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

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CPT II 4049F: Documentation that order was given to discontinue prophylactic antibiotics within 24 hours of surgical end time, non-cardiac procedure
Note: *CPT Category II code 4049F is provided for documentation that antibiotic discontinuation was ordered or that antibiotic discontinuation was accomplished. Report CPT Category II code 4049F if antibiotics were discontinued within 24 hours.*
AND
CPT II 4046F: Documentation that prophylactic antibiotics were given within 4 hours prior to surgical incision or given intraoperatively

OR

Prophylactic Parenteral Antibiotics not Discontinued for Medical Reasons
(Two CPT II codes [4049F-1P & 4046F] are required on the claim form to submit this numerator option)
Append a modifier (1P) to CPT Category II code 4049F to report documented circumstances that appropriately exclude patients from the denominator.
4049F *with* 1P: Documentation of medical reason(s) for not discontinuing prophylactic antibiotics within 24 hours of surgical end time
AND
CPT II 4046F: Documentation that prophylactic antibiotics were given within 4 hours prior to surgical incision or given intraoperatively

OR

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

OR

Prophylactic Parenteral Antibiotics not Discontinued, Reason not Specified
(Two CPT II codes [4049F-8P & 4046F] are required on the claim form to submit this numerator option)
Append a reporting modifier (8P) to CPT Category II code 4049F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.
4049F *with* 8P: Order was not given to discontinue prophylactic antibiotics within 24 hours of surgical end time, non-cardiac procedure, reason not otherwise specified
AND
CPT II 4046F: Documentation that prophylactic antibiotics were given within 4 hours prior to surgical incision or given intraoperatively

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

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CLINICAL RECOMMENDATION STATEMENTS:

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

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

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

2011 PHYSICIAN QUALITY REPORTING OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

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

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.

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

Measure Reporting via Registry:
CPT codes and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure. The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

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

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Denominator Instructions: CPT Category I procedure codes billed by surgeons performing surgery on the same patient, submitted with modifier 62 (indicating two surgeons, i.e., dual procedures) will be included in the denominator population. Both surgeons participating in the Physician Quality Reporting System 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	22558, 22600, 22612, 22630, 61313, 61510, 61512, 61518, 61548, 61697, 61700, 62230, 63015, 63020, 63047, 63056, 63081, 63267, 63276
Hip Reconstruction	27125, 27130, 27132, 27134, 27137, 27138
Knee Reconstruction	27440, 27441, 27442, 27443, 27445, 27446, 27447
Genitourinary Surgery	50020, 50220, 50225, 50230, 50234, 50236, 50240, 50320, 50340, 50360, 50365, 50370, 50380, 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, 58200, 58210, 58240, 58285, 58951, 58953, 58954, 58956
Hip Fracture Surgery	27235, 27236, 27244, 27245, 27269

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SURGICAL PROCEDURE	CPT CODE
General Surgery	19260, 19271, 19272, 19301, 19302, 19303, 19304, 19305, 19306, 19307, 19316, 19318, 19324, 19325, 19328, 19330, 19342, 19350, 19355, 19357, 19361, 19364, 19366, 19367, 19368, 19369, 19370, 19371, 19380, 38100, 38101, 38115, 38120, 38571, 38572, 38700, 38720, 38724, 38740, 38745, 38747, 38760, 38765, 38770, 38780, 39501, 39503, 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, 43775, 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, 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, 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, 47100, 47120, 47122, 47125, 47130, 47135, 47136, 47140, 47141, 47142, 47300, 47350, 47360, 47361, 47362, 47370, 47371, 47380,

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SURGICAL PROCEDURE	CPT CODE
General Surgery, cont'd	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, 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, 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
CPT II 4044F: Documentation that an order was given for venous thromboembolism (VTE) prophylaxis to be given within 24 hours prior to incision time or 24 hours after surgery end time
Note: *A single CPT Category II code is provided for VTE prophylaxis ordered or VTE prophylaxis given. If VTE prophylaxis is given, report 4044F.*

OR

VTE Prophylaxis not Ordered for Medical Reasons
Append a modifier (1P) to CPT Category II code 4044F to report documented circumstances that appropriately exclude patients from the denominator.
4044F *with* 1P: Documentation of medical reason(s) for patient not receiving any form of VTE prophylaxis (LMWH, LDUH, adjusted-dose warfarin, fondaparinux or mechanical prophylaxis) within 24 hours prior to incision time or 24 hours after surgery end time

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OR

VTE Prophylaxis not Ordered, Reason not Specified

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

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

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. Many of these procedures are done in hospitals and ASCs, but quite a few are performed in the physician's office. There are many reasons for the differences in the site of service, including that breast lesions and breast tissue varies considerably. Some women have a small breast and a small lesion that can be expeditiously treated as a minor office procedure done in 20 minutes under local anesthesia. In this instance, the evidence for DVT prophylaxis is simply not present. Other patients have small or large lesions located in difficult positions within a dense complex breast. In this instance, the patients have long procedures under general anesthesia. Both of these instances can occur within the same CPT code. It should be noted that the number of medical exclusions for these codes will likely be much higher than other codes to account for the variation in major and minor procedures within the same CPT code. Duration of VTE prophylaxis is not specified in the measure due to varying guideline recommendations for different patient populations.

CLINICAL RECOMMENDATION STATEMENTS:

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

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

Recommend consideration of renal impairment when deciding on doses of LMWH, fondaparinux, the direct thrombin inhibitors, and other antithrombotic drugs that are cleared by the kidneys, particularly in elderly patients and those who are at high risk for bleeding (Grade 1C+).
Moderate-risk general surgery patients are those patients undergoing a non-major procedure and are between the ages of 40 and 60 years or have additional risk factors, or those patients who are undergoing major operations and are < 40 years of age with no additional risk factors. Recommend prophylaxis with LDUH, 5,000 U bid or LMWH ≤ 3,400 U once daily (both Grade 1A).
Higher-risk general surgery patients are those undergoing non-major surgery and are > 60 years of age or have additional risk factors, or patients undergoing major surgery who are > 40 years of age or have additional risk factors. Recommend thromboprophylaxis with LDUH, 5,000 U tid or LMWH, > 3,400 U daily (both Grade 1A).

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

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

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

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

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*Measure #24: 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

2011 PHYSICIAN QUALITY REPORTING OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

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

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

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

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

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

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure. The quality-data codes listed do not

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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): 733.00, 733.01, 733.02, 733.03, 733.09, 805.00, 805.01, 805.02, 805.03, 805.04, 805.05, 805.06, 805.07, 805.08, 805.2, 805.4, 805.6, 805.8, 813.40, 813.41, 813.42, 813.44, 813.45, 813.47, 813.50, 813.51, 813.52, 813.54, 820.00, 820.01, 820.02, 820.03, 820.09, 820.20, 820.21, 820.22, 820.8
AND
Patient encounter during the reporting period (CPT) – Service codes: 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215,

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): 733.00, 733.01, 733.02, 733.03, 733.09 805.00, 805.01, 805.02, 805.03, 805.04, 805.05, 805.06, 805.07, 805.08, 805.2, 805.4, 805.6, 805.8, 813.40, 813.41, 813.42, 813.44, 813.45, 813.47, 813.50, 813.51, 813.52, 813.54, 820.00, 820.01, 820.02, 820.03, 820.09, 820.20, 820.21, 820.22, 820.8
AND
Patient encounter during the reporting period (CPT) – Procedure codes: 22305, 22310, 22315, 22318, 22319, 22325, 22326, 22327, 22520, 22521, 22523, 22524, 25600, 25605, 25606, 25607, 25608, 25609, 27230, 27232, 27235, 27236, 27238, 27240, 27244, 27245, 27246, 27248

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

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

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Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Post Fracture Care Communication Documented

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

OR

Post Fracture Care not Communicated for Medical or Patient Reasons

Append a modifier (1P or 2P) to CPT Category II code 5015F to report documented circumstances that appropriately exclude patients from the denominator.

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

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

OR

Post Fracture Care not Communicated, Reason not Specified

Append a reporting modifier (8P) to CPT Category II code 5015F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

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

RATIONALE:

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

CLINICAL RECOMMENDATION STATEMENTS:

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

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

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

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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)

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

2011 PHYSICIAN QUALITY REPORTING OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

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

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

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

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

Measure Reporting via Registry:
ICD-9-CM diagnosis codes and CPT codes are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure. The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

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

Denominator Criteria (Eligible Cases):
Diagnosis for acute myocardial infarction (ICD-9-CM): 410.00, 410.01, 410.10, 410.11, 410.20, 410.21, 410.30, 410.31, 410.40, 410.41, 410.50, 410.51, 410.60, 410.61, 410.70, 410.71, 410.80, 410.81, 410.90, 410.91
AND

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Patient encounter during the reporting period (CPT): 99281, 99282, 99283, 99284, 99285, 99291
AND
Place of Service Indicator: 23
(The Part B claim form place of service field must indicate emergency department)

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

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

OR

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

OR

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

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

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

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*Measure #30: Perioperative Care: Timely Administration of Prophylactic Parenteral Antibiotics

2011 PHYSICIAN QUALITY REPORTING OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

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

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

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

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

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

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

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Measure Reporting via Registry:
CPT codes and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure. The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

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

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

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

NUMERATOR:
Surgical patients for whom administration of the prophylactic parenteral antibiotic ordered has been initiated within one hour (if fluoroquinolone or vancomycin, two hours) prior to the surgical incision (or start of procedure when no incision is required)

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Numerator Instructions: This measure seeks to identify the timely administration of prophylactic parenteral antibiotic. This administration should begin within one hour (if fluoroquinolone or vancomycin, two hours) prior to surgical incision.

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
The antimicrobial drugs listed below are considered prophylactic parenteral antibiotics for the purposes of this measure. *4048F-8P should be reported when antibiotics from this table were not ordered.*

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

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

Documentation that Prophylactic Parenteral Antibiotic was Administered Within Specified Timeframe
CPT II 4048F: Documentation that administration of prophylactic parenteral antibiotic was initiated within one hour (if fluoroquinolone or vancomycin, two hours) prior to surgical incision (or start of procedure when no incision is required), as ordered.

OR

Prophylactic Parenteral Antibiotic not Administered for Medical Reasons (e.g., contraindicated, patient already receiving antibiotics)
Append a modifier (1P) to CPT Category II code 4048F to report documented circumstances that appropriately exclude patients from the denominator.
4048F *with* 1P: Documentation of medical reason(s) for not initiating administration of prophylactic parenteral antibiotics as specified (e.g., contraindicated, patient already receiving antibiotics).

OR

If patient is not eligible for this measure because prophylactic parenteral antibiotic not ordered, report:
Prophylactic Parenteral Antibiotic not Ordered
Append a reporting modifier (8P) to CPT Category II code 4047F to report circumstances when the patient is not eligible for the measure.
4047F *with* 8P: No documentation of order for prophylactic parenteral antibiotics to be given within one hour (if fluoroquinolone or vancomycin, two hours) prior to surgical incision (or start of procedure when no incision is required)

OR

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

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

4048F *with* 8P: Administration of prophylactic parenteral antibiotic was not initiated within one hour (if fluoroquinolone or vancomycin, two hours) prior to the surgical incision (or start of procedure when no incision is required), reason not otherwise specified.

RATIONALE:

The appropriate timing of administration of prophylactic parenteral antibiotics has been demonstrated to reduce the incidence of surgical wound infections. Available evidence suggests that although most surgical patients receive a prophylactic antibiotic, many do not receive the drug within one hour before incision as recommended. The anesthesia services included in the denominator are associated with some surgical procedures for which prophylactic parenteral antibiotics may not be indicated. As a result, clinicians should exclude patients from the denominator in those instances in which anesthesia services are provided but not associated with surgical procedures for which prophylactic parenteral antibiotics are indicated.

CLINICAL RECOMMENDATION STATEMENTS:

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

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

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

2011 PHYSICIAN QUALITY REPORTING OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

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

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

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

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

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT codes and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure. The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

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

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

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Diagnosis for ischemic stroke or intracranial hemorrhage (ICD-9-CM): 431, 433.01, 433.11, 433.21, 433.31, 433.81, 433.91, 434.01, 434.11, 434.91
AND
Patient encounter during the reporting period (CPT): 99221, 99222, 99223, 99291

NUMERATOR:
Patients who received Deep Vein Thrombosis (DVT) prophylaxis by the end of hospital day two

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

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
DVT Prophylaxis Received
CPT II 4070F: Deep Vein Thrombosis (DVT) prophylaxis received by end of hospital day 2

OR

DVT Prophylaxis not Received for Medical or Patient Reasons
Append a modifier (1P or 2P) to CPT Category II code 4070F to report documented circumstances that appropriately exclude patients from the denominator.
4070F *with* 1P: Documentation of medical reason(s) for not receiving DVT Prophylaxis by end of hospital day 2, including physician documentation that patient is ambulatory
4070F *with* 2P: Documentation of patient reason(s) for not receiving DVT Prophylaxis by end of hospital day 2

OR

DVT Prophylaxis not Received, Reason not Specified
Append a reporting modifier (8P) to CPT Category II code 4070F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.
4070F *with* 8P: Deep Vein Thrombosis (DVT) prophylaxis was not received by end of hospital day 2, reason not otherwise specified

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

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CLINICAL RECOMMENDATION STATEMENTS:

Subcutaneous unfractionated heparin, LMW heparins, and heparinoids may be considered for DVT prophylaxis in at-risk patients with acute ischemic stroke, recognizing that nonpharmacologic treatments for DVT prevention also exist. (Coull, AAN/ASA, 2002) (Grade A)

The use of intermittent external compression stockings or aspirin for patients who cannot receive anticoagulants is strongly recommended to prevent deep vein thrombosis among immobilized patients. (Adams, ASA, 2003) (Grades A and B)

For acute stroke patients with restricted mobility, it is recommended prophylactic low-dose subcutaneous heparin or low-molecular-weight heparins or heparinoid. (Grade 1A) In patients with an acute ICH, it is recommended the initial use of intermittent pneumatic compression for the prevention of DVT and PE. (Grade 1C+) In stable patients, we suggest low-dose subcutaneous heparin may be initiated as soon as the second day after the onset of the hemorrhage. (Grade 2C) (Albers, ACCP, 2004)

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*Measure #32: Stroke and Stroke Rehabilitation: Discharged on Antiplatelet Therapy

2011 PHYSICIAN QUALITY REPORTING 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 antiplatelet therapy at discharge

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

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

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

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT codes and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure. The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All patients aged 18 years and older with the 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 (TIA)
> (ICD-9-CM): 433.01, 433.11, 433.21, 433.31, 433.81, 433.91, 434.01, 434.11, 434.91, 435.0, 435.1, 435.2, 435.3, 435.8, 435.9
> AND

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

NUMERATOR:
Patients who were prescribed antiplatelet therapy at discharge

Numerator Instructions: If the consulting physician orders or agrees with a prior antiplatelet therapy order (from current or previous episodes of care during the reporting period) and there is supporting documentation, report 4073F.

Definitions:
Antiplatelet Therapy – Aspirin, combination of aspirin and extended-release dipyridamole, clopidogrel, ticlopidine
Prescribed – May include prescription given to the patient for antiplatelet therapy during the measurement period OR patient already taking antiplatelet therapy as documented in the current medication list.

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

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Antiplatelet Therapy Prescribed
CPT II 4073F: Oral antiplatelet therapy prescribed at discharge

OR

Antiplatelet Therapy Prescription not Prescribed for Medical or Patient Reasons
Append a modifier (1P or 2P) to CPT Category II code 4073F to report documented circumstances that appropriately exclude patients from the denominator.
4073F *with* 1P: Documentation of medical reason(s) for not prescribing oral antiplatelet therapy at discharge
4073F *with* 2P: Documentation of patient reason(s) for not prescribing oral antiplatelet therapy at discharge

OR

Antiplatelet Therapy Prescription not Prescribed, Reason not Specified
Append a reporting modifier (8P) to CPT Category II code 4073F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.
4073F *with* 8P: Oral antiplatelet therapy was not prescribed at discharge, reason not otherwise specified

RATIONALE:
Following a stroke, patients should be prescribed antiplatelet therapy to decrease the risk of additional strokes.

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CLINICAL RECOMMENDATION STATEMENTS:

It is recommended that every patient who has experienced a noncardioembolic (atherothrombotic, lacunar, or cryptogenic) stroke or TIA and has no contraindication receives an antiplatelet agent regularly to reduce the risk of recurrent stroke and other vascular events. Aspirin, 50 to 325 mg qd; the combination of aspirin, 25 mg, and extended-release dipyridamole, 200 mg bid; or clopidogrel, 75 mg qd, are all acceptable options for initial therapy. (Albers, ACCP, 2001) (Grade 1A)

For patients with noncardioembolic ischemic stroke or TIA, antiplatelet agents rather than oral anticoagulation are recommended to reduce the risk of recurrent stroke and other cardiovascular events. (Sacco, ASA, 2006) (Class I, Level of Evidence: A)

Aspirin (50 to 325 mg/d), the combination of aspirin and extended-release dipyridamole, and clopidogrel are all acceptable options for initial therapy. (Sacco, ASA, 2006) (Class IIa, Level of Evidence: A)

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*Measure #33: Stroke and Stroke Rehabilitation: Anticoagulant Therapy Prescribed for Atrial Fibrillation at Discharge

2011 PHYSICIAN QUALITY REPORTING OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

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

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

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure. The quality-data codes have been provided for registry only measures for use by registries that utilize claims data. It is not necessary to submit these codes for registry-based submissions. Do not report this measure via claims.

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

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Diagnosis for ischemic stroke or transient ischemic attack (TIA) (ICD-9-CM): 433.01, 433.11, 433.21, 433.31, 433.81, 433.91, 434.01, 434.11, 434.91, 435.0, 435.1, 435.2, 435.3, 435.8, 435.9
AND
Diagnosis for atrial fibrillation (ICD-9-CM): 427.31
AND
Patient encounter during the reporting period (CPT): 99221, 99222, 99223, 99238, 99239

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NUMERATOR:
Patients who were prescribed an anticoagulant at discharge

Definitions:
Persistent Atrial Fibrillation – Recurrent atrial fibrillation, not self-terminating or terminated electrically or pharmacologically
Paroxysmal Atrial Fibrillation – Recurrent atrial fibrillation, self-terminating
Permanent Atrial Fibrillation – Long-standing atrial fibrillation (> 1 year), cardioversion failed or not attempted
Prescribed – May include prescription given to the patient for anticoagulant therapy at discharge or patient already taking anticoagulant therapy as documented in the current medication list.

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

Numerator Options:
Anticoagulant therapy prescribed at discharge (4075F)
OR
Anticoagulant therapy not prescribed at discharge for medical reason (4075F *with* 1P)
OR
Anticoagulant therapy not prescribed at discharge for patient reason (4075F *with* 2P)
OR
Anticoagulant therapy not prescribed at discharge, reason not specified (4075F *with* 8P)

RATIONALE:
Patients with atrial fibrillation (permanent, persistent, or paroxysmal) and stroke should be prescribed an anticoagulant to prevent recurrent strokes.

CLINICAL RECOMMENDATION STATEMENTS:
Administer antithrombotic therapy (oral anticoagulation or aspirin) to all patients with AF, except those with lone AF, to prevent thromboembolism. (ACC/AHA/ESC, 2001) (Class I, Level of Evidence: A)

It is recommended that clinicians use long-term oral anticoagulation (target INR of 2.5; range, 2.0 to 3.0) for prevention of stroke in atrial fibrillation patients who have suffered a recent stroke or TIA. Oral anticoagulation is also beneficial for prevention of recurrent stroke in patients with several other high-risk cardiac sources. (Albers, ACCP, 2001) (Grade 1A)

For patients with ischemic stroke or TIA with persistent or paroxysmal AF, anticoagulation with adjusted-dose warfarin (target INR, 2.5; range 2.0 to 3.0) is recommended. (Sacco, ASA, 2006) (Class I, Level of Evidence: A)

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*Measure #35: Stroke and Stroke Rehabilitation: Screening for Dysphagia

2011 PHYSICIAN QUALITY REPORTING OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of patients aged 18 years and older with a diagnosis of ischemic stroke or intracranial hemorrhage who underwent a dysphagia screening process before taking any foods, fluids or medication by mouth

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

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

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

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT codes and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure. The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

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

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

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Diagnosis for ischemic stroke or intracranial hemorrhage (ICD-9-CM):
431, 433.01, 433.11, 433.21, 433.31, 433.81, 433.91, 434.01, 434.11, 434.91
AND
Patient encounter during the reporting period (CPT): 99221, 99222, 99223

NUMERATOR:
Patients who underwent a dysphagia screening process before taking any foods, fluids or medication by mouth

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

Definition:
Dysphagia Screening – Use of a tested and validated dysphagia screening tool (e.g., Burke dysphagia screening test, 3 oz. water swallow test, Mann assessment of swallowing ability [MASA], standardized bedside swallowing assessment [SSA]) OR a dysphagia screening tool approved by the hospital's speech/language pathology (SLP) services.

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

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Dysphagia Screening Conducted
(Two CPT II codes [6010F & 6015F] are required on the claim form to submit this numerator option)
CPT II 6010F: Dysphagia screening conducted prior to order for or receipt of any foods, fluids or medication by mouth
AND
CPT II 6015F: Patient receiving or eligible to receive foods, fluids or medication by mouth

OR

Dysphagia Screening not Conducted for Medical Reasons
(Two CPT II codes [6010F-1P & 6015F] are required on the claim form to submit this numerator option)
Append a modifier (1P) to CPT Category II code 6010F to report documented circumstances that appropriately exclude patients from the denominator.
6010F *with* 1P: Documentation of medical reason(s) for not conducting dysphagia screening prior to taking any foods, fluids or medication by mouth
AND
CPT II 6015F: Patient receiving or eligible to receive foods, fluids or medication by mouth

OR

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If patient is not eligible for this measure because patient is NPO, report:
(One CPT II code [6020F] is required on the claim form to submit this numerator option)
CPT II 6020F: NPO (nothing by mouth) ordered

OR

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

RATIONALE:
All patients should have their swallowing evaluated prior to receiving food, fluids or oral medications to help prevent aspiration. The evaluation should be performed with a validated or hospital-approved dysphagia screening tool; a routine cranial nerve examination is not sufficient.

CLINICAL RECOMMENDATION STATEMENTS:
Recommend that all patients have their swallow screened before initiating oral intake of fluids or food, utilizing a simple valid bedside testing protocol. (VA/DoD, 2003) (Evidence II-2, Grade B)

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*Measure #36: Stroke and Stroke Rehabilitation: Consideration of Rehabilitation Services

2011 PHYSICIAN QUALITY REPORTING OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of patients aged 18 years and older with a diagnosis of ischemic stroke or intracranial hemorrhage for whom consideration of rehabilitation services is documented

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

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

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

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT codes and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure. The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data. There are no allowable performance exclusions for this measure.

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

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

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Diagnosis for ischemic stroke or intracranial hemorrhage (ICD-9-CM): 431, 433.01, 433.11, 433.21, 433.31, 433.81, 433.91, 434.01, 434.11, 434.91
AND
Patient encounter during the reporting period (CPT): 99221, 99222, 99223, 99238, 99239

NUMERATOR:
Patients for whom consideration of rehabilitation services (ordered rehabilitation or documented that rehabilitation was not indicated) is documented

Definition:
Consideration of Rehabilitation Services – Includes an order for rehabilitation services or documentation that rehabilitation was not indicated.

NUMERATOR NOTE: In order to meet the measure, rehabilitation services are to be considered at the time of discharge. If a physician other than the discharging physician (e.g., consulting physician) is reporting on this measure, it should be clear from the documentation that the rehabilitation services considered are those that may be appropriate for patients after discharge.

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Rehabilitation Services Ordered or Considered
CPT II 4079F: Documentation that rehabilitation services were considered

OR

Rehabilitation Services not Ordered or Considered, Reason not Specified
Append a reporting modifier (8P) to CPT Category II code 4079F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.
4079F *with* 8P: Rehabilitation services were not considered, reason not otherwise specified

RATIONALE:
All patients should be considered for rehabilitation services to meet the individual patient needs.

CLINICAL RECOMMENDATION STATEMENTS:
Strongly recommend that patients in need of rehabilitation services have access to a setting with a coordinated and organized rehabilitation care team that is experienced in providing stroke services. The coordination and organization of inpatient post–acute stroke care will improve patient outcome. (VA/DoD, 2003)

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

2011 PHYSICIAN QUALITY REPORTING OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

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

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

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

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

Measure Reporting via Registry:
CPT codes and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure. The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All female patients aged 65 years and older

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

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

Definitions:
Pharmacologic Therapy – U.S. Food and Drug Administration approved pharmacologic options for osteoporosis prevention and/or treatment of postmenopausal osteoporosis include, in alphabetical order: bisphosphonates (alendronate, ibandronate, and risedronate), calcitonin, estrogens (estrogens and/or hormone therapy), parathyroid hormone [PTH (1-34), teriparatide], and selective estrogen receptor modules or SERMs (raloxifene).
Prescribed – Includes patients who are currently receiving medication(s) that follow the treatment plan recommended at an encounter during the reporting period, even if the prescription for that medication was ordered prior to the encounter.

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Central DXA Measurement Ordered or Performed or Pharmacologic Therapy Prescribed
G8399: Patient with central Dual-energy X-Ray Absorptiometry (DXA) results documented or ordered or pharmacologic therapy (other than minerals/vitamins) for osteoporosis prescribed

OR

Central DXA Measurement not Ordered or Performed or Pharmacologic Therapy not Prescribed for Documented Reasons
G8401: Clinician documented that patient was not an eligible candidate for screening or therapy for osteoporosis for women measure

OR

Central DXA Measurement not Ordered or Performed or Pharmacologic Therapy not Prescribed, Reason not Specified
G8400: Patient with central Dual-energy X-Ray Absorptiometry (DXA) results not documented or not ordered or pharmacologic therapy (other than minerals/vitamins) for osteoporosis not prescribed

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)

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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)

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

2011 PHYSICIAN QUALITY REPORTING OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

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

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

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

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

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

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT codes and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure. The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

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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): 733.00, 733.01, 733.02, 733.03, 733.09, 805.00, 805.01, 805.02, 805.03, 805.04, 805.05, 805.06, 805.07, 805.08, 805.2, 805.4, 805.6, 805.8, 813.40, 813.41, 813.42, 813.44, 813.45, 813.47, 813.50, 813.51, 813.52, 813.54, 820.00, 820.01, 820.02, 820.03, 820.09, 820.20, 820.21, 820.22, 820.8
AND
Patient encounter during the reporting period (CPT) - Service codes: 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215

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): 733.00, 733.01, 733.02, 733.03, 733.09, 805.00, 805.01, 805.02, 805.03, 805.04, 805.05, 805.06, 805.07, 805.08, 805.2, 805.4, 805.6, 805.8, 813.40, 813.41, 813.42, 813.44, 813.45, 813.47, 813.50, 813.51, 813.52, 813.54, 820.00, 820.01, 820.02, 820.03, 820.09, 820.20, 820.21, 820.22, 820.8
AND
Patient encounter during the reporting period (CPT) - Procedure codes: 22305, 22310, 22315, 22318, 22319, 22325, 22326, 22327, 22520, 22521, 22523, 22524, 25600, 25605, 25606, 25607, 25608, 25609, 27230, 27232, 27235, 27236, 27238, 27240, 27244, 27245, 27246, 27248

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

Numerator Instructions: Modifiers may be appended to any of the CPT Category II codes for medical reasons, patient reasons, system reasons, or reasons not otherwise specified.

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).

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

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Central DXA Measurement Ordered or Results Documented or Pharmacologic Therapy Prescribed

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

OR

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

OR

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

OR

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

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

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

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

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

OR

Pharmacologic Therapy not Prescribed for Documented Reasons

G8634: Clinician documented patient not an eligible candidate to receive pharmacologic therapy for osteoporosis

OR

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

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

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

OR

Pharmacologic Therapy not Prescribed, Reason not Specified

G8635: Pharmacologic therapy for osteoporosis was not prescribed, reason not otherwise specified

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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)

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

2011 PHYSICIAN QUALITY REPORTING OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

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

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

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

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

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure. The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

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

> Denominator Criteria (Eligible Cases):
> Patients aged ≥ 50 years on date of encounter
> AND
> Diagnosis for osteoporosis (ICD-9-CM): 733.00, 733.01, 733.02, 733.03, 733.09
> AND
> Patient encounter during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215

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NUMERATOR:
Patients who were prescribed pharmacologic therapy for osteoporosis within 12 months

Definitions:
Pharmacologic Therapy – U.S. Food and Drug Administration approved pharmacologic options for osteoporosis prevention and/or treatment of postmenopausal osteoporosis include, in alphabetical order: bisphosphonates (alendronate, ibandronate, and risedronate), calcitonin, estrogens (estrogens and/or hormone therapy), parathyroid hormone [PTH (1-34), teriparatide], and selective estrogen receptor modules or SERMs (raloxifene).
Prescribed – May include prescription given to the patient for treatment of osteoporosis (as listed above) at one or more encounters during the reporting period, OR documentation that patient is already taking pharmacologic therapy for osteoporosis, as documented in the current medication list.

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Pharmacologic Therapy Prescribed
CPT II 4005F: Pharmacologic therapy (other than minerals/vitamins) for osteoporosis prescribed

OR

Pharmacologic Therapy not Prescribed for Medical, Patient, or System Reasons
Append a modifier (1P, 2P or 3P) to CPT Category II code 4005F to report documented circumstances that appropriately exclude patients from the denominator.
4005F *with* 1P: Documentation of medical reason(s) for not prescribing pharmacologic therapy for osteoporosis
4005F *with* 2P: Documentation of patient reason(s) for not prescribing pharmacologic therapy for osteoporosis
4005F *with* 3P: Documentation of system reason for not prescribing pharmacologic therapy for osteoporosis

OR

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

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

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

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

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

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

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

2011 PHYSICIAN QUALITY REPORTING OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

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

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

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

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

Measure Reporting via Registry:
CPT codes and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure. The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All patients undergoing isolated CABG

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

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NUMERATOR:
Patients who received an IMA graft in isolated CABG

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
IMA Graft Performed
CPT II 4110F: Internal mammary artery graft performed for primary, isolated coronary artery bypass graft procedure

OR

IMA Graft not Performed for Medical Reasons
Append a modifier (1P) to the CPT Category II code 4110F to report documented circumstances that appropriately exclude patients from the denominator.
4110F *with* 1P: Documentation of medical reason(s) for not performing an internal mammary artery graft for primary, isolated coronary artery bypass graft procedure

OR

IMA Graft not Performed, Reason not Specified
Append a reporting modifier (8P) to CPT Category II code 4110F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.
4110F *with* 8P: Internal mammary artery graft not performed for primary, isolated coronary artery bypass graft procedure, reason not otherwise specified

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

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

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

2011 PHYSICIAN QUALITY REPORTING OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

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

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

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

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

Measure Reporting via Registry:
CPT codes and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure. The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
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 a beta-blocker within 24 hours prior to surgical incision

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Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Preoperative Beta-blocker Received

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

OR

Preoperative Beta-blocker not Received for Medical Reasons

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

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

OR

Preoperative Beta-blocker not Received, Reason not Specified

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

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

RATIONALE:

In patients at risk of cardiovascular complications in a variety of medical conditions, beta-blockers have been shown to reduce that risk. Studies show that patients with a history of myocardial infarction, who have had beta-blocker therapy initiated and continued, have a 20 to 30% reduction in subsequent coronary events, cardiovascular mortality, and all-cause mortality (Yusuf, 1985). In a meta analysis by McGory et al (2005), long-term cardiac mortality and myocardial ischemia were reduced significantly by perioperative beta blockade. Patients maintained on beta-blockers, without complications that might warrant discontinuation, are good candidates for continuation of beta-blockers through the perioperative period.

CLINICAL RECOMMENDATION STATEMENTS:

Prevention of Postoperative Arrhythmias

Class I

Preoperative or early postoperative administration of beta-blockers in patients without contraindications should be used as the standard therapy to reduce the incidence and/or clinical sequelae of atrial fibrillation after CABG. (Level of Evidence: B)

The use of b-blockers, calcium channel blockers, and nitrates plays a significant role in ensuring that the myocardial oxygen demand does not exceed the supply. Patients well compensated while receiving these agents should be continued on their therapy through the perioperative period. Special attention should be paid to avoiding excess catecholamine effects by the sudden withdrawal of b-blocker therapy. At least one study supports the use of b-blocker immediately prior to surgery: in 1988, Stone and colleagues gave oral b-blockers 2 hours prior to surgery and reported a decrease in frequency of ST segment depression from 28% among control patients to 2% in treated patients. Similarly, in 1987, Pasternack and colleagues reported a reduction from 18% to 3% incidence of acute perioperative myocardial infarction in patients treated with metoprolol immediately prior to and following surgery. More recently, Podesser and colleagues demonstrated in patients undergoing coronary artery bypass procedures that the combination of nifedipine and metoprolol was associated with a lower incidence of ischemic events than nifedipine alone.

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

2011 PHYSICIAN QUALITY REPORTING OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of cardiac surgical patients aged 18 years and older undergoing procedures with the indications for prophylactic antibiotics AND who received a prophylactic antibiotic, who have an order for discontinuation of prophylactic antibiotics within 48 hours of surgical end time

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

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

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

Measure Reporting via Registry:
CPT codes and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure. The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

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

Denominator Instructions:

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

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- For the purpose of this measure of antibiotic discontinuation, patients may be counted as having "received a prophylactic 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 cardiac surgical procedures for which prophylactic antibiotics are indicated.

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

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

Numerator Instructions: There must be documentation of order (written order, verbal order, or standing order/protocol) specifying that the prophylactic antibiotic is to be discontinued within 48 hours of surgical end time OR specifying a course of antibiotic administration limited to that 48-hour period (e.g., "to be given every 8 hours for three doses" or for "one time" IV dose orders) OR documentation that prophylactic antibiotic was discontinued within 48 hours of surgical end time.

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

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Documentation of order for discontinuation of prophylactic antibiotics (written order, verbal order, or standing order/protocol) within 48 hours of surgical end time
(Two CPT II codes [4043F & 4046F] are required on the claim form to submit this numerator option)
CPT II 4043F: Documentation that an order was given to discontinue prophylactic antibiotics within 48 hours of surgical end time, cardiac procedures
Note: *CPT Category II code 4043F may be provided for documentation that antibiotic discontinuation within 48 hours was ordered or that antibiotic discontinuation was accomplished.*

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AND

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

OR

Prophylactic Antibiotics not Discontinued for Medical Reasons

(Two CPT II codes [4043F-1P & 4046F] are required on the claim form to submit this numerator option)

Append a modifier (1P) to CPT Category II code 4043F to report documented circumstances that appropriately exclude patients from the denominator.

4043F *with* 1P: Documentation of medical reason(s) for not discontinuing prophylactic antibiotics within 48 hours of surgical end time, cardiac procedures

AND

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 was not documented to have prophylactic antibiotics given within 4 hours prior to surgical incision, report:

(One CPT II code [4042F] is required on the claim form to submit this numerator option)

CPT II 4042F: Documentation that prophylactic antibiotics were neither given within 4 hours prior to surgical incision nor given intraoperatively

OR

Prophylactic Antibiotics not Discontinued, Reason not Specified

(Two CPT II codes [4043F-8P & 4046F] are required on the claim form to submit this numerator option)

Append a reporting modifier (8P) to CPT Category II code 4043F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

4043F *with* 8P: Order was not given to discontinue prophylactic antibiotics within 48 hours of surgical end time, cardiac procedures, reason not otherwise specified

AND

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 antibiotic use. Prolonged use may increase antibiotic resistant organisms.

CLINICAL RECOMMENDATION STATEMENTS:

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

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There is evidence indicating that antibiotic prophylaxis of 48 hours duration is effective. There is some evidence that single-dose prophylaxis or 24-hour prophylaxis may be as effective as 48-hour prophylaxis, but additional studies are necessary before confirming the effectiveness of prophylaxis lasting less than 48 hours. There is no evidence that prophylaxis administered for longer than 48 hours is more effective than a 48-hour regimen. Optimal practice: Antibiotic prophylaxis is not continued for more than 48 hours postoperatively. (STS) (Class IIa, Level B)

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*Measure #46: Medication Reconciliation: Reconciliation After Discharge from an Inpatient Facility

2011 PHYSICIAN QUALITY REPORTING OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of patients aged 65 years and older discharged from any inpatient facility (e.g., hospital, skilled nursing facility, or rehabilitation facility) and seen within 60 days following discharge in the office by the physician providing on-going care who had a reconciliation of the discharge medications with the current medication list in the medical record documented

INSTRUCTIONS:
This measure is to be reported at an outpatient visit occurring within 60 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 60 days prior to the outpatient visit.

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 ICD-9-CM diagnosis codes, CPT codes, and the appropriate CPT Category II code(s) OR the CPT Category II code(s) with the modifier. The 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 codes and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure. The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data. There are no allowable performance exclusions for this measure.

DENOMINATOR:
All patients aged 65 years and older discharged from any inpatient facility (e.g., hospital, skilled nursing facility, or rehabilitation facility) and seen within 60 days following discharge in the office by the physician providing on-going care

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Denominator Criteria (Eligible Cases):
Patients aged ≥ 65 years on date of encounter
AND
Patient encounter during the reporting period (CPT): 90801, 90802, 90804, 90805, 90806, 90807, 90808, 90809, 90810, 90811, 90812, 90813, 90814, 90815, 90845, 90862, 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

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

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

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Documentation of Reconciliation of Discharge Medication with Current Medication List in the Medical Record

(Two CPT II codes [1111F & 1110F] are required on the claim form to submit this numerator option)
CPT II 1111F: Discharge medications reconciled with the current medication list in outpatient medical record
AND
CPT II 1110F: Patient discharged from an inpatient facility (e.g., hospital, skilled nursing facility, or rehabilitation facility) within the last 60 days

OR

If patient is not eligible for this measure because patient was not discharged from an inpatient facility within the last 60 days, there are no reporting requirements in this case.

OR

Discharge Medication not Reconciled with Current Medication List in the Medical Record, Reason Not Specified
(Two CPT II codes [1111F-8P & 1110F] are required on the claim form to submit this numerator option)
Append a reporting modifier (8P) to CPT Category II code 1111F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.
1111F *with* 8P: Discharge medications not reconciled with the current medication list in outpatient medical record, reason not specified
AND

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CPT II 1110F: Patient discharged from an inpatient facility (e.g. hospital, skilled nursing facility, or rehabilitation facility) within the last 60 days

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

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

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

At the end of the outpatient visit, a clinician needs to verify three questions:
1. Based on what occurred in the visit, should any medication that the patient was taking or receiving prior to the visit be discontinued or altered?
2. Based on what occurred in the visit, should any prior medication be suspended pending consultation with the prescriber?
3. Have any new prescriptions been added today?

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

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*Measure #47: Advance Care Plan

2011 PHYSICIAN QUALITY REPORTING OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

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

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

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

Measure Reporting via Claims:
CPT 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 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 codes and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure. The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data. There are no allowable performance exclusions for this measure.

DENOMINATOR:
All patients aged 65 years and older

Denominator Criteria (Eligible Cases):
Patients aged ≥ 65 years on date of encounter
AND

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Patient encounter during the reporting period (CPT): 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

**Clinicians indicating the place of service as the emergency department will not be included in this measure.*

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

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

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

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

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

OR

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

RATIONALE:
It is essential that the patient's wishes regarding medical treatment be established as much as possible prior to incapacity. The Work Group has determined that the measure should remain as specified with no required timeframe based on a review of the literature. Studies have shown that people do change their preferences often with regard to advanced care planning, but it primarily

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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 repository of state-by-state advance directives.

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

2011 PHYSICIAN QUALITY REPORTING 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 codes and patient demographics are used to identify patients who are included in the measure's denominator. CPT Category II codes are used to report the numerator of the measure.

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

Measure Reporting via Registry:
CPT codes and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure. The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All 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, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350

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

Definition:
Urinary Incontinence – Any involuntary leakage of urine.

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Presence or Absence of Urinary Incontinence Assessed
CPT II 1090F: Presence or absence of urinary incontinence assessed

OR

Presence or Absence of Urinary Incontinence not Assessed for Medical Reasons
Append a modifier (1P) to CPT Category II code 1090F to report documented circumstances that appropriately exclude patients from the denominator.
1090F *with* 1P: Documentation of medical reason(s) for not assessing for the presence or absence of urinary incontinence

OR

Presence or Absence of Urinary Incontinence not Assessed, Reason not Specified
Append a reporting modifier (8P) to CPT Category II code 1090F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.
1090F *with* 8P: Presence or absence of urinary incontinence not assessed, reason not otherwise specified

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

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

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

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

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

2011 PHYSICIAN QUALITY REPORTING OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

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

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

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

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

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure. The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data. There are no allowable performance exclusions for this measure.

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

> Denominator Criteria (Eligible Cases):
> Patients aged ≥ 65 years on date of encounter
> AND
> Diagnosis for urinary incontinence (ICD-9-CM): 307.6, 625.6, 788.30, 788.31, 788.33, 788.34, 788.35, 788.36, 788.37, 788.38, 788.39
> AND

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Patient encounter during the reporting period (CPT): 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

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

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

OR

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

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

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

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

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

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*Measure #50: Urinary Incontinence: Plan of Care for Urinary Incontinence in Women Aged 65 Years and Older

2011 PHYSICIAN QUALITY REPORTING OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

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

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

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

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

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure. The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data. There are no allowable performance exclusions for this measure.

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

Denominator Criteria (Eligible Cases):
Patients aged ≥ 65 years on date of encounter
AND
Diagnosis for urinary incontinence (ICD-9-CM): 307.6, 625.6, 788.30, 788.31, 788.33, 788.34, 788.35, 788.36, 788.37, 788.38, 788.39
AND

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Patient encounter during the reporting period (CPT): 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

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

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

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

OR

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

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

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

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

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

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

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

2011 PHYSICIAN QUALITY REPORTING OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

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

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

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

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

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure. The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

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

> Denominator Criteria (Eligible Cases):
> Patients aged ≥ 18 years on date of encounter
> AND
> Diagnosis for COPD (ICD-9-CM): 491.0, 491.1, 491.20, 491.21, 491.22, 491.8, 491.9, 492.0, 492.8, 496
> AND

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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 evaluation results in the medical record; do not limit the search to the reporting period.

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Spirometry Results Documented
CPT II 3023F: Spirometry results documented and reviewed

OR

Spirometry Results not Documented for Medical, Patient, or System Reasons
Append a modifier (1P, 2P or 3P) to CPT Category II code 3023F to report documented circumstances that appropriately exclude patients from the denominator.
3023F *with* 1P: Documentation of medical reason(s) for not documenting and reviewing spirometry results
3023F *with* 2P: Documentation of patient reason(s) for not documenting and reviewing spirometry results
3023F *with* 3P: Documentation of system reason(s) for not documenting and reviewing spirometry results

OR

Spirometry Results not Documented, Reason not Specified
Append a reporting modifier (8P) to CPT Category II code 3023F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.
3023F *with* 8P: Spirometry results not documented and reviewed, reason not otherwise specified

RATIONALE:
Evaluation of lung function for a patient with COPD is vital to determine what treatments are needed and whether those treatments are effective.

CLINICAL RECOMMENDATION STATEMENTS:
Spirometry should be performed in all patients suspected of COPD. This is necessary for diagnosis, assessment of severity of the disease and for following the progress of the disease. (ATS and ERS)

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 postbronchodilator FEV_1 < 80% predicted confirms the presence of airflow limitation that is not fully reversible. (NHLBI/WHO)

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A patient's decline in lung function is best tracked by periodic spirometry measurements. Useful information about lung function decline is unlikely from spirometry measurements performed more than once a year. Spirometry should be performed if there is a substantial increase in symptoms or a complication. (NHLBI/WHO)

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

2011 PHYSICIAN QUALITY REPORTING 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 70% and have symptoms who were prescribed an inhaled bronchodilator

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

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

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

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure. The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All patients aged 18 years and older with a diagnosis of COPD, who have an FEV_1/FVC <70% and have symptoms (e.g., dyspnea, cough/sputum, wheezing)

> Denominator Criteria (Eligible Cases):
> Patients aged ≥ 18 years on date of encounter
> AND
> Diagnosis for COPD (ICD-9-CM): 491.0, 491.1, 491.20, 491.21, 491.22, 491.8, 491.9, 492.0, 492.8, 496
> AND

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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
(Two CPT II codes [4025F & 3025F] are required on the claim form to submit this numerator option)
CPT II 4025F: Inhaled bronchodilator prescribed
AND
CPT II 3025F: Spirometry test results demonstrate $FEV_1/FVC < 70\%$ with COPD symptoms (e.g., dyspnea, cough/sputum, wheezing)

OR

Patient not Documented to have Inhaled Bronchodilator Prescribed for Medical, Patient, or System Reasons
(Two CPT II codes [4025F-xP & 3025F] are required on the claim form to submit this numerator option)
Append a modifier (1P, 2P or 3P) to CPT Category II code 4025F to report documented circumstances that appropriately exclude patients from the denominator.
4025F *with* 1P: Documentation of medical reason(s) for not prescribing an inhaled bronchodilator
4025F *with* 2P: Documentation of patient reason(s) for not prescribing an inhaled bronchodilator
4025F *with* 3P: Documentation of system reason(s) for not prescribing an inhaled bronchodilator
AND
CPT II 3025F: Spirometry test results demonstrate $FEV_1/FVC < 70\%$ with COPD symptoms (e.g., dyspnea, cough/sputum, wheezing)

OR

If patient is not eligible for this measure because spirometry results demonstrate $FEV_1/FVC \geq 70\%$ **or patient does** not have COPD symptoms, report:
Spirometry Results Demonstrate $FEV_1/FVC \geq 70\%$ **or Patient Does** not Have COPD Symptoms

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(One CPT II code [3027F] is required on the claim form to submit this numerator option)
CPT II 3027F: Spirometry test results demonstrate $FEV_1/FVC \geq 70\%$ or patient does not have COPD symptoms
OR
Spirometry Test not Performed or Documented
(One CPT II code [3025F-8P] is required on the claim form to submit this numerator option)
Append a reporting modifier (8P) to CPT Category II code 3025F to report circumstances when the patient is not eligible for the measure.
3025F *with* 8P: Spirometry test not performed or documented

OR

Patient not Documented to have Inhaled Bronchodilator Prescribed, Reason not Specified
(Two CPT II codes [4025F-8P & 3025F] are required on the claim form to submit this numerator option)
Append a reporting modifier (8P) to CPT Category II code 4025F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.
4025F *with* 8P: Inhaled bronchodilator not prescribed, reason not otherwise specified
AND
CPT II 3025F: Spirometry test results demonstrate $FEV_1/FVC < 70\%$ with COPD symptoms (e.g., dyspnea, cough/sputum, wheezing)

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.

CLINICAL RECOMMENDATION STATEMENTS:
Short-acting bronchodilators can increase exercise tolerance acutely in COPD. (ATS and ERS)

Bronchodilator medications are central to the symptomatic management of COPD. (Evidence A) (NHLBI/ WHO)

A combination of a short-acting β_2-agonist and an anticholinergic produces greater and more sustained improvements in FEV_1 than either alone and does not produce evidence of tachyphylaxis over 90 days of treatment. (Evidence A) (NHLBI/WHO)

In patients with Stage II: Moderate COPD to Stage IV: Very Severe COPD whose symptoms are not adequately controlled with as-needed short-acting bronchodilators, adding regular treatment with a long-acting inhaled bronchodilator is recommended. (Evidence A) NHLBI/WHO)

Regular treatment with long-acting bronchodilators is more effective and convenient than treatment with short-acting bronchodilators, but more expensive. (Evidence A) (NHLBI/WHO)

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▲ Measure #53: Asthma: Pharmacologic Therapy

2011 PHYSICIAN QUALITY REPORTING OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of patients aged 5 through 50 years with a diagnosis of mild, moderate, or severe persistent asthma who were prescribed either the preferred long-term control medication (inhaled corticosteroid) or an acceptable alternative treatment

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

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

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

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure. The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All patients aged 5 through 50 years with a diagnosis of mild, moderate, or severe persistent asthma

> Denominator Criteria (Eligible Cases):
> Patients aged 5 through 50 years on date of encounter
> AND
> Diagnosis for asthma (ICD-9-CM): 493.00, 493.02, 493.10, 493.12, 493.20, 493.22, 493.81, 493.82, 493.90, 493.92
> AND
> Patient encounter during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215

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NUMERATOR:
Patients who were prescribed *either* the preferred long-term control medication (inhaled corticosteroid or inhaled corticosteroid with long-acting inhaled beta$_2$-agonist) or an acceptable alternative treatment (leukotriene modifiers, cromolyn sodium, nedocromil sodium, or sustained-released methylaxanthines)

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

Definition:
Prescribed – May include prescription given to the patient for long-term control medication (inhaled corticosteroid or inhaled corticosteroid with long-acting inhaled beta$_2$-agonist) or an acceptable alternative treatment (leukotriene modifiers, cromolyn sodium, nedocromil sodium, or sustained-released methylaxanthines) at one or more visits in the 12-month period or patient already taking long-term control medication or an acceptable alternative treatment as documented in current medication list.

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

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Preferred Long-Term Control Medication or Acceptable Alternative Treatment Prescribed
(Two CPT II codes [4015F & 1038F] are required on the claim form to submit this numerator option)
CPT II 4015F: Persistent asthma, preferred long term control medication or acceptable alternative treatment prescribed
AND
CPT II 1038F: Persistent asthma (mild, moderate or severe)

OR

Preferred Long-Term Control Medication or Acceptable Alternative Treatment not Prescribed for Patient Reasons
(Two CPT II codes [4015F-2P & 1038F] are required on the claim form to submit this numerator option)
Append a modifier (2P) to CPT Category II code 4015F to report documented circumstances that appropriately exclude patients from the denominator.
4015F *with* 2P: Documentation of patient reason(s) for not prescribing either the preferred long-term control medication (inhaled corticosteroid or inhaled corticosteroid with long-acting inhaled beta2-agonist) or an acceptable alternative treatment (leukotriene modifiers, cromolyn sodium, nedocromil sodium, or sustained-released methylaxanthines)
AND
CPT II 1038F: Persistent asthma (mild, moderate or severe)

OR

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If patient is not eligible for this measure because patient does not have persistent asthma, report:
(One CPT II code [1039F] is required on the claim form to submit this numerator option)
CPT II 1039F: Intermittent asthma

OR

Preferred Long-Term Control Medication or Acceptable Alternative Treatment not Prescribed, Reason not Specified
(Two CPT II codes [4015F-8P & 1038F] are required on the claim form to submit this numerator option)
Append a reporting modifier (8P) to CPT Category II code 4015F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.
4015F *with* 8P: Persistent asthma, preferred long term control medication or acceptable alternative treatment not prescribed, reason not otherwise specified

AND

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

RATIONALE:
Although current guidelines recommend inhaled corticosteroids as the preferred pharmacological treatment for persistent asthma, other long-term control medications are acceptable alternatives. Long Acting-inhaled $Beta_2$ Agonists (LABA) are recommended in combination with Inhaled Corticosteroids.

CLINICAL RECOMMENDATION STATEMENTS:
A stepwise approach to therapy is recommended to maintain long-term control:

Step 1: Mild Intermittent Asthma
- No daily medication needed

Step 2: Mild Persistent Asthma
- *Preferred treatment:* Low-dose inhaled corticosteroids (ICS)
- *Alternative treatment:* Cromolyn, leukotriene modifier, nedocromil, OR sustained-release theophylline

Step 3: Moderate Persistent Asthma
- *Preferred treatment:* Low-medium dose ICS + long-acting inhaled $beta_2$-agonists (LABA)
- *Alternative treatment:* Increase medium-dose ICS OR low-medium dose ICS and either leukotriene modifier or theophylline (If needed, may increase ICS within medium-dose range in either treatment)

Step 4: Severe Persistent Asthma
- *Preferred treatment:* High-dose ICS + LABA AND, if needed, corticosteroid tablets or syrup long-term

Studies comparing ICS to cromolyn, nedocromil, theophylline, or leukotriene receptor antagonists are limited, but available evidence shows that none of these long-term control medications appear to be as effective as ICS in improving asthma outcomes.

For quick relief for all patients, a short-acting bronchodilator is recommended as needed for symptoms. (NAEPP/NHLBI)

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*Measure #54: 12-Lead Electrocardiogram (ECG) Performed for Non-Traumatic Chest Pain

2011 PHYSICIAN QUALITY REPORTING OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

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

INSTRUCTIONS:
This measure is to be reported each time a patient has been discharged from the emergency department with a discharge diagnosis of non-traumatic chest pain during the reporting period. Claims data will be analyzed to determine the emergency department discharge. Patients who were discharged from an emergency department with a diagnosis of non-traumatic chest pain should have documentation in the medical record of having a 12-lead ECG performed. It is anticipated that clinicians who provide care in the emergency department will submit this measure. The Part B claim form place of service field must indicate that the encounter has taken place in the emergency department.

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

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

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure. The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All patients aged 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

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Diagnosis for non-traumatic chest pain (ICD-9-CM): 413.0, 413.1, 413.9, 786.50, 786.51, 786.52, 786.59
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 had a 12-lead ECG performed

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

OR

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

OR

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

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

CLINICAL RECOMMENDATION STATEMENTS:
A 12-lead ECG should be performed and shown to an experienced emergency physician within 10 minutes of ED arrival for all patients with chest discomfort (or anginal equivalent) or other symptoms of STEMI. (ACC/AHA)(Class I, Level C)

If pain is severe or pressure or substernal or exertional or radiating to jaw, neck, shoulder or arm, then the following are recommended:

- 12-lead ECG (Rule)
- IV access, supplemental oxygen, cardiac monitor, serum cardiac markers (e.g., CKMB), CXR, nitrates, management of on-going pain, admit (ACEP)

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*Measure #55: 12-Lead Electrocardiogram (ECG) Performed for Syncope

2011 PHYSICIAN QUALITY REPORTING OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of patients aged 60 years and older with an emergency department discharge diagnosis of syncope who had a 12-lead ECG performed

INSTRUCTIONS:
This measure is to be reported each time a patient has been discharged from the emergency department with a discharge diagnosis of syncope during the reporting period. Claims data will be analyzed to determine the emergency department discharge. Patients who experienced syncope should have documentation in the medical record of having a 12-lead ECG performed. It is anticipated that clinicians who provide care in the emergency department will submit this measure. The Part B claim form place of service field must indicate that the encounter has taken place in the emergency department.

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

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

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure. The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All patients aged 60 years and older with an emergency department discharge diagnosis of syncope

Denominator Criteria (Eligible Cases):
Patients aged ≥ 60 years on date of encounter
AND
Diagnosis for syncope (ICD-9-CM): 780.2
AND

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Patient encounter during the reporting period (CPT): 99281, 99282, 99283, 99284, 99285, 99291
AND
Place of Service Indicator: 23
(The Part B claim form place of service field must indicate emergency department)

NUMERATOR:
Patients who had a 12-lead ECG performed

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

OR

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

OR

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

RATIONALE:
12-lead ECG can occasionally pick up potentially life-threatening conditions such as pre-excitation syndromes, prolonged QT syndromes, or Brugada's syndrome in otherwise healthy appearing young adults. 12-lead ECG testing is performed inconsistently, even in high risk patients; the largest study to date of 12-lead ECG testing variation in ED syncope visits using a 9 year national sample illustrated that 12-lead ECG testing was documented in only 59% of ED syncope visits.

CLINICAL RECOMMENDATION STATEMENTS:
Obtain a standard 12-lead ECG in patients with syncope when history and physical examination do not reveal a diagnosis. (ACEP) (Level A)

- A patient with normal 12-lead ECG has a low likelihood of dysrhythmias as a cause of syncope.
- Abnormal 12-lead ECG has been associated as being the most important predictor of serious outcomes and a multivariate predictor for arrhythmia or death within 1 year after the syncopal episode.

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*Measure #56: Community-Acquired Pneumonia (CAP): Vital Signs

2011 PHYSICIAN QUALITY REPORTING OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of patients aged 18 years and older with a diagnosis of community-acquired bacterial pneumonia with vital signs documented and reviewed

INSTRUCTIONS:
This measure is to be reported once for each occurrence of community-acquired bacterial pneumonia during the reporting period. Each unique occurrence is defined as a 45-day period from onset of community-acquired bacterial pneumonia. Claims data will be analyzed to determine unique occurrences. All patients 18 years and older with a diagnosis of community-acquired bacterial pneumonia should have documentation in the medical record of having vital signs recorded and reviewed. It is anticipated that clinicians who provide care in the emergency department or office setting will submit this measure. Clinicians utilizing the critical care code must indicate the emergency department place of service code in order to be counted in the measure's denominator.

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

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

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure. The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data. There are no allowable performance exclusions for this measure.

DENOMINATOR:
All patients aged 18 years and older with a diagnosis of community-acquired bacterial pneumonia

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

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Diagnosis for community-acquired bacterial pneumonia (ICD-9-CM): 481, 482.0, 482.1, 482.2, 482.30, 482.31, 482.32, 482.39, 482.40, 482.41, 482.42, 482.49, 482.81, 482.82, 482.83, 482.84, 482.89, 482.9, 483.0, 483.1, 483.8, 485, 486, 487.0
AND
Patient encounter during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99281, 99282, 99283, 99284, 99285, 99291*, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350

** Clinicians utilizing the critical care code (99291) must indicate the emergency department place of service (23) on the Part B claim form in order to report this measure.*

NUMERATOR:
Patients with vital signs (temperature, pulse, respiratory rate, and blood pressure) documented and reviewed

Definitions:
Vital Signs – Are defined as temperature, pulse, respiratory rate, and blood pressure
Documented and Reviewed – May include one of the following: Clinician documentation that vital signs were reviewed, dictation by the clinician including vital signs, clinician initials in the chart that vital signs were reviewed, or other indication that vital signs had been acknowledged by the clinician

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Vital Signs Documented and Reviewed
CPT II 2010F: Vital signs (temperature, pulse, respiratory rate, and blood pressure) documented and reviewed

OR

Vital Signs not Documented and Reviewed, Reason not Specified
Append a reporting modifier (8P) to CPT Category II code 2010F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.
2010F *with* 8P: Vital signs (temperature, pulse, respiratory rate, and blood pressure) not documented and reviewed, reason not otherwise specified

RATIONALE:
Each of the vital signs should be recorded in the emergency department. While vital signs may be routinely recorded, there likely is a gap in care on acting on those values that warrant further evaluation. Moreover, it is important for physicians to review the vital signs to ensure continuous quality improvement and consistent patient care.

CLINICAL RECOMMENDATION STATEMENTS:
It is necessary to assess the severity of illness. This includes the radiographic findings (multilobar pneumonia or pleural effusion) and physical findings (respiratory rate, systolic and diastolic blood pressure, signs of dehydration and mental status). (ATS) (Level II Evidence)

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*Measure #57: Community-Acquired Pneumonia (CAP): Assessment of Oxygen Saturation

2011 PHYSICIAN QUALITY REPORTING OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of patients aged 18 years and older with a diagnosis of community-acquired bacterial pneumonia with oxygen saturation documented and reviewed

INSTRUCTIONS:
This measure is to be reported once for each occurrence of community-acquired bacterial pneumonia during the reporting period. Each unique occurrence is defined as a 45-day period from onset of community-acquired bacterial pneumonia. Claims data will be analyzed to determine unique occurrences. All patients 18 years and older with a diagnosis of community-acquired bacterial pneumonia should have documentation in the medical record of having oxygen saturation assessed. It is anticipated that clinicians who provide care in the emergency department or office setting will submit this measure. Clinicians utilizing the critical care code must indicate the emergency department place of service code in order to be counted in the measure's denominator.

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

When reporting the measure via claims, submit the listed ICD-9-CM diagnosis codes, CPT codes, and the appropriate CPT Category II code OR the CPT Category II code **with** the modifier. The modifiers allowed for this measure are: 1P- medical reasons, 2P- patient reasons, 3P- system reasons, 8P- reason not otherwise specified. Clinicians utilizing the critical care code must indicate the emergency department place of service code in order to be counted in the measure's denominator. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure. The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All patients aged 18 years and older with a diagnosis of community-acquired bacterial pneumonia

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Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Diagnosis for community-acquired bacterial pneumonia (ICD-9-CM): 481, 482.0, 482.1, 482.2, 482.30, 482.31, 482.32, 482.39, 482.40, 482.41, 482.42, 482.49, 482.81, 482.82, 482.83, 482.84, 482.89, 482.9, 483.0, 483.1, 483.8, 485, 486, 487.0
AND
Patient encounter during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99281, 99282, 99283, 99284, 99285, 99291*, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350
** Clinicians utilizing the critical care code (99291) must indicate the emergency department place of service (23) on the Part B claim form in order to report this measure.*

NUMERATOR:
Patients with oxygen saturation documented and reviewed

Definitions:
Oxygen Saturation – Includes assessment through pulse oximetry or arterial blood gas measurement
Documented and Reviewed – May include one of the following: Clinician documentation that oxygen saturation was reviewed, dictation by the clinician including oxygen saturation, clinician initials in the chart that oxygen saturation was reviewed, or other indication that oxygen saturation had been acknowledged by the clinician

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Oxygen Saturation Documented and Reviewed
CPT II 3028F: Oxygen saturation results documented and reviewed (includes assessment through pulse oximetry or arterial blood gas measurement)

OR

Oxygen Saturation not Documented and Reviewed for Medical, Patient, or System Reasons
Append a modifier (1P, 2P or 3P) to CPT Category II code 3028F to report documented circumstances that appropriately exclude patients from the denominator.
3028F *with* 1P: Documentation of medical reason(s) for not documenting and reviewing oxygen saturation
3028F *with* 2P: Documentation of patient reason(s) for not documenting and reviewing oxygen saturation
3028F *with* 3P: Documentation of system reason(s) for not documenting and reviewing oxygen saturation

OR

Oxygen Saturation not Documented and Reviewed, Reason not Specified
Append a reporting modifier (8P) to CPT Category II code 3028F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.
3028F *with* 8P: Oxygen saturation results not documented and reviewed, reason not otherwise specified

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RATIONALE:
The assessment of oxygenation helps to assess the severity of the illness.

CLINICAL RECOMMENDATION STATEMENTS:
It is necessary to assess the severity of illness. This includes the radiographic findings (multilobar pneumonia or pleural effusion) and physical findings (respiratory rate, systolic and diastolic blood pressure, signs of dehydration and mental status). For those patients with chronic heart or lung disease, the assessment of oxygenation by pulse oximetry will help identify the need for hospitalization. (ATS) (Level II Evidence)

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*Measure #58: Community-Acquired Pneumonia (CAP): Assessment of Mental Status

2011 PHYSICIAN QUALITY REPORTING OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of patients aged 18 years and older with a diagnosis of community-acquired bacterial pneumonia with mental status assessed

INSTRUCTIONS:
This measure is to be reported once for each occurrence of community-acquired bacterial pneumonia during the reporting period. Each unique occurrence is defined as a 45-day period from onset of community-acquired bacterial pneumonia. Claims data will be analyzed to determine unique occurrences. All patients 18 years and older with a diagnosis of community-acquired bacterial pneumonia should have documentation in the medical record of having mental status assessed. It is anticipated that clinicians who provide care in the emergency department or office setting will submit this measure. Clinicians utilizing the critical care code must indicate the emergency department place of service code in order to be counted in the measure's denominator.

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

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

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure. The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data. There are no allowable performance exclusions for this measure.

DENOMINATOR:
All patients aged 18 years and older with a diagnosis of community-acquired bacterial pneumonia

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

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Diagnosis for community-acquired bacterial pneumonia (ICD-9-CM): 481, 482.0, 482.1, 482.2, 482.30, 482.31, 482.32, 482.39, 482.40, 482.41, 482.42, 482.49, 482.81, 482.82, 482.83, 482.84, 482.89, 482.9, 483.0, 483.1, 483.8, 485, 486, 487.0
AND
Patient encounter during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99281, 99282, 99283, 99284, 99285, 99291*, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350

** Clinicians utilizing the critical care code (99291) must indicate the emergency department place of service (23) on the Part B claim form in order to report this measure.*

NUMERATOR:
Patients for whom mental status was assessed

Definition:
Assessed – May include: Documentation by clinician that patient's mental status was noted (e.g., patient is oriented or disoriented).

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Mental Status Assessed
CPT II 2014F: Mental status assessed

OR

Mental Status not Assessed, Reason not Specified
Append a reporting modifier (8P) to CPT Category II code 2014F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.
2014F *with* 8P: Mental status not assessed, reason not otherwise specified

RATIONALE:
The assessment of mental status helps to assess the severity of the illness.

CLINICAL RECOMMENDATION STATEMENTS:
It is necessary to assess the severity of illness. This includes the radiographic findings (multilobar pneumonia or pleural effusion) and physical findings (respiratory rate, systolic and diastolic blood pressure, signs of dehydration and mental status). (ATS) (Level II Evidence)

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*Measure #59: Community-Acquired Pneumonia (CAP): Empiric Antibiotic

2011 PHYSICIAN QUALITY REPORTING OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of patients aged 18 years and older with a diagnosis of community-acquired bacterial pneumonia with an appropriate empiric antibiotic prescribed

INSTRUCTIONS:
This measure is to be reported once for each occurrence of community-acquired bacterial pneumonia during the reporting period. Each unique occurrence is defined as a 45-day period from onset of community-acquired bacterial pneumonia. Claims data will be analyzed to determine unique occurrences. All patients 18 years and older with a diagnosis of community-acquired bacterial pneumonia should have documentation in the medical record of having an appropriate empiric antibiotic prescribed. It is anticipated that clinicians who provide care in the emergency department or office setting will submit this measure. Clinicians utilizing the critical care code must indicate the emergency department place of service code in order to be counted in the measure's denominator.

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

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

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure. The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All patients aged 18 years and older with the diagnosis of community-acquired bacterial pneumonia

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

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Diagnosis for community-acquired bacterial pneumonia (ICD-9-CM): 481, 482.0, 482.1, 482.2, 482.30, 482.31, 482.32, 482.39, 482.40, 482.41, 482.42, 482.49, 482.81, 482.82, 482.83, 482.84, 482.89, 482.9, 483.0, 483.1, 483.8, 485, 486, 487.0
AND
Patient encounter during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99281, 99282, 99283, 99284, 99285, 99291*, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350

** Clinicians utilizing the critical care code (99291) must indicate the emergency department place of service (23) on the Part B claim form in order to report this measure.*

NUMERATOR:
Patients with appropriate empiric antibiotic prescribed

Definitions:
Appropriate Empiric Antibiotic – For treatment of community-acquired bacterial pneumonia (CAP) should include any medication from one of the following four drug classes: Fluoroquinolones, Macrolides, Doxycycline, Beta Lactam with Macrolide or Doxycycline (as defined by current ATS/IDSA guidelines).
Prescribed – Includes patients who are currently receiving medication(s) that follow the treatment plan recommended at an encounter during the reporting period, even if the prescription for that medication was ordered prior to the encounter.

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Appropriate Empiric Antibiotic Prescribed
CPT II 4045F: Appropriate empiric antibiotic prescribed

OR

Appropriate Empiric Antibiotic not Prescribed for Medical, Patient, or System Reasons
Append a modifier (1P, 2P or 3P) to CPT Category II code 4045F to report documented circumstances that appropriately exclude patients from the denominator.
4045F *with* 1P: Documentation of medical reason(s) for not prescribing appropriate empiric antibiotic
4045F *with* 2P: Documentation of patient reason(s) for not prescribing appropriate empiric antibiotic
4045F *with* 3P: Documentation of system reason(s) for not prescribing appropriate empiric antibiotic

OR

Appropriate Empiric Antibiotic not Prescribed, Reason not Specified
Append a reporting modifier (8P) to CPT Category II code 4045F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.
4045F *with* 8P: Appropriate empiric antibiotic not prescribed, reason not otherwise specified

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RATIONALE:
All patients need to be treated empirically according to the guideline recommendations.

CLINICAL RECOMMENDATION STATEMENTS:
All patients should be treated empirically. Patients treated as outpatients with no cardiopulmonary disease and no modifying factors should be treated with advanced generation macrolide: azithromycin or clarithromycin or doxycycline. Patients treated as an outpatient with cardiopulmonary disease and/or risk factors should be treated with beta lactam plus macrolide or doxycycline or fluoroquinolone alone. Empiric therapy based on the ATS guidelines lead to better outcomes than if the guidelines are not followed. (ATS) (Level II Evidence)

Fluoroquinolones (gatifloxacin, gemifloxacin, levofloxacin, and moxifloxacin) are recommended for initial empiric therapy of selected outpatients with CAP. (Level A Recommendation, Level I Evidence)

Other options (macrolides and doxycycline) are generally preferred for uncomplicated infections in outpatients. (IDSA) (Level A Recommendation, Level I Evidence)

A macrolide is recommended as monotherapy for selected outpatients, such as those who were previously well and not recently treated with antibiotics. (Level A Recommendation, Level I Evidence)

A macrolide plus a beta lactam is recommended for initial empiric treatment of outpatients in whom resistance is an issue. (IDSA) (Level A Recommendation, Level I Evidence)

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▲ Measure #64: Asthma: Asthma Assessment

2011 PHYSICIAN QUALITY REPORTING OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of patients aged 5 through 50 years with a diagnosis of asthma who were evaluated during at least one office visit within 12 months for the frequency (numeric) of daytime and nocturnal asthma symptoms

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

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

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

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure. The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data. There are no allowable performance exclusions for this measure.

DENOMINATOR:
All patients aged 5 through 50 years with a diagnosis of asthma

> Denominator Criteria (Eligible Cases):
> Patients aged 5 through 50 years on date of encounter
> AND
> Diagnosis for asthma (ICD-9-CM): 493.00, 493.02, 493.10, 493.12, 493.20, 493.22, 493.81, 493.82, 493.90, 493.92
> AND

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

NUMERATOR:
Patients who were evaluated during at least one office visit within 12 months for the frequency (numeric) of daytime and nocturnal asthma symptoms

Numerator Instructions: To be counted in calculation of this measure, symptom frequency must be numerically quantified. Measure may also be met by clinician documentation or patient completion of an asthma assessment tool/survey/questionnaire. Assessment tool may include the Quality Metric Asthma Control Test™, National Asthma Education & Prevention Program (NAEPP) Asthma Symptoms, and Peak Flow Diary.

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Asthma Symptom Frequency Evaluated
CPT II 1005F: Asthma symptoms evaluated (includes physician documentation of numeric frequency of symptoms or patient completion of an asthma assessment tool/survey/questionnaire)

OR

Asthma Symptom Frequency not Evaluated, Reason not Specified
Append a reporting modifier (8P) to CPT Category II code 1005F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.
1005F *with* 8P: Asthma symptoms not evaluated, reason not otherwise specified

RATIONALE:
Appropriate treatment of asthma patients requires accurate classification of asthma severity. Physician assessment of the frequency of asthma symptoms is the first step in classifying asthma severity.

CLINICAL RECOMMENDATION STATEMENTS:
To determine whether the goals of therapy are being met, monitoring is recommended in the 6 areas listed below:

- Signs and symptoms (daytime; nocturnal awakening) of asthma
- Pulmonary function (spirometry; peak flow monitoring)
- Quality of life/functional status
- History of asthma exacerbations
- Pharmacotherapy (as-needed use of inhaled short-acting beta2-agonist, adherence to regimen of long-term-control medications)
- Patient-provider communication and patient satisfaction (NAEPP/NHLBI)

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♦ Measure #65: Treatment for Children with Upper Respiratory Infection (URI): Avoidance of Inappropriate Use

2011 PHYSICIAN QUALITY REPORTING OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of children aged 3 months through 18 years with a diagnosis of URI who were not prescribed or dispensed an antibiotic prescription on or within 3 days of the initial date of service

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

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

When reporting the measure via claims, submit the listed ICD-9-CM diagnosis codes, CPT codes, and the appropriate CPT Category II code OR the CPT Category II code with the modifier. The modifier allowed for this measure is: 1P- medical reasons. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure. The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All patients aged 3 months through 18 years with a diagnosis of upper respiratory infection

Denominator Criteria (Eligible Cases):
Patients aged 3 months through 18 years on date of encounter
AND
Diagnosis for URI (ICD-9-CM): 460, 465.0, 465.8, 465.9
AND
Patient encounter during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99217, 99218, 99219, 99220

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NUMERATOR:
Patients who were not dispensed an antibiotic prescription on or within 3 days of the initial date of service

Numerator Instructions: For performance, the measure will be calculated as the number of patients for whom antibiotics were neither prescribed nor dispensed over the number of patients in the denominator (patients aged 3 months through 18 years with URI). A higher score indicates appropriate treatment of patients with URI (e.g., the proportion for whom antibiotics were not prescribed or dispensed).

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Antibiotic not Prescribed or Dispensed
CPT II 4124F: Antibiotic neither prescribed nor dispensed

OR

Antibiotic Prescribed or Dispensed for Medical Reasons
Append a modifier (1P) to CPT Category II code 4120F to report documented circumstances that appropriately exclude patients from the denominator.
4120F *with* 1P: Documentation of medical reason(s) for prescribing or dispensing antibiotic

OR

Antibiotic Prescribed or Dispensed
CPT II 4120F: Antibiotic prescribed or dispensed

RATIONALE:
Existing clinical guidelines do not support the use of antibiotics for the common cold/upper respiratory infection.

CLINICAL RECOMMENDATION STATEMENTS:
Recent clinical practice guidelines set out the evidence supporting the recommendations for treating a host of upper respiratory tract infections in pediatrics. The guidelines do not recommend antibiotics for a majority of upper respiratory tract infections, except for conditions with bacterial etiology such as acute otitis media, bacterial sinusitis, mucopurulent rhinitis with prolonged symptoms, i.e., at least 10 days of continual symptoms, and group A streptococcal pharyngitis (but only cases with a confirmatory test for group A strep). The guidelines support targeting treatment of non-specific URI (the common cold) or viral rhinosinusitis with antibiotics as an indicator of inappropriate antibiotic prescribing.

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♦ Measure #66: Appropriate Testing for Children with Pharyngitis

2011 PHYSICIAN QUALITY REPORTING OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of children aged 2 through 18 years with a diagnosis of pharyngitis, who were prescribed an antibiotic and who received a group A streptococcus (strep) test for the episode

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

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

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

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure. The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All patients aged 2 through 18 years with a diagnosis of pharyngitis

> Denominator Criteria (Eligible Cases):
> Patients aged 2 through 18 years on date of encounter
> AND
> Diagnosis for pharyngitis (ICD-9-CM): 034.0, 462, 463
> AND
> Patient encounter during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99217, 99218, 99219, 99220

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NUMERATOR:
Patients who were dispensed an antibiotic and who received a group A streptococcus (strep) test for the episode

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

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Group A Streptococcus Test Performed and Antibiotic Prescribed
(Two CPT II codes [3210F & 4120F] are required on the claim form to submit this numerator option)

CPT II 3210F: Group A Strep Test Performed
AND
CPT II 4120F: Antibiotic prescribed or dispensed

OR

Group A Streptococcus Test not Performed for Medical Reasons
(Two CPT II codes [3210F-1P & 4120F] are required on the claim form to submit this numerator option)
Append a modifier (1P) to CPT Category II codes 3210F to report documented circumstances that appropriately exclude patients from the denominator.
3210F *with* 1P: Documentation of medical reason(s) for not Performing Group A Strep Test
AND
CPT II 4120F: Antibiotic prescribed or dispensed

OR

If patient is not eligible for this measure because patient was not prescribed antibiotics, report:
(One CPT II code [4124F] is required on the claim form to submit this numerator option)
CPT II 4124F: Antibiotic neither prescribed nor dispensed

OR

Group A Streptococcus Test not Performed, Reason not Specified
(Two CPT II codes [3210F-8P & 4120F] are required on the claim form to submit this numerator option)
Append a reporting modifier (8P) to CPT Category II code 3210F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.
3210F *with* 8P: Group A Strep Test not Performed, reason not otherwise specified
AND
CPT II 4120F: Antibiotic prescribed or dispensed

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RATIONALE:
Clinical practice guidelines recommend group A streptococcus pharyngitis be treated with antibiotics (Schwartz et al, 1998).

CLINICAL RECOMMENDATION STATEMENTS:
The group A strep test (rapid assay or throat culture) is the definitive test of group A strep pharyngitis. Pharyngitis is the only respiratory tract infection with an objective diagnostic test that can be validated with administrative data, and not medical records. A process measure that requires the performance of a group A strep test for children given antibiotics for pharyngitis is supported by the guidelines. (Ibid)

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♣ Measure #67: Myelodysplastic Syndrome (MDS) and Acute Leukemias: Baseline Cytogenetic Testing Performed on Bone Marrow

2011 PHYSICIAN QUALITY REPORTING OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

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

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for patients seen during the reporting period, regardless of when the baseline testing is performed. It is anticipated that clinicians who provide services for patients with the diagnosis of myelodysplastic syndromes or an acute leukemia (not in remission) will submit this measure.

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

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

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure. The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

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

> Denominator Criteria (Eligible Cases):
> Patients aged ≥ 18 years on date of encounter
> AND
> Diagnosis for MDS or acute leukemia – not in remission (ICD-9-CM): 204.00, 204.02, 205.00, 205.02, 206.00, 206.02, 207.00, 207.02, 207.20, 207.22, 208.00, 208.02, 238.72, 238.73, 238.74, 238.75
> AND

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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 Quality-Data Coding Options for Reporting Satisfactorily:
Baseline Cytogenetic Testing Performed
CPT II 3155F: Cytogenetic testing performed on bone marrow at time of diagnosis or prior to initiating treatment

OR

Baseline Cytogenetic Testing not Performed for Medical, Patient, or System Reasons
Append a modifier (1P, 2P or 3P) to CPT Category II code 3155F to report documented circumstances that appropriately exclude patients from the denominator.
3155F *with* 1P: Documentation of medical reason(s) for not performing baseline cytogenetic testing on bone marrow (e.g., no liquid bone marrow or fibrotic marrow)
3155F *with* 2P: Documentation of patient reason(s) for not performing baseline cytogenetic testing on bone marrow (e.g., at time of diagnosis receiving palliative care or not receiving treatment as defined above)
3155F *with* 3P: Documentation of system reason(s) for not performing baseline cytogenetic testing on bone marrow (e.g., patient previously treated by another physician at the time cytogenetic testing performed)

OR

Baseline Cytogenetic Testing not Performed, Reason not Specified
Append a reporting modifier (8P) to CPT Category II code 3155F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.
3155F *with* 8P: Cytogenetic testing not performed on bone marrow at time of diagnosis or prior to initiating treatment, reason not otherwise specified

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

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

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CLINICAL RECOMMENDATION STATEMENTS:

For MDS:

Bone marrow aspiration and biopsy are needed to calculate 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. Marrow cytogenetics should be obtained because they are of major importance for prognosis (Category 2A Recommendation). (NCCN)

The decision to treat patients having marrow blasts in the range of 20% to 30% with intensive AML therapy is thus complex and should be individualized. The clinician should consider such factors as age, antecedent factors, cytogenetics, comorbidities, pace of disease, and performance status (Category 2A Recommendation). (NCCN)

A chromosome abnormality confirms the presence of a clonal disorder aiding the distinction between MDS and reactive causes of dysplasia, and in addition has major prognostic value. Cytogenetic analysis should therefore be performed for all patients in whom a bone marrow examination is indicated. (BCSH)

For acute leukemias:

The initial evaluation has two objectives. The first is to identify the pathology causing the disease including factors such as prior toxic exposure or myelodysplasia, cytogenetics and molecular markers that may have an impact on chemoresponsiveness and propensity for relapse which may guide choice of treatment. The second objective focuses on patient-specific factors including comorbid conditions that may affect an individual's ability to tolerate chemotherapy (Category 2A Recommendation). (NCCN)

Although cytogenetic information is usually unknown when treatment is initiated in patients with de novo AML, karyotype represents the single most important prognostic factor for predicting remission rate, relapse, and overall survival. Therefore, the importance of obtaining sufficient samples of marrow or peripheral blood blasts at diagnosis for this analysis cannot be overemphasized (Category 2A Recommendation). (NCCN)

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♣ Measure #68: Myelodysplastic Syndrome (MDS): Documentation of Iron Stores in Patients Receiving Erythropoietin Therapy

2011 PHYSICIAN QUALITY REPORTING OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of patients aged 18 years and older with a diagnosis of MDS who are receiving erythropoietin therapy with documentation of iron stores prior to initiating erythropoietin therapy

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for all MDS patients seen during the reporting period, regardless of when the documentation of iron stores occurs. It is anticipated that clinicians who provide services for patients with the diagnosis of myelodysplastic syndromes will submit this measure.

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

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

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure. The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

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

> Denominator Criteria (Eligible Cases):
> Patients aged ≥ 18 years on date of encounter
> AND
> Diagnosis for MDS (ICD-9-CM): 238.72, 238.73, 238.74, 238.75
> AND
> Patient encounter during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215

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

Definitions:
Documentation of Iron Stores – Includes either: bone marrow examination including iron stain OR serum iron measurement by ferritin or serum iron and TIBC
Erythropoietin Therapy – Includes the following medications: epoetin and darbepoetin for the purpose of this measure

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

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Documentation of Iron Stores Prior to Initiating Erythropoietin Therapy Performed
(Two CPT II codes [3160F & 4090F] are required on the claim form to submit this numerator option)
CPT II 3160F: Documentation of iron stores prior to initiating erythropoietin therapy
AND
CPT II 4090F: Patient receiving erythropoietin therapy

OR

Documentation of Iron Stores Prior to Initiating Erythropoietin Therapy not Performed for System Reasons
(Two CPT II codes [3160F-3P & 4090F] are required on the claim form to submit this numerator option)
Append a modifier (3P) to CPT Category II code 3160F to report documented circumstances that appropriately exclude patients from the denominator.
3160F *with* 3P: Documentation of system reason(s) for not documenting iron stores prior to initiating erythropoietin therapy
AND
CPT II 4090F: Patient receiving erythropoietin therapy

OR

If patient is not eligible for this measure because patient is not receiving erythropoietin therapy, report:
(One CPT II code [4095F] is required on the claim form to submit this numerator option)
CPT II 4095F: Patient not receiving erythropoietin therapy

OR

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Documentation of Iron Stores Prior to Initiating Erythropoietin Therapy not Performed, Reason not Specified
(Two CPT II codes [3160F-8P & 4090F] are required on the claim form to submit this numerator option)
Append a reporting modifier (8P) to CPT Category II code 3160F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.
3160F ***with*** 8P: Iron stores prior to initiating erythropoietin therapy not documented, reason not otherwise specified
AND
CPT II 4090F: Patient receiving erythropoietin therapy

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

CLINICAL RECOMMENDATION STATEMENTS:
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 therapy (Category 2A Recommendation). (NCCN)

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♣ Measure #69: Multiple Myeloma: Treatment with Bisphosphonates

2011 PHYSICIAN QUALITY REPORTING OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

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

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

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

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

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure. The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

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

> Denominator Criteria (Eligible Cases):
> Patients aged ≥ 18 years on date of encounter
> AND
> Diagnosis for multiple myeloma – not in remission (ICD-9-CM): 203.00, 203.02
> 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

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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 Quality-Data Coding Options for Reporting Satisfactorily:
Intravenous Bisphosphonate Therapy Prescribed or Received
CPT II 4100F: Bisphosphonate therapy, intravenous, ordered or received

OR

Intravenous Bisphosphonate Therapy not Prescribed or Received for Medical or Patient Reasons
Append a modifier (1P or 2P) to CPT Category II code 4100F to report documented circumstances that appropriately exclude patients from the denominator.
4100F *with* 1P: Documentation of medical reason(s) for not prescribing bisphosphonates (e.g., patients who do not have bone disease, patients with dental disease, patients with renal insufficiency)
4100F *with* 2P: Documentation of patient reason(s) for not prescribing bisphosphonates

OR

Intravenous Bisphosphonate Therapy not Prescribed, Reason not Specified
Append a reporting modifier (8P) to CPT Category II code 4100F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.
4100F *with* 8P: Bisphosphonate therapy, intravenous, not ordered or received, reason not otherwise specified

RATIONALE:
Multiple myeloma is a disease characterized by bone destruction, in the form of diffuse osteopenia and/or osteolytic lesions, which develop in 85% of patients. Bisphosphonates can inhibit bone resorption by reducing the number and activity of osteoclasts and therefore could “reduce pain and bone fractures in people with multiple myeloma”.

CLINICAL RECOMMENDATION STATEMENTS:
Based on published data and clinical experience, the guidelines recommend the use of bisphosphonates for all patients with multiple myeloma who have bone disease, including osteopenia. In 10% to 20% of patients with earlier-stage disease who do not have bone disease, bisphosphonates may be considered but preferably in a clinical trial (Category 1 Recommendation). (NCCN)

Intravenous bisphosphonates should be administered monthly for patients with MM and lytic disease evident on plain radiographs (Grade A, Level II). It is reasonable to start intravenous bisphosphonates in patients with MM who do not have lytic bone disease if there is evidence of osteopenia or osteoporosis on bone mineral density studies (Consensus Recommendation, Level N/A). No randomized clinical trials support the use of bisphosphonates in patients with smoldering MM. We believe that bisphosphonates should be used only in the setting of a clinical trial [in these patients] (Consensus Recommendation, Level N/A). (Mayo Clinic)

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♣ Measure #70: Chronic Lymphocytic Leukemia (CLL): Baseline Flow Cytometry

2011 PHYSICIAN QUALITY REPORTING OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of patients aged 18 years and older with a diagnosis of CLL who had baseline flow cytometry studies performed

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for patients seen during the reporting period, regardless of when the baseline flow cytometry studies are performed. It is anticipated that clinicians who provide services for patients with the diagnosis of chronic lymphocytic leukemia, not in remission, will submit this measure.

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

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

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure. The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

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

> Denominator Criteria (Eligible Cases):
> Patients aged ≥ 18 years on date of encounter
> AND
> Diagnosis for CLL – not in remission (ICD-9-CM): 204.10, 204.12
> AND
> Patient encounter during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215

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NUMERATOR:
Patients who had baseline flow cytometry studies performed

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

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Baseline Flow Cytometry Studies Performed
CPT II 3170F: Flow cytometry studies performed at time of diagnosis or prior to initiating treatment

OR

Baseline Flow Cytometry Studies not Performed for Medical, Patient, or System Reasons
Append a modifier (1P, 2P or 3P) to CPT Category II code 3170F to report documented circumstances that appropriately exclude patients from the denominator.
3170F *with* 1P: Documentation of medical reason(s) for not performing baseline flow cytometry studies
3170F *with* 2P: Documentation of patient reason(s) for not performing baseline flow cytometry studies (e.g., receiving palliative care or not receiving treatment as defined above).
3170F *with* 3P: Documentation of system reason(s) for not performing baseline flow cytometry studies (e.g., patient previously treated by another physician at the time baseline flow cytometry studies were performed).

OR

Baseline Flow Cytometry Studies not Performed, Reason not Specified
Append a reporting modifier (8P) to CPT Category II code 3170F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.
3170F *with* 8P: Flow cytometry studies not performed at time of diagnosis or prior to initiating treatment, reason not otherwise specified

RATIONALE:
Due to the distinct pattern of protein antigens expressed in CLL, flow cytometry should be performed in order to confirm the diagnosis, correctly characterize the pathological cells, and determine prognosis. In some instances, flow cytometry may also offer additional therapeutically relevant information.

CLINICAL RECOMMENDATION STATEMENTS:
As with all the lymphoid neoplasms, adequate hematopathologic review is essential to establish an accurate diagnosis of chronic lymphocytic leukemia and small lymphocytic lymphoma CLL/SLL. …a combination of morphologic and flow cytometric studies may provide adequate information to provide a diagnosis. This is particularly true for the diagnosis of CLL. Flow cytometric studies performed on patients with leukemic cell burden include kappa/lambda to [assess] clonality… Distinguishing CLL/SLL from mantle cell lymphoma is essential (Category 2A Recommendation). (NCCN)

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¥ Measure #71: Breast Cancer: Hormonal Therapy for Stage IC–IIIC Estrogen Receptor/ Progesterone Receptor (ER/PR) Positive Breast Cancer

2011 PHYSICIAN QUALITY REPORTING OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of female patients aged 18 years and older with Stage IC through IIIC, ER or PR positive breast cancer who were prescribed tamoxifen or aromatase inhibitor (AI) during the 12-month reporting period

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for all female patients with breast cancer seen during the reporting period. Review estrogen receptor (ER) or progesterone receptor (PR) AND breast cancer stage status AND tumor size to determine which quality-data codes should be submitted. It is anticipated that clinicians who treat female breast cancer patients will submit this measure.

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

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

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure. The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All female patients aged 18 years and older with Stage IC through IIIC, estrogen receptor (ER) or progesterone receptor (PR) positive breast cancer

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Diagnosis for breast cancer (ICD-9-CM): 174.0, 174.1, 174.2, 174.3, 174.4, 174.5, 174.6, 174.8, 174.9, V10.3

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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) within the12 months reporting period

Definition:

Prescribed – Prescribed may include prescription given to the patient for tamoxifen or aromatase inhibitor (AI) at one or more visits in the 12-month period OR patient already taking tamoxifen or aromatase inhibitor (AI) as documented in the current medication list.

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

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Tamoxifen or Aromatase Inhibitor Prescribed

(Three CPT II codes [4179F & 337xF & 3315F] are required on the claim form to submit this numerator option)

CPT II 4179F: Tamoxifen or aromatase inhibitor (AI) prescribed

AND

CPT II 3374F: AJCC Breast Cancer Stage I: TIC (tumor size > 1cm to 2cm), documented

OR

CPT II 3376F: AJCC Breast Cancer Stage II, documented

OR

CPT II 3378F: AJCC Breast Cancer Stage III, documented

AND

CPT II 3315F: Estrogen receptor (ER) or progesterone receptor (PR) positive breast cancer

OR

Tamoxifen or Aromatase Inhibitor not Prescribed for Medical, Patient, or System Reasons

(Three CPT II codes [4179F-xP & 337xF & 3315F] are required on the claim form to submit this numerator option)

Append a modifier (1P, 2P or 3P) to CPT Category II code 4179F to report documented circumstances that appropriately exclude patients from the denominator.

4179F *with* 1P: Documentation of medical reason(s) for not prescribing tamoxifen or aromatase inhibitor (e.g., patient's disease has progressed to metastatic; patient is receiving a gonadotropin-releasing hormone analogue, patient has received oophorectomy, patient is receiving radiation or chemotherapy, patient's diagnosis date was ≥ 5 years from reporting date)

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4179F *with* 2P: Documentation of patient reason(s) for not prescribing tamoxifen or aromatase inhibitor (e.g., patient refusal)
4179F *with* 3P: Documentation of system reason(s) for not prescribing tamoxifen or aromatase inhibitor (e.g., patient is currently enrolled in a clinical trial)
AND

CPT II 3374F: AJCC Breast Cancer Stage I: T1C (tumor size > 1cm to 2cm), 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.

CPT II 3370F: AJCC Breast Cancer Stage 0, documented
OR
CPT II 3372F: AJCC Breast Cancer Stage I: T1 mic, T1a or T1b (tumor size ≤ 1cm), documented
OR
CPT II 3380F: AJCC Breast Cancer Stage IV, documented

OR

If patient is not eligible for this measure because patient is estrogen receptor (ER) and progesterone receptor (PR) negative, report:
Patient is Estrogen Receptor (ER) and Progesterone Receptor (PR) Negative
(One CPT II code [3316F] is required on the claim form to submit this numerator option)
Note: If reporting code 3316F, it is not necessary to report the patient's AJCC Cancer Stage.

CPT II 3316F: Estrogen receptor (ER) and progesterone receptor (PR) negative breast cancer

OR

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If patient is not eligible for this measure because the cancer stage is not documented OR the ER/PR is not documented, report:
Cancer Stage not Documented OR ER/PR not Documented
(One CPT II code [33xxF-8P] is required on the claim form to submit this numerator option)
Append a reporting modifier (8P) to CPT Category II codes 3370F or 3316F to report circumstances when the patient is not eligible for the measure.
3370F ***with*** 8P: No documentation of cancer stage
OR
3316F ***with*** 8P: No documentation of estrogen receptor (ER) and progesterone receptor (PR) status

OR

Tamoxifen or Aromatase Inhibitor not Prescribed, Reason not Specified
(Three CPT II codes [4179F-8P & 337xF & 3315F] are required on the claim form to submit this numerator option)
Append a reporting modifier (8P) to CPT Category II code 4179F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.
4179F ***with*** 8P: Tamoxifen or aromatase inhibitor not prescribed, reason not otherwise specified
AND

CPT II 3374F: AJCC Breast Cancer Stage I: TIC (tumor size > 1cm to 2cm), 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.

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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)

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)

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)

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. Several studies have evaluated aromatase inhibitors in the treatment of postmenopausal women with early-stage breast cancer (Category 2A). (NCCN)

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¥ Measure #72: Colon Cancer: Chemotherapy for Stage III Colon Cancer Patients

2011 PHYSICIAN QUALITY REPORTING OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of patients aged 18 years and older with Stage IIIA through IIIC 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 Stage IIIA through IIIC colon cancer will submit this measure.

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

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

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure. The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All patients aged 18 years and older with Stage IIIA through IIIC colon cancer

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Diagnosis for colon cancer (ICD-9-CM): 153.0, 153.1, 153.2, 153.3, 153.4, 153.5, 153.6, 153.7, 153.8, 153.9, V10.05
AND
Patient encounter during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215

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NUMERATOR:
Patients who are referred for adjuvant chemotherapy, prescribed adjuvant chemotherapy, or who have previously received adjuvant chemotherapy within the 12-month reporting period

Definitions:
Adjuvant Chemotherapy – According to current NCCN guidelines, the following therapies are recommended: 5-fluorouracil/leucovorin or capecitabine, or 5-fluorouracil/leucovorin/ oxaliplatin
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
(Two CPT II codes [4180F & 3388F] are required on the claim form to submit this numerator option)
CPT II 4180F: Adjuvant chemotherapy referred, prescribed or previously received for Stage IIIA through Stage IIIC colon cancer
AND
CPT II 3388F: AJCC Colon Cancer Stage III, documented

OR

Adjuvant Chemotherapy not Referred, Prescribed or Previously Received for Medical, Patient, or System Reasons
(Two CPT II codes [4180F-xP & 3388F] are required on the claim form to submit this numerator option)
Append a modifier (1P, 2P or 3P) to CPT Category II code 4180F to report documented circumstances that appropriately exclude patients from the denominator.
4180F *with* 1P: Documentation of medical reason(s) for not referring for or prescribing adjuvant chemotherapy (e.g., medical comorbidities, diagnosis date more than 5 years prior to the current visit date; patient's cancer has metastasized; medical contraindication/allergy, poor performance status)
4180F *with* 2P: Documentation of patient reason(s) for not referring for or prescribing adjuvant chemotherapy (e.g., patient refusal)
4180F *with* 3P: Documentation of system reason(s) for not referring for or prescribing adjuvant chemotherapy (e.g., patient is currently enrolled in a clinical trial that precludes prescription of chemotherapy)
AND
CPT II 3388F: AJCC Colon Cancer Stage III, documented

OR

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If patient is not eligible for this measure because patient is not stage III colon cancer, report:
Patient not Stage III Colon Cancer
(One CPT II code [33xxF] is required on the claim form to submit this numerator option)
CPT II 3382F: AJCC Colon Cancer Stage 0, documented
OR
CPT II 3384F: AJCC Colon Cancer Stage I, documented
OR
CPT II 3386F: AJCC Colon Cancer Stage II, documented
OR
CPT II 3390F: AJCC Colon Cancer Stage IV, documented

OR

If patient is not eligible for this measure because cancer stage is not documented, report:
Cancer Stage not Documented
(One CPT II code [3382F-8P] is required on the claim form to submit this category)
Append a reporting modifier (8P) to CPT Category II code 3382F to report circumstances when the patient is not eligible for the measure.
3382F ***with*** 8P: No documentation of cancer stage

OR

Adjuvant Chemotherapy not Referred, Prescribed or Previously Received, Reason not Specified
(Two CPT II codes [4180F-8P & 3388F] are required on the claim form to submit this numerator option)
Append a reporting modifier (8P) to CPT Category II code 4180F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.
4180F ***with*** 8P: Adjuvant chemotherapy not prescribed or previously received, reason not otherwise specified
AND
CPT II 3388F: AJCC Colon Cancer Stage III, documented

RATIONALE:
Patients with Stage IIIA through Stage IIIC colon cancer do not always receive the recommended treatment of adjuvant chemotherapy. This measure is intended to determine whether and how often chemotherapy is administered. The specific chemotherapy drugs specified in this measure reflect the most current guidelines of the National Comprehensive Cancer Network.

CLINICAL RECOMMENDATION STATEMENTS:
Following primary surgical treatment, the panel recommends six months of 5-fluorouracil/leucovorin capecitabine, or 5-fluorouracil/leucovorin/oxaliplatin as adjuvant chemotherapy for patients with stage III (T1-4, N1-2, M0) colon cancer (Category 2A). (NCCN)

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▲ Measure #76: Prevention of Catheter-Related Bloodstream Infections (CRBSI): Central Venous Catheter (CVC) Insertion Protocol

2011 PHYSICIAN QUALITY REPORTING OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of patients, regardless of age, who undergo CVC insertion for whom CVC was inserted with all elements of maximal sterile barrier technique [cap AND mask AND sterile gown AND sterile gloves AND a large sterile sheet AND hand hygiene AND 2% chlorhexidine for cutaneous antisepsis (or acceptable alternative antiseptics per current guideline)] followed

INSTRUCTIONS:
This measure is to be reported each time a CVC insertion is performed during the reporting period. There is no diagnosis associated with this measure. It is anticipated that clinicians who perform CVC insertion will submit this measure.

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

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

Measure Reporting via Registry:
CPT codes are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure. The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All patients, regardless of age, who undergo CVC insertion

> Denominator Criteria (Eligible Cases):
> Patient encounter during the reporting period (CPT): 36555, 36556, 36557, 36558, 36560, 36561, 36563, 36565, 36566, 36568, 36569, 36570, 36571, 36578, 36580, 36581, 36582, 36583, 36584, 36585, 93503

NUMERATOR:
Patients for whom central venous catheter (CVC) was inserted with all elements of maximal sterile barrier technique [cap AND mask AND sterile gown AND sterile gloves AND a large sterile sheet AND hand hygiene AND 2% chlorhexidine for cutaneous antisepsis (or acceptable alternative antiseptics, per current guideline)] followed

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Definition:
Maximal Sterile Barrier Technique during CVC Insertion – Includes use of all of the following: Cap AND mask AND sterile gown AND sterile gloves AND a large sterile sheet AND hand hygiene AND 2% chlorhexidine for cutaneous antisepsis (or acceptable alternative antiseptics, per current guideline).

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
All Elements of Maximal Sterile Barrier Technique Followed
CPT II 6030F: All elements of maximal sterile barrier technique followed including: cap AND mask AND sterile gown AND sterile gloves AND a large sterile sheet AND hand hygiene AND 2% chlorhexidine for cutaneous antisepsis (or acceptable alternative antiseptics, per current guideline)

OR

All Elements of Maximal Sterile Barrier Technique not Followed for Medical Reasons
Append a modifier (1P) to CPT Category II code 6030F to report documented circumstances that appropriately exclude patients from the denominator.
6030F *with* 1P: Documentation of medical reason(s) for not following all elements of maximal sterile barrier technique during CVC insertion (including CVC insertion performed on emergency basis)

OR

All Elements of Maximal Sterile Barrier Technique not Followed, Reason not Specified
Append a reporting modifier (8P) to CPT Category II code 6030F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.
6030F *with* 8P: All elements of maximal sterile barrier technique not followed including: cap AND mask AND sterile gown AND sterile gloves AND a large sterile sheet AND hand hygiene AND 2% chlorhexidine for cutaneous antisepsis (or acceptable alternative antiseptics, per current guideline), reason not otherwise specified

RATIONALE:
Catheter-related bloodstream infection is a costly complication of central venous catheter insertion, but may be avoided with routine use of aseptic technique during catheter insertion. This measure is constructed to require that *all* of the listed elements of aseptic technique are followed and documented.

Existing hospital-level measures for this topic were consulted and, to the extent feasible, harmonization between physician- and hospital- level measurement was achieved.

CLINICAL RECOMMENDATION STATEMENTS:
Maximal sterile barrier precautions during catheter insertion: Use aseptic technique including the use of a cap, mask, sterile gown, sterile gloves, and a large sterile sheet, for the insertion of CVCs (including PICCS) or guidewire exchange. (CDC/MMWR) (Category IA)

Hand hygiene: Observe proper hand-hygiene procedures either by washing hands with conventional antiseptic-containing soap and water or with waterless alcohol-based gels or foams.

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Observe hand hygiene before and after palpating catheter insertion sites, as well as before and after inserting, replacing, accessing, repairing, or dressing an intravascular catheter. Palpation of the insertion site should not be performed after the application of antiseptic, unless aseptic technique is maintained. Use of gloves does not obviate the need for hand hygiene. (CDC/MMWR) (Category IA)

Cutaneous antisepsis: Disinfect clean skin with an appropriate antiseptic before catheter insertion and during dressing changes. Although a 2% chlorhexidine-based preparation is preferred, tincture of iodine, an iodophor, or 70% alcohol can be used. (CDC/MMWR) (Category IA)

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▲ Measure #79: End Stage Renal Disease (ESRD): Influenza Immunization in Patients with ESRD

2011 PHYSICIAN QUALITY REPORTING OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of patients aged 18 years and older with a diagnosis of ESRD and receiving dialysis seen for a visit between October 1 and February 28 who received an influenza immunization during the visit OR patient reported previous receipt of an influenza immunization

INSTRUCTIONS:
This measure is to be reported a minimum of once for visits occurring between January 1, 2011 and February 28, 2011 for the 2010-2011 influenza season AND a minimum of once for visits occurring between October 1, 2011 and December 31, 2011 for the 2011-2012 influenza season for ESRD patients receiving dialysis seen during the reporting period. This measure is intended to determine whether or not ESRD patients receiving dialysis received an influenza immunization during the flu season. It is anticipated that clinicians providing care for patients with ESRD will submit this measure.

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

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

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT codes and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure. The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All patients aged 18 years and older with a diagnosis of ESRD and receiving dialysis seen for a visit between October 1 and February 28

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Diagnosis for ESRD (ICD-9-CM): 585.6
AND

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Patient encounter during the reporting period (CPT): 90935, 90937, 90945, 90947, 90957, 90958, 90959, 90960, 90961, 90962, 90965, 90966, 90969, 90970

NUMERATOR:
Patients who received the influenza immunization during the visit OR patient reported previous receipt of influenza immunization

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

NUMERATOR NOTE: Report G8636 if eligible professional verified that influenza immunization was previously administered during the current flu season.

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Influenza Immunization Received
G8636: Influenza immunization administered or previously received

OR

Influenza Immunization not Received for Documented Reasons
G8637: Clinician documented that patient is not eligible to receive the influenza immunization (e.g., patient allergy, patient declined, vaccine not available)

OR

Influenza Immunization not Received, Reason not Specified
G8638: Influenza immunization not administered or previously received, reason not otherwise specified

RATIONALE:
Infectious disease is a common cause of death in late-stage kidney disease patients. Immunizing this high risk population is therefore critical to increasing patient well-being and potentially reducing morbidity and mortality. Despite its importance, a review of Medicare billing data has indicated that the ESRD population had a less than 50% immunization rate for the years 1997 to 1998 and 1998 to 1999.

CLINICAL RECOMMENDATION STATEMENTS:
Annual influenza vaccine is recommended for all persons aged 65 and older and persons in selected high-risk groups. (B recommendation) (USPSTF)

Vaccination is recommended for the following persons who are at increased risk for complications from influenza: adults and children who have required regular medical follow-up or hospitalization during the preceding year because of chronic metabolic diseases (including diabetes mellitus), renal dysfunction, hemoglobinopathies, or immunosuppression (including immunosuppression caused by medications or by human immunodeficiency virus [HIV]); (CDC)

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▲ Measure #81: End Stage Renal Disease (ESRD): Plan of Care for Inadequate Hemodialysis in ESRD Patients

2011 PHYSICIAN QUALITY REPORTING OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Percentage of patient calendar months during the 12-month reporting period in which patients aged 18 years and older with a diagnosis of ESRD receiving hemodialysis have a Kt/V ≥ 1.2 OR patients who have a Kt/V < 1.2 with a documented plan of care for inadequate hemodialysis

INSTRUCTIONS:
This measure is to be reported each calendar month hemodialysis is performed on ESRD patients seen during the reporting period. It is anticipated that clinicians providing care for patients with ESRD will submit this measure.

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT codes, 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 have been provided for registry only measures for use by registries that utilize claims data. It is not necessary to submit these codes for registry-based submissions. There are no allowable performance exclusions for this measure. Do not report this measure via claims.

DENOMINATOR:
Patient calendar months for all patients aged 18 years and older with a diagnosis of ESRD who are receiving hemodialysis

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Diagnosis for ESRD (ICD-9-CM): 585.6
AND
Patient encounter during the reporting period (CPT): 90935, 90937, 90957, 90958, 90959, 90960, 90961, 90962

NUMERATOR:
Number of patient calendar months during which patients have a Kt/V ≥1.2 OR have Kt/V <1.2 with a documented plan of care for inadequate hemodialysis

Definition:
Documented Plan of Care – May include checking for adequacy of the AV access, increasing the blood flow, increasing the dialyzer size, increasing the time of dialysis sessions, adjusting dialysis prescription, or documenting residual renal function.

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Numerator Options:
Kt/V ≥ 1.2 and less than 1.7 (Clearance of urea (Kt)/volume(V)) (3083F)
OR
Kt/V ≥ 1.7 [Clearance of urea (Kt)/volume(V)] (3084F)

OR

Kt/V < 1.2 [Clearance of urea (Kt)/volume(V)] (3082F)
AND
Hemodialysis plan of care documented (0505F)

OR

Kt/V not performed or documented, reason not specified (3083F *with* 8P)

OR

Hemodialysis plan of care not documented, reason not specified (0505F *with* 8P)
AND
Kt/V < 1.2 [Clearance of urea (Kt)/volume(V)] (3082F)

RATIONALE:
Patients receiving hemodialysis must be monitored (by assessing Kt/V) regularly to ensure that their dialysis dose is sufficient. A patient receiving hemodialysis whose Kt/V level is less than 1.2 is not receiving optimal dialysis. This measure assesses whether the treating physician addressed the low Kt/V level. A plan of care (action defined as checking for adequacy of the AV access, increasing the blood flow, increasing the dialyzer size, or increasing the time of dialysis sessions) should be documented by the physician for every time Kt/V is less than 1.2.

CLINICAL RECOMMENDATION STATEMENTS:
Quantifying HD is the first step toward assessment of its adequacy. Fortunately, the intermittent rapid decrease in urea concentration during HD allows a relatively easy measurement of the dose. The delivered dose of HD should be measured at regular intervals no less than monthly (A). (KDOQI™)

The minimally adequate dose of HD given 3 times per week to patients with K_r less than 2 mL/min/1.73 m^2 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 K_r less than 2 mL/min/1.73 m^2 should be an spKt/V of 1.4 per dialysis not including RKF, or URR of 70% (A). (KDOQI™)

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▲ Measure #82: End Stage Renal Disease (ESRD): Plan of Care for Inadequate Peritoneal Dialysis

2011 PHYSICIAN QUALITY REPORTING OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Percentage of patients aged 18 years and older with a diagnosis of ESRD receiving peritoneal dialysis who have a Kt/V ≥ 1.7 OR patients who have a Kt/V < 1.7 with a documented plan of care for inadequate peritoneal dialysis at least three times (every 4 months) during the 12-month reporting period

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:

- 1-4 months – report once during the reporting period
- 5-8 months – report twice during the reporting period
- 9-12 months – report three times during the reporting period

It is anticipated that clinicians providing care for patients with ESRD will submit this measure.

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT codes, 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 have been provided for registry only measures for use by registries that utilize claims data. It is not necessary to submit these codes for registry-based submissions. There are no allowable performance exclusions for this measure. Do not report this measure via claims.

DENOMINATOR:
All patients aged 18 years and older with a diagnosis of ESRD receiving peritoneal dialysis

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Diagnosis for ESRD (ICD-9-CM): 585.6
AND
Patient encounter during the reporting period (CPT): 90945, 90947, 90965, 90966, 90969, 90970

NUMERATOR:
Patients who have a Kt/V ≥1.7 OR have a Kt/V <1.7 with a documented plan of care for inadequate peritoneal dialysis at least three times (every 4 months) during the 12 month reporting period

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Definition:
Documented Plan of Care – May include assessing for non-adherence with the peritoneal prescription, sampling, and collection; assessing for error in the peritoneal dialysis prescription and/or inadequate monitoring of the delivered dose; performing peritoneal equilibrium testing; assessing for inadequate patient education; increasing the exchange volume; increasing the number of exchanges per 24 hours; assessing for modality (CAPD or CCPD).

Numerator Options:
Kt/V ≥ 1.7 [Clearance of urea (Kt)/volume(V)] (3084F)

OR

Kt/V < 1.2 [Clearance of urea (Kt)/volume(V)] (3082F)
OR
Kt/V ≥ 1.2 and less than 1.7 [Clearance of urea (Kt)/volume(V)] (3083F)

AND
Peritoneal dialysis plan of care documented (0507F)
OR
Kt/V not performed or documented, reason not specified (3084F *with* 8P)

OR

Peritoneal dialysis plan of care not documented, reason not specified (0507F *with* 8P)
AND

Kt/V < 1.2 [Clearance of urea (Kt)/volume(V)] (3082F)
OR
Kt/V ≥ 1.2 and less than 1.7 [Clearance of urea (Kt)/volume(V)] (3083F)

RATIONALE:
Patients receiving peritoneal dialysis must be monitored (by assessing Kt/V) regularly to ensure that their dialysis dose is sufficient. A patient receiving peritoneal dialysis whose Kt/V level is less than 1.7 is not receiving optimal dialysis. This measure assesses whether the treating physician addressed the low Kt/V level. A plan of care (may include assessing for non-adherence with the peritoneal prescription, sampling, and collection; assessing for error in the peritoneal dialysis prescription and/or inadequate monitoring of the delivered dose; performing peritoneal equilibrium testing; assessing for inadequate patient education; increasing the exchange volume; or increasing the number of exchanges per 24 hours) should be documented by the physician for every time Kt/V is less than 1.7. Measurement of Kt/V should occur at regular intervals during the calendar year.

CLINICAL RECOMMENDATION STATEMENTS:
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™)

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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™)

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▲ Measure #83: Hepatitis C: Testing for Chronic Hepatitis C – Confirmation of Hepatitis C Viremia

2011 PHYSICIAN QUALITY REPORTING OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Percentage of patients aged 18 years and older with a diagnosis of hepatitis C seen for an initial evaluation who had HCV RNA testing ordered or previously performed

INSTRUCTIONS:
This measure should be reported on the first visit occurring during the reporting period for all patients with a diagnosis of hepatitis C seen during the reporting period. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT codes, 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 have been provided for registry only measures for use by registries that utilize claims data. It is not necessary to submit these codes for registry-based submissions. Do not report this measure via claims.

DENOMINATOR:
All patients aged 18 years and older with a diagnosis of hepatitis C seen for initial evaluation

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Diagnosis for hepatitis C (ICD-9-CM): 070.51, 070.54, 070.70
AND
Patient encounter during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215

NUMERATOR:
Patients for whom HCV RNA testing was ordered or previously performed

Numerator Options:
Ribonucleic acid (RNA) testing for Hepatitis C viremia ordered or results documented (3265F)
AND
Initial evaluation for condition (1119F)
OR
Documentation of medical reason(s) for not ordering or performing RNA testing for HCV (3265F *with* 1P)

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OR
Documentation of patient reason(s) for not ordering or performing RNA testing for HCV (3265F *with* 2P)

AND
Initial evaluation for condition (1119F)

OR

Subsequent evaluation for condition (1121F)

OR

RNA testing for HCV was not ordered or results not documented, reason not otherwise specified (3265F *with* 8P)
AND
Initial evaluation for condition (1119F)

RATIONALE:
HCV RNA testing is needed to establish and confirm diagnosis of chronic hepatitis C. HCV is an RNA virus of the Flaviviridae family. HCV replicates preferentially in hepatocytes but is not directly cytopathic, leading to persistent infection. During chronic infection, HCV RNA reaches high levels, generally ranging from 10^5 to 10^7 international units (IU)/mL, but the levels can fluctuate widely. However, within the same individual, RNA levels are usually relatively stable. (NIH)
After initial exposure, HCV RNA can be detected in blood within 1 to 3 weeks and is present at the onset of symptoms.

Antibodies to HCV are detected by enzyme immunoassay (EIA) in only 50 to 70 percent of patients at the onset of symptoms, increasing to more than 90 percent after 3 months.

The clinical utility of serial HCV viral levels in a patient is predicated on continued use of the same specific quantitative assay that was used in the initial determination of the viral level. While there is little correlation between disease severity or disease progression with the absolute level of HCV RNA, quantitative determination of the HCV level provides important information on the likelihood of response to treatment in patients undergoing antiviral therapy.

CLINICAL RECOMMENDATION STATEMENTS:
HCV ribonucleic acid (RNA) testing should be performed in:

a. patients with a positive anti-HCV test (Grade II-2);
b. patients for whom antiviral treatment is being considered, using a quantitative assay (Grade II-2);
c. patients with unexplained liver disease whose anti-HCV test is negative and who are immunocompromised or suspected of having acute HCV infection (Grade II-2). (AASLD)

The diagnosis of chronic hepatitis C infection is often suggested by abnormalities in ALT levels and is established by EIA followed by confirmatory determination of HCV RNA. (NIH)

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

2011 PHYSICIAN QUALITY REPORTING OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

If reporting Measure #84: Hepatitis C: RNA Testing Before Initiating Treatment, also report Measure #85: Hepatitis C HCV Genotype Testing Prior to Treatment.

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

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for all patients with a diagnosis of chronic hepatitis C seen during the reporting period. This measure is intended to reflect the quality of services provided for patients with chronic hepatitis C who are receiving antiviral treatment. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

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

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

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure. The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All patients aged 18 years and older with a diagnosis of chronic hepatitis C who are receiving antiviral treatment

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

Diagnosis for chronic hepatitis C (ICD-9-CM): 070.54
AND
Patient encounter during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215

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

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

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
RNA Testing Performed within Six Months
(Two CPT II codes [3218F & 4150F] are required on the claim form to submit this numerator option)
CPT II 3218F: RNA testing for Hepatitis C documented as performed within six months prior to initiation of antiviral treatment for Hepatitis C
AND
CPT II 4150F: Patient receiving antiviral treatment for Hepatitis C

OR

RNA Testing not Performed within Six Months for Medical Reason
(Two CPT II codes [3218F-1P & 4150F] are required on the claim form to submit this numerator option)
Append a modifier (1P) to CPT Category II code 3218F to report documented circumstances that appropriately exclude patients from the denominator.
3218F *with* 1P: Documentation of medical reason(s) for not performing RNA testing within six months prior to initiation of antiviral treatment for Hepatitis C (e.g., if patient is first seen by physician after initiation of treatment)
AND
CPT II 4150F: Patient receiving antiviral treatment for Hepatitis C

OR

If patient is not eligible for this measure because patient is not receiving antiviral treatment, report:
(One CPT II code [4151F] is required on the claim form to submit this numerator option)
CPT II 4151F: Patient not receiving antiviral treatment for Hepatitis C

OR

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RNA Testing not Performed within Six Months, Reason not Specified
(Two CPT II codes [3218F-8P & 4150F] are required on the claim form to submit this numerator option)
Append a reporting modifier (8P) to CPT Category II code 3218F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.
3218F *with* 8P: RNA testing for Hepatitis C was not documented as performed within six months prior to initiation of antiviral treatment for Hepatitis C, reason not otherwise specified
AND
CPT II 4150F: Patient receiving antiviral treatment for Hepatitis C

RATIONALE:
Establish baseline level against which to monitor virologic response and indicate likelihood of response. The clinical utility of serial HCV viral levels in a patient is predicated on continued use of the same specific quantitative assay that was used in the initial determination of the viral level. While there is little correlation between disease severity or disease progression with the absolute level of HCV RNA, quantitative determination of the HCV level provides important information on the likelihood of response to treatment in patients undergoing antiviral therapy. (NIH)

CLINICAL RECOMMENDATION STATEMENTS:
HCV RNA testing should be performed in patients with a positive anti-HCV test (Grade II-2), patients for whom antiviral treatment is being considered, using a quantitative assay (Grade II-2), patients with unexplained liver disease whose anti-HCV test is negative and patients who are immune compromised or suspected of having acute HCV infection (Grade II-2). (AASLD)

All candidates for antiviral therapy should be tested for HCV RNA with a quantitative amplification assay, which provides both a baseline level against which to monitor virologic response and a prognostic indicator of the likelihood of response. (AGA)

The diagnosis of chronic hepatitis C infection is often suggested by abnormalities in ALT levels and is established by EIA followed by confirmatory determination of HCV RNA. (NIH)

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

2011 PHYSICIAN QUALITY REPORTING OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

If reporting Measure #85: Hepatitis C HCV Genotype Testing Prior to Treatment, also report Measure #84: Hepatitis C: RNA Testing Before Initiating Treatment.

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

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for all patients with a diagnosis of chronic hepatitis C seen during the reporting period. This measure is intended to reflect the quality of services provided for patients with chronic hepatitis C who are receiving antiviral treatment. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

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

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

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure. The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All patients aged 18 years and older with a diagnosis of chronic hepatitis C who are receiving antiviral treatment

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Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Diagnosis for chronic hepatitis C (ICD-9-CM): 070.54
AND
Patient encounter during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215

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

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

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Hepatitis C Genotype Testing Performed
(One CPT II code & one G-code [3266F & G8459] are required on the claim form to submit this numerator option)
CPT II 3266F: Hepatitis C genotype testing documented as performed prior to initiation of antiviral treatment for Hepatitis C
AND
G8459: Clinician documented that patient is receiving antiviral treatment for Hepatitis C

OR

If patient is not eligible for this measure because patient is not receiving antiviral treatment, report:
(One G-code [G8458] is required on the claim form to submit this numerator option)
G8458: Clinician documented that patient is not an eligible candidate for genotype testing; patient not receiving antiviral treatment for Hepatitis C

OR

Genotype Testing not Performed, Reason not Specified
(One CPT II code & one G-code [3266F-8P & G8459] are required on the claim form to submit this numerator option)
Append a reporting modifier (8P) to CPT Category II code 3266F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.
3266F *with* 8P: Hepatitis C genotype testing was not documented as performed prior to initiation of antiviral treatment for Hepatitis C, reason not otherwise specified
AND
G8459: Clinician documented that patient is receiving antiviral treatment for Hepatitis C

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RATIONALE:
To guide treatment decisions regarding duration of therapy and likelihood of response. There are 6 HCV genotypes and more than 50 subtypes. These genotypes differ by as much as 31 to 34 percent in their nucleotide sequences, whereas subtypes differ by 20 to 23 percent based on full-length genomic sequence comparisons. Genotype determinations influence treatment decisions. Patients with genotypes 2 or 3 have better response rates to re-treatment than those with genotype 1. (NIH)

CLINICAL RECOMMENDATION STATEMENTS:
HCV genotype should be determined in all HCV-infected persons prior to treatment in order to determine the duration of therapy and likelihood of response (Grade I). (AASLD)

Information on the genotype of the virus is important to guide treatment decisions. Genotype 1, most commonly found in the United States, is less amenable to treatment than genotypes 2 or 3. (NIH)

All candidates for antiviral therapy should be tested for HCV RNA with a quantitative amplification assay and should be tested for HCV genotype. (AGA)

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▲ Measure #86: Hepatitis C: Antiviral Treatment Prescribed

2011 PHYSICIAN QUALITY REPORTING OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

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

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

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

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

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure. The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All patients aged 18 years and older with a diagnosis of chronic hepatitis C

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Diagnosis for chronic hepatitis C (ICD-9-CM): 070.54
AND
Patient encounter during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215

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

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

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Peginterferon and Ribavirin Therapy Prescribed
CPT II 4153F: Combination peginterferon and ribavirin therapy prescribed

OR

Peginterferon and Ribavirin Therapy not Prescribed for Medical, Patient or System Reasons
Append a modifier (1P, 2P or 3P) to CPT Category II code 4153F to report documented circumstances that appropriately exclude patients from the denominator.
4153F *with* 1P: Documentation of medical reason(s) for not prescribing peginterferon and ribavarin therapy within 12 month reporting period (e.g., patient was not a candidate for therapy, could not tolerate).
4153F *with* 2P: Documentation of patient reason(s) for not prescribing peginterferon and ribavirin therapy within 12 month reporting period (e.g., patient declined).
4153F *with* 3P: Documentation of system reason(s) for not prescribing peginterferon and ribavirin therapy within 12 month reporting period (e.g., patient has no insurance coverage, therapy not covered).

OR

Peginterferon and Ribavirin Therapy not Prescribed, Reason not Specified
Append a reporting modifier (8P) to CPT Category II code 4153F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.
4153F *with* 8P: Combination peginterferon and ribavirin therapy was not prescribed, reason not otherwise specified

RATIONALE:
Assure that antiviral therapy is prescribed for all patients with confirmed Hepatitis C.

The current standard of care for the treatment of previously untreated patients with chronic hepatitis C is combination pegylated interferon (PEG-IFN) alfa by subcutaneous injection once a week and oral ribavirin daily. For patients with contraindications to ribavirin but who have indications for antiviral therapy, PEG-IFN represents the best available treatment. (AGA)

Current contraindications to therapy include decompensated cirrhosis, pregnancy, uncontrolled depression or severe mental illness, active substance abuse in the absence of concurrent participation in a drug treatment program, advanced cardiac or pulmonary disease, severe cytopenias, poorly controlled diabetes, retinopathy, seizure disorders, immunosuppressive treatment, autoimmune diseases, or other inadequately controlled comorbid conditions. (AGA)

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CLINICAL RECOMMENDATION STATEMENTS:

The treatment of choice is peginterferon plus ribavirin (Grade I). (AASLD)

The current standard of care for the treatment of previously untreated patients with chronic hepatitis C is a combination of pegylated interferon (PEG-IFN) alfa by subcutaneous injection once a week and oral ribavirin daily. For patients with contraindications to ribavirin but who have indications for antiviral therapy, PEG-IFN represents the best available treatment. (Category I) (AGA summ)

Current contraindications to therapy include decompensated cirrhosis, pregnancy, uncontrolled depression or severe mental illness, active substance abuse in the absence of concurrent participation in a drug treatment program, advanced cardiac or pulmonary disease, severe cytopenias, poorly controlled diabetes, retinopathy, seizure disorders, immunosuppressive treatment, autoimmune diseases, or other inadequately controlled comorbid conditions (Category I). (AGA)

Combination therapy results in better treatment responses than monotherapy, but the highest response rates have been achieved with pegylated interferon in combination with ribavirin. (NIH)

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

2011 PHYSICIAN QUALITY REPORTING OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of patients aged 18 years and older with a diagnosis of chronic hepatitis C who are receiving antiviral treatment for whom quantitative HCV RNA testing was performed at 12 weeks from the initiation of antiviral treatment

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for all patients with a diagnosis of chronic hepatitis C seen during the reporting period. This measure is intended to reflect the quality of services provided for patients with chronic hepatitis C who are receiving antiviral treatment. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

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

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

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure. The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All patients aged 18 years and older with a diagnosis of chronic hepatitis C who are receiving antiviral treatment

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Diagnosis for chronic hepatitis C (ICD-9-CM): 070.54

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AND

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

NUMERATOR:

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

Definition:

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

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

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Hepatitis C Quantitative RNA Testing at 12 weeks

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

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

AND

G8461: Patient receiving antiviral treatment for Hepatitis C

OR

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

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

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

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

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

AND

G8461: Patient receiving antiviral treatment for Hepatitis C

OR

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

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

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

OR

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Hepatitis C Quantitative RNA Testing not Performed at 12 Weeks, Reason not Specified
(One CPT II code & one G-code [3220F-8P & G8461] are required on the claim form to submit this numerator option)
Append a reporting modifier (8P) to CPT Category II code 3220F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.
3220F ***with*** 8P: Hepatitis C quantitative RNA testing was not documented as performed at 12 weeks from initiation of antiviral treatment, reason not otherwise specified
AND
G8461: Patient receiving antiviral treatment for Hepatitis C

RATIONALE:
Monitor effectiveness of antiviral therapy. An early virologic response (EVR), during the first 12 weeks of therapy, is a valuable clinical milestone. In the absence of an EVR, the likelihood of an SVR is 0–3%. If the only goal of therapy is to achieve an SVR, therapy can be discontinued after 12 weeks if an EVR is not achieved. Potentially, histologic benefit can accrue even in the absence of an SVR; therefore, some authorities treat beyond 12 weeks even in patients who have not achieved an EVR. For documentation of a virologic response at the end of therapy (end-of-treatment response) or an SVR ≥ 6 months after completing therapy, a more sensitive quantitative assay with a lower limit of ≤ 50 IU/mL, if available, or a qualitative HCV RNA assay is recommended.

CLINICAL RECOMMENDATION STATEMENTS:
Baseline and 12-week monitoring of HCV RNA levels should be performed with the same quantitative amplification assay. An early virologic response (EVR), defined as a ≥ 2-$\log_{10}$ reduction in HCV RNA levels during the first 12 weeks of therapy, is a valuable clinical milestone (Category I). (AGA)

Clinical and virologic monitoring during therapy should be conducted at intervals ranging from once a month to once every 3 months. Frequent hematologic monitoring is necessary to identify marked anemia, neutropenia, and thrombocytopenia; monitoring of thyroid stimulating hormone level is indicated to identify hypothyroidism or hyperthyroidism (Category I). (AGA)

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

2011 PHYSICIAN QUALITY REPORTING OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

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

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

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

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

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure. The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data. There are no allowable performance exclusions for this measure.

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

> Denominator Criteria (Eligible Cases):
> Patients aged ≥ 18 years on date of encounter
> AND
> Diagnosis for hepatitis C (ICD-9-CM): 070.51, 070.54, 070.70
> AND
> Patient encounter during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215

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

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

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Counseling Regarding Risk of Alcohol Consumption
CPT II 4158F: Patient counseled about risks of alcohol use

OR

Counseling Regarding Risk of Alcohol Consumption not Performed, Reason not Specified
Append a reporting modifier (8P) to CPT Category II code 4158F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.
4158F *with* 8P: Patient counseled about risks of alcohol use not performed, reason not otherwise specified

RATIONALE:
Minimize progression of liver disease. Higher levels of alcohol promote the development of progressive liver disease, with strong evidence for the detrimental effects of 30 g/day in men (~ equivalent to 2 beers, 2 glasses of wine, or 2 mixed drinks) and 20 g/day in women. Lower amounts of alcohol also may increase the risk of liver damage associated with HCV. (NIH)

CLINICAL RECOMMENDATION STATEMENTS:
Higher levels of alcohol use play an important role in promoting the development of progressive liver disease, with strong evidence for the detrimental effects of 30 g/day in men (~ equivalent to 2 beers, 2 glasses of wine, or 2 mixed drinks) and 20 g/day in women. Lower amounts of alcohol also may increase the risk of liver damage associated with HCV. (NIH)

Abstinence should be recommended before and during antiviral treatment in alcoholic persons, and treatment of alcohol abuse should be linked with efforts to treat hepatitis C in alcoholic patients. A safe level of alcohol consumption in patients with hepatitis C has not been established (Category II-1b). (AGA)

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

2011 PHYSICIAN QUALITY REPORTING OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

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

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for all patients with a diagnosis of chronic hepatitis C seen during the reporting period. This measure is intended to reflect the quality of services provided for patients with chronic hepatitis C who are receiving antiviral treatment. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

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

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

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure. The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All women aged 18 through 44 years and all men aged 18 years and older with a diagnosis of chronic hepatitis C who are receiving antiviral treatment

> Denominator Criteria (Eligible Cases):
> Patients (females aged 18 through 44 years or males aged ≥ 18 years) on date of encounter
> AND

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Diagnosis for chronic hepatitis (ICD-9-CM): 070.54
AND
Patient encounter during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215

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

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

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Counseling Regarding Contraception Received
(One CPT II code & one G-code [4159F & G8463] are required on the claim form to submit this numerator option)
CPT II 4159F: Counseling regarding contraception received prior to initiation of antiviral treatment
AND
G8463: Patient receiving antiviral treatment for Hepatitis C documented

OR

Counseling Regarding Contraception not Received for Medical Reason
(One CPT II code & one G-code [4159F-1P & G8463] are required on the claim form to submit this numerator option)
Append a modifier (1P) to CPT Category II code 4159F to report documented circumstances that appropriately exclude patients from the denominator.
4159F *with* 1P: Documentation of medical reason(s) for not counseling patient regarding contraception
AND
G8463: Patient receiving antiviral treatment for Hepatitis C documented

OR

If patient is not eligible for this measure because patient is not receiving antiviral treatment, report:
(One G-code [G8462] is required on the claim form to submit this numerator option)
G8462: Clinician documented that patient is not an eligible candidate for counseling regarding contraception prior to antiviral treatment; patient not receiving antiviral treatment for Hepatitis C

OR

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Counseling Regarding Contraception not Received, Reason not Specified
(One CPT II code & one G-code [4159F-8P & G8463] are required on the claim form to submit this numerator option)
Append a reporting modifier (8P) to CPT Category II code 4159F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.
4159F *with* 8P: Counseling regarding contraception not received prior to initiation of antiviral treatment, reason not otherwise specified
AND
G8463: Patient receiving antiviral treatment for Hepatitis C documented

RATIONALE:
Ribavirin is contraindicated in pregnancy. Therefore, counseling regarding strict precautions and contraception in women of childbearing age and their sexual partners and in HCV-infected men with female partners of childbearing age needs to be provided to those receiving treatment for chronic hepatitis C prior to the initiation of treatment. Although this measure only captures data related to counseling prior to therapy it should be subsequently re-enforced during treatment and for a period of 6 months after treatment.

CLINICAL RECOMMENDATION STATEMENTS:
Because of the concern of birth defects from the use of ribavirin, it is imperative that persons who receive the drug use strict contraception methods both during treatment and for a period of 6 months after treatment. (AASLD)

Ribavirin is contraindicated in pregnancy, necessitating strict precautions and contraception in women of childbearing age and their sexual partners and in HCV-infected men with female partners of childbearing age. (AGA)

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▲ Measure #91: Acute Otitis Externa (AOE): Topical Therapy

2011 PHYSICIAN QUALITY REPORTING OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of patients aged 2 years and older with a diagnosis of AOE who were prescribed topical preparations

INSTRUCTIONS:
This measure is to be reported once for each occurrence of AOE during the reporting period. Each unique occurrence is defined as a 30-day period from onset of AOE. Claims data will be analyzed to determine unique occurrences. If multiple claims are submitted within that 30-day period, only one instance of reporting will be counted. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

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

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

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure. The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All patients aged 2 years and older with a diagnosis of AOE

> Denominator Criteria (Eligible Cases):
> Patients aged ≥ 2 years on date of encounter
> AND
> Diagnosis for AOE (ICD-9-CM): 380.10, 380.11, 380.12, 380.13, 380.22
> AND
> Patient encounter during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99281, 99282, 99283, 99284, 99285

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NUMERATOR:
Patients who were prescribed topical preparations

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

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Topical Preparations Prescribed
CPT II 4130F: Topical preparations (including OTC) prescribed for acute otitis externa

OR

Topical Preparations not Prescribed for Medical or Patient Reasons
Append a modifier (1P or 2P) to CPT Category II code 4130F to report documented circumstances that appropriately exclude patients from the denominator.

4130F *with* 1P: Documentation of medical reason(s) for not prescribing topical preparations (including OTC) for acute otitis externa (e.g., coexisting acute otitis media, tympanic membrane perforation)

4130F *with* 2P: Documentation of patient reason(s) for not prescribing topical preparations (including OTC) for acute otitis externa

OR

Topical Preparations not Prescribed, Reason not Specified
Append a reporting modifier (8P) to CPT Category II code 4130F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

4130F *with* 8P: Topical preparations (including OTC) for acute otitis externa (AOE) not prescribed, reason not otherwise specified

RATIONALE:
Topical preparations should be used to treat AOE as they are active against the most common bacterial pathogens in AOE, Pseudomonas aeruginosa and Staphylococcus aureus. Topical preparations have demonstrated efficacy in the treatment of AOE with resolution in about 65-90% of patients.

CLINICAL RECOMMENDATION STATEMENTS:
Clinicians should use topical preparations for initial therapy of diffuse, uncomplicated AOE. (Recommendation based on randomized controlled trials with minor limitations and a preponderance of benefit over harm. [Aggregate evidence quality – Grade B]) (AAO-HNSF)

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▲ Measure #92: Acute Otitis Externa (AOE): Pain Assessment

2011 PHYSICIAN QUALITY REPORTING OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of patient visits for those patients aged 2 years and older with a diagnosis of AOE with assessment for auricular or periauricular pain

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

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

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

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure. The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All patient visits for those patients aged 2 years and older with a diagnosis of AOE

> Denominator Criteria (Eligible Cases):
> Patients aged ≥ 2 years on date of encounter
> AND
> Diagnosis for AOE (ICD-9-CM): 380.10, 380.11, 380.12, 380.13, 380.22
> AND
> Patient encounter during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99281, 99282, 99283, 99284, 99285

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NUMERATOR:
Patient visits with assessment for auricular or periauricular pain

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Auricular or Periauricular Pain Assessed
CPT II 1116F: Auricular or periauricular pain assessed

OR

Auricular or Periauricular Pain not Assessed for Medical Reasons
Append a modifier (1P) to CPT Category II code 1116F to report documented circumstances that appropriately exclude patients from the denominator.
1116F *with* 1P: Documentation of medical reason(s) for not assessing auricular or periauricular pain

OR

Auricular or Periauricular Pain not Assessed, Reason not Specified
Append a reporting modifier (8P) to CPT Category II code 1116F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.
1116F *with* 8P: Auricular or periauricular pain not assessed, reason not otherwise specified

RATIONALE:
Pain relief is a major goal in the management of AOE. Frequent use of analgesics is often necessary to permit patients to achieve comfort, rest, and to resume normal activities. On-going assessment of the severity of discomfort is essential for proper management.

CLINICAL RECOMMENDATION STATEMENTS:
The management of diffuse AOE should include an assessment of pain. The clinician should recommend analgesic treatment based on the severity of pain. (Strong recommendation based on well-designed randomized trials with a preponderance of benefit over harm. [Aggregate evidence quality – Grade B]) (AAO-HNSF)

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▲ Measure #93: Acute Otitis Externa (AOE): Systemic Antimicrobial Therapy – Avoidance of Inappropriate Use

2011 PHYSICIAN QUALITY REPORTING OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of patients aged 2 years and older with a diagnosis of AOE who were not prescribed systemic antimicrobial therapy

INSTRUCTIONS:
This measure is to be reported once for each occurrence of AOE during the reporting period. Each unique occurrence is defined as a 30-day period from onset of AOE. Claims data will be analyzed to determine unique occurrences. If multiple claims are submitted within that 30-day period, only one instance of reporting will be counted. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

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

When reporting the measure via claims, submit the appropriate ICD-9-CM diagnosis codes, CPT codes, and the appropriate CPT Category II code OR the CPT Category II code with the modifier. The modifier allowed for this measure is: 1P- medical reasons. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure. The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All patients aged 2 years and older with a diagnosis of AOE

> Denominator Criteria (Eligible Cases):
> Patients aged ≥ 2 years on date of encounter
> AND
> Diagnosis for AOE (ICD-9-CM): 380.10, 380.11, 380.12, 380.13, 380.22
> AND
> Patient encounter during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99281, 99282, 99283, 99284, 99285

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NUMERATOR:
Patients who were not prescribed systemic antimicrobial therapy

Numerator Instructions: For performance, the measure will be calculated as the number of patients for whom systemic antimicrobial therapy was not prescribed over the number of patients in the denominator (patients aged 2 years and older with acute otitis externa). A higher score indicates appropriate treatment of patients with AOE (e.g., the proportion for whom systemic antimicrobials were not prescribed).

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Systemic Antimicrobial Therapy not Prescribed
CPT II 4132F: Systemic antimicrobial therapy not prescribed

OR

Systemic Antimicrobial Therapy Prescribed for Medical Reasons
Append a modifier (1P) to CPT Category II code 4131F to report documented circumstances that appropriately exclude patients from the denominator
4131F *with* 1P: Documentation of medical reason(s) for prescribing systemic antimicrobial therapy (e.g., coexisting diabetes, immune deficiency)

OR

Systemic Antimicrobial Therapy Prescribed
CPT II 4131F: Systemic antimicrobial therapy prescribed

RATIONALE:
Despite their limited utility, many patients with AOE receive systemic antimicrobial therapy, often in addition to topical therapy. “There are no data on the efficacy of systemic therapy with the use of appropriate antibacterials and stratified by severity of the infection. Moreover, orally administered antibiotics have significant adverse effects that include rashes, vomiting, diarrhea, allergic reactions, altered nasopharyngeal flora, and development of bacterial resistance.” The use of systemic antimicrobial therapy to treat AOE should be limited only to those clinical situations in which it is indicated.

CLINICAL RECOMMENDATION STATEMENTS:
Systemic antimicrobial therapy should not be used unless there is extension outside the ear canal or the presence of specific host factors that would indicate a need for systemic therapy. (Recommendation based on randomized controlled trials with minor limitations and a preponderance of benefit over harm. [Aggregate evidence quality – Grade B]) (AAO-HNSF)

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▲ Measure #94: Otitis Media with Effusion (OME): Diagnostic Evaluation – Assessment of Tympanic Membrane Mobility

2011 PHYSICIAN QUALITY REPORTING OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of patient visits for those patients aged 2 months through 12 years with a diagnosis of OME with assessment of tympanic membrane mobility with pneumatic otoscopy or tympanometry

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

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

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

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure. The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All patient visits for those patients aged 2 months through 12 years with a diagnosis of OME

Denominator Criteria (Eligible Cases):
Patients aged 2 months through 12 years on date of encounter
AND
Diagnosis for OME (ICD-9-CM): 381.10, 381.19, 381.20, 381.29, 381.3, 381.4
AND
Patient encounter during the reporting period (CPT): 92567, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215

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NUMERATOR:
Patient visits with assessment of tympanic membrane mobility with pneumatic otoscopy or tympanometry

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Tympanic Membrane Mobility Assessed
CPT II 2035F: Tympanic membrane mobility assessed with pneumatic otoscopy or tympanometry

OR

Tympanic Membrane Mobility not Assessed for Medical or Patient Reasons
Append a modifier (1P or 2P) to CPT Category II code 2035F to report documented circumstances that appropriately exclude patients from the denominator.
2035F *with* 1P: Documentation of medical reason(s) for not assessing tympanic membrane mobility with pneumatic otoscopy or tympanometry
2035F *with* 2P: Documentation of patient reason(s) for not assessing tympanic membrane mobility with pneumatic otoscopy or tympanometry

OR

Tympanic Membrane Mobility not Assessed, Reason not Specified
Append a reporting modifier (8P) to CPT Category II code 2035F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.
2035F *with* 8P: Tympanic membrane mobility not assessed with pneumatic otoscopy or tympanometry, reason not otherwise specified

RATIONALE:
Correctly diagnosing middle ear effusion is essential for proper management. OME is often characterized by a cloudy tympanic membrane with distinctly impaired mobility which can best be determined with pneumatic otoscopy or tympanometry.

CLINICAL RECOMMENDATION STATEMENTS:
Clinicians should use pneumatic otoscopy as the primary diagnostic method for OME. OME should be distinguished from AOM. (Strong Recommendation based on systematic review of cohort studies and preponderance of benefit over harm. [Aggregate evidence quality – Grade A]) Tympanometry can be used to confirm the diagnosis of OME. (Option based on cohort studies and a balance of benefit and harm. [Aggregate evidence quality – Grade B]) (AAFP/AAO-HNSF/AAP)

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€ Measure #99: Breast Cancer Resection Pathology Reporting: pT Category (Primary Tumor) and pN Category (Regional Lymph Nodes) with Histologic Grade

2011 PHYSICIAN QUALITY REPORTING 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 Physician Quality Reporting. If the specimen is not primary breast tissue (e.g., liver, lung), report only CPT II code 3250F.

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

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

Measure Reporting via Registry:
ICD-9-CM diagnosis codes and CPT codes are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure. The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All breast cancer resection pathology reports (excluding biopsies)

Denominator Criteria (Eligible Cases):
Diagnosis for breast cancer (ICD-9-CM): 174.0, 174.1, 174.2, 174.3, 174.4, 174.5, 174.6, 174.8, 174.9, 175.0, 175.9
AND
Patient encounter during the reporting period (CPT): 88307, 88309

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NUMERATOR:
Reports that include the pT category, the pN category and the histologic grade

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
pT Category, pN Category and Histologic Grade Documented
CPT II 3260F: pT category (primary tumor), pN category (regional lymph nodes), and histologic grade documented in pathology report

OR

pT Category, pN Category and Histologic Grade not Documented for Medical Reasons
Append a modifier (1P) to CPT Category II code 3260F to report documented circumstances that appropriately exclude patients from the denominator.
3260F *with* 1P: Documentation of medical reason(s) for not including pT category, pN category, and histologic grade in the pathology report (e.g., re-excision without residual tumor)

OR

If patient is not eligible for this measure because the specimen is not primary breast tissue (e.g., liver, lung) report:
CPT II 3250F: Specimen site other than anatomic location of primary tumor

OR

pT Category, pN Category and Histologic Grade not Documented, Reason not Specified
Append a reporting modifier (8P) to CPT Category II code 3260F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.
3260F *with* 8P: pT category, pN category, and histologic grade were not documented in pathology report, reason not otherwise specified

RATIONALE:
Therapeutic decisions for breast cancer management are stage driven and cannot be made without a complete set of pathology descriptors. Incomplete cancer resection pathology reports may result in misclassification of patients, rework and delays, and suboptimal management. The College of American Pathologists (CAP) has produced evidence-based checklists of essential pathologic parameters that are recommended to be included in cancer resection pathology reports. These checklists have been endorsed as a voluntary standard by National Quality Forum (NQF) and are considered the reporting standard by the Commission on Cancer (CoC) of the American College of Surgeons (ACS).

The CAP recently conducted a structured audit of breast cancer pathology report adequacy at 86 institutions. Overall, 35% of eligible reports were missing at least one of the ten CAP-recommended breast cancer elements. Cancer Care Ontario (CCO) conducted a similar study in 2005 and found that 25% of breast cancer pathology reports did not include all of the information required by the CAP standards. While the exact percentage of breast cancer resection pathology reports that are missing the pT category, the pN category and the histologic grade is unknown,

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these are essential elements in breast cancer treatment decisions and should be included in every pathology report when possible.

CLINICAL RECOMMENDATION STATEMENTS:

Patient management and treatment guidelines promote an organized approach to providing quality care. The (American College of Surgeons Commission 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. (ACSCoC)

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)

TNM staging information is included in factors proven to be of prognostic import and useful in clinical patient management. (CAP)

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€ Measure #100: Colorectal Cancer Resection Pathology Reporting: pT Category (Primary Tumor) and pN Category (Regional Lymph Nodes) with Histologic Grade

2011 PHYSICIAN QUALITY REPORTING 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 Physician Quality Reporting. If the specimen is not primary colorectal tissue (e.g., liver, lung), report only CPT II 3250F.

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

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

Measure Reporting via Registry:
ICD-9-CM diagnosis codes and CPT codes are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure. The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All colon and rectum cancer resection pathology reports

Denominator Criteria (Eligible Cases):
Diagnosis for colon or rectum cancer (ICD-9-CM): 153.0, 153.1, 153.2, 153.3, 153.4, 153.5, 153.6, 153.7, 153.8, 153.9, 154.0, 154.1, 154.8
AND
Patient encounter during the reporting period (CPT): 88309

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NUMERATOR:
Reports that include the pT category, the pN category and the histologic grade

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
pT Category, pN Category and Histologic Grade Documented
CPT II 3260F: pT category (primary tumor), pN category (regional lymph nodes), and histologic grade documented in pathology report

OR

pT Category, pN Category and Histologic Grade not Documented for Medical Reasons
Append a modifier (1P) to CPT Category II code 3260F to report documented circumstances that appropriately exclude patients from the denominator.
3260F *with* 1P: Documentation of medical reason(s) for not including pT category, pN category and histologic grade in the pathology report (e.g., anal canal)

OR

If patient is not eligible for this measure because the specimen is not primary colorectal tissue (e.g., liver, lung) report:
CPT II 3250F: Specimen site other than anatomic location of primary tumor

OR

pT Category, pN Category and Histologic Grade not Documented, Reason not Specified
Append a reporting modifier (8P) to CPT Category II code 3260F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.
3260F *with* 8P: pT category, pN category and histologic grade were not documented in the pathology report, reason not otherwise specified

RATIONALE:
Therapeutic decisions for colorectal cancer management are stage driven and cannot be made without a complete set of pathology descriptors. Incomplete cancer resection pathology reports may result in misclassification of patients, rework and delays, and suboptimal management. The College of American Pathologists (CAP) has produced evidence-based checklists of essential pathologic parameters that are recommended to be included in cancer resection pathology reports. These checklists have been endorsed as a voluntary standard by National Quality Forum (NQF) and are considered the reporting standard by the Commission on Cancer (CoC) of the American College of Surgeons (ACS).

The CAP recently conducted a structured audit of colorectal cancer pathology report adequacy at 86 institutions. Overall, 34% of eligible reports were missing at least one of the ten CAP-recommended colorectal cancer elements. Cancer Care Ontario (CCO) conducted a similar study in 2005 and found that 31% of colorectal cancer pathology reports did not include all of the information required by the CAP standards.

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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:

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. (ACSCoC)

Surgical resection is the primary therapy for most colorectal carcinomas, and the most important prognostic indicators are related to the pathologic findings in the resection specimen. The anatomic extent of disease is by far the most important prognostic factor in colorectal cancer. Pathologic staging depends on pathologic documentation of the anatomic extent of disease, whether or not the primary tumor has been completely removed. If a biopsied tumor is not resected for any reason (e.g., when technically unfeasible) and if the highest T and N categories or the M1 category of the tumor can be confirmed microscopically, the criteria for pathologic classification and staging have been satisfied without total removal of the primary cancer. (CAP)

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▲ Measure #102: Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low-Risk Prostate Cancer Patients

2011 PHYSICIAN QUALITY REPORTING OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of patients, regardless of age, with a diagnosis of prostate cancer at low risk of recurrence receiving interstitial prostate brachytherapy, OR external beam radiotherapy to the prostate, OR radical prostatectomy, OR cryotherapy who did not have a bone scan performed at any time since diagnosis of prostate cancer

INSTRUCTIONS:
This measure is to be reported once per episode of treatment (i.e., interstitial prostate brachytherapy, OR external beam radiotherapy to the prostate, OR radical prostatectomy, OR cryotherapy) for all patients with prostate cancer who receive interstitial prostate brachytherapy, external beam radiotherapy to the prostate, radical prostatectomy, or cryotherapy during the reporting period. Claims data will be analyzed to determine unique episodes of radiation therapy. Each episode of radiation therapy in an eligible patient receiving external beam radiotherapy to the prostate occurring during the reporting period will be counted when calculating the reporting and performance rates. The Physician Quality Reporting quality-data code needs to be submitted only once during the episode of radiation therapy (e.g., 8 weeks of therapy). It is anticipated that clinicians who perform the listed procedures as specified in the denominator coding will submit this measure.

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

When reporting the measure via claims, submit the appropriate ICD-9-CM diagnosis codes, CPT codes, and the appropriate CPT Category II code(s) OR the CPT Category II code(s) with the modifier. The modifiers allowed for this measure are: 1P- medical reasons, 3P- system reasons. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
ICD-9-CM diagnosis codes and CPT codes are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure. The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All patients, regardless of age, with a diagnosis of prostate cancer at low risk of recurrence receiving interstitial prostate brachytherapy, OR external beam radiotherapy to the prostate, OR radical prostatectomy, OR cryotherapy

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DENOMINATOR NOTE: Only patients with prostate cancer with low risk of recurrence will be counted in the performance denominator of this measure

Denominator Criteria (Eligible Cases):
Diagnosis for prostate cancer (ICD-9-CM): 185
AND
Patient encounter during the reporting period (CPT): 55810, 55812, 55815, 55840, 55842, 55845, 55866, 55873, 77427, 77776, 77777, 77778, 77787

NUMERATOR:
Patients who did *not* have a bone scan performed at any time since diagnosis of prostate cancer

Definitions:
Risk Strata: Low, Intermediate, or High –
Low Risk – PSA ≤10 mg/dL; AND Gleason score 6 or less; AND clinical stage T1c or T2a[2]
Intermediate Risk – PSA >10 to 20 mg/dL; OR Gleason score 7; OR clinical stage T2b, and not qualifying for high risk[2]
High Risk – PSA >20 mg/dL; OR Gleason score 8 to 10; OR clinically localized stage T3a1

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

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Bone Scan not Performed
(Two CPT II codes [3270F & 3271F] are required on the claim form to submit this numerator option)
CPT II 3270F: Bone scan not performed prior to initiation of treatment nor at any time since diagnosis of prostate cancer
AND
CPT II 3271F: Low risk of recurrence, prostate cancer

OR

Bone Scan Performed for Medical or System Reasons
(Two CPT II codes [3269F-xP & 3271F] are required on the claim form to submit this numerator option)
Append a modifier (1P or 3P) to CPT Category II code 3269F to report documented circumstances that appropriately exclude patients from the denominator.
3269F *with* 1P: Documentation of medical reason(s) for performing a bone scan (including documented pain, salvage therapy, other medical reasons)
3269F *with* 3P: Documentation of system reason(s) for performing a bone scan (including bone scan ordered by someone other than reporting physician)
AND

CPT II 3271F: Low risk of recurrence, prostate cancer

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OR

If patient is not eligible for this measure because the risk of recurrence is intermediate, high or not determined, report:
(One CPT II code [327xF] is required on the claim form to submit this numerator option)
Intermediate Risk of Recurrence

CPT II 3272F: Intermediate risk of recurrence, prostate cancer

OR

High Risk of Recurrence

CPT II 3273F: High risk of recurrence, prostate cancer

OR

Risk of Recurrence not Determined

CPT II 3274F: Prostate cancer risk of recurrence not determined or neither low, intermediate nor high

OR

Bone Scan Performed
(Two CPT II codes [3269F & 3271F] are required on the claim form to submit this numerator option)
CPT II 3269F: Bone scan performed prior to initiation of treatment or at any time since diagnosis of prostate cancer
AND
CPT II 3271F: Low risk of recurrence, prostate cancer

RATIONALE:
A bone scan is generally not required for staging prostate cancer in men with a low risk of recurrence and receiving primary therapy. This measure is written as a negative measure so that the performance goal is 100%, consistent with the other measures for this condition.

CLINICAL RECOMMENDATION STATEMENTS:
Routine use of a bone scan is not required for staging asymptomatic men with clinically localized prostate cancer when their PSA is equal to or less than 20.0 ng/mL. (AUA)

Patients with a life expectancy > 5 years or symptomatic:

- A bone scan is appropriate for T1 to T2 disease in the presence of a PSA greater than 20 ng/mL, Gleason score of 8 or higher, clinical stage of T3 to T4, or symptomatic disease.
- Patients at higher risk of metastatic disease may undergo pelvic computed tomography (CT) or magnetic resonance imaging (MRI) scanning with possible fine-needle aspiration of enlarged lymph nodes or staging lymph node dissection. Nomograms or risk tables may be used to identify patients with a higher likelihood of having metastatic disease. If the nomogram indicates a probability of lymph node involvement greater than 20% or if the patient is stage T3 or T4, this is recommended as a threshold for doing a staging CT scan or MRI evaluation.

For all other patients, no additional imaging is required for staging. (NCCN) (Category 2A)

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▲ Measure #104: Prostate Cancer: Adjuvant Hormonal Therapy for High-Risk Prostate Cancer Patients

2011 PHYSICIAN QUALITY REPORTING OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of patients, regardless of age, with a diagnosis of prostate cancer at high risk of recurrence receiving external beam radiotherapy to the prostate who were prescribed adjuvant hormonal therapy (GnRH agonist or antagonist)

INSTRUCTIONS:
This measure is to be reported once per episode of radiation therapy for all patients with prostate cancer who receive external beam radiotherapy to the prostate during the reporting period. Claims data will be analyzed to determine unique episodes of radiation therapy. Each episode of radiation therapy in an eligible patient receiving external beam radiotherapy to the prostate occurring during the reporting period will be counted when calculating the reporting and performance rates. The Physician Quality Reporting quality-data code needs to be submitted only once during the episode of radiation therapy (e.g., 8 weeks of therapy). It is anticipated that clinicians who perform external beam radiotherapy to the prostate will submit this measure.

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

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

Measure Reporting via Registry:
ICD-9-CM diagnosis codes and CPT codes are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure. The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All patients, regardless of age, with a diagnosis of prostate cancer at high risk of recurrence receiving external beam radiotherapy to the prostate

> *DENOMINATOR NOTE: Only patients with prostate cancer with high risk of recurrence will be counted in the performance denominator of this measure.*

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Denominator Criteria (Eligible Cases):
Diagnosis for prostate cancer (ICD-9-CM): 185
AND
Patient encounter during the reporting period (CPT): 77427

NUMERATOR:
Patients who were prescribed adjuvant hormonal therapy (GnRH [gonadotropin-releasing hormone] agonist or antagonist)

Definitions:
Risk Strata: Low, Intermediate, or High –
Low Risk – PSA ≤ 10 mg/dL; AND Gleason score 6 or less; AND clinical stage T1c or T2a[2]
Intermediate Risk – PSA > 10 to 20 mg/dL; OR Gleason score 7; OR clinical stage T2b, and not qualifying for high risk[2]
High Risk – PSA > 20 mg/dL; OR Gleason score 8 to 10; OR clinically localized stage T3a[1]

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

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

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Adjuvant Hormonal Therapy Prescribed/Administered
(One CPT II code & one G-code [4164F & G8465] are required on the claim form to submit this numerator option)
CPT II 4164F: Adjuvant (i.e., in combination with external beam radiotherapy to the prostate for prostate cancer) hormonal therapy (GnRH [gonadotropin-releasing hormone] agonist or antagonist) prescribed/administered
AND
G8465: High risk of recurrence of prostate cancer

OR

Adjuvant Hormonal Therapy not Prescribed/Administered for Medical or Patient Reasons
(One CPT II code & one G-code [4164F-xP & G8465] are required on the claim form to submit this numerator option)
Append a modifier (1P or 2P) to CPT Category II code 4164F to report documented circumstances that appropriately exclude patients from the denominator.
4164F *with* 1P: Documentation of medical reason(s) for not prescribing/administering adjuvant hormonal therapy (e.g., salvage therapy)
4164F *with* 2P: Documentation of patient reason(s) for not prescribing/administering adjuvant hormonal therapy

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AND
G8465: High risk of recurrence of prostate cancer

OR

If patient is not eligible for this measure because the risk of recurrence is low, intermediate or not determined, report:
(One G-code [G8464] is required on the claim form to submit this numerator option)
G8464: Clinician documented that prostate cancer patient is not an eligible candidate for adjuvant hormonal therapy; Low or intermediate risk of recurrence OR risk of recurrence not determined

OR

Adjuvant Hormonal Therapy not Prescribed/Administered, Reason not Specified
(One CPT II code & one G-code [4164F-8P & G8465] are required on the claim form to submit this numerator option)
Append a reporting modifier (8P) to CPT Category II code 4164F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.
4164F *with* 8P: Patients who were not prescribed/administered adjuvant hormonal therapy, reason not otherwise specified
AND
G8465: High risk of recurrence of prostate cancer

RATIONALE:
If receiving external beam radiotherapy as primary therapy, prostate cancer patients with a high risk of recurrence should also be prescribed hormonal therapy, which has been shown to increase the effectiveness of the radiotherapy.

CLINICAL RECOMMENDATION STATEMENTS:
High risk patients who are considering specific treatment options should be informed of findings of recent high quality clinical trials, including that: for those considering external beam radiotherapy, use of hormonal therapy combined with conventional radiotherapy may prolong survival. (AUA) (Standard)

Men with prostate cancer that is clinically localized stage T3a1, with Gleason score of 8 to 10, or PSA level greater than 20 ng/mL are categorized by the NCCN panel to be at high risk of recurrence after definitive therapy. Note that patients with multiple adverse factors may be shifted into the very high-risk category. Hormonal therapy (e.g., androgen ablation) plus external-beam RT is recommended. (NCCN) (Category 1)

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▲ Measure #105: Prostate Cancer: Three-Dimensional (3D) Radiotherapy

2011 PHYSICIAN QUALITY REPORTING OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of patients, regardless of age, with a diagnosis of clinically localized prostate cancer receiving external beam radiotherapy as a primary therapy to the prostate with or without nodal irradiation (no metastases; no salvage therapy) who receive three-dimensional conformal radiotherapy (3D-CRT) or intensity modulated radiation therapy (IMRT)

INSTRUCTIONS:
This measure is to be reported once per episode of radiation therapy for all patients with prostate cancer who receive external beam radiotherapy to the prostate during the reporting period. Claims data will be analyzed to determine unique episodes of radiation therapy. Each episode of radiation therapy in an eligible patient receiving external beam radiotherapy to the prostate occurring during the reporting period will be counted when calculating the reporting and performance rates. The Physician Quality Reporting quality-data code needs to be submitted only once during the episode of radiation therapy (e.g., 8 weeks of therapy). It is anticipated that clinicians who perform external beam radiotherapy to the prostate will submit this measure.

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

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

Measure Reporting via Registry:
ICD-9-CM diagnosis codes and CPT codes are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure. The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All patients, regardless of age, with a diagnosis of clinically localized prostate cancer receiving external beam radiotherapy as primary therapy to the prostate with or without nodal irradiation (no metastases; no salvage therapy)

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Denominator Criteria (Eligible Cases):
Diagnosis for clinically localized prostate cancer (ICD-9-CM): 185
WITHOUT
Secondary malignant neoplasm diagnosis of a specified site – respiratory, digestive, and of other specified sites (ICD-9-CM): 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
AND
Patient encounter during the reporting period (CPT): 77427

NUMERATOR:
Patients who receive three-dimensional conformal radiotherapy (3D-CRT) or intensity modulated radiation therapy (IMRT)

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:
3D-CRT or IMRT Received
(Two CPT II codes [4165F & 4200F] are required on the claim form to submit this numerator option)
CPT II 4165F: Three-dimensional conformal radiotherapy (3D-CRT) or intensity modulated radiation therapy (IMRT) received
AND
CPT II 4200F: External beam radiotherapy as primary therapy to the prostate with or without nodal irradiation

OR

If patient is not eligible for this measure because the 3D-CRT or IMRT is to region(s) other than the prostate only, report:
(One CPT II code [4201F] is required on the claim form to submit this numerator option)
CPT II 4201F: External beam radiotherapy with or without nodal irradiation as adjuvant or salvage therapy for prostate cancer patient

OR

3D-CRT or IMRT not Received, Reason not Specified
(Two CPT II codes [4165F-8P & 4200F] are required on the claim form to submit this numerator option)
Append a reporting modifier (8P) to CPT Category II code 4165F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.
4165F *with* 8P: Patients who did not receive three-dimensional conformal radiotherapy (3D-CRT) or intensity modulated radiation therapy (IMRT), reason not otherwise specified
AND
CPT II 4200F: External beam radiotherapy as primary therapy to the prostate with or without nodal irradiation

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RATIONALE:
Current, computer-aided radiotherapy techniques improve the precision of the irradiation of cancerous tissue and should be employed for all patients receiving external beam radiotherapy as primary therapy to the prostate.

CLINICAL RECOMMENDATION STATEMENTS:
Three-dimensional CRT or intensity-modulated radiation therapy (IMRT) techniques should be employed over conventional techniques. These techniques use computer software to integrate CT images of the patients' internal anatomy in the treatment position, which allows the volume receiving the high radiation dose to "conform" more exactly to the shape of the tumor. Three-dimensional CRT has reduced both acute and late normal tissue toxicity in patients with prostate cancer and allows higher cumulative doses to be delivered with a lower risk of late effects. (NCCN) (Category 2A)

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▲ Measure #106: Major Depressive Disorder (MDD): Diagnostic Evaluation

2011 PHYSICIAN QUALITY REPORTING OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of patients aged 18 years and older with a new diagnosis or recurrent episode of MDD who met the DSM-IV criteria during the visit in which the new diagnosis or recurrent episode was identified during the measurement period

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for all patients with an active diagnosis of major depressive disorder seen during the reporting period, including episodes of MDD that began prior to the reporting period. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

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

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

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure. The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data. There are no allowable performance exclusions for this measure.

DENOMINATOR:
All patients aged 18 years and older with a new diagnosis or recurrent episode of MDD

> Denominator Criteria (Eligible Cases):
> Patients aged ≥ 18 years on date of encounter
> AND
> Diagnosis for MDD (ICD-9-CM): 296.20, 296.21, 296.22, 296.23, 296.24, 296.30, 296.31, 296.32, 296.33, 296.34
> AND

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Patient encounter during the reporting period (CPT): 90801, 90802, 90804, 90805, 90806, 90807, 90808, 90809, 90810, 90811, 90812, 90813, 90814, 90815, 90845, 90862, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215

NUMERATOR:
Patients with documented evidence that they met the DSM-IV criteria [At least 5 elements (must include: 1) depressed mood or 2) loss of interest or pleasure) with symptom duration of 2 weeks or longer] during the visit in which the new diagnosis or recurrent episode was identified

Definitions:
DSM-IV Criteria – Includes presence of depressed mood, marked diminished interest/pleasure, significant weight loss or weight gain, insomnia or hypersomnia, psychomotor agitation or retardation, fatigue or loss of energy, feelings of worthlessness, diminished ability to concentrate and recurrent suicidal ideation.
Remission – Patient no longer meets DSM-IV criteria

NUMERATOR NOTE: PATIENTS WHOSE EPISODE OF MDD BEGAN PRIOR TO THE CURRENT REPORTING PERIOD: The clinician should report that DSM IV criteria was assessed during the visit in which the new diagnosis or recurrent episode was identified.

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
DSM-IV Criteria for Major Depressive Disorder Documented
CPT II 1040F: DSM-IV criteria for major depressive disorder documented at the initial evaluation

OR

DSM-IV Criteria for Major Depressive Disorder not Documented, Reason not Specified
Append a reporting modifier (8P) to CPT Category II code 1040F report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.
1040F *with* 8P: DSM-IV criteria for major depressive disorder not documented at the initial evaluation, reason not otherwise specified

RATIONALE:
Thorough assessment of depressive symptoms sets the basis for accurate diagnosis and treatment of major depressive disorder.

CLINICAL RECOMMENDATION STATEMENTS:
Successful treatment of patients with major depressive disorder is promoted by a thorough assessment of the patient. (APA; Level I Recommendation)

Diagnostic criteria for 296.20-296.24 – Major Depressive Disorder, Single Episode

A. Presence of a single Major Depressive Episode.
B. The Major Depressive Episode is not better accounted for by Schizoaffective Disorder and is not superimposed on Schizophrenia, Schizophreniform Disorder, Delusional Disorder, or Psychotic Disorder Not Otherwise Specified.

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C. There has never been a Manic Episode, a Mixed Episode, or a Hypomanic Episode.
Note: This exclusion does not apply if all of the manic-like, mixed-like, or hypomanic-like episodes are substance or treatment induced or are due to the direct physiological effects of a general medical condition. (DSM IV)

Diagnostic criteria for 296.30-296.34 – Major Depressive Disorder, Recurrent

A. Presence of two or more Major Depressive Episodes.
Note: To be considered separate episodes, there must be an interval of at least 2 consecutive months in which criteria are not met for a Major Depressive Episode.
B. The Major Depressive Episodes are not better accounted for by Schizoaffective Disorder and are not superimposed on Schizophrenia, Schizophreniform Disorder, Delusional Disorder, or Psychotic Disorder Not Otherwise Specified.
C. There has never been a Manic Episode, a Mixed Episode, or a Hypomanic Episode.
Note: This exclusion does not apply if all of the manic-like, mixed-like, or hypomanic-like episodes are substance or treatment induced or are due to the direct physiological effects of a general medical condition. (DSM IV)

Criteria for Major Depressive Episode

A. At least five of the following symptoms have been present during the same 2-week period and represent a change from previous functioning; at least one of the symptoms is either 1) depressed mood or 2) loss of interest or pleasure (do not include symptoms that are clearly due to general medical condition or mood-incongruent delusions or hallucinations).
    1) Depressed mood most of the day, nearly every day as indicated by either subjective report (e.g., feels sad or empty) or observation made by others (e.g., appears tearful)
    2) Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation made by others)
    3) Significant weight loss when not dieting or weight gain (e.g., a change of more than 5% body weight in a month), or decrease in appetite nearly every day
    4) Insomnia or hypersomnia nearly every day
    5) Psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down)
    6) Fatigue or loss of energy nearly every day
    7) Feelings of worthlessness or excessive inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick)
    8) Diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or observed by others)
    9) Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or specific plan for committing suicide

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B. The symptoms do not meet criteria for a mixed episode
C. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning
D. The symptoms are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., hypothyroidism)
E. The symptoms are not better accounted for by bereavement (i.e., after the loss of a loved one, the symptoms persist for longer than 2 months or are characterized by marked functional impairment, morbid preoccupation with worthlessness, suicidal ideation, psychotic symptoms, or psychomotor retardation). (DSM-IV)

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▲ Measure #107: Major Depressive Disorder (MDD): Suicide Risk Assessment

2011 PHYSICIAN QUALITY REPORTING OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of patients aged 18 years and older with a new diagnosis or recurrent episode of MDD who had a suicide risk assessment completed at each visit during the measurement period

INSTRUCTIONS:
This measure is to be reported at each visit for a new diagnosis or recurrent episode of MDD, for patients seen individually during the reporting period. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

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

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

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure. The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All patients aged 18 years and older with a new diagnosis or recurrent episode of MDD

> Denominator Criteria (Eligible Cases):
> Patients aged ≥ 18 years on date of encounter
> AND
> Diagnosis for MDD (ICD-9-CM): 296.20, 296.21, 296.22, 296.23, 296.24, 296.30, 296.31, 296.32, 296.33, 296.34
> AND
> Patient encounter during the reporting period (CPT): 90801, 90802, 90804, 90805, 90806, 90807, 90808, 90809, 90810, 90811, 90812, 90813, 90814, 90815, 90845, 90862, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215

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NUMERATOR:
Patients who had suicide risk assessment completed at each visit

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Suicide Risk Assessed
CPT II 3085F: Suicide risk assessed

OR

If patient is not eligible for this measure because MDD is in remission, report:
CPT II 3092F: Major depressive disorder, in remission

OR

Suicide Risk not Assessed, Reason not Specified
Append a reporting modifier (8P) to CPT Category II code 3085F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.
3085F *with* 8P: Suicide risk not assessed, reason not otherwise specified

RATIONALE:
Research has shown that patients with major depressive disorder are at a high risk for suicide, which makes this assessment an important aspect of care that should be assessed at each visit.

CLINICAL RECOMMENDATION STATEMENTS:
Successful treatment of patients with major depressive disorder is promoted by a thorough assessment of the patient. (APA; Level I Recommendation)

Psychiatric management consists of a broad array of interventions and activities that should be instituted by psychiatrists for all patients with major depressive disorder. (APA; Level I Recommendation)

The components of an evaluation for suicide risk should include:

1) An assessment of the presence of suicidal or homicidal ideation, intent, or plans
2) Access to means for suicide and the lethality of those means
3) Presence of psychotic symptoms, command hallucinations, or severe anxiety
4) Presence of alcohol or substance abuse
5) History of seriousness of previous attempts
6) Family history or recent exposure to suicide (APA)

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

2011 PHYSICIAN QUALITY REPORTING OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

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

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for RA patients seen during the reporting period. It is anticipated that clinicians who provide care for patients with a diagnosis of RA will submit this measure.

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

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

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure. The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All patients aged 18 years and older with a diagnosis of rheumatoid arthritis (RA)

> Denominator Criteria (Eligible Cases):
> Patients aged ≥ 18 years on date of encounter
> AND
> Diagnosis for rheumatoid arthritis (ICD-9-CM): 714.0, 714.1, 714.2, 714.81
> AND
> Patient encounter during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350

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

Definitions:
Prescribed – May include prescription given to the patient for DMARD therapy at one or more visits in the 12-month period OR patient already taking DMARD therapy as documented in current medication list.
Biologic DMARD Therapy – Includes Adalimunab, Etanercept, Infliximab, Abatacept, Anakinra and Rituximab

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
DMARD Prescribed, Dispensed, or Administered
CPT II 4187F: Disease modifying anti-rheumatic drug therapy prescribed, dispensed, or administered

OR

DMARD not Prescribed, Dispensed, or Administered for Medical Reasons
Append a modifier (1P) to CPT Category II code 4187F to report documented circumstances that appropriately exclude patients from the denominator.
4187F *with* 1P: Documentation of medical reason(s) for not prescribing, dispensing, or administering disease modifying anti-rheumatic drug therapy

OR

DMARD not Prescribed, Dispensed, or Administered, Reason not Specified
Append a reporting modifier (8P) to CPT Category II code 4187F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.
4187F *with* 8P: Disease modifying anti-rheumatic drug therapy was not prescribed, dispensed, or administered, reason not otherwise specified

RATIONALE:
Arthritis and other rheumatic conditions comprise the leading cause of disability among adults in the United States, and the cost of this public health burden is expected to increase as the U.S. population ages. Rheumatoid arthritis (RA) affects 1 percent of the adult population. Although the course of RA in individual patients is highly variable, most patients with persistent RA develop progressive functional limitation and physical disability. In addition, there is excess mortality and decreased survival among patients with persistent RA compared with the general population. While the prevalence of RA is low, the associated costs are very high over the lifetime of the affected person. Costs of RA amount to approximately 1 percent of the U.S. Gross National Product.

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RA is a chronic autoimmune disorder often characterized by progressive joint destruction and multi-system involvement. RA affects approximately 2.5 million Americans, disproportionately women. There is no cure; consequently, the goal of treatment is to slow the progression of disease, thereby delaying or preventing joint destruction, relieving pain and maintaining functional capacity. RA pain is often most effectively managed in the long term by altering the natural history of the active progressive disease with DMARDs, but analgesics and anti-inflammatory drugs also have an important place in pain management.

CLINICAL RECOMMENDATION STATEMENTS:
RA should be treated as early as possible with DMARDs to control symptoms and delay disease progression.

Good Practice Point: All patients with persistent inflammatory joint disease (> 6–8 weeks duration) already receiving simple analgesics and NSAIDs should be considered for referral for specialist rheumatology opinion and DMARD therapy, preferably within 12 weeks.

Early DMARD therapy in RA is important to maintain function and reduce later disability. DMARD therapy should be sustained in inflammatory disease in order to maintain disease suppression.

American College of Rheumatology (ACR) Subcommittee on Rheumatoid Arthritis Guidelines: Guidelines for the *Management of Rheumatoid Arthritis.* The majority of patients with newly diagnosed RA should be started on DMARD therapy within three months of diagnosis. All patients with RA are candidates for DMARD therapy. Although NSAIDs and glucocorticoids may alleviate symptoms, joint damage may continue to occur and progress.

Initiation of DMARD therapy should not be delayed beyond three months for any patient with an established diagnosis who, despite adequate treatment with NSAIDs, has on-going joint pain, significant morning stiffness or fatigue, active synovitis, persistent elevation of the ESR or CRP level or radiographic joint damage. For any untreated patient with persistent synovitis and joint damage, DMARD treatment should be started promptly to prevent or slow further damage. (ACR: Wherever possible, guidelines are evidence-based. However, because significant gaps in knowledge still exist, some recommendations are based on best practices and a consensus of the committee.)

Scottish Intercollegiate Guidelines Network: *Management of Early Rheumatoid Arthritis.*
There is clear evidence from placebo-controlled trials that DMARDs reduce symptoms in RA (as measured by joint pain, swelling and tenderness, and duration and severity of morning stiffness). DMARDs also improve global well being, as assessed by both patients and physicians. It is becoming increasingly clear that DMARDs should be introduced as soon as possible. Protracted benefit may be achieved in RA patients if appropriate DMARD therapy is introduced early. Refer to Scottish Intercollegiate Guidelines Network. *Management of Early Rheumatoid Arthritis, 2000*.

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▲ Measure #109: Osteoarthritis (OA): Function and Pain Assessment

2011 PHYSICIAN QUALITY REPORTING OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of patient visits for patients aged 21 years and older with a diagnosis of OA with assessment for function and pain

INSTRUCTIONS:
This measure is to be reported at each visit occurring during the reporting period for patients with osteoarthritis seen during the reporting period. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

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

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

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure. The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data. There are no allowable performance exclusions for this measure.

DENOMINATOR:
All patient visits for patients aged 21 years and older with a diagnosis of OA

> Denominator Criteria (Eligible Cases):
> Patients aged ≥ 21 years on date of encounter
> AND
> Diagnosis for OA (ICD-9-CM): 715.00, 715.04, 715.09, 715.10, 715.11, 715.12, 715.13, 715.14, 715.15, 715.16, 715.17, 715.18, 715.20, 715.21, 715.22, 715.23, 715.24, 715.25, 715.26, 715.27, 715.28, 715.30, 715.31, 715.32, 715.33, 715.34, 715.35, 715.36, 715.37, 715.38, 715.80, 715.89, 715.90, 715.91, 715.92, 715.93, 715.94, 715.95, 715.96, 715.97, 715.98

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AND

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

NUMERATOR:

Patient visits with assessment for level of function and pain documented

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Osteoarthritis Symptoms and Functional Status Assessed

CPT II 1006F: Osteoarthritis symptoms and functional status assessed (may include the use of a standardized scale or the completion of an assessment questionnaire, such as the SF-36, AAOS Hip & Knee Questionnaire)

OR

Osteoarthritis Symptoms and Functional Status not Assessed, Reason not Specified

Append a reporting modifier (8P) to CPT Category II code 1006F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

1006F *with* 8P: Osteoarthritis symptoms and functional status not assessed, reason not otherwise specified

RATIONALE:

Osteoarthritis can be a debilitating condition. An assessment of patient symptoms and functional status is important as it serves as the basis for making treatment modifications, which in turn, assists in improving the patient's quality of life.

CLINICAL RECOMMENDATION STATEMENTS:

Because pain is a major cause of disability in people with arthritis, assessment of functional status should be included in the pain assessment. When selecting a functional status measure, consideration should be given to the cognitive-developmental abilities of the person, the type of practice setting, the domains of function to be assessed, and the time and resources needed to complete the assessment. (APS; B Recommendation)

Any persistent pain that has an impact on physical function, psychosocial function, or other aspects of quality of life should be recognized as a significant problem. (AGA; IIA Recommendation)

Control of pain and maintenance of activity correlate well with satisfactory quality of life. (AAOS)

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

2011 PHYSICIAN QUALITY REPORTING OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

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

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for patients seen during the reporting period. This measure is intended to determine whether or not all patients aged 50 years and older received or had an order for influenza immunization during the flu season (September through February). 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, 2011 and August 31, 2011, G-code G8482 should be reported when the influenza vaccination is ordered or administered to the patient during the months of September, October, November, December of 2010 or January and February of 2011 for the flu season ending February 28, 2011.
- If reporting this measure between September 1, 2011 and December 31, 2011, G-code G8482 should be reported when the influenza vaccination is ordered or administered to the patient during the months of September, October, November, and December of 2011 for the flu season ending February 28, 2012.

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

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

Measure Reporting via Registry:
CPT codes and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure. The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

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DENOMINATOR:
All patients aged 50 years and older

Denominator Criteria (Eligible Cases):
Patients aged ≥ 50 years on date of encounter
AND
Patient encounter during the reporting period (CPT): 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

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

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Influenza Immunization Administered
G8482: Influenza immunization was ordered or administered

OR

Influenza Immunization not Administered for Documented Reasons
G8483: Influenza immunization was not ordered or administered for reasons documented by clinician

OR

Influenza Immunization not Administered, Reason not Specified
G8484: Influenza immunization was not ordered or administered, reason not specified

RATIONALE:
Influenza vaccination has shown to decrease hospitalizations for influenza, especially for those with risk factors, however annual influenza vaccination rates remain low.

CLINICAL RECOMMENDATION STATEMENTS:
Annual influenza immunization is recommended for all groups who are at increased risk for complications from influenza including persons aged ≥ 50 years. (CDC, USPSTF)

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

2011 PHYSICIAN QUALITY REPORTING OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

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

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for patients seen during the reporting period. There is no diagnosis associated with this measure. Performance for this measure is not limited to the reporting period. This measure may be reported by clinicians who perform the quality actions described in the measure based on services provided and the measure-specific denominator coding.

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

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

Measure Reporting via Registry:
CPT codes and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure. The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All patients 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, 99218, 99219, 99220, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, 99356, 99357

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NUMERATOR:
Patients who have ever received a pneumococcal vaccination

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Pneumonia Vaccination Administered or Previously Received
CPT II 4040F: Pneumococcal vaccine administered or previously received

OR

Pneumonia Vaccination not Administered or Previously Received for Medical Reasons
Append a modifier (1P) to CPT Category II code 4040F to report documented circumstances that appropriately exclude patients from the denominator.
4040F *with* 1P: Documentation of medical reason(s) for not administering or previously receiving pneumococcal vaccination

OR

Pneumonia Vaccination not Administered or Previously Received, Reason not Specified
Append a reporting modifier (8P) to CPT Category II code 4040F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.
4040F *with* 8P: Pneumococcal vaccine was not administered or previously received, reason not otherwise specified

RATIONALE:
The elderly have a much higher mortality from community-acquired pneumonia due to increased risk factors such as comorbidities, an increase in the number of medications taken and weaknesses or disease of lung tissue. Pneumonia accounts for an estimated 20 percent of nosocomial infections among the elderly, second only to urinary tract infections. The disease burden is large for older adults and the potential for prevention is high. (Ely, E., 1997)

Drugs such as penicillin were once effective in treating these infections; but the disease has become more resistant, making treatment of pneumococcal infections more difficult. This makes prevention of the disease through vaccination even more important. (CDC. National Immunization Program—*Pneumococcal Disease,* 2005)

CLINICAL RECOMMENDATION STATEMENTS:
The U.S. Preventive Services Task Force's *Guide to Clinical Preventive Services* 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 may be appropriate in immunocompetent individuals at high risk for morbidity and mortality from pneumococcal disease (e.g., persons $\geq$ 75 years of age or with severe chronic disease) who were vaccinated more than five years previously. Medicare Part B fully covers the cost of the vaccine and its administration every five years. (United States Preventive Services Task Force, 1998) Pneumococcal infection is a common cause of illness and death in the elderly and persons with certain underlying conditions. In 1998, an estimated 3,400 adults aged ≥ 65 years died as a result of invasive pneumococcal disease.

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Pneumococcal infection accounts for more deaths than any other vaccine-preventable bacterial disease. (CDC, 2002; Pneumococcal Pneumonia, NIAID Fact Sheet, December 2004.)

One of the *Healthy People 2010* objectives is to increase pneumococcal immunization levels for the non-institutionalized, high-risk populations to at least 90 percent (objective no. 14.29). While the percent of persons 65 years and older receiving the pneumococcal vaccine has increased, it still remains considerably below the *Health People 2010* objective. According to the National Health Interview Survey (NHIS), which is used to track performance on year 2010 objectives, in 1998 only 46 percent of adults age 65 years and older report receiving the vaccine. The figure was 45 percent based on the 1997 Behavioral Risk Factor Surveillance System (BRFSS) survey. (National Center for Health Statistics., 2005; CDC, 1997)

A particular strength of this measure is that it provides an opportunity to compare performance against national, state and/or regional benchmarks, which are collected through nationally organized and administered surveys.

At the physician practice level where a patient survey may not be feasible, data collection on pneumonia vaccination status through chart abstraction is a viable option.

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

2011 PHYSICIAN QUALITY REPORTING OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

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

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for female patients seen during the reporting period. There is no diagnosis associated with this measure. The patient should either be screened for breast cancer on the date of service OR there should be documentation that the patient was screened for breast cancer at least once within 24 months prior to the date of service. Performance for this measure is not limited to the reporting period. This measure may be reported by clinicians who perform the quality actions described in the measure based on services provided and the measure-specific denominator coding.

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

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

Measure Reporting via Registry:
CPT codes and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure. The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All female patients aged 40 through 69 years

> Denominator Criteria (Eligible Cases):
> Patients aged 40 through 69 years on date of encounter
> AND
> Patient encounter during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215

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NUMERATOR:
Patients who had a mammogram at least once within 24 months

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Mammogram Performed
CPT II 3014F: Screening mammography results documented and reviewed

OR

Mammogram not Performed for Medical Reasons
Append a modifier (1P) to CPT Category II code 3014F to report documented circumstances that appropriately exclude patients from the denominator.
3014F *with* 1P: Documentation of medical reason(s) for not performing a mammogram (i.e., women who had a bilateral mastectomy or two unilateral mastectomies).

OR

Mammogram not Performed, Reason not Specified
Append a reporting modifier (8P) to CPT Category II code 3014F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.
3014F *with* 8P: Screening mammography results were not documented and reviewed, reason not otherwise specified

RATIONALE:
Breast cancer ranks as the second leading cause of death in women. For women 40 to 49 years of age mammography can reduce mortality by 17 percent. (AMA, 2003)

CLINICAL RECOMMENDATION STATEMENT:
The U.S. Preventive Services Task Force (USPSTF) recommends screening mammography, with or without clinical breast examination (CBE), every 1-2 years for women aged 40 and older. (USPSTF, 2002)

- The USPSTF found fair evidence that mammography screening every 12-33 months significantly reduces mortality from breast cancer. Evidence is strongest for women aged 50-69, the age group generally included in screening trials. (USPSTF, 2002)
- For women aged 40-49, the evidence that screening mammography reduces mortality from breast cancer is weaker, and the absolute benefit of mammography is smaller, than it is for older women. Most, but not all, studies indicate a mortality benefit for women undergoing mammography at ages 40-49, but the delay in observed benefit in women younger than 50 makes it difficult to determine the incremental benefit of beginning screening at age 40 rather than at age 50. (USPSTF, 2002)
- The absolute benefit is smaller because the incidence of breast cancer is lower among women in their 40s than it is among older women. (USPSTF, 2002)

The USPSTF concluded that the evidence is also generalizable to women aged 70 and older (who face a higher absolute risk for breast cancer) if their life expectancy is not compromised by comorbid disease. The absolute probability of benefits of regular mammography increases along a continuum with age, whereas the likelihood of harms from screening (false-positive results and

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unnecessary anxiety, biopsies, and cost) diminishes from ages 40-70. The balance of benefits and potential harms, therefore, grows more favorable as women age. The precise age at which the potential benefits of mammography justify the possible harms is a subjective choice. (USPSTF, 2002)

American Cancer Society: Yearly Mammograms starting at age 40 and continuing for as long as a woman is in good health. (Smith, 2003)

American College of Preventative Medicine (ACPM):

- Low-risk women (no family history, familial cancer syndrome, or prior cancer). There is inadequate evidence for or against mammography screening of women under the age of 50. Women between the ages of 50-69 should have annual or biennial, high-quality, two-view mammography. Women aged 70 and older should continue undergoing mammography screening provided their health status permits breast cancer treatment. (Ferrini, 1996)
- Higher-risk women: Women with a family history of pre-menopausal breast cancer in a first-degree relative or those with a history of breast and/or gynecologic cancer may warrant more aggressive screening. Women with these histories often begin screening at an earlier age, although there is no direct evidence of effectiveness to support this practice. The future availability of genetic screening may define new recommendations for screening high-risk women. (Ferrini, 1996)

The American Medical Association (AMA), the American College of Obstetricians and Gynecologists (ACOG), and the American College of Radiology (ACR), all support screening with mammography and CBE beginning at age 40. (AMA, 1999; ACOG, 2000; Feig, 1998)

The Canadian Task Force on Preventive Health Care (CTFPHC), and the American Academy of Family Physicians (AAFP), recommends beginning mammography for average-risk women at age 50. (Canadian Task Force on the Periodic Health Examination, 1999; AAFP, 2005)

AAFP recommends that mammography in high-risk women begin at age 40, and recommends that all women aged 40-49 be counseled about the risks and benefits of mammography before making decisions about screening. (AAFP, 2005)

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

2011 PHYSICIAN QUALITY REPORTING OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

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

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for patients seen during the reporting period. There is no diagnosis associated with this measure. Performance for this measure is not limited to the reporting period. This measure may be reported by clinicians who perform the quality actions described in the measure based on services provided and the measure-specific denominator coding.

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

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

Measure Reporting via Registry:
CPT codes and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure. The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All patients aged 50 through 75 years

> Denominator Criteria (Eligible Cases):
> Patients aged 50 through 75 years on date of encounter
> AND
> Patient encounter during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337

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

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

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

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Colorectal Cancer Screening
CPT II 3017F: Colorectal cancer screening results documented and reviewed

OR

Colorectal Cancer Screening not Performed for Medical Reasons
Append a modifier (1P) to CPT Category II code 3017F to report documented circumstances that appropriately exclude patients from the denominator.
3017F *with* 1P: Documentation of medical reason(s) for not performing a colorectal cancer screening

OR

Colorectal Cancer Screening not Performed, Reason not Specified
Append a reporting modifier (8P) to CPT Category II code 3017F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.
3017F *with* 8P: Colorectal cancer screening results were not documented and reviewed, reason not otherwise specified

RATIONALE:
Colorectal cancer is the second leading cause of cancer-related death in the United States. There were an estimated 135,400 new cases and 56,700 deaths from the disease during 2001. Colorectal cancer (CRC) places significant economic burden on the society as well with treatment costs over $6.5 billion per year and, among malignancies, is second only to breast cancer at $6.6 billion per year (Schrag, 1999).

Colorectal cancer screening can detect pre-malignant polyps and early stage cancers. Unlike other screening tests that only detect disease, colorectal cancer screening can guide removal of pre-malignant polyps, which in theory can prevent development of colon cancer. Three tests are currently recommended for screening: fecal occult blood testing (FOBT), flexible sigmoidoscopy, and colonoscopy.

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CLINICAL RECOMMENDATION STATEMENTS:

During the past decade, compelling evidence has accumulated that systematic screening of the population can reduce mortality from colorectal cancer. Three randomized, controlled trials demonstrated that fecal occult blood testing (FOBT), followed by complete diagnostic evaluation of the colon for a positive test, reduced colorectal cancer mortality (Hardcastle et al., 1996; Mandel & Oken, 1998; Kronborg; 1996). One of these randomized trials (Mandel et al., 1993) compared annual FOBT screening to biennial FOBT screening, and found that annual screening resulted in greater reduction in colorectal cancer mortality. Two case control studies have provided evidence that sigmoidoscopy reduces colorectal cancer mortality (Selby et al., 1992; Newcomb et al., 1992). Approximately 75% of all colorectal cancers arise sporadically (Stephenson et al., 1991). Part of the effectiveness of colorectal cancer screening is mediated by the removal of the precursor lesion—an adenomatous polyp (Vogtelstein et al., 1988). It has been shown that removal of polyps in a population can reduce the incidence of colorectal cancer (Winawer, 1993). Colorectal screening may also lower mortality by allowing detection of cancer at earlier stages, when treatment is more effective (Kavanaugh, 1998).

The U.S. Preventive Services Task Force (USPSTF) published an updated recommendation for colorectal cancer screening in 2008. The guideline strongly recommends that clinicians screen men and women ages 50 to 75 years of age for colorectal cancer (A recommendation). The USPSTF recommends not screening adults age 85 and older due to possible harms (D recommendation). The appropriateness of colorectal cancer screening for men and women aged 76 to 85 years old should be considered on an individual basis (C recommendation). While the approved modalities vary for patients 50 to 75 years old, the USPSTF found there is insufficient evidence to assess the benefits and harms of computed tomographic colonography (CTC) and fecal DNA (fDNA) testing as screening modalities for colorectal cancer for all patients (I statement).

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♦ Measure #116: Antibiotic Treatment for Adults with Acute Bronchitis: Avoidance of Inappropriate Use

2011 PHYSICIAN QUALITY REPORTING OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of adults aged 18 through 64 years with a diagnosis of acute bronchitis who were not prescribed or dispensed an antibiotic prescription on or within 3 days of the initial date of service

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

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

When reporting the measure via claims, submit the listed ICD-9-CM diagnosis codes, CPT codes, and the appropriate CPT Category II code OR the CPT Category II code with the modifier. The modifier allowed for this measure is: 1P- medical reasons. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure. The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All patients aged 18 through 64 years with a diagnosis of acute bronchitis

Denominator Criteria (Eligible Cases):
Patients aged 18 through 64 years on date of encounter
AND
Diagnosis for acute bronchitis (ICD-9-CM): 466.0
AND
Patient encounter during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99217, 99218, 99219, 99220

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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 patients for whom antibiotics were neither prescribed nor dispensed on or within 3 days of the initial date of service over the number of patients in the denominator (patients aged 18 through 64 years with acute bronchitis). A higher score indicates appropriate treatment of patients with acute bronchitis (e.g., the proportion for whom antibiotics *were not* prescribed or dispensed on or three days after the initial date of service).

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Table 1A: The antibiotics listed below are considered antibiotics for the purposes of this measure.

DESCRIPTION	PRESCRIPTION		
5-aminosalicylates	• sulfasalazine		
Aminoglycosides	• amikacin • gentamicin	• kanamycin • neomycin	• tobramycin
Aminopenicillins	• amoxicillin	• ampicillin	
Antipseudomonal penicillins	• piperacillin	• ticarcillin	
Beta-lactamase inhibitors	• amoxicillin-clavulanate • ampicillin-sulbactam	• piperacillin-tazobactam	• ticarcillin-clavulanate
First generation cephalosporins	• cefadroxil • cefazolin	• cephalexin • cephradine	
Fourth generation cephalosporins	• cefepime		
Ketolides	• telithromycin		
Lincomycin derivatives	• clindamycin	• lincomycin	
Macrolides	• azithromycin • clarithromycin	• erythromycin • erythromycin ethylsuccinate	• erythromycin lactobionate • erythromycin stearate
Miscellaneous antibiotics	• aztreonam • chloramphenicol • dalfopristin-quinupristin	• daptomycin • erythromycin-sulfisoxazole • linezolid	• metronidazole • vancomycin
Sulfamethoxazole-trimethoprim DS	• sulfamethoxazole-trimethoprim		
Natural penicillins	• penicillin G benzathine-procaine • penicillin G potassium	• penicillin G procaine • penicillin G sodium	• penicillin V potassium

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DESCRIPTION	PRESCRIPTION		
Penicillinase resistant penicillins	• dicloxacillin	• nafcillin	• oxacillin
Quinolones	• ciprofloxacin • gatifloxacin • gemifloxacin	• levofloxacin • lomefloxacin • moxifloxacin	• Norfloxacin • ofloxacin • sparfloxacin
Rifamycin derivatives	• rifampin		
Second generation cephalosporin	• cefaclor • cefotetan	• cefoxitin • cefprozil	• cefuroxime • loracarbef
Sulfonamides	• sulfadiazine • sulfamethoxazole-trimethoprim		• sulfisoxazole
Tetracyclines	• doxycycline	• minocycline	• tetracycline
Third generation cephalosporins	• cefdinir • cefditoren • cefixime	• cefotaxime • cefpodoxime • ceftazidime	• ceftibuten • ceftizoxime • ceftriaxone
Urinary anti-infectives	• fosfomycin • nitrofurantoin • nitrofurantoin macrocrystals	• nitrofurantoin macrocrystals-monohydrate • trimethoprim	

Antibiotic not Prescribed or Dispensed
CPT II 4124F: Antibiotic neither prescribed nor dispensed

OR

Antibiotic Prescribed or Dispensed for Medical Reasons
Append a modifier (1P) to CPT Category II code 4120F to report documented circumstances that appropriately exclude patients from the denominator.
4120F *with* 1P: Documentation of medical reason(s) for prescribing or dispensing antibiotic

OR

Antibiotic Prescribed or Dispensed
CPT II 4120F: Antibiotic prescribed or dispensed

RATIONALE:
Antibiotics are commonly misused and overused for a number of viral respiratory conditions where antibiotic treatment is not clinically indicated. (Scott J.G., D. Cohen, B. Dicicco-Bloom, 2001) About 80 percent of antibiotics prescribed for acute respiratory infections in adults are unnecessary, according to CDC prevention guidelines. In adults, antibiotics are most often (65–80 percent) prescribed for acute bronchitis, despite its viral origin. The misuse and overuse of antibiotics contributes to antibiotic drug resistance, which is of public health concern due to the diminished efficacy of antibiotics against bacterial infections, particularly in sick patients and the elderly. (Austin D.J., K.G. Kristinsson, R.M. Anderson, 1999, Patterson, JE, 2001, Cohen ML, 1992, Lipsitch M, 2001)

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A HEDIS measure that highlights inappropriate antibiotic prescribing in adults for a common respiratory condition will help to raise awareness among clinicians and patients about inappropriate antibiotic use. Antibiotics are most often inappropriately prescribed in adults with acute bronchitis. This measure builds on an existing HEDIS measure targeting inappropriate antibiotic prescribing for children with upper respiratory infection (common cold), where antibiotics are also most often inappropriately prescribed. (Chandran R., 2001, Gonzales R., J.F. Steiner, et al, 1999)

CLINICAL RECOMMENDATION STATEMENTS:

Clinical guidelines do not support antibiotic treatment of otherwise healthy adults with acute bronchitis due to the viral origin of acute bronchitis. Patients with chronic bronchitis, COPD or other chronic comorbidity may be treated with antibiotics and are therefore excluded from the measure denominator. (Gonzales R., D.C. Malone, J.H. Maselli, et al, 2001)

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

2011 PHYSICIAN QUALITY REPORTING OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

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

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

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

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

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT codes, G-codes, and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure. The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data. There are no allowable performance exclusions for this measure.

DENOMINATOR:
All patients aged 18 through 75 years with a diagnosis of diabetes

Denominator Criteria (Eligible Cases):
Patients aged 18 through 75 years on date of encounter
AND

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Diagnosis for diabetes (ICD-9-CM): 250.00, 250.01, 250.02, 250.03, 250.10, 250.11, 250.12, 250.13, 250.20, 250.21, 250.22, 250.23, 250.30, 250.31, 250.32, 250.33, 250.40, 250.41, 250.42, 250.43, 250.50, 250.51, 250.52, 250.53, 250.60, 250.61, 250.62, 250.63, 250.70, 250.71, 250.72, 250.73, 250.80, 250.81, 250.82, 250.83, 250.90, 250.91, 250.92, 250.93, 357.2, 362.01, 362.02, 362.03, 362.04, 362.05, 362.06, 362.07, 366.41, 648.00, 648.01, 648.02, 648.03, 648.04

AND

Patient encounter during the reporting period (CPT or HCPCS): 92002, 92004, 92012, 92014, 97802, 97803, 97804, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, G0270, G0271

NUMERATOR:

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

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

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Dilated Eye Exam Performed by an Eye Care Professional

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

OR

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

OR

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

OR

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

OR

Dilated Eye Exam not Performed, Reason not Specified

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

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

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RATIONALE:
Examination of the eyes is the first step in the treatment of any existing or developing conditions related to retinopathy and the first step in the prevention of blindness.

CLINICAL RECOMMENDATION STATEMENTS:
AACE/ACE, ADA, and American Academy of Ophthalmology (AAO): Recommend that a dilated eye examination be performed on patients with diabetes during an initial assessment and at least annually thereafter. (AACE/ACE, 2002; ADA, 2004; AAO, 1998; Hammond, 1998)

American Association of Clinical Endocrinologists and American College of Endocrinology (AACE/ACE): Recommend that the annual eye examination be performed as part of a retinal module. The module includes test of visual acuity (Snellen chart); funduscopic examination and intraocular pressure (IOP) test. The AACE/ACE recommends that diabetic patients should be under the care of an ophthalmologist experienced in the management of diabetic retinopathy. AACE/ACE further believes that a dilated eye exam should only be done by an MD/DO. (AACE/ACE, 2002)

American Diabetes Association (ADA): Patients with type 1 diabetes should have an initial dilated and comprehensive eye examination by an ophthalmologist or optometrist within 3-5 years after the onset of diabetes. In general evaluation for diabetic eye disease is not necessary before 10 years of age. However, some evidence suggests that the prepubertal duration of diabetes may be important in the development of microvascular complications; therefore, clinical judgment should be used when applying these recommendations to individual patients. (Level of Evidence: B) Patients with type 2 diabetes should have an initial dilated and comprehensive eye examination by an ophthalmologist or optometrist shortly after diabetes diagnosis. (Level of Evidence: B)

Subsequent examinations for type 1 and type 2 diabetic patients should be repeated annually by an ophthalmologist or optometrist who is knowledgeable and experienced in diagnosing the presence of diabetic retinopathy and is aware of its management. Examination will be required more frequently if retinopathy is progressing. This follow-up interval is recommended recognizing that there are limited data addressing this issue. (Level of Evidence: B)

Seven standard field stereoscopic 30° fundus photography is an accepted method for examining diabetic retinopathy. (ADA, 2004)

American Academy of Ophthalmology (AAO): Recommends that diabetic patients should be under the care of an ophthalmologist experienced in the management of diabetic retinopathy. Ophthalmologists with specialized knowledge and experience in managing the disease are best able to detect and treat serious disease. Stereoscopic photographs offer an advantage over nonstereoscopic photographs, and the traditional “seven stereo fields” provide the most complete coverage. (AAO, 1998; Hammond, 1996)

American Geriatrics Society (AGS): Dilated eye examinations should be performed every two years at a minimum, and more often if there are additional risk factors for diabetic eye disease or evidence of age-related eye disease. (CHF/AGS, 2003)

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▲ Measure #118: Coronary Artery Disease (CAD): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Patients with CAD and Diabetes and/or Left Ventricular Systolic Dysfunction (LVSD)

2011 PHYSICIAN QUALITY REPORTING OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Percentage of patients aged 18 years and older with a diagnosis of CAD who also have diabetes mellitus and/or LVSD (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 based on the services provided and the measure-specific denominator coding.

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure. The quality-data codes have been provided for registry only measures for use by registries that utilize claims data. It is not necessary to submit these codes for registry-based submissions. Do not report this measure via claims.

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

OR

(2) Patients who are 18 years and older with a diagnosis of CAD who are also diabetic

> The eligible professional should submit data on one of the reporting criteria, depending on the clinical findings. If the patient has CAD (without a diagnosis of Diabetes), use Denominator Reporting Criteria 1. If the patient has CAD and Diabetes, use Denominator Reporting Criteria 2. If the patient has both diabetes and LVSD, the eligible professional may report quality data for Reporting Criteria 2 and this will count as appropriate reporting for this patient.

REPORTING CRITERIA 1: All patients with CAD (without a diagnosis of diabetes)

DENOMINATOR (REPORTING CRITERIA 1):
All patients aged 18 years and older with a diagnosis of CAD who also have a diagnosis of LVSD (LVEF < 40%)

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

NUMERATOR:
Patients who were prescribed ACE inhibitor or ARB therapy

Numerator Instructions: It is necessary to determine the LVEF for the patient, either through quantitative or qualitative assessment. Examples of a quantitative or qualitative assessment may include an echocardiogram: 1) that provides a numerical value of LVSD or 2) that uses descriptive terms such as moderately or severely depressed left ventricular function.

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

Numerator Options:
Angiotensin converting enzyme (ACE) inhibitor or angiotensin receptor blocker (ARB) therapy prescribed for patients with a left ventricular ejection fraction (LVEF) <40% or documentation of moderately or severely depressed left ventricular systolic function (G8468)

OR

Clinician documented that patient with a left ventricular ejection fraction (LVEF) <40% or documentation of moderately or severely depressed left ventricular systolic function was not an eligible candidate for angiotensin converting enzyme (ACE) inhibitor or angiotensin receptor blocker (ARB) therapy (G8469)

OR

Patient with left ventricular ejection fraction (LVEF) ≥40% or documentation as normal or mildly depressed left ventricular systolic function (G8470)
OR
Left ventricular ejection fraction (LVEF) was not performed or documented (G8471)

OR

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Angiotensin converting enzyme (ACE) inhibitor or angiotensin receptor blocker (ARB) therapy not prescribed for patients with a left ventricular ejection fraction (LVEF) <40% or documentation of moderately or severely depressed left ventricular systolic function, reason not specified (G8472)

OR

REPORTING CRITERIA 2: Patients with CAD and diabetes

DENOMINATOR (REPORTING CRITERIA 2):
All patients aged 18 years and older with a diagnosis of CAD who also have a diagnosis of diabetes

Note: If a patient has both diabetes and LVSD, reporting criteria #2 will count as appropriate reporting for this patient.

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Diagnosis for CAD (ICD-9-CM): 410.00, 410.01, 410.02, 410.10, 410.11, 410.12, 410.20, 410.21, 410.22, 410.30, 410.31, 410.32, 410.40, 410.41, 410.42, 410.50, 410.51, 410.52, 410.60, 410.61, 410.62, 410.70, 410.71, 410.72, 410.80, 410.81, 410.82, 410.90, 410.91, 410.92, 411.0, 411.1, 411.81, 411.89, 412, 413.0, 413.1, 413.9, 414.00, 414.01, 414.02, 414.03, 414.04, 414.05, 414.06, 414.07, 414.8, 414.9, V45.81, V45.82
AND
Diagnosis for diabetes (ICD-9-CM): 250.00, 250.01, 250.02, 250.03, 250.10, 250.11, 250.12, 250.13, 250.20, 250.21, 250.22, 250.23, 250.30, 250.31, 250.32, 250.33, 250.40, 250.41, 250.42, 250.43, 250.50, 250.51, 250.52, 250.53, 250.60, 250.61, 250.62, 250.63, 250.70, 250.71, 250.72, 250.73, 250.80, 250.81, 250.82, 250.83, 250.90, 250.91, 250.92, 250.93
AND
Patient encounter during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350

NUMERATOR:
Patients who were prescribed ACE inhibitor or ARB therapy

Numerator Options:
Angiotensin converting enzyme (ACE) inhibitor or angiotensin receptor blocker (ARB) therapy prescribed (G8473)

OR

Angiotensin converting enzyme (ACE) inhibitor or angiotensin receptor blocker (ARB) therapy not prescribed for reasons documented by the clinician (G8474)

OR

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Angiotensin converting enzyme (ACE) inhibitor or angiotensin receptor blocker (ARB) therapy not prescribed, reason not specified (G8475)

RATIONALE:
In the absence of contraindications, ACE inhibitors or ARBs are recommended for patients with coronary artery disease; especially those with diabetes and /or left ventricular systolic dysfunction. ACE inhibitors and ARBs have shown to decrease morbidity and mortality, including significant reductions in the occurrence of myocardial infarction, stroke, and diabetic complications.

CLINICAL RECOMMENDATION STATEMENTS:
ACE inhibitor use is recommended in all patients with CAD who also have diabetes and/or left ventricular systolic dysfunction. (ACC/AHA)

ACE inhibitor use is also recommended in patients with CAD or other vascular disease. (ACC/AHA)

In ST elevation myocardial infarction (STEMI) patients who tolerate ACE inhibitors, an angiotensin receptor blocker (ARB) can be useful as an alternative to ACE inhibitors in the long-term management of STEMI patients, provided there are either clinical or radiological signs of heart failure or LVEF less than 0.40. (ACC/AHA)

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

2011 PHYSICIAN QUALITY REPORTING OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

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

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

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

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

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT codes, G-codes, and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure. The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data. There are no allowable performance exclusions for this measure.

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

Denominator Criteria (Eligible Cases):
Patients aged 18 years through 75 years on date of encounter
AND

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Diagnosis for diabetes (ICD-9-CM): 250.00, 250.01, 250.02, 250.03, 250.10, 250.11, 250.12, 250.13, 250.20, 250.21, 250.22, 250.23, 250.30, 250.31, 250.32, 250.33, 250.40, 250.41, 250.42, 250.43, 250.50, 250.51, 250.52, 250.53, 250.60, 250.61, 250.62, 250.63, 250.70, 250.71, 250.72, 250.73, 250.80, 250.81, 250.82, 250.83, 250.90, 250.91, 250.92, 250.93, 357.2, 362.01, 362.02, 362.03, 362.04, 362.05, 362.06, 362.07, 366.41, 648.00, 648.01, 648.02, 648.03, 648.04

AND

Patient encounter during the reporting period (CPT or HCPCS): 97802, 97803, 97804, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, G0270, G0271

NUMERATOR:

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

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

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Nephropathy Screening Performed

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

OR

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

OR

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

OR

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

OR

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

OR

Nephropathy Screening not Performed, Reason not Specified

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

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

RATIONALE:

Nephropathy is a frequent complication of renal disease for both type 1 and type 2 diabetes and often ends in end-stage renal disease (ESRD) (ADA, 2002). Of all people with diabetes, 10-21% have nephropathy (ADA 2002).

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CLINICAL RECOMMENDATION STATEMENTS:

American Association of Clinical Endocrinologists and American College of Endocrinology (AACE/ACE): Recommends that the initial assessment should include a urinalysis, test for microalbuminuria and creatinine clearance. The renal complication module should be performed annually and includes a test for microalbuminuria and creatinine clearance (AACE/ACE, 2002).

American Diabetes Association (ADA): A test for the presence of microalbumin should be performed at diagnosis in patients with type 2 diabetes. Microalbuminuria rarely occurs with short duration of type 1 diabetes; therefore, screening in individuals with type 1 diabetes should begin after 5 years' disease duration (Level of Evidence: E). However, some evidence suggests that the prepubertal duration of diabetes may be important in the development of microvascular complications; therefore, clinical judgment should be exercised when individualizing these recommendations. Because of the difficulty in precise dating of the onset of type 2 diabetes, such screening should begin at the time of diagnosis. After the initial screening and in the absence of previously demonstrated microalbuminuria, a test for the presence of microalbumin should be performed annually (ADA, 2004).

Screening for microalbuminuria can be performed by three methods:

1) measurement of the albumin-to-creatinine ratio in a random spot collection
2) 24-h collection with creatinine, allowing the simultaneous measurement of creatinine clearance
3) timed (e. g. 4-h or overnight) collection – the analysis of a spot sample for the albumin-to-creatinine ratio is strongly recommended.

The role of annual microalbuminuria assessment is less clear after diagnosis of microalbuminuria and institution of angiotensin-converting enzyme (ACE) inhibitor or angiotensin receptor blocker (ARB) therapy and blood pressure control. Many experts recommend continued surveillance to assess both response to therapy and progression of disease.

National Kidney Foundation (NKF): Individuals at increased risk, but found not to have chronic kidney disease, should be advised to follow a program of risk factor reduction, if appropriate, and undergo repeat periodic evaluation (NKF, 2003).

A comparative analysis of recommendations and evidence in diabetes guidelines from 13 countries (including the American Diabetes Association and Canadian Medical Association) found there was agreement among the guidelines that ACE inhibitors should be recommended to patients with hypertension and renal disease (Burgers, 2002).

The ADA also recommends that for the treatment of both micro- and macroalbuminuria, ARBs should be used except during pregnancy (ADA, 2005).

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

2011 PHYSICIAN QUALITY REPORTING OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of patients aged 18 years and older with a diagnosis of advanced CKD (stage 4 or 5, not receiving Renal Replacement Therapy [RRT]), who had the following laboratory testing ordered within 12 months: serum levels of calcium, phosphorus and intact PTH, and lipid profile

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for patients with advanced CKD seen during the reporting period. It is anticipated that clinicians providing care for patients with advanced CKD will submit this measure.

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

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

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure. The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All patients aged 18 years and older with the diagnosis of advanced CKD (stage 4 or 5, not receiving RRT)

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Diagnosis for stage 4 or 5 CKD (ICD-9-CM): 585.4, 585.5
AND
Patient encounter during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215

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NUMERATOR:
Patients who had the following laboratory testing ordered at least once during the 12 month reporting period: serum levels of calcium, phosphorus and intact PTH, and lipid profile

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Serum Levels of Calcium, Phosphorus, Intact Parathyroid Hormone (iPTH) and Lipid Profile Ordered
CPT II 3278F: Serum levels of calcium, phosphorus, intact Parathyroid Hormone (iPTH) and lipid profile ordered

OR

Serum Levels of Calcium, Phosphorus, Intact Parathyroid Hormone (iPTH) and Lipid Profile not Ordered for Medical or Patient Reasons
Append a modifier (1P or 2P) to CPT Category II code 3278F to report documented circumstances that appropriately exclude patients from the denominator.
3278F *with* 1P: Documentation of medical reason(s) for not ordering serum levels of calcium, phosphorus, intact Parathyroid Hormone (iPTH) and lipid profile
3278F *with* 2P: Documentation of patient reason(s) for not ordering serum levels of calcium, phosphorus, intact Parathyroid Hormone (iPTH) and lipid profile

OR

Serum Levels of Calcium, Phosphorus, Intact Parathyroid Hormone (iPTH) and Lipid Profile not Ordered, Reason not Specified
Append a reporting modifier (8P) to CPT Category II code 3278F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.
3278F *with* 8P: Serum levels of calcium, phosphorus, intact Parathyroid Hormone (iPTH) and lipid profile not ordered, reason not otherwise specified

RATIONALE:
Bone disease is a common complication of chronic kidney disease. Patients with CKD should be monitored for calcium and phosphate imbalances and secondary hyperparathyroidism. Disturbances in mineral and bone metabolism are prevalent in CKD and are an important cause of morbidity, decrease in quality of life, and extraskeletal calcification that has been associated with increased CV mortality (taken verbatim from Definition, evaluation, and classification of renal osteodystrophy: a position statement from the Kidney Disease: Improving Global Outcomes (KDIGO), Moe, et al, Kidney Int, 2006; 69:1945-53). Gaps: USRDS 2006 data show that less than 30% of Medicare (and less than 20% of EGHP) pts receive Ca, Phos, PTH measures within a year.

Process/goal of care to be improved: identification of abnormalities in mineral and bone metabolism that relate to increased morbidity and mortality.

CLINICAL RECOMMENDATION STATEMENTS:
Serum levels of calcium, phosphorus, and intact plasma parathyroid hormone (PTH) should be measured in all patients with CKD and GFR < 60 ml/min/1.73m². (Evidence) (NKF 2003)

If a patient has GFR ≤ 30 ml/min/1.73m², then s/he should have his/her serum calcium and phosphorus measured at least every three months, and iPTH levels measured at least once. (Grade B) (RPA 2002)

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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) (NKF 2004)

All adults and adolescents with CKD should be evaluated for dyslipidemias. (Grade B) (NKF 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) (NKF 2003)

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

2011 PHYSICIAN QUALITY REPORTING OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

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

INSTRUCTIONS:
This measure is to be reported at each visit for patients with a diagnosis of advanced CKD seen during the reporting period. It is anticipated that clinicians providing care for patients with advanced CKD will submit this measure.

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

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

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure. The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data. There are no allowable performance exclusions for this measure.

DENOMINATOR:
All visits for patients aged 18 years and older with the diagnosis of advanced CKD (stage 4 or 5, not receiving RRT)

> Denominator Criteria (Eligible Cases):
> Patients aged ≥ 18 years on date of encounter
> AND
> Diagnosis for stage 4 or 5 CKD (ICD-9-CM): 585.4, 585.5
> AND
> Patient encounter during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215

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

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

Definition:
Documented Plan of Care – Should include one or more of the following: recheck blood pressure at specified future date; initiate or alter pharmacologic therapy; initiate or alter non-pharmacologic therapy; documented review of patient's home blood pressure log which indicates that patient's blood pressure is or is not well controlled.

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

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Patient Visits with Blood Pressure < 130/80 mmHg
(One G-code [G8476] is required on the claim form to submit this numerator option)
G8476: Most recent blood pressure has a systolic measurement of <130 mmHg and a diastolic measurement of <80 mmHg

OR

Blood Pressure Plan of Care Documented for Patient Visits with Systolic Blood Pressure **≥ 130 mmHg and/or Diastolic Blood Pressure ≥ 80 mmHg** (If either systolic blood pressure is ≥ 130 mmHg OR diastolic blood pressure is ≥ 80 mmHg, patient requires a plan of care):
(One G-code & one CPT II code [G8477 & 0513F] are required on the claim form to submit this numerator option)
G8477: Most recent blood pressure has a systolic measurement of ≥130 mmHg and/or a diastolic measurement of ≥80 mmHg
AND
CPT II 0513F: Elevated blood pressure plan of care documented

OR

Blood Pressure Measurement not Performed, Reason not Specified
(One G-code [G8478] is required on the claim form to submit this numerator option)
G8478: Blood pressure measurement not performed or documented, reason not specified

OR

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

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

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

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

AND

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

RATIONALE:

Identification of hypertension in patients with CKD is an essential part of management of the disease. Hypertension is common in patients with CKD, and if hypertension is left untreated, it will speed the progression of the disease. Recent research has shown that during office visits, approximately 20% to 30% of CKD patients do not have their blood pressure measured. Additionally, if the CKD patient is has an anemia/ESA visit, they are even less likely to have their blood pressure measured. In these patients, recent research has shown that 75% do not have their blood pressure measured at an anemia/ESA visit. Patients with CKD should have their blood pressure measured at each office visit so that changes can be identified and treatment initiated as soon as it is necessary. Blood pressure control is important in slowing the progression of chronic kidney disease. By slowing the progression of the disease, quality of life is improved for the patient, and it results in a longer period of time before a patient requires renal replacement therapy. Patients with chronic kidney disease should have a lower target blood pressure (< 130/80) than other patients with hypertension.

CLINICAL RECOMMENDATION STATEMENTS:

Blood pressure should be measured at each health encounter. (Grade A) (NKF 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)

If a patient has a GFR ≤ 30 ml/min/1.73m², and if blood pressure is determined to be elevated (systolic > 130 mmHg OR diastolic > 80 mmHg), then s/he should receive intensified antihypertensive therapy (Grade B). (RPA, 2002)

Patients with CKD should be considered in the "highest-risk" group for CVD for implementing recommendations for pharmacological therapy, irrespective of cause of CKD (Grade A). (NKF, 2004)

Target blood pressure for CVD risk reduction in CKD and diabetic/nondiabetic kidney disease should be < 130/80 mmHg (Grade B). (NKF, 2004)

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

2011 PHYSICIAN QUALITY REPORTING OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of calendar months during the 12-month reporting period in which patients aged 18 years and older with a diagnosis of advanced CKD (stage 4 or 5, not receiving Renal Replacement Therapy [RRT]), receiving ESA therapy, have a hemoglobin < 13 g/dL OR patients whose hemoglobin is ≥ 13 g/dL and have a documented plan of care

INSTRUCTIONS:
This measure is to be reported each calendar month patients are seen with a diagnosis of advanced CKD (stage 4 or 5) during the reporting period. The most recent quality code submitted will be used for performance calculation. It is anticipated that clinicians providing care for patients with advanced CKD will submit this measure.

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

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

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure. The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
Calendar months for all patients aged 18 years and older with the diagnosis of advanced CKD (stage 4 or 5, not receiving RRT), receiving ESA therapy

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Diagnosis for stage 4 or 5 CKD (ICD-9-CM): 585.4, 585.5
AND

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

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

Definitions:
Documented Plan of Care – Should include reducing the ESA dose and repeating hemoglobin at a specified future date.
Erythropoiesis-Stimulating Agents (ESA) – includes epoetin or darbepoetin

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

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Hemoglobin level < 13 g/dL
(Two CPT II codes [328xF & 4171F] are required on the claim form to submit this numerator option)
CPT II 3281F: Hemoglobin level less than 11 g/dL
OR
CPT II 3280F: Hemoglobin level 11 g/dL to 12.9 g/dL
AND
CPT II 4171F: Patient receiving Erythropoiesis-Stimulating Agents (ESA) therapy

OR

Hemoglobin level **≥ 13 g/dL with** a Documented Plan of Care
(Three CPT II codes [3279F & 0514F & 4171F] are required on the claim form to submit this numerator option)
CPT II 3279F: Hemoglobin level greater than or equal to 13 g/dL
AND
CPT II 0514F: Plan of care for elevated hemoglobin level documented for patient receiving Erythropoiesis-Stimulating Agent (ESA) therapy
AND
CPT II 4171F: Patient receiving Erythropoiesis-Stimulating Agents (ESA) therapy

OR

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

OR

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

AND

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

OR

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

AND

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

AND

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

RATIONALE:

The clinical recommendation regarding Hb levels for CKD patients receiving ESA therapy is that Hb level should generally be in the range of 11.0 to 12.0 g/dL. Additionally, these patients should also have their Hb level checked at least monthly. Given that Hb levels vary for each patient due to numerous factors, it is necessary to monitor Hb level closely in order to make the individualized treatment decisions required in maintaining Hb level in the target range. There is no evidence of benefit from ESA therapy when Hb levels are maintained at greater than 13.0 g/dL. Maintaining Hb at higher levels may result in potential harm to the patient, as well as incur unjustified cost. Evidence linking increased risks for patients with CKD and higher Hb levels were for target Hb levels greater than 13.0g/dL. The intention of this measure is not to suggest that the goal of ESA treatment is to reach an achieved Hb of 13.0 g/dL. Rather, as a patient safety measures, it is to realize that patients who reach Hb levels higher than 13.0 g/dL are at increased risk for adverse events, and that these elevated Hb levels need to be addressed by adjusting ESA dosage.

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CLINICAL RECOMMENDATION STATEMENTS:

The frequency of Hb monitoring in patients treated with ESAs should be at least monthly. (Opinion) (NKF 2006)

The Hb target is the intended aim of ESA therapy for the individual patient with CKD. In clinical practice, achieved Hb results vary considerably from Hb target.

- Selection of the Hb target and selection of the Hb level at which ESA therapy is initiated in the individual patient should include consideration of potential benefits (including improvement in the quality of life and avoidance of transfusion) and potential harms including the risk of life-threatening adverse events). (Clinical Practice Recommendation) (NKF 2007)
- In 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) (NKF 2007)
- In dialysis and nondialysis patients with CKD receiving ESA therapy, the Hb target should not be greater than 13.0 g/dL. (Clinical Practice Guideline; Moderately Strong Evidence) (NKF, 2007)

The initial ESA dose and the ESA dose adjustments should be determined by the patient's Hb level, the target Hb level, the observed rate of increase in Hb level, and clinical circumstances. (Opinion) (NKF 2006)

ESA doses should be decreased, but not necessarily held, when a downward adjustment of Hb level is needed. (Opinion) (NKF 2006)

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♠ Measure #124: Health Information Technology (HIT): Adoption/Use of Electronic Health Records (EHR)

2011 PHYSICIAN QUALITY REPORTING OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Documents whether provider has adopted and is using health information technology. To report this measure, the eligible professional must have adopted and be using a certified, Physician Quality Reporting System qualified or other acceptable EHR system

INSTRUCTIONS:
This measure is to be reported at 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 clinicians who have adopted and are using a certified, Physician Quality Reporting System qualified or other acceptable EHR system.

Measure Reporting via Claims:
CPT codes and HCPCS (D- or G-) codes are used to identify patients who are included in the measure's denominator. G-codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed CPT codes, HCPCS codes, and the appropriate numerator G-code. There are no allowable performance exclusions for this measure. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
CPT codes and HCPCS (D-or G-) codes are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure. The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data. There are no allowable performance exclusions for this measure. If no G-code is reported this will count as a performance and reporting failure.

DENOMINATOR:
All patient encounters

Denominator Criteria (Eligible Cases):
Patient encounter during the reporting period (CPT or HCPCS): 90801, 90802, 90804, 90805, 90806, 90807, 90808, 90809, 92002, 92004, 92012, 92014, 92506, 92507, 92526, 92541, 92542, 92543, 92544 92548, 92552, 92553, 92555, 92557, 92561, 92562, 92563, 92564, 92565, 92567, 92568, 92570, 92571, 92572, 92575, 92576, 92577, 92579, 92582, 92584, 92585, 92586, 92587, 92588, 92601, 92602, 92603, 92604, 92610, 92611, 92612, 92620, 92621, 92625, 92626, 92627, 92640, 95920, 96150, 96151, 96152, 97001, 97002, 97003, 97004, 97750, 97802, 97803, 97804, 98940, 98941, 98942, 99201, 99202, 99203,

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99204, 99205, 99211, 99212, 99213, 99214, 99215, D7140, D7210, G0101, G0108, G0109, G0270, G0271

NUMERATOR:
Patient encounter documentation substantiates use of a certified, Physician Quality Reporting System qualified or other acceptable EHR system.

NUMERATOR NOTE: If an eligible professional does not use a qualified system to record the encounter, they should not report any G-code.

Definitions:
Health Information Technology (HIT) – A system that incorporates both computer hardware and software that deals with the storage, retrieval, sharing, and use of health care information, data, and knowledge for communication and decision making.
Authorized Testing and Certification Bodies (ATCB) – Review bodies that have been authorized to test and certify electronic health record (EHR) systems for compliance with the standards and certification criteria that were issued by the U.S. Department of Health and Human Services.
Certified or Qualified Electronic Health Record – A certified or qualified EHR can be any of the following:

- Certified by an ATCB
- Physician Quality Reporting System qualified* for EHR based reporting

Other Acceptable Systems

- Other systems that are not certified or Physician Quality Reporting System qualified as above must meet all of the following criteria:
  - Ability to manage a medication list
  - Ability to manage a problem list
  - Ability to manually enter or electronically receive, store and display laboratory results as discrete searchable data elements
  - Ability to meet basic privacy and security elements

*A list of qualified EHR Vendors for the 2011 Physician Quality Reporting System will be available on the Alternative Reporting Mechanisms section available from the navigation bar on the left side of the CMS Physician Quality Reporting website at http://www.cms.gov/PQRS. Please visit this site periodically for updates and contact your EHR vendor to determine if they are planning to become qualified.

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Encounter Documented Using a Certified, Physician Quality Reporting System Qualified or Other Acceptable EHR System
G8447: Patient encounter was documented using an EHR system that has been certified by an Authorized Testing and Certification Body (ATCB)
OR
G8448: Patient encounter was documented using a Physician Quality Reporting System qualified EHR or other acceptable systems

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RATIONALE:

The widespread use of electronic health records (EHRs) in the United States is inevitable. EHRs will improve caregivers' decisions and patients' outcomes. Once patients experience the benefits of this technology, they will demand nothing less from their providers. Hundreds of thousands of physicians have already seen these benefits in their clinical practice. (Blumenthal et al, 2010)

Health care experts, policymakers, payers, and consumers consider health information technologies, such as electronic health records and computerized provider order entry, to be critical to transforming the health care industry. Information management is fundamental to health care delivery. Given the fragmented nature of health care, the large volume of transactions in the system, the need to integrate new scientific evidence into practice, and other complex information management activities, the limitations of paper-based information management are intuitively apparent.

Health care is growing increasingly complex, and most clinical research focuses on new approaches to diagnosis and treatment. In contrast, relatively little effort has been targeted at the perfection of operational systems, which are partly responsible for the well-documented problems with medical safety. Safe care now requires a degree of individualization that is becoming unimaginable without computerized decision support. Multiple studies now demonstrate that computer-based decision support can improve physicians' performance and, in some instances, patient outcomes. In the past decade, the risk of harm caused by medical care has received increasing scrutiny. The growing sophistication of computers and software should allow information technology to play a vital part in reducing that risk — by streamlining care, catching and correcting errors, assisting with decisions, and providing feedback on performance. Given the large potential risks and benefits as well as the costs involved, this article includes an analysis of what is known about the role and effect of information technology with respect to safety and considers the implications for medical care, research, and policy. (Bates et al, 2003)

The need for clinical information systems to provide high-quality, safe care is a well recognized fact. This need was well publicized by Dr. Ed Wagner in his "Chronic Care Model" as one of the key elements to provide high-quality care. To quote from the Improving Chronic Care Web site, "Effective chronic illness care is virtually impossible without information systems that assure ready access to key data on individual patients as well as populations of patients. A comprehensive clinical information system can enhance the care of individual patients by providing timely reminders about needed services and summarized data to track and plan care. At the practice population level, they identify groups of patients needing additional care, as well as facilitate performance monitoring and quality improvement efforts." To be able to take advantage of many of the more advanced applications of health information technology, the facility must first implement an EMR and use it to document patient encounters.

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Measure #126: Diabetes Mellitus: Diabetic Foot and Ankle Care, Peripheral Neuropathy – Neurological Evaluation

2011 PHYSICIAN QUALITY REPORTING OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of patients aged 18 years and older with a diagnosis of diabetes mellitus who had a neurological examination of their lower extremities within 12 months

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for patients with diabetes mellitus seen during the reporting period. Evaluation of neurological status in patients with diabetes to assign risk category and therefore have appropriate foot and ankle care to prevent ulcerations and infections ultimately reduces the number and severity of amputations that occur. Risk catagorization and follow up treatment plan should be done according to the following table:

Risk Categorization System:

Category	Risk Profile	Evaluation Frequency
0	Normal	Annual
1	Peripheral Neuropathy (LOPS)	Semi-annual
2	Neuropathy, deformity, and/or PAD	Quarterly
3	Previous ulcer or amputation	Monthly to quarterly

This measure may be reported by non-MD/DO clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

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

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

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure. The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

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

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Diagnosis for diabetes (ICD-9-CM): 250.00, 250.01, 250.02, 250.03, 250.10, 250.11, 250.12, 250.13, 250.20, 250.21, 250.22, 250.23, 250.30, 250.31, 250.32, 250.33, 250.40, 250.41, 250.42, 250.43, 250.50, 250.51, 250.52, 250.53, 250.60, 250.61, 250.62, 250.63, 250.70, 250.71, 250.72, 250.73, 250.80, 250.81, 250.82, 250.83, 250.90, 250.91, 250.92, 250.93
AND
Patient encounter during the reporting period (CPT): 11042, 11043, 11044, 11055, 11056, 11057, 11719, 11720, 11721, 11730, 11740, 97001, 97002, 97597, 97598, 97802, 97803, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350

NUMERATOR:
Patients who had a lower extremity neurological exam performed at least once within 12 months

Definition:
Lower Extremity Neurological Exam – Consists of a documented evaluation of motor and sensory abilities and may include: reflexes, vibratory, proprioception, sharp/dull and 5.07 filament detection. The components listed are consistent with the neurological assessment recommended by the Task Force of the Foot Care Interest Group of the American Diabetes Association. They generally recommend at least two of the listed tests be performed when evaluating for loss of protective sensation; however the clinician should perform all necessary tests to make the proper evaluation.

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Lower Extremity Neurological Exam Performed
G8404: Lower extremity neurological exam performed and documented
OR
Lower Extremity Neurological Exam not Performed for Documented Reasons
G8406: Clinician documented that patient was not an eligible candidate for lower extremity neurological exam measure
OR
Lower Extremity Neurological Exam not Performed
G8405: Lower extremity neurological exam not performed

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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)

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♪ Measure #127: Diabetes Mellitus: Diabetic Foot and Ankle Care, Ulcer Prevention – Evaluation of Footwear

2011 PHYSICIAN QUALITY REPORTING OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of patients aged 18 years and older with a diagnosis of diabetes mellitus who were evaluated for proper footwear and sizing

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

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

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

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure. The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

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

> Denominator Criteria (Eligible Cases):
> Patients aged ≥ 18 years on date of encounter
> AND
> Diagnosis for diabetes (ICD-9-CM): 250.00, 250.01, 250.02, 250.03, 250.10, 250.11, 250.12, 250.13, 250.20, 250.21, 250.22, 250.23, 250.30, 250.31, 250.32, 250.33, 250.40, 250.41, 250.42, 250.43, 250.50, 250.51, 250.52, 250.53, 250.60, 250.61, 250.62, 250.63, 250.70, 250.71, 250.72, 250.73, 250.80, 250.81, 250.82, 250.83, 250.90, 250.91, 250.92, 250.93
> AND

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Patient encounter during the reporting period (CPT): 11042, 11043, 11044, 11055, 11056, 11057, 11719, 11720, 11721, 11730, 11740, 97001, 97002, 97597, 97598, 97802, 97803, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350

NUMERATOR:
Patients who were evaluated for proper footwear and sizing at least once within 12 months

Definition:
Evaluation for Proper Footwear – Includes a foot examination documenting the vascular, neurological, dermatological, and structural/biomechanical findings. The foot should be measured using a standard measuring device and counseling on appropriate footwear should be based on risk categorization.

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Footwear Evaluation Performed
G8410: Footwear evaluation performed and documented

OR

Footwear Evaluation not Performed for Documented Reasons
G8416: Clinician documented that patient was not an eligible candidate for footwear evaluation measure

OR

Footwear Evaluation not Performed
G8415: Footwear evaluation was not performed

RATIONALE:
Foot ulceration is the most common single precursor to lower extremity amputations among persons with diabetes. Shoe trauma, in concert with loss of protective sensation and concomitant foot deformity, is the leading event precipitating foot ulceration in persons with diabetes. Treatment of infected foot wounds accounts for up to one-quarter of all inpatient hospital admissions for people with diabetes in the United States. Peripheral sensory neuropathy in the absence of perceived trauma is the primary factor leading to diabetic foot ulcerations. Approximately 45-60% of all diabetic ulcerations are purely neuropathic. In people with diabetes, 22.8% have foot problems – such as amputations and numbness – compared with 10% of nondiabetics. Over the age of 40 years old, 30% of people with diabetes have loss of sensation in their feet.

CLINICAL RECOMMENDATION STATEMENTS:
The multifactorial etiology of diabetic foot ulcers is evidenced by the numerous pathophysiologic pathways that can potentially lead to this disorder. Among these are two common mechanisms by which foot deformity and neuropathy may induce skin breakdown in persons with diabetes. The first mechanism of injury refers to prolonged low pressure over a bony prominence (i.e., bunion or hammertoe deformity). This generally causes wounds over the medial, lateral, and dorsal aspects of the forefoot and is associated with tight or ill-fitting shoes. (ACFAS/ACFAOM Clinical Practice Guidelines)

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

2011 PHYSICIAN QUALITY REPORTING OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

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

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

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for patients seen during the reporting period. The most recent quality code submitted will be used for performance calculation. There is no diagnosis associated with this measure. This measure may be reported by eligible professionals who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding. BMI measured and documented in the medical record may be reported if done in the provider's office/facility or if BMI calculation within the past six months is documented in outside medical records obtained by the provider. For justification of BMI parameters for this measure please refer to the rationale and clinical recommendation statements. The documentation of a follow up plan should be based on the most recently calculated BMI.

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

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

Measure Reporting via Registry:
CPT codes, HCPCS (D- and G-) codes, and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure. The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

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DENOMINATOR:
All patients 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): 90801, 90802, 90804, 90805, 90806, 90807, 90808, 90809, 97001, 97003, 97802, 97803, 98960, 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, D7140, D7210, G0101, G0108, G0270

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

Definitions:
BMI – Body mass index (BMI), expressed as weight/height (BMI; kg/m2), is commonly used to classify overweight (BMI 25.0-29.9), obesity (BMI greater than or equal to 30.0) and extreme obesity (BMI greater than or equal to 40) among adults (CDC). BMI is calculated either as weight in pounds divided by height in inches squared multiplied by 703, or as weight in kilograms divided by height in meters squared. The National Institutes of Health (NIH) provides a BMI calculator table at http://www.nhlbi.nih.gov/guidelines/obesity/bmi_tbl.htm. (AHRQ Preventive Guidelines 2009)
Elderly BMI – Most experts suggest use of a higher BMI threshold for underweight elderly individuals, compared to what is used for the general population (Chernoff, Cook, Mahan). *International Dietetics and Nutrition Terminology* defines underweight in persons >65 years of age as a BMI of <23. This BMI value is one indicator of malnutrition when forming a nutrition diagnosis for the elderly population (American Dietetic Association). A BMI of <23 classifies an older adult (older than age 65) as underweight and may require nutrition intervention.
Calculated BMI – Requires that both the height and weight are actually measured. Values merely reported by the patient cannot be used.
Follow-up Plan – Proposed outline of treatment to be conducted as a result of abnormal BMI measurement. Such follow-up can include documentation of a future appointment, education referral, (such as, a registered dietician, nutritionist, occupational therapy, primary care physician, exercise physiologist, mental health professional, surgeon, etc.) prescription/administration of medications/dietary supplements, etc.
Not Eligible/Not Appropriate for BMI Measurement – Patients can be considered not eligible in the following situations:

- There is documentation in the medical record that the patient is over or under weight and is being managed by another provider
- If the patient has a terminal illness – life expectancy less than 6 months
- If the patient refuses BMI measurement
- If there is any other reason documented in the medical record by the provider explaining why BMI measurement was not appropriate

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- Patient is in an urgent or emergent medical situation where time is of the essence and to delay treatment would jeopardize the patient's health status

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
BMI Calculated, No Follow-up Plan Needed or BMI Calculated, Follow-up Plan Documented
G8420: Calculated BMI within normal parameters and documented
OR
G8417: Calculated BMI above the upper parameter and a follow-up plan was documented in the medical record
OR
G8418: Calculated BMI below the lower parameter and a follow-up plan was documented in the medical record

OR

Patient not Eligible for BMI Calculation for Documented Reasons
G8422: Patient not eligible for BMI calculation

OR

BMI not Performed and/or Calculated BMI Outside of Normal Parameters, Follow-up Plan not Documented, Reason not Specified
G8421: BMI not calculated
OR
G8419: Calculated BMI outside normal parameters, no follow-up plan documented in the medical record

RATIONALE:
In 2009, no U.S. state met the *Healthy People 2010* adult obesity prevalence target of 15 percent, and the number of states with an obesity prevalence ≥30 increased from zero in 2000 to nine in 2009 (CDC, 2010). Further, the report revealed that the overall self-reported obesity prevalence in the United States was 26.7 percent, an increase of 1.1 percentage points from 2007 to 2009 among adults aged 18 years or older (CDC, 2010).

Obesity continues to be a public health concern in the United States and throughout the world (Flegal, et al, 2005; Ogden, et al, 2007)). In the United States, obesity prevalence doubled among adults between 1980 and 2004 (Flegal, et al, 2002; Ogden, et al, 2006). Obesity is associated with increased risk of a number of conditions, including diabetes mellitus, cardiovascular disease, hypertension, and certain cancers, and with increased risk of disability and a modestly elevated risk of all-cause mortality. With obesity on the rise, the medical community anticipates an increase in the complications of obesity, including type 2 diabetes mellitus, hypertension, dyslipidemia, cardiovascular disease, obstructive sleep apnea, degenerative arthritis, non-alcoholic steatohepatitis, gallbladder disease and others.

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Results from the 2005-2006 National Health and Nutrition Examination Survey (NHANES) indicate that an estimated 32.7 percent of U.S. adults 20 years and older are overweight, 34.3 percent are obese and 5.9 percent are extremely obese. Although prevalence of adults in the U.S. who are obese is still high, with about one-third of adults obese in 2007-2008, although new data suggest that the rate of increase for obesity in the U.S. in recent decades may be slowing (Flegal, et al, 2010).

In 2000, obesity was responsible for an estimated 400,000 deaths, compared to 300,000 in 1990 (Flegal, et al, 2005). Obesity places second only to smoking as the leading preventable cause of death in the United States. In addition, obesity is a significant contributor to premature death. In Caucasians ages 20 to30 with a BMI >45 kg/m2, it has been estimated that obesity decreases life expectancy by 13 years in men and 8 years in women (Fontaine, et al, 2003).

Poor nutrition or underlying health conditions can result in underweight. Results from the 2003-2006 National Health and Nutrition Examination Survey (NHANES), using measured heights and weights, indicate that an estimated 1.8% of U.S. adults are underweight. (Source: The National Center for Health Statistics (NCHS) Health E-Stat. Prevalence of Underweight Among Adults: United States, 2003-2006, Accessed September 15, 2010 at http://www.cdc.gov/nchs/data/hestat/underweight/underweight_adults.htm. A tremendous gap still exists between our knowledge of malnutrition and its sequelae and our actions in preventing and treating it. To date professionals in various disciplines have applied their own approaches to solving the problem. Yet the causes of malnutrition are multi-factorial and the solutions demand an integration of knowledge and expertise from the many different disciplines involved in geriatric care. Older people have special nutritional needs due to age and disease processes.

Elderly patients with unintentional weight loss are at higher risk for infection, depression and death. The leading causes of involuntary weight loss are depression (especially in residents of long-term care facilities), cancer (lung and gastrointestinal malignancies), cardiac disorders and benign gastrointestinal diseases. Medications that may cause nausea and vomiting, dysphagia, dysgeusia and anorexia have been implicated. Polypharmacy can cause unintended weight loss, as can psychotropic medication reduction (e.g., by unmasking problems such as anxiety). In one study it was found that a BMI of less than 22 kg per m2 in women and less than 23.5 in men is associated with increased mortality. In another study it was found that the optimal BMI in the elderly is 24 to 29 kg per m2. (Huffman, G. B., Evaluation and Treatment of Unintentional Weight Loss in the Elderly, American Family Physician, 2002 Feb, 4:640-650). Ranhoff, et al (2005), identified through an observational study that using a BMI<23, resulted in a positive screen for malnutrition (sensitivity 0.86, specificity 0.71), giving 0.75 correctly classified subjects. Thus leading to the recommendation that a score of BMI<23 should be followed by MNA-SF when the aim is to identify poor nutritional status in elderly.

In 1998 the medical costs of obesity were estimated to be as high as $78.5 billion, with roughly half financed by Medicare and Medicaid (Finkelstein, et al, 2009). This analysis presents updated estimates of the costs of obesity for the United States across payers (Medicare, Medicaid, and private insurers), in separate categories for inpatient, non-inpatient, and prescription drug spending.

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Finkelstein, et al (2009), found that the increased prevalence of obesity is responsible for almost $40 billion of increased medical spending through 2006, including $7 billion in Medicare prescription drug costs. We estimate that the medical costs of obesity could have risen to $147 billion per year by 2008.

Ma, et al (2009) performed a retrospective, cross-sectional analysis of ambulatory visits in the National Ambulatory Medical Care Survey from 2005 and 2006. The study findings on obesity and office-based quality of care concluded the evidence is compelling that obesity is underappreciated in office-based physician practices across the United States (Ma, et al, 2009). Many opportunities are missed for obesity screening and diagnosis, as well as for the prevention and treatment of obesity and related health risks, regardless of patient and provider characteristics (Ma, et al, 2009).

A Web search of the National Quality Measures Clearinghouse on the key words of BMI, body mass index, produced four measures, all focused on possible follow-up for overweight and obesity for a broader age range and/or related to a specific disease/condition. There were no measures that focused on underweight or a follow-up plan.

CLINICAL RECOMMENDATION STATEMENTS:

Although multiple clinical recommendations addressing Obesity have been developed by professional organizations, societies and associations, two recommendations, which exemplify the intent of the measure and address the numerator and denominator, have been identified.

The US Preventive Health Services Task Force (USPSTF) (2003) recommends that clinicians screen all adult patients for obesity and offer intensive counseling and behavioral interventions to promote sustained weight loss for obese adults (Level Evidence B).

Institute for Clinical Systems Improvement (ICSI) (2009) Prevention and Management of Obesity (Mature Adolescents and Adults) provides the following guidance:

- Calculate the body mass index; classify the individual based on the body mass index categories. Educate patients about their body mass index and their associated risks. *(Annotation #1; Aim #1)*

- Weight management requires a team approach. Be aware of clinical and community resources. The patient needs to have an ongoing therapeutic relationship and follow-up with a health care team. Weight control is a lifelong commitment, and the health care team can assist with setting specific goals with the patient. *(Annotations #10, 13; Aim #4)*

There are no current clinical recommendations addressing Underweight or Unintentional Weight Loss in the elderly population that have been developed by professional organizations, societies or associations.

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♠ Measure #130: Documentation of Current Medications in the Medical Record

2011 PHYSICIAN QUALITY REPORTING OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of patients aged 18 years and older with a list of current medications (includes prescription, over-the-counter, herbals, vitamin/mineral/dietary [nutritional] supplements) documented by the provider, including drug name, dosage, frequency and route

INSTRUCTIONS:
This measure is to be reported at each visit occurring during the reporting period for patients seen during the reporting period. This measure is intended to determine whether or not documentation of a current medication list occurred for all patients aged 18 years and older. 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 codes, G-codes, and patient demographics are used to identify patients who are included in the measure's denominator. G-codes are used to report the numerator of the measure.

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

Measure Reporting via Registry:
CPT codes, G-codes, and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure. The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All patients aged 18 years and older

> Denominator Criteria (Eligible Cases):
> Patients aged ≥ 18 years on date of encounter
> AND
> Patient encounter during the reporting period (CPT or HCPCS): 90801, 90802, 90957, 90958, 90959, 90960, 90962, 90965, 90966, 92002, 92004, 92012, 92014, 92541, 92542, 92543, 92544, 92545, 92547, 92548, 92557, 92567, 92568, 92570, 92585, 92588, 92626, 96116, 96150, 96152, 97001, 97002, 97003, 97004, 97802, 97803, 97804, 98960, 98961, 98962, 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, G0101, G0108, G0270

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NUMERATOR:
Current medications including name, dosages, frequency and route documented by the provider

Definitions:
Current Medications – All medications (includes prescription, over-the-counter, herbals, vitamin/mineral/dietary [nutritional] supplements) a patient may be taking routinely and/or on a PRN basis OR documentation of no medications currently prescribed.
Not Eligible – A patient is not eligible if one or more of the following condition(s) exist:

- Patient refuses to participate
- 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
- Patient cognitively impaired and no authorized representative available

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Current Medications with Name, Dosages, Frequency and Route Documented
G8427: List of current medications (includes prescription, over-the-counter, herbals, vitamin/mineral/dietary [nutritional] supplements) documented by the provider, including drug name, dosage, frequency and route

OR

Current Medications with Dosages not Documented, Patient not Eligible
G8430: Provider documentation that patient is not eligible for medication assessment

OR

Current Medications with Name, Dosages, Frequency, Route not Documented, Reason not Specified
G8428: Current medications (includes prescription, over-the-counter, herbals, vitamin/mineral/dietary [nutritional] supplements) with drug name, dosage, frequency and route not documented by the provider, reason not specified

RATIONALE:
Medication safety efforts have primarily focused on hospitals; however, the majority of health care services are provided in the outpatient setting. 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 (Nassarella, et al, 2007). Since 2002, there has been a sharp increase in the number of ambulatory care visits secondary to adverse drug events. The National Scorecard for U.S. Health System Performance identified increased utilization of ambulatory care services and demonstrates that inadequate medication reconciliation often leads to poor safety.

Adverse drug events prove to be more fatal in outpatient settings (1 of 131 outpatient deaths) than in hospitals (1 of 854 inpatient deaths) (Nassarella, 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 adverse drug events 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 adverse drug events increased from 2.9 million in 1995 to 4.3 million visits in 2001.

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Community-dwelling individuals in the U.S. made ambulatory care visits for the treatment of adverse drug events (VADEs) at a rate of 3.3 to 4.0 per 1,000 visits, or 10.9 to 15.3 per 1,000 population during 1995–2001 (Zhan et al. 2005). Fields, et al (2005) concluded adverse drug events (ADE) in the ambulatory setting substantially increase the healthcare costs of elderly persons and estimated costs associated with adverse drug events among older adults in the ambulatory setting were $1,983 per case. The Commonwealth Fund (2010) identified implications based on previous studies of ADEs in ambulatory care (Gandhi et al. 2003; Gurwitz, et al. 2003) and the assumption can be generalized to the data, 11 percent to 28 percent of the 4.3 million VADEs in 2001 might have been prevented with improved systems of care and better patient education, yielding an estimate of 473,000 to 1.2 million potentially preventable VADEs annually. Further, assuming the average cost of treating a preventable ADE is $1,983 the potential cost-savings that could be achieved by reducing VADEs would be $946 million to $2.4 billion.

In the Institute for Safe Medication Practices White Paper (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.

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 regimen.

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The National Healthcare Disparities Report (2008) identified the rate of adverse drug events (ADE) among Medicare beneficiaries in ambulatory settings 50 per 1,000 person-years. In 2005, the Agency for Healthcare Quality (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.

CLINICAL RECOMMENDATION STATEMENTS:

After a comprehensive and thorough search of Cochrane Library, National Quality Measures Clearing House, and relevant specialty society web sites, it was identified a relevant clinical recommendation, which addresses the intent, numerator and denominator of this measure is not available for reference. However, the following supportive documents from various specialty associations and organization's recognize the importance and need for this process to occur consistently in safe clinical practice.

In 2007, the American Medical Association published The Physician's Role in Medication Reconciliation, which identified the best 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. American Medical Association: The Physician's Role in Medication Reconciliation. Accessed June 1, 2010 http://www.ama-assn.org/ama1/pub/upload/mm/370/med-rec-monograph.pdf

While the role of the physician is important, all health care professionals are responsible for providing accurate information related to medication safety. The American Academy of Audiology issued a Position Statement which supports that audiologists obtain a comprehensive medical and family history as well as a list of all medications the patient is taking that could influence test results.

The American Physical Therapy Association (APTA) House of Delegates adopted a position statement which stated; "*Physical therapist patient/client management integrates an understanding of a patient's/client's prescription and nonprescription medication regimen with consideration of its impact upon health, impairments, functional limitations, and disabilities. The administration and storage of medications used for physical therapy interventions is also a component of patient/client management and thus within the scope of physical therapist practice.*" (American Physical Therapy Association)

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In addition to medication name and dosage, documentation and verification should also include frequency and route to be in alignment with recommendations presented by the Institute for Safe Medication Practices and the Institute for Healthcare Improvement and the Agency for Healthcare Research and Quality. This modification would also align expectations for outpatient documentation and verification with those of the hospital setting to improve continuity of information transfers between settings.

In addition, as part of its efforts to promote patient safety and reduce the growing incidence of medical errors in the office setting, the Institute for Healthcare Improvement created a recommended medication list for patients and their families to carry with them to medical appointments to help providers reconcile medications during medical visits. [Institute for Healthcare Improvement Medication List for Patients and Families and the Massachusetts Coalition for the Prevention of Medical Error (in collaboration with the Massachusetts Medical Society), http://www.ihi.org/IHI/Topics/OfficePractices/Access/Tools]

American Academy of Audiology: Position Statement on the Audiologist's Role in the Diagnosis and Treatment of Vestibular Disorders. Accessed 5/26/2010, http://www.audiology.org/resources/documentlibrary/Pages/VestibularDisorders.aspx?PF=1b
Patients who are seen for vestibular evaluation often present with complicated medical and case histories as well as a complex description of their symptoms. Prior to undertaking the evaluation, it is important for audiologists to obtain a comprehensive medical and family history as well as a list of all medications the patient is taking that could influence test results.

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♠ Measure #131: Pain Assessment Prior to Initiation of Patient Therapy and Follow-Up

2011 PHYSICIAN QUALITY REPORTING OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of patients aged 18 years and older with documentation of a pain assessment (if pain is present, including location, intensity and description) through discussion with the patient including the use of a standardized tool on each qualifying visit prior to initiation of therapy AND documentation of a follow-up plan

INSTRUCTIONS:
This measure is to be reported for each qualifying 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.

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

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

Measure Reporting via Registry:
CPT codes and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure. The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All 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): 90801, 90802, 96116, 96150, 97001, 97003, 98940, 98941, 98942

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NUMERATOR:
Patient's pain assessment prior to initiation of therapy is documented through discussion with the patient including the use of a standardized tool AND a follow-up plan is documented

Definitions:
Qualifying Visit – Meets denominator criteria (age and CPT encounter codes) as listed above.
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 which address location and/or intensity and/or description, 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), Visual Analog Scale (VAS).
Follow-up Plan – Proposed outline of treatment to be conducted as a result of pain assessment. Such follow-up must include a reassessment of pain and may include documentation of a future appointment, education, referral, notification or primary care provider, etc.
Not Eligible – A patient is not eligible if the following condition(s) exist:

Pain Assessment

- Patient refuses to participate
- 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

Follow-Up Plan

- Absence of pain on assessment
- Diagnosis/condition/illness is not situationally related to pain

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Pain Assessment Documented AND Follow-Up Plan Documented
G8440: Documentation of pain assessment (including location, intensity and description) prior to initiation of therapy or documentation of the absence of pain as a result of assessment through discussion with the patient including the use of a standardized tool AND a follow-up plan is documented

OR

Pain Assessment not Documented, Patient not Eligible
G8442: Documentation that patient is not eligible for a pain assessment

OR

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Pain Assessment Documented, Follow-up Plan not Documented, Patient not Eligible
G8508: Documentation of pain assessment (including location, intensity and description) prior to initiation of therapy or documentation of the absence of pain as a result of assessment through discussion with the patient including the use of a standardized tool; no documentation of a follow-up plan, patient not eligible

OR

Pain Assessment not Documented, Reason not Specified
G8441: No documentation of pain assessment (including location, intensity and description) prior to initiation of therapy

OR

Pain Assessment Documented, Follow-up Plan not Documented, Reason not Specified
G8509: Documentation of pain assessment (including location, intensity and description) prior to initiation of therapy or documentation of the absence of pain as a result of assessment through discussion with the patient including the use of a standardized tool; no documentation of a follow-up plan, reason not specified

RATIONALE:
Several provisions from the National Pain Care Policy Act (H.R. 756/S. 660) have been included in the Health Care Reform Bill to Improve Pain Care, which was signed into law by President Barack Obama, on March 5, 2010. The provisions from the National Pain Care Policy Act 2009 (H.R. 756/S660) incorporated into the Health Care Reform Bill includes:

- Mandating an Institute of Medicine 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; and,
- Enhancing the pain research agenda for the National Institute of Health (NIH).

The American Pain Associations (2009) identified pertinent facts related to the impact of pain as follows:

- 76.5 million Americans suffering 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.

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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 (more than 40% during the past decade) (President's Council of Economic Advisors, 2009), the NIH statistics (1998) ($100 billion annually in health care utilization and lost productivity for those in the workforce, and $86 billion annually for just one diagnosis, Martin, et al, 2008) make it likely that the total U.S. spending on pain is at least comparable to the costs associated with other chronic illnesses. The annual costs associated with pain are probably at least as high as the estimated annual cost of $174 billion that is attributed to diabetes (The Mayday Fund, 2009). More needs to be known about the economic impact of chronic pain. But even in the absence of adequate data, it is clear the enormous pain-related costs represent both a great challenge and an opportunity in terms of improving the quality and cost-effectiveness of care (The Mayday Fund, 2009).

The prevalence of pain has a tremendous impact on business, with an estimated annual cost of $61.2 billion in lost productive time. Studies show that most of the pain-related lost productive time occurs while employees are at work and is in the form of reduced performance. The cost of pain is an enormous burden on today's society, particularly to employers (American Academy of Pain Medicine, 2010). Stewart et al (2003) identified almost thirteen percent of the total workforce experienced a loss in productive time during a two-week period due to a common pain condition: 5.4% for headache; 3.2% for back pain; 2.0% for arthritis pain; 2.0% for other musculoskeletal pain.

Green (2003) identified pain to be widely recognized as an undertreated health problem in the general population. Failure to assess pain is a critical factor leading to undertreatment. In September 2008, the World Health Organization (WHO) estimated that approximately 80 percent of the world population has either no or insufficient access to treatment for moderate to severe pain.

Chronic pain—commonly defined as pain persisting longer than six months—affects an estimated 70 million Americans and is a tragically overlooked public health problem (USDHHS, 2006). Significant gaps exist in the provision of effective quality pain care (Green, 2003; Green, 2006; Freeman, et al, 2000). Findings of the Mayday Fund Pain Committee (2009) identified chronic pain treatment needs major reforms to enhance assessment, increase access to the right care, improve quality and equitable care, and cut costs. Initiatives to address the huge public health problem of unrelieved chronic pain should be part of any discussion on reforming the health care system to enhance access and reduce costs.

While national attention has become increasingly focused on health disparities, less attention has been given specifically to inequities in pain care (APS, 2002; IOM, 2002). Bonham (2001) identified the reasons for deficiencies in pain management included cultural, societal, religious, and political attitudes, including acceptance of torture. There are clear variations in the way pain is assessed and managed among all minority populations (Green, 2003; Green, 2006; Freeman, et al, 2000). Significant gaps exist in the provision of effective quality pain care due to the lack of research and medical training focused on pain care disparities (Green, 2003; Green, 2006; Freeman, et al, 2000).

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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).

A growing body of research reveals even more extensive gaps in pain assessment and treatment among racial and ethnic populations, with minorities receiving less care for pain than non-Hispanic whites (Green, 2003; Green, 2006; Todd, et all, 2004; Todd, et al 2007). Differences in pain care occur across all types of pain (e.g., acute, chronic, cancer-related) and medical settings (e.g., emergency departments and primary care) (Green, 2003; Green, 2006; 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, 2006; Paulson, et al, 2007).

CLINICAL RECOMMENDATION STATEMENTS:

The Institute for Clinical Systems Improvement chronic pain guidelines was chosen because they address the key factors of the plan of care, pain assessment, and outcomes, are based on a very broad foundation of evidence, and addresses a wide range of clinical conditions.

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. *(Annotations #2, 3, 12; Aim #2)*

A patient-centered, multifactorial, comprehensive care plan is necessary, one that includes addressing biopsychosocial factors. Addressing spiritual and cultural issues is also important. It is important to have a multidisciplinary team approach coordinated by the primary care physician to lead a team including specialty areas of psychology and physical rehabilitation. *(Annotation #14; Aim #3)*

SORT Strength A: Consistent, good-quality patient-oriented evidence on benefits of pain assessment prior to therapy.

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♠ Measure #134: Screening for Clinical Depression and Follow-Up Plan

2011 PHYSICIAN QUALITY REPORTING OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of patients aged 18 years and older screened for clinical depression using a standardized tool AND follow-up plan documented

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.

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

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

Measure Reporting via Registry:
CPT codes and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure. The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All 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): 90801, 90802, 90804, 90805, 90806, 90807, 90808, 90809, 92557, 92567, 92568, 92590, 92625, 92626, 96150, 96151, 97003

NUMERATOR:
Patient's screening for clinical depression using a standardized tool AND follow-up plan is documented

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Definitions:

Screening – Testing done on people at risk of developing a certain disease, even if they have no symptoms. Screening tests can predict the likelihood of someone having or developing a particular disease. This measure looks for the test being done in the practitioner's office that is filing the code.

Standardized Tool – An assessment tool that has been appropriately normalized and validated for the population in which it is used. Some depression screening tools include: Patient Health Questionnaire (PHQ9), 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), GDS – Short Version, Hopkins Symptom Checklist (HSCL), The Zung Self-Rating Depression Scale (SDS), and Cornell Scale Screening (this is a screening tool which is used in situations where the patient has cognitive impairment and is administered through the caregiver).

Follow-Up Plan – Proposed outline of treatment to be conducted as a result of clinical depression screen. Such follow-up must include further evaluation if screen is positive and may include documentation of a future appointment, education, additional evaluation and/or referral to a practitioner who is qualified to diagnose and treat depression, and/or notification of primary care provider.

Not Eligible/Not Appropriate – A patient is not eligible if one or more of the following conditions exist:

- Patient refuses to participate
- Patient is in an urgent or emergent situation where time is of the essence and to delay treatment would jeopardize the patient's health status
- Situations where the patient's motivation to improve may impact the accuracy of results of nationally recognized standardized depression assessment tools. For example: certain court appointed cases
- Patient was referred with a diagnosis of depression
- Patient has been participating in on-going treatment with screening of clinical depression in a preceding reporting period
- Severe mental and/or physical incapacity where the person is unable to express himself/herself in a manner understood by others. For example: cases such as delirium or severe cognitive impairment, where depression cannot be accurately assessed through use of nationally recognized standardized depression assessment tools

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Positive Screen for Clinical Depression, Follow-up Plan Documented

G8431: Positive screen for clinical depression using a standardized tool and a follow-up plan documented

OR

Negative Screen for Clinical Depression Documented, Follow-up Plan not Indicated

G8510: Negative screen for clinical depression using standardized tool, patient not eligible/appropriate for follow-up plan documented

OR

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Screening for Clinical Depression not Documented, Patient not Eligible/Appropriate
G8433: Screening for clinical depression using a standardized tool not documented, patient not eligible/appropriate

OR

Screening for Clinical Depression not Documented, Reason not Specified
G8432: No documentation of clinical depression screening using a standardized tool
OR
Screening for Clinical Depression Documented, Follow-Up Plan not Documented, Reason not Specified
G8511: Screen for clinical depression using a standardized tool documented, follow-up plan not documented, reason not specified

RATIONALE:
The World Health Organization identified major depression as the fourth leading cause of worldwide disease in 1990, causing more disability than either ischemic heart disease or cerebrovascular disease. In primary care settings, the point prevalence of major depression ranges from 5 to 9 percent among adults, and up to 50 percent of depressed patients are not recognized. Depressive disorders are also relatively common in younger persons, with estimated prevalence of 0.8 to 2.0 percent in children and 4.5 percent in adolescents.

U.S. Preventive Services Task Force compared the effects of integrated recognition and management depression screening programs with "usual care" in community primary care practices. Results showed significantly improved patient outcomes.

The National Center for Policy Analysis and the U.S. Surgeons General, among others, estimate the direct and indirect costs of depression to American businesses ranging from $36.2 billion to $80 billion annually.

Major depression is " ranked second only to ischemic heart disease in magnitude of disease burden in established market economies" and "is the leading cause of *disability* (measured by the number of years *lived* with a disabling condition) worldwide among persons age 5 and older." Murray CJL, Lopez AD, eds. The Global Burden Of Disease And Injury Series, Volume 1: A Comprehensive Assessment Of Mortality And Disability From Diseases, Injuries, And Risk Factors In 1990 And Projected To 2020. Cambridge, MA: Published by the Harvard School of Public Health on behalf of the World Health Organization and the World Bank, Harvard University Press, 1996.

Despite the high prevalence and substantial impact of depression, detection and treatment in the primary care setting have been suboptimal. Studies have shown that usual care by primary care physicians fails to recognize 30% to 50% of depressed patients. Because patients in whom depression goes unrecognized cannot be appropriately treated, systematic screening has been advocated as a means of improving detection, treatment, and outcomes of depression.

Compared with usual care, screening for depression can improve outcomes, particularly when screening is coupled with system changes that help ensure adequate treatment and follow-up.

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A search of the literature in PubMed concerning social workers and depression screening showed nothing to indicate that these practitioners are routinely screening their patients for depression.

A search of the National Quality Measures Clearinghouse database found no depression screening measures that address Medicare eligible patients and there was only one measure from the Physician Consortium for Performance Improvement addressing screening for patients aged 18 years and older with suspected major depressive disorder.

CLINICAL RECOMMENDATION STATEMENTS:

USPSTF recommends screening adults for depression in clinical practices that have systems in place to assure accurate diagnosis, effective treatment, and follow-up. Small benefits have been observed in studies that simply feed back screening results to clinicians. Larger benefits have been observed in studies in which the communication of screening results is coordinated with effective follow-up and treatment. (Evidence: B)

The Canadian Task Force on Preventive Health Care used the rigorous USPSTF 2002 systematic review to update their recommendations regarding depression screening. The Canadian task force arrived at the same practice recommendations as USPSTF.

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▲ Measure #135: Chronic Kidney Disease (CKD): Influenza Immunization

2011 PHYSICIAN QUALITY REPORTING OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of patients aged 18 years and older with a diagnosis of advanced CKD (stage 4 or 5, not receiving Renal Replacement Therapy [RRT]) who were seen for a visit between October 1 and February 28 who received the influenza immunization during the visit OR patient reported previous receipt of an influenza immunization

INSTRUCTIONS:
This measure is to be reported a minimum of once for visits occurring between January 1, 2011 and February 28, 2011 for the 2010-2011 influenza season AND a minimum of once for visits occurring between October 1, 2011 and December 31, 2011 for the 2011-2012 influenza season for CKD patients seen during the reporting period. This measure is intended to determine whether or not CKD patients received an influenza immunization during the flu season. It is anticipated that clinicians providing care for patients with CKD will submit this measure.

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

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

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure. The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All patients aged 18 years and older with the diagnosis of advanced CKD (stage 4 or 5, not receiving RRT) seen for a visit between October 1 and February 28

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Diagnosis for stage 4 or 5 CKD (ICD-9-CM): 585.4, 585.5
AND

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

NUMERATOR:
Patients who received an influenza immunization during the visit OR patient reported previous receipt of influenza immunization

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

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Influenza Immunization Administered or Previously Received
G8639: Influenza immunization was administered or previously received

OR

Influenza Immunization not Administered or Previously Received for Documented Reasons
G8640: Clinician has documented that patient is not eligible to receive the influenza immunization (e.g., patient allergy, patient declined, vaccine not available)

OR

Influenza Immunization not Administered or Previously Received, Reason not Specified
G8641: Influenza immunization was not administered or previously received, reason not otherwise specified

RATIONALE:
USRDS data shows that Medicare patients with CKD are more likely to receive a flu vaccine versus employer group health plan patients with CKD (0.43 versus 0.08 respectively). Additionally, it is estimated that fewer than 20% of all patients in high risk groups receive a flu vaccine each year. Patients with CKD need to be vaccinated yearly in order to decrease morbidity and mortality related to influenza and its complications.

CLINICAL RECOMMENDATION STATEMENTS:
Vaccination with TIV (trivalent inactivated flu vaccine) is recommended for the following persons who are at increased risk for severe complications from influenza, or at higher risk for influenza-associated clinic, emergency department, or hospital visits: adults and children who have chronic pulmonary (including asthma), cardiovascular (except hypertension), renal, hepatic, hematological, or metabolic disorders (including diabetes mellitus). (CDC, 2007)

In any given year, the optimal time to vaccinate patients cannot be determined because influenza seasons vary in their timing, and more than one outbreak might occur in a single community in a single year. (CDC, 2007)

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In general, health-care providers should begin offering vaccination soon after vaccine becomes available and if possible, by October. (CDC, 2007)

Vaccine efforts should continue throughout the season, because the duration of the influenza season varies, and influenza might not occur in certain communities until February or March. The majority of adults have antibody protection against influenza within 2 weeks after vaccination. (CDC, 2007)

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*Measure #137: Melanoma: Continuity of Care – Recall System

2011 PHYSICIAN QUALITY REPORTING OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Percentage of patients, regardless of age, with a current diagnosis of melanoma or a history of melanoma whose information was entered, at least once within a 12 month period, into a recall system that includes:

- A target date for the next complete physical skin exam, AND
- A process to follow up with patients who either did not make an appointment within the specified timeframe or who missed a scheduled appointment

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for melanoma patients seen during the reporting period. It is anticipated that clinicians providing care for patients with melanoma or a history of melanoma will submit this measure.

Measure Reporting via Registry:
ICD-9-CM diagnosis codes and CPT codes are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure. The quality-data codes have been provided for registry only measures for use by registries that utilize claims data. It is not necessary to submit these codes for registry-based submissions. Do not report this measure via claims.

DENOMINATOR:
All patients, regardless of age, with a current diagnosis of melanoma or a history of melanoma

Denominator Criteria (Eligible Cases):
Diagnosis for melanoma or history of melanoma (ICD-9-CM): 172.0, 172.1, 172.2, 172.3, 172.4, 172.5, 172.6, 172.7, 172.8, 172.9, V10.82
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 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

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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), dates(s) of initial cancer diagnosis (if known), and the target date for the next complete physical exam.

Numerator Options:

Patient information entered into a recall system that includes target date for the next exam specified AND a process to follow up with patients regarding missed or unscheduled appointments (7010F)

OR

Documentation of system reason(s) for not entering patient's information into a recall system (e.g., melanoma being monitored by another physician provider) (7010F *with* 3P)

OR

Recall system not utilized, reason not otherwise specified (7010F *with* 8P)

RATIONALE:

Lack of follow-up with providers noted in the Institute of Medicine (IOM) report on patient errors. Follow-up for skin examination and surveillance is an important aspect in the management of patients with a current diagnosis or a history of melanoma. The presence of a recall system, whether it is electronic or paper based, enables providers to ensure that patients receive follow-up appointments in accordance with their individual needs.

CLINICAL RECOMMENDATION STATEMENTS:

Skin examination and surveillance at least once a year for life is recommended for all melanoma patients, including those with stage 0 in situ-melanoma. Frequency of dermatologic surveillance should be determined individually, based on risk factors, including skin type, family history, presence of dysplastic nevi, and history of non-melanoma skin cancers. Clinicians should also consider educating patients about monthly self-exam of their skin and lymph nodes. (NCCN)

For patients with stage IA melanoma, a comprehensive H&P (with specific emphasis on the regional nodes and skin) should be performed every 3 to 12 months as clinically indicated. For patients with stage IB-III melanomas, a comprehensive H&P (with emphasis on the regional nodes and skin) should be performed every 3 to 6 months for 3 years; then every 4 to 12 months for 2 years; and annually (at least) thereafter, as clinically indicated. (NCCN) (Level of Evidence - Category 2A)

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).

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- 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)

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*Measure #138: Melanoma: Coordination of Care

2011 PHYSICIAN QUALITY REPORTING OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Percentage of patient visits, regardless of patient age, with a new occurrence of melanoma who have a treatment plan documented in the chart that was communicated to the physician(s) providing continuing care within one month of diagnosis

INSTRUCTIONS:
This measure is to be reported at each visit occurring during the reporting period for melanoma patients seen during the reporting period. It is anticipated that clinicians providing care for patients with melanoma will submit this measure.

Measure Reporting via Registry:
ICD-9-CM diagnosis codes and CPT codes are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure. The quality-data codes have been provided for registry only measures for use by registries that utilize claims data. It is not necessary to submit these codes for registry-based submissions. Do not report this measure via claims.

DENOMINATOR:
All visits for patients, regardless of age, diagnosed with a new occurrence of melanoma

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

Option 1 - Denominator Criteria (eligible Cases):
Diagnosis for melanoma (ICD-9-CM): 172.0, 172.1, 172.2, 172.3, 172.4, 172.5, 172.6, 172.7, 172.8, 172.9
AND
CPT codes for excision of malignant melanoma: 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, 14302, 17311, 17313

OR

Option 2 - Denominator Criteria (Eligible Cases):
Diagnosis for melanoma (ICD-9-CM): 172.0, 172.1, 172.2, 172.3, 172.4, 172.5, 172.6, 172.7, 172.8, 172.9
AND
Patient encounter during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215

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NUMERATOR:
Patient visits with a treatment plan documented in the chart that was communicated to the physician(s) providing continuing care within one month of diagnosis

Numerator Instructions: A treatment plan should include the following elements: diagnosis, tumor thickness, and plan for surgery or alternate care.

Definition:
Communication – may include documentation in the medical record that the physician(s) treating the melanoma communicated (e.g., verbally, by letter, copy of treatment plan sent) with the physician(s) providing the continuing care OR a copy of a letter in the medical record outlying whether the patient was or should be treated for melanoma.

Numerator Options:
Treatment plan communicated to provider(s) managing continuing care within one month of diagnosis (5050F)

OR

Documentation of patient reason(s) for not communicating treatment plan (e.g., patient asks that treatment plan not be communicated to the physician(s) providing continuing care) (5050F *with* 2P)
OR
Documentation of system reason(s) for not communicating treatment plan (e.g., patient does not have a primary care physician or referring physician) (5050F *with* 3P)

OR

Treatment plan not communicated, reason not otherwise specified (5050F *with* 8P)

RATIONALE:
Perceived lack of follow-up with primary care providers which is reinforced in the Institute of Medicine (IOM) report on patient errors. The intention of this measure is to enable the primary care provider to support, facilitate, and coordinate the care of the patient.

CLINICAL RECOMMENDATION STATEMENTS:
Each local skin cancer multi-disciplinary team (LSMDT) and specialist skin cancer multi-disciplinary team (SSMDT) should have at least one skin cancer clinical nurse specialist (CNS) who will play a leading role in supporting patients and caregivers. There should be equity of access to information and support regardless of where the care is delivered. A checklist may be used by healthcare professionals to remind them to give patients and caregivers the information they need in an appropriate format for pre-diagnosis, diagnosis, treatment, follow-up, and palliative care. This may also include a copy of the letter confirming the diagnosis and treatment plan sent by the consultant to the general practitioner (GP).

- Provide a rapid referral service for patients who require specialist management through the LSMDT/SSMDT.
- Be responsible for the provision of information, advice, and support for patients managed in primary care and their care givers.

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- 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)

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*Measure #140: Age-Related Macular Degeneration (AMD): Counseling on Antioxidant Supplement

2011 PHYSICIAN QUALITY REPORTING OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of patients aged 50 years and older with a diagnosis of AMD and/or their caregiver(s) who were counseled within 12 months on the benefits and/or risks of the Age-Related Eye Disease Study (AREDS) formulation for preventing progression of AMD

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for AMD patients seen during the reporting period. It is anticipated that clinicians who provide the primary management of patients with AMD will submit this measure.

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

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

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure. The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data. There are no allowable performance exclusions for this measure.

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

Denominator Criteria (Eligible Cases):
Patients aged ≥ 50 years on date of encounter
AND
Diagnosis for AMD (ICD-9-CM): 362.50, 362.51, 362.52
AND

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

NUMERATOR:
Patients and/or their caregiver(s) who were counseled within 12 months on the benefits and/or risks of the AREDS formulation for preventing progression of AMD

Definition:
Counseling – Documentation in the medical record should include a discussion of risk or benefits of the AREDS formulation. Counseling can be discussed with all patients with AMD, even those who do not meet the criteria for the AREDS formulation, patients who are smokers (beta-carotene can increase the risk for cancer in these patients) or other reasons why the patient would not meet criteria for AREDS formulation as outlined in the AREDS. The ophthalmologist or optometrist can explain why these supplements are not appropriate for their particular situation. Also, given the purported risks associated with antioxidant use, patients would be informed of the risks and benefits and make their choice based on valuation of vision loss vs. other risks. As such, the measure seeks to educate patients about overuse as well as appropriate use.

NUMERATOR NOTE: If patient is already receiving AREDS formulation, the assumption is that counseling about AREDS has already been performed

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
AREDS Counseling Performed
CPT II 4177F: Counseling about the benefits and/or risks of the Age-Related Eye Disease Study (AREDS) formulation for preventing progression of age-related macular degeneration (AMD) provided to patient and/or caregiver(s)

OR

AREDS Counseling not Performed, Reason not Specified
Append a reporting modifier (8P) to CPT Category II code 4177F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.
4177F *with* 8P: AREDS counseling not performed, reason not otherwise specified

RATIONALE:
1. Scientific basis for counseling regarding use of AREDS formulation for patients with AMD

Antioxidant vitamins and mineral supplements help to reduce the rate of progression to advanced AMD for those patients with intermediate or advanced AMD in one eye. From the same AREDS study, there is no evidence that the use of antioxidant vitamin and mineral supplements for patients with mild AMD alters the natural history of mild AMD.

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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. (Level A:I Recommendation) (AAO)

TABLE 1
Antioxidant Vitamin and Mineral Supplements Used in the AREDS

Supplement	Daily Dose (See note below)
Vitamin C	500 mg
Vitamin E	400 IU
Beta-carotene	15 mg (25,000 IU)
Zinc oxide	80 mg
Cupric oxide	2 mg

Note: These doses are not those listed on the commercially available vitamin/mineral supplements because of a change in labeling rules by the U.S. Food and Drug Administration that specifies that the doses must reflect the amounts available at the end of the shelf life.

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*Measure #141: Primary Open-Angle Glaucoma (POAG): Reduction of Intraocular Pressure (IOP) by 15% OR Documentation of a Plan of Care

2011 PHYSICIAN QUALITY REPORTING OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of patients aged 18 years and older with a diagnosis of 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 Claims:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. CPT Category II codes are used to report the numerator of the measure.

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

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure. The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data. There are no allowable performance exclusions for this measure.

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

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Diagnosis for POAG (ICD-9-CM): 365.10, 365.11, 365.12, 365.15
AND

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

NUMERATOR:
Patients whose glaucoma treatment has not failed (the most recent IOP was reduced by at least 15% from the pre-intervention level) OR if the most recent IOP was not reduced by at least 15% from the pre-intervention level a plan of care was documented within 12 months

Definitions:
Plan of Care – May include: recheck of IOP at specified time, change in therapy, perform additional diagnostic evaluations, monitoring per patient decisions or health system reasons, and/or referral to a specialist
Plan to Recheck – In the event certain factors do not allow for the IOP to be measured (e.g., patient has an eye infection) but the physician has a plan to measure the IOP at the next visit, the plan of care code should be reported.
Glaucoma Treatment Not Failed – The most recent IOP was reduced by at least 15% in the affected eye or if both eyes were affected, the reduction of at least 15% occurred in both eyes.

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

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Intraocular Pressure (IOP) Reduced Greater than or Equal to 15% Pre-intervention Level
(One CPT II code [3284F] is required on the claim form to submit this numerator option)
CPT II 3284F: Intraocular pressure (IOP) reduced by a value of greater than or equal to 15% from the pre-intervention level

OR

Intraocular Pressure (IOP) Reduced Less than 15% Pre-intervention Level with Plan of Care
(Two CPT II codes [0517F & 3285F] are required on the claim form to submit this numerator option)
CPT II 0517F: Glaucoma plan of care documented
AND
CPT II 3285F: Intraocular pressure (IOP) reduced by a value less than 15% from the pre-intervention level

OR

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Glaucoma Plan of Care not Documented, Reason not Specified
(Two CPT II codes [0517F-8P & 3285F] are required on the claim form to submit this numerator option)
Append a reporting modifier (8P) to CPT Category II code 0517F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.
0517F ***with*** 8P: Glaucoma plan of care not documented, reason not otherwise specified
AND
CPT II 3285F: Intraocular pressure (IOP) reduced by a value less than 15% from the pre-intervention level

OR

Intraocular Pressure (IOP) Measurement not Documented, Reason not Specified
(One CPT II code [3284F-8P] is required on the claim form to submit this numerator option)
Append a reporting modifier (8P) to CPT Category II code 3284F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.
3284F ***with*** 8P: IOP measurement not documented, reason not otherwise specified

RATIONALE:
1. Scientific basis for intraocular pressure (IOP) control as outcomes measure (intermediate)

Analyses of results of several randomized clinical trials all demonstrate that reduction of IOP of at least 18% (EMGT, CIGTS, AGIS, CNTGS) reduces the rate of worsening of visual fields by at least 40%. The various studies, however, achieved different levels of mean IOP lowering in realizing their benefit in patient outcomes, ranging from 18% in the "normal pressure" subpopulation of EMGT to 42% in the CIGTS study. (Level I studies) As such, an appropriate "failure" indicator is to NOT achieve at least a 15% IOP reduction. The rationales for a failure indicator are that 1) the results of different studies can lead experienced clinicians to believe that different levels of IOP reduction are appropriate; 2) to minimize the impact of adverse selection for those patients whose IOPs are more difficult to control; and 3) because each patient's clinical course may require IOP reduction that may vary from 18 to 40+%.

In addition, "…[s]several population based studies have demonstrated that the prevalence of POAG as well as the incidence of POAG, increases as the level of IOP increases. These studies provide strong evidence that IOP plays an important role in the neuropathy of POAG. Furthermore, studies have demonstrated that reduction in the level of IOP lessens the risk of visual field progression in open-angle glaucoma. In addition, treated eyes that have a greater IOP fluctuation are at increased risk of progression.

Intraocular pressure is the intermediate outcome of therapy used by the FDA for approval of new drugs and devices and, as noted above, has been shown to be directly related to ultimate patient outcomes of vision loss. As such, failure to achieve minimal pressure lowering, absent an appropriate plan of care to address the situation, would constitute performance whose improvement would directly benefit patients with POAG.

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2. Evidence for gap in care

Based on studies in the literature reviewing documentation of IOP achieved under care, the gap could be as great as 50% or more in the community of ophthalmologists and optometrists treating patients with primary open-angle glaucoma. Based on loose criteria for control, IOP was controlled in 66% of follow-up visits for patients with mild glaucoma and 52% of visits for patients with moderate to severe glaucoma. Another study of a single comprehensive insurance plan suggested that a large proportion of individuals felt to require treatment for glaucoma or suspect glaucoma are falling out of care and are being monitored at rates lower than expected from recommendations of published guidelines.

CLINICAL RECOMMENDATION STATEMENTS:

The initial target pressure selected should be at least 20% lower than the pretreatment IOP, depending upon the clinical findings. Further reduction of the target IOP is often also justified by the severity of existing optic nerve damage, the level of the measured pretreatment IOP, the rapidity with which the damage occurred, and other risk factors. In general, the more advanced the damage, the lower the initial pressure should be (Level A: III Recommendation).

Please note that the American Optometric Association's (AOA) 2002 guideline on Open-angle Glaucoma was not reviewed during the development of this measure prior to the public comment period and therefore is not presented here verbatim. Review of the AOA guideline subsequent to initial measure development indicates that the recommendations in the AOA guideline are consistent with the intent of the measure. As such, the intent of this measure is to have this indicator apply to both optometrists and ophthalmologists (and any other physician who provides glaucoma care); the use of "ophthalmologists" only in the preceding verbatim section reflects the wording in the American Academy of Ophthalmology Preferred Practice pattern.

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▲ Measure #142: Osteoarthritis (OA): Assessment for Use of Anti-Inflammatory or Analgesic Over-the-Counter (OTC) Medications

2011 PHYSICIAN QUALITY REPORTING OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of patient visits for patients aged 21 years and older with a diagnosis of OA with an assessment for use of anti-inflammatory or analgesic OTC medications

INSTRUCTIONS:
This measure is to be reported at each visit occurring during the reporting period for OA patients seen during the reporting period. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

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

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

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure. The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data. There are no allowable performance exclusions for this measure.

DENOMINATOR:
All patient visits for patients aged 21 years and older with a diagnosis of OA

Denominator Criteria (Eligible Cases):
Patients aged ≥ 21 years on date of encounter
AND

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Diagnosis for OA (ICD-9-CM): 715.00, 715.04, 715.09, 715.10, 715.11, 715.12, 715.13, 715.14, 715.15, 715.16, 715.17, 715.18, 715.20, 715.21, 715.22, 715.23, 715.24, 715.25, 715.26, 715.27, 715.28, 715.30, 715.31, 715.32, 715.33, 715.34, 715.35, 715.36, 715.37, 715.38, 715.80, 715.89, 715.90, 715.91, 715.92, 715.93, 715.94, 715.95, 715.96, 715.97, 715.98

AND

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

NUMERATOR:

Patient visits with assessment for use of anti-inflammatory or analgesic OTC medications documented

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Assessment for Anti-inflammatory or Analgesic OTC Medications Performed

CPT II 1007F: Use of anti-inflammatory or analgesic over-the-counter (OTC) medications for symptom relief assessed

OR

Assessment for Anti-inflammatory or Analgesic OTC Medications not Performed, Reason not Specified

Append a reporting modifier (8P) to CPT Category II code 1007F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

1007F *with* 8P: Use of anti-inflammatory or analgesic OTC medications not assessed, reason not otherwise specified

RATIONALE:

Management of pain in patients with osteoarthritis is an important aspect of care. Patients who are able to have their pain controlled are more likely to be able to function at their desired level, which leads to improved quality of life.

CLINICAL RECOMMENDATION STATEMENTS:

Initial treatment should include activity modification and trial of analgesic or non-steroidal anti-inflammatory medication (NSAID). (AAOS; A Recommendation)

Acetaminophen has been shown to be as effective a pain reliever as NSAIDs in patients with OA of the knee. (AAOS, A Recommendation)

Analgesic and anti-inflammatory medications are important in arthritis pain management, but should be used concurrently with nutritional, physical, educational, and cognitive-behavioral interventions. (APS; A Recommendation)

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▲ Measure #143: Oncology: Medical and Radiation – Pain Intensity Quantified

2011 PHYSICIAN QUALITY REPORTING OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

This is a two-part measure which is paired with Measure #144: Oncology: Medical and Radiation: Plan of Care for Pain. If pain is present, Measure #144 *should* also be reported.

DESCRIPTION:
Percentage of patient visits, regardless of patient age, with a diagnosis of cancer currently receiving chemotherapy or radiation therapy in which pain intensity is quantified

INSTRUCTIONS:
This measure is to be reported at each visit occurring during the reporting period for patients with a diagnosis of cancer who are seen during the reporting period. It is anticipated that clinicians providing care for patients with cancer will submit this measure.

Measure Reporting via Registry:
ICD-9-CM diagnosis codes and CPT codes are used to identify patients who are included in the measure's denominator. There are no allowable performance exclusions for this measure. The listed numerator options are used to report the numerator of the measure. The quality-data codes have been provided for registry only measures for use by registries that utilize claims data. It is not necessary to submit these codes for registry-based submissions. There are no allowable performance exclusions for this measure. Do not report this measure via claims.

DENOMINATOR:
All patient visits, regardless of patient age, with a diagnosis of cancer currently receiving chemotherapy or radiation therapy

Denominator Criteria (Eligible Cases):
Diagnosis for cancer (ICD-9-CM): 140.0, 140.1, 140.3, 140.4, 140.5, 140.6, 140.8, 140.9, 141.0, 141.1, 141.2, 141.3, 141.4, 141.5, 141.6, 141.8, 141.9, 142.0, 142.1, 142.2, 142.8, 142.9, 143.0, 143.1, 143.8, 143.9, 144.0, 144.1, 144.8, 144.9, 145.0, 145.1, 145.2, 145.3, 145.4, 145.5, 145.6, 145.8, 145.9, 146.0, 146.1, 146.2, 146.3, 146.4, 146.5, 146.6, 146.7, 146.8, 146.9, 147.0, 147.1, 147.2, 147.3, 147.8, 147.9, 148.0, 148.1, 148.2, 148.3, 148.8, 148.9, 149.0, 149.1, 149.8, 149.9, 150.0, 150.1, 150.2, 150.3, 150.4, 150.5, 150.8, 150.9, 151.0, 151.1, 151.2, 151.3, 151.4, 151.5, 151.6, 151.8, 151.9, 152.0, 152.1, 152.2, 152.3, 152.8, 152.9, 153.0, 153.1, 153.2, 153.3, 153.4, 153.5, 153.6, 153.7, 153.8, 153.9, 154.0, 154.1, 154.2, 154.3, 154.8, 155.0, 155.1, 155.2, 156.0, 156.1, 156.2, 156.8, 156.9, 157.0, 157.1, 157.2, 157.3, 157.4, 157.8, 157.9, 158.0, 158.8, 158.9, 159.0, 159.1, 159.8, 159.9, 160.0, 160.1, 160.2, 160.3, 160.4, 160.5, 160.8, 160.9, 161.0, 161.1, 161.2, 161.3, 161.8, 161.9, 162.0, 162.2, 162.3, 162.4, 162.5, 162.8, 162.9, 163.0, 163.1, 163.8, 163.9, 164.0, 164.1, 164.2, 164.3, 164.8, 164.9, 165.0, 165.8, 165.9, 170.0, 170.1, 170.2, 170.3, 170.4, 170.5, 170.6, 170.7, 170.8, 170.9, 171.0, 171.2, 171.3, 171.4, 171.5, 171.6, 171.7, 171.8, 171.9, 172.0, 172.1, 172.2, 172.3, 172.4, 172.5, 172.6, 172.7, 172.8, 172.9, 173.0, 173.1,

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173.2, 173.3, 173.4, 173.5, 173.6, 173.7, 173.8, 173.9, 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,

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237.71, 237.72, 237.9, 238.0, 238.1, 238.2, 238.3, 238.4, 238.5, 238.6, 238.71, 238.72, 238.73, 238.74, 238.75, 238.76, 238.77, 238.8, 238.9, 239.0, 239.1, 239.2, 239.3, 239.4, 239.5, 239.6, 239.7, 239.81, 239.89, 239.9

AND EITHER:

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 was quantified

Numerator Instructions: Pain intensity should be quantified using a standard instrument, such as a 0-10 numeric rating scale, a categorical scale, or the pictorial scale.

Numerator Options:
Pain severity quantified; pain present (1125F)
OR
Pain severity quantified; no pain present (1126F)
OR
Pain severity not documented, reason not otherwise specified (1125F *with* 8P)

RATIONALE:
Inadequate cancer pain management is widely prevalent, harmful to the patient, and costly.

CLINICAL RECOMMENDATION STATEMENTS:
All patients with cancer should be screened during the initial evaluation, at regular intervals, and whenever new therapy is initiated. The standard means for determining how much pain a patient is experiencing relies on a patient's self-report. Severity should be quantified using a 0-10 numerical rating scale, a categorical scale, or the pictorial scale (Wong-Baker Faces Pain Rating Scale). Faces can be used with patients who have difficulty with the above scales, e.g., children, the elderly, and patients with language or cultural differences or other communication barriers (Category 2A). (NCCN)

Pain intensity must be quantified, as the algorithm bases therapeutic decisions on a numerical value assigned to the severity of pain. Opioid naïve patients experiencing severe or increasing pain should receive rapid escalating doses of short-acting opioids, a bowel regimen, and Nonopioid

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analgesics as indicated. Psychosocial support is needed to ensure that patients encountering common barriers to appropriate pain control (e.g., fear of addiction or side effects, inability to purchase opioids) or needing additional assistance (e.g., depression, rapidly declining functional status) receive appropriate aid. Although pain intensity ratings will be obtained frequently to judge opioid dose increases, a formal reassessment is mandated in 24 hours for severe pain (Category 2A). (NCCN)

Regular, on-going assessment of pain, non-pain symptoms (including but not limited to shortness of breath, nausea, fatigue and weakness, anorexia, insomnia, anxiety, depression, confusion, and constipation), treatment side effects, and functional capacities are documented. Validated instruments, where available, should be used. (NCP)

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)

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▲ Measure #144: Oncology: Medical and Radiation – Plan of Care for Pain

2011 PHYSICIAN QUALITY REPORTING OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

This is a two-part measure which is paired with Measure #143: Oncology: Medical and Radiation: Pain Intensity Quantified. This measure *should* be reported if patient reports pain for Measure #143.

DESCRIPTION:
Percentage of patient visits, regardless of patient 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 have been provided for registry only measures for use by registries that utilize claims data. It is not necessary to submit these codes for registry-based submissions. There are no allowable performance exclusions for this measure. Do not report this measure via claims.

DENOMINATOR:
All patient visits, regardless of age, with a diagnosis of cancer currently receiving chemotherapy or radiation therapy who report having pain

Denominator Criteria (Eligible Cases):
All eligible instances when pain severity quantified; pain present (1125F) is reported in the numerator for Measure #143

AND

Diagnosis for cancer (ICD-9-CM): 140.0, 140.1, 140.3, 140.4, 140.5, 140.6, 140.8, 140.9, 141.0, 141.1, 141.2, 141.3, 141.4, 141.5, 141.6, 141.8, 141.9, 142.0, 142.1, 142.2, 142.8, 142.9, 143.0, 143.1, 143.8, 143.9, 144.0, 144.1, 144.8, 144.9, 145.0, 145.1, 145.2, 145.3, 145.4, 145.5, 145.6, 145.8, 145.9, 146.0, 146.1, 146.2, 146.3, 146.4, 146.5, 146.6, 146.7, 146.8, 146.9, 147.0, 147.1, 147.2, 147.3, 147.8, 147.9, 148.0, 148.1, 148.2, 148.3, 148.8, 148.9, 149.0, 149.1, 149.8, 149.9, 150.0, 150.1, 150.2, 150.3, 150.4, 150.5, 150.8, 150.9, 151.0, 151.1, 151.2, 151.3, 151.4, 151.5, 151.6, 151.8, 151.9, 152.0, 152.1, 152.2, 152.3, 152.8, 152.9, 153.0, 153.1, 153.2, 153.3, 153.4, 153.5, 153.6, 153.7, 153.8, 153.9, 154.0, 154.1, 154.2, 154.3, 154.8, 155.0, 155.1, 155.2, 156.0, 156.1, 156.2, 156.8, 156.9, 157.0,

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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, 173.0, 173.1, 173.2, 173.3, 173.4, 173.5, 173.6, 173.7, 173.8, 173.9, 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,

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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, 237.9, 238.0, 238.1, 238.2, 238.3, 238.4, 238.5, 238.6, 238.71, 238.72, 238.73, 238.74, 238.75, 238.76, 238.77, 238.8, 238.9, 239.0, 239.1, 239.2, 239.3, 239.4, 239.5, 239.6, 239.7, 239.81, 239.89, 239.9

AND EITHER:

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 that included a documented plan of care to address pain

Numerator Instructions: A documented plan of care may include: use of opioids, non-opioid analgesics, psychological support, patient and/or family education, referral to a pain clinic, or reassessment of pain at an appropriate time interval.

Numerator Options:
Plan of care to address pain documented (0521F)

OR

Plan of care for pain not documented, reason not otherwise specified (0521F *with* 8P)

RATIONALE:
Inadequate cancer pain management is widely prevalent, harmful to the patient, and costly.

CLINICAL RECOMMENDATION STATEMENTS:
All patients with cancer should be screened during the initial evaluation, at regular intervals, and whenever new therapy is initiated. The standard means for determining how much pain a patient is experiencing relies on a patient's self-report. Severity should be quantified using a 0-10 numerical rating scale, a categorical scale, or the pictorial scale (Wong-Baker Faces Pain Rating Scale). Faces can be used with patients who have difficulty with the above scales, e.g., children, the

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elderly, and patients with language or cultural differences or other communication barriers (Category 2A). (NCCN)

Pain intensity must be quantified, as the algorithm bases therapeutic decisions on a numerical value assigned to the severity of pain. Opioid naïve patients experiencing severe or increasing pain should receive rapid escalating doses of short-acting opioids, a bowel regimen, and Nonopioid analgesics as indicated. Psychosocial support is needed to ensure that patients encountering common barriers to appropriate pain control (e.g., fear of addiction or side effects, inability to purchase opioids) or needing additional assistance (e.g., depression, rapidly declining functional status) receive appropriate aid. Although pain intensity ratings will be obtained frequently to judge opioid dose increases, a formal reassessment is mandated in 24 hours for severe pain (Category 2A). (NCCN)

For patients whose pain is less than 7 at presentation, the pathways are similar. The main differences include the option to perform the formal pain intensity reassessment less frequently (24-48 hours) and to consider beginning with slower titration of short-acting opioids for patients with moderate pain intensity rating 4-6 or with NSAID or acetaminophen if the patient has mild pain intensity rating from 1 to 0 and is opioid and NSAID-naïve (Category 2A). (NCCN)

Regular, on-going assessment of pain, non-pain symptoms (including but not limited to shortness of breath, nausea, fatigue and weakness, anorexia, insomnia, anxiety, depression, confusion, and constipation), treatment side effects, and functional capacities are documented. Validated instruments, where available, should be used. (NCP)

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)

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❑ Measure #145: Radiology: Exposure Time Reported for Procedures Using Fluoroscopy

2011 PHYSICIAN QUALITY REPORTING 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 codes and G-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, G-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 codes and G-codes are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure. The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data. There are no allowable performance exclusions for this measure.

DENOMINATOR:
All final reports for procedures using fluoroscopy

Denominator Criteria (Eligible Cases):
Patient encounter during the reporting period (CPT or HCPCS): 0234T, 0235T, 0238T, 0075T, 0080T, 25606, 25651, 26608, 26650, 26676, 26706, 26727, 27235, 27244, 27245, 27509, 27756, 27759, 28406, 28436, 28456, 28476, 36147, 36598, 37182, 37183, 37184, 37187, 37188, 37210, 37225, 37227, 37229, 37231, 43260, 43261, 43262, 43263, 43264, 43265, 43267, 43268, 43269, 43271, 43272, 43752, 44500, 49440, 49441, 49442, 49446, 49450, 49451, 49452, 49460, 49465, 50382, 50384, 50385, 50386, 50387, 50389, 50590, 61623, 62263, 62264, 62280, 62281, 62282, 63610, 64610, 64620, 70010, 70015, 70170, 70332, 70370, 70371, 70373, 70390, 71023, 71034, 71040, 71060, 71090, 72240, 72255,

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72265, 72270, 72275, 72285, 72291, 72295, 73040, 73085, 73115, 73525, 73542, 73580, 73615, 74190, 74210, 74220, 74230, 74235, 74240, 74241, 74245, 74246, 74247, 74249, 74250, 74251, 74260, 74270, 74280, 74283, 74290, 74291, 74300, 74305, 74320, 74327, 74328, 74329, 74330, 74340, 74355, 74360, 74363, 74425, 74430, 74440, 74445, 74450, 74455, 74470, 74475, 74480, 74485, 74740, 74742, 75600, 75605, 75625, 75630, 75650, 75658, 75660, 75662, 75665, 75671, 75676, 75680, 75685, 75705, 75710, 75716, 75722, 75724, 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, 75900, 75901, 75902, 75940, 75952, 75953, 75954, 75956, 75957, 75958, 75959, 75960, 75961, 75962, 75966, 75970, 75978, 75980, 75982, 75984, 76000, 76001, 76080, 76120, 76496, 77001, 77002, 77003, 92611,93565, 93566, 93567, 93568, G0106, G0120, G0275, G0278

NUMERATOR:
Final reports for procedures using fluoroscopy that include documentation of radiation exposure or exposure time

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Radiation Exposure or Exposure Time Documented in Fluoroscopy Report
CPT II 6045F: Radiation exposure or exposure time in final report for procedure using fluoroscopy, documented

OR

Radiation Exposure or Exposure Time not Documented in Fluoroscopy Report, Reason not Specified
Append a reporting modifier (8P) to CPT Category II code 6045F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.
6045F *with* 8P: Final fluoroscopy report does not include documentation of radiation exposure or exposure time, reason not otherwise specified

RATIONALE:
Data suggests that the lifetime risk for cancer can be increased, albeit by a small amount, with frequent or repeated exposure to ionizing radiation, including procedures using fluoroscopy. (NCI, 2002) The BEIR report concluded that "the linear no-threshold model (LNT) provided the most reasonable description of the relation between low-dose exposure to ionizing radiation and the incidence of solid cancers that are induced by ionizing radiation." (NRC, 2006) In order to monitor these long-term effects, the exposure time or radiation dose that a patient receives as a result of the procedure should be measured and recorded in the patient's record.

CLINICAL RECOMMENDATION STATEMENTS:
Radiation dose related information provided by automated dosimetry systems should be recorded in the patient's permanent record for procedures involving more than 10 minutes of fluoroscopic exposure. If automated dosimetry data is not available, fluoroscopic exposure times should be recorded in the patient's medical record for such procedures. (ACR, 2003)

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[ACR] should now encourage practices to record actual fluoroscopy time for all fluoroscopic procedures. The fluoroscopy time for various procedures (e.g., upper gastrointestinal, pediatric voiding cystourethrography, diagnostic angiography) should then be compared with benchmark figures. More complete patient radiation dose data should be recorded for all high-dose interventional procedures, such as embolizations, transjugular intrahepatic portosystemic shunts, and arterial angioplasty or stent placement anywhere in the abdomen and pelvis. (Amis et al., ACR, 2007)

Measure & record patient radiation dose:

- Record fluoroscopy time
- Record available measures – DAP (dose area product), cumulative dose, skin dose (NCI, 2005)

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❑ Measure #146: Radiology: Inappropriate Use of "Probably Benign" Assessment Category in Mammography Screening

2011 PHYSICIAN QUALITY REPORTING OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of final reports for screening mammograms that are classified as "probably benign"

INSTRUCTIONS:
This measure is to be reported each time a screening mammogram is performed during the reporting period. It is anticipated that clinicians who provide the physician component of diagnostic imaging studies for screening mammograms will submit this measure.

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

When reporting the measure via claims, submit the listed ICD-9-CM diagnosis codes, CPT codes, G-codes, and the appropriate CPT Category II codes. There are no allowable performance exclusions for this measure. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT codes, and G-codes are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure. The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data. There are no allowable performance exclusions for this measure.

DENOMINATOR:
All final reports for screening mammograms

Denominator Criteria (Eligible Cases):
Diagnosis for screening mammogram (ICD-9-CM): V76.11, V76.12
AND
Patient encounter during the reporting period (CPT or HCPCS): 77057, G0202

NUMERATOR:
Final reports classified as "probably benign"

Numerator Instructions: For performance, a lower percentage, with a definitional target approaching 0%, indicates appropriate assessment of screening mammograms (e.g., the proportion of screening mammograms that are classified as "probably benign").

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The mammogram assessment category (and corresponding CPT Category II [33xxF] code) to be reported is the single overall final assessment for the mammographic study. Separate breast assessment categories should not be reported for this measure.

Definition:
"Probably Benign" Classification – MQSA assessment category of "probably benign"; BI-RADS® category 3; or FDA-approved equivalent assessment category

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Mammogram Assessment Category of "Probably Benign" Documented
CPT II 3343F: Mammogram assessment category of "probably benign", documented
OR
CPT II 3340F: Mammogram assessment category of "incomplete: need additional imaging evaluation," documented
OR
CPT II 3341F: Mammogram assessment category of "negative", documented
OR
CPT II 3342F: Mammogram assessment category of "benign", documented
OR
CPT II 3344F: Mammogram assessment category of "suspicious", documented
OR
CPT II 3345F: Mammogram assessment category "highly suggestive of malignancy", documented
OR
CPT II 3350F: Mammogram assessment category of "known biopsy proven malignancy", documented

RATIONALE:
Although a mammogram assessment category of "probably benign" is not recommended for use in interpreting screening mammograms, it is associated with up to 11% of screening mammograms and accounts for over 40%–50% of abnormal screening mammograms. (Yasmeen et al., 2003A) Mammogram assessment category of "probably benign" is coupled with a recommendation for short-interval follow-up (typically 6 months), resulting in economic and emotional consequences for the women that receive them.

CLINICAL RECOMMENDATION STATEMENTS:
Do not use Category 3 in interpreting screening examinations. (ACR, 2003)

All the published studies emphasize the need to conduct a complete diagnostic imaging evaluation before making a probably benign (Category 3) assessment; hence it is inadvisable to render such an assessment when interpreting a screening examination. (ACR, 2003)

The use of Category 3, probably benign, is reserved for findings that are almost certainly benign. It must be emphasized that this is NOT an indeterminate category for malignancy, but one that, for mammography, has a less than 2% chance of malignancy (i.e. is almost certainly benign). (ACR, 2003)

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Such findings are generally identified on baseline screening or on screening for which previous examinations are unavailable for comparison. Immediate evaluation with additional mammographic views and/or ultrasound is required to render a Category 3, probably benign assessment. (ACR, 2003)

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▲ Measure #147: Nuclear Medicine: Correlation with Existing Imaging Studies for All Patients Undergoing Bone Scintigraphy

2011 PHYSICIAN QUALITY REPORTING OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of final reports for all patients, regardless of age, undergoing bone scintigraphy that include physician documentation of correlation with existing relevant imaging studies (e.g., x-ray, MRI, CT, etc.) that were performed

INSTRUCTIONS:
This measure is to be reported each time bone scintigraphy is performed during the reporting period. There is no diagnosis associated with this measure. It is anticipated clinicians performing the bone scintigraphy study will report on this measure.

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

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

Measure Reporting via Registry:
CPT codes are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure. The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All final reports for patients, regardless of age, undergoing bone scintigraphy

> Denominator Criteria (Eligible Cases):
> Patient encounter during the reporting period (CPT): 78300, 78305, 78306, 78315, 78320

NUMERATOR:
Final reports that include physician documentation of correlation with existing relevant imaging studies (e.g., x-ray, MRI, CT, etc.)

> Definition:
> Relevant Imaging Studies – Studies that correspond to the same anatomical region in question.

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Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Bone Scintigraphy Report Correlated with Existing Studies

CPT II 3570F: Final report for bone scintigraphy study includes correlation with existing relevant imaging studies (e.g., 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.

3570F *with* 3P: Documentation of system reason(s) for not documenting correlation with existing relevant imaging studies in final report (e.g. 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 Specified

Append a reporting modifier (8P) to CPT Category II code 3570F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

3570F *with* 8P: Bone scintigraphy report not correlated, reason not otherwise specified

RATIONALE:

Radionuclide bone imaging plays an integral part in tumor staging and management; the majority of bone scans are performed in patients with a diagnosis of malignancy, especially carcinoma of the breast, prostate gland, and lung. This modality is extremely sensitive for detecting skeletal abnormalities, and numerous studies have confirmed that it is considerably more sensitive than conventional radiography for this purpose. However, the specificity of bone scan abnormalities can be low since many other conditions may mimic tumor; therefore, it is important that radionuclide bone scans are correlated with available, relevant imaging studies. Existing imaging studies that are available can help inform the diagnosis and treatment for the patient. Furthermore, correlation with existing radiographs is considered essential to insure that benign conditions are not interpreted as tumor. While there are no formal studies on variations in care in how often correlation with existing studies is not performed, there is significant anecdotal information from physicians practicing in the field that there is a gap in care and that correlation is not occurring frequently when images are available.

Literature suggests that as many as 30% of Radiology reports contain errors, regardless of the imaging modality, Radiologists experience, or time spent in interpretation. Evidence has also suggested that Radiology reports are largely non-standardized and commonly incomplete, vague, untimely, and error-prone and may not serve the needs of referring physicians. Therefore, it is imperative that existing imaging reports be correlated with the Nuclear Medicine bone scintigraphy procedure to ensure proper diagnosis and appropriate patient treatment.

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CLINICAL RECOMMENDATION STATEMENTS:

Bone scintigraphic abnormalities should be correlated with appropriate physical examination and imaging studies to ascertain that osseous or soft-tissue abnormalities, which might cause cord or other nerve compression or pathologic fracture in an extremity, are not present. (SNM, 2003)

Relevant radiographs and/or MR imaging of painful sites to exclude cord compression or severe lytic lesions which carry an increased risk of pathologic fracture should be examined by the physician. (SNM, 2003)

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

2011 PHYSICIAN QUALITY REPORTING OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

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

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for patients with a diagnosis of advanced CKD seen during the reporting period. It is anticipated that clinicians providing care for patients with advanced CKD will submit this measure.

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

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

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT codes and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure. The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All patients aged 18 years and older with the diagnosis of advanced CKD (stage 4 or 5, not receiving RRT)

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Diagnosis for stage 4 or 5 CKD (ICD-9-CM): 585.4, 585.5
AND
Patient encounter during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215

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

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
AV Fistula Referred
CPT II 4051F: Referred for an arteriovenous (AV) fistula

OR

AV Fistula not Referred for Medical or Patient Reasons
Append a modifier (1P or 2P) to CPT Category II code 4051F to report documented circumstances that appropriately exclude patients from the denominator.
4051F *with* 1P: Documentation of medical reason(s) for not referring for an AV fistula
4051F *with* 2P: Documentation of patient reason(s) for not referring for an AV fistula

OR

AV Fistula not Referred, Reason not Specified
Append a reporting modifier (8P) to CPT Category II code 4051F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.
4051F *with* 8P: AV fistula not referred, reason not otherwise specified

RATIONALE:
For patients who will require dialysis, an AV fistula is the preferred permanent vascular access. Patients who have an AV fistula as their permanent vascular access for dialysis have fewer complications, such as infection. However USRDS data shows that only 35% of male and 15% of female hemodialysis patients have an AV fistula compared to 50% of male and 60% of female hemodialysis patients that have a long-term catheter as their vascular access. By improving the rate of which AV fistulas are used, morbidity and mortality due to complications of other types of permanent vascular access will decrease.

CLINICAL RECOMMENDATION STATEMENTS:
1.3 Patients should have a functional permanent access at the initiation of dialysis therapy.

- 1.3.1 A fistula should be placed at least 6 months before the anticipated start of HD treatments. This timing allows for access evaluation and additional time for revision to ensure a working fistula is available at initiation of dialysis therapy. (NKF 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 (NKF 2006)
  - 2.1.1.1 A wrist (radiocephalic) primary fistula (NKF 2006)
  - 2.1.1.2 An elbow (brachiocephalic) primary fistula (NKF 2006)
  - 2.1.1.3 A transposed brachial basilic vein fistula (NKF 2006)
- 2.1.2 Acceptable: AVG of synthetic or biological material, such as: (NKF 2006)
  - 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. (NKF 2006)

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- 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 (NKF 2006)
- 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 (NKF 2006)
- 2.1.3.3 Long-term catheters should not be placed on the same side as a maturing AV access, if possible (NKF 2006)
- 2.1.4 Patients should be considered for construction of a primary fistula after failure of every dialysis AV access (NKF 2006)

8.1.2 The goals for permanent HD access placement should include:

- 8.1.2.1 Prevalent functional AVF placement rate of greater than 65% of patients. (NKF 2006)
- 8.1.2.2 Cuffed catheter for permanent dialysis access (e.g., not as a bridge) in less than 10% of patients. Long-term catheter access is defined as the use of dialysis catheter for more than three months in the absence of a maturing permanent access – graft of fistula. (NKF 2006)

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*Measure #154: Falls: Risk Assessment

2011 PHYSICIAN QUALITY REPORTING OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

This is a two-part measure which is paired with Measure #155: Falls: Plan of Care. If the falls risk assessment indicates the patient has documentation of two or more falls in the past year or any fall with injury in the past year (CPT II code 1100F is submitted), #155 *should* also be reported.

DESCRIPTION:
Percentage of patients aged 65 years and older with a history of falls who had a risk assessment for falls completed within 12 months

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for patients seen during the reporting period. There is no diagnosis associated with this measure. This measure is appropriate for use in all non-acute settings (excludes emergency departments and acute care hospitals). This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

Measure Reporting via Claims:
CPT 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 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 codes and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure. The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All patients aged 65 years and older who have a history of falls

Denominator Criteria (Eligible Cases):
Patients aged ≥ 65 years on date of encounter
AND

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Patient encounter during the reporting period (CPT): 97001, 97002, 97003, 97004, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350

NUMERATOR:
Patients who had a risk assessment for falls completed within 12 months

Numerator Instructions: All components do not need to be completed during one patient visit, but should be documented in the medical record as having been performed within the past 12 months.

Definitions:
Fall – A sudden, unintentional change in position causing an individual to land at a lower level, on an object, the floor, or the ground, other than as a consequence of sudden onset of paralysis, epileptic seizure, or overwhelming external force.
Risk Assessment – Comprised of balance/gait AND one or more of the following: postural blood pressure, vision, home fall hazards, and documentation on whether medications are a contributing factor or not to falls within the past 12 months.

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

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Risk Assessment for Falls Completed
(Two CPT II codes [3288F & 1100F] are required on the claim form to submit this numerator option)
CPT II 3288F: Falls risk assessment documented
AND
CPT II 1100F: Patient screened for future fall risk; documentation of two or more falls in the past year or any fall with injury in the past year

OR

Risk Assessment for Falls not Completed for Medical Reasons
(Two CPT II codes [3288F-1P & 1100F] are required on the claim form to submit this numerator option)
Append a modifier (1P) to CPT Category II code 3288F to report documented circumstances that appropriately exclude patients from the denominator.
3288F *with* 1P: Documentation of medical reason(s) for not completing a risk assessment for falls
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

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If patient is not eligible for this measure because patient has documentation of no falls or only one fall without injury the past year, report:
Patient not at Risk for Falls
(One CPT II code [1101F] is required on the claim form to submit this numerator option)
CPT II 1101F: Patient screened for future fall risk; documentation of no falls in the past year or only one fall without injury in the past year

OR

If patient is not eligible for this measure because falls status is not documented, report:
Falls Status not Documented
(One CPT II code [1101F-8P] is required on the claim form to submit this numerator option)
Append a reporting modifier (8P) to CPT Category II code 1101F to report circumstances when the patient is not eligible for the measure.
1101F *with* 8P: No documentation of falls status

OR

Risk Assessment for Falls not Completed, Reason not Specified
(Two CPT II codes [3288F-8P & 1100F] are required on the claim form to submit this numerator option)
Append a reporting modifier (8P) to CPT Category II code 3288F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.
3288F *with* 8P: Falls risk assessment not completed, reason not otherwise specified
AND
CPT II 1100F: Patient screened for future fall risk; documentation of two or more falls in the past year or any fall with injury in the past year

RATIONALE:
Screening for specific medical conditions may direct the therapy. Although the clinical guidelines and supporting evidence calls for an evaluation of many factors, it was felt that for the purposes of measuring performance and facilitating implementation this initial measure must be limited in scope. For this reason, the work group defined an evaluation of balance and gait as a core component that must be completed on all patients with a history of falls as well as four additional evaluations – at least one of which must be completed within the 12 month period. Data elements required for the measure can be captured and the measure is actionable by the physician.

CLINICAL RECOMMENDATION STATEMENTS:
Older people who present for medical attention because of a fall, or report recurrent falls in the past year, or demonstrate abnormalities of gait and/or balance should be offered a multifactorial falls risk assessment. This assessment should be performed by a health care professional with appropriate skills and experience, normally in the setting of a specialist falls service. This assessment should be part of an individualized, multifactorial intervention. (NICE) (Grade C)
Multifactorial assessment may include the following:

- identification of falls history
- assessment of gait, balance and mobility, and muscle weakness

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- 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)

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*Measure #155: Falls: Plan of Care

2011 PHYSICIAN QUALITY REPORTING OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

This is a two-part measure which is paired with Measure #154: Falls: Risk Assessment. This measure *should* be reported if CPT II code 1100F "Patient screened for future falls risk; documentation of two or more falls in the past year or any fall with injury in the past year" is submitted for Measure #154.

DESCRIPTION:
Percentage of patients aged 65 years and older with a history of falls who had a plan of care for falls documented within 12 months

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for patients seen during the reporting period. There is no diagnosis associated with this measure. This measure is appropriate for use in all non-acute settings (excludes emergency departments and acute care hospitals). This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

Measure Reporting via Claims:
All eligible instances when CPT II code 1100F (Patient screened for future falls risk; documentation of two or more falls in the past year or any fall with injury in the past year) is reported in the numerator for Measure #154 make up the denominator for this measure. CPT Category II codes are used to report the numerator of the measure.

When CPT II code 1100F is reported with Measure #154, add the appropriate CPT Category II codes OR the CPT Category II code(s) with the modifier. The modifiers allowed for this measure are: 1P- medical reasons, 8P- reason not otherwise specified. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
All eligible instances when patient is reported in the numerator for Measure #154 as screened for future falls risk; documentation of two or more falls in the past year or any fall with injury in the past year are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure. The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All patients aged 65 years and older with a history of falls (history of falls is defined as 2 or more falls in the past year or any fall with injury in the past year)

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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): 97001, 97002, 97003, 97004, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350

NUMERATOR:
Patients with a plan of care for falls documented within 12 months

Numerator Instructions: All components do not need to be completed during one patient visit, but should be documented in the medical record as having been performed within the past 12 months.

Definitions:
Plan of Care – Must include: 1) consideration of appropriate assistance device AND 2) balance, strength, and gait training.
Consideration of Appropriate Assistance Device – Medical record must include: documentation that an assistive device was provided or considered OR referral for evaluation for an appropriate assistance device
Balance, Strength, and Gait Training – Medical record must include: documentation that balance, strength, and gait training/instructions were provided OR referral to an exercise program, which includes at least one of the three components: balance, strength or gait
Fall – A sudden, unintentional change in position causing an individual to land at a lower level, on an object, the floor, or the ground, other than as a consequence of sudden onset of paralysis, epileptic seizure, or overwhelming external force

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Plan of Care Documented
CPT II 0518F: Falls plan of care documented
OR
Plan of Care not Documented for Medical Reasons
Append a modifier (1P) to CPT Category II code 0518F to report documented circumstances that appropriately exclude patients from the denominator.
0518F *with* 1P: Documentation of medical reason(s) for no plan of care for falls
OR
Plan of Care not Documented, Reason not Specified
Append a reporting modifier (8P) to CPT Category II code 0518F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.
0518F *with* 8P: Plan of care not documented, reason not otherwise specified

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RATIONALE:
Interventions to prevent future falls should be documented for the patient with 2 or more falls or injurious falls.

CLINICAL RECOMMENDATION STATEMENTS:
Among community-dwelling older persons (i.e., those living in their own homes), multifactorial interventions should include:

- gait training and advice on the appropriate use of assistive devices (Grade B)
- review and modification of medication, especially psychotropic medication (Grade B)
- exercise programs, with balance training as one of the components (Grade B)
- treatment of postural hypotension (Grade B)
- modification of environmental hazards (Grade C)
- treatment for cardiovascular disorders (Grade D) (AGS/BGS/AAOS)

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▲ Measure #156: Oncology: Radiation Dose Limits to Normal Tissues

2011 PHYSICIAN QUALITY REPORTING OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of patients, regardless of age, with a diagnosis of pancreatic or lung cancer receiving 3D conformal radiation therapy with documentation in medical record that radiation dose limits to normal tissues were established prior to the initiation of a course of 3D conformal radiation for a minimum of two tissues

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for patients with a diagnosis of cancer receiving 3D conformal radiation therapy seen during the reporting period. It is anticipated that clinicians providing radiation therapy for patients with cancer will submit this measure.

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

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

Measure Reporting via Registry:
ICD-9-CM diagnosis codes and CPT codes are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure. The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data. There are no allowable performance exclusions for this measure.

DENOMINATOR:
All patients, regardless of age, with a diagnosis of pancreatic or lung cancer who receive 3D conformal radiation therapy

> Denominator Criteria (Eligible Cases):
> Diagnosis for pancreatic or lung cancer (ICD-9-CM): 157.0, 157.1, 157.2, 157.3, 157.4, 157.8, 157.9, 162.0, 162.2, 162.3, 162.4, 162.5, 162.8, 162.9
> AND
> Patient encounter during the reporting period (CPT): 77295

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NUMERATOR:
Patients who had documentation in medical record that radiation dose limits to normal tissues were established prior to the initiation of a course of 3D conformal radiation for a minimum of two tissues

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Radiation Dose Limits to Normal Tissues Established
CPT II 0520F: Radiation dose limits to normal tissues established prior to the initiation of a course of 3D conformal radiation for a minimum of two tissues/organs

OR

Radiation Dose Limits to Normal Tissues not Established, Reason not Specified
Append a reporting modifier (8P) to CPT Category II code 0520F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.
0520F *with* 8P: Radiation dose limits to normal tissues not established prior to the initiation of a course of 3D conformal radiation for a minimum of two tissues/organs, reason not otherwise specified

RATIONALE:
Identifying radiation dose limits to normal tissues is an important step in the process of care for patients receiving radiation therapy treatments. Although no specific data is available, in its practice accreditation reviews, the American College of Radiation Oncology has found that radiation dose limits to normal tissues are included in the patient chart less frequently than reviewers expected. While dose constraint specification is an integral part of IMRT, it is not required for 3D conformal radiation therapy. Patients treated with 3D conformal radiation therapy are often subjected to dose levels that exceed normal tissue tolerance, and precise specification of maximum doses to be received by normal tissues represent both an intellectual process for the physician during radiation treatment planning, and a fail-safe point for the treating therapists. In most circumstances where facilities require specification of radiation dose limits to normal tissues prior to initiation of therapy, policies and procedures exist that prohibit exceeding those limits in the absence of written physician approval.

CLINICAL RECOMMENDATION STATEMENTS:
"The cognitive process of treatment planning requires the radiation oncologist to have knowledge of the natural history of the tumor to be treated and to determine the tumor site, its extent, and its relationship with adjacent normal tissues. This process is based on consideration of the history, physician examination, endoscopy, diagnostic imaging, findings at surgery, and histology. When ionizing radiation is to be used, the radiation oncologist must select beam characteristics and/or radionuclide sources, method of delivery, doses, and sequencing with other treatments. The sequencing with other treatments should be coordinated in collaboration with medical and surgical oncologists. The radiation oncologist determines the dose to be delivered to the tumor, limiting doses to critical structures (emphasis added), and the fractionation desired." (ACR 2004)

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Ω Measure #157: Thoracic Surgery: Recording of Clinical Stage for Lung Cancer and Esophageal Cancer Resection

2011 PHYSICIAN QUALITY REPORTING OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of surgical patients aged 18 years and older undergoing resection for lung or esophageal cancer who had clinical TNM staging provided prior to surgery

INSTRUCTIONS:
This measure is to be reported each time a major cancer resection of the lung or esophagus is performed. This measure is intended to reflect the quality of services provided for patients undergoing resection for lung or esophageal cancer. The clinical staging of lung and esophageal cancer patients guides the decision-making process when choosing optimal treatment modality which may or may not include surgery. It is anticipated that clinicians who perform the listed surgical procedures with a diagnosis of lung or esophageal cancer will submit this measure.

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

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

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure. The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All patients aged 18 years and older undergoing resection for lung or esophageal cancer

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Diagnosis for lung or esophageal cancer (ICD-9-CM): 150.3, 150.4, 150.5, 162.2, 162.3, 162.4, 162.5
AND

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Patient encounter during the reporting period (CPT): 32440, 32442, 32445, 32480, 32482, 32484, 32486, 32488, 32500, 32503, 32504, 32657, 32663, 43107, 43108, 43112, 43113, 43117, 43118, 43121, 43122, 43123

NUMERATOR:
Patients undergoing resection for lung and esophageal cancer who had clinical TNM staging provided prior to surgery

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Clinical TNM Staging Provided
CPTII 3323F: Clinical tumor, node and metastases (TNM) staging documented and reviewed prior to surgery

OR

Clinical TNM Staging not Provided for Medical Reasons
Append a modifier (1P) to CPT Category II code 3323F to report documented circumstances that appropriately exclude patients from the denominator.
3323F *with* 1P: Documentation of medical reason(s) for clinical tumor, node and metastases (TNM) staging not documented and reviewed prior to surgery

OR

Clinical TNM Staging not Provided, Reason not Specified
Append a reporting modifier (8P) to CPT Category II code 3323F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.
3323F *with* 8P: Clinical tumor, node and metastases (TNM) staging not documented and reviewed prior to surgery, reason not otherwise specified

RATIONALE:
Evaluation of patients with suspected lung cancer and esophageal cancer includes both diagnosis of the primary tumor and evaluation of the extent of disease. The current system for staging lung and esophageal cancer is based on the AJCC TNM classification. The clinical staging of lung and esophageal cancer patients guides the decision-making process when choosing optimal treatment modality which may or may not include surgery. Review of the 5000 lobectomies recorded in the current STS General Thoracic Database identified a significant gap with respect to recording of clinical stage; it was reported in only 80% of patients undergoing resection for lung cancer. Remediation of this process gap should improve quality by reducing inappropriate selection of treatment modalities including surgery.

CLINICAL RECOMMENDATION STATEMENTS:
BTS Guidelines on the selection of patients with lung cancer for surgery, Thorax 2001;56,89-108(February), and National Cancer Institute Web site: Non-Small Cell Lung Cancer PDQ®: Treatment. Available for download at the following address as of 11/3/08 - http://www.cancer.gov/cancertopics/pdq/treatment/non-small-cell-lung/HealthProfessional, page3, and Surgical treatment of esophageal cancer. Manchester (MA): Society for Surgery of the Alimentary Tract (SSAT); 2002. 3 p.ASSESSMENT OF OPERABILITY (Clinical Staging Importance in Lung Cancer)

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“Assuming satisfactory performance status, operability in patients with lung cancer depends on the clinical assessment of tumor stage. Preoperative clinical staging (cTNM), as accurately as possible given the limitations of the investigations available, is therefore crucial.
Recommendations

1. All patients being considered for surgery should have a plain chest radiograph and a computed tomographic (CT) scan of the thorax including the liver and adrenal glands. [B]
2. Confirmatory diagnostic percutaneous needle biopsy in patients presenting with peripheral lesions is not mandatory in patients who are otherwise fit, particularly if there are previous chest radiographs showing no evidence of a lesion. [B]
3. Patients with mediastinal nodes greater than 1 cm in short axis diameter on the CT scan should undergo biopsy by staging mediastinoscopy, anterior mediastinotomy, or needle biopsy as appropriate. [B]

On the basis of these investigations, cTNM staging should be possible and appropriate surgery undertaken in the light of current knowledge of results.”

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✦ Measure #158: Carotid Endarterectomy: Use of Patch During Conventional Carotid Endarterectomy

2011 PHYSICIAN QUALITY REPORTING OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of patients aged 18 years and older undergoing conventional (non-eversion) carotid endarterectomy (CEA) who undergo patch closure of the arteriotomy

INSTRUCTIONS:
This measure is to be reported each time a patient undergoes a carotid endarterectomy procedure during the reporting period. It is anticipated that clinicians who perform the listed surgical procedure as specified in the denominator coding will submit this measure.

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

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

Measure Reporting via Registry:
CPT codes and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure. The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
Patients aged 18 years and older undergoing CEA requiring patch arteriotomy (vein or synthetic)

> Denominator Criteria (Eligible Cases):
> Patients aged ≥ 18 years on date of encounter
> AND
> Patient encounter during the reporting period (CPT): 35301

NUMERATOR:
Patients undergoing an elective, conventional CEA who undergo patch closure of the arteriotomy site

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Definitions:
Non-Eversion, Conventional CEA – Involves a longitudinal arteriotomy incision with plaque extraction requiring closure of the arteriotomy with or without a patch (vein or synthetic).
Eversion Carotid Endarterectomy – Involves the complete transection of the internal carotid artery at its origin and the removal of the atheroma circumferentially is performed followed by re-implantation of the vessel.

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Conventional CEA with Patch
G8524: Patch closure used for patient undergoing conventional CEA

OR

If patient is not eligible for this measure because a conventional CEA was not performed, report:
G8525: Clinician documented that endarterectomy patient did not receive conventional CEA

OR

Conventional CEA Performed without Patch
G8526: Patch closure not used for patient undergoing conventional CEA, reason not specified

RATIONALE:
Carotid endarterectomy (CEA) can be performed in the conventional manner, in which a longitudinal arteriotomy is used to expose the plaque for subsequent endarterectomy, or with the eversion technique, in which the artery is transected and everted for plaque removal. With conventional endarterectomy, multiple randomized trials have demonstrated the benefit of patching to reduce postoperative stroke and prevent recurrent stenosis. With conventional endarterectomy, multiple randomized trials have demonstrated the benefit of patching to reduce postoperative stroke and prevent recurrent stenosis (Ref 1-10). In a systematic review of this question, Bond et al concluded that patch angioplasty was associated with a reduction of stroke risk (P=.004), ipsilateral stroke (P=.001), stroke or death postoperatively (P=.007) and both perioperative occlusion (P=.0001) and recurrent stenosis during long-term follow-up (P<.0001) (Ref 11). This report concluded that patching should be performed during conventional CEA. There does not appear to be any difference or advantage among various types of patches (autogenous vein, polyester, polytetrafluoroethylene, or bovine pericardium).

Because eversion CEA involves a transverse closure, it does not require patching. In fact a Cochrane review based on multiple randomized studies have shown that eversion CEA is comparable in outcome to conventional CEA with patching in terms of stroke, death, and recurrent stenosis.

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CLINICAL RECOMMENDATION STATEMENTS:

There are no current practice guidelines concerning use of patch during conventional CEA, but such guidelines are currently being prepared by the Society for Vascular Surgery. The VSGNNE uses carotid patching during conventional CEA as a quality indicator in its reports to regional centers. A 2007 analysis of nearly 3000 conventional CEAs performed in VSGNNE showed that the use of patching varied from 60% to 100% (mean 90%) among 11 hospitals. This demonstrates potential for improvement even for a group of surgeons where this result is known.

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❑ Measure #159: HIV/AIDS: CD4+ Cell Count or CD4+ Percentage

2011 PHYSICIAN QUALITY REPORTING OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

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

INSTRUCTIONS:
This measure is to be reported either once or twice per reporting period for patients with HIV/AIDS. If the patient is seen during both the first and second halves of the year, we would expect 2 QDCs: one during the first half of the year and one in the second half of the year. However, if the two visits both occurred in either the first or second half of the year, only 1 QDC needs to be reported. This measure is intended to reflect the quality of services provided for the primary management of patients with HIV/AIDS.

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT 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 have been provided for registry only measures for use by registries that utilize claims data. It is not necessary to submit these codes for registry-based submissions. There are no allowable performance exclusions for this measure. Do not report this measure via claims.

DENOMINATOR:
Patients aged 6 months and older with a diagnosis of HIV/AIDS who had at least two medical visits during the measurement year, with at least 60 days between each visit

Denominator Criteria (Eligible Cases):
Patients aged ≥ 6 months on date of encounter
AND
Diagnosis for HIV/AIDS (ICD-9-CM): 042, 079.53, V08
AND
Patient encounters during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215

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

Numerator Options:
CD4+ cell count or CD4+ cell percentage documented as performed (3500F)
OR
CD4+ cell count or percentage not documented as performed, reason not specified (3500F *with* 8P)

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RATIONALE:
CD4+ cell counts help to establish monitoring frequency, and are taken into account when establishing a patient's disease stage.

CLINICAL RECOMMENDATION STATEMENTS:
Asymptomatic patients with normal CD4 cell counts and low virus loads can be monitored infrequently, repeating virus load measurements every 3-4 months and CD4 cell counts every 3-6 months. (Level of Evidence: B) (IDSA)

CD4 percentage or count should be measured at the time of diagnosis of HIV infection and at least every 3-4 months thereafter. (DHHS)

Clinicians should measure CD4 cell counts at the time of diagnosis of HIV infection and every 3 to 4 months thereafter. (NYSDOH)

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

2011 PHYSICIAN QUALITY REPORTING OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

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

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for patients with HIV/AIDS seen during the reporting period. Only patients who had at least two visits during the reporting period, with at least 60 days between each visit will be counted in the denominator for this measure. This measure is intended to reflect the quality of services provided for the primary management of patients with HIV/AIDS.

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT 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 have been provided for registry only measures for use by registries that utilize claims data. It is not necessary to submit these codes for registry-based submissions. Do not report this measure via claims.

DENOMINATOR:
Patients aged 6 years and older with a diagnosis of HIV/AIDS whose CD4+ cell count < 200 cells/mm^3, and who had at least two medical visits during the measurement year, with at least 60 days between each visit

> Denominator Criteria (Eligible Cases):
> Patients aged ≥ 6 years on date of encounter
> AND
> Diagnosis for HIV/AIDS (ICD-9-CM): 042, 079.53, V08
> AND
> Patient encounters during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215

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

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

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Numerator Options:
Pneumocystis jiroveci pneumonia prophylaxis prescribed within 3 months of low CD4+ cell count or percentage (4280F)
AND
CD4+ cell count <200 cells/mm^3 (3494F)

OR

Pneumocystis jiroveci pneumonia prophylaxis not prescribed within 3 months of low CD4+ cell count or percentage for medical reason (4280F *with* 1P)
(i.e., patient's CD4+ cell count above threshold within 3 months after CD4+ cell count below threshold, indicating that the patient's CD4+ levels are within an acceptable range and the patient does not require PCP prophylaxis)
AND
CD4+ cell count <200 cells/mm^3 (3494F)

OR

CD4+ cell count 200 – 499 cells/mm^3 (3495F)
OR
CD4+ cell count ≥500 cells/mm^3 (3496F)

OR

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

OR

PCP prophylaxis was not prescribed within 3 months of low CD4+ cell count, reason not specified (4280F *with* 8P)
AND
CD4+ cell count <200 cells/mm^3 (3494F)

RATIONALE:
Although advances in the management of HIV and AIDS diseases have been made, Pneumocystis carinii pneumonia (PCP) remains an important complication and cause of morbidity. Without PCP prophylaxis, patients with HIV/AIDS are at increased risk of developing PCP, especially when CD4 cell counts fall 200 cells/mm^3 to 250 cells/mm^3 (Kaplan, 1998; Phair, 1990). PCP prophylaxis is very effective and has been demonstrated to prolong life.

CLINICAL RECOMMENDATION STATEMENTS:
HIV-infected adults and adolescents, including pregnant women and those on HAART, should receive chemoprophylaxis against PCP if they have a CD4+T lymphocyte count of <200/mL or a history of oropharyngeal candidiasis. (USPH/IDSA, 2002)

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❑ Measure #161: HIV/AIDS: Adolescent and Adult Patients with HIV/AIDS Who Are Prescribed Potent Antiretroviral Therapy

2011 PHYSICIAN QUALITY REPORTING OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Percentage of patients with a diagnosis of HIV/AIDS aged 13 years and older: who have a history of a nadir CD4+ cell count below 350/mm^3 or who have a history of an AIDS-defining condition, regardless of CD4+ cell count; or who are pregnant, regardless of CD4+ cell count or age, who were prescribed potent antiretroviral therapy

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for patients with HIV/AIDS seen during the reporting period. Only patients who had at least two visits during the reporting period, with at least 60 days between each visit will be counted in the denominator for this measure. This measure is intended to reflect the quality of services provided for the primary management of patients with HIV/AIDS.

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT 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 have been provided for registry only measures for use by registries that utilize claims data. It is not necessary to submit these codes for registry-based submissions. Do not report this measure via claims.

There are two reporting criteria for this measure:
(1) Patients who are aged 13 years and older with a diagnosis of HIV/AIDS who have a history of a nadir CD4+ cell count below 350/mm^3 or who have a history of an AIDS-defining condition, regardless of CD4+ cell count.
OR
(2) Patients with a diagnosis of HIV/AIDS and who are pregnant, regardless of CD4+ cell count or age

> Eligible professionals should submit data on one set of reporting criteria, depending on the clinical findings. If patient has HIV/AIDS (without a diagnosis of pregnancy) and a history of a nadir CD4+ cell count below 350/mm^3 or a history of AIDS-defining condition, use Denominator Reporting Criteria 1. If the patient has HIV/AIDS and pregnant, use Denominator Reporting Criteria 2. If the patient can be included in both criteria, the eligible professional may report quality data for either reporting criteria and this will count as appropriate reporting for this patient.

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REPORTING CRITERIA 1: For all patients with HIV/AIDS (without a diagnosis of pregnancy)

DENOMINATOR (REPORTING CRITERIA 1):
Patients aged 13 years or older with a diagnosis of HIV/AIDS who have a history of nadir CD4+ cell count below 350/mm^3 or who have a history of an AIDS-defining condition, regardless of CD4+ cell count who had at least two medical visits during the measurement year, with at least 60 days between each visit

Denominator Criteria (Eligible Cases):
Patients aged ≥ 13 years on date of encounter
AND
Diagnosis for HIV/AIDS (ICD-9-CM): 042, 079.53, V08
AND
Patient encounters during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215

NUMERATOR:
Patients who were prescribed potent antiretroviral therapy

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

Definitions:
Potent Antiretroviral Therapy – Potent antiretroviral therapy is described as any antiretroviral therapy that has demonstrated optimal efficacy and results in durable suppression of HIV as shown by prior clinical trials. For potent antiretroviral therapy recommendations, refer to current DHHS guidelines available for download at the following address as of 11/3/08 - http://www.aids.gov.
Prescribed – May include prescription given to the patient for potent antiretroviral therapy at one or more visits in the 12-month period OR patient already taking potent antiretroviral therapy as documented in current medication list.
AIDS-defining Condition – Conditions included in the 1993 AIDS surveillance case definition:

- Candidiasis of bronchi, trachea, or lungs;
- Candidiasis, esophageal;
- Cervical cancer, invasive;
- Coccidiodomycosis, disseminated or extrapulmonary;
- Cryptococcosis, extrapulmonary;
- Crytosporidiosis, chronic intestinal (greater than 1 month's duration);
- Cytomegalovirus disease (other than liver, spleen, or nodes);
- Cytomegalovirus retinitis (with loss of vision);
- Encephalopathy, HIV-related;
- Herpes simplex: chronic ulcer(s) (greater than 1 month's duration);
- Bronchitis, pneumonitis, or esophagitis;
- Histoplasmosis, disseminated or extrapulmonary;
- Isosporiasis, chronic intestinal (greater than 1 month's duration);
- Kaposi's sarcoma;

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- Lymphoma, Burkitt's (or equivalent term);
- Lymphoma, immunoblastic (or equivalent term);
- Lymphoma, primary, of brain;
- Mycobacterium avium complex or M. kansasii, disseminated or extrapulmonary;
- Mycobacterium tuberculosis, any site (pulmonary or extrapulmonary);
- Mycobacterium, other species or unidentified species, disseminated or extrapulmonary;
- Pneumocystis carinii pneumonia;
- Pneumonia, recurrent;
- Progressive multifocal leukoencephalopathy;
- Salmonella septicemia, recurrent;
- Toxoplasmosis of brain;
- Wasting syndrome due to HIV. (NYSDOH, 2007)

Numerator Options:
Potent antiretroviral therapy prescribed (4276F)
AND

History of nadir CD4+ cell count <350 cells/mm^3 (3492F)
OR
History of AIDS-defining condition (3490F)

OR

No history of nadir CD4+ cell count <350 cells/mm^3 AND no history of AIDS-defining condition (3493F)

OR

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

History of nadir CD4+ cell count < 350 cells/mm^3 (3492F)
OR
History of AIDS-defining condition (3490F)

OR

REPORTING CRITERIA 2: For patients with HIV/AIDS who are pregnant

DENOMINATOR (REPORTING CRITERIA 2):
Patients with a diagnosis of HIV/AIDS who are pregnant, regardless of CD4+ cell count or age who had at least two medical visits during the measurement year, with at least 60 days between each visit

Denominator Criteria (Eligible Cases):
Diagnosis for HIV/AIDS (ICD-9-CM): 042, V08, 079.53
AND

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Diagnosis for pregnancy (ICD-9-CM): V22.0, V22.1, V22.2, V23.0, V23.1, V23.2, V23.3, V23.41, V23.49, V23.5, V23.7, V23.81, V23.82, V23.83, V23.84, V23.89, V23.9
AND
Patient encounter during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215

NUMERATOR:
Patients who were prescribed potent antiretroviral therapy

Definitions:
Potent Antiretroviral Therapy – Potent antiretroviral therapy is described as any antiretroviral therapy that has demonstrated optimal efficacy and results in durable suppression of HIV as shown by prior clinical trials. For potent antiretroviral therapy recommendations, refer to current DHHS guidelines available for download at the following address as of 11/3/08 - http://www.aids.gov.
Prescribed – May include prescription given to the patient for potent antiretroviral therapy at one or more visits in the 12-month period OR patient already taking potent antiretroviral therapy as documented in current medication list.

Numerator Options:
Potent antiretroviral therapy prescribed (4276F)
OR
Potent antiretroviral therapy not prescribed, reason not specified (4276F *with* 8P)

RATIONALE:
Potent antiretroviral therapy slows disease progression, extends survival, and results in maintained quality of life by suppressing HIV RNA viral load.

CLINICAL RECOMMENDATION STATEMENTS:
Antiretroviral therapy should be initiated in patients with a history of an AIDS-defining illness (AI) or with a CD4 T-cell count < 350 cells/mm^3. The data supporting this recommendation are stronger for those with a CD4 T-cell count < 200 cells/mm^3 and with a history of AIDS (AI) than for those with CD4 T-cell counts between 200 and 350 cells/mm^3 (AII). Antiretroviral therapy should also be initiated in the following groups of patients regardless of CD4 T-cell count: a) pregnant women (AI); b) patients with HIV-associated nephropathy (AI); and c) patients coinfected with HBV when treatment for HBV infection is indicated (BIII). (DHHS)

Clinicians should prescribe a HAART regimen that is best able to delay disease progression, prolong survival, and maintain quality of life through maximal viral suppression. (NYSDOH)

Initiation of HAART is recommended for patients who:
are symptomatic* from HIV, OR
have an AIDS-defining condition,** including those with CD4 counts < 200 cells/mm^3, *or*
are asymptomatic with two successive measurements of CD4 counts < 350 cells/mm^3 *and*
patient-related barriers to adherence are minimized.
*Signs and symptoms include but are not limited to oropharyngeal candidiasis (thrush); vulvovaginal candidiasis that is frequent or responds poorly to therapy; cervical dysplasia

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(moderate or severe)/cervical carcinoma *in situ*; HIV nephropathy in the setting of worsening serum creatinine; severe seborrheic dermatitis, constitutional symptoms, such as fever or diarrhea lasting >1 months; oral hairy leukoplakia; herpes zoster (shingles) involving at least two distinct episodes or more than one dermatome; thrombocytopenia; listeriosis; pelvic inflammatory disease, particularly if complicated by tubo-ovarian abscess; peripheral neuropathy; bacillary angiomatosis; or any conditions included in the CDC-defined AIDS definition.

**All HIV-infected persons with CD4+ T-lymphocyte counts of less than 200 cells/uL or a CD4+ percentage of less than 14. Conditions included in the 1993 AIDS surveillance case definition: Candidiasis of bronchi, trachea, or lungs; candidiasis, esophageal; cervical cancer, invasive; coccidiodomycosis, disseminated or extrapulmonary; cryptococcosis, extrapulmonary; crytosporidiosis, chronic intestinal (greater than 1 month's duration); cytomegalovirus disease (other than liver, spleen, or nodes); cytomegalovirus retinitis (with loss of vision); encephalopathy, HIV-related; herpes simplex: chronic ulcer(s) (greater than 1 month's duration); or bronchitis, pneumonitis, or esophagitis; histoplasmosis, disseminated or extrapulmonary; isosporiasis, chronic intestinal (greater than 1 month's duration); Kaposi's sarcoma; lymphoma, Burkitt's (or equivalent term); lymphoma, immunoblastic (or equivalent term); lymphoma, primary, of brain; mycobacterium avium complex or M. kansasii, disseminated or extrapulmonary; mycobacterium tuberculosis, any site (pulmonary or extrapulmonary); mycobacterium, other species or unidentified species, disseminated or extrapulmonary; pneumocystis carinii pneumonia; pneumonia, recurrent; progressive multifocal leukoencephalopathy; salmonella septicemia, recurrent; toxoplasmosis of brain; wasting syndrome due to HIV. (NYSDOH).

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❑ Measure #162: HIV/AIDS: HIV RNA Control After Six Months of Potent Antiretroviral Therapy

2011 PHYSICIAN QUALITY REPORTING OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

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

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for patients with HIV/AIDS who are receiving potent antiretroviral therapy during the reporting period. Only patients who had at least two visits during the reporting period, with at least 60 days between each visit will be counted in the denominator for this measure. This measure is intended to reflect the quality of services provided for the primary management of patients with HIV/AIDS.

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT 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 have been provided for registry only measures for use by registries that utilize claims data. It is not necessary to submit these codes for registry-based submissions. Do not report this measure via claims.

DENOMINATOR:
All patients aged 13 years and older with a diagnosis of HIV/AIDS who had at least two medical visits during the measurement year, with at least 60 days between each visit, who have received potent antiretroviral therapy for at least 6 months

> Denominator Criteria (Eligible Cases):
> Patients aged ≥ 13 years on date of encounter
> AND
> Diagnosis for HIV/AIDS (ICD-9-CM): 042, 079.53, V08
> AND
> Patient encounters during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215

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

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

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Definitions:
Potent Antiretroviral Therapy – Potent antiretroviral therapy is described as any antiretroviral therapy that has demonstrated optimal efficacy and results in durable suppression of HIV as shown by prior clinical trials. For potent antiretroviral therapy recommendations, refer to current DHHS guidelines available for download at the following address as of 11/3/08 - http://www.aids.gov.
Plan of Care – May include altering the therapy regimen, reaffirming to the patient the importance of high adherence to the regimen, or reassessment of viral load at a specified future date

Numerator Options:
HIV RNA viral load below limits of quantification (3502F)
AND
Patient receiving potent antiretroviral therapy for 6 months or longer (4270F)

OR

HIV RNA viral load not below limits of quantification (3503F)
AND
HIV RNA control plan of care, documented (0575F)
AND
Patient receiving potent antiretroviral therapy for 6 months or longer (4270F)

OR

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

OR

Viral load not performed or documented, reason not specified (3502F *with* 8P)
AND
Patient receiving potent antiretroviral therapy for 6 months or longer (4270F)

OR

Plan of care for viral load not below limits of quantification was not documented, reason not specified (0575F *with* 8P)
AND
HIV RNA viral load not below limits of quantification (3503F)
AND
Patient receiving potent antiretroviral therapy for 6 months or longer (4270F)

RATIONALE:
The goal of potent antiretroviral therapy is to establish HIV RNA viral load below limits of quantification.

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CLINICAL RECOMMENDATION STATEMENTS:

The goal of treatment for patients with prior drug exposure and drug resistance is to re-establish maximal virologic suppression, HIV RNA <50 copies/ml (AI). (DHHS) Clinicians should prescribe a HAART regimen that is best able to delay disease progression, prolong survival, and maintain quality of life through maximal viral suppression. (NYSDOH)

Initiation of HAART is recommended for patients who:
are symptomatic* from HIV, OR
have an AIDS-defining condition,** including those with CD4 counts <200 cells/mm^3, *or*
are asymptomatic with two successive measurements of CD4 counts <350 cells/mm^3 *and*
patient-related barriers to adherence are minimized.

*Signs and symptoms include but are not limited to oropharyngeal candidiasis (thrush); vulvovaginal candidiasis that is frequent or responds poorly to therapy; cervical dysplasia (moderate or severe)/cervical carcinoma *in situ*; HIV nephropathy in the setting of worsening serum creatinine; severe seborrheic dermatitis, constitutional symptoms, such as fever or diarrhea lasting >1 months; oral hairy leukoplakia; herpes zoster (shingles) involving at least two distinct episodes or more than one dermatome; thrombocytopenia; listeriosis; pelvic inflammatory disease, particularly if complicated by tubo-ovarian abscess; peripheral neuropathy; bacillary angiomatosis; or any conditions included in the CDC-defined AIDS definition.

**All HIV-infected persons with CD4+ T-lymphocyte counts of less than 200 cells/uL or a CD4+ percentage of less than 14. Conditions included in the 1993 AIDS surveillance case definition: Candidiasis of bronchi, trachea, or lungs; candidiasis, esophageal; cervical cancer, invasive; coccidiodomycosis, disseminated or extrapulmonary; cryptococcosis, extrapulmonary; crytosporidiosis, chronic intestinal (greater than 1 month's duration); cytomegalovirus disease (other than liver, spleen, or nodes); cytomegalovirus retinitis (with loss of vision); encephalopathy, HIV-related; herpes simplex: chronic ulcer(s) (greater than 1 month's duration); or bronchitis, pneumonitis, or esophagitis; histoplasmosis, disseminated or extrapulmonary; isosporiasis, chronic intestinal (greater than 1 month's duration); Kaposi's sarcoma; lymphoma, Burkitt's (or equivalent term); lymphoma, immunoblastic (or equivalent term); lymphoma, primary, of brain; mycobacterium avium complex or M. kansasii, disseminated or extrapulmonary; mycobacterium tuberculosis, any site (pulmonary or extrapulmonary); mycobacterium, other species or unidentified species, disseminated or extrapulmonary; pneumocystis carinii pneumonia; pneumonia, recurrent; progressive multifocal leukoencephalopathy; salmonella septicemia, recurrent; toxoplasmosis of brain; wasting syndrome due to HIV. (NYSDOH)

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♦ Measure #163: Diabetes Mellitus: Foot Exam

2011 PHYSICIAN QUALITY REPORTING OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

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

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

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

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

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT codes, G-codes, and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure. The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

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

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

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Patient encounter during the reporting period (CPT or HCPCS): 97802, 97803, 97804, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, G0270, G0271

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

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Foot Exam Performed
CPT II 2028F: Foot examination performed (includes examination through visual inspection, sensory exam with monofilament, and pulse exam – report when any of the three components are completed)

OR

Foot Exam not Performed for Medical Reason
Append a modifier (1P) to CPT Category II code 2028F to report documented circumstances that appropriately exclude patients from the denominator.
2028F *with* 1P: Documentation of medical reason for not performing foot exam (i.e., patient with bilateral foot/leg amputation)

OR

Foot Exam not Performed, Reason not Specified
Append a reporting modifier (8P) to CPT Category II code 2028F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.
2028F *with* 8P: Foot exam was not performed, reason not otherwise specified

RATIONALE:
The most common consequences of diabetic neuropathy are amputation and foot ulceration (ADA, 2006). In developed countries, up to five percent of diabetic patients have foot ulcers (IDF, 2005). One in every six diabetics will have an ulcer during their lifetime (IDF, 2005). Amputation and foot ulceration are also major causes of morbidity and mortality. One half to 80% of all amputations are diabetes-related (Mayfield, 1998; Reiber, 1995; ADA, 2001; Unwin, 2000).The risk of ulcers or amputations increases the longer someone has diabetes. Early recognition and management of risk factors can prevent or delay adverse outcomes. (ADA, 2006)

CLINICAL RECOMMENDATION STATEMENTS:
American Association of Clinical Endocrinologists/American College of Endocrinology (AACE/ACE) and American Diabetes Association (ADA) recommend that a foot examination (visual inspection, sensory exam, and pulse exam) be performed during an initial assessment.

AACE/ACE (2002) recommends that a foot examination be a part of every follow-up assessment visit, which should occur quarterly.

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ADA (2004) recommends that all individuals with diabetes should receive an annual foot examination to identify high-risk foot conditions. This examination should include assessment of protective sensation, foot structure and biomechanics, vascular status, and skin integrity.

The ADA (2004) recommends that people with one or more high-risk foot conditions should be evaluated more frequently for the development of additional risk factors. People with neuropathy should have a visual inspection of their feet at every contact with a health care professional.

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

2011 PHYSICIAN QUALITY REPORTING OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

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

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

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 have been provided for registry only measures for use by registries that utilize claims data. It is not necessary to submit these codes for registry-based submissions. There are no allowable performance exclusions for this measure. Do not report this measure via claims.

DENOMINATOR:
All patients undergoing isolated CABG surgery

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

NUMERATOR:
Patients undergoing isolated CABG who require intubation > 24 hours

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

Numerator Options:
Prolonged intubation (> 24 hrs) required (G8569)
OR
Prolonged intubation (> 24 hrs) not required (G8570)

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RATIONALE:
Based on the STS coronary artery bypass graft (CABG) study population, the morbidity rate associated with prolonged intubation following CABG is 5.96%. Also, prolonged ventilation (defined as >24 hours) was an independent predictor for readmission to the ICU following CABG surgery (OR=10.53; CI: 6.18 to 17.91). Shorter ventilation times are linked to high quality of care (i.e., reduced in-hospital and operative mortality, as well as better long-term outcomes as compared to prolonged ventilation).

CLINICAL RECOMMENDATION STATEMENTS:
Extubation greater than (>) 24 hours is considered a “pulmonary complication.” Patients who were extubated after 24 hours had a longer duration of hospital stay and a greater incidence of postoperative complications.

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

2011 PHYSICIAN QUALITY REPORTING OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

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

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. This measure does not include patients undergoing repeat CABG procedures.

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 have been provided for registry only measures for use by registries that utilize claims data. It is not necessary to submit these codes for registry-based submissions. There are no allowable performance exclusions for this measure. Do not report this measure via claims.

DENOMINATOR:
All patients undergoing isolated CABG surgery

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

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

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

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Numerator Options:

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

OR

No deep sternal wound infection (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.

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

2011 PHYSICIAN QUALITY REPORTING OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

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

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. This measure does not include patients undergoing repeat CABG procedures.

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 have been provided for registry only measures for use by registries that utilize claims data. It is not necessary to submit these codes for registry-based submissions. There are no allowable performance exclusions for this measure. Do not report this measure via claims.

DENOMINATOR:
All patients undergoing isolated CABG surgery, excluding patients with a prior CVA

Denominator Criteria (Eligible Cases):
All patients aged ≥ 18 years on date of encounter
AND
Patient encounter during the reporting period (CPT): 33510, 33511, 33512, 33513, 33514, 33516, 33517, 33518, 33519, 33521, 33522, 33523, 33533, 33534, 33535, 33536
WITHOUT
History of prior CVA

NUMERATOR:
Patients who have a stroke/CVA within 24 hours postoperatively

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

Numerator Options:
Stroke/CVA following isolated CABG surgery (G8573)
OR
No stroke/CVA following isolated CABG surgery (G8574)

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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 is 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 was 2.59, p<0.001. Outcomes are better when patient age is younger and with beating-heart surgery rather than on-pump surgery.

CLINICAL RECOMMENDATION STATEMENTS:
The 1999 ACC/AHA guidelines describe strategies for reducing the risk of postoperative stroke such as an aggressive approach to the management of patients with severely diseased ascending aortas identified by intraoperative echocardiographic imaging, prevention or aggressive management of postoperative atrial fibrillation, delay of bypass surgery in the case of a left ventricular mural thrombus or a recent, preoperative CVA and preoperative carotid screening. Patients should carefully be screened for cerebrovascular disease to help prevent stroke and its associated morbidities.

Use of beta-adrenergic antagonists was associated with a lower incidence of stroke in patients undergoing elective CABG (OR=0.45; 95% CI 0.23 to 0.83; p=0.016). Use of antiplatelet agents within 48 hours of surgery is associated with a decreased risk of stroke (OR=0.51, p=0.01). Increased use of beating-heart surgery without cardiopulmonary bypass may lead to a lower prevalence of stroke following cardiac surgery and thus improve patient outcomes.

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

2011 PHYSICIAN QUALITY REPORTING OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

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

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

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 have been provided for registry only measures for use by registries that utilize claims data. It is not necessary to submit these codes for registry-based submissions. There are no allowable performance exclusions for this measure. Do not report this measure via claims.

DENOMINATOR:
All patients undergoing isolated CABG surgery, excluding patients with either a documented history of renal insufficiency or baseline serum creatinine > 2.0

Denominator Criteria (Eligible Cases):
All patients aged ≥ 18 years on date of encounter
AND
Patient encounter during the reporting period (CPT): 33510, 33511, 33512, 33513, 33514, 33516, 33517, 33518, 33519, 33521, 33522, 33523, 33533, 33534, 33535, 33536
WITHOUT
History of renal insufficiency or baseline serum creatinine > 2.0

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

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

Numerator Options:
Developed postoperative renal insufficiency or required dialysis (G8575)

OR

No postoperative renal insufficiency/dialysis not required (G8576)

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 comorbidity and postoperative complications.

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

2011 PHYSICIAN QUALITY REPORTING 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) for mediastinal bleeding/tamponade, graft occlusion (due to acute closure, thrombosis, technical or embolic origin), or other cardiac reason

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

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 have been provided for registry only measures for use by registries that utilize claims data. It is not necessary to submit these codes for registry-based submissions. There are no allowable performance exclusions for this measure. Do not report this measure via claims.

DENOMINATOR:
All patients undergoing isolated CABG surgery

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

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

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

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Numerator Options:

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

OR

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

RATIONALE:

In 2000, coronary artery bypass graft (CABG) surgery was performed on more than 350,000 patients at a cost of close to $20 billion. Re-exploration after surgery is a serious complication that impacts length of stay, efficient use of resources, and increases risk for additional complications and death. As one of several major complications of cardiac surgery, repeat surgery is particularly worrisome for consumers and is an inefficient use of resources.

CLINICAL RECOMMENDATION STATEMENTS:

Re-exploration after surgery is a serious complication that impacts length of stay, efficient use of resources, and increases risk for additional complications and death. This measure is currently in use by approximately 65% of providers in the United States who perform cardiac surgery and report data to the STS National Database.

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

2011 PHYSICIAN QUALITY REPORTING OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

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

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. This measure does not include patients undergoing repeat CABG procedures.

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 have been provided for registry only measures for use by registries that utilize claims data. It is not necessary to submit these codes for registry-based submissions. Do not report this measure via claims.

DENOMINATOR:
All patients undergoing isolated CABG surgery, who did not have in-hospital mortality

Denominator Criteria (Eligible Cases):
All patients aged ≥ 18 years on date of encounter
AND
Patient encounter during the reporting period (CPT): 33510, 33511, 33512, 33513, 33514, 33516, 33517, 33518, 33519, 33521, 33522, 33523, 33533, 33534, 33535, 33536
AND
Patient not deceased prior to discharge

NUMERATOR:
Patients who were discharged on antiplatelet medication

Numerator Options:
Antiplatelet medication at discharge (G8579)
OR
Antiplatelet medication contraindicated/not indicated (G8580)
OR
No antiplatelet medication at discharge (G8581)

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RATIONALE:
Use of aspirin soon after coronary artery bypass graft (CABG) is associated with reduced risk of death and ischemic complications involving the heart, brain, kidneys, and gastrointestinal tract. High-risk patients now represent the majority of patients who undergo bypass surgery, giving rise to rates of 15% or higher for complications affecting heart, brain, kidneys, and intestines.

Guidelines from the American College of Chest Physicians recommend the administration of aspirin soon after CABG, specifically 325 mg per day starting six hours after surgery.

CLINICAL RECOMMENDATION STATEMENTS:
Evidence-based discharge therapies are underutilized in older patients who underwent CABG during hospitalization for AMI.

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

2011 PHYSICIAN QUALITY REPORTING OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

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

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

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 have been provided for registry only measures for use by registries that utilize claims data. It is not necessary to submit these codes for registry-based submissions. Do not report this measure via claims.

DENOMINATOR:
All patients undergoing isolated CABG surgery who did not have in-hospital mortality

Denominator Criteria (Eligible Cases):
All patients aged ≥ 18 years on date of encounter
AND
Patient encounter during the reporting period (CPT): 33510, 33511, 33512, 33513, 33514, 33516, 33517, 33518, 33519, 33521, 33522, 33523, 33533, 33534, 33535, 33536
AND
Patient not deceased prior to discharge

NUMERATOR:
Patients who were discharged on beta-blockers

Numerator Options:
Beta-blocker at discharge (G8582)
OR
Beta-blocker contraindicated/not indicated (G8583)
OR
No beta-blocker at discharge (G8584)

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RATIONALE:

Upwards of 70% of patients who undergo revascularization procedures have had a myocardial infarction (MI). Cumulative evidence and randomized trials indicate that patients with a previous MI live longer if they are on beta blockers. For many years, patients were taken off beta-blocker medications in preparation for surgery. Evidence from the STS National Database demonstrated that beta blocker use is safe and effective in many CABG patients previously thought to be at high risk for adverse events of beta blocker therapy (women, elderly, diabetes, congestive heart failure). The Society of Thoracic Surgeons National Database reported an increase in use of preoperative beta blockers during the time period 1996 (50% use) and 1999 (60% use).

CLINICAL RECOMMENDATION STATEMENTS:

Beta blockade reduces atrial fibrillation complications following CABG. At four to five years, survival was approximately 13% worse in patients who developed postoperative atrial fibrillation ($p < 0.001$).

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

2011 PHYSICIAN QUALITY REPORTING OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

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

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. This measure does not include patients undergoing repeat CABG procedures.

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 have been provided for registry only measures for use by registries that utilize claims data. It is not necessary to submit these codes for registry-based submissions. Do not report this measure via claims.

DENOMINATOR:
All patients undergoing isolated CABG surgery, who did not have in-hospital mortality

Denominator Criteria (Eligible Cases):
All patients aged ≥ 18 years on date of encounter
AND
Patient encounter during the reporting period (CPT): 33510, 33511, 33512, 33513, 33514, 33516, 33517, 33518, 33519, 33521, 33522, 33523, 33533, 33534, 33535, 33536
AND
Patient not deceased prior to discharge

NUMERATOR:
Patients with an anti-lipid treatment at discharge

Numerator Options:
Anti-lipid treatment at discharge (G8585)
OR
Anti-lipid treatment contraindicated/not indicated (G8586)
OR
No anti-lipid treatment at discharge (G8587)

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RATIONALE:

Atherosclerosis is a chronic disease. Events such as acute myocardial infarction (MI) and coronary artery bypass graft (CABG) surgery identify patients with the disease, but acute therapy is not sufficient for optimal long-term outcomes. In post-bypass patients, atherosclerosis continues to progress in the native circulation and develops at an accelerated rate in saphenous vein bypass grafts. Management of the chronic disease is critically important in patients with atherosclerosis, such as those undergoing CABG.

The advantages of adherence to the American College of Cardiology/American Heart Association "Get with the Guidelines" program are discussed in a recent article, which also demonstrates both variation in quality and opportunity for improvement (38% compliance with guidelines before program implementation, 98.4% compliance thereafter). The article also discusses educational and process measures used by a major medical center to achieve compliance.

CLINICAL RECOMMENDATION STATEMENTS:

Compliance rates for patients receiving personalized follow-up for lipid management over two years were significantly better than in the control group. Lipid lowering in coronary heart disease has been demonstrated distinctively through three trials (CLAS, post-CABG, and CARE) to delay the progression of atherosclerosis and/or reduce deaths, and non- fatal MI following bypass surgery. Aggressive (low-density lipoprotein [LDL]) cholesterol-lowering treatment (target <85 mg/dl) was correlated to a slower rate of disease progression (31%) after 4-5 years in comparison to the control group, which was comprised of patients receiving moderate lipid- lowering treatment (target <130 to 140 mg/dl).

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✦ Measure #172: Hemodialysis Vascular Access Decision-Making by Surgeon to Maximize Placement of Autogenous Arterial Venous (AV) Fistula

2011 PHYSICIAN QUALITY REPORTING OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of patients aged 18 years and older with a diagnosis of advanced Chronic Kidney Disease (CKD) (stage 4 or 5) or End Stage Renal Disease (ESRD) requiring hemodialysis vascular access documented by surgeon to have received autogenous AV fistula

INSTRUCTIONS:
This measure is to be reported each time a procedure for hemodialysis access is performed during the reporting period. It is anticipated that clinicians who perform the listed surgical procedures as specified in the denominator coding will submit this measure.

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

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

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure. The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All patients with advanced CKD or ESRD who undergo open surgical placement of permanent hemodialysis access

> Denominator Criteria (Eligible Cases):
> Patients aged ≥ 18 years on date of encounter
> AND
> Diagnosis for stage 4 or 5 CKD or ESRD (ICD-9-CM): 585.4, 585.5, 585.6, 996.73
> AND
> Patient encounter during the reporting period (CPT): 36818, 36819, 36820, 36821, 36825, 36830

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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
G8530: Autogenous AV fistula received

OR

Autogenous AV Fistula not Performed for Documented Reasons
G8531: Clinician documented that patient was not an eligible candidate for autogenous AV fistula

OR

Autogenous AV Fistula not Performed, Reason not Specified
G8532: Clinician documented that patient received vascular access other than autogenous AV fistula, reason not specified

RATIONALE:
AV access complications account for more than 15% of hospital admissions among hemodialysis patients. As the number of patients in need of chronic hemodialysis increases—estimated at 10% per year starting at a base population of 345,000 in 2000 – the cost to the health care system of dialysis access-related complications will increase proportionally.

CLINICAL RECOMMENDATION STATEMENTS:
For the surgeon, the most directly measurable performance parameter is the percentage of autogenous accesses placed as a proportion of the total number of accesses, (autogenous and prosthetic) placed by the particular surgeon.

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

2011 PHYSICIAN QUALITY REPORTING OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

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

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for patients seen during the reporting period. This measure is intended to determine whether or not all patients aged 18 years and older were screened for unhealthy alcohol use during the reporting period. There is no diagnosis associated with this measure. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

Measure Reporting via Claims:
CPT codes, G-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(s) with the modifier. The modifiers allowed for this measure are: 1P- medical reason, 8P- reason not otherwise specified. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
CPT codes, G-codes, and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure. The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All patients aged 18 years and older

> Denominator Criteria (Eligible Cases):
> Patients aged ≥ 18 years on date of encounter
> AND
> Patient encounter during the reporting period (CPT or HCPCS): 90801, 90802, 90804, 90805, 90806, 90807, 90808, 90809, 90810, 90811, 90812, 90813, 90814, 90815, 90845, 90862, 96150, 96152, 97003, 97004, 97802, 97803, 97804, 98960, 98961, 98962, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, G0270, G0271

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

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

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Unhealthy Alcohol Use Screening Performed
CPT II 3016F: Patient screened for unhealthy alcohol use using a systematic screening method

OR

Unhealthy Alcohol Use Screening not Performed, for Medical Reasons
Append a modifier (1P) to CPT Category II code 3016F to report documented circumstances that appropriately exclude patients from the denominator.
3016F *with* 1P: Documentation of medical reason(s) for not screening for unhealthy alcohol use (e.g., limited life expectancy)

OR

Unhealthy Alcohol Use Screening not Performed, Reason not Specified
Append a reporting modifier (8P) to CPT Category II code 3016F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.
3016F *with* 8P: Unhealthy alcohol use screening not performed, reason not otherwise specified

RATIONALE:
Screening for unhealthy alcohol use can identify patients can identify patients whose habits may put them at risk for adverse health outcomes due to their alcohol use. While this measure does not require counseling for those patients to be found at risk, brief counseling interventions for unhealthy alcohol use have shown to be effective in reducing alcohol use. It would be expected that if a provider found their patient to be at risk after screening that intervention would be provided. A systematic method of assessing for unhealthy alcohol use should be utilized. Please refer to the National Institute on Alcohol Abuse and Alcoholism publication: *Helping Patients Who Drink Too Much: A Clinician's Guide* for additional information regarding systematic screening methods.

CLINICAL RECOMMENDATION STATEMENTS:
The USPSTF strongly recommends screening and behavioral counseling interventions to reduce alcohol misuse by adults, including pregnant women, in primary care settings. (B Recommendation) (USPSTF, 2004)

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During new patient encounters and at least annually, patients in general and mental healthcare settings should be screened for at-risk drinking, alcohol use problems and illnesses, and any tobacco use. (NQF, 2007)

All patients identified with alcohol use in excess of National Institute on Alcohol Abuse and Alcoholism guidelines and/or any tobacco use should receive brief motivational counseling intervention by a healthcare worker trained in this technique. (NQF, 2007)

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▲ Measure #175: Pediatric End Stage Renal Disease (ESRD): Influenza Immunization

2011 PHYSICIAN QUALITY REPORTING OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of patients aged 6 months through 17 years with a diagnosis of ESRD and receiving dialysis seen for a visit between October 1 and February 28 who received an influenza immunization during the visit OR patient reported previous receipt of an influenza immunization

INSTRUCTIONS:
This measure is to be reported a minimum of once for visits occurring between January 1, 2011 and February 28, 2011 for the 2010-2011 influenza season AND a minimum of once for visits occurring between October 1, 2011 and December 31, 2011 for the 2011-2012 influenza season for ESRD patients receiving dialysis seen during the reporting period. This measure is intended to determine whether or not ESRD patients receiving dialysis received an influenza immunization during the flu season. It is anticipated that clinicians providing care for pediatric patients with ESRD will submit this measure.

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

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

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure. The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All patients aged 6 months through 17 years with a diagnosis of ESRD and receiving dialysis seen for a visit between October 1 and February 28

Denominator Criteria (Eligible Cases):
Patients aged 6 months through 17 years on date of encounter
AND
Diagnosis for ESRD (ICD-9-CM): 585.6

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AND

Patient encounter during the reporting period (CPT): 90951, 90952, 90953, 90954, 90955, 90956, 90957, 90958, 90959, 90963, 90964, 90965

NUMERATOR:

Patients who received an influenza immunization during the visit OR patient reported previous receipt of influenza immunization

Definition:

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

NUMERATOR NOTE: *Children with renal disease should receive the inactivated flu vaccine*

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Influenza Immunization Received

CPT II 4274F: Influenza immunization administered or previously received

OR

Influenza Immunization not Received, for Medical, Patient or System Reasons

Append a modifier (1P, 2P or 3P) to CPT Category II code 4274F to report documented circumstances that appropriately exclude patients from the denominator.

4274F *with* 1P: Documentation of medical reason(s) for patient not receiving influenza immunization during the flu season (e.g., patient allergy, other contraindication)

4274F *with* 2P: Documentation of patient reason(s) for patient not receiving influenza immunization during the flu season (e.g., patient/caregiver declined)

4274F *with* 3P: Documentation of system reason(s) for patient not receiving influenza immunization during the flu season (e.g., vaccine not available)

OR

Influenza Immunization not Received, Reason not Specified

Append a reporting modifier (8P) to CPT Category II code 4274F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

4274F *with* 8P: Influenza immunization not administered or previously received, reason not otherwise specified

RATIONALE:

Infectious disease is a common reason for hospitalization, morbidity, and mortality among pediatric end stage renal disease patients. All-cause hospital admission rates for pediatric end stage renal disease patients was 14% higher in 2005 when compared to all-cause hospital admission rates for adults. Hospitalizations for infections are also higher in children with end stage renal disease (46%) than in adults.

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CLINICAL RECOMMENDATION STATEMENTS:

Vaccination of all children aged 6 months-18 years should begin before or during the 2008-09 influenza season if feasible, but no later than during the 2009-10 influenza season. Vaccination of all children aged 5-18 years is a new ACIP recommendation. (CDC/ACIP, 2008)

Children and adolescents at high risk for influenza complications should continue to be a focus of vaccination efforts as providers and programs transition to routinely vaccinating all children and adolescents. Recommendations for these children have not changed. Children and adolescents at higher risk for influenza complication are those:

- aged 6 months-4 years
- who have chronic pulmonary (including asthma), cardiovascular (except hypertension), renal, hepatic, hematological, or metabolic disorders (including diabetes mellitus)
- who are immunosuppressed (including immunosuppression caused by medication or by human immunodeficiency virus) (CDC/ACIP, 2008)

All children aged 6 months-8 years who have not received vaccination against influenza previously should receive 2 doses of the vaccine the first influenza season they are vaccinated. The second dose should be administered 4 or more weeks after the initial dose. (CDC/ACIP, 2008)

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

2011 PHYSICIAN QUALITY REPORTING OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

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

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for all RA patients who are being considered or prescribed a first course of biologic disease-modifying anti-rheumatic drug therapy. It is anticipated that clinicians who provide care for patients with a diagnosis of RA will submit this measure.

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

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

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure. The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All patients aged 18 years and older with a diagnosis of rheumatoid arthritis (RA) who are receiving a first course of therapy using a biologic DMARD

> Denominator Criteria (Eligible Cases):
> Patients aged ≥ 18 years on date of encounter
> AND
> Diagnosis for rheumatoid arthritis (ICD-9-CM): 714.0, 714.1, 714.2, 714.81
> AND
> Patient encounter during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350

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

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

Definition:
Biologic DMARD Therapy – Includes Adalimunab, Etanercept, Infliximab, Abatacept, Anakinra (Rituximab is excluded)

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

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Tuberculosis Screening Performed and Results Interpreted
(Two CPT II codes [3455F & 4195F] are required on the claim form to submit this numerator option)
CPT II 3455F: TB screening performed and results interpreted within six months prior to initiation of first-time biologic disease modifying anti-rheumatic drug therapy for RA
AND
CPT II 4195F: Patient receiving first-time biologic disease modifying anti-rheumatic drug therapy for rheumatoid arthritis

OR

TB Screening not Performed or Results not Interpreted for Medical Reasons
(Two CPT II codes [3455F-1P & 4195F] are required on the claim form to submit this numerator option)
Append a modifier (1P) to CPT Category II code 3455F to report documented circumstances that appropriately exclude patients from the denominator.
3455F *with* 1P: Documentation of medical reason for not screening for TB or interpreting results (i.e., patient positive for TB and documentation of past treatment; patient has recently completed a course of anti-TB therapy)
AND
CPT II 4195F: Patient receiving first-time biologic disease modifying anti-rheumatic drug therapy for rheumatoid arthritis

OR

If patient does not meet denominator inclusion because biologic DMARD prescription is Rituximab or this is not the first course of biologic DMARD therapy for RA, report:
(One CPT II code [4196F] is required on the claim form to submit this numerator option)
CPT II 4196F: Patient not receiving first-time biologic disease modifying anti-rheumatic drug therapy for rheumatoid arthritis

OR

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TB Screening not Performed or Results not Interpreted, Reason not Specified
(Two CPT II codes [3455F-8P& 4195F] are required on the claim form to submit this numerator option)
Append a reporting modifier (8P) to CPT Category II code 3455F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.
3455F *with* 8P: TB screening not performed or results not interpreted, reason not otherwise specified

AND

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

RATIONALE:
Before initiating biologic DMARDs for a patient with RA, it is essential to screen the patient for tuberculosis, as research has documented a higher incidence of TB after anti-TNFα therapy. All patients being considered for biologic DMARD should receive a tuberculin skin test, even if the patient has previously received the BCG vaccination. Test results, in addition to patient risk for TB and other tests, should be used to assess the patient's risk for latent TB infection. This is a patient safety measure.

CLINICAL RECOMMENDATION STATEMENTS:
The American College of Rheumatology's updated Recommendations for the use of nonbiologic and biologic therapies in RA recommend routine tuberculosis screening to identify latent TB infection (LTBI) in patients being considered for therapy with biologics. The evidence for TB testing is based on a documented higher incidence of TB following ant-TNFα therapy. To begin, clinicians should ask all RA patients being considered for biologic DMARDs about their potential risk factors for TB infection (see below) and, irrespective of prior Bacillus-Calmette-Guérin (BCG) vaccination, use a Tuberculin Skin Test (TST) as a diagnostic aid to assess their patient's probability of latent TB infection.

In addition to the ACR recommendations, guidelines from the British Society for Rheumatology have consistent recommendations. There have been a large number of cases of tuberculosis (TB) reported in association with the use of infliximab, and studies that demonstrate a significantly higher rate of TB in patients on this treatment compared with controls. Cases of TB have also been reported in association with etanercept and adalimumab. Reactivation of latent TB is highest in the first 12 months of treatment, so particular vigilance is required during this time. With infliximab, the majority of cases occurred within three cycles of treatment, with a median of 12 weeks after starting treatment, suggesting reactivation of latent TB as the main factor predisposing to TB in these cases. The following are the British Society for Rheumatology's recommended guidelines for patients with RA: Prior to commencing treatment with anti-TNF, all patients should be screened for TB in accordance with the British Thoracic Society (BTS) guidelines. Active TB needs to be adequately treated before anti-TNF therapy can be started; prior to commencing anti-TNF therapy, consideration of prophylactic anti-TB therapy (as directed by the BTS guidelines) should be given to patients with evidence of potential latent disease (past history of TB treatment or abnormal chest X-ray raising the possibility of TB) after consultation with a local TB specialist; all patients commenced on anti-TNF therapies need to be closely monitored for TB.

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This needs to continue for 6 months after discontinuing infliximab treatment due to the prolonged elimination phase of infliximab; patients on anti-TNF therapy who develop symptoms suggestive of TB should receive full anti-TB chemotherapy, but may continue with their anti-TNF therapy if it is clinically indicated; anti-TNF therapy should only be resumed in accordance with the BTS guidelines and after agreement in collaboration with a TB specialist. (Level of Evidence C)

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

2011 PHYSICIAN QUALITY REPORTING OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

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

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for patients with RA seen during the reporting period. While there are disease activity assessment tools and instruments used as examples in this measure, they are not required. The intent of this measure is to promote physician assessment of the level of RA disease activity to inform treatment decisions. It is anticipated that clinicians who provide care for patients with a diagnosis of RA will submit this measure.

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

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

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure. The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data. There are no allowable performance exclusions for this measure.

DENOMINATOR:
All patients aged 18 years and older with a diagnosis of rheumatoid arthritis (RA)

> Denominator Criteria (Eligible Cases):
> Patients aged ≥ 18 years on date of encounter
> AND
> Diagnosis for rheumatoid arthritis (ICD-9-CM): 714.0, 714.1, 714.2, 714.81
> AND

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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

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

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

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Disease Activity Assessed and Classified
CPT II 3470F: Rheumatoid arthritis (RA) disease activity, low
OR
CPT II 3471F: Rheumatoid arthritis (RA) disease activity, moderate
OR
CPT II 3472F: Rheumatoid arthritis (RA) disease activity, high

OR

Disease Activity not Assessed and Classified, Reason not Specified
Append a reporting modifier (8P) to CPT Category II code 3470F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.
3470F *with* 8P: Disease activity not assessed and classified, reason not otherwise specified

RATIONALE:
After establishing a diagnosis of RA, risk assessment is crucial for guiding optimal treatment. For the purposes of selecting therapies, physicians should consider the patient's disease activity at the time of the treatment decisions.

CLINICAL RECOMMENDATION STATEMENTS:
Several indices to measure RA disease activity have been developed each of which has advantages and disadvantages. Evidence-based guidelines require clear definitions of disease activity to make rational therapeutic choices, but it is not possible or appropriate to mandate use of a single disease activity score for the individual physician, and different studies have used different definitions. Therefore, the TFP was asked to consider a combined estimation of disease activity, which allowed reference to many past definitions. With these instruments as our guide, we rated RA disease activity in an ordinal manner as low, moderate, or high, as previously requested by the CEP.

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

2011 PHYSICIAN QUALITY REPORTING OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

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

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for patients with RA seen during the reporting period. It is anticipated that clinicians who provide care for patients with a diagnosis of RA will submit this measure.

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

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

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure. The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data. There are no allowable performance exclusions for this measure.

DENOMINATOR:
All patients aged 18 years and older with a diagnosis of rheumatoid arthritis (RA)

> Denominator Criteria (Eligible Cases):
> Patients aged ≥ 18 years on date of encounter
> AND
> Diagnosis for rheumatoid arthritis (ICD-9-CM): 714.0, 714.1, 714.2, 714.81
> AND
> Patient encounter during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350

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

Definitions:
Functional Status Assessment – This measure assesses if physicians are using a standardized descriptive or numeric scale, standardized questionnaire, or notation of assessment of the impact of RA on patient activities of daily living. Examples of tools used to assess functional status include but are not limited to: Health Assessment Questionnaire (HAQ), Modified HAQ, HAQ-2; American College of Rheumatology's Classification of Functional Status in Rheumatoid Arthritis.
Activities of Daily Living – Could include a description of any of the following: dressing/grooming, rising from sitting, walking/running/ability to ambulate, stair climbing, reaching, gripping, shopping/running errands/house or yard work.

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Functional Status Assessed
CPT II 1170F: Functional status assessed

OR

Functional Status not Assessed, Reason not Specified
Append a reporting modifier (8P) to CPT Category II code 1170F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.
1170F *with* 8P: Functional status not assessed, reason not otherwise specified

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 (i.e., presence of joint pain, duration of morning stiffness, degree of fatigue), functional status, objective evidence of disease activity (i.e., synovitis, as assessed by tender and swollen joint counts, and the ESR or CRP level), mechanical joint problems, etc.

At each follow up visit, the physician must assess whether the disease is active or inactive. Symptoms of inflammatory (as contrasted with mechanical) joint disease, which include prolonged morning stiffness, duration of fatigue, and active synovitis on joint examination, indicate active

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disease and necessitate consideration of changing the treatment program. Occasionally, findings of the joint examination alone may not adequately reflect disease activity and structural damage; therefore, periodic measurements of the ESR or CRP level and functional status, as well as radiographic examinations of involved joints should be performed. It is important to determine whether a decline in function is the result of inflammation, mechanical damage, or both; treatment strategies will differ accordingly.

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

2011 PHYSICIAN QUALITY REPORTING OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

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

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for patients with RA seen during the reporting period. It is anticipated that clinicians who provide care for patients with a diagnosis of RA will submit this measure.

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

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

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure. The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data. There are no allowable performance exclusions for this measure.

DENOMINATOR:
All patients aged 18 years and older with a diagnosis of rheumatoid arthritis (RA)

> Denominator Criteria (Eligible Cases):
> Patients aged ≥ 18 years on date of encounter
> AND
> Diagnosis for rheumatoid arthritis (ICD-9-CM): 714.0, 714.1, 714.2, 714.81
> AND
> Patient encounter during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350

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

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

Definitions:
Poor Prognosis – RA patients with features of poor prognosis have active disease with high tender and swollen joint counts, often have evidence of radiographic erosions, elevated levels of rheumatoid factor (RF) and or anti-cyclic citrullinated peptide (anti-CCP) antibodies, and an elevated erythrocyte sedimentation rate, and an elevated C-reactive protein level.
Clinically Important Markers of Poor Prognosis – Classification should be based upon at a minimum the following: functional limitation (e.g., HAQ Disability Index), extraarticular disease (e.g. vasculitis, Sjorgen's syndrome, RA lung disease, rheumatoid nodules), RF positivity, positive anti-CCP antibodies (both characterized dichotomously, per CEP recommendation), and/or bony erosions by radiography.

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Disease Prognosis Assessed and Classified
CPT II 3475F: Disease prognosis for rheumatoid arthritis assessed, poor prognosis documented
OR
CPT II 3476F: Disease prognosis for rheumatoid arthritis assessed, good prognosis documented

OR

Disease Prognosis not Assessed and Classified, Reason not Specified
Append a reporting modifier (8P) to CPT Category II code 3475F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.
3475F *with* 8P: Disease prognosis for rheumatoid arthritis not assessed and classified, reason not otherwise specified

RATIONALE:
After establishing a diagnosis of RA, risk assessment is crucial for guiding optimal treatment. For the purposes of selecting therapies, physicians should consider the presence of these prognostic factors at the time of the treatment decisions.

CLINICAL RECOMMENDATION STATEMENTS:
Important clinical markers of disease prognosis were reviewed by a recent expert panel convened by the American College of Rheumatology as part of an effort to update clinical recommendations. The American College of Rheumatology 2008 Recommendations for the Use of Nonbiologic and Biologic Therapies in Rheumatoid Arthritis were published in Arthritis & Rheumatism, June 2008.

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Poor prognosis is suggested by earlier age at disease onset, high titer of RF, elevated ESR, and swelling of >20 joints. Extraarticular manifestations of RA, such as rheumatoid nodules, Sjogren's syndrome, episcleritis and scleritis, interstitial lung disease, pericardial involvement, systemic vasculitis, and Felty's syndrome, may also indicate a worse prognosis. Since studies have demonstrated that treatment with DMARDs may alter the disease course in patients with recent-onset RA, particularly those with unfavorable prognostic factors, aggressive treatment should be initiated as soon as the diagnosis has been established. (Level C evidence)

Assessment of prognosis should be performed at baseline, before starting medications, to assess organ dysfunction due to comorbid diseases. The literature agrees that a thorough assessment includes recording a complete blood cell count, electrolyte levels, creatinine levels, hepatic enzyme levels (AST – aspartate aminotransferase, ALT – alanine aminotransferase, and albumin), and performing a urinalysis and stool guaiac. If necessary prognosis at baseline should rule out other diseases; this may be repeated during disease flares to rule out septic arthritis through synovial fluid analysis. (Level C evidence)

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

2011 PHYSICIAN QUALITY REPORTING OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY,

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

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for patients with RA seen during the reporting period. It is anticipated that clinicians who provide care for patients with a diagnosis of RA will submit this measure.

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

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

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure. The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All patients aged 18 years and older with a diagnosis of rheumatoid arthritis (RA)

> Denominator Criteria (Eligible Cases):
> Patients aged ≥ 18 years on date of encounter
> AND
> Diagnosis for rheumatoid arthritis (ICD-9-CM): 714.0, 714.1, 714.2, 714.81
> AND
> Patient encounter during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350

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

Definitions:
Prolonged Dose – Doses > 6 months in duration
Prednisone Equivalents – Determine using the following:
1 mg of prednisone = 1 mg of prednisolone; 5 mg of cortisone; 4 mg of hydrocortisone; 0.8 mg of triamcinolone; 0.8 mg of methylprednisolone; 0.15 mg of dexamethasone; 0.15 mg of betamethasone
Glucocorticoid Management Plan – Includes documentation of attempt to taper steroids OR documentation of a new prescription for a non-glucocorticoid disease-modifying antirheumatic drug (DMARD) OR increase in dose of non-glucocorticoid DMARD dose for persistent RA disease activity at current or reduced dose

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

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Glucocorticoid Use Assessed
(One CPT II code [419xF] is required on the claim form to submit this numerator option)
CPT II 4192F: Patient not receiving glucocorticoid therapy
OR
CPT II 4193F: Patient receiving < 10 mg daily prednisone (or equivalent), or RA disease activity is worsening, or glucocorticoid use is for less than 6 months

OR

Glucocorticoid Use Assessed and Management Plan Documented
(Two CPT II codes [4194F and 0540F] are required on the claim form to submit this numerator option)
CPT II 4194F: Patient receiving ≥ 10 mg daily prednisone (or equivalent) for longer than 6 months, and improvement or no change in disease activity
AND
CPT II 0540F: Glucocorticoid Management Plan documented

OR

Glucocorticoid Plan not Documented for Medical Reasons
(Two CPT II codes [0540F-1P and 4194F] are required on the claim form to submit this numerator option)
Append a modifier (1P) to CPT Category II code 0540F to report documented circumstances that appropriately exclude patients from the denominator.
0540F *with* 1P: Documentation of medical reason(s) for not documenting glucocorticoid dose and documenting management plan (i.e., glucocorticoid prescription is for a medical condition other than RA)
AND

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

OR

Glucocorticoid Dose not Documented, Reason not Specified
(One CPT II code [4194F-8P] is required on the claim form to submit this category)
Append a reporting modifier (8P) to CPT Category II code 4194F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.
4194F ***with*** 8P: Glucocorticoid dose was not documented, reason not otherwise specified

OR

Glucocorticoid Plan not Documented, Reason not Specified
(Two CPT II codes [0540F-8P and 4194F] are required on the claim form to submit this numerator option)
Append a reporting modifier (8P) to CPT Category II code 0540F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.
0540F ***with*** 8P: Glucocorticoid plan not documented, reason not otherwise specified
AND
CPT II 4194F: Patient receiving ≥ 10 mg daily prednisone (or equivalent) for longer than 6 months, and improvement or no change in disease activity

RATIONALE:
Glucocorticoids are an important part of RA treatment as they inhibit inflammation and may control synovitis. However, long-term use of glucocorticoids, especially at high doses, should be avoided, due to the potential health complications. Monitoring length and dose of glucocorticoid treatment for patients with RA is integral to making other clinical decisions.

CLINICAL RECOMMENDATION STATEMENTS:
The 1993 American College of Rheumatology guidelines acknowledge the importance of the use and the tracking of glucocorticoid as a RA symptom reliever. The benefits of low-dose systemic glucocorticoids, however, should always be weighed against their adverse effects. The adverse effects of long-term oral glucocorticoids at low doses are protean and include osteoporosis, hypertension, weight gain, fluid retention, hyperglycemia, cataracts, and skin fragility, as well as the potential for premature atherosclerosis. These adverse effects should be considered and should be discussed in detail with the patient before glucocorticoid therapy is begun. For long term disease control, the glucocorticoid dosage should be kept to a minimum. For the majority of patients with RA, this means equal or less than 10 mg of prednisone per day.

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♠ Measure #181: Elder Maltreatment Screen and Follow-Up Plan

2011 PHYSICIAN QUALITY REPORTING OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of patients aged 65 years and older with documentation of a screen for elder maltreatment AND documented follow-up plan

INSTRUCTIONS:
This measure is to be reported for each initial patient evaluation during the reporting period. When reporting CPT service code 96116, 97803, and G0270 the measure is to be reported each time the code is submitted. The not eligible code can be used to report if it is not an initial evaluation with screening for elder maltreatment. This measure may be reported by non-MD/DO clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

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

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

Measure Reporting via Registry:
CPT codes, G-codes, and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure. The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All patients aged 65 years and older

> Denominator Criteria (Eligible Cases):
> Patients aged ≥ 65 years on date of encounter
> AND
> Patient encounter during the reporting period (CPT or HCPCS): 90801, 90802, 96116*, 96150, 97003, 97802, 97803*, G0270*
>
> Note: **When reporting CPT code 96116, 97803, and G0270, the measure is to be reported* each *time the code is submitted.*

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NUMERATOR:
Patients with a documented screen for elder maltreatment and follow-up plan

Definitions:
Documented – Evidenced in the clinical record. Such evidence can include narrative notes, a formal screen and/or an assessment and treatment plan tool/form, copy of a documented plan or referral request for further evaluation, etc.
Screen for Elder Maltreatment – The screen includes a review of the following components: (1) physical abuse, (2) emotional or psychological abuse, (3) neglect, (4) sexual abuse, (5) abandonment, (6) financial or material exploitation, (7) self-neglect, and (8) unwanted control. (Institute of Medicine 2002)
Physical Abuse – Infliction of physical injury by punching, beating, kicking, biting, burning, shaking or other actions that result in harm. (Institute of Medicine, 2002)
Emotional or Psychological Abuse – Involves psychological abuse, verbal abuse, or mental injury and includes act 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. (Reyes-Ortiz 2001)
Active – Behavior that is willful, the caregiver intentionally withholds care or necessities. The neglect may be motivated by financial gain or reflect interpersonal conflicts. (NCPEA)
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. (NCPEA)
Sexual Abuse – Involves adults who are unable to fully comprehend and/or give informed consent in sexual activities that violate the taboos of society. (Institute of Medicine 2002)
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. (NCPEA)
Financial or Material Exploitation – Taking advantage of a person for monetary gain or profit. (Institute of Medicine 2002)
Self-Neglect – Self-imposed attitudes or actions that contribute to decline in the persons overall health and well being, may be associated with an inappropriate or nontraditional lifestyle. Other names used may include Diogenes syndrome (DS), aged reclusion, social breakdown, and squalor syndrome. (Reyes-Ortiz 2001)
Unwarranted Control – Controlling a person's ability to make choices about living situations, household finances, and medical care. (Institute of Medicine 2002)
Follow-Up Plan – May include but is not limited to documentation of a referral or discussion with other providers, on-going monitoring or assessment, and/or a direct intervention.

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Not Eligible – A patient is not eligible if the following condition(s) exist:

- Patient refuses to participate.
- Patient is in an urgent or emergent situation where time is of the essence and to delay treatment would jeopardize the patient's health status.
- Patient elder maltreatment screen was negative and no further follow-up required.

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Elder Maltreatment Screen and Follow-Up Plan Documented
G8534: Documentation of an elder maltreatment screen and follow-up plan
OR
Elder Maltreatment Screen Documented, Follow-Up Plan not Documented, Patient not Eligible
G8537: Elder maltreatment screen documented, follow-up plan not documented, patient not eligible
OR
Elder Maltreatment Screen not Documented, Patient not Eligible
G8535: No documentation of an elder maltreatment screen, patient not eligible
OR
Elder Maltreatment Screen not Documented, Reason not Specified
G8536: No documentation of an elder maltreatment screen, reason not specified
OR
Elder Maltreatment Screen Documented, Follow-Up Plan not Documented, Reason not Specified
G8538: Elder maltreatment screen documented, follow-up plan not documented, reason not specified

RATIONALE:
Elder abuse is the infliction of physical, emotional, or psychological harm on an older adult, but also can take the form of financial exploitation or intentional or unintentional neglect of an older adult by the caregiver. Over the past ten years there has been an increase in elder abuse, which is not being picked up and reported to appropriate authorities. The reasons for underreporting are two-fold: health care professionals don't ask patients if they are being abused and patients don't tell, for fear of retaliation by their caregivers. In the American Psychological Association's "Elder Abuse and Neglect: In Search of Solutions," found on their website, it is reported that every year an estimated 2.1 million older Americans are victims of physical, psychological, or other forms of abuse and neglect and that for every reported case of elder abuse and neglect, it is estimated that there may be as many as five unreported cases. Recent research suggests that elders who have been abused tend to die earlier than those who are not abused, even in the absence of chronic conditions or life threatening disease.

It is difficult to obtain accurate information on the extent of elder abuse and neglect in the United States. Studies often focus on reports of selected populations and many cases are unreported. Victims may be embarrassed, intimidated and overwhelmed by the situation. They may be fearful of reprisals or unaware of the availability of help. In some cases, victims may be unable to report maltreatment or do not realize that they are being maltreated. Finally, health professionals may

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ignore the signs and symptoms of elder maltreatment because they are unaware of the extent of the problem and uncomfortable with the responsibility of further assessment and action.

The extent to which elder maltreatment affects the health care system is largely unknown. Common clinical findings associated with maltreatment include bruises, lacerations, abrasions, head injury, fractures, dehydration, and malnutrition. These injuries commonly result in hospitalization. In one descriptive study that tracked the emergency department utilization of known elderly victims of physical abuse identified through adult protective services, 114 individuals had 628 emergency department visits during a 5-year window surrounding the referral; 30 percent of these visits resulted in hospital admission. (Institute of Medicine 2002)

Studies do indicate that the effects of elder maltreatment increase the medical needs of victims. One longitudinal study of elderly victims of maltreatment documented a threefold increased risk of death in the 3-year period following maltreatment, after adjusting for comorbidity and other factors that predict death in older cohorts (Lachs 1998). In addition, maltreatment may exacerbate or interfere with the treatment of other medical and psychosocial conditions. For example, angina pectoris, emphysema, diabetes mellitus, and arthritis are much more challenging to treat in an abusive environment (Lachs 1997). No studies of the costs associated with these increased medical needs have been published. (Institute of Medicine 2002)

Website searches of the National Quality Measures Database (NQMC) using the keywords Elder Abuse and Elder Neglect resulted in 9 measures. The measures only pertain to intimate partner violence and not the broader topic of elder maltreatment. One measure was focused on preventive counseling on violence and abuse, which is not the measure focus.

CLINICAL RECOMMENDATION STATEMENTS:

Every clinical setting should have a protocol for the detection and assessment of elder maltreatment. This may be a narrative, a checklist, or some other type of standardized form that enables all providers in that practice setting to rapidly assess for elder maltreatment and document it in a way that allows clinicians to look at patterns over time. (Aravanis and Adelman 1993)

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♠ Measure #182: Functional Outcome Assessment in Chiropractic Care

2011 PHYSICIAN QUALITY REPORTING OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of patients aged 18 years and older with documentation of a current functional outcome assessment using a standardized tool AND documentation of a care plan based on identified functional outcome deficiencies

INSTRUCTIONS:
This measure is to be reported each visit indicating the appropriate numerator code; however, the assessment is required to be current as defined for patients seen during the reporting period. This measure may be reported by non-MD/DO clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

> Clarification:
> The intent of the measure is for the functional outcome assessment tool to be utilized at a minimum of every 30 days but reporting is required each visit due to coding limitations. Therefore, for visits between each 30 day functional outcome assessment, the denominator exclusion code not documented/not eligible would be used for reporting purposes.

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

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

Measure Reporting via Registry:
CPT codes and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure. The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All 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): 98940, 98941, 98942

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NUMERATOR:
Patients with a documented current functional outcome assessment using a standardized tool AND a documented care plan

Definitions:
Standardized Tool – An assessment tool that has been appropriately normalized and validated for the population in which it is used. Examples of tools for functional outcome assessment include, but are not limited to, Oswestry Disability Index (ODI), Roland Morris Disability/Activity Questionnaire (RM), and Neck Disability Index (NDI).
Functional Outcome Assessment – Questionnaires designed to measure a patient's limitations in performing the usual human tasks of living. Functional questionnaires seek to quantify symptoms, functional and behavior directly, rather than to infer them from less relevant physiological tests. (Mercy guideline, pg. 143)
Current – A patient having a documented functional assessment within the previous 30 days.
Functional Outcome Deficiencies – Impairment or loss of physical function related to neuromusculoskeletal capacity, including but 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 or planned activities, including 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 upon one or more of the patient's health care problems. Care plans may include order sets as actionable elements, usually supporting a single session or phase. Also known as Treatment Plan.
Not Eligible – A patient is not eligible if the following condition(s) exist:

- Patient refuses to participate.
- Patient unable to complete questionnaire.

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Current Functional Outcome Assessment and Care Plan Documented
G8539: Documentation of a current functional outcome assessment using a standardized tool AND care plan based on identified deficiencies
OR
Current Functional Assessment Documented, Care Plan not Documented, Patient not Eligible
G8542: Documentation of a current functional outcome assessment using a standardized tool; no documentation of a care plan, patient not eligible
OR
Current Functional Outcome Assessment not Documented, Patient not Eligible
G8540: Documentation that the patient is not eligible for a functional outcome assessment using a standardized tool
OR
Current Functional Outcome Assessment not Documented, Reason not Specified
G8541: No documentation of a current functional outcome assessment using a standardized tool, reason not specified
OR

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Current Functional Assessment Documented, Care Plan not Documented, Reason not Specified
G8543: Documentation of a current functional outcome assessment using a standardized tool; no documentation of a care plan, reason not specified

RATIONALE:
Researchers studying the efficacy of chiropractic care have long recognized that patient focused assessment is a critical component of the evaluation process. Chiropractors can utilize the standardized tools to help establish patient centered treatment goals and objective evaluation of achievement of treatment goals if done more frequently. The benefits are also cited by the American College of Physicians (Nelson and Wasson1994) such as: detecting, quantifying, and identifying the source(s) of decreased functional capacity; guiding management decisions; guiding the efficient use of resources; improving the prediction of the course of chronic disease; and improving patient outcomes: symptoms, mortality, satisfaction with care, function, and quality of life. Although the benefits of utilizing standardized functional assessment outcome tools are known, they are not typically utilized and instead information is gathered only by patient interview.

The use of outcome assessment is imperative for the practicing clinician as a means to document health status and improvement (van Hemert 1998). Goertz (1994) identified the importance of using a self-report questionnaire as a means of obtaining a functional health status assessment. Through use of a questionnaire, communication is increased between the physician and patient by focusing not only on location and severity of a specific condition but also on how the condition is affecting the patient's physical and emotional health status. Questionnaires, which measure pain level (visual analog scale), patient satisfaction, or functional assessment (Oswestry) take little time and are valid and reliable (Liebenson 1995). Use of a standardized tool to assess functional status provides a consistent approach in demonstrating the patient's status and response to treatment.

A recent unpublished review of the literature found more than 50 references to the use of functional health status assessment tools in evaluating chiropractic spinal manipulation. Among those most commonly identified were the Oswestry Pain Disability Index (ODI), Roland Morris Disability/Activity Questionnaire (RM), and Neck Disability Index (NDI). While there is a strong scientific basis for the use of outcome assessment in evaluating the impact of chiropractic manipulative procedures, these tools have not yet been widely incorporated into the clinical setting as a quality benchmark.

A review of the National Quality Measures Clearinghouse revealed no same or similar measures.

CLINICAL RECOMMENDATION STATEMENTS:
Functional questionnaires seek to quantify symptoms, function and behavior directly, rather than to infer them from less relevant physiological tests. Clinicians contemplating the use of functional instruments should be aware of differences between them and be able to choose the most appropriate assessment for their specific situation. (Haldeman, et al., 2005)

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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. (Evidence Class: I, II, III, Consensus Level: 1) (Haldeman, et al., 2005)

Keep appropriate records of the patient's evaluation and case management. (The Council on Chiropractic Education, 2007)

Appropriately respond to changes in patient status, or failure of the patient to respond to care. (The Council on Chiropractic Education, 2007)

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

2011 PHYSICIAN QUALITY REPORTING OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

If reporting Measure #183 - Hepatitis C: Hepatitis A Vaccination in Patients with HCV, also report Measure #184 - Hepatitis C: Hepatitis B Vaccination in Patients with HCV.

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

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

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

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

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure. The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

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

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Diagnosis for hepatitis C (ICD-9-CM): 070.51, 070.54, 070.70
AND

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

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

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Hepatitis A Vaccine Injection Received or Patient Has Documented Immunity to Hepatitis A
CPT II 4148F: Hepatitis A vaccine injection administered or previously received
OR
CPT II 3215F: Patient has documented immunity to Hepatitis A

OR

Hepatitis A Vaccine Injection not Received for Medical or Patient Reasons
Append a modifier (1P or 2P) to CPT Category II code 4148F to report documented circumstances that appropriately exclude patients from the denominator.
4148F *with* 1P: Documentation of medical reason(s) for not administering at least one injection of hepatitis A vaccine
4148F *with* 2P: Documentation of patient reason(s) for not administering at least one injection of hepatitis A vaccine

OR

Hepatitis A Vaccine Injection not Received, Reason not Specified
Append a reporting modifier (8P) to CPT Category II code 4148F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.
4148F *with* 8P: Hepatitis A Vaccine not received, reason not otherwise specified

RATIONALE:
Assure that hepatitis A vaccination is received except for cases of documented medical or patient reasons. This vaccination decreases the potential for a patient acquiring hepatitis A which would contribute to further liver damage.

CLINICAL RECOMMENDATION STATEMENTS:
All patients with chronic hepatitis C should be vaccinated against hepatitis A, and seronegative persons with risk factors for hepatitis B virus (HBV) should be vaccinated against hepatitis B. (NIH)

Persons in whom the diagnosis of hepatitis C is established are candidates for hepatitis A and hepatitis B vaccines. (AGA)

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▲ Measure #184: Hepatitis C: Hepatitis B Vaccination in Patients with HCV

2011 PHYSICIAN QUALITY REPORTING OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

If reporting Measure #184 - Hepatitis C: Hepatitis B Vaccination in Patients with HCV, also report Measure #183 - Hepatitis C: Hepatitis A Vaccination in Patients with HCV.

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

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

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

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

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure. The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

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

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Diagnosis for hepatitis C (ICD-9-CM): 070.51, 070.54, 070.70
AND

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

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

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Hepatitis B Vaccine Injection Received or Patient Has Documented Immunity to Hepatitis B
CPT II 4149F: Hepatitis B vaccine injection administered or previously received
OR
CPT II 3216F: Patient has documented immunity to Hepatitis B

OR

Hepatitis B Vaccine Injection not Received for Medical or Patient Reasons
Append a modifier (1P or 2P) to CPT Category II code 4149F to report documented circumstances that appropriately exclude patients from the denominator.
4149F *with* 1P: Documentation of medical reason(s) for not administering at least one injection of hepatitis B vaccine
4149F *with* 2P: Documentation of patient reason(s) for not administering at least one injection of Hepatitis B vaccine

OR

Hepatitis B Vaccine not Received, Reason not Specified
Append a reporting modifier (8P) to CPT Category II code 4149F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.
4149F *with* 8P: Hepatitis B Vaccine not received, reason not otherwise specified

RATIONALE:
Assure that hepatitis B vaccination is received except for cases of documented medical or patient reasons. These vaccinations decrease the potential for a patient acquiring hepatitis B which would contribute to further liver damage.

CLINICAL RECOMMENDATION STATEMENTS:
All patients with chronic hepatitis C should be vaccinated against hepatitis A, and seronegative persons with risk factors for hepatitis B virus (HBV) should be vaccinated against hepatitis B. (NIH)

Persons in whom the diagnosis of hepatitis C is established are candidates for hepatitis A and hepatitis B vaccines. (AGA)

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⌘ Measure #185: Endoscopy & Polyp Surveillance: Colonoscopy Interval for Patients with a History of Adenomatous Polyps – Avoidance of Inappropriate Use

2011 PHYSICIAN QUALITY REPORTING OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of patients aged 18 years and older receiving a surveillance colonoscopy with a history of colonic polyp(s) in a previous colonoscopy, who had a follow-up interval of 3 or more years since their last colonoscopy documented in the colonoscopy report

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 diagnosis codes, CPT code or G-codes, and patient demographics are used to identify patients who are included in the measure's denominator. CPT Category II codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed ICD-9-CM diagnosis codes, CPT codes, G-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 diagnosis codes, CPT codes, G-codes and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure. The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All patients aged 18 years and older receiving a surveillance colonoscopy with a history of colonic polyp(s) in a previous colonoscopy

> 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.

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Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Diagnosis for history of colonic polyp(s) (ICD-9-CM): V12.72
AND
Patient encounter during the reporting period (CPT or HCPCS): 44388, 44389, 44392, 44393, 44394, 45355, 45378, 45380, 45381, 45383, 45384, 45385, G0105
WITHOUT
CPT Category I Modifiers: 52, 53, 73 or 74

NUMERATOR:
Patients who had an interval of 3 or more years since their last colonoscopy

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Interval of Three or More Years Since Patient's Last Colonoscopy
CPT II 0529F: Interval of three or more years since patient's last colonoscopy, documented

OR

Interval of Less Than Three Years Since Patient's Last Colonoscopy for Medical or System Reasons
Append a modifier (1P or 3P) to CPT Category II code 0529F to report documented circumstances that appropriately exclude patients from the denominator.
0529F *with* 1P: Documentation of medical reason(s) for an interval of less than three years since the last colonoscopy (e.g., patients with high risk for colon cancer, last colonoscopy incomplete, last colonoscopy had inadequate prep, piecemeal removal of adenomas, or last colonoscopy found greater than 10 adenomas)
0529F *with* 3P: Documentation of system reason(s) for an interval of less than three years since the last colonoscopy (e.g., unable to locate previous colonoscopy report)

OR

Interval of Less Than Three Years Since Patient's Last Colonoscopy, Reason not Specified
Append a reporting modifier (8P) to CPT Category II code 0529F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.
0529F *with* 8P: Interval of less than three years since patient's last colonoscopy, reason not otherwise specified

RATIONALE:
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 timing of follow-up colonoscopy should be tailored to the number, size, and pathologic findings of the adenomatous polyps removed. The time interval for the development of malignant changes in adenomatous polyps is estimated at 5 to 25 years (ICSI, 2006). A randomized controlled trial of 699 patients showed that after newly diagnosed adenomatous polyps have been removed by colonoscopy, follow-up colonoscopy at three years detects important colonic lesions as effectively as follow-up colonoscopy at both one and three years. (ICSI, 2006)

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Performing colonoscopy too often not only increases patients' exposure to procedural harm, but also drains limited resources that could be more effectively used to adequately screen those in need. Recent evidence from four surveys indicated that postpolypectomy surveillance colonoscopy in the United States is frequently performed at intervals that are shorter than those recommended in guidelines (Rex et al, 2006). Some endoscopists in these studies performed colonoscopy in patients with only small hyperplastic polyps or a single tubular adenoma at one year. These surveys underscore the importance of measuring intervals between examinations in continuous quality improvement programs.

CLINICAL RECOMMENDATION STATEMENTS:

Patients with one to two small (1 cm) tubular adenomas with only low-grade dysplasia should undergo follow-up colonoscopy no earlier than five years later. Patients with advanced adenomatous lesions or >3 adenomas should have repeat colonoscopy in three years as long as all visualized polyps were completely removed, the colonoscopy was completed up the cecum, and the colonic preparation was adequate. A shorter interval of follow-up is recommended in those patients with numerous adenomatous (>10) polyps and in those whom the colonoscopy was incomplete or the preparation was inadequate. After a surveillance colonoscopy has normal results, repeat examinations should be done at five-year intervals. Patients with large, sessile adenomatous lesions removed in a piecemeal fashion should have a repeat examination within two to six months to exclude and remove any remnant polypoid tissue. (Grade 1a) (Davila et al, 2006)

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⌘ Measure #186: Wound Care: Use of Compression System in Patients with Venous Ulcers

2011 PHYSICIAN QUALITY REPORTING OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of patients aged 18 years and older with a diagnosis of venous ulcer who were prescribed compression therapy within the 12-month reporting period

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for patients with venous ulcer(s) seen during the reporting period. This measure is intended to reflect the quality of services provided for the primary management of patients with venous ulcers of the lower extremities.

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

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

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure. The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

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

Option 1- Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Diagnosis for venous ulcer (ICD-9-CM): 454.0, 454.2, 459.11, 459.13, 459.31, 459.33
AND
Patient encounter during the reporting period (CPT): 29580, 29581, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215

OR

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Option 2- Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Diagnosis for venous ulcer (ICD-9-CM): 459.81
AND
Diagnosis for ulcer of lower limbs (ICD-9-CM): 707.12, 707.13, 707.14, 707.15, 707.19
AND
Patient encounter during the reporting period (CPT): 29580, 29581, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215

NUMERATOR:
Patients who were prescribed compression therapy within the 12 month reporting period

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Compression Therapy Prescribed
CPT II 4267F: Compression therapy prescribed

OR

Compression Therapy not Prescribed for Medical, Patient or System Reasons
Append a modifier (1P, 2P or 3P) to CPT Category II code 4267F to report documented circumstances that appropriately exclude patients from the denominator.
4267F *with* 1P: Documentation of medical reason(s) for not prescribing compression therapy (e.g., severe arterial occlusive disease)
4267F *with* 2P: Documentation of patient reason(s) for not prescribing compression therapy
4267F *with* 3P: Documentation of system reason(s) for not prescribing compression therapy

OR

Compression Therapy not Prescribed, Reason not Specified
Append a reporting modifier (8P) to CPT Category II code 4267F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.
4267F *with* 8P: Compression therapy not prescribed, reason not otherwise specified

RATIONALE:
Compression therapy is fundamental to promote healing and prevent recurrence of ulcers in patients with venous abnormality. Although it has proven efficacy, research has shown that it is not universally used in the treatment of patients with venous ulcers. One study found that one third of patients did not receive compression of any sort and there was great variability in the level and type of compression therapy used. Graduated high compression (>30 mmHg) produces the best results. However, some compression is better than no compression.

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CLINICAL RECOMMENDATION STATEMENTS:

For patients with venous hypertension or risk for venous insufficiency, consider graduated compression stockings. (Grade B) (ASPS, 2007)

The use of a Class 3 (most supportive) high-compression system (three layer, four layer, short stretch, paste-containing bandages, e.g., Unna's boot, Duke boot) is indicated in the treatment of venous ulcers. Although these modalities are similar in effectiveness, they can differ significantly in comfort and cost. The degree of compression must be modified when mixed venous/arterial disease is confirmed during the diagnostic work-up. Intermittent pneumatic pressure (IPC) can be used with or without compression dressings and can provide another option in patients who cannot or will not use an adequate compression dressing system. (Level I) (WHS, 2006)

Compression therapy heals more venous leg ulcers than no compression therapy as well as decreases the healing time. High compression is more effective than low compression, but there are no differences in the effectiveness of the different types of products available for high compression. (Level A) (WOCN, 2005)

Compression options:

- Elastic compression bandage heals more than inelastic compression (Grade A)
- Multi-layer (2, 3, or 4 layers) sustained, elastic high-compression bandage (Grade A)
- Elastic high-compression stockings to heal venous ulcers (Grade A)
- Elastic multiple-layer high-compression stockings to heal venous ulcers (Grade A)
- Duke Boot or Unna Boot + elastic compression (Grade A)
- Gradient compression better than uniform compression (Grade C)
- Short stretch bandage (Grade A)
- Unna boot zinc paste impregnated bandage (Grade A)
- Intermittent pneumatic compression (Grade A)
- Non-elastic compression with Circaid [or similar device] (Grade B)
- Sequential-gradient pneumatic compression (Grade C) (AAWC, 2005)

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Measure #187: Stroke and Stroke Rehabilitation: Thrombolytic Therapy

2011 PHYSICIAN QUALITY REPORTING OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Percentage of patients aged 18 years and older with a diagnosis of acute ischemic stroke who arrive at the hospital within two hours of time last known well and for whom IV t-PA was initiated within three hours of time last known well

INSTRUCTIONS:
This measure is to be reported for each episode of acute ischemic stroke for patients who arrive at the hospital within two hours of time last known well and for whom IV t-PA was initiated within three hours of time last known well. It is anticipated that clinicians providing care for patients with acute ischemic stroke in the hospital setting will submit this measure.

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure. The quality-data codes have been provided for registry only measures for use by registries that utilize claims data. It is not necessary to submit these codes for registry-based submissions. Do not report this measure via claims.

DENOMINATOR:
All patients aged 18 years and older with a diagnosis of acute ischemic stroke whose time of arrival is within two hours (≤ 120 minutes) of time last known well

> Denominator Criteria (Eligible Cases):
> Patients aged ≥ 18 years on date of encounter.
> AND
> Diagnosis for ischemic stroke (ICD-9-CM): 433.01, 433.10, 433.11, 433.21, 433.31, 433.81, 433.91, 434.00, 434.01, 434.11, 434.91, 436
> AND
> Patient encounter during reporting period (CPT): 99221, 99222, 99223, 99291
> AND
> Time last known well to arrival in the emergency department less than or equal to two hours (**≤120 minutes)**

NUMERATOR:
Patients for whom IV thrombolytic therapy was initiated at the hospital within three hours (≤ 180 minutes) of time last known well

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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:
IV t-PA initiated within three hours (≤180 minutes) of time last known well (G8600)

OR

IV t-PA not initiated within three hours (≤180 minutes) of time last known well for reasons documented by clinician (e.g., patient enrolled in clinical trial for stroke, patient admitted for elective carotid intervention) (G8601)

OR

IV t-PA not initiated within three hours (≤180 minutes) of time last known well, reason not specified (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 h of clearly defined symptom onset (Class 1, Grade 1A) (ACP).

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Measure #188: Referral for Otologic Evaluation for Patients with Congenital or Traumatic Deformity of the Ear

2011 PHYSICIAN QUALITY REPORTING OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of patients aged birth and older referred to a physician (preferably a physician with training in disorders of the ear) for an otologic evaluation subsequent to an audiologic evaluation after presenting with a congenital or traumatic deformity of the ear (internal or external).

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for all patients seen during the reporting period who present with congenital or traumatic deformity of the ear. This measure is intended to ensure that patients with congenital or traumatic deformity of the ear receive a referral in order to facilitate appropriate care and follow-up. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

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

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

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure. The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
Patients age birth and older who present with congenital or traumatic deformity of the ear

> Denominator Criteria (Eligible Cases):
> Patients age birth and older on date of encounter
> AND
> Diagnosis for congenital and traumatic anomalies (ICD-9-CM): 380.00, 380.01, 380.02, 380.03, 380.10, 380.30, 380.31, 380.32, 380.39, 380.51, 380.81, 380.89, 380.9, 744.01, 744.02, 744.03, 744.09
> AND
> Patient encounter during reporting period (CPT): 92557, 92567, 92568, 92575

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NUMERATOR:
Patients referred to a physician (preferably a physician with training in disorders of the ear) for an otologic evaluation subsequent to an audiologic evaluation who present with congenital or traumatic deformity of the ear

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Referral for Otologic Evaluation
G8556: Referred to a physician (preferably a physician with training in disorders of the ear) for an otologic evaluation

OR

Referral for Otologic Evaluation not Performed for Documented Reasons
G8557: Patient is not eligible for the referral for otologic evaluation measure (e.g. patients for whom an assessment of the congenital or traumatic deformity of the ear has been performed by a physician (preferably a physician with training in disorders of the ear) within the past six months, patients who are already under the care of a physician (preferably a physician with training in disorders of the ear) for congenital or traumatic deformity of the ear.)

OR

Referral for Otologic Evaluation not Performed, Reason not Specified
G8558: Not referred to a physician (preferably a physician with training in disorders of the ear) for an otologic evaluation, reason not specified

RATIONALE:
Studies demonstrate that patients who present with congenital or traumatic deformity of the ear may suffer from underlying problems, so therefore referral is necessary. Without referral, patients may suffer consequences of the underlying problems.

CLINICAL RECOMMENDATION STATEMENTS:
The American Academy of Otolaryngology-Head and Neck Surgery policy statement (approved 9/12/2002):

Hearing loss and balance disorders are medical conditions. Only licensed physicians with medical training may diagnose and direct the management of disease and medical disorders. A full history and physical examination by a physician (preferably a physician specially trained in disorders of the ear) to determine the accurate medical diagnosis and appropriate medical/surgical treatment for hearing loss and balance disorders are indicated for patients with the following "red flags":

1) Hearing loss with a positive history of familial hearing loss, TB, syphilis, HIV, Meniere's disease, autoimmune disorder, otosclerosis, von Recklinghausen's neurofibromatosis, Paget's disease of bone, head trauma related to onset.
2) History of pain, active drainage, or bleeding from an ear.
3) Sudden onset or rapidly progressive hearing loss.
4) Acute, chronic, or recurrent episodes of dizziness.
5) Evidence of congenital or traumatic deformity of the ear.
6) Visualization of blood, pus, cerumen plug, or foreign body in the ear canal.
7) Conductive hearing loss or abnormal tympanogram.
8) Unilateral or asymmetric hearing loss; or bilateral hearing loss > 80 dB.
9) Unilateral or pulsatile tinnitus.
10) Unilateral or asymmetrically poor speech discrimination scores.

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The red flags do not include all indications for a medical referral and are not intended to replace clinical judgment in determining the need for consultation with an otolaryngologist.

21 C.F.R. section 801.420:

A hearing aid dispenser should advise a prospective hearing aid user to consult promptly with a licensed physician (preferably an ear specialist) before dispensing a hearing aid if the hearing aid dispenser determines through inquiry, actual observation, or review of any other available information concerning the prospective user, that the prospective user has any of the following conditions:

I. Congenital or traumatic deformity of the ear.
II. History of active drainage from the ear within the previous 90 days.
III. History of sudden or rapidly progressive hearing loss within the previous 90 days.
IV. Acute or chronic dizziness.
V. Unilateral hearing loss of sudden or recent onset within the previous 90 days.
VI. Audiometric air-bone gap equal to or greater than 15 decibels at 500 hertz (Hz), 1,000 Hz, and 2,000 Hz.
VII. Evidence of significant cerumen accumulation or a foreign body in the ear canal.
VIII. Pain or discomfort in the ear.

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Measure #189: Referral for Otologic Evaluation for Patients with a History of Active Drainage From the Ear Within the Previous 90 Days

2011 PHYSICIAN QUALITY REPORTING OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of patients aged birth and older who have disease of the ear and mastoid processes referred to a physician (preferably a physician with training in disorders of the ear) for an otologic evaluation subsequent to an audiologic evaluation after presenting with a history of active drainage from the ear within the previous 90 days

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 a history of active drainage from the ear within the previous 90 days. This measure is intended to ensure that patients with active drainage receive a referral in order to receive appropriate care. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

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

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

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure. The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
Patients age birth and older who have disease of the ear and mastoid processes who present with active drainage from the ear within the previous 90 days

Denominator Criteria (Eligible Cases):
Patients age birth and older on date of encounter
AND
Diagnosis for disease of the ear and mastoid processes (ICD-9-CM): 381.01, 382.00, 382.01, 382.02, 382.1, 382.2, 382.3, 382.4, 382.9, 388.60, 388.61, 388.69
AND
Patient encounter during reporting period (CPT): 92557, 92567, 92568, 92575

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NUMERATOR:
Patients referred to a physician (preferably a physician with training in disorders of the ear) for an otologic evaluation subsequent to an audiologic evaluation who present with a history of active drainage from the ear within the previous 90 days

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Referral for Otologic Evaluation
(Two G-codes [G8559 & G8560] are required on the claim form to submit this numerator option)
G8559: Patient referred to a physician (preferably a physician with training in disorders of the ear) for an otologic evaluation
AND
G8560: Patient has a history of active drainage from the ear within the previous 90 days

OR

Referral for Otologic Evaluation not Performed for Documented Reasons
(Two G-codes [G8561 & G8560] are required on the claim form to submit this numerator option)
G8561: Patient is not eligible for the referral for otologic evaluation for patients with a history of active drainage measure (e.g. Patients who are already under the care of a physician for active ear drainage.)
AND
G8560: Patient has a history of active drainage from the ear within the previous 90 days

OR
If patient is not eligible for this measure because no history of active drainage, report:
(One G-code [G8562] is required on the claim form to submit this numerator option)
G8562: Patient does not have a history of active drainage from the ear within the previous 90 days

OR

Referral for Otologic Evaluation not Performed, Reason not Specified
(Two G-codes [G8563 & G8560] are required on the claim form to submit this numerator option)
G8563: Patient not referred to a physician (preferably a physician with training in disorders of the ear) for an otologic evaluation, reason not specified
AND
G8560: Patient has a history of active drainage from the ear within the previous 90 days

RATIONALE:
Studies demonstrate that patients who present with a history of active drainage from the ear within the previous 90 days may suffer from underlying problems, so therefore referral is necessary. Without referral, patients may suffer consequences of the underlying problems.

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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":

4) 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.
5) History of pain, active drainage, or bleeding from an ear.
6) Sudden onset or rapidly progressive hearing loss.
7) Acute, chronic, or recurrent episodes of dizziness.
8) Evidence of congenital or traumatic deformity of the ear.
9) Visualization of blood, pus, cerumen plug, or foreign body in the ear canal.
10) Conductive hearing loss or abnormal tympanogram.
11) Unilateral or asymmetric hearing loss; or bilateral hearing loss > 80 dB.
12) Unilateral or pulsatile tinnitus.
13) 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.

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Measure #190: Referral for Otologic Evaluation for Patients with a History of Sudden or Rapidly Progressive Hearing Loss

2011 PHYSICIAN QUALITY REPORTING OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of patients aged birth and older referred to a physician (preferably a physician with training in disorders of the ear) for an otologic evaluation immediately following an audiologic evaluation that verifies and documents sudden or rapidly progressive hearing loss.

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 a history of sudden or rapidly progressive hearing loss.

This measure is intended to ensure that patients with sudden or rapidly progressive hearing loss receive a referral in order to receive appropriate care. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

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

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

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure. The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
Patients aged birth and older with verification and documentation of sudden or rapidly progressive hearing loss

Denominator Criteria (Eligible Cases):
Patients age birth and older on date of encounter
AND
Diagnosis for hearing loss (ICD-9-CM): 389.00, 389.01, 389.02, 389.03, 389.04, 389.05, 389.06, 389.08, 389.10, 389.11, 389.12, 389.13, 389.14, 389.15, 389.16, 389.17, 389.18, 389.20, 389.21, 389.22, 389.8, 389.9
AND

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Patient encounter during reporting period (CPT): 92550, 92557, 92567, 92568, 92570, 92575

NUMERATOR:
Patients referred to a physician (preferably a physician with training in disorders of the ear) for an otologic evaluation immediately following an audiologic evaluation that verifies and documents sudden or rapidly progressive hearing loss

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Referral for Otologic Evaluation
(Two G-codes [G8564 & G8565] are required on the claim form to submit this numerator option)
G8564: Patient was referred to a physician (preferably a physician with training in disorders of the ear) for an otologic evaluation
AND
G8565: Verification and documentation of sudden or rapidly progressive hearing loss

OR

Referral for Otologic Evaluation not Performed for Documented Reasons
(Two G-codes [G8566 & G8565] are required on the claim form to submit this numerator option)
G8566: Patient is not eligible for the "Referral for Otologic Evaluation for Sudden or Rapidly Progressive Hearing Loss" measure (e.g. patients who are under current care of a physician for sudden or rapidly progressive hearing loss.)
AND
G8565: Verification and documentation of sudden or rapidly progressive hearing loss

OR
If patient is not eligible for this measure because there is no documentation of sudden or rapidly progressive hearing loss, report:
(One G-code [G8567] is required on the claim form to submit this numerator option)
G8567: Patient does not have verification and documentation of sudden or rapidly progressive hearing loss

OR

Referral for Otologic Evaluation not Performed, Reason not Specified
(Two G-codes [G8568 & G8565] are required on the claim form to submit this numerator option)
G8568: Patient was not referred to a physician (preferably a physician with training in disorders of the ear) for an otologic evaluation, reason not specified
AND
G8565: Verification and documentation of sudden or rapidly progressive hearing loss

RATIONALE:
Studies demonstrate that patients who present sudden or rapidly progressive hearing loss not only suffer from hearing loss, but may suffer from underlying problems, so therefore referral is necessary. Without referral, patients may suffer consequences of the underlying problems.

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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":

14) 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.
15) History of pain, active drainage, or bleeding from an ear.
16) Sudden onset or rapidly progressive hearing loss.
17) Acute, chronic, or recurrent episodes of dizziness.
18) Evidence of congenital or traumatic deformity of the ear.
19) Visualization of blood, pus, cerumen plug, or foreign body in the ear canal.
20) Conductive hearing loss or abnormal tympanogram.
21) Unilateral or asymmetric hearing loss; or bilateral hearing loss > 80 dB.
22) Unilateral or pulsatile tinnitus.
23) 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.

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*Measure #191: Cataracts: 20/40 or Better Visual Acuity within 90 Days Following Cataract Surgery

2011 PHYSICIAN QUALITY REPORTING OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

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

INSTRUCTIONS:
This measure is to be calculated each time a procedure for uncomplicated cataracts is performed during the reporting period. This measure is intended to reflect the quality of services provided for the patients receiving uncomplicated cataract surgery.

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

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

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT codes and patient demographics are used to 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 have been provided for registry only measures for use by registries that utilize claims data. It is not necessary to submit these codes for registry-based submissions. There are no allowable performance exclusions for this measure. Do not report this measure via claims.

DENOMINATOR:
All patients aged 18 years and older who had cataract surgery and no significant pre-operative ocular conditions impacting the visual outcome of surgery

> Denominator Instructions: Clinicians who indicate modifier 56, preoperative management only, will not qualify for this measure.

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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
Patients WITHOUT any of the following comorbid conditions that impact the visual outcome of surgery
(Patients with documentation of any of the following comorbid conditions that impact the visual outcome of surgery prior to date of cataract surgery are excluded from the measure calculation)

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

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Comorbid Condition	Corresponding ICD-9-CM Codes
Glaucoma	365.10, 365.11, 365.12, 365.13, 365.14, 365.15, 365.20, 365.21, 365.22, 365.23, 365.24, 365.31, 365.32, 365.51, 365.52, 365.59, 365.60, 365.61, 365.62, 365.63, 365.64, 365.65, 365.81, 365.82, 365.83, 365.89
Glaucoma associated with congenital anomalies, dystrophies, and systemic syndromes	365.41, 365.42, 365.43, 365.44, 365.60, 365.61, 365.62, 365.63, 365.64, 365.65, 365.81, 365.82, 365.83, 365.89, 365.9
Hereditary corneal dystrophies	371.50, 371.51, 371.52, 371.53, 371.54, 371.55, 371.56, 371.57, 371.58
Hereditary choroidal dystrophies	363.50, 363.51, 363.52, 363.53, 363.54, 363.55, 363.56, 363.57
Hereditary retinal dystrophies	362.70, 362.71, 362.72, 362.73, 362.74, 362.75, 362.76
High myopia	360.20, 360.21
Injury to optic nerve and pathways	950.0, 950.1, 950.2, 950.3, 950.9
Keratitis	370.03
Moderate or severe impairment, better eye, profound impairment lesser eye	369.10, 369.11, 369.12, 369.13, 369.14, 369.15, 369.16, 369.17, 369.18
Nystagmus and other irregular eye movements	379.51
Open wound of eyeball	871.0, 871.1, 871.2, 871.3, 871.4, 871.5, 871.6, 871.7, 871.9, 921.3
Optic Atrophy	377.10, 377.11, 377.12, 377.13, 377.14, 377.15, 377.16
Optic neuritis	377.30, 377.31, 377.32, 377.33, 377.34, 377.39
Other background retinopathy and retinal vascular changes	362.12, 362.16, 362.18
Other corneal deformities	371.70, 371.71, 371.72, 371.73
Other disorders of optic nerve	377.41
Other disorders of sclera	379.11, 379.12
Other endophthalmitis	360.11, 360.12, 360.13, 360.14, 360.19
Other retinal disorders	362.81, 362.82, 362.83, 362.84, 362.85, 362.89
Other and unspecified forms of chorioretinitis and retinochoroiditis	363.20, 363.21, 363.22
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,

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Comorbid Condition	Corresponding ICD-9-CM Codes
Retinopathy of prematurity	362.20, 362.21, 362.22, 362.23, 362.24, 362.25, 362.26, 362.27
Scleritis and episcleritis	379.04, 379.05, 379.06, 379.07, 379.09
Separation of retinal layers	362.41, 362.42, 362.43
Uveitis	360.11, 360.12
Visual field defects	368.41

NUMERATOR:
Patients who had best-corrected visual acuity of 20/40 or better (distance or near) achieved within 90 days following cataract surgery

Numerator Options:
Best-corrected visual acuity of 20/40 or better (distance or near) achieved within 90 days following cataract surgery (4175F)

OR

Best-corrected visual acuity of 20/40 or better (distance or near) not achieved within 90 days following cataract surgery, reason not otherwise specified (4175F *with* 8P)

RATIONALE:

4. Scientific basis for measuring visual acuity outcomes after cataract surgery

The only reason to perform cataract surgery (other than for a limited set of medical indications) is to improve a patient's vision and associated functioning. The use of a 20/40 visual acuity threshold is based on several considerations. First, it is the level for unrestricted operation of a motor vehicle in the US. Second, it has been consistently used by the FDA in its assessment for approval of IOL and other vision devices. Third, it is the literature standard to denote success in cataract surgery. Fourth, work by West et al in the Salisbury Eye Study suggests that 20/40 is a useful threshold for 50th percentile functioning for several vision-related tasks.

Most patients achieve excellent visual acuity after cataract surgery (20/40 or better). This outcome is achieved consistently through careful attention through the accurate measurement of axial length and corneal power and the appropriate selection of an IOL power calculation formula. As such, it reflects the care and diligence with which the surgery is assessed, planned and executed. Failure to achieve this after surgery in eyes without comorbid ocular conditions that would impact the success of the surgery would reflect care that should be assessed for opportunities for improvement.

The exclusion of patients with other ocular and systemic conditions known to increase the risk of an adverse outcome reflects the findings of the two published prediction rule papers for cataract surgery outcomes, by Mangione et al and Steinberg et al. In both papers, the presence of comorbid glaucoma and macular degeneration negatively impacted the likelihood of successful outcomes of surgery. Further, as noted in the prior indicator, exclusion of eyes with ocular conditions that could impact the success of the surgery would NOT eliminate the large majority of eyes undergoing surgery while also minimizing the potential adverse selection that might otherwise occur relative to those patients with the most complex situations who might benefit the most from having surgery to maximize their remaining vision.

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5. 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.33 Best-corrected visual acuity of 20/40 was achieved by 89% of all NEON patients and 96% of NEON patients without preoperative ocular comorbid conditions. Seventy-eight percent of patients were within ± 1.0 D of target spherical equivalent. Ninety-five percent of patients reported being satisfied with the results of their surgery. Patients who were dissatisfied with the results of their surgery were slightly older and more likely to have ocular comorbidity.
In studies of phacoemulsification cataract surgery performed by ophthalmology residents, the reported range of patients with postoperative BCVA of 20/40 or better is 80% to 91%. Eyes with ocular comorbidities are excluded, the reported range of patients with postoperative BCVA of 20/40 or better is 86% to 98%.37 (AAO)

CLINICAL RECOMMENDATION STATEMENTS:

This is an outcomes measure. As such, there are no statements in the guideline specific to this measurement topic.

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*Measure #192: Cataracts: Complications within 30 Days Following Cataract Surgery Requiring Additional Surgical Procedures

2011 PHYSICIAN QUALITY REPORTING OPTIONS FOR INDIVIDUAL MEASURES:

REGISTRY ONLY

DESCRIPTION:
Percentage of patients aged 18 years and older with a diagnosis of uncomplicated cataract who had cataract surgery and had any of a specified list of surgical procedures in the 30 days following cataract surgery which would indicate the occurrence of any of the following major complications: retained nuclear fragments, endophthalmitis, dislocated or wrong power IOL, retinal detachment, or wound dehiscence.

INSTRUCTIONS:
This measure is to be calculated each time a procedure for non-complicated cataracts is performed during the reporting period. This measure is intended to reflect the quality of services provided for the patients receiving uncomplicated cataract surgery.

Note: This is an outcomes measure and can be calculated solely using registry data.

- For patients who receive the cataract surgical procedures specified in the denominator coding, claims should be reviewed to determine if any of the procedure codes listed in the numerator were performed within 30 days of the date of cataract surgery.
- Patients who have any of the listed comorbid conditions in the exclusion criteria should be removed from the denominator, and not considered as having a complication within 30 days following cataract surgery.

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT codes and patient demographics are used to 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 have been provided for registry only measures for use by registries that utilize claims data. It is not necessary to submit these codes for registry-based submissions. There are no allowable performance exclusions for this measure. Do not report this measure via claims.

DENOMINATOR:
All patients aged 18 years and older who had cataract surgery and no significant pre-operative ocular conditions impacting the surgical complication rate

Denominator Instructions: Clinicians who indicate modifier 56, preoperative management only, will not qualify for this measure.

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Patient encounter during the reporting period (CPT): 66840, 66850, 66852, 66920, 66930, 66940, 66982, 66983, 66984

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AND

Patients WITHOUT comorbid conditions that impact the visual outcome of surgery. *(Patients with documentation of one or more of the following comorbid conditions prior to date of cataract surgery are excluded from the measure calculation).*

Comorbid Condition	Corresponding ICD-9-CM Codes
Acute and subacute iridocyclitis	364.00, 364.01, 364.02, 364.03, 364.04, 364.05
Adhesions and disruptions of iris and ciliary body	364.70, 364.71, 364.72, 364.73, 364.74, 364.75, 364.76, 364.77, 364.81, 364.82, 364.89
Anomalies of puillary function	379.42
Aphakia and other disorders of lens	379.32, 379.33, 379.34
Burn confined to eye and adnexa	940.0, 940.1, 940.2, 940.3, 940.4, 940.5, 940.9
Cataract secondary to ocular disorders	366.32, 366.33
Cataract, congenital	743.30
Cataract, mature or hypermature	366.9
Cataract, posterior polar	743.31
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

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Comorbid Condition	Corresponding ICD-9-CM Codes
High myopia	360.21
Hypotony of eye	360.30, 360.31, 360.32, 360.33, 360.34
Injury to optic nerve and pathways	950.0, 950.1, 950.2, 950.3, 950.9
Keratitis	370.03
Open wound of eyeball	871.0, 871.1, 871.2, 871.3, 871.4, 871.5, 871.6, 871.7, 871.9, 921.3
Pathologic myopia	360.20, 360.21
Posterior lenticonus	743.36
Prior pars plana vitrectomy	67036, 67039, 67040, 67041, 67042, 67043 (patient with history of this procedure)
Pseudoexfoliation syndrome	365.52
Retinopathy of prematurity	362.21
Senile cataract	366.11
Traumatic cataract	366.21, 366.22, 366.23, 366.20
Use of systemic sympathetic alpha-1a antagonist medication for treatment of prostatic hypertrophy	Patient taking tamsulosin hydrochloride
Uveitis	360.11, 360.12
Vascular disorders of iris and ciliary body	364.42

NUMERATOR:
Patients who had one or more specified operative procedures for any of the following major complications within 30 days following cataract surgery: retained nuclear fragments, endophthalmitis, dislocated or wrong power IOL, retinal detachment, or wound dehiscence

Numerator Instructions: Codes for major complications (e.g., retained nuclear fragments, endophthalmitis, dislocated or wrong power IOL, retinal detachment, or wound dehiscence): 65235, 65800, 65810, 65815, 65860, 65880, 65900, 65920, 65930, 66030, 66250, 66820, 66825, 66830, 66852, 66986, 67005, 67010, 67015, 67025, 67028, 67030, 67031, 67036, 67039, 67041, 67042, 67043, 67101, 67105, 67107, 67108, 67110, 67112, 67141, 67145, 67250, 67255

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NUMERATOR NOTE: For performance, a lower rate indicates better performance.

Numerator Options:

Surgical procedure performed within 30 days following cataract surgery for major complications (e.g., retained nuclear fragments, endophthalmitis, dislocated or wrong power IOL, retinal detachment or wound dehiscence) (G8627)

OR

Surgical procedure not performed within 30 days following cataract surgery for major complications (e.g., retained nuclear fragments, endophthalmitis, dislocated or wrong power IOL, retinal detachment or wound dehiscence) (G8628)

RATIONALE:

1. Scientific basis for assessing short-term complications following cataract surgery.

Complications that may result in a permanent loss of vision following cataract surgery are uncommon. This short-term outcomes of surgery indicator seeks to identify those complications from surgery that can reasonably be attributed to the surgery and surgeon and which reflect situations which - if untreated - generally result in significant avoidable vision loss that would negatively impact patient functioning. Further, it seeks to reduce surgeon burden and enhance accuracy in reporting by focusing on those significant complications that can be assessed from administrative data alone and which can be captured by the care of another physician or the provision of additional, separately coded, post-operative services. Finally, it focuses on patient safety and monitoring for events that, while hopefully uncommon, can signify important issues in the care being provided. For example, the need to reposition or exchange an IOL reflects in part "wrong power" IOL placement, a major patient safety issue.

In order to achieve these ends, the indicator excludes patients with other known, pre-operative ocular conditions that could impact the likelihood of developing a complication. Based on the results of the Cataract Appropriateness Project at RAND, other published studies, and one analysis performed by on 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.

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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)

CLINICAL RECOMMENDATION STATEMENTS:

This is an outcomes measure. As such, there are no statements in the guideline specific to this measurement topic.

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▲ Measure #193: Perioperative Temperature Management

2011 PHYSICIAN QUALITY REPORTING 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 or 8P- reasons not otherwise specified. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
CPT codes are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure. The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All patients, regardless of age, undergoing surgical or therapeutic procedures under general or neuraxial anesthesia of 60 minutes duration or longer, except patients undergoing cardiopulmonary bypass

Denominator Criteria (Eligible Cases):
Patient encounter during the reporting period (CPT): Anesthesia codes for surgical or therapeutic procedures under general or neuraxial anesthesia:
00100, 00102, 00103, 00104, 00120, 00124, 00126, 00140, 00142, 00144, 00145, 00147, 00148, 00160, 00162, 00164, 00170, 00172, 00174, 00176, 00190, 00192, 00210, 00211, 00212, 00214, 00215, 00216, 00218, 00220, 00222, 00300, 00320, 00322, 00326, 00350, 00352, 00400, 00402, 00404, 00406, 00410, 00450, 00452, 00454, 00470, 00472, 00474,

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00500, 00520, 00522, 00524, 00528, 00529, 00530, 00532, 00534, 00537, 00539, 00540, 00541, 00542, 00546, 00548, 00550, 00560, 00566, 00580, 00600, 00604, 00620, 00622, 00625, 00626, 00630, 00632, 00634, 00635, 00640, 00670, 00700, 00702, 00730, 00740, 00750, 00752, 00754, 00756, 00770, 00790, 00792, 00794, 00796, 00797, 00800, 00802, 00810, 00820, 00830, 00832, 00834, 00836, 00840, 00842, 00844, 00846, 00848, 00851, 00860, 00862, 00864, 00865, 00866, 00868, 00870, 00872, 00873, 00880, 00882, 00902, 00904, 00906, 00908, 00910, 00912, 00914, 00916, 00918, 00920, 00921, 00922, 00924, 00926, 00928, 00930, 00932, 00934, 00936, 00938, 00940, 00942, 00944, 00948, 00950, 00952, 01112, 01120, 01130, 01140, 01150, 01160, 01170, 01173, 01180, 01190, 01200, 01202, 01210, 01212, 01214, 01215, 01220, 01230, 01232, 01234, 01250, 01260, 01270, 01272, 01274, 01320, 01340, 01360, 01380, 01382, 01390, 01392, 01400, 01402, 01404, 01420, 01430, 01432, 01440, 01442, 01444, 01462, 01464, 01470, 01472, 01474, 01480, 01482, 01484, 01486, 01490, 01500, 01502, 01520, 01522, 01610, 01620, 01622, 01630, 01634, 01636, 01638, 01650, 01652, 01654, 01656, 01670, 01680, 01682, 01710, 01712, 01714, 01716, 01730, 01732, 01740, 01742, 01744, 01756, 01758, 01760, 01770, 01772, 01780, 01782, 01810, 01820, 01829, 01830, 01832, 01840, 01842, 01844, 01850, 01852, 01860, 01924, 01925, 01926, 01930, 01931, 01932, 01933, 01935, 01936, 01951, 01952, 01961, 01962, 01963, 01965, 01966, 01968, 01969

NUMERATOR:

Patients for whom *either*

- Active warming was used intraoperatively for the purpose of maintaining normothermia
  OR
- At least one body temperature equal to or greater than 36 degrees Centigrade (or 96.8 degrees Fahrenheit) was recorded within the 30 minutes immediately before or the 15 minutes immediately after anesthesia end time

Numerator Instructions: The anesthesia time used for this measure should be the time recorded in the anesthesia record.

Definition:

For purposes of this measure, "active warming" – is limited to over-the-body active warming (e.g., forced air, warm-water garments, and resistive heating blankets).

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Active Warming Used Intraoperatively OR At Least One Body Temperature Equal to or Greater than 36 Degrees Centigrade Recorded Within Designated Timeframe

(Two CPT II codes [4250F & 4255F] are required on the claim form to submit this numerator option)

CPT II 4250F: Active warming used intraoperatively for the purpose of maintaining normothermia, OR at least one body temperature equal to or greater than 36 degrees Centigrade (or 96.8 degrees Fahrenheit) recorded within the 30 minutes immediately before or the 15 minutes immediately after anesthesia end time.

AND

CPT II 4255F: Duration of general or neuraxial anesthesia 60 minutes or longer, as documented in the anesthesia record

OR

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Active Warming Not Performed OR at Least One Body Temperature Equal to or Greater than 36 Degrees Centigrade not Achieved Within Designated Timeframe for one of the following Medical Reasons:

(Two CPT II codes [4250F-1P & 4255F] are required on the claim form to submit this numerator option)

Append a modifier (1P) to CPT Category II code 4250F to report one of the following documented circumstances that appropriately exclude patients from the denominator.

4250F with 1P: Intentional hypothermia OR active warming not indicated due to anesthetic technique: peripheral nerve block without general anesthesia, OR monitored anesthesia care

AND

CPT II 4255F: Duration of general or neuraxial anesthesia 60 minutes or longer, as documented in the anesthesia record

OR

If patient does not meet denominator inclusion because anesthesia time as indicated on the anesthesia record is less than 60 minutes duration (including anesthesia services provided using monitored anesthesia care [MAC] or peripheral nerve block [PNB] less than 60 minutes duration):

(One CPT II code [4256F] is required on the claim form to submit this numerator option)

CPT II 4256F: Duration of general or neuraxial anesthesia less than 60 minutes, as documented in the anesthesia record

OR

Active Warming Not Performed OR at Least One Body Temperature Equal to or Greater than 36 Degrees Centigrade Not Achieved Within Designated Timeframe, Reason Not Specified

(Two CPT II codes [4250F-8P & 4255F] are required on the claim form to submit this numerator option)

Append a reporting modifier (8P) to CPT Category II code 4250F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

4250F with 8P: Active warning 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

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for this measure. Several methods to maintain normothermia are available to the anesthesiologist in the perioperative period; various studies have demonstrated the superior efficacy of over-the-body active warming (e.g., forced air, warm-water garments, and resistive heating blankets). Data elements required for the measure can be captured and the measure is actionable by the physician.

Existing hospital-level measures for this topic were consulted and, to the extent feasible, harmonization between physician- and hospital-level measurement was achieved.

CLINICAL RECOMMENDATION STATEMENTS:
Preoperative patient management
Assessment: Identify patient's risk factors for unplanned perioperative hypothermia. Measure patient temperature on admission. Determine patient's thermal comfort level (ask the patients if they are cold). Assess for other signs and symptoms of hypothermia (shivering, piloerection, and/or cold extremities).
Interventions: Institute preventive warming measures for patients who are normothermic (normothermia is defined as a core temperature range from 36°C-38°C (96.8°F-100.4°F)). A variety of measures may be used, unless contraindicated. Passive insulation may include warmed cotton blankets, socks, head covering, limited skin exposure, circulating water mattresses, and increase in ambient room temperature (minimum 68ºF- 75ºF). Institute active warming measures for patients who are hypothermic (defined as a core temperature less than 36°C). Active warming is the application of a forced air convection warming system. Apply appropriate passive insulation and increase the ambient room temperature (minimum 68ºF-75ºF). Consider warmed intravenous (IV) fluids. (ASPAN)
Intraoperative patient management
Assessment: Identify patient's risk factors for unplanned perioperative hypothermia. Determine patient's thermal comfort level (ask the patients if they are cold). Assess for other signs and symptoms of hypothermia (shivering, piloerection, and/or cold extremities). Monitor patient's temperature intraoperatively.
Intervention: Implement warming methods. (ASPAN)
Maintenance of body temperature in a normothermic range is recommended for most procedures other than during periods in which mild hypothermia is intended to provide organ protection (e.g., during high aortic cross-clamping). (Class I Recommendation, Level of Evidence B) (ACC/AHA)

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Measure #194: Oncology: Cancer Stage Documented

2011 PHYSICIAN QUALITY REPORTING OPTIONS FOR INDIVIDUAL MEASURES:

CLAIMS, REGISTRY

DESCRIPTION:
Percentage of patients, regardless of age, with a diagnosis of breast, colon, or rectal cancer who are seen in the ambulatory setting who have a baseline AJCC cancer stage or documentation that the cancer is metastatic in the medical record at least once within 12 months

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for patients with breast, colon or rectal cancer seen during the reporting period. This measure is intended to reflect the quality of services provided for the primary management of patients with breast, colon or rectal cancer who are seen in the ambulatory setting or receiving radiation treatment planning.

Measure Reporting via Claims:
ICD-9-CM diagnosis codes and CPT codes are used to identify patients who are included in the measure's denominator. CPT Category II codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed CPT Procedure code, ICD-9-CM diagnosis codes, and the appropriate CPT Category II codes OR the CPT Category II code(s) with the modifier. The reporting modifier allowed for this measure is: 8P-reasons not otherwise specified. There are no allowable performance exclusions for this measure. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
ICD-9-CM diagnosis codes and CPT codes are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure. The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data. There are no allowable performance exclusions for this measure.

DENOMINATOR:
All patients, regardless of age, with a diagnosis of breast, colon, or rectal cancer who are seen in the ambulatory setting

> Denominator Criteria (Eligible Cases):
> Diagnosis for breast, colon or rectal cancer (ICD-9-CM): 153.0, 153.1, 153.2, 153.3, 153.4, 153.5, 153.6, 153.7, 153.8, 153.9, 154.0, 154.1, 154.2, 154.3, 154.8, 174.0, 174.1, 174.2, 174.3, 174.4, 174.5, 174.6, 174.8, 174.9, V10.3, V10.05, V10.06
> AND
> Patient encounter during reporting period (CPT): 77261, 77262, 77263, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215

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NUMERATOR:
Patients who have a baseline AJCC cancer stage* or documentation that the cancer is metastatic in the medical record at least once within 12 months

Numerator Instructions: *Cancer stage refers to stage at diagnosis

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
CPT II 3300F: American Joint Committee on Cancer (AJCC) stage documented and reviewed
OR
CPT II 3301F: Cancer stage documented in medical record as metastatic and reviewed

OR

Cancer Stage not Documented, Reason Not Specified
Append a reporting modifier (8P) to CPT Category II code 3301F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.
3301F with 8P: Cancer stage not documented, reason not otherwise specified

RATIONALE:
Cancer stage is a critical component in determining treatment options for patients with cancer. Though critically important, cancer stage is not always documented in the medical record. This measure is intended to be reported at least once per 12 month reporting period.

CLINICAL RECOMMENDATION STATEMENTS:
A simple classification scheme, which can be incorporated into a form for staging and can be universally applied, is the goal of the TNM system as proposed by the 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. (Joint Committee on Cancer 2002)

A central component of the treatment of breast cancer is full knowledge of extent of disease and biological features. The need for and selection of various local or systemic therapies are based on a number of prognostic and predictive factors. These factors include tumor histology, clinical and pathologic characteristics of the primary tumor, axillary node status, tumor hormone receptor content, tumor HER2 status, presence or absence of detectable metastatic disease, patient comorbid conditions, patient age, and menopausal status. (NCCN, 2007)

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*Measure #195: Radiology: Stenosis Measurement in Carotid Imaging Reports

2011 PHYSICIAN QUALITY REPORTING OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of final reports for all patients, regardless of age, for carotid imaging studies (neck MR angiography [MRA], neck CT angiography [CTA], neck duplex ultrasound, carotid angiogram) performed that include direct or indirect reference to measurements of distal internal carotid diameter as the denominator for stenosis measurement

INSTRUCTIONS:
This measure is to be reported each time a carotid imaging study is performed during the reporting period for all patients, regardless of age. There is no diagnosis associated with these measures. Clinicians who provide component of diagnostic imaging studies of the carotids will be reporting 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 procedure codes and the appropriate CPT Category II code OR the CPT Category II code with the modifier. The reporting modifier allowed for this measure is: 8P- reason not otherwise specified. There are no allowable performance exclusions for this measure. All measure-specific coding should be reporting on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
CPT codes are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure. The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data. There are no allowable performance exclusions for this measure.

DENOMINATOR:
All final reports for carotid imaging studies (neck MR angiography [MRA], neck CT angiography [CTA], neck duplex ultrasound, carotid angiogram) performed

Denominator Criteria (Eligible Cases):
Patient encounter during the reporting period (CPT): 70498, 70547, 70548, 70549, 75660, 75662, 75665, 75671, 75676, 75680, 93880, 93882

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NUMERATOR:
Final carotid imaging study reports that include direct or indirect reference to measurements of distal internal carotid diameter as the denominator for stenosis measurement

Definition:
"Direct or indirect reference to measurements of distal internal carotid diameter as the denominator for stenosis measurement" – includes direct angiographic stenosis calculation based on the distal lumen as the denominator for stenosis measurement OR an equivalent validated method referenced to the above method (e.g., for duplex ultrasound studies, velocity parameters that correlate with anatomic measurements that use the distal internal carotid lumen as the denominator for stenosis measurement)

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Reference to Measurements of Distal Internal Carotid Diameter as the Denominator for Stenosis Measurement Referenced
CPT II 3100F: Carotid image 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 Specified
Append a reporting modifier (8P) to CPT Category II code 3100F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.
3100F with 8P: Carotid image study report did not include direct or indirect reference to measurements of distal internal carotid diameter as the denominator for stenosis measurement, reason not otherwise specified

RATIONALE:
Since the clinical decision-making is based on randomized trial evidence and degree of stenosis is an important element of the decision for carotid intervention, characterization of the degree of stenosis needs to be standardized. Requiring that stenosis calculation be based on a denominator of distal internal carotid diameter or, in the case of duplex ultrasound, velocity measurements that have been correlated to angiographic stenosis calculation based on distal internal carotid diameter, makes the measure applicable to both imaging and duplex studies.

CLINICAL RECOMMENDATION STATEMENTS:
……the NASCET method of calculating stenosis measurement should be employed when angiography is used to correlate US findings. (Grant et al., SRU, 2003)

For patients with symptomatic atherosclerotic carotid stenosis > 70%, as defined using the NASCET criteria, the value of carotid endarterectomy (CEA) has been clearly established from the results of 3 major prospective randomized trials: the NASCET, the European Carotid Surgery Trial (ECST), and the Veterans Affairs Cooperative Study Program. Among symptomatic patients with TIAs or minor strokes and high-grade carotid stenosis, each trial showed impressive relative and absolute risk reductions for those randomized to surgery. For patients with carotid stenosis < 50%, these trials showed that there was no significant benefit of surgery. (Sacco, ASA, 2006)

It is important to consider that the degree of carotid stenosis in ECST was measured differently than that in NASCET. The degree of carotid stenosis is significantly higher if calculated by the NASCET

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rather than the ECST method. In summary, it appears that patients with a recent TIA or nondisabling stroke with ipsilateral carotid stenosis benefit from surgery if the stenosis is > 50% as measured by the NASCET method; however, this benefit appears to be less pronounced in women. Recently symptomatic patients with > 70% stenosis as measured by the NASCET method can expect a far greater benefit from carotid endarterectomy. (Albers, AHA, 1999)

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▲ Measure #196: Coronary Artery Disease (CAD): Symptom and Activity Assessment

2011 PHYSICIAN QUALITY REPORTING OPTIONS FOR INDIVIDUAL MEASURES:

REGISTRY ONLY

DESCRIPTION:
Percentage of patients aged 18 years and older with a diagnosis of CAD who were evaluated for both level of activity and anginal symptoms during one or more visits.

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for patients with CAD seen during the reporting period. This measure is intended to reflect the quality of services provided for the primary management of patients with CAD who are seen in the ambulatory setting.

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 have been provided for registry only measures for use by registries that utilize claims data. It is not necessary to submit these codes for registry-based submissions. There are no allowable performance exclusions for this measure. Do not report this measure via claims.

DENOMINATOR:
All patients aged 18 years and older with CAD

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Diagnosis for CAD (ICD-9-CM): 410.00, 410.01, 410.02, 410.10, 410.11, 410.12, 410.20, 410.21, 410.22, 410.30, 410.31, 410.32, 410.40, 410.41, 410.42, 410.50, 410.51, 410.52, 410.60, 410.61, 410.62, 410.70, 410.71, 410.72, 410.80, 410.81, 410.82, 410.90, 410.91, 410.92, 411.0, 411.1, 411.81, 411.89, 412, 413.0, 413.1, 413.9, 414.00, 414.01, 414.02, 414.03, 414.04, 414.05, 414.06, 414.07, 414.8, 414.9, V45.81, V45.82
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 evaluated for both level of activity and anginal symptoms during one or more office visits

Numerator Options:
Anginal symptoms and level of activity assessed (1002F)

OR

Anginal symptoms and level of activity assessed not assessed, reason not specified (1002F *with* 8P)

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RATIONALE:
The cardinal symptom of CAD is anginal chest pain or equivalent symptoms, such as exertional dyspnea, which may result in limitations on the patient's activities. Clinical management of these symptoms and associated limitations can best be achieved if the patient's level of activity and anginal symptoms are regularly assessed.

CLINICAL RECOMMENDATION STATEMENTS:
Regular assessment of patients' anginal symptoms and levels of activity is recommended (ACC/AHA).

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▲ Measure #197: Coronary Artery Disease (CAD): Drug Therapy for Lowering LDL-Cholesterol

2011 PHYSICIAN QUALITY REPORTING OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Percentage of patients aged 18 years and older with a diagnosis of CAD who were prescribed a lipid-lowering therapy (based on current ACC/AHA guidelines).

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for patients with CAD seen during the reporting period. This measure is intended to reflect the quality of services provided for the primary management of patients with CAD.

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 have been provided for registry only measures for use by registries that utilize claims data. It is not necessary to submit these codes for registry-based submissions. Do not report this measure via claims.

DENOMINATOR:
All patients aged 18 years and older with CAD

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Diagnosis for CAD (ICD-9-CM): 410.00, 410.01, 410.02, 410.10, 410.11, 410.12, 410.20, 410.21, 410.22, 410.30, 410.31, 410.32, 410.40, 410.41, 410.42, 410.50, 410.51, 410.52, 410.60, 410.61, 410.62, 410.70, 410.71, 410.72, 410.80, 410.81, 410.82, 410.90, 410.91, 410.92, 411.0, 411.1, 411.81, 411.89, 412, 413.0, 413.1, 413.9, 414.00, 414.01, 414.02, 414.03, 414.04, 414.05, 414.06, 414.07, 414.8, 414.9, V45.81, V45.82
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 lipid-lowering therapy

Definition:
Prescribed – May include prescription given to the patient for a lipid-lowering therapy at one or more visits in the 12 month period OR patient already taking a lipid-lowering therapy as documented in the current medication list.

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NUMERATOR NOTE: For those registries that utilize claims data, the quality-data code 4002F may be used for this measure.

Numerator Options:
Lipid-lowering therapy prescribed

OR

Lipid-lowering therapy not prescribed for medical reason
OR
Lipid-lowering therapy not prescribed for patient reason
OR
Lipid-lowering therapy not prescribed for system reason

OR

Lipid-lowering therapy not prescribed, reason not specified

RATIONALE:
Studies have demonstrated that active treatment with lipid-lowering therapy is associated with stabilization and regression of coronary atherosclerotic plaques and decreased incidence of clinical events. Recent clinical trials have further documented that LDL-lowering agents can decrease the risk of adverse ischemic events in patients with established CAD.

CLINICAL RECOMMENDATION STATEMENTS:
The LDL-C treatment goal is <100 mg/dl. Persons with established coronary heart disease (CHD) who have a baseline LDL-C ³130 mg/dl should be started on a cholesterol-lowering drug simultaneously with therapeutic lifestyle changes and control of nonlipid risk factors (National Cholesterol Education Program [NCEP]).

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▲ Measure #198: Heart Failure: Left Ventricular Function (LVF) Assessment

2011 PHYSICIAN QUALITY REPORTING OPTIONS FOR INDIVIDUAL MEASURES:

REGISTRY ONLY

DESCRIPTION:
Percentage of patients aged 18 years and older with a diagnosis of heart failure who have quantitative or qualitative results of LVF assessment recorded

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for patients with heart failure seen during the reporting period, regardless of when the education of left ventricular function was performed. This measure is intended to reflect the quality of services provided for the primary management of patients with heart failure. The left ventricular systolic dysfunction may be determined by quantitative or qualitative assessment, which may be current or historical. Examples of a quantitative or qualitative assessment may include an echocardiogram: 1) that provides a numerical value of left ventricular systolic function or 2) that uses descriptive terms such as moderately or severely depressed left ventricular systolic function. This measure may be reported by clinicians who perform the quality actions described based on the services provided and the measure-specific denominator coding.

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT codes and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure. The quality-data codes have been provided for registry only measures for use by registries that utilize claims data. It is not necessary to submit these codes for registry-based submissions. There are no allowable performance exclusions for this measure. Do not report this measure via claims.

DENOMINATOR:
All patients aged ≥ 18 years and older with a diagnosis of heart failure

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Diagnosis for HF (ICD-9-CM): 402.01, 402.11, 402.91, 404.01, 404.03, 404.11, 404.13, 404.91, 404.93, 428.0, 428.1, 428.20, 428.21, 428.22, 428.23, 428.30, 428.31, 428.32, 428.33, 428.40, 428.41, 428.42, 428.43, 428.9
AND
Patient encounter during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350

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NUMERATOR:
Patients with quantitative or qualitative results of LVF assessment recorded

Numerator Options:
Left ventricular function (LVF) assessment (e.g., echocardiography, nuclear test, or ventriculography) documented in the medical record (Includes: Quantitative or qualitative assessment results) (3020F)

OR

Quantitative or qualitative results of LVF assessment not Performed or Assessed, Reason Not Specified (3020F *with* 8P)

RATIONALE:
Evaluation of LVEF in patients with heart failure provides important information that is required to appropriately direct treatment. Several pharmacologic therapies have demonstrated efficacy in slowing disease progression and improving outcomes in patients with left ventricular systolic dysfunction. LVEF assessed during the initial evaluation of patients presenting with heart failure can be considered valid unless the patient has demonstrated a major change in clinical status, experienced or recovered from a clinical event, or received therapy that might have a significant effect on cardiac function. A comprehensive 2-dimensional echocardiogram with Doppler flow studies has been identified as the single most useful diagnostic test in the evaluation of patients with heart failure.

CLINICAL RECOMMENDATION STATEMENTS:
Two-dimensional echocardiography with Doppler should be performed during initial evaluation of patients presenting with HF to assess LVEF, LV size, wall thickness, and valve function. Radionuclide ventriculography can be performed to assess LVEF and volumes. Radionuclide ventriculography can be performed to assess LVEF and volumes. (Class I, Level of Evidence: C) (ACC/AHA, 2009)

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▲ Measure #199: Heart Failure: Patient Education

2011 PHYSICIAN QUALITY REPORTING OPTIONS FOR INDIVIDUAL MEASURES:

REGISTRY ONLY

DESCRIPTION:
Percentage of patients aged 18 years and older with a diagnosis of heart failure who were provided with patient education on disease management and health behavior changes during one or more visit(s) within 12 months

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for patients with heart failure seen during the reporting period. This measure is intended to reflect the quality of services provided for the management of patients with heart failure.

Measure Reporting via Registry:
ICD-9 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 have been provided for registry only measures for use by registries that utilize claims data. It is not necessary to submit these codes for registry-based submissions. There are no allowable performance exclusions for this measure. Do not report this measure via claims.

DENOMINATOR:
All patients aged 18 years and older with a diagnosis of heart failure who were seen at least twice for any visits within 12 months

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter.
AND
Diagnosis for HF (ICD-9-CM): 402.01, 402.11, 402.91, 404.01, 404.03, 404.11, 404.13, 404.91, 404.93, 428.0, 428.1, 428.20, 428.21, 428.22, 428.23, 428.30, 428.31, 428.32, 428.33, 428.40, 428.41, 428.42, 428.43, 428.9
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 provided with patient education on disease management and health behavior changes* during one or more visits within 12 months

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Definition:
*Patient education should include one or more of the following – Weight monitoring; Diet (sodium restriction); Symptom management; Physical activity; Smoking cessation; Medication instruction; Minimizing or avoiding use of NSAIDs; Referral for visiting nurse, or specific educational or management programs; Prognosis/end-of-life issues

Numerator Options:
Patient education, written/oral, appropriate for patients with heart failure performed (4003F)

OR

Patient education, written/oral, appropriate for patients with heart failure not performed, Reason not Specified (4003F *with* 8P)

RATIONALE:
Patient education is an essential nonpharmacological component to heart failure care. It may reduce the likelihood of noncompliance with recommended therapeutic strategies and lead to early identification of worsening clinical status and subsequent treatment. Heart failure disease management programs, in which patient education is an integral component, have been shown to be effective in improving self-care and reducing readmissions.

CLINICAL RECOMMENDATION STATEMENTS:
Patients at high risk for developing HF should be counseled to avoid behaviors that may increase the risk of HF (e.g., smoking, excessive alcohol consumption, and illicit drug use). (Class I, Level of Evidence: C) (ACC/AHA, 2009).

It is recommended that patients with HF and their family members or caregivers receive individualized education and counseling that emphasizes self-care. (Strength of Evidence=B) (HFSA, 2006).

Essential Elements of Patient Education With Associated Skills and Target Behaviors (HFSA, 2006).

Elements of Education	Skill Building and Critical Target Behaviors
Definition of HF (linking disease, symptoms, and treatment) and cause of patient's HF	Discuss basic HF information, cause of patient's HF, and how symptoms are related
Recognition of escalating symptoms and selection of appropriate treatments in response to particular symptoms	• Monitor for specific signs and symptoms (e.g., increasing fatigue doing usual activities, increasing shortness of breath with activity, shortness of breath at rest, need to sleep with increasing number of pillows, waking at night with shortness of breath, edema) • Perform and document daily weights • Develop action plan for how and when to notify the provider • Institute flexible diuretic regimen, if appropriate
Indications and use of each medication	• Reiterate medication dosing schedule, basic reason for specific medications, and what to do if a dose is missed

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Elements of Education	Skill Building and Critical Target Behaviors
Importance of risk factor modification	• Smoking cessation • State blood pressure goal and know own blood pressure from recent measurement • Maintain normal HgA1c, if diabetic • Maintain specific body weight
Specific diet recommendations: individualized low-sodium diet; recommendation for alcohol intake	• Reiterate recommended sodium intake • Demonstrate how to read a food label to check sodium amount per serving and sort foods into high- and low-sodium groups • Reiterate limits for alcohol consumption or need for abstinence if history of alcohol abuse
Specific activity/exercise recommendations	• Reiterate goals for exercise and plan for achieving • Reiterate ways to increase activity level
Importance of treatment adherence and behavioral strategies to promote	• Plan and use a medication system that promotes routine adherence • Plan for refills

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▲ Measure #200: Heart Failure: Warfarin Therapy for Patients with Atrial Fibrillation

2011 PHYSICIAN QUALITY REPORTING OPTIONS FOR INDIVIDUAL MEASURES:

REGISTRY ONLY

DESCRIPTION:
Percentage of all patients aged 18 and older with a diagnosis of heart failure and paroxysmal or chronic atrial fibrillation who were prescribed warfarin therapy

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for patients with heart failure seen during the reporting period. This measure is intended to reflect the quality of services provided for the primary management of patients with heart failure and with paroxysmal or chronic atrial fibrillation.

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 have been provided for registry only measures for use by registries that utilize claims data. It is not necessary to submit these codes for registry-based submissions. Do not report this measure via claims.

DENOMINATOR:
All heart failure patients aged 18 years and older with paroxysmal or chronic atrial fibrillation

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Diagnosis for HF (ICD-9-CM): 402.01, 402.11, 402.91, 404.01, 404.03, 404.11, 404.13, 404.91, 404.93, 428.0, 428.1, 428.20, 428.21, 428.22, 428.23, 428.30, 428.31, 428.32, 428.33, 428.40, 428.41, 428.42, 428.43, 428.9
AND
Diagnosis for atrial fibrillation (ICD-9-CM): 427.31
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 were prescribed warfarin therapy

Definition:
Prescribed – May include prescription given to the patient for warfarin at one or more visits in the 12 month period OR patient already taking warfarin as documented in current medication list.

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Numerator Options:
Warfarin therapy prescribed (4012F)

OR

Warfarin therapy not prescribed for medical reason (4012F *with* 1P)
OR
Warfarin therapy not prescribed for patient reason (4012F *with* 2P)
OR
Warfarin therapy not prescribed for system reason (4012F *with* 3P)

OR

Warfarin therapy not prescribed, reason not specified (4012F *with* 8P)

RATIONALE:
Adjusted-dose warfarin is highly efficacious in preventing thromboembolism in patients with AF and should be prescribed for all patients with AF and heart failure except those with contraindications to anticoagulation.

CLINICAL RECOMMENDATION STATEMENTS:
Physicians should prescribe anticoagulants in patients with HF who have paroxysmal or persistent atrial fibrillation or a previous thromboembolic event. (Class I, Level of Evidence: A)

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♦ Measure #201: Ischemic Vascular Disease (IVD): Blood Pressure Management Control

2011 PHYSICIAN QUALITY REPORTING OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of patients aged 18 years and older with Ischemic Vascular Disease (IVD) who had most recent blood pressure in control (less than 140/90 mmHg)

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for patients with ischemic vascular disease seen during the reporting period. The performance period for this measure is 12 months. The most recent quality code submitted will be used for performance calculation. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

Measure Reporting via Claims:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. G-codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed ICD-9-CM diagnosis codes, CPT codes, and the appropriate G-code(s). There are no allowable performance exclusions for this measure. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure. The quality-data codes listed do not need to be submitted for registry-based submissions however these codes may be submitted for those registries that utilize claims data. There are no allowable performance exclusions for this measure.

DENOMINATOR:
Patients aged 18 years and older with the diagnosis of ischemic vascular disease, or who were discharged alive for acute myocardial infarction (AMI), coronary artery bypass graft (CABG) or percutaneous transluminal coronary angioplasty (PTCA)

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND

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Diagnosis for ischemic vascular disease (ICD-9-CM): 410.11, 410.21, 410.31, 410.41, 410.51, 410.61, 410.71, 410.81, 410.91, 411.0, 411.1, 411.81, 411.89, 413.0, 413.1, 413.9, 414.00, 414.01, 414.02, 414.03, 414.04, 414.05, 414.06, 414.07, 414.8, 414.9, 429.2, 433.00, 433.01, 433.10, 433.11, 433.20, 433.21, 433.30, 433.31, 433.80, 433.81, 433.90, 433.91, 434.00, 434.01, 434.10, 434.11, 434.90, 434.91, 440.1, 440.20, 440.21, 440.22, 440.23, 440.24, 440.29, 440.4, 444.0, 444.1, 444.21, 444.22, 444.81, 444.89, 444.9, 445.01, 445.02, 445.81, 445.89

AND

Patient encounter during reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99217, 99218, 99219, 99220, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, 99455, 99456

OR

Patient encounter during the reporting period (CPT) - Procedure: 33510, 33511, 33512, 33513, 33514, 33516, 33517, 33518, 33519, 33521, 33522, 33523, 33533, 33534, 33535, 33536, 33140, 92980, 92982, 92995

NUMERATOR:

Patients whose most recent blood pressure < 140/90 mmHg

Numerator Instructions: To describe both systolic and diastolic blood pressure values, each must be reported separately. If there are multiple blood pressures on the same date of service, use the lowest systolic and lowest diastolic blood pressure on that date as the representative blood pressure.

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Most Recent Blood Pressure Measurement Performed

Systolic Pressure (Select one (1) code from this section):

G8588: Most recent systolic blood pressure < 140 mmHg

OR

G8589: Most recent systolic blood pressure ≥ 140 mmHg

AND

Diastolic Pressure (Select one (1) code from this section):

G8590: Most recent diastolic blood pressure < 90 mmHg

OR

G8591: Most recent diastolic blood pressure ≥ 90 mmHg

OR

Blood Pressure Measurement not Documented, Reason not Specified

G8592: No documentation of blood pressure measurement

RATIONALE:

Fifty million or more Americans have high blood pressure that warrants treatment, according to the NHANES survey (JNC-7, 2003). The USPSTF recommends that clinicians screen adults aged 18 and older for high blood pressure (USPSTF, 2007).

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The most frequent and serious complications of uncontrolled hypertension include coronary heart disease, congestive heart failure, stroke, ruptured aortic aneurysm, renal disease, and retinopathy. The increased risks of hypertension are present in individuals ranging from 40 to 89 years of age. For every 20 mmHg systolic or 10 mmHg diastolic increase in BP, there is a doubling of mortality from both IHD and stroke (JNC-7, 2003).

Better control of BP has been shown to significantly reduce the probability that these undesirable and costly outcomes will occur. Thus, the relationship between the measure (control of hypertension) and the long-term clinical outcomes listed is well established. In clinical trials, antihypertensive therapy has been associated with reductions in stroke incidence (35-40%), myocardial infarction (20-25%) and heart failure (>50%) (JNC-7, 2003).

CLINICAL RECOMMENDATION STATEMENTS:

The U.S. Preventive Services Task Force (USPSTF) recommends screening for high blood pressure in adults age 18 years and older.

The JNC-7 indicates that treating systolic BP and diastolic BP to targets that are <140/90 mmHg is associated with a decrease in CVD complications.

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♦ Measure #202: Ischemic Vascular Disease (IVD): Complete Lipid Profile

2011 PHYSICIAN QUALITY REPORTING OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of patients aged 18 years and older with Ischemic Vascular Disease (IVD) who received at least one lipid profile within 12 months

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for patients with IVD seen during the reporting period. The performance period for this measure is 12 months from the date of service. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

Measure Reporting via Claims:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. G-codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed ICD-9-CM diagnosis codes, CPT codes, and the appropriate G-code. There are no allowable performance exclusions for this measure. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure. The quality-data codes listed do not need to be submitted for registry-based submissions however these codes may be submitted for those registries that utilize claims data. There are no allowable performance exclusions for this measure.

DENOMINATOR:
Patients aged 18 years and older with the diagnosis of ischemic vascular disease, or who were discharged alive for acute myocardial infarction (AMI), coronary artery bypass graft (CABG) or percutaneous transluminal coronary angioplasty (PTCA)

> Denominator Criteria (Eligible Cases):
> Patients aged ≥ 18 years on date of encounter
> AND
> Diagnosis for ischemic vascular disease (ICD-9-CM): 410.11, 410.21, 410.31, 410.41, 410.51, 410.61, 410.71, 410.81, 410.91, 411.0, 411.1, 411.81, 411.89, 413.0, 413.1, 413.9, 414.00, 414.01, 414.02, 414.03, 414.04, 414.05, 414.06, 414.07, 414.8, 414.9, 429.2, 433.00, 433.01, 433.10, 433.11, 433.20, 433.21, 433.30, 433.31, 433.80, 433.81, 433.90, 433.91, 434.00, 434.01, 434.10, 434.11, 434.90, 434.91, 440.1, 440.20, 440.21, 440.22, 440.23, 440.24, 440.29, 440.4, 444.0, 444.1, 444.21, 444.22, 444.81, 444.89, 444.9, 445.01, 445.02, 445.81, 445.89
> AND

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Patient encounter during reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99217, 99218, 99219, 99220, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, 99455, 99456

OR

Patient encounter during the reporting period (CPT) - Procedure: 33510, 33511, 33512, 33513, 33514, 33516, 33517, 33518, 33519, 33521, 33522, 33523, 33533, 33534, 33535, 33536, 33140, 92980, 92982, 92995

NUMERATOR:
Patients who received at least one lipid profile (or ALL component tests)

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Lipid Profile Performed
G8593: Lipid panel results documented and reviewed (must include total cholesterol, HDL-C, triglycerides and calculated LDL-C)

Note: *If LDL-C could not be calculated due to high triglycerides, count as complete lipid profile.*

OR

Lipid Profile not Performed, Reason not Specified
G8594: Lipid profile not performed, reason not otherwise specified

RATIONALE:
There is general agreement in the literature that individuals with existing coronary artery disease can reduce their risk of subsequent morbidity and premature mortality by management of cholesterol levels. Total cholesterol in general and LDL level specifically, is the leading indicator for management of these patients. Treatments include limits on dietary fat and cholesterol, or in certain cases, cholesterol lowering medications.

A 10% decrease in total cholesterol levels (population wide) may result in an estimated 30% reduction in the incidence of CHD (CDC, 2000). Based on data from the Third Report of the Expert Panel on Detection, Evaluation, and Treatment of High Blood Cholesterol in Adults:

- Less than half of persons who qualify for any kind of lipid-modifying treatment for CHD risk reduction are receiving it.
- Less than half of even the highest-risk persons, those who have symptomatic CHD, are receiving lipid-lowering treatment.
- Only about a third of treated patients are achieving their LDL goal; less than 20% of CHD patients are at their LDL goal. (2002)

Several studies have shown that reducing high lipid levels will reduce cardiovascular morbidity and mortality. These studies include the Coronary Primary Prevention Trial, the Framingham Heart Study, the Oslo Study Diet and Anti-smoking Trial, the Helsinki Heart Study, the Coronary Drug Project, the Stockholm Ischemic Heart Study, the Scandinavian Simvastatin Survival Study, the West of Scotland Coronary Prevention Study, the Program on the Surgical Control of the Hyperlipidemias, and Cholesterol and Recurrent Events trial.

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CLINICAL RECOMMENDATION STATEMENTS:

Third report of the National Cholesterol Education Program (NCEP) Expert Panel on Detection, Evaluation, and Treatment of High Blood Cholesterol in Adults (Adult Treatment Panel III). (2001) AND Implications of recent clinical trials for the National Cholesterol Education Program Adult Treatment Panel III guidelines (2004)

In high-risk persons, the recommended LDL-C goal is <100 mg/dL.

- An LDL-C goal of <70 mg/dL is a therapeutic option on the basis of available clinical trial evidence, especially for patients at very high risk.
- If LDL-C is >100 mg/dL, an LDL-lowering drug is indicated simultaneously with lifestyle changes.
- If baseline LDL-C is <100 mg/dL, institution of an LDL-lowering drug to achieve an LDL-C level <70 mg/dL is a therapeutic option on the basis of available clinical trial evidence.
- If a high-risk person has high triglycerides or low HDL-C, consideration can be given to combining a fibrate or nicotinic acid with an LDL-lowering drug. When triglycerides are >200 mg/dL, non-HDL-C is a secondary target of therapy, with a goal 30 mg/dL higher than the identified LDL-C goal.

The U.S. Preventive Services Task Force (USPSTF) strongly recommends screening men aged 35 and older for lipid disorders and recommends screening men aged 20 to 35 for lipid disorders if they are at increased risk for coronary heart disease. The USPSTF also strongly recommends screening women aged 45 and older for lipid disorders if they are at increased risk for coronary heart disease and recommends screening women aged 20 to 45 for lipid disorders if they are at increased risk for coronary heart disease.

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♦Measure #203: Ischemic Vascular Disease (IVD): Low Density Lipoprotein (LDL-C) Control

2011 PHYSICIAN QUALITY REPORTING OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of patients aged 18 years and older with Ischemic Vascular Disease (IVD) who had most recent LDL-C level in control (less than 100 mg/dl)

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. The most recent quality code submitted will be used for performance calculation. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

Measure Reporting via Claims:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. G-codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed ICD-9-CM diagnosis codes, CPT codes, and the appropriate G-code. There are no allowable performance exclusions for this measure. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure. The quality-data codes listed do not need to be submitted for registry-based submissions however these codes may be submitted for those registries that utilize claims data. There are no allowable performance exclusions for this measure.

DENOMINATOR:
Patients aged 18 years and older with the diagnosis of ischemic vascular disease, or who were discharged alive for acute myocardial infarction (AMI), coronary artery bypass graft (CABG) or percutaneous transluminal coronary angioplasty (PTCA)

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND

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Diagnosis for ischemic vascular disease (ICD-9-CM): 410.11, 410.21, 410.31, 410.41, 410.51, 410.61, 410.71, 410.81, 410.91, 411.0, 411.1, 411.81, 411.89, 413.0, 413.1, 413.9, 414.00, 414.01, 414.02, 414.03, 414.04, 414.05, 414.06, 414.07, 414.8, 414.9, 429.2, 433.00, 433.01, 433.10, 433.11, 433.20, 433.21, 433.30, 433.31, 433.80, 433.81, 433.90, 433.91, 434.00, 434.01, 434.10, 434.11, 434.90, 434.91, 440.1, 440.20, 440.21, 440.22, 440.23, 440.24, 440.29, 440.4, 444.0, 444.1, 444.21, 444.22, 444.81, 444.89, 444.9, 445.01, 445.02, 445.81, 445.89

AND

Patient encounter during reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99217, 99218, 99219, 99220, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, 99455, 99456

OR

Patient encounter during the reporting period (CPT) - Procedure: 33510, 33511, 33512, 33513, 33514, 33516, 33517, 33518, 33519, 33521, 33522, 33523, 33533, 33534, 33535, 33536, 33140, 92980, 92982, 92995

NUMERATOR:

Patients with most recent LDL-C < 100 mg/dL

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Most Recent LDL-C < 100 mg/dL

G8595: Most recent LDL-C < 100 mg/dL

OR

LDL-C was not Performed

G8596: LDL-C was not performed

OR

Most Recent LDL-C **≥ 100 mg/dL**

G8597: Most recent LDL-C ≥ 100 mg/dL

RATIONALE:

There is general agreement in the literature that individuals with existing coronary artery disease can reduce their risk of subsequent morbidity and premature mortality by management of cholesterol levels. Total cholesterol in general and LDL level specifically, is the leading indicator for management of these patients. Treatments include limits on dietary fat and cholesterol, or in certain cases, cholesterol lowering medications.

A 10% decrease in total cholesterol levels (population wide) may result in an estimated 30% reduction in the incidence of CHD (CDC, 2000). Based on data from the Third Report of the Expert Panel on Detection, Evaluation, and Treatment of High Blood Cholesterol in Adults:

- Less than half of persons who qualify for any kind of lipid-modifying treatment for CHD risk reduction are receiving it.
- Less than half of even the highest-risk persons, those who have symptomatic CHD, are receiving lipid-lowering treatment.
- Only about a third of treated patients are achieving their LDL goal; less than 20% of CHD patients are at their LDL goal. (2002)

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Several studies have shown that reducing high lipid levels will reduce cardiovascular morbidity and mortality. These studies include the Coronary Primary Prevention Trial, the Framingham Heart Study, the Oslo Study Diet and Anti-smoking Trial, the Helsinki Heart Study, the Coronary Drug Project, the Stockholm Ischemic Heart Study, the Scandinavian Simvastatin Survival Study, the West of Scotland Coronary Prevention Study, the Program on the Surgical Control of the Hyperlipidemias, and Cholesterol and Recurrent Events trial.

CLINICAL RECOMMENDATION STATEMENTS:

Third report of the National Cholesterol Education Program (NCEP) Expert Panel on Detection, Evaluation, and Treatment of High Blood Cholesterol in Adults (Adult Treatment Panel III). (2001) AND Implications of recent clinical trials for the National Cholesterol Education Program Adult Treatment Panel III guidelines (2004)

In high-risk persons, the recommended LDL-C goal is <100 mg/dL.

- An LDL-C goal of <70 mg/dL is a therapeutic option on the basis of available clinical trial evidence, especially for patients at very high risk.
- If LDL-C is >100 mg/dL, an LDL-lowering drug is indicated simultaneously with lifestyle changes.
- If baseline LDL-C is <100 mg/dL, institution of an LDL-lowering drug to achieve an LDL-C level <70 mg/dL is a therapeutic option on the basis of available clinical trial evidence.
- If a high-risk person has high triglycerides or low HDL-C, consideration can be given to combining a fibrate or nicotinic acid with an LDL-lowering drug. When triglycerides are >200 mg/dL, non-HDL-C is a secondary target of therapy, with a goal 30 mg/dL higher than the identified LDL-C goal.

The U.S. Preventive Services Task Force (USPSTF) strongly recommends screening men aged 35 and older for lipid disorders and recommends screening men aged 20 to 35 for lipid disorders if they are at increased risk for coronary heart disease. The USPSTF also strongly recommends screening women aged 45 and older for lipid disorders if they are at increased risk for coronary heart disease and recommends screening women aged 20 to 45 for lipid disorders if they are at increased risk for coronary heart disease.

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♦ Measure #204: Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic

2011 PHYSICIAN QUALITY REPORTING OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of patients aged 18 years and older with Ischemic Vascular Disease (IVD) with documented use of aspirin or other antithrombotic

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for patients with IVD seen during the reporting period. The performance period for this measure is 12 months from the date of service. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

Measure Reporting via Claims:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. G-codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed ICD-9-CM diagnosis codes, CPT codes, and the appropriate G-code. There are no allowable performance exclusions for this measure. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure. The quality-data codes listed do not need to be submitted for registry-based submissions however these codes may be submitted for those registries that utilize claims data. There are no allowable performance exclusions for this measure.

DENOMINATOR:
Patients aged 18 years and older with the diagnosis of ischemic vascular disease, or who were discharged alive for acute myocardial infarction (AMI), coronary artery bypass graft (CABG) or percutaneous transluminal coronary angioplasty (PTCA)

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND

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Diagnosis for ischemic vascular disease (ICD-9-CM): 410.11, 410.21, 410.31, 410.41, 410.51, 410.61, 410.71, 410.81, 410.91, 411.0, 411.1, 411.81, 411.89, 413.0, 413.1, 413.9, 414.00, 414.01, 414.02, 414.03, 414.04, 414.05, 414.06, 414.07, 414.8, 414.9, 429.2, 433.00, 433.01, 433.10, 433.11, 433.20, 433.21, 433.30, 433.31, 433.80, 433.81, 433.90, 433.91, 434.00, 434.01, 434.10, 434.11, 434.90, 434.91, 440.1, 440.20, 440.21, 440.22, 440.23, 440.24, 440.29, 440.4, 444.0, 444.1, 444.21, 444.22, 444.81, 444.89, 444.9, 445.01, 445.02, 445.81, 445.89

AND

Patient encounter during reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99217, 99218, 99219, 99220, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, 99455, 99456

OR

Patient encounter during the reporting period (CPT) - Procedure: 33510, 33511, 33512, 33513, 33514, 33516, 33517, 33518, 33519, 33521, 33522, 33523, 33533, 33534, 33535, 33536, 33140, 92980, 92982, 92995

NUMERATOR:

Patients who are using aspirin or another antithrombotic therapy

Numerator Instructions: Oral antithrombotic therapy consists of aspirin, clopidogrel or combination of aspirin and extended release dipyridamole.

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Aspirin or Another Antithrombotic Therapy Used

G8598: Aspirin or another antithrombotic therapy used

OR

Aspirin or Another Antithrombotic Therapy not Used, Reason not Specified

G8599: Aspirin or another antithrombotic therapy not used, reason not otherwise specified

RATIONALE:

Aspirin therapy has been shown to directly reduce 14% of the odds of cardiovascular events among men and 12% of the odds for women (Berger, 2006). Aspirin use reduced the number of strokes by 20%, MI by 30%, and other vascular events by 30% (Weisman, 2002). Also, aspirin treatments have been shown to prevent 1 cardiovascular event over an average follow-up of 6.4 years. This means that on average in a 6.4 year time period the use of aspirin therapy results in a benefit of 3 cardiovascular events prevented per 1000 women and 4 events prevented per 1000 men (Berger, 2006). Even for patients with peripheral arterial disease, aspirin has been shown to reduce CHD in people (Kikano, 2007).

CLINICAL RECOMMENDATION STATEMENTS:

The U.S. Preventive Services Task Force (USPSTF) strongly recommends that clinicians discuss aspirin chemoprevention with adults who are at increased risk (5-year risk of greater than or equal to 3 percent) for coronary heart disease (CHD). Discussions with patients should address both the potential benefits and harms of aspirin therapy.

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The USPSTF found good evidence that aspirin decreases the incidence of coronary heart disease in adults who are at increased risk for heart disease. They also found good evidence that aspirin increases the incidence of gastrointestinal bleeding and fair evidence that aspirin increases the incidence of hemorrhagic strokes. The USPSTF concluded that the balance of benefits and harms is most favorable in patients at high risk of CHD (5-year risk of greater than or equal to 3 percent) but is also influenced by patient preferences.

USPSTF encourages men age 45 to 79 years to use aspirin when the potential benefit of a reduction in myocardial infarctions outweighs the potential harm of an increase in gastrointestinal hemorrhage. They encourage women age 55 to 79 years to use aspirin when the potential benefit of a reduction in ischemic strokes outweighs the potential harm of an increase in gastrointestinal hemorrhage.

The ADA recommends use aspirin therapy (75-162 mg/day) as a primary prevention strategy in those with type 1 or 2 diabetes at increased cardiovascular risk, including those who are 40 years of age or who have additional risk factors (family history of CVD, hypertension, smoking, dyslipidemia, or albuminuria).

AHA/ACC: Start aspirin 75 to 162 mg/d and continue indefinitely in all patients with coronary and other vascular disease unless contraindicated.

ICSI: Aspirin should be prescribed to all patients with stable coronary disease. If a patient is aspirin intolerant, then use clopidogrel.

VA/DoD: Ensure that all patients with ischemic heart disease or angina symptoms receive antiplatelet therapy (aspirin 81-325 mg/day). For patients who require warfarin therapy, aspirin may be safely used at a dose of 80 mg/day. If use of aspirin is contraindicated, clopidogrel (75 mg/day) may be used.

AHA/ASA: The use of aspirin is recommended for cardiovascular (including but not specific to stroke) prophylaxis among persons whose risk is sufficiently high for the benefits to outweigh the risks associated with treatment (a 10-year risk of cardiovascular events of 6% to 10%).

ACCP: For long-term treatment after PCI, the guideline developers recommend aspirin, 75 to 162 mg/day. For long-term treatment after PCI in patients who receive antithrombotic agents such as clopidogrel or warfarin, the guideline developers recommend lower-dose aspirin, 75 to 100 mg/day. For patients with ischemic stroke who are not receiving thrombolysis, the guideline developers recommend early aspirin therapy, 160 to 325 mg/day.

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❑ Measure #205: HIV/AIDS: Sexually Transmitted Disease Screening for Chlamydia and Gonorrhea

2011 PHYSICIAN QUALITY REPORTING OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Percentage of patients aged 13 years and older with a diagnosis of HIV/AIDS for whom chlamydia and gonorrhea screenings were performed at least once since the diagnosis of HIV infection

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for patients with HIV/AIDS seen during the reporting period. Only patients who had at least two visits during the reporting period, with at least 60 days between each visit will be counted in the denominator for this measure. This measure is intended to reflect the quality of services provided for the primary management of patients with HIV/AIDS.

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT 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 have been provided for registry only measures for use by registries that utilize claims data. It is not necessary to submit these codes for registry-based submissions. Do not report this measure via claims.

DENOMINATOR:
Patients aged 13 and older with a diagnosis of HIV/AIDS who had at least two medical visits during the measurement year, with at least 60 days between each visit

Denominator Criteria (Eligible Cases):
Patients aged ≥ 13 years of age on date of encounter
AND
Diagnosis for HIV/AIDS (ICD-9-CM): 042, 079.53, V08
AND
Patient encounters during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215

NUMERATOR:
Patients with chlamydia and gonorrhea screenings performed at least once since the diagnosis of HIV infection

Numerator Options:
Chlamydia and gonorrhea screenings documented as performed (3511F)
OR
Chlamydia and gonorrhea screenings not documented as performed, due to patient reason (3511F *with* 2P)
OR

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Chlamydia and gonorrhea screenings not documented as performed, reason not specified (3511F *with* 8P)

RATIONALE:
Sexually transmitted diseases that cause mucosal inflammation (such as gonorrhea and chlamydia) increase the risk for HIV-infection (as these diseases and other sexually transmitted diseases can increase the infectiousness of and a person's susceptibility to HIV) (Galvin, 2004).

CLINICAL RECOMMENDATION STATEMENTS:
All patients should be screened with laboratory tests for STDs at the initial encounter (A-II for syphilis, for trichomoniasis in women, and for chlamydial infection in women aged less than 25 years; B-II for gonorrhea and chlamydial infection in all men and women), and thereafter, depending on reported high-risk behavior, the presence of other STDs, and the prevalence of STDs in the community (B-III). (Aberg, 2004)

Consideration should be given to screening all HIV-infected men and women for gonorrhea and chlamydial infections. However, because of the cost of screening and the variability of prevalence of these infections, decisions about routine screening for these infections should be based on epidemiologic factors (including prevalence of infection in the community or the population being served), availability of tests, and cost. (Some HIV specialists also recommend type-specific serologic testing for herpes simplex virus type 2 for both men and women.) (B-II, for identifying STDs) (CDC, HRSA, NIH, HIVMA of IDSA, 2003)

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❑ Measure #206: HIV/AIDS: Screening for High Risk Sexual Behaviors

2011 PHYSICIAN QUALITY REPORTING OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Percentage of patients aged 13 years and older with a diagnosis of HIV/AIDS who were screened for high risk sexual behaviors at least once within 12 months

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for patients with HIV/AIDS seen during the reporting period. Only patients who had at least two visits during the reporting period, with at least 60 days between each visit will be counted in the denominator for this measure. This measure is intended to reflect the quality of services provided for the primary management of patients with HIV/AIDS.

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT 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 have been provided for registry only measures for use by registries that utilize claims data. It is not necessary to submit these codes for registry-based submissions. There are no allowable performance exclusions for this measure. Do not report this measure via claims.

DENOMINATOR:
Patients aged 13 and older with a diagnosis of HIV/AIDS who had at least two medical visits during the measurement year, with at least 60 days between each visit

Denominator Criteria (Eligible Cases):
Patients aged ≥ 13 years on date of encounter
AND
Diagnosis for HIV/AIDS (ICD-9-CM): 042, 079.53, V08
AND
Patient encounters during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215

NUMERATOR:
Patients who were screened for high risk sexual behaviors at least once within 12 months

Numerator Options:
Patient screened for high risk sexual behavior (4293F)

OR

Patient not screened for high risk sexual behaviors, reason not specified (4293F *with* 8P)

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RATIONALE:

Each visit of an HIV-infected person to a health care provider should include screening for high-risk behavior. (IDSA, 2004)

Within the context of HIV care, brief general HIV prevention messages should be regularly provided to HIV-infected patients at each visit or periodically, as determined by the clinician, and at a minimum of twice yearly. These messages should emphasize the need for safer behaviors to protect their own health and the health of their sex or needle-sharing partners, regardless of perceived risk. Messages should be tailored to the patient's needs and circumstances. (CDC, HRSA, NIH, HIVMA of IDSA, 2003)

CLINICAL RECOMMENDATION STATEMENTS:

Within the context of HIV care, brief general HIV prevention messages should be regularly provided to HIV-infected patients at each visit or periodically, as determined by the clinician, and at a minimum of twice yearly. These messages should emphasize the need for safer behaviors to protect their own health and the health of their sex or needle-sharing partners, regardless of perceived risk. Messages should be tailored to the patient's needs and circumstances. (CDC, HRSA, NIH, HIVMA of IDSA, 2003)

HIV-infected patients should be screened for behaviors associated with HIV transmission by using a straightforward, nonjudgmental approach. This should be done at the initial visit and subsequent routine visits or periodically, as the clinician feels necessary, but at a minimum of yearly. Any indication of risky behavior should prompt a more thorough assessment of HIV transmission risks. (CDC, 2003)

Obtain a sexual and injection drug use risk assessment and record in medical chart (e.g., number of sex partners in last 3 months, location of partner meeting, number of anonymous partners, condom use, drug/alcohol use around sexual activity). Obtain an STD history (disease/infection, number of times, approximate dates) and record in medical chart. Provide educational material about STD symptoms and advise about the importance of refraining from sexual activity until a diagnosis is made and treatment is completed. (CSTDCA, 2001)

Clinicians should screen all HIV-infected patients for substance use at baseline and at least annually. Screening questions should be phrased to include both alcohol and drug use. (NYSDOH, 2005)

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❑ Measure #207: HIV/AIDS: Screening for Injection Drug Use

2011 PHYSICIAN QUALITY REPORTING OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Percentage of patients aged 13 years and older with a diagnosis of HIV/AIDS who were screened for injection drug use at least once within 12 months

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for patients with HIV/AIDS seen during the reporting period. Only patients who had at least two visits during the reporting period, with at least 60 days between each visit will be counted in the denominator for this measure. This measure is intended to reflect the quality of services provided for the primary management of patients with HIV/AIDS.

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT 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 have been provided for registry only measures for use by registries that utilize claims data. It is not necessary to submit these codes for registry-based submissions. There are no allowable performance exclusions for this measure. Do not report this measure via claims.

DENOMINATOR:
Patients aged 13 and older with a diagnosis of HIV/AIDS who had at least two medical visits during the measurement year, with at least 60 days between each visit

Denominator Criteria (Eligible Cases):
Patients aged ≥ 13 years on date of encounter
AND
Diagnosis for HIV/AIDS (ICD-9-CM): 042, 079.53, V08
AND
Patient encounters during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215

NUMERATOR:
Patients who were screened for injection drug use at least once within 12 months

Numerator Options:
Patient screened for injection drug use (4290F)
OR
Patient not screened for injection drug use reason not specified (4290F *with* 8P)

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RATIONALE:
Each visit of an HIV-infected person to a health care provider should include screening for high-risk behavior. (IDSA, 2004)

Within the context of HIV care, brief general HIV prevention messages should be regularly provided to HIV-infected patients at each visit or periodically, as determined by the clinician, and at a minimum of twice yearly. These messages should emphasize the need for safer behaviors to protect their own health and the health of their sex or needle-sharing partners, regardless of perceived risk. Messages should be tailored to the patient's needs and circumstances. (CDC, HRSA, NIH, HIVMA of IDSA, 2003)

CLINICAL RECOMMENDATION STATEMENTS:
Within the context of HIV care, brief general HIV prevention messages should be regularly provided to HIV-infected patients at each visit or periodically, as determined by the clinician, and at a minimum of twice yearly. These messages should emphasize the need for safer behaviors to protect their own health and the health of their sex or needle-sharing partners, regardless of perceived risk. Messages should be tailored to the patient's needs and circumstances. (CDC, HRSA, NIH, HIVMA of IDSA, 2003)

HIV-infected patients should be screened for behaviors associated with HIV transmission by using a straightforward, nonjudgmental approach. This should be done at the initial visit and subsequent routine visits or periodically, as the clinician feels necessary, but at a minimum of yearly. Any indication of risky behavior should prompt a more thorough assessment of HIV transmission risks. (CDC, 2003)

Obtain a sexual and injection drug use risk assessment and record in medical chart (e.g., number of sex partners in last 3 months, location of partner meeting, number of anonymous partners, condom use, drug/alcohol use around sexual activity). Obtain an STD history (disease/infection, number of times, approximate dates) and record in medical chart. Provide educational material about STD symptoms and advise about the importance of refraining from sexual activity until a diagnosis is made and treatment is completed. (CSTDCA, 2001)

Clinicians should screen all HIV-infected patients for substance use at baseline and at least annually. Screening questions should be phrased to include both alcohol and drug use. (NYSDOH, 2005)

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❑ Measure #208: HIV/AIDS: Sexually Transmitted Disease Screening for Syphilis

2011 PHYSICIAN QUALITY REPORTING OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Percentage of patients aged 13 years and older with a diagnosis of HIV/AIDS who were screened for syphilis at least once within 12 months

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for patients with HIV/AIDS seen during the reporting period. Only patients who had at least two visits during the reporting period, with at least 60 days between each visit will be counted in the denominator for this measure. This measure is intended to reflect the quality of services provided for the primary management of patients with HIV/AIDS.

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT 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 have been provided for registry only measures for use by registries that utilize claims data. It is not necessary to submit these codes for registry-based submissions. Do not report this measure via claims.

DENOMINATOR:
Patients aged 13 and older with a diagnosis of HIV/AIDS who had at least two medical visits during the measurement year, with at least 60 days between each visit

Denominator Criteria (Eligible Cases):
Patients aged ≥ 13 years on date of encounter
AND
Diagnosis for HIV/AIDS (ICD-9-CM): 042, 079.53, V08
AND
Patient encounters during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215

NUMERATOR:
Patients who were screened for syphilis at least once within 12 months

Numerator Options:
Syphilis screening documented as performed (3512F)
OR
Syphilis screening not documented as performed, due to patient reason (3512F *with* 2P)
OR
Syphilis screening not documented as performed, reason not specified (3512F *with* 8P)

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RATIONALE:

A 2000 literature review investigated the rates of HIV prevalence in U.S. patients with syphilis. Data from the thirty studies identified and analyzed for the review revealed that HIV prevalence is high among patients infected with syphilis. The mean rate for HIV-infection among patients with syphilis was 15.7 (with an interquartile range of 13.6-21.8). This study would indicate that identifying and treating HIV among patients with syphilis (and vice versa) is an important goal for health systems (Blocker, 2000).

Another study investigated the effect of syphilis infection on the health of patients infected with HIV. HIV viral loads and CD4 cell counts were analyzed for 52 patients in the San Francisco and Los Angeles areas for three time periods: before syphilis infection, during syphilis infection and after syphilis treatment). When compared to levels before syphilis infection, HIV viral loads were significantly higher during syphilis infection. Patients' CD4 cell counts were also significantly lower during syphilis infection than before syphilis infection (Buchacz, 2004). This study further supports the need to identify and treat syphilis infection among HIV-infected patient.

Currently, the Centers for Disease Prevention and Control, the Health Resources and Services Administration, the National Institutes of Health, and the Infectious Diseases Society of America/HIV Medicine Association recommend that all HIV-infected patients should be screened annually for syphilis. However, according to data collected for 3,840 HIV-infected patients within the Veterans Affairs system, only 74% had been screened for syphilis (serum RPR or VDRL) in the past year. The same study reports data from the HIV Cost and Services Utilization Study (HCSUS), the only national probability sample of HIV-infected persons, which indicates that only 49% of participants had been screened for syphilis (Korthius, 2004). These data would indicate that there is indeed room for improvement.

Data from the HIVQual Continuous Quality Program also indicates that there is room for improvement. According to data from 2006, the median rate for syphilis screening among patients infected with HIV/AIDS was 86%. It is important to note that these rates represent only those Title III and IV grantees that are participating in the HIVQUAL Project, a continuous quality improvement project sponsored by the Ryan White Division of Community Based Programs and managed by the New York State Department of Health AIDS institute. Nationwide rates are likely to vary (and be lower) than the rates reported by HIVQUAL. (NYSDOH AIDS Institute, 2007).

CLINICAL RECOMMENDATION STATEMENTS:

Because many STDs are asymptomatic, routine screening for curable STDs (e.g., syphilis, gonorrhea, and Chlamydia) should be performed at least yearly for sexually active persons. (CDC, 2006)

Screening for STDs should be repeated periodically (i.e., at least annually) if the patient is sexually active or if earlier screening revealed STDs. (Grade B-III) (CDC, HRSA, NIH, HIVMA of IDSA, 2003)

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Measure #209: Functional Communication Measure – Spoken Language Comprehension

2011 PHYSICIAN QUALITY REPORTING OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Percentage of patients aged 16 years and older with a diagnosis of late effects of cerebrovascular disease (CVD) that make progress on the Spoken Language Comprehension Functional Communication Measure

INSTRUCTIONS:
This measure is to be reported once per episode of treatment for all patients with late effects of CVD who are treated for a spoken language comprehension deficit by a speech-language pathologist (SLP) during the reporting period. Only patients who had at least two visits in the reporting period will be counted in the denominator for this measure. This is an outcome measure, and its calculation requires reporting of the patient's score (see below under numerator) on the measure at the admission to and discharge from SLP treatment for spoken language comprehension. The admission score is noted by the SLP at the conclusion of the first treatment session, and the discharge score at the conclusion of the final treatment session for spoken language comprehension.

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure. The quality-data codes have been provided for registry only measures for use by registries that utilize claims data. It is not necessary to submit these codes for registry-based submissions. There are no allowable performance exclusions for this measure. Do not report this measure via claims.

DENOMINATOR:
Patients ≥ 16 years and older with late effects of CVD who received SLP treatment for spoken language comprehension

> Denominator Criteria (Eligible Cases):
> Patients aged ≥ 16 years on date of encounter
> AND
> Diagnosis of late effects of CVD (ICD-9-CM): 438.10, 438.11, 438.12, 438.13, 438.14, 438.19, 438.20, 438.21, 438.22, 438.30, 438.31, 438.32, 438.40, 438.41, 438.42, 438.50, 438.51, 438.52, 438.53, 438.6, 438.7, 438.81, 438.82, 438.83, 438.84, 438.85, 438.89, 438.9, 784.3
> AND
> Two (2) or more patient encounters during reporting period (CPT): 92507, 92508

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NUMERATOR:
Patients whose score on the functional communication measure at discharge were higher than at admission

Definitions:
Admission – The conclusion of the first treatment session for spoken language comprehension by an SLP
Discharge – The conclusion of the final treatment session for spoken language comprehension by an SLP, regardless of whether the patient is also being discharged from the facility and/or other SLP services.
Patient's Score –

LEVEL 1: The individual is alert, but unable to follow simple directions or respond to yes/no questions, even with cues.

LEVEL 2: With consistent, maximal cues, the individual is able to follow simple directions, respond to simple yes/no questions in context, and respond to simple words or phrases related to personal needs.

LEVEL 3: The individual usually responds accurately to simple yes/no questions. The individual is able to follow simple directions out of context, although moderate cueing is consistently needed. Accurate comprehension of more complex directions/messages is infrequent.

LEVEL 4: The individual consistently responds accurately to simple yes/no questions and occasionally follows simple directions without cues. Moderate contextual support is usually needed to understand complex sentences/messages. The individual is able to understand limited conversations about routine daily activities with familiar communication partners.

LEVEL 5: The individual is able to understand communication in structured conversations with both familiar and unfamiliar communication partners. The individual occasionally requires minimal cueing to understand more complex sentences/ messages. The individual occasionally initiates the use of compensatory strategies when encountering difficulty.

LEVEL 6: The individual is able to understand communication in most activities, but some limitations in comprehension are still apparent in vocational, avocational, and social activities. The individual rarely requires minimal cueing to understand complex sentences. The individual usually uses compensatory strategies when encountering difficulty.

LEVEL 7: The individual's ability to independently participate in vocational, avocational, and social activities are not limited by spoken language comprehension. When difficulty with comprehension occurs, the individual consistently uses a compensatory strategy.

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Numerator Options:

Score on the spoken language comprehension functional communication measure at discharge was higher than at admission (G8603)

OR

Score on the spoken language comprehension functional communication measure at discharge was not higher than at admission, reason not specified (G8604)

OR

Patient was not scored on the spoken language comprehension functional communication measure either at admission or at discharge (G8605)

RATIONALE:

Assessment of communication ability is important for determining the patient's capabilities and limitations in expressing their wants, needs, and understanding; their ability to contribute to their plan of care (including consent forms and advanced directives), and their ability to comprehend instructions affecting the success of the rehabilitation process. The results of the assessment may impact the choice of treatment and disposition.

Disorders of communication (i.e., problems with speaking, listening, reading, writing, gesturing, and/or pragmatics) and related cognitive impairments may occur in as many as 40% of post-stroke patients. The most common communication disorders occurring after stroke are aphasia and dysarthria. Rapid spontaneous improvement is common, but early evaluation can identify communication problems and monitor change. If indicated, intervention can help maximize recovery of communication abilities and prevent learning of ineffective or inappropriate compensatory behaviors. Goals of speech and language treatment are to (1) facilitate the recovery of communication, (2) assist patients in developing strategies to compensate for communication disorders, and (3) counsel and educate people in the patient's environment to facilitate communication, decrease isolation, and meet the patient's desires and needs.

CLINICAL RECOMMENDATION STATEMENTS:

Aphasic stroke patients should be referred for speech and language therapy. Where the patient is sufficiently well and motivated, aim for minimum of two hours per week. (Scottish Intercollegiate Guidelines Network).

Recommend that the clinician use standardized, valid assessments to evaluate the patient's stroke-related impairments and functional status and encourage patient's participation in community and social activities. Recommend that the standardized assessment results be used to assess probability of outcome, determine the appropriate level of care, and develop interventions. (US Department of Veterans' Affairs; endorsed by the American Heart Association)

Recommend that all patients be evaluated and treated by the SLP for residual communication difficulties (i.e., speaking, listening, reading, writing, and pragmatics). (US Department of Veterans' Affairs; endorsed by the American Heart Association)

Interventions for people with aphasia may include: treatment of phonological and semantic deficits following models derived from cognitive neuropsychology, constraint-induced therapy, and computer-based therapy programs. (National Stroke Foundation of Australia)

It is recommended that patients who are conscious with communication difficulties be evaluated by a SLP who can develop appropriate communication techniques. SLP assessment should include

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screening for hearing and vision and restoration of glasses or hearing aids. Appropriate patients (with reasonable cognition and language skills) should be considered for alternative or augmentative communication. Patients with communication difficulties should be monitored and assessed regularly to determine appropriateness for speech and language therapy. An appropriate treatment program with a system for monitoring progress should be in place for any individuals receiving speech-language therapy. In developing a communication program, consideration for premorbid communication style, underlying cognitive deficits, environmental context, social needs, and necessary communication aids should be given.(Royal College of Medicine and the British Society of Rehabilitation Medicine)

Where achievable goals can be identified, and continuing progress demonstrated, patients with communication difficulties should be offered an appropriate treatment program, with monitoring of progress. The program should: take into account the patient's premorbid communication style and any underlying cognitive deficits; give the opportunity to rehearse communication skills in situations appropriate to the context in which the patient will live/work/study/socialize after discharge; include the family and caregivers in developing strategies for optimum communication within the immediate social circle; and consider the need for communication aids including gesture drawing, communication charts and computerized systems.(Royal College of Medicine and the British Society of Rehabilitation Medicine)

The speech and language therapist will be involved in all cases where there are communication problems following stroke.(Republic of South Africa Department of Health; Stroke Foundation of South Africa)

People with aphasia following stroke should be referred to a speech and language therapist for assessment and appropriate management of their communication difficulty. (Stroke Foundation of New Zealand)

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Measure #210: Functional Communication Measure - Attention

2011 PHYSICIAN QUALITY REPORTING OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Percentage of patients aged 16 years and older with a diagnosis of late effects of cerebrovascular disease (CVD) that make progress on the Attention Functional Communication Measure.

INSTRUCTIONS:
This measure is to be reported once per episode of treatment for all patients with late effects of CVD who are treated for an attention deficit by a speech-language pathologist (SLP) during the reporting period. Only patients who had at least two visits in the reporting period will be counted in the denominator for this measure. This is an outcome measure, and its calculation requires reporting of the patient's score (see below under numerator) on the measure at the admission to and discharge from SLP treatment for attention. The admission score is noted by the SLP at the conclusion of the first treatment session, and the discharge score at the conclusion of the final treatment session for attention.

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure. The quality-data codes have been provided for registry only measures for use by registries that utilize claims data. It is not necessary to submit these codes for registry-based submissions. There are no allowable performance exclusions for this measure. Do not report this measure via claims.

DENOMINATOR:
Patients aged 16 years and older with late effects of CVD who received SLP treatment for attention

> Denominator Criteria (Eligible Cases):
> Patients aged ≥ 16 years on date of encounter
> AND
> Diagnosis of late effects of CVD (ICD-9-CM): 438.0, 438.10, 438.11, 438.12, 438.13, 438.14, 438.19, 438.20, 438.21, 438.22, 438.30, 438.31, 438.32, 438.40, 438.41, 438.42, 438.50, 438.51, 438.52, 438.53, 438.6, 438.7, 438.81, 438.82, 438.83, 438.84, 438.85, 438.89, 438.9
> AND
> Two (2) or more patient encounters during reporting period (CPT): 97532

NUMERATOR:
Patients whose score on the functional communication measure at discharge were higher than at admission

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Definitions:
Admission – The conclusion of the first treatment session for attention by an SLP
Discharge – The conclusion of the final treatment session for attention by an SLP, regardless of whether the patient is also being discharged from the facility and/or other SLP services.

Patient's Score –
LEVEL 1: Attention is nonfunctional. The individual is generally unresponsive to most stimuli.

LEVEL 2: The individual can briefly attend with consistent maximal stimulation, but not long enough to complete even simple living tasks.

LEVEL 3: The individual maintains attention over time to complete simple living tasks of short duration with consistent maximal cueing in the absence of distracting stimuli.

LEVEL 4: The individual maintains attention during simple living tasks of multiple steps and long duration within a minimally distracting environment with consistent minimal cueing.

LEVEL 5: The individual maintains attention within simple living activities with occasional minimal cues within distracting environments. The individual requires increased cueing to start, continue, and change attention during complex activities.

LEVEL 6: The individual maintains attention within complex activities, and can attend simultaneously to multiple demands with rare minimal cues. The individual usually uses compensatory strategies when encountering difficulty. The individual has mild difficulty or takes more than a reasonable amount of time to attend to multiple tasks/stimuli.

LEVEL 7: The individual's ability to participate in vocational, avocational, or social activities is not limited by attentional abilities. Independent functioning may occasionally include the use of compensatory strategies.

Numerator Options:
Score on the attention functional communication measure at discharge was higher than at admission (G8606)

OR

Score on the attention functional communication measure at discharge was not higher than at admission, reason not specified (G8607)
OR
Patient was not scored on the attention functional communication measure either at admission or at discharge (G8608)

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RATIONALE:
Assessment of cognition and arousal is important for determining the patient's capabilities and limitations for coping with their stroke and assuring success of the rehabilitation process. The results of the assessment may impact the choice of treatment and disposition.

Impairments in cognitive functioning are common after a stroke. In particular, impairments in attention, memory, and executive functioning (i.e., integrating multiple and complex processes) can be especially disabling. The treatment of cognitive deficits through cognitive remediation designed to reduce deficits can be approached in a variety of ways. Cicerone and colleagues completed a comprehensive review of the evidence-based literature for cognitive remediation for both traumatic brain injury (TBI) and stroke.

The review revealed a large number of randomized control trials (RCTs) in a variety of areas of cognitive functioning and provided comprehensive guidelines for cognitive rehabilitation specific to these populations. There is support for cognitive remediation of deficits in both the acute and post-acute phases of recovery from stroke and TBI, although some of the improvements were relatively small and task-specific. Some benefits were specific to the TBI population, although it seems reasonable to extend some of these results to the stroke population.

CLINICAL RECOMMENDATION STATEMENTS:
Recommend that the clinician use standardized, valid assessments to evaluate the patient's stroke-related impairments and functional status and encourage patient's participation in community and social activities. Recommend that the standardized assessment results be used to assess probability of outcome, determine the appropriate level of care, and develop interventions. (US Department of Veterans' Affairs; endorsed by the American Heart Association)

Recommend that patients be assessed for cognitive deficits and be given cognitive retraining, if any of the following conditions are present:
• Attention deficits
• Visual neglect
• Memory deficits
• Executive function and problem-solving difficulties
(US Department of Veterans' Affairs; endorsed by the American Heart Association)

Cognitive therapy may be used in rehabilitation of attention and concentration deficits. (National Stroke Foundation of Australia)

Patients with persistent cognitive deficits following acquired brain injury (ABI) should be offered cognitive rehabilitation which may include management in a structured and distraction-free environment and targeted programs for those with executive difficulties (i.e. problems with planning, organization, problem solving and divided attention), and attempts to improve attention and information processing skills. (Royal College of Medicine and the British Society of Rehabilitation Medicine)

The speech and language therapist will be involved in all cases where there are communication problems following stroke. (Republic of South Africa Department of Health; Stroke Foundation of South Africa)

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Measure #211: Functional Communication Measure - Memory

2011 PHYSICIAN QUALITY REPORTING OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Percentage of patients aged 16 years and older with a diagnosis of late effects of cerebrovascular disease (CVD) that make progress on the Memory Functional Communication Measure

INSTRUCTIONS:
This measure is to be reported once per episode of treatment for all patients with late effects of CVD who are treated for a memory deficit by a speech-language pathologist (SLP) during the reporting period. Only patients who had at least two visits in the reporting period will be counted in the denominator for this measure. This is an outcome measure, and its calculation requires reporting of the patient's score (see below under numerator) on the measure at the admission to and discharge from SLP treatment for memory. The admission score is noted by the SLP at the conclusion of the first treatment session, and the discharge score at the conclusion of the final treatment session for memory.

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure. The quality-data codes have been provided for registry only measures for use by registries that utilize claims data. It is not necessary to submit these codes for registry-based submissions. There are no allowable performance exclusions for this measure. Do not report this measure via claims.

DENOMINATOR:
Patients aged 16 years and older with late effects of CVD who received SLP treatment for memory

> Denominator Criteria (Eligible Cases):
> Patients aged ≥ 16 years on date of encounter
> AND
> Diagnosis of late effects of CVD (ICD-9-CM): 438.0, 438.10, 438.11, 438.12, 438.13, 438.14, 438.19, 438.20, 438.21, 438.22, 438.30, 438.31, 438.32, 438.40, 438.41, 438.42, 438.50, 438.51, 438.52, 438.53, 438.6, 438.7, 438.81, 438.82, 438.83, 438.84, 438.85, 438.89, 438.9
> AND
> Two (2) or more patient encounters during reporting period (CPT): 97532

NUMERATOR:
Patients whose score on the functional communication measure at discharge were higher than at admission

> Definitions:
> Admission – The conclusion of the first treatment session for memory by an SLP
> Discharge – The conclusion of the final treatment session for memory by an SLP, regardless of whether the patient is also being discharged from the facility and/or other SLP services.

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Patient's Score –

LEVEL 1: The individual is unable to recall any information, regardless of cueing.

LEVEL 2: The individual consistently requires maximal verbal cues or uses external aids to recall personal information (e.g., family members, biographical information, physical location, etc.) in structured environments.

LEVEL 3: The individual usually requires maximum cues to recall or use external aids for simple routine and personal information (e.g., schedule, names of familiar staff, location of therapy areas, etc.) in structured environments.

LEVEL 4: The individual occasionally requires minimal cues to recall or use external memory aids for simple routine and personal information in structured environments. The individual requires consistent maximal cues to recall or use memory aids for complex and novel information (e.g., carry out multiple steps activities, accommodate schedule changes, anticipate meal times, etc.), plan and follow through on simple future events (e.g., use calendar to keep appointments, use log books to complete a single assignment/task, etc.) in structured environments.

LEVEL 5: The individual consistently requires minimal cues to recall or use external memory aids for complex and novel information. The individual consistently requires minimal cues to plan and follow through on complex future events (e.g., menu planning and meal preparation, planning a party, etc.).

LEVEL 6: The individual is able to recall or use external aids/memory strategies for complex information and planning complex future events most of the time. When there is a breakdown in the use of recall/memory strategies/external memory aids, the individual occasionally requires minimal cues. These breakdowns may occasionally interfere with the individual's functioning in vocational, avocational, and social activities.

LEVEL 7: The individual is successful and independent in recalling or using external aids/memory strategies for complex information and planning future events in all vocational, avocational, and social activities.

Numerator Options:

Score on the memory functional communication measure at discharge was higher than at admission (G8609)

OR

Score on the memory functional communication measure at discharge was not higher than at admission, reason not specified (G8610)

OR

Patient was not scored on the memory functional communication measure at either admission or at discharge (G8611)

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RATIONALE:
Impairments in cognitive functioning are common after a stroke. In particular, impairments in attention, memory, and executive functioning (i.e., integrating multiple and complex processes) can be especially disabling. The treatment of cognitive deficits through cognitive remediation designed to reduce deficits can be approached in a variety of ways. Cicerone and colleagues completed a comprehensive review of the evidence-based literature for cognitive remediation for both traumatic brain injury (TBI) and stroke. The review revealed a large number of randomized control trials (RCTs) in a variety of areas of cognitive functioning and provided comprehensive guidelines for cognitive rehabilitation specific to these populations. There is support for cognitive remediation of deficits in both the acute and post-acute phases of recovery from stroke and TBI, although some of the improvements were relatively small and task specific. Some benefits were specific to the TBI population, although it seems reasonable to extend some of these results to the stroke population.

Assessment of cognition and arousal is important for determining the patient's capabilities and limitations for coping with their stroke and assuring success of the rehabilitation process. The results of the assessment may impact the choice of treatment and disposition.

CLINICAL RECOMMENDATION STATEMENTS:
Recommend that the clinician use standardized, valid assessments to evaluate the patient's stroke-related impairments and functional status and encourage patient's participation in community and social activities. Recommend that the standardized assessment results be used to assess probability of outcome, determine the appropriate level of care, and develop interventions. (US Department of Veterans' Affairs; endorsed by the American Heart Association)

Recommend the use of training to develop compensatory strategies for memory deficits in post-stroke patients who have mild short-term memory deficits. (US Department of Veterans' Affairs; endorsed by the American Heart Association)

Patients with persistent cognitive deficits following acquired brain injury (ABI) should be offered cognitive rehabilitation which may include the use of external memory aids to enhance independence in the presence of memory deficits. (Royal College of Medicine and the British Society of Rehabilitation Medicine)

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Measure #212: Functional Communication Measure – Motor Speech

2011 PHYSICIAN QUALITY REPORTING OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Percentage of patients aged 16 years and older with a diagnosis of late effects of cerebrovascular disease (CVD) that make progress on the Motor Speech Functional Communication Measure.

INSTRUCTIONS:
This measure is to be reported once per episode of treatment for all patients with late effects of CVD who are treated for a motor speech deficit by a speech-language pathologist (SLP) during the reporting period. Only patients who had at least two visits in the reporting period will be counted in the denominator for this measure. This is an outcome measure, and its calculation requires reporting of the patient's score (see below under numerator) on the measure at the admission to and discharge from SLP treatment for motor speech. The admission score is noted by the SLP at the conclusion of the first treatment session, and the discharge score at the conclusion of the final treatment session for motor speech.

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure. The quality-data codes have been provided for registry only measures for use by registries that utilize claims data. It is not necessary to submit these codes for registry-based submissions. There are no allowable performance exclusions for this measure. Do not report this measure via claims.

DENOMINATOR:
Patients aged 16 years and older with late effects of CVD who received SLP treatment for motor speech

> Denominator Criteria (Eligible Cases):
> Patients aged ≥ 16 years on date of encounter
> AND
> Diagnosis of late effects of CVD (ICD-9-CM): 438.10, 438.11, 438.12, 438.13, 438.14, 438.19, 438.20, 438.21, 438.22, 438.30, 438.31, 438.32, 438.40, 438.41, 438.42, 438.50, 438.51, 438.52, 438.53, 438.6, 438.7, 438.81, 438.82, 438.83, 438.84, 438.85, 438.89, 438.9, 784.3
> AND
> Two (2) or more patient encounters during reporting period (CPT): 92507, 92508

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NUMERATOR:
Patients whose score on the functional communication measure at discharge were higher than at admission

Definitions:
Admission – The conclusion of the first treatment session for motor speech by an SLP.
Discharge – The conclusion of the final treatment session for motor speech by an SLP, regardless of whether the patient is also being discharged from the facility and/or other SLP services.
Patient's Score –
LEVEL 1: The individual attempts to speak, but speech cannot be understood by familiar or unfamiliar listeners at any time.

LEVEL 2: The individual attempts to speak. The communication partner must assume responsibility for interpreting the message, and with consistent and maximal cues, the patient can produce short consonant-vowel combinations or automatic words that are rarely intelligible in context.

LEVEL 3: The communication partner must assume primary responsibility for interpreting the communication exchange. However, the individual is able to produce short consonant-vowel combinations or automatic words intelligibly. With consistent and moderate cueing, the individual can produce simple words and phrases intelligibly, although accuracy may vary.

LEVEL 4: In simple structured conversation with familiar communication partners, the individual can produce simple words and phrases intelligibly. The individual usually requires moderate cueing in order to produce simple sentences intelligibly, although accuracy may vary.

LEVEL 5: The individual is able to speak intelligibly using simple sentences in daily routine activities with both familiar and unfamiliar communication partners. The individual occasionally requires minimal cueing to produce more complex sentences/ messages in routine activities, although accuracy may vary and the individual may occasionally use compensatory strategies.

LEVEL 6: The individual is successfully able to communicate intelligibly in most activities, but some limitations in intelligibility are still apparent in vocational, avocational, and social activities. The individual rarely requires minimal cueing to produce complex sentences/messages intelligibly. The individual usually uses compensatory strategies when encountering difficulty.

LEVEL 7: The individual's ability to successfully and independently participate in vocational, avocational, or social activities is not limited by speech production. Independent functioning may occasionally include the use of compensatory techniques.

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Numerator Options:

Score on the motor speech functional communication measure at discharge was higher than at admission (G8612)

OR

Score on the motor speech functional communication measure at discharge was not higher than at admission, reason not specified (G8613)

OR

Patient was not scored on the motor speech functional communication measure either at admission or at discharge (G8614)

RATIONALE:

Assessment of communication ability is important for determining the patient's capabilities and limitations in expressing their wants, needs, and understanding; their ability to contribute to their plan of care (including consent forms and advanced directives), and their ability to comprehend instructions affecting the success of the rehabilitation process. The results of the assessment may impact the choice of treatment and disposition.

Disorders of communication (i.e., problems with speaking, listening, reading, writing, gesturing, and/or pragmatics) and related cognitive impairments may occur in as many as 40% of post-stroke patients. The most common communication disorders occurring after stroke are aphasia and dysarthria. Rapid spontaneous improvement is common, but early evaluation can identify communication problems and monitor change. If indicated, intervention can help maximize recovery of communication abilities and prevent learning of ineffective or inappropriate compensatory behaviors. Goals of speech and language treatment are to (1) facilitate the recovery of communication, (2) assist patients in developing strategies to compensate for communication disorders, and (3) counsel and educate people in the patient's environment to facilitate communication, decrease isolation, and meet the patient's desires and needs.

CLINICAL RECOMMENDATION STATEMENTS:

Recommend that the clinician use standardized, valid assessments to evaluate the patient's stroke-related impairments and functional status and encourage patient's participation in community and social activities. Recommend that the standardized assessment results be used to assess probability of outcome, determine the appropriate level of care, and develop interventions. (US Department of Veterans' Affairs; endorsed by the American Heart Association)

Recommend that all patients be evaluated and treated by the SLP for residual communication difficulties (i.e., speaking, listening, reading, writing, and pragmatics). (US Department of Veterans' Affairs; endorsed by the American Heart Association)

It is recommended that patients who are conscious with communication difficulties be evaluated by a SLP who can develop appropriate communication techniques. SLP assessment should include screening for hearing and vision and restoration of glasses or hearing aids. Appropriate patients (with reasonable cognition and language skills) should be considered for alternative or augmentative communication. Patients with communication difficulties should be monitored and assessed regularly to determine appropriateness for speech and language therapy. An appropriate treatment program with a system for monitoring progress should be in place for any individuals receiving speech-language therapy. In developing a communication program, consideration for premorbid communication style, underlying cognitive deficits, environmental context, social needs, and necessary communication aids should be given. (Royal College of Medicine and the British Society of Rehabilitation Medicine)

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Where achievable goals can be identified, and continuing progress demonstrated, patients with communication difficulties should be offered an appropriate treatment program, with monitoring of progress. The program should: take into account the patient's premorbid communication style and any underlying cognitive deficits; give the opportunity to rehearse communication skills in situations appropriate to the context in which the patient will live/work/study/socialize after discharge; include the family and caregivers in developing strategies for optimum communication within the immediate social circle; consider the need for communication aids including gesture drawing, communication charts and computerized systems. (Royal College of Medicine and the British Society of Rehabilitation Medicine) The speech and language therapist will be involved in all cases where there are communication problems following stroke. (Republic of South Africa Department of Health; Stroke Foundation of South Africa)

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Measure #213: Functional Communication Measure - Reading

2011 PHYSICIAN QUALITY REPORTING OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Percentage of patients aged 16 years and older with a diagnosis of late effects of cerebrovascular disease (CVD) that make progress on the Reading Functional Communication Measure

INSTRUCTIONS:
This measure is to be reported once per episode of treatment for all patients with late effects of CVD who are treated for a reading deficit by a speech-language pathologist (SLP) during the reporting period. Only patients who had at least two visits in the reporting period will be counted in the denominator for this measure. This is an outcome measure, and its calculation requires reporting of the patient's score (see below under numerator) on the measure at the admission to and discharge from SLP treatment for reading. The admission score is noted by the SLP at the conclusion of the first treatment session, and the discharge score at the conclusion of the final treatment session for reading.

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure. The quality-data codes have been provided for registry only measures for use by registries that utilize claims data. It is not necessary to submit these codes for registry-based submissions. There are no allowable performance exclusions for this measure. Do not report this measure via claims.

DENOMINATOR:
Patients aged 16 years and older with late effects of CVD who received SLP treatment for reading

> Denominator Criteria (Eligible Cases):
> Patients aged ≥ 16 years on date of encounter
> AND
> Diagnosis of late effects of CVD (ICD-9-CM): 438.10, 438.11, 438.12, 438.13, 438.14, 438.19, 438.20, 438.21, 438.22, 438.30, 438.31, 438.32, 438.40, 438.41, 438.42, 438.50, 438.51, 438.52, 438.53, 438.6, 438.7, 438.81, 438.82, 438.83, 438.84, 438.85, 438.89, 438.9, 784.3
> AND
> Two (2) or more patient encounters during reporting period (CPT): 92507, 92508

NUMERATOR:
Patients whose score on the functional communication measure at discharge were higher than at admission

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Definitions:
Admission – The conclusion of the first treatment session for reading by an SLP
Discharge – The conclusion of the final treatment session for reading by an SLP, regardless of whether the patient is also being discharged from the facility and/or other SLP services.
Patient's Score –

LEVEL 1: The individual attends to printed material, but doesn't recognize even single letters or common words.

LEVEL 2: The individual reads single letters and common words with consistent maximal cueing.

LEVEL 3: The individual reads single letters and common words, and with consistent moderate cueing, can read some words that are less familiar, longer, and more complex.

LEVEL 4: The individual reads words and phrases related to routine daily activities, and words that are less familiar, longer, and more complex. The individual usually requires moderate cueing to read sentences of approximately 5–7 words.

LEVEL 5: The individual reads sentence-level material containing some complex words. The individual occasionally requires minimal cueing to read more complex sentences and paragraph-level material. The individual occasionally uses compensatory strategies.

LEVEL 6: The individual is successfully able to read most material but some limitations in reading are still apparent in vocational, avocational, and social activities. The individual rarely requires minimal cueing to read complex material. Although reading is successful, it may take the individual longer to read the material. The individual usually uses compensatory strategies when encountering difficulty.

LEVEL 7: The individual's ability to successfully and independently participate in vocational, avocational, and social activities is not limited by reading skills. Independent functioning may occasionally include use of compensatory strategies.

Numerator Options:
Score on the reading functional communication measure at discharge was higher than at admission (G8615)

OR

Score on the reading functional communication measure at discharge was not higher than at admission, reason not specified (G8616)

OR

Patient was not scored on the reading functional communication measure either at admission or at discharge (G8617)

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RATIONALE:
Assessment of communication ability is important for determining the patient's capabilities and limitations in expressing their wants, needs, and understanding; their ability to contribute to their plan of care (including consent forms and advanced directives), and their ability to comprehend instructions affecting the success of the rehabilitation process. The results of the assessment may impact the choice of treatment and disposition.

Disorders of communication (i.e., problems with speaking, listening, reading, writing, gesturing, and/or pragmatics) and related cognitive impairments may occur in as many as 40% of post-stroke patients. The most common communication disorders occurring after stroke are aphasia and dysarthria. Rapid spontaneous improvement is common, but early evaluation can identify communication problems and monitor change. If indicated, intervention can help maximize recovery of communication abilities and prevent learning of ineffective or inappropriate compensatory behaviors. Goals of speech and language treatment are to (1) facilitate the recovery of communication, (2) assist patients in developing strategies to compensate for communication disorders, and (3) counsel and educate people in the patient's environment to facilitate communication, decrease isolation, and meet the patient's desires and needs.

CLINICAL RECOMMENDATION STATEMENTS:
Recommend that the clinician use standardized, valid assessments to evaluate the patient's stroke-related impairments and functional status and encourage patient's participation in community and social activities. Recommend that the standardized assessment results be used to assess probability of outcome, determine the appropriate level of care, and develop interventions. *(US Department of Veterans' Affairs; endorsed by the American Heart Association)*

Recommend that all patients be evaluated and treated by the SLP for residual communication difficulties (i.e., speaking, listening, reading, writing, and pragmatics). *(US Department of Veterans' Affairs; endorsed by the American Heart Association)*

Interventions for people with aphasia may include: treatment of phonological and semantic deficits following models derived from cognitive neuropsychology, constraint-induced therapy, and computer-based therapy programs. *(National Stroke Foundation of Australia)*

It is recommended that patients who are conscious with communication difficulties be evaluated by a SLP who can develop appropriate communication techniques. SLP assessment should include screening for hearing and vision and restoration of glasses or hearing aids. Appropriate patients (with reasonable cognition and language skills) should be considered for alternative or augmentative communication. Patients with communication difficulties should be monitored and assessed regularly to determine appropriateness for speech and language therapy. An appropriate treatment program with a system for monitoring progress should be in place for any individuals receiving speech-language therapy. In developing a communication program, consideration for premorbid communication style, underlying cognitive deficits, environmental context, social needs, and necessary communication aids should be given. *(Royal College of Medicine and the British Society of Rehabilitation Medicine)*

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Where achievable goals can be identified, and continuing progress demonstrated, patients with communication difficulties should be offered an appropriate treatment program, with monitoring of progress. The program should: take into account the patient's premorbid communication style and any underlying cognitive deficits; give the opportunity to rehearse communication skills in situations appropriate to the context in which the patient will live/work/study/socialize after discharge; include the family and caregivers in developing strategies for optimum communication within the immediate social circle; and consider the need for communication aids including gesture drawing, communication charts and computerized systems. *(Royal College of Medicine and the British Society of Rehabilitation Medicine)*

The speech and language therapist will be involved in all cases where there are communication problems following stroke. *(Republic of South Africa Department of Health; Stroke Foundation of South Africa)*

People with aphasia following stroke should be referred to a speech and language therapist for assessment and appropriate management of their communication difficulty. *(Stroke Foundation of New Zealand)*

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Measure #214: Functional Communication Measure – Spoken Language Expression

2011 PHYSICIAN QUALITY REPORTING OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Percentage of patients aged 16 years and older with a diagnosis of late effects of cerebrovascular disease (CVD) that make progress on the Spoken Language Expression Functional Communication Measure

INSTRUCTIONS:
This measure is to be reported once per episode of treatment for all patients with late effects of CVD who are treated for a spoken language expression deficit by a speech-language pathologist (SLP) during the reporting period. Only patients who had at least two visits in the reporting period will be counted in the denominator for this measure. This is an outcome measure, and its calculation requires reporting of the patient's score (see below under numerator) on the measure at the admission to and discharge from SLP treatment for spoken language expression. The admission score is noted by the SLP at the conclusion of the first treatment session, and the discharge score at the conclusion of the final treatment session for spoken language expression.

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure. The quality-data codes have been provided for registry only measures for use by registries that utilize claims data. It is not necessary to submit these codes for registry-based submissions. There are no allowable performance exclusions for this measure. Do not report this measure via claims.

DENOMINATOR:
Patients aged 16 years and older with late effects of CVD who received SLP treatment for spoken language expression

> Denominator Criteria (Eligible Cases):
> Patients aged ≥ 16 years on date of encounter
> AND
> Diagnosis of late effects of CVD (ICD-9-CM): 438.10, 438.11, 438.12, 438.13, 438.14, 438.19, 438.20, 438.21, 438.22, 438.30, 438.31, 438.32, 438.40, 438.41, 438.42, 438.50, 438.51, 438.52, 438.53, 438.6, 438.7, 438.81, 438.82, 438.83, 438.84, 438.85, 438.89, 438.9, 784.3
> AND
> Two (2) or more patient encounters during reporting period (CPT): 92507, 92508

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NUMERATOR:
Patients whose score on the functional communication measure at discharge were higher than at admission

Definitions:
Admission – The conclusion of the first treatment session for spoken language expression by an SLP
Discharge – The conclusion of the final treatment session for spoken language expression by an SLP, regardless of whether the patient is also being discharged from the facility and/or other SLP services.
Patient's Score –

LEVEL 1: The individual attempts to speak, but verbalizations are not meaningful to familiar or unfamiliar communication partners at any time.

LEVEL 2: The individual attempts to speak, although few attempts are accurate or appropriate. The communication partner must assume responsibility for structuring the communication exchange, and with consistent and maximal cueing, the individual can only occasionally produce automatic and/or imitative words and phrases that are rarely meaningful in context.

LEVEL 3: The communication partner must assume responsibility for structuring the communication exchange, and with consistent and moderate cueing, the individual can produce words and phrases that are appropriate and meaningful in context.

LEVEL 4: The individual is successfully able to initiate communication using spoken language in simple, structured conversations in routine daily activities with familiar communication partners. The individual usually requires moderate cueing, but is able to demonstrate use of simple sentences (i.e., semantics, syntax, and morphology) and rarely uses complex sentences/messages.

LEVEL 5: The individual is successfully able to initiate communication using spoken language in structured conversations with both familiar and unfamiliar communication partners. The individual occasionally requires minimal cueing to frame more complex sentences in messages. The individual occasionally self-cues when encountering difficulty.

LEVEL 6: The individual is successfully able to communicate in most activities, but some limitations in spoken language are still apparent in vocational, avocational, and social activities. The individual rarely requires minimal cueing to frame complex sentences. The individual usually self-cues when encountering difficulty.

LEVEL 7: The individual's ability to successfully and independently participate in vocational, avocational, and social activities is not limited by spoken language skills. Independent functioning may occasionally include use of self-cueing.

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Numerator Options:

Score on the spoken language expression functional communication measure at discharge was higher than at admission (G8618)

OR

Score on the spoken language expression functional communication measure at discharge was not higher than at admission, reason not specified (G8619)

OR

Patient was not scored on the spoken language expression reading functional communication measure either at admission or at discharge (G8620)

RATIONALE:

Assessment of communication ability is important for determining the patient's capabilities and limitations in expressing their wants, needs, and understanding; their ability to contribute to their plan of care (including consent forms and advanced directives), and their ability to comprehend instructions affecting the success of the rehabilitation process. The results of the assessment may impact the choice of treatment and disposition.

Disorders of communication (i.e., problems with speaking, listening, reading, writing, gesturing, and/or pragmatics) and related cognitive impairments may occur in as many as 40% of post-stroke patients. The most common communication disorders occurring after stroke are aphasia and dysarthria. Rapid spontaneous improvement is common, but early evaluation can identify communication problems and monitor change. If indicated, intervention can help maximize recovery of communication abilities and prevent learning of ineffective or inappropriate compensatory behaviors. Goals of speech and language treatment are to (1) facilitate the recovery of communication, (2) assist patients in developing strategies to compensate for communication disorders, and (3) counsel and educate people in the patient's environment to facilitate communication, decrease isolation, and meet the patient's desires and needs.

CLINICAL RECOMMENDATION STATEMENTS:

Aphasic stroke patients should be referred for speech and language therapy. Where the patient is sufficiently well and motivated, aim for minimum of two hours per week. *(Scottish Intercollegiate Guidelines Network).*

Recommend that the clinician use standardized, valid assessments to evaluate the patient's stroke-related impairments and functional status and encourage patient's participation in community and social activities. Recommend that the standardized assessment results be used to assess probability of outcome, determine the appropriate level of care, and develop interventions. *(US Department of Veterans' Affairs; endorsed by the American Heart Association)*

Recommend that all patients be evaluated and treated by the SLP for residual communication difficulties (i.e., speaking, listening, reading, writing, and pragmatics). *(US Department of Veterans' Affairs; endorsed by the American Heart Association)*

Interventions for people with aphasia may include: treatment of phonological and semantic deficits following models derived from cognitive neuropsychology, constraint-induced therapy, and computer-based therapy programs. *(National Stroke Foundation of Australia)*

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It is recommended that patients who are conscious with communication difficulties be evaluated by a SLP who can develop appropriate communication techniques. SLP assessment should include screening for hearing and vision and restoration of glasses or hearing aids. Appropriate patients (with reasonable cognition and language skills) should be considered for alternative or augmentative communication. Patients with communication difficulties should be monitored and assessed regularly to determine appropriateness for speech and language therapy. An appropriate treatment program with a system for monitoring progress should be in place for any individuals receiving speech-language therapy. In developing a communication program, consideration for premorbid communication style, underlying cognitive deficits, environmental context, social needs, and necessary communication aids should be given. *(Royal College of Medicine and the British Society of Rehabilitation Medicine)*

Where achievable goals can be identified, and continuing progress demonstrated, patients with communication difficulties should be offered an appropriate treatment program, with monitoring of progress. The program should: take into account the patient's premorbid communication style and any underlying cognitive deficits; give the opportunity to rehearse communication skills in situations appropriate to the context in which the patient will live/work/study/socialize after discharge; include the family and caregivers in developing strategies for optimum communication within the immediate social circle; and consider the need for communication aids including gesture drawing, communication charts and computerized systems. *(Royal College of Medicine and the British Society of Rehabilitation Medicine)*

The speech and language therapist will be involved in all cases where there are communication problems following stroke. *(Republic of South Africa Department of Health; Stroke Foundation of South Africa)*

People with aphasia following stroke should be referred to a speech and language therapist for assessment and appropriate management of their communication difficulty. *(Stroke Foundation of New Zealand)*

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Measure #215: Functional Communication Measure - Writing

2011 PHYSICIAN QUALITY REPORTING OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Percentage of patients aged 16 years and older with a diagnosis of late effects of cerebrovascular disease (CVD) that make progress on the Writing Functional Communication Measure

INSTRUCTIONS:
This measure is to be reported once per episode of treatment for all patients with late effects of CVD who are treated for a writing deficit by a speech-language pathologist (SLP) during the reporting period. Only patients who had at least two visits in the reporting period will be counted in the denominator for this measure. This is an outcome measure, and its calculation requires reporting of the patient's score (see below under numerator) on the measure at the admission to and discharge from SLP treatment for writing. The admission score is noted by the SLP at the conclusion of the first treatment session, and the discharge score at the conclusion of the final treatment session for writing.

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure. The quality-data codes have been provided for registry only measures for use by registries that utilize claims data. It is not necessary to submit these codes for registry-based submissions. There are no allowable performance exclusions for this measure. Do not report this measure via claims.

DENOMINATOR:
Patients aged 16 years and older on date of encounter who received SLP treatment for writing

> Denominator Criteria (Eligible Cases):
> Patients aged ≥ 16 years on date of encounter
> AND
> Diagnosis of late effects of CVD (ICD-9-CM): 438.10, 438.11, 438.12, 438.13, 438.14, 438.19, 438.20, 438.21, 438.22, 438.30, 438.31, 438.32, 438.40, 438.41, 438.42, 438.50, 438.51, 438.52, 438.53, 438.6, 438.7, 438.81, 438.82, 438.83, 438.84, 438.85, 438.89, 438.9, 784.3
> AND
> Two (2) or more patient encounters during reporting period (CPT): 92507, 92508

NUMERATOR:
Patients whose score on the functional communication measure at discharge were higher than at admission

> Definitions:
> Admission – The conclusion of the first treatment session for writing by an SLP

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Discharge – The conclusion of the final treatment session for writing by an SLP, regardless of whether the patient is also being discharged from the facility and/or other SLP services.
Patient's Score –

LEVEL 1: The individual attempts to write, but doesn't produce recognizable single Letters or common words.

LEVEL 2: The individual writes single letters and common words with consistent maximal cueing.

LEVEL 3: The individual writes single letters and common words, and with consistent moderate cueing, can write some words that are less familiar, longer, and more complex.

LEVEL 4: The individual writes words and phrases related to routine daily activities and words that are less familiar, longer, and more complex. The individual usually requires moderate cueing to write sentences of approximately 5–7 words.

LEVEL 5: The individual writes sentence-level material containing some complex words. The individual occasionally requires minimal cueing to write more complex sentences and paragraph-level material. The individual occasionally uses compensatory strategies.

LEVEL 6: The individual is successfully able to write most material, but some limitations in writing are still apparent in vocational, avocational, and social activities. The individual rarely requires minimal cueing to write complex material. The individual usually uses compensatory strategies when encountering difficulty.

LEVEL 7: The individual's ability to successfully and independently participate in vocational, avocational, and social activities is not limited by writing skills. Independent functioning may occasionally include use of compensatory strategies.

Numerator Options:
Score on the writing functional communication measure at discharge was higher than at admission (G8621)

OR

Score on the writing functional communication measure at discharge was not higher than at admission, reason not specified (G8622)

OR

Patient was not scored on the writing functional communication measure either at admission or at discharge (G8623)

RATIONALE:
Assessment of communication ability is important for determining the patient's capabilities and limitations in expressing their wants, needs, and understanding; their ability to contribute to their plan of care (including consent forms and advanced directives), and their ability to comprehend instructions affecting the success of the rehabilitation process. The results of the assessment may impact the choice of treatment and disposition.

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Disorders of communication (i.e., problems with speaking, listening, reading, writing, gesturing, and/or pragmatics) and related cognitive impairments may occur in as many as 40% of post stroke patients. The most common communication disorders occurring after stroke are aphasia and dysarthria. Rapid spontaneous improvement is common, but early evaluation can identify communication problems and monitor change. If indicated, intervention can help maximize recovery of communication abilities and prevent learning of ineffective or inappropriate compensatory behaviors. Goals of speech and language treatment are to (1) facilitate the recovery of communication, (2) assist patients in developing strategies to compensate for communication disorders, and (3) counsel and educate people in the patient's environment to facilitate communication, decrease isolation, and meet the patient's desires and needs.

CLINICAL RECOMMENDATION STATEMENTS:

Recommend that the clinician use standardized, valid assessments to evaluate the patient's stroke-related impairments and functional status and encourage patient's participation in community and social activities. Recommend that the standardized assessment results be used to assess probability of outcome, determine the appropriate level of care, and develop interventions. *(US Department of Veterans' Affairs; endorsed by the American Heart Association)*

Recommend that all patients be evaluated and treated by the SLP for residual communication difficulties (i.e., speaking, listening, reading, writing, and pragmatics). *(US Department of Veterans' Affairs; endorsed by the American Heart Association)*

Interventions for people with aphasia may include: treatment of phonological and semantic deficits following models derived from cognitive neuropsychology, constraint-induced therapy, and computer-based therapy programs. *(National Stroke Foundation of Australia)*

It is recommended that patients who are conscious with communication difficulties be evaluated by a speech-language pathologist who can develop appropriate communication techniques. SLP assessment should include screening for hearing and vision and restoration of glasses or hearing aids. Appropriate patients (with reasonable cognition and language skills) should be considered for alternative or augmentative communication. Patients with communication difficulties should be monitored and assessed regularly to determine appropriateness for speech and language therapy. An appropriate treatment program with a system for monitoring progress should be in place for any individuals receiving speech-language therapy. In developing a communication program, consideration for premorbid communication style, underlying cognitive deficits, environmental context, social needs, and necessary communication aids should be given. *(Royal College of Medicine and the British Society of Rehabilitation Medicine)*

Where achievable goals can be identified, and continuing progress demonstrated, patients with communication difficulties should be offered an appropriate treatment program, with monitoring of progress. The program should: take into account the patient's premorbid communication style and any underlying cognitive deficits; give the opportunity to rehearse communication skills in situations appropriate to the context in which the patient will live/work/study/socialize after discharge; include the family and caregivers in developing strategies for optimum communication within the immediate social circle; consider the need for communication aids including gesture drawing, communication charts and computerized systems. *(Royal College of Medicine and the British Society of Rehabilitation Medicine)*

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The speech and language therapist will be involved in all cases where there are communication problems following stroke. *(Republic of South Africa Department of Health; Stroke Foundation of South Africa)*

People with aphasia following stroke should be referred to a speech and language therapist for assessment and appropriate management of their communication difficulty. *(Stroke Foundation of New Zealand)*

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Measure #216: Functional Communication Measure - Swallowing

2011 PHYSICIAN QUALITY REPORTING OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Percentage of patients aged 16 years and older with a diagnosis of late effects of cerebrovascular disease (CVD) that make progress on the Swallowing Functional Communication Measure

INSTRUCTIONS:
This measure is to be reported once per episode of treatment for all patients with late effects of CVD who are treated for dysphagia by a speech-language pathologist (SLP) during the reporting period. Only patients who had at least two visits in the reporting period will be counted in the denominator for this measure. This is an outcome measure, and its calculation requires reporting of the patient's score (see below under numerator) on the measure at the admission to and discharge from SLP treatment for attention. The admission score is noted by the SLP at the conclusion of the first treatment session, and the discharge score at the conclusion of the final treatment session for dysphagia.

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure. The quality-data codes have been provided for registry only measures for use by registries that utilize claims data. It is not necessary to submit these codes for registry-based submissions. There are no allowable performance exclusions for this measure. Do not report this measure via claims.

DENOMINATOR:
Patients aged 16 years and older with late effects of CVD who received SLP treatment for dysphagia

> Denominator Criteria (Eligible Cases):
> Patients aged ≥ 16 years on date of encounter
> AND
> Diagnosis of late effects of CVD (ICD-9-CM): 438.82, 784.51, 787.20, 787.21, 787.22, 787.23, 787.24, 787.29
> AND
> Two (2) or more patient encounters during reporting period (CPT): 92526

NUMERATOR:
Patients whose score on the functional communication measure at discharge were higher than at admission.

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Definitions:
Admission – The conclusion of the first treatment session for dysphagia by an SLP
Discharge – The conclusion of the final treatment session for dysphagia by an SLP, regardless of whether the patient is also being discharged from the facility and/or other SLP services.

Patient's Score –
LEVEL 1: Individual is not able to swallow anything safely by mouth. All nutrition and hydration is received through non-oral means (e.g., nasogastric tube, PEG).

LEVEL 2: Individual is not able to swallow safely by mouth for nutrition and hydration, but may take some consistency with consistent maximal cues in therapy only. Alternative method of feeding required.

LEVEL 3: Alternative method of feeding required as individual takes less than 50% of nutrition and hydration by mouth, and/or swallowing is safe with consistent use of moderate cues to use compensatory strategies and/or requires maximum diet restriction.

LEVEL 4: Swallowing is safe, but usually requires moderate cues to use compensatory strategies, and/or the individual has moderate diet restrictions and/or still requires tube feeding and/or oral supplements.

LEVEL 5: Swallowing is safe with minimal diet restriction and/or occasionally requires minimal cueing to use compensatory strategies. The individual may occasionally self-cue. All nutrition and hydration needs are met by mouth at mealtime.

LEVEL 6: Swallowing is safe, and the individual eats and drinks independently and may rarely require minimal cueing. The individual usually self-cues when difficulty occurs. May need to avoid specific food items (e.g., popcorn and nuts), or require additional time (due to dysphasia).

LEVEL 7: The individual's ability to eat independently is not limited by swallow function. Swallowing would be safe and efficient for all consistencies. Compensatory strategies are effectively used when needed.

Numerator Options:
Score on the swallowing functional communication measure at discharge was higher than at admission (G8624)

OR

Score on the swallowing functional communication measure at discharge was not higher than at admission, reason not specified (G8625)
OR
Patient was not scored on the swallowing functional communication measure at admission or at discharge (G8626)

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RATIONALE:
Dysphagia, an abnormality in swallowing fluids or food, is common, occurring in about 45% of all stroke patients admitted to the hospital. It can seriously affect the patient's quality of life and potentially lead to death. It is associated with severe strokes and with worse outcome. The presence of aspiration may be associated with an increased risk of developing pneumonia after stroke. Malnutrition is also common, being present in about 15% of all patients admitted to the hospital, and increasing to about 30% over the first week after stroke.

Malnutrition is associated with a worse outcome and a slower rate of recovery. Assessment of dysphagia by personnel who are not adequately trained in the anatomy and physiology of swallowing is often times problematic. Traditionally, SLPs receive formal training in oropharyngeal anatomy and physiology.

CLINICAL RECOMMENDATION STATEMENTS:
Treatment outcome studies have provided evidence that compensatory strategies designed to have an immediate effect on the swallow (i.e., postural changes or diet manipulation) can improve swallowing safety and efficiency. Postural techniques eliminated aspiration on thin liquids in 75 to 80% of dysphagic patients. Likewise, data are beginning to emerge that demonstrate the utility of pharyngeal muscle strengthening exercises for improving swallowing physiology. Treatment approaches improve nutritional status and hydration, and reduce morbidity from pneumonia. The speech-language pathologist's intervention in swallowing disorders helps contain medical costs by reducing the length of hospital stays, decreasing the need for non oral feedings, reducing nutritional problems, and decreasing expenses associated with pneumonia and other pulmonary complications. *(American Speech-Language-Hearing Association)*

Recommend that the clinician use standardized, valid assessments to evaluate the patient's stroke-related impairments and functional status and encourage patient's participation in community and social activities. Recommend that the standardized assessment results be used to assess probability of outcome, determine the appropriate level of care, and develop interventions. *(US Department of Veterans' Affairs; endorsed by the American Heart Association)*

Recommend that the dysphagic stroke patient receive both direct swallowing treatment and management by the SLP, when available, when a treatable disorder in swallow anatomy or physiology is identified. *(US Department of Veterans' Affairs; endorsed by the American Heart Association)*

The speech and language therapist will be involved in all cases where there are communication problems following stroke. Such therapy should include augmentative communication systems in cases where intelligible speech is not a reasonable goal. The role of the speech therapist includes diagnosis and treatment of swallowing disorders. *(Republic of South Africa Department of Health; Stroke Foundation of South Africa)*

Any person with an abnormal swallow should be seen by a speech and language therapist, who should assess the person further and advise the person and staff on safe swallowing techniques and strategies and the consistency of diet and fluids. *(Stroke Foundation of New Zealand)*

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☾ Measure #217: Functional Deficit: Change in Risk-Adjusted Functional Status for Patients with Knee Impairments

2011 PHYSICIAN QUALITY REPORTING OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Percentage of patients aged 18 or older that receive treatment for a functional deficit secondary to a diagnosis that affects the knee in which the change in their Risk-Adjusted Functional Status is measured

INSTRUCTIONS:
This outcomes measure is to be reported once per treatment episode for all patients with a functional deficit related to the knee. This is an outcomes measure and its calculation requires reporting of the patient's functional status score, as a minimum, at admission to and again at discharge from an episode of rehabilitation. The admission score, estimated using patient self-report surveys, is recorded during the first rehabilitation treatment encounter and the discharge score is recorded at or near the conclusion of the final rehabilitation treatment encounter. It is anticipated that physical and occupational therapists providing treatment for functional knee deficits will report this measure.

Definitions:

Treatment Episode – A Treatment Episode is defined as beginning with an Admission for a functional knee deficit, progressing to development of a plan of care, including treatment, without interruption of care (for example a hospitalization or surgical intervention), and ending with Discharge from clinical care by the Eligible Professional. A patient currently under clinical care for a knee deficit remains in a single episode of care until the Discharge is conducted and documented by the Eligible Professional.

Admission – An Admission is the first encounter for a functional deficit involving the knee and includes an evaluation (CPT 97001 or 97003) and development of a plan of care by the Eligible Professional. A patient presenting with a knee impairment, who has had an interruption of a Treatment Episode for the same functional knee deficit secondary to an appropriate reason like hospitalization or surgical intervention, is a new Admission.

Discharge – Discharge is accompanied by a re-evaluation (CPT 97002 or 97004) identifying the close of a Treatment Episode for the same knee deficit identified at admission and documented by a discharge report by the Eligible Professional. An interruption in clinical care for an appropriate reason like hospitalization or surgical intervention requires a discharge from the current Treatment Episode.

Encounter – A face to face visit between the patient and the provider for the purpose of assessing and/or improving a functional deficit.

Patient Reported – The patient directly, or through a proxy, provides answers to functional status survey items using standardized, reliable and valid, computerized adaptive testing or paper and pencil survey methods.

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Measure Reporting via Registry:
CPT codes, patient demographics, and functional deficits 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 have been provided for registry only measures for use by registries that utilize claims data. It is not necessary to submit these codes for registry-based submissions. Do not report this measure via claims.

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 (CPT) identifying evaluation: 97001
AND
Patient encounter during the reporting period (CPT) identifying re-evaluation: 97002
AND
Functional deficit affecting knee

OR

Option 2 – Occupational Therapy Denominator Criteria (Eligible Cases):
All patients aged ≥ 18 years on date of encounter
AND
Patient encounter during the reporting period (CPT) identifying evaluation: 97003
AND
Patient encounter during the reporting period (CPT) identifying re-evaluation: 97004
AND
Functional deficit affecting knee

NUMERATOR:
Patients presented FOTO's Functional Intake Survey for the Knee at admission and FOTO's Functional Status Survey at discharge for the purpose of calculating the patient's Risk-adjusted Functional Status Change Residual Score

Definitions:
Patient's Functional Status Score – A functional status score is produced when the patient completes the FOTO functional status survey (either by paper and pencil or computerized adaptive testing administration). The functional status score is continuous and linear. Scores range from 0 (low function) to 100 (high function). The survey is standardized, and the scores are validated for the measurement of function for this population.
Patient's Functional Status Change Score – A functional status change score is calculated by subtracting the Patient's Functional Status Score at Admission from the Patient's Functional Status Score at Discharge.
Predicted Functional Status Change Score – Functional Status Change Scores for patients are risk adjusted using multiple linear regression methods that include the following independent variables: Patient's Functional Status Score at Admission, patient age, symptom

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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:

Risk-Adjusted Functional Status Change Residual Score for the knee successfully calculated and the score was equal to zero (0) or greater than zero (>0) (G8647)

OR

Risk-Adjusted Functional Status Change Residual Score for the knee successfully calculated and the score was less than zero (<0) (G8648)

OR

Risk-Adjusted Functional Status Change Residual Scores for the knee not measured because the patient did not complete FOTO's Functional Intake on admission and/or follow up Status Survey near discharge, patient Not Eligible/Not Appropriate (G8649)

OR

Risk-Adjusted Functional Status Change Residual Scores for the knee not measured because the patient did not complete FOTO's Functional Intake on admission and/or follow up Status Survey near discharge, reason not specified (G8650)

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RATIONALE:
Functional deficits are common in the general population and are costly to the individual, their family and society. Improved functional status has been associated with greater quality of life, self-efficacy, improved financial well-being and lower future medical costs. Improving functional status in people seeking rehabilitation has become a goal of the American Physical Therapy Association. Therefore, measuring change in functional status is important for providers treating patients in rehabilitation and can be used to assess the success of treatment and direct modification of treatment.

Change in functional status represents the activity domain of the International Classification of Function. If treatment is designed to improve the functional deficit, it is logical to assess functional status at discharge using a standardized score to determine if treatment improved the functional status of the patient over the treatment episode.

The National Quality Measures Clearinghouse has approved the measurement of change in functional status, using this survey. NQMC-1873.

CLINICAL RECOMMENDATION STATEMENTS:
The American Physical Therapy Association (APTA), in their *Guide to Physical Therapy Practice*, described five recommended elements of patient management: examination, evaluation, diagnosis, prognosis and intervention. The elements were intended to direct therapists in their approach to patient treatment for the purpose of optimizing patient outcomes. The APTA clearly indentifies functional status data as one of the major forms of data to be collected for patients receiving rehabilitation. The functional status measures should be used to assist in the planning, implementation and modification of treatment interventions and should be used as measures of outcomes. The current functional status scores can be used by therapists to fulfill the recommended methods of the APTA in the management of patients in rehabilitation.

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☾ Measure #218: Functional Deficit: Change in Risk-Adjusted Functional Status for Patients with Hip Impairments

2011 PHYSICIAN QUALITY REPORTING OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Percentage of patients aged 18 or older that receive treatment for a functional deficit secondary to a diagnosis that affects the hip in which the change in their Risk-Adjusted Functional Status is measured

INSTRUCTIONS:
This outcomes measure is to be reported once per treatment episode for all patients with a functional deficit related to the hip. This is an outcomes measure and its calculation requires reporting of the patient's functional status score, as a minimum, at admission to and again at discharge from an episode of rehabilitation. The admission score, estimated using patient self-report surveys, is recorded during the first rehabilitation treatment encounter and the discharge score is recorded at or near the conclusion of the final rehabilitation treatment encounter. It is anticipated that physical and occupational therapists providing treatment for functional hip deficits will report this measure.

Definitions:

Treatment Episode – A Treatment Episode is defined as beginning with an Admission for a functional hip deficit, progressing to development of a plan of care, including treatment, without interruption of care (for example a hospitalization or surgical intervention), and ending with Discharge from clinical care by the Eligible Professional. A patient currently under clinical care for a hip deficit remains in a single episode of care until the Discharge is conducted and documented by the Eligible Professional.

Admission – An Admission is the first encounter for a functional deficit involving the hip and includes an evaluation (CPT 97001 or 97003) and development of a plan of care by the Eligible Professional. A patient presenting with a hip impairment, who has had an interruption of a Treatment Episode for the same functional hip deficit secondary to an appropriate reason like hospitalization or surgical intervention, is a new Admission.

Discharge – Discharge is accompanied by a re-evaluation (CPT 97002 or 97004) identifying the close of a Treatment Episode for the same hip deficit identified at admission and documented by a discharge report by the Eligible Professional. An interruption in clinical care for an appropriate reason like hospitalization or surgical intervention requires a discharge from the current Treatment Episode.

Encounter – A face to face visit between the patient and the provider for the purpose of assessing and/or improving a functional deficit.

Patient Reported – The patient directly, or through a proxy, provides answers to functional status survey items using standardized, reliable and valid, computerized adaptive testing or paper and pencil survey methods.

Measure Reporting via Registry:
CPT codes, patient demographics, and functional deficits 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 have been provided for registry only measures for use by registries

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that utilize claims data. It is not necessary to submit these codes for registry-based submissions. Do not report this measure via claims.

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 (CPT) identifying evaluation: 97001
AND
Patient encounter during the reporting period (CPT) identifying re-evaluation: 97002
AND
Functional deficit affecting the hip

OR

Option 2 – Occupational Therapy Denominator Criteria (Eligible Cases):
All patients aged ≥ 18 years on date of encounter
AND
Patient encounter during the reporting period (CPT) identifying evaluation: 97003
AND
Patient encounter during the reporting period (CPT) identifying re-evaluation: 97004
AND
Functional deficit affecting the hip

NUMERATOR:
Patients presented FOTO's Functional Intake Survey for the Hip at admission and FOTO's Functional Status Survey at discharge for the purpose of calculating the patient's Risk-adjusted Functional Status Change Residual Score

Definitions:
Patient's Functional Status Score – A functional status score is produced when the patient completes the FOTO functional status survey (either by paper and pencil or computerized adaptive testing administration). The functional status score is continuous and linear. Scores range from 0 (low function) to 100 (high function). The survey is standardized, and the scores are validated for the measurement of function for this population.
Patient's Functional Status Change Score – A functional status change score is calculated by subtracting the Patient's Functional Status Score at Admission from the Patient's Functional Status Score at Discharge.
Predicted Functional Status Change Score – Functional Status Change Scores for patients are risk adjusted using multiple linear regression methods that include the following independent variables: Patient's Functional Status Score at Admission, patient age, symptom acuity, surgical history, gender, number of co-morbidities and level of fear-avoidance. The Patient's Functional Status Change Score is the dependent variable. The statistical regression produces a Risk-Adjusted Predicted Functional Status Change Score.

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Risk-Adjusted Functional Status Change Residual Score – The difference between the raw non-risk-adjusted Patient's Functional Status Change Score and the Risk-Adjusted Predicted Functional Status Change Score (raw minus predicted) is the Risk-Adjusted Functional Status Change Residual Score, which is in the same units as the Patient's Functional Status Scores, and should be interpreted as the unit of functional status change different than predicted given the risk-adjustment variables of the patient being treated. As such, the Risk-Adjusted Residual Change Score represents Risk-Adjusted Change corrected for the level of severity of the patient. Risk-Adjusted Residual Change Scores of zero (0) or greater (>0) should be interpreted as functional status change scores that were predicted or better than predicted given the risk-adjustment variables of the patient and risk-adjusted residual change scores less than zero (<0) should be interpreted as functional status change scores that were less than predicted given the risk-adjustment variables of the patient. Aggregated Risk-Adjusted Residual Scores allow meaningful comparisons amongst clinicians or clinics.
Not Eligible/Not Appropriate – A patient is not eligible if one or more of the following conditions exist:

- Patient refused to participate
- Patient unable to complete the questionnaire due to blindness, illiteracy, severe mental incapacity or language incompatibility and an adequate proxy is not available
- Prior to conclusion of Plan of Care, intervention was interrupted or discontinued for any reason including by the referring physician, the provider, the payer or the patient, and attempts by the provider to complete a follow-up functional status survey near Discharge were unsuccessful.

Numerator Options:
Risk-Adjusted Functional Status Change Residual Score for the hip successfully calculated and the score was equal to zero (0) or greater than zero (>0) (G8651)
OR
Risk-Adjusted Functional Status Change Residual Score for the hip successfully calculated and the score was less than zero (<0) (G8652)

OR

Risk-Adjusted Functional Status Change Residual Scores for the hip not measured because the patient did not complete FOTO's Functional Intake on admission and/or follow up Status Survey near discharge, patient Not Eligible/Not Appropriate (G8653)

OR

Risk-Adjusted Functional Status Change Residual Scores for the hip not measured because the patient did not complete FOTO's Functional Intake on admission and/or follow up Status Survey near discharge, reason not specified (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.

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Change in functional status represents the activity domain of the International Classification of Function. If treatment is designed to improve the functional deficit, it is logical to assess functional status at discharge using a standardized score to determine if treatment improved the functional status of the patient over the treatment episode.

The National Quality Measures Clearinghouse has approved the measurement of change in functional status, using this survey. NQMC-1872.

CLINICAL RECOMMENDATION STATEMENTS:

The American Physical Therapy Association (APTA), in their *Guide to Physical Therapy Practice*, described five recommended elements of patient management: examination, evaluation, diagnosis, prognosis and intervention. The elements were intended to direct therapists in their approach to patient treatment for the purpose of optimizing patient outcomes. The APTA clearly indentifies functional status data as one of the major forms of data to be collected for patients receiving rehabilitation. The functional status measures should be used to assist in the planning, implementation and modification of treatment interventions and should be used as measures of outcomes. The current functional status scores can be used by therapists to fulfill the recommended methods of the APTA in the management of patients in rehabilitation.

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☾ Measure #219: Functional Deficit: Change in Risk-Adjusted Functional Status for Patients with Lower Leg, Foot or Ankle Impairments

2011 PHYSICIAN QUALITY REPORTING OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Percentage of patients aged 18 or older that receive treatment for a functional deficit secondary to a diagnosis that affects the lower leg, foot or ankle in which the change in their Risk-Adjusted Functional Status is measured

INSTRUCTIONS:
This outcomes measure is to be reported once per treatment episode for all patients with a functional deficit related to the lower leg, foot or ankle. This is an outcomes measure and its calculation requires reporting of the patient's functional status score, as a minimum, at admission to and again at discharge from an episode of rehabilitation. The admission score, estimated using patient self-report surveys, is recorded during the first rehabilitation treatment encounter and the discharge score is recorded at or near the conclusion of the final rehabilitation treatment encounter. It is anticipated that physical and occupational therapists providing treatment for functional lower leg, foot or ankle deficits will report this measure.

Definitions:
Treatment Episode – A Treatment Episode is defined as beginning with an Admission for a functional lower leg, foot or ankle deficit, progressing to development of a plan of care, including treatment, without interruption of care (for example a hospitalization or surgical intervention), and ending with Discharge from clinical care by the Eligible Professional. A patient currently under clinical care for a lower leg, foot or ankle deficit remains in a single episode of care until the Discharge is conducted and documented by the Eligible Professional.
Admission – An Admission is the first encounter for a functional deficit involving the lower leg, foot or ankle and includes an evaluation (CPT 97001 or 97003) and development of a plan of care by the Eligible Professional. A patient presenting with a lower leg, foot or ankle impairment, who has had an interruption of a Treatment Episode for the same functional lower leg, foot or ankle deficit secondary to an appropriate reason like hospitalization or surgical intervention, is a new Admission.
Discharge – Discharge is accompanied by a re-evaluation (CPT 97002 or 97004) identifying the close of a Treatment Episode for the same lower leg, foot or ankle deficit identified at admission and documented by a discharge report by the Eligible Professional. An interruption in clinical care for an appropriate reason like hospitalization or surgical intervention requires a discharge from the current Treatment Episode.
Encounter – A face to face visit between the patient and the provider for the purpose of assessing and/or improving a functional deficit.
Patient Reported – The patient directly, or through a proxy, provides answers to functional status survey items using standardized, reliable and valid, computerized adaptive testing or paper and pencil survey methods.

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Measure Reporting via Registry:
CPT codes, patient demographics, and functional deficits 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 have been provided for registry only measures for use by registries that utilize claims data. It is not necessary to submit these codes for registry-based submissions. Do not report this measure via claims.

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 (CPT) identifying evaluation: 97001
AND
Patient encounter during the reporting period (CPT) identifying re-evaluation: 97002
AND
Functional deficit affecting the lower leg, foot or ankle

OR

Option 2 – Occupational Therapy Denominator Criteria (Eligible Cases):
All patients aged ≥ 18 years on date of encounter
AND
Patient encounter during the reporting period (CPT) identifying evaluation: 97003
AND
Patient encounter during the reporting period (CPT) identifying re-evaluation: 97004
AND
Functional deficit affecting the lower leg, foot or ankle

NUMERATOR:
Patients presented FOTO's Functional Intake Survey for the Lower Leg, Foot or Ankle at admission and FOTO's Functional Status Survey at discharge for the purpose of calculating the patient's Risk-adjusted Functional Status Change Residual Score

Definitions:
Patient's Functional Status Score – A functional status score is produced when the patient completes the FOTO functional status survey (either by paper and pencil or computerized adaptive testing administration). The functional status score is continuous and linear. Scores range from 0 (low function) to 100 (high function). The survey is standardized, and the scores are validated for the measurement of function for this population.
Patient's Functional Status Change Score – A functional status change score is calculated by subtracting the Patient's Functional Status Score at Admission from the Patient's Functional Status Score at Discharge.
Predicted Functional Status Change Score – Functional Status Change Scores for patients are risk adjusted using multiple linear regression methods that include the following independent variables: Patient's Functional Status Score at Admission, patient age, symptom

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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:

Risk-Adjusted Functional Status Change Residual Score for the lower leg, foot or ankle successfully calculated and the score was equal to zero (0) or greater than zero (>0) (G8655)

OR

Risk-Adjusted Functional Status Change Residual Score for the lower leg, foot or ankle successfully calculated and the score was less than zero (<0) (G8656)

OR

Risk-Adjusted Functional Status Change Residual Scores for the lower leg, foot or ankle not measured because the patient did not complete FOTO's Functional Intake on admission and/or follow up Status Survey near discharge, patient Not Eligible/Not Appropriate (G8657)

OR

Risk-Adjusted Functional Status Change Residual Scores for the lower leg, foot or ankle not measured because the patient did not complete FOTO's Functional Intake on admission and/or follow up Status Survey near discharge, reason not specified (G8658)

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RATIONALE:
Functional deficits are common in the general population and are costly to the individual, their family and society. Improved functional status has been associated with greater quality of life, self-efficacy, improved financial well-being and lower future medical costs. Improving functional status in people seeking rehabilitation has become a goal of the American Physical Therapy Association. Therefore, measuring change in functional status is important for providers treating patients in rehabilitation and can be used to assess the success of treatment and direct modification of treatment.

Change in functional status represents the activity domain of the International Classification of Function. If treatment is designed to improve the functional deficit, it is logical to assess functional status at discharge using a standardized score to determine if treatment improved the functional status of the patient over the treatment episode.

The National Quality Measures Clearinghouse has approved the measurement of change in functional status, using this survey. NQMC-1874.

CLINICAL RECOMMENDATION STATEMENTS:
The American Physical Therapy Association (APTA), in their *Guide to Physical Therapy Practice*, described five recommended elements of patient management: examination, evaluation, diagnosis, prognosis and intervention. The elements were intended to direct therapists in their approach to patient treatment for the purpose of optimizing patient outcomes. The APTA clearly indentifies functional status data as one of the major forms of data to be collected for patients receiving rehabilitation. The functional status measures should be used to assist in the planning, implementation and modification of treatment interventions and should be used as measures of outcomes. The current functional status scores can be used by therapists to fulfill the recommended methods of the APTA in the management of patients in rehabilitation.

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☾ Measure #220: Functional Deficit: Change in Risk-Adjusted Functional Status for Patients with Lumbar Spine Impairments

2011 PHYSICIAN QUALITY REPORTING OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Percentage of patients aged 18 or older that receive treatment for a functional deficit secondary to a diagnosis that affects the lumbar spine in which the change in their Risk-Adjusted Functional Status is measured

INSTRUCTIONS:
This outcomes measure is to be reported once per treatment episode for all patients with a functional deficit related to the lumbar spine. This is an outcomes measure, and its calculation requires reporting of the patient's functional status score, as a minimum, at admission to and again at discharge from an episode of rehabilitation. The admission score, estimated using patient self-report surveys, is recorded during the first rehabilitation treatment encounter, and the discharge score is recorded at or near the conclusion of the final rehabilitation treatment encounter. It is anticipated that physical and occupational therapists providing treatment for functional lumbar spine deficits will report this measure.

Definitions:
Treatment Episode – A Treatment Episode is defined as beginning with an Admission for a functional lumbar spine deficit, progressing to development of a plan of care, including treatment, without interruption of care (for example a hospitalization or surgical intervention), and ending with Discharge from clinical care by the Eligible Professional. A patient currently under clinical care for a lumbar spine deficit remains in a single episode of care until the Discharge is conducted and documented by the Eligible Professional.
Admission – An Admission is the first encounter for a functional deficit involving the lumbar spine and includes an evaluation (CPT 97001 or 97003) and development of a plan of care by the Eligible Professional. A patient presenting with a lumbar spine impairment, who has had an interruption of a Treatment Episode for the same functional lumbar spine deficit secondary to an appropriate reason like hospitalization or surgical intervention, is a new Admission.
Discharge – Discharge is accompanied by a re-evaluation (CPT 97002 or 97004) identifying the close of a Treatment Episode for the same lumbar spine deficit identified at admission and documented by a discharge report by the Eligible Professional. An interruption in clinical care for an appropriate reason like hospitalization or surgical intervention requires a discharge from the current Treatment Episode.
Encounter – A face to face visit between the patient and the provider for the purpose of assessing and/or improving a functional deficit.
Patient Reported – The patient directly, or through a proxy, provides answers to functional status survey items using standardized, reliable and valid, computerized adaptive testing or paper and pencil survey methods.

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Measure Reporting via Registry:
CPT codes, patient demographics, and functional deficits 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 have been provided for registry only measures for use by registries that utilize claims data. It is not necessary to submit these codes for registry-based submissions. Do not report this measure via claims.

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 (CPT) identifying evaluation: 97001
AND
Patient encounter during the reporting period (CPT) identifying re-evaluation: 97002
AND
Functional deficit affecting the lumbar spine

OR

Option 2 – Occupational Therapy Denominator Criteria (Eligible Cases):
All patients aged ≥ 18 years on date of encounter
AND
Patient encounter during the reporting period (CPT) identifying evaluation: 97003
AND
Patient encounter during the reporting period (CPT) identifying re-evaluation: 97004
AND
Functional deficit affecting the lumbar spine

NUMERATOR:
Patients presented FOTO's Functional Intake Survey for the Lumbar Spine at admission and FOTO's Functional Status Survey at discharge for the purpose of calculating the patient's Risk-adjusted Functional Status Change Residual Score

Definitions:
Patient's Functional Status Score – A functional status score is produced when the patient completes the FOTO functional status survey (either by paper and pencil or computerized adaptive testing administration). The functional status score is continuous and linear. Scores range from 0 (low function) to 100 (high function). The survey is standardized, and the scores are validated for the measurement of function for this population.
Patient's Functional Status Change Score – A functional status change score is calculated by subtracting the Patient's Functional Status Score at Admission from the Patient's Functional Status Score at Discharge.
Predicted Functional Status Change Score – Functional Status Change Scores for patients are risk adjusted using multiple linear regression methods that include the following independent variables: Patient's Functional Status Score at Admission, patient age, symptom

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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:

Risk-Adjusted Functional Status Change Residual Score for the lumbar spine successfully calculated and the score was equal to zero (0) or greater than zero (>0) (G8659)

OR

Risk-Adjusted Functional Status Change Residual Score for the lumbar spine successfully calculated and the score was less than zero (<0) (G8660)

OR

Risk-Adjusted Functional Status Change Residual Scores for the lumbar spine not measured because the patient did not complete FOTO's Functional Intake on admission and/or follow up Status Survey near discharge, patient Not Eligible/Not Appropriate (G8661)

OR

Risk-Adjusted Functional Status Change Residual Scores for the lumbar spine not measured because the patient did not complete FOTO's Functional Intake on admission and/or follow up Status Survey near discharge, reason not specified (G8662)

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RATIONALE:
Functional deficits are common in the general population and are costly to the individual, their family and society. Improved functional status has been associated with greater quality of life, self-efficacy, improved financial well-being and lower future medical costs. Improving functional status in people seeking rehabilitation has become a goal of the American Physical Therapy Association. Therefore, measuring change in functional status is important for providers treating patients in rehabilitation and can be used to assess the success of treatment and direct modification of treatment.

Change in functional status represents the activity domain of the International Classification of Function. If treatment is designed to improve the functional deficit, it is logical to assess functional status at discharge using a standardized score to determine if treatment improved the functional status of the patient over the treatment episode.

The National Quality Measures Clearinghouse has approved the measurement of change in functional status, using this survey. NQMC-2632.

CLINICAL RECOMMENDATION STATEMENTS:
The American Physical Therapy Association (APTA), in their *Guide to Physical Therapy Practice*, described five recommended elements of patient management: examination, evaluation, diagnosis, prognosis and intervention. The elements were intended to direct therapists in their approach to patient treatment for the purpose of optimizing patient outcomes. The APTA clearly indentifies functional status data as one of the major forms of data to be collected for patients receiving rehabilitation. The functional status measures should be used to assist in the planning, implementation and modification of treatment interventions and should be used as measures of outcomes. The current functional status scores can be used by therapists to fulfill the recommended methods of the APTA in the management of patients in rehabilitation.

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☾ Measure #221: Functional Deficit: Change in Risk-Adjusted Functional Status for Patients with Shoulder Impairments

2011 PHYSICIAN QUALITY REPORTING OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Percentage of patients aged 18 or older that receive treatment for a functional deficit secondary to a diagnosis that affects the shoulder in which the change in their Risk-Adjusted Functional Status is measured

INSTRUCTIONS:
This outcomes measure is to be reported once per treatment episode for all patients with a functional deficit related to the shoulder. This is an outcomes measure and its calculation requires reporting of the patient's functional status score, as a minimum, at admission to and again at discharge from an episode of rehabilitation. The admission score, estimated using patient self-report surveys, is recorded during the first rehabilitation treatment encounter and the discharge score is recorded at or near the conclusion of the final rehabilitation treatment encounter. It is anticipated that physical and occupational therapists providing treatment for functional shoulder deficits will report this measure.

Definitions:
Treatment Episode – A Treatment Episode is defined as beginning with an Admission for a functional shoulder deficit, progressing to development of a plan of care, including treatment, without interruption of care (for example a hospitalization or surgical intervention), and ending with Discharge from clinical care by the Eligible Professional. A patient currently under clinical care for a shoulder deficit remains in a single episode of care until the Discharge is conducted and documented by the Eligible Professional.
Admission – An Admission is the first encounter for a functional deficit involving the shoulder and includes an evaluation (CPT 97001 or 97003) and development of a plan of care by the Eligible Professional. A patient presenting with a shoulder impairment, who has had an interruption of a Treatment Episode for the same functional shoulder deficit secondary to an appropriate reason like hospitalization or surgical intervention, is a new Admission.
Discharge – Discharge is accompanied by a re-evaluation (CPT 97002 or 97004) identifying the close of a Treatment Episode for the same shoulder deficit identified at admission and documented by a discharge report by the Eligible Professional. An interruption in clinical care for an appropriate reason like hospitalization or surgical intervention requires a discharge from the current Treatment Episode.
Encounter – A face to face visit between the patient and the provider for the purpose of assessing and/or improving a functional deficit.
Patient Reported – The patient directly, or through a proxy, provides answers to functional status survey items using standardized, reliable and valid, computerized adaptive testing or paper and pencil survey methods.

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Measure Reporting via Registry:
CPT codes, patient demographics, and functional deficits 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 have been provided for registry only measures for use by registries that utilize claims data. It is not necessary to submit these codes for registry-based submissions. Do not report this measure via claims.

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 (CPT) identifying evaluation: 97001
AND
Patient encounter during the reporting period (CPT) identifying re-evaluation: 97002
AND
Functional deficit affecting the shoulder

OR

Option 2 – Occupational Therapy Denominator Criteria (Eligible Cases):
All patients aged ≥ 18 years on date of encounter
AND
Patient encounter during the reporting period (CPT) identifying evaluation: 97003
AND
Patient encounter during the reporting period (CPT) identifying re-evaluation: 97004
AND
Functional deficit affecting the shoulder

NUMERATOR:
Patients presented FOTO's Functional Intake Survey for the Shoulder at admission and FOTO's Functional Status Survey at discharge for the purpose of calculating the patient's Risk-adjusted Functional Status Change Residual Score

Definitions:
Patient's Functional Status Score – A functional status score is produced when the patient completes the FOTO functional status survey (either by paper and pencil or computerized adaptive testing administration). The functional status score is continuous and linear. Scores range from 0 (low function) to 100 (high function). The survey is standardized, and the scores are validated for the measurement of function for this population.
Patient's Functional Status Change Score – A functional status change score is calculated by subtracting the Patient's Functional Status Score at Admission from the Patient's Functional Status Score at Discharge.

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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:

Risk-Adjusted Functional Status Change Residual Score for the shoulder successfully calculated and the score was equal to zero (0) or greater than zero (>0) (G8663)

OR

Risk-Adjusted Functional Status Change Residual Score for the shoulder successfully calculated and the score was less than zero (<0) (G8664)

OR

Risk-Adjusted Functional Status Change Residual Scores for the shoulder not measured because the patient did not complete FOTO's Functional Intake on admission and/or follow up Status Survey near discharge, patient Not Eligible/Not Appropriate (G8665)

OR

Risk-Adjusted Functional Status Change Residual Scores for the shoulder not measured because the patient did not complete FOTO's Functional Intake on admission and/or follow up Status Survey near discharge, reason not specified (G8666)

RATIONALE:

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Functional deficits are common in the general population and are costly to the individual, their family and society. Improved functional status has been associated with greater quality of life, self-efficacy, improved financial well-being and lower future medical costs. Improving functional status in people seeking rehabilitation has become a goal of the American Physical Therapy Association. Therefore, measuring change in functional status is important for providers treating patients in rehabilitation and can be used to assess the success of treatment and direct modification of treatment.

Change in functional status represents the activity domain of the International Classification of Function. If treatment is designed to improve the functional deficit, it is logical to assess functional status at discharge using a standardized score to determine if treatment improved the functional status of the patient over the treatment episode.

The National Quality Measures Clearinghouse has approved the measurement of change in functional status, using this survey. NQMC-2633.

CLINICAL RECOMMENDATION STATEMENTS:

The American Physical Therapy Association (APTA), in their *Guide to Physical Therapy Practice*, described five recommended elements of patient management: examination, evaluation, diagnosis, prognosis and intervention. The elements were intended to direct therapists in their approach to patient treatment for the purpose of optimizing patient outcomes. The APTA clearly indentifies functional status data as one of the major forms of data to be collected for patients receiving rehabilitation. The functional status measures should be used to assist in the planning, implementation and modification of treatment interventions and should be used as measures of outcomes. The current functional status scores can be used by therapists to fulfill the recommended methods of the APTA in the management of patients in rehabilitation.

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☾ Measure #222: Functional Deficit: Change in Risk-Adjusted Functional Status for Patients with Elbow, Wrist or Hand Impairments

2011 PHYSICIAN QUALITY REPORTING OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Percentage of patients aged 18 or older that receive treatment for a functional deficit secondary to a diagnosis that affects the elbow, wrist or hand in which the change in their Risk-Adjusted Functional Status is measured

INSTRUCTIONS:
This outcomes measure is to be reported once per treatment episode for all patients with a functional deficit related to the elbow, wrist or hand. This is an outcomes measure and its calculation requires reporting of the patient's functional status score, as a minimum, at admission to and again at discharge from an episode of rehabilitation. The admission score, estimated using patient self-report surveys, is recorded during the first rehabilitation treatment encounter and the discharge score is recorded at or near the conclusion of the final rehabilitation treatment encounter. It is anticipated that physical and occupational therapists providing treatment for functional elbow, wrist or hand deficits will report this measure.

Definitions:
Treatment Episode – A Treatment Episode is defined as beginning with an Admission for a functional elbow, wrist or hand deficit, progressing to development of a plan of care, including treatment, without interruption of care (for example a hospitalization or surgical intervention), and ending with Discharge from clinical care by the Eligible Professional. A patient currently under clinical care for an elbow, wrist or hand deficit remains in a single episode of care until the Discharge is conducted and documented by the Eligible Professional.
Admission – An Admission is the first encounter for a functional deficit involving the elbow, wrist or hand and includes an evaluation (CPT 97001 or 97003) and development of a plan of care by the Eligible Professional. A patient presenting with an elbow, wrist or hand impairment, who has had an interruption of a Treatment Episode for the same functional elbow, wrist or hand deficit secondary to an appropriate reason like hospitalization or surgical intervention, is a new Admission.
Discharge – Discharge is accompanied by a re-evaluation (CPT 97002 or 97004) identifying the close of a Treatment Episode for the same elbow, wrist or hand deficit identified at admission and documented by a discharge report by the Eligible Professional. An interruption in clinical care for an appropriate reason like hospitalization or surgical intervention requires a discharge from the current Treatment Episode.
Encounter – A face to face visit between the patient and the provider for the purpose of assessing and/or improving a functional deficit.
Patient Reported – The patient directly, or through a proxy, provides answers to functional status survey items using standardized, reliable and valid, computerized adaptive testing or paper and pencil survey methods.

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Measure Reporting via Registry:
CPT codes, patient demographics, and functional deficits 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 have been provided for registry only measures for use by registries that utilize claims data. It is not necessary to submit these codes for registry-based submissions. Do not report this measure via claims.

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 (CPT) identifying evaluation: 97001
AND
Patient encounter during the reporting period (CPT) identifying re-evaluation: 97002
AND
Functional deficit affecting elbow, wrist or hand

OR

Option 2 – Occupational Therapy Denominator Criteria (Eligible Cases):
All patients aged ≥ 18 years on date of encounter
AND
Patient encounter during the reporting period (CPT) identifying evaluation: 97003
AND
Patient encounter during the reporting period (CPT) identifying re-evaluation: 97004
AND
Functional deficit affecting elbow, wrist or hand

NUMERATOR:
Patients presented FOTO's Functional Intake Survey for the Elbow, Wrist or Hand at admission and FOTO's Functional Status Survey at discharge for the purpose of calculating the patient's Risk-adjusted Functional Status Change Residual Score

Definitions:
Patient's Functional Status Score – A functional status score is produced when the patient completes the FOTO functional status survey (either by paper and pencil or computerized adaptive testing administration). The functional status score is continuous and linear. Scores range from 0 (low function) to 100 (high function). The survey is standardized, and the scores are validated for the measurement of function for this population.
Patient's Functional Status Change Score – A functional status change score is calculated by subtracting the Patient's Functional Status Score at Admission from the Patient's Functional Status Score at Discharge.
Predicted Functional Status Change Score – Functional Status Change Scores for patients are risk adjusted using multiple linear regression methods that include the following independent variables: Patient's Functional Status Score at Admission, patient age, symptom

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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:

Risk-Adjusted Functional Status Change Residual Score for the elbow, wrist or hand successfully calculated and the score was equal to zero (0) or greater than zero (>0) (G8667)

OR

Risk-Adjusted Functional Status Change Residual Score for the elbow, wrist or hand successfully calculated and the score was less than zero (<0) (G8668)

OR

Risk-Adjusted Functional Status Change Residual Scores for the elbow, wrist or hand not measured because the patient did not complete FOTO's Functional Intake on admission and/or follow up Status Survey near discharge, patient Not Eligible/Not Appropriate (G8669)

OR

Risk-Adjusted Functional Status Change Residual Scores for the elbow, wrist or hand not measured because the patient did not complete FOTO's Functional Intake on admission and/or follow up Status Survey near discharge, reason not specified (G8670)

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RATIONALE:
Functional deficits are common in the general population and are costly to the individual, their family and society. Improved functional status has been associated with greater quality of life, self-efficacy, improved financial well-being and lower future medical costs. Improving functional status in people seeking rehabilitation has become a goal of the American Physical Therapy Association. Therefore, measuring change in functional status is important for providers treating patients in rehabilitation and can be used to assess the success of treatment and direct modification of treatment.

Change in functional status represents the activity domain of the International Classification of Function. If treatment is designed to improve the functional deficit, it is logical to assess functional status at discharge using a standardized score to determine if treatment improved the functional status of the patient over the treatment episode.

The National Quality Measures Clearinghouse has approved the measurement of change in functional status, using this survey. NQMC-1874.

CLINICAL RECOMMENDATION STATEMENTS:
The American Physical Therapy Association (APTA), in their *Guide to Physical Therapy Practice*, described five recommended elements of patient management: examination, evaluation, diagnosis, prognosis and intervention. The elements were intended to direct therapists in their approach to patient treatment for the purpose of optimizing patient outcomes. The APTA clearly indentifies functional status data as one of the major forms of data to be collected for patients receiving rehabilitation. The functional status measures should be used to assist in the planning, implementation and modification of treatment interventions and should be used as measures of outcomes. The current functional status scores can be used by therapists to fulfill the recommended methods of the APTA in the management of patients in rehabilitation.

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☾ Measure #223: Functional Deficit: Change in Risk-Adjusted Functional Status for Patients with Neck, Cranium, Mandible, Thoracic Spine, Ribs, or Other General Orthopedic Impairments

2011 PHYSICIAN QUALITY REPORTING OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Percentage of patients aged 18 or older that receive treatment for a functional deficit secondary to a diagnosis that affects the neck, cranium, mandible, thoracic spine, ribs or other general orthopedic impairment in which the change in their Risk-Adjusted Functional Status is measured

INSTRUCTIONS:
This outcomes measure is to be reported once per treatment episode for all patients with a functional deficit related to the neck, cranium, mandible, thoracic spine, ribs or other general orthopedic impairment. This is an outcomes measure and its calculation requires reporting of the patient's functional status score, as a minimum, at admission to and again at discharge from an episode of rehabilitation. The admission score, estimated using patient self-report surveys, is recorded during the first rehabilitation treatment encounter and the discharge score is recorded at or near the conclusion of the final rehabilitation treatment encounter. It is anticipated that physical and occupational therapists providing treatment for functional neck, cranium, mandible, thoracic spine, ribs or other general orthopedic deficits will report this measure.

Definitions:

Treatment Episode – A Treatment Episode is defined as beginning with an Admission for a functional neck, cranium, mandible, thoracic spine, ribs or other general orthopedic deficit, progressing to development of a plan of care, including treatment, without interruption of care (for example a hospitalization or surgical intervention), and ending with Discharge from clinical care by the Eligible Professional. A patient currently under clinical care for a neck, cranium, mandible, thoracic spine, ribs or other general orthopedic deficit remains in a single episode of care until the Discharge is conducted and documented by the Eligible Professional.

Admission – An Admission is the first encounter for a functional deficit involving the neck, cranium, mandible, thoracic spine, ribs or other general orthopedic impairment and includes an evaluation (CPT 97001 or 97003) and development of a plan of care by the Eligible Professional. A patient presenting with a neck, cranium, mandible, thoracic spine, ribs or other general orthopedic impairment, who has had an interruption of a Treatment Episode for the same functional neck, cranium, mandible, thoracic spine, ribs or other general orthopedic deficit secondary to an appropriate reason like hospitalization or surgical intervention, is a new Admission.

Discharge – Discharge is accompanied by a re-evaluation (CPT 97002 or 97004) identifying the close of a Treatment Episode for the same neck, cranium, mandible, thoracic spine, ribs or other general orthopedic deficit identified at admission and documented by a discharge report by the Eligible Professional. An interruption in clinical care for an appropriate reason like hospitalization or surgical intervention requires a discharge from the current Treatment Episode.

Encounter – A face to face visit between the patient and the provider for the purpose of assessing and/or improving a functional deficit.

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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, patient demographics, and functional deficits 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 have been provided for registry only measures for use by registries that utilize claims data. It is not necessary to submit these codes for registry-based submissions. Do not report this measure via claims.

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 (CPT) identifying evaluation: 97001
AND
Patient encounter during the reporting period (CPT) identifying re-evaluation: 97002
AND
Functional deficit affecting neck, cranium, mandible, thoracic spine, ribs or other general orthopedic impairment

OR

Option 2 – Occupational Therapy Denominator Criteria (Eligible Cases):
All patients aged ≥ 18 years on date of encounter
AND
Patient encounter during the reporting period (CPT) identifying evaluation: 97003
AND
Patient encounter during the reporting period (CPT) identifying re-evaluation: 97004
AND
Functional deficit affecting neck, cranium, mandible, thoracic spine, ribs or other general orthopedic impairment

NUMERATOR:
Patients presented FOTO's Functional Intake Survey for the Neck, Cranium, Mandible, Thoracic Spine, Ribs, or Other General Orthopedic Impairment at admission and FOTO's Functional Status Survey at discharge for the purpose of calculating the patient's Risk-adjusted Functional Status Change Residual Score

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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 <u>not</u> 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.

<u>Numerator Options:</u>

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)

<u>OR</u>

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)

<u>OR</u>

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Risk-Adjusted Functional Status Change Residual Scores for the neck, cranium, mandible, thoracic spine, ribs or other general orthopedic impairment not measured because the patient did not complete FOTO's Functional Intake on admission and/or follow up Status Survey near discharge, patient Not Eligible/Not Appropriate (G8673)

OR

Risk-Adjusted Functional Status Change Residual Scores for the neck, cranium, mandible, thoracic spine, ribs or other general orthopedic impairment not measured because the patient did not complete FOTO's Functional Intake on admission and/or follow up Status Survey near discharge, reason not specified (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 indentifies functional status data as one of the major forms of data to be collected for patients receiving rehabilitation. The functional status measures should be used to assist in the planning, implementation and modification of treatment interventions and should be used as measures of outcomes. The current functional status scores can be used by therapists to fulfill the recommended methods of the APTA in the management of patients in rehabilitation.

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▲Measure #224: Melanoma: Overutilization of Imaging Studies in Stage 0-IA Melanoma

2011 PHYSICIAN QUALITY REPORTING OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Percentage of patients, regardless of age, with Stage 0 or IA melanoma, without signs or symptoms, for whom no diagnostic imaging studies have been ordered related to the melanoma diagnosis

INSTRUCTIONS:
This measure is to be reported once per reporting period for patients with stage 0-IA 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 stage 0-IA Melanoma who have an office visit during the reporting period.

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. Do not report this measure via claims.

DENOMINATOR:
All patients, regardless of age, with stage 0 or IA melanoma, seen for an office visit during the one-year measurement period

> Denominator Criteria (Eligible Cases):
> Diagnosis for melanoma (ICD-9-CM): 172.0, 172.1, 172.2, 172.3, 172.4, 172.5, 172.6, 172.7, 172.8, 172.9, V10.82
> AND
> Patient encounter during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215

NUMERATOR:
Patients with stage 0 or IA melanoma, without signs or symptoms, for whom no diagnostic imaging studies have been ordered related to the melanoma diagnosis

> Numerator Instructions: Only patients with Melanoma Stage 0 or IA will be counted in this measure for performance.

> Definition:
> Diagnostic Imaging Studies – include 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 exclusion.

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Numerator Options:
None of the following diagnostic imaging studies ordered: chest x-ray, CT, ultrasound, MRI, PET, and nuclear medicine scans (3320F)
AND
AJCC Cancer Stage 0 or IA Melanoma, documented (3321F)

OR

Documentation of medical reason(s) for ordering diagnostic imaging studies (3319F *with* 1P)
OR
Documentation of system reason(s) for ordering diagnostic imaging studies (3319F *with* 3P)
AND
AJCC Cancer Stage 0 or IA Melanoma, documented (3321F)

OR

If patient is not eligible for this measure because cancer stage is not 0-IA, report:
Melanoma greater than AJCC Stage 0 or IA (3322F)

OR

One of the following diagnostic imagining studies ordered; chest x-ray, CT, ultrasound, MRI, PET, or nuclear medicine scans (3319F)
AND
AJCC Melanoma Cancer Stage 0 or IA Melanoma, documented (3321F)

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.

CLINICAL RECOMMENDATION STATEMENTS:
The panel unanimously agreed that no specific search for occult visceral metastases, with either chest x-ray or blood work, is necessary in patients with 0 and IA melanoma. This National Comprehensive Cancer Network (NCCN) recommendation is consistent with the National Institutes of Health (NIH) consensus guidelines, (2006). Imaging studies such as computed tomography (CT) scan, positron emission tomography (PET), and/or magnetic resonance imaging (MRI) may be performed for all patients to evaluate specific signs or symptoms. For patients with IB-II melanomas, a baseline chest x-ray is optional because this test in insensitive for detecting clinically occult distant disease in the lungs. (NCCN, 2006). (Level of Evidence – Category 2A)

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No investigations are necessary for patients with Stage I disease. Stage I and IIA melanoma patients should not be staged by imaging, as the true-positive pick-up rate is low and the false-positive rate is high. Patients at intermediate or high risk of recurrent disease (stage IIB and over) should have the following staging investigations: chest x-ray; liver ultrasound or computed tomographic (CT) scan with contrast of the chest, abdomen + pelvis; liver function tests/lactate dehyrdogenase; and full blood count. In the absence of effective chemotherapy for melanoma, however, it may be reasonable to omit scanning in individual Stage IIB patients. There is no place for a bone scan in staging except where symptoms point to possible bone disease. (National Institute for Health and Clinical Excellence, 2006).

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▲ Measure #225: Radiology: Reminder System for Mammograms

2011 PHYSICIAN QUALITY REPORTING 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 a minimum of once per reporting period for patients seen during the reporting period. This measure is intended to reflect the quality of services provided for reminding patients when follow-up mammograms are due.

Measure Reporting via Claims:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. CPT Category II codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the appropriate ICD-9-CM diagnosis codes, CPT codes, and the appropriate CPT Category II code OR the CPT Category II code with the modifier. The modifier allowed for this measure is: 8P- reasons not otherwise specified. There are no allowable performance exclusions for this measure. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure. The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data. There are no allowable performance exclusions for this measure.

DENOMINATOR:
All patients aged 40 years and older undergoing a screening mammogram

> Denominator Criteria (Eligible Cases):
> Patients aged ≥ 40 years on date of encounter
> AND
> Diagnosis for mammogram screening (ICD-9-CM): V76.11, V76.12
> AND
> Patient encounter during the reporting period (CPT): 77057, G0202

NUMERATOR:
Patients whose information is entered into a reminder system with a target due date for the next mammogram

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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
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 Specified
Append a reporting modifier (8P) to CPT Category II code 7025F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.
7025F *with* 8P: Patient Information not entered into a Reminder System, reason not otherwise specified

RATIONALE:
Although screening mammograms can reduce breast cancer mortality by 20-35% in women aged 40 years and older, recent evidence has suggested a decreasing trend in screening rates and a need for intervention (MMWR, 2007). Moreover, many American women do not receive mammograms at recommended intervals, as illustrated by a multiyear study of mammography utilization in a large screening center at Massachusetts General Hospital. The study found that more than half of women who received a mammogram in 1992 had fewer than five mammograms during the subsequent 10 years (the expected number if following a 2-year screening interval), and that only 6 percent received annual mammograms during the entire 10 years (Blanchard, K., Colbart JA, Puri D, et al., 2004). The use of patient reminders is associated with an increase in screening mammography and is currently recommended based on the results of a systematic review of studies conducted by the Task Force on Community Preventive Services (Nass S, Ball J, eds., 2005). Encouraging the implementation of a reminder system could therefore help to reverse the trend and lead to an increase in mammography.

CLINICAL RECOMMENDATION STATEMENTS:
The U.S. Preventive Services Task Force (USPSTF) recommends screening mammography, with or without clinical breast examination (CBE), every 1-2 years for women aged 40 and older. (B Recommendation) (USPSTF, 2002). Asymptomatic women 40 years of age or older should have an annual screening mammogram. (ACR, 2003). The Task Force [on Community Preventive Services] recommends client reminders to increase breast cancer screening on the basis of strong evidence of effectiveness. (TFCPS, 2005)

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▲Measure #226: Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention

2011 PHYSICIAN QUALITY REPORTING 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 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 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, or 8P- reason not otherwise specified. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
CPT codes and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure. The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All patients 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):
> 90801, 90802, 90804, 90805, 90806, 90807, 90808, 90809, 90810, 90811, 90812, 90813, 90815, 90845, 90862, 92002, 92004, 92012, 92014, 96150, 96151, 96152, 97003, 97004, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215

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

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Definitions:
Tobacco Use – Includes any type of tobacco
Cessation Counseling Intervention – Includes counseling or pharmacotherapy

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Patient Screened for Tobacco Use
CPT II 4004F: Patient screened for tobacco use AND received tobacco cessation counseling, if identified as a tobacco user
OR
Patient Screened for Tobacco Use and Identified as a Non-User of Tobacco
CPT II 1036F: Current tobacco non-user

OR

Tobacco Screening not Performed for Medical Reasons
Append a modifier (1P) to CPT Category II code 4004F to report documented circumstances that appropriately exclude patients from the denominator
4004F *with* 1P: Documentation of medical reason(s) for not screening for tobacco use (e.g., limited life expectancy)

OR

Tobacco Screening not Performed Reason Not Specified
Append a reporting modifier (8P) to CPT Category II code 4004F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.
4004F *with* 8P: Tobacco Screening not performed, reason not otherwise specified

RATIONALE:
There is good evidence that tobacco screening and brief cessation intervention (including counseling and pharmacotherapy) in the primary care setting is successful in helping tobacco users quit (USPSTF, 2003). Tobacco users who are able to stop smoking lower their risk for heart disease, lung disease, and stroke (USPSTF, 2003).

CLINICAL RECOMMENDATION STATEMENTS:
The following evidence statements are quoted verbatim from the referenced clinical guidelines.

The USPSTF strongly recommends that clinicians screen all adults for tobacco use and provide tobacco cessation interventions for those who use tobacco products. (A Recommendation) (USPSTF, 2003)

During new patient encounters and at least annually, patients in general and mental healthcare settings should be screened for at-risk drinking, alcohol use problems and illnesses, and any tobacco use. (NQF, 2007)

All patients should be asked if they use tobacco and should have their tobacco-use status documented on a regular basis. Evidence has shown that clinic screening systems, such as expanding the vital signs to include tobacco status or the use of other reminder systems such as chart stickers or computer prompts, significantly increase rates of clinician intervention. (Strength of Evidence = A) (U.S. Department of Health & Human Services-Public Health Service, 2008)

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All *physicians* should strongly advise every patient who smokes to quit because evidence shows that physician advice to quit smoking increases abstinence rates. (Strength of Evidence = A) (U.S. Department of Health & Human Services-Public Health Service, 2008)
Minimal interventions lasting less than 3 minutes increase overall tobacco abstinence rates. Every tobacco user should be offered at least a minimal intervention whether or not he or she is referred to an intensive intervention. (Strength of Evidence = A) (U.S. Department of Health & Human Services-Public Health Service, 2008)

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☼ Measure #228: Heart Failure (HF): Left Ventricular Function (LVF) Testing

2011 PHYSICIAN QUALITY REPORTING OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Percentage of patients with LVF testing during the current year for patients hospitalized with a principal diagnosis of HF during the measurement period

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for HF patients hospitalized with a principal diagnosis of HF during the reporting period. This measure is intended to reflect the quality of services provided for HF patients hospitalized with a principal diagnosis of HF during the measurement period. The measurement period includes 12-months back from the date of service or during the hospitalization. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure. The quality-data codes have been provided for registry only measures for use by registries that utilize claims data. It is not necessary to submit these codes for registry-based submissions. Do not report this measure via claims.

DENOMINATOR:
All patients with a principal diagnosis of HF ≥ 18 years of age hospitalized during the measurement period

> Denominator Criteria (Eligible Cases):
> Patients aged ≥ 18 years on date of encounter
> AND
> Principal diagnosis for HF (ICD-9-CM): 402.01, 402.11, 402.91, 404.01, 404.03, 404.11, 404.13, 404.91, 404.93, 428.0, 428.1, 428.20, 428.21, 428.22, 428.23, 428.30, 428.31, 428.32, 428.33, 428.40, 428.41, 428.42, 428.43, 428.9
> AND
> Patient encounter during reporting period (CPT): 99221, 99222, 99223, 99231, 99232, 99233, 99238, 99239, 99291

NUMERATOR:
Patients with LVF testing during the measurement period

> Numerator Instructions: May include documentation of order (written order, verbal order, or standing order/protocol) for LVF testing

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Numerator Options:

Left ventricular function testing performed during the measurement period (G8682)

OR

Clinician documented that patient is not an eligible candidate for left ventricular function testing during the measurement period (G8683)

OR

Left ventricular function testing not performed during the measurement period, reason not specified (G8685)

RATIONALE:

Appropriate selection of medications to reduce morbidity and mortality in heart failure requires the identification of patients with impaired left ventricular systolic function. National guidelines advocate the evaluation of left ventricular systolic function as the single most important diagnostic test in the management of all patients with heart failure (Hunt, 2005). Despite these recommendations, left ventricular systolic function is not evaluated in a substantial proportion of eligible older patients hospitalized with heart failure (Jencks, 2000).

CLINICAL RECOMMENDATION STATEMENTS:

In patients with HF, an assessment of left ventricular systolic function with 2-dimensional echocardiography or radionuclide ventriculography is recommended. (Class 1 Recommendation, Level-C Evidence) (ACC/AHA)

In patients with a change in clinical status or clinical event/treatment with significant effect on cardiac function, repeat measurement of ejection fraction is recommended. (Level-C Evidence) (ACC/AHA)

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❑ Measure #231: Asthma: Tobacco Use Screening - Ambulatory Care Setting

2011 PHYSICIAN QUALITY REPORTING OPTIONS FOR INDIVIDUAL MEASURES:

CLAIMS, REGISTRY

DESCRIPTION:
Percentage of patients aged 5 through 50 years with a diagnosis of asthma who were queried about tobacco use and exposure to second hand smoke in their home environment at least once within 12 months

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for patients with asthma seen during the reporting period. This measure is intended to reflect the quality of services provided for the primary management of patients with asthma.

Measure Reporting via Claims:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. G-codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the appropriate ICD-9-CM diagnosis codes, CPT codes and the appropriate G-code. There are no allowable performance exclusions for this measure. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT codes and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure. The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data. There are no allowable performance exclusions for this measure.

DENOMINATOR:
All patients aged 5 through 50 years with a diagnosis of asthma

> Denominator Criteria (Eligible Cases):
> Patients aged 5 through 50 years of age on date of encounter
> AND
> Diagnosis for asthma (ICD-9-CM): 493.00, 493.02, 493.10, 493.12, 493.20, 493.22, 493.81, 493.82, 493.90, 493.92
> AND
> Patient encounter during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99217, 99218, 99219, 99220, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350

NUMERATOR:
Patients who were queried about tobacco use and exposure to second hand smoke in their home environment at least once within 12 months

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Numerator Instructions: Information regarding tobacco exposure for patients under 18 obtained from a parent or guardian is valid for reporting the numerator. In order to meet the measure, there must be a note in the medical record documenting that the patient was queried about both smoking status AND exposure to environmental smoke in the home environment.

NUMERATOR NOTE: For the purpose of this measure, "tobacco user" refers to tobacco smokers and "tobacco non-user" refers to non-smokers (including non-smoker tobacco users e.g. chew, snuff).

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Tobacco Use Assessed, Including Exposure to Secondhand Smoke
Current Tobacco Smoker OR Current Exposure to Secondhand Smoke
G8686: Currently a Tobacco Smoker OR Current Exposure to Secondhand Smoke
OR
Current Tobacco Non-User AND No Exposure to Secondhand Smoke
G8687: Currently a Tobacco Non-User AND No Exposure to Secondhand Smoke
OR
Tobacco Use not Assessed, Reason Not Specified
G8689: Tobacco Use not assessed, reason not otherwise specified

RATIONALE:
Patients with asthma who smoke or are exposed to second hand smoke are at greater risk for experiencing increased frequency in asthma symptoms, a decrease in lung function, and an increased use of health services (Sippel JM 1999; Eisner MD 2007). By identifying patients who are tobacco users or who are exposed to second hand smoke, intervention can be offered, resulting in the possibility of decreasing the adverse effects.

CLINICAL RECOMMENDATION STATEMENTS:
The following evidence statements are quoted verbatim from the referenced clinical guidelines.

The Expert Panel recommends that clinicians advise persons who have asthma not to smoke or be exposed to environmental tobacco smoke (ETS). (Evidence C) (NHLBI August 2007).

Query patients about their smoking status and specifically consider referring to smoking cessation programs adults who smoke and have young children who have asthma in the household. (Evidence B) (NHLBI August 2007).

All patients should be asked if they use tobacco and should have their tobacco-use status documented on a regular basis. Evidence has shown that clinic screening systems, such as expanding the vital signs to include tobacco status or the use of other reminder systems such as chart stickers or computer prompts, significantly increase rates of clinician intervention. (Strength of Evidence = A) (Fiore, Jaen et al. 2008).

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❑ Measure #232: Asthma: Tobacco Use Intervention - Ambulatory Care Setting

2011 PHYSICIAN QUALITY REPORTING OPTIONS FOR INDIVIDUAL MEASURES:

CLAIMS, REGISTRY

DESCRIPTION:
Percentage of patients aged 5 through 50 years with a diagnosis of asthma who were identified as tobacco users (patients who currently use tobacco AND patients who do not currently use tobacco, but are exposed to second hand smoke in their home environment) who received tobacco cessation intervention within 12 months

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for patients with asthma seen during the reporting period. This measure is intended to reflect the quality of services provided for the primary management of patients with asthma.

Measure Reporting via Claims:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. CPT Category II and/or G-codes are used to report the numerator of the measure.

When reporting the measure via claims, appropriate ICD-9-CM diagnosis codes, CPT codes, and the appropriate CPT Category II code AND/OR G-code OR the CPT Category II code with the modifier AND G-code. The modifier allowed for this measure is: 8P- reasons not otherwise specified. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure. The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All patients aged 5 through 50 years with a diagnosis of asthma identified as tobacco users

> Denominator Criteria (Eligible Cases):
> Patients aged 5 through 50 years on date of encounter
> AND
> Diagnosis for asthma (ICD-9-CM): 493.00, 493.02, 493.10, 493.12, 493.20, 493.22, 493.81, 493.82, 493.90, 493.92
> AND
> Patient encounter during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99217, 99218, 99219, 99220, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350

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NUMERATOR:
Patients who received tobacco use cessation intervention

Numerator Instructions: Practitioners providing tobacco cessation interventions to a pediatric patient's primary caregiver are still numerator complaint even if the primary caregiver is not the source of second hand smoke in the home.

Definitions:
Tobacco Users – Tobacco users include patients who currently use tobacco AND patients who do not currently use tobacco, but are exposed to second hand smoke in their home environment.
Tobacco Use Cessation Intervention – May include brief counseling (3 minutes or less) and/or pharmacotherapy.

NUMERATOR NOTE: For the purpose of this measure, "tobacco user" refers to tobacco smokers and "tobacco non-user" refers to non-smokers (including non-smoker tobacco users e.g. chew, snuff).

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Patients who Received Tobacco Use Cessation Intervention
(One CPT II code & one G-code [400xF & G8690] are required on the claim form to submit this numerator option)
CPT II 4000F: Tobacco Use Cessation Intervention, Counseling
OR
CPT II 4001F: Tobacco Use Cessation Intervention, Pharmacologic Therapy

AND
Current Tobacco Smoker OR Current Exposure to Secondhand Smoke
G8690: Current Tobacco Smoker OR Current Exposure to Secondhand Smoke

OR

If patient is not eligible for this measure because patient is a non-tobacco user AND Has No Exposure to Secondhand Smoke, report:
(One G-code [G8691] is required on the claim form to submit this numerator option)
G8691: Current Tobacco Non-User AND No Exposure to Secondhand Smoke

OR

Tobacco Use not Assessed, Reason Not Specified
(One G-code [G8693] OR one CPT II code [4000F-8P or 4001F-8P] & one G-code [G8690] are required on the claim form to submit this numerator option)
G8693: Tobacco Use not assessed, reason not specified

OR

Tobacco Use Cessation Intervention not Performed, Reason Not Specified
Append a reporting modifier (8P) to CPT Category II code 4000F OR 4001F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.
4000F *with* 8P: Tobacco Use Cessation Intervention, Counseling, not performed, reason not otherwise specified

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OR
4001F *with* 8P: Tobacco Use Cessation Intervention, Pharmacologic Therapy, not performed, reason not otherwise specified

AND
Current Tobacco Smoker OR Current Exposure to Secondhand Smoke
(One G-code [G8690] is required on the claim form to submit this numerator option)
G8690: Current Tobacco Smoker OR Current Exposure to Secondhand Smoke

RATIONALE:
There is good evidence that tobacco screening and brief cessation intervention (including counseling and pharmacotherapy) in both the primary care setting and hospital settings is successful in helping tobacco users quit.(Fiore MC May 2008) Patients who are able to stop smoking or their exposure to second hand smoke may experience and increase in quality of life, a decrease in asthma symptoms, and may not use health resources as often (NHLBI August 2007).

CLINICAL RECOMMENDATION STATEMENTS:
The following evidence statements are quoted verbatim from the referenced clinical guidelines.

The Expert Panel recommends that clinicians advise persons who have asthma not to smoke or be exposed to environmental tobacco smoke (ETS). (Evidence C) (NHLBI August 2007).

Query patients about their smoking status and specifically consider referring to smoking cessation programs adults who smoke and have young children who have asthma in the household. (Evidence B) (NHLBI August 2007).

All *physicians* should strongly advise every patient who smokes to quit because evidence shows that physician advice to quit smoking increases abstinence rates. (Strength of Evidence = A) (Fiore, Jaen et al. 2008).

Minimal interventions lasting less than 3 minutes increase overall tobacco abstinence rates. Every tobacco user should be offered at least a minimal intervention whether or not he or she is referred to an intensive intervention. (Strength of Evidence = A) (Fiore MC 2008).

The interventions found to be effective in this Guideline have been shown to be effective in a variety of populations. In addition, many of the studies supporting these interventions comprised diverse samples of tobacco users. Therefore, interventions identified as effective in this Guideline are recommended for all individuals who use tobacco, except when the medication use is contraindicated or with specific populations in which medication has not been shown to be effective (pregnant women, smokeless tobacco users, light smokers, and adolescents). (Strength of Evidence = B) (Fiore MC 2008)

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Ω Measure #233: Thoracic Surgery: Recording of Performance Status Prior to Lung or Esophageal Cancer Resection

2011 PHYSICIAN QUALITY REPORTING OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Percentage of patients aged 18 years and older undergoing resection for lung or esophageal cancer who had performance status documented and reviewed within 2 weeks prior to surgery

INSTRUCTIONS:
This measure is to be reported each time a major cancer resection of the lung or esophagus is performed. This measure is intended to reflect the quality of services provided for patients undergoing resection for lung or esophageal cancer. The performance status of lung and esophageal cancer patients guides the decision-making process when choosing optimal treatment modality which may or may not include surgery. It is anticipated that clinicians who perform the listed surgical procedures with a diagnosis of lung or esophageal cancer will submit this measure.

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure. The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data. Do not report this measure via claims. There are no allowable performance exclusions for this measure.

DENOMINATOR:
All patients aged 18 years and older undergoing resection for lung or esophageal cancer

> Denominator Criteria (Eligible Cases):
> Patients aged ≥ 18 years on date of encounter
> AND
> Diagnosis for lung or esophageal cancer (ICD-9-CM): 150.1, 150.2, 150.3, 150.4, 150.5, 150.8, 150.9, 151.0, 162.2, 162.3, 162.4, 162.5, 162.8, 162.9
> AND
> Patient encounter during the reporting period (CPT): 32440, 32442, 32445, 32480, 32482, 32484, 32486, 32488, 32500, 32503, 32504, 32657, 32663, 43107, 43108, 43112, 43113, 43117, 43118, 43121, 43122, 43123

NUMERATOR:
Patients undergoing resection for lung and esophageal cancer who had performance status documented and reviewed within 2 weeks prior to surgery

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Numerator Options:

Performance status documented and reviewed within 2 weeks prior to surgery (3328F)

OR

Performance status not documented and reviewed within 2 weeks prior to surgery, reason not otherwise specified (3328F *with* 8P)

RATIONALE:

There is wide consensus, supported by the source documentation, that preoperative assessment (within two weeks of surgery) of performance status in lung and esophageal cancer resection is a necessary step in evaluating and appropriately selecting patients for surgical therapy. For lung and esophageal cancer, the patient's functional status or performance status (PS) is a key determinant of not only the patient's ability to undergo therapy, but also the patient's prognosis. PS is a general measure of a patient's physiologic status, taking into account the cancer and its associated effects along with other concurrent medical problems, such as cardiac or pulmonary disease. Preoperative assessment of PS provides a standardized measure to compare patient and treatment outcomes in order to provide continuing quality improvement.

Review of the current STS General Thoracic Database identified a 10% gap in recording for PS in patients undergoing major pulmonary resection for cancer. Remediation of this gap should decrease the morbidity and mortality rates for these procedures by reducing the number of high-risk patients inappropriately selected to undergo surgery.

CLINICAL RECOMMENDATION STATEMENTS:

We identified 3 preoperative factors that were associated with an increased risk of pulmonary complications: age, spirometric values, and PS. Others have demonstrated that advanced age and preoperative respiratory dysfunction are associated with postoperative pulmonary complications. It may be intuitively apparent that the factors we identified are predictive of the relative risk of development of pulmonary complications. The benefit of this analysis does not lie in the uniqueness of our observations. Instead, it directs the clinician to focus on a few specific factors and provides the ability to quantitate the relative effect of these factors before making treatment recommendations. (Annuals of Thoracic Surgery, 2000) & (Journal Thoracic Cardiovascular Surgery, 2002)

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Ω Measure #234: Thoracic Surgery: Pulmonary Function Tests Before Major Anatomic Lung Resection (Pneumonectomy, Lobectomy, or Formal Segmentectomy)

2011 PHYSICIAN QUALITY REPORTING OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Percentage of surgical patients aged 18 years and older undergoing a major lung resection who had a pulmonary function test performed within 12 months prior to surgery

INSTRUCTIONS:
This measure is to be reported each time a major resection of the lung is performed. This measure is intended to reflect the quality of services provided for patients undergoing lung resection. There is wide consensus that preoperative pulmonary function testing is a necessary step in evaluating and appropriately selecting patients with lung cancer for major anatomic resection. Preoperative pulmonary function testing also provides a standardized measure to compare patient and treatment outcomes in order to provide continuing quality improvement.

Measure Reporting via Registry:
CPT codes and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure. The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data. Do not report this measure via claims.

DENOMINATOR:
All patients aged 18 years and older undergoing major anatomic lung resection

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Patient encounter during the reporting period (CPT): 32440, 32442, 32445, 32480, 32482, 32484, 32486, 32488, 32503, 32504, 32663

NUMERATOR:
Patients who had a pulmonary function test performed within 12 months prior to a major anatomic lung resection

Numerator Options:
Pulmonary function test performed within 12 months prior to surgery (3038F)

OR

Documentation of medical reason(s) for pulmonary function test not being performed within 12 months prior to surgery (3038F *with* 1P)

OR

Pulmonary function test not performed within 12 months prior to surgery, reason not otherwise specified (3038F *with* 8P)

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RATIONALE:

Evaluation of lung function for patients having thoracic surgery, for patients having thoracotomies, for patients having surgery in which the chest is opened and in patients with respiratory disease, eg esophagectomy, lung excision or resection is vital to determine what treatment is needed, safe and effective. Evaluation of lung function for patients being considered for lung cancer resection is critical to assessing suitability for resection and prediction of post-operative lung function. Review of the 5000 lobectomies recorded in the current STS General Thoracic Database identified a significant gap with respect to preoperative pulmonary function testing; it was missing in 22% of patients undergoing resection for lung cancer. Remediation of this process gap should improve quality by reducing inappropriate selection of high-risk patients for surgery.

CLINICAL RECOMMENDATION STATEMENTS:

"Lung function tests were considered to be appropriate for patients undergoing spinal surgery, for ASA grade 3 patients having thoracic surgery, for patients having thoracotomies and for surgery in which the chest is opened in patients with respiratory disease, e.g. esophagectomy, lung excision or resection (Chest, 2003)
ASA grade 3 - A patient with severe systemic disease
ASA grade 4 - A patient with severe systemic disease that is a constant threat to life
Preoperative tests: The use of routine preoperative tests for elective surgery

In patients being considered for lung cancer resection, spirometry should be performed. If the forced expiratory volume in 1 second (FEV1) is >80% predicted normal or >2 L, the patient is suitable for resection including pneumonectomy without further evaluation. If the FEV1 is >1.5 L, the patient is suitable for a lobectomy without further evaluation. Level of evidence, fair; benefit, substantial; grade of recommendation, B. (National Institute for Clinical Excellence, 2003)

In patients being considered for lung cancer resection, if either the FEV1 or DLCO are < 80% predicted, postoperative lung function should be predicted through additional testing. Level of evidence, fair; benefit, substantial; grade of recommendation, B. (National Institute for Clinical Excellence, 2003)

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▲Measure #235: Hypertension (HTN): Plan of Care

2011 PHYSICIAN QUALITY REPORTING OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of patient visits for patients aged 18 years and older with a diagnosis of HTN during which either systolic blood pressure ≥ 140 mmHg OR diastolic blood pressure ≥ 90mmHg with documented plan of care for hypertension

INSTRUCTIONS:
This measure is to be reported at each visit during the reporting period for patients with HTN seen during the reporting period. This measure is intended to reflect the quality of services provided for the primary management of patients with HTN who are seen for a visit during the reporting period.

Measure Reporting via Claims:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. CPT Category II codes and/or G-codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed ICD-9-CM diagnosis codes, CPT codes, and the appropriate CPT Category II code AND/OR G-code(s), OR the CPT Category II code with the modifier AND G-code. The modifier allowed for this measure is: 8P- reasons not otherwise specified. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT codes and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure. The quality-data codes have been provided for registry only measures for use by registries that utilize claims data. It is not necessary to submit these codes for registry-based submissions.

DENOMINATOR:
Total number of patient visits for patients aged 18 years and older with a diagnosis of HTN with either systolic blood pressure ≥ 140 mmHg OR diastolic blood pressure ≥ 90 mmHg

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Diagnosis for HTN (ICD-9-CM): 401.0, 401.1, 401.9, 402.00, 402.01, 402.10, 402.11, 402.90, 402.91, 403.00, 403.01, 403.10, 403.11, 403.90, 403.91, 404.00, 404.01, 404.02, 404.03, 404.10, 404.11, 404.12, 404.13, 404.90, 404.91, 404.92, 404.93
AND

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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:
Total number of patient visits with documented plan of care for HTN

Numerator Instructions: If BP measurement is repeated during the visit in the same arm and the same position, use the last BP reading. If the sequence of readings is unknown, use the lowest BP reading.

Definition:
Plan of Care – May include the following: rechecking the blood pressure at a later date, initiating or altering medical therapy or initiating or altering non-pharmacological therapy.

NUMERATOR NOTE: If a blood pressure measurement is not documented during the visit, report CPT II 4050F with 8P

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Hypertension Plan of Care Documented for Visits with Elevated Blood Pressure.
(One CPT II code & one G-code [4050F & G867x] are required on the claim form to submit this numerator option)
CPT II 4050F: Hypertension plan of care documented as appropriate
AND

G8675: Most recent systolic blood pressure ≥ 140 mmHg
OR
G8676: Most recent diastolic blood pressure ≥ 90 mmHg

OR

If patient does not meet denominator inclusion because blood pressure is not elevated, report:
(One systolic G-code [G8677 or G8678] & one diastolic G-code [G8679 or G8680] are required on the claim form to submit this numerator option)
G8677: Most recent systolic blood pressure < 130 mmHg
OR
G8678: Most recent systolic blood pressure 130 to 139 mmHg
AND

G8679: Most recent diastolic blood pressure < 80 mmHg
OR
G8680: Most recent diastolic blood pressure 80 - 89 mmHg

OR

Hypertension Plan of Care not Documented for Visits with Elevated Blood Pressure, Reason Not Specified
(One CPT II code & one G-code [4050F & G867x] are required on the claim form to submit this numerator option)

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Append a reporting modifier (8P) to CPT Category II code 4050F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.
CPT II 4050F *with* 8P: Hypertension plan of care not documented, reason not otherwise specified
AND
G8675: Most recent systolic blood pressure ≥ 140 mmHg
OR
G8676: Most recent diastolic blood pressure ≥ 90 mmHg

RATIONALE:
Effective management of blood pressure in patients with hypertension can help prevent cardiovascular events, including myocardial infarction, stroke and the development of heart failure.

CLINICAL RECOMMENDATION STATEMENTS:
Nonpharmacological therapy is recommended and may include weight reduction, decreased sodium and alcohol intake and exercise (Williams MA, Fleg JL, Ades PA, et al., 2002). Selection of pharmacological therapy should be based on the presence of comorbidities, severity of hypertension, presence of risk factors and target organ damage (Williams MA, Fleg JL, Ades PA, et al., 2002). Frequent follow-up visits are recommended (WHO, 2002). After initiation of the initial therapy, a follow-up visit is recommended within 1-2 months, to assess hypertension control, patient compliance to treatment and adverse effects [Level I Recommendation, Level-C Evidence] (Chandler JM, Connito D, Demme RA, et al., 1999).

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