

2007 Physician Quality Reporting Initiative Specifications Document

This document contains the complete specifications for the 74 measures that make up the 2007 Physician Quality Reporting Initiative (PQRI). In general, the 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 certain ICD-9 and CPT Category I codes specified in the measure that are submitted as part of a claim for Medicare Physician Fee Schedule services by eligible professionals. If the specified denominator codes for a measure are not included in the patient's claim as submitted, then the patient does not fall into the denominator population, and the PQRI measure does not apply to the patient.

If the patient does fall into the denominator population, the applicable CPT Category II code (or temporary G code, where CPT Category II codes are not yet available) that defines the numerator should be submitted.

Where a patient falls in the denominator population but specifications define circumstances in which a patient may be excluded from the measure's denominator population, CPT Category II code modifiers 1-P, 2-P, or 3-P are available to describe medical, patient, or system reasons, respectively, for such exclusion. Where exclusion does not apply, the CPT Category II modifier 8-P may be used to indicate that the process of care was not provided for a reason not otherwise specified.

To successfully report quality data for a measure under the PQRI program, it is necessary in all circumstances to report a numerator code (CPT Category II code or G code), with or without an applicable CPT Category II code modifier (1-P, 2-P, 3-P, or 8-P). Instructions specific to each measure provide additional reporting information.

Instructions for some measures 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.

The measure specifications are organized to provide the following information:

- Measure title
- Measure description
- Instructions on reporting including frequency, timeframes, and applicability
- Numerator coding
- Definitions of terms
- Coding instructions
- Use of CPT Category II exclusion modifiers, where applicable
- Denominator coding
- Rationale statement for measure
- Clinical recommendations forming the basis for the measure

2007 Physician Quality Reporting Initiative (PQRI) Measure Specifications

◆Measure #1: Hemoglobin A1c Poor Control in Type 1 or 2 Diabetes Mellitus

DESCRIPTION:

Percentage of patients aged 18 through 75 years with diabetes (type 1 or type 2) 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 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. It is anticipated that clinicians who provide services for the primary management of diabetes mellitus will submit this measure.

This measure can be reported using CPT Category II codes:

ICD-9 diagnosis codes, CPT E/M service codes, G-codes, and patient demographics (age, gender, etc..) 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, submit the listed ICD-9 diagnosis codes, CPT E/M service codes or 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- reasons not otherwise specified. There are no allowable performance exclusions for this measure.

NUMERATOR:

Patients with most recent hemoglobin A1c level > 9.0%

Numerator Instructions: This is a poor control measure. A lower rate indicates better performance (e.g., low rates of poor control indicate better care)

Numerator Coding:

Most Recent Hemoglobin A1c Performed

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

OR

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

OR

CPT II 3045F: Most recent hemoglobin A1c level 7.0% to 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.

- **8P:** Hemoglobin A1c level was not performed during the performance period (12 months), reason not otherwise specified

DENOMINATOR:

Patients aged 18-75 years with the diagnosis of diabetes

Denominator Coding:

An ICD-9 diagnosis code for diabetes and a CPT E/M service code or G-code are required to identify patients for denominator inclusion.

ICD-9 diagnosis codes: 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, 648.00, 648.01, 648.02, 648.03, 648.04

AND

CPT E/M service codes or G-codes: 97802, 97803, 97804, 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, G0270, G0271

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 $\leq 6.5\%$. (AACE/ACE)

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)

◆Measure #2: Low Density Lipoprotein Control in Type 1 or 2 Diabetes Mellitus

DESCRIPTION:

Percentage of patients aged 18 through 75 years with diabetes (type 1 or type 2) 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 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. It is anticipated that clinicians who provide services for the primary management of diabetes mellitus will submit this measure.

This measure can be reported using CPT Category II codes:

ICD-9 diagnosis codes, CPT E/M service codes, G-codes, and patient demographics (age, gender, etc.) 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, submit the listed ICD-9 diagnosis codes, CPT E/M service codes or 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- reasons not otherwise specified. There are no allowable performance exclusions for this measure.

NUMERATOR:

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

Numerator Coding:

Most Recent LDL-C Performed

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

OR

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.

- **8P:** LDL-C was not performed during the performance period (12 months), reason not otherwise specified

DENOMINATOR:

Patients aged 18-75 years with the diagnosis of diabetes

Denominator Coding:

An ICD-9 diagnosis code for diabetes and a CPT E/M service code or G-code are required to identify patients for denominator inclusion.

ICD-9 diagnosis codes: 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, 648.00, 648.01, 648.02, 648.03, 648.04

AND

CPT E/M service codes or G-codes: 97802, 97803, 97804, 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, G0270, G0271

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)

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)

◆Measure #3: High Blood Pressure Control in Type 1 or 2 Diabetes Mellitus

DESCRIPTION:

Percentage of patients aged 18 through 75 years with diabetes (type 1 or type 2) who had most recent blood pressure in control (less than 140/80 mm Hg)

INSTRUCTIONS:

This measure is to be reported a minimum of once per reporting period for patients 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. It is anticipated that clinicians who provide services for the primary management of diabetes mellitus will submit this measure.

This measure can be reported using either CPT Category II codes:

ICD-9 diagnosis codes, CPT E/M service codes, G-codes, and patient demographics (age, gender, etc.) 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, submit the listed ICD-9 diagnosis codes, CPT E/M service codes or 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- reasons not otherwise specified. There are no allowable performance exclusions for this measure.

NUMERATOR:

Patients whose most recent blood pressure < 140/80 mm Hg

Numerator Instructions: To describe both systolic and diastolic values, two codes must be reported for this measure. For the systolic blood pressure value, report one of the systolic codes; for the diastolic blood pressure value, report one of the diastolic codes. 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 Coding:

Most Recent Blood Pressure Measurement Performed

Systolic codes

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

OR

CPT II 3075F: Most recent systolic blood pressure 130 to 139 mm Hg

OR

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

AND

Diastolic codes

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

OR

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

OR

CPT II 3080F: Most recent diastolic blood pressure \geq 90 mm Hg

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.

- **8P:** No documentation of blood pressure measurement, reason not otherwise specified

DENOMINATOR:

Patients aged 18-75 years with the diagnosis of diabetes

Denominator Coding:

An ICD-9 diagnosis code for diabetes and a CPT E/M service code are required to identify patients for denominator inclusion.

ICD-9 diagnosis codes: 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, 648.00, 648.01, 648.02, 648.03, 648.04

AND

CPT E/M service codes: 97802, 97803, 97804, 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, G0270, G0271

RATIONALE:

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

CLINICAL RECOMMENDATION STATEMENTS:

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)

***Measure #4: Screening for Future Fall Risk**

DESCRIPTION:

Percentage of patients aged 65 years and older who were screened for future fall risk (patients are considered at risk for future falls if they have had 2 or more falls in the past year or any fall with injury in the past year) 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 all non-acute settings (excludes emergency departments and acute care hospitals). It is anticipated that clinicians who provide primary care for the patient will submit this measure.

This measure can be reported using CPT Category II codes:

CPT E/M service codes and patient demographics (age, gender, etc.) 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, submit the listed CPT E/M service 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- reasons not otherwise specified.

NUMERATOR:

Patients who were screened for future fall risk (patients are considered at risk for future falls if they have had 2 or more falls in the past year or any fall with injury in the past year) at least once within 12 months

Numerator Instructions: Patients are considered at risk for future falls if they have had two or more falls in the past year or any fall with injury in the past year

Definition: A fall is defined as 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 (Tinetti).

Numerator Coding:

Screening for Future Fall Risk Performed

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

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

Screening for Future Fall Risk not Performed for Medical Reasons

Append a modifier (**1P**) to CPT Category II code **1100F** or **1101F** to report documented circumstances that appropriately exclude patients from the denominator.

- **1P:** Documentation of medical reason(s) for not screening for future fall risk (e.g., patient is not ambulatory)

OR

Screening for Future Fall Risk not Performed, Reason Not Specified

Append a reporting modifier (**8P**) to CPT Category II code **1100F** to allow the reporting of circumstances when an action described in a measure's numerator is not performed and the reason is not otherwise specified.

- **8P:** Patient was not screened for future fall risk, reason not otherwise specified

DENOMINATOR:

All patients aged 65 years and older

Denominator Coding:

A CPT E/M service code to identify patients aged 65 years and older who were seen by the clinician is required for denominator inclusion.

CPT E/M service codes: 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, 99387, 99397, 99401, 99402, 99403, 99404

RATIONALE:

Patients may not volunteer information regarding falls.

CLINICAL RECOMMENDATION STATEMENTS:

All older persons who are under the care of a health professional (or their caregivers) should be asked at least once a year about falls. (AGS/BGS/AAOS)

Older persons who present for medical attention because of a fall, report recurrent falls in the past year, or demonstrate abnormalities of gait and/or balance should have a fall evaluation performed. This evaluation should be performed by a clinician with appropriate skills and experience, which may necessitate referral to a specialist (e.g., geriatrician). (AGS/BGS/AAOS)

Older people in contact with health care professionals should be asked routinely whether they have fallen in the past year and asked about the frequency, context and characteristics of the falls. (NICE) (Grade C)

Older people reporting a fall or considered at risk of falling should be observed for balance and gait deficits and considered for their ability to benefit from interventions to improve strength and balance. (NICE) (Grade C)

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

DESCRIPTION:

Percentage of patients aged 18 years and older with a diagnosis of heart failure and left ventricular systolic dysfunction (LVSD) who were prescribed ACE inhibitor or ARB 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 the primary management of patients with heart failure and decreased left ventricular systolic function. The left ventricular systolic dysfunction may be determined by quantitative or qualitative assessment. 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 dysfunction. It is anticipated that clinicians who provide primary management of patients with heart failure will submit this measure.

This measure can be reported using CPT Category II codes:

ICD-9 diagnosis codes, CPT E/M service codes, and patient demographics (age, gender, etc.) 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, submit the listed ICD-9 diagnosis codes, CPT E/M service 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- reasons not otherwise specified.

NUMERATOR:

Patients who were prescribed ACE inhibitor or ARB therapy

Numerator Coding:

ACE Inhibitor or ARB Therapy Prescribed

CPT II 4009F: Angiotensin converting enzyme (ACE) inhibitor or angiotensin receptor blocker (ARB) therapy prescribed

AND

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

OR

ACE Inhibitor or ARB Therapy not Prescribed for Medical, Patient, or System Reasons

Append a modifier (**1P, 2P, or 3P**) to CPT Category II code **4009F** to report documented circumstances that appropriately exclude patients from the denominator

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

AND

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

OR

If patient does not meet denominator inclusion because:

Left ventricular ejection fraction (LVEF) ≥ 40%:

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

OR

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

Append a reporting modifier (**8P**) to CPT Category II code **3021F** to report circumstances when the action described does not meet denominator inclusion and the reason is not otherwise specified

- **8P:** Left ventricular ejection fraction (LVEF) was not performed or documented, reason not otherwise specified

OR

ACE Inhibitor or ARB Therapy not Prescribed, Reason Not Specified

Append a reporting modifier (**8P**) to CPT Category II code **4009F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

- **8P:** Angiotensin converting enzyme (ACE) inhibitor or angiotensin receptor blocker (ARB) therapy not prescribed, reason not otherwise specified

AND

CPT II 3021F: Left ventricular ejection fraction <40% or documentation of moderately or severely depressed left ventricular systolic dysfunction

DENOMINATOR:

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

Denominator Coding:

An ICD-9 diagnosis code for heart failure and a CPT E/M service code are required to identify patients for denominator inclusion.

ICD-9 diagnosis codes: 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

CPT E/M service codes: 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99238, 99239, 99241, 99242, 99243, 99244, 99245, 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

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 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)

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

DESCRIPTION:

Percentage of patients aged 18 years and older with a diagnosis of coronary artery disease who were prescribed oral antiplatelet therapy

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 coronary artery disease will submit this measure.

This measure can be reported using CPT Category II codes:

ICD-9 diagnosis codes, CPT E/M service codes, and patient demographics (age, gender, etc.) 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, submit the listed ICD-9 diagnosis codes, CPT E/M service 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- reasons not otherwise specified.

NUMERATOR:

Patients who were prescribed oral antiplatelet therapy

Numerator Instructions: Oral antiplatelet therapy consists of aspirin, clopidogrel/Plavix, or combination of aspirin and dipyridamole/Aggrenox

Numerator Coding:

Oral Antiplatelet Therapy Prescribed

CPT II 4011F: Oral antiplatelet therapy prescribed (eg, aspirin, clopidogrel/Plavix, or combination of aspirin and dipyridamole/Aggrenox)

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.

- **1P:** Documentation of medical reason(s) for not prescribing oral antiplatelet therapy (eg, aspirin, clopidogrel/Plavix, or combination of aspirin and dipyridamole/Aggrenox)
- **2P:** Documentation of patient reason(s) for not prescribing oral antiplatelet therapy (eg, aspirin, clopidogrel/Plavix, or combination of aspirin and dipyridamole/Aggrenox)
- **3P:** Documentation of system reason(s) for not prescribing oral antiplatelet therapy (eg, aspirin, clopidogrel/Plavix, or combination of aspirin and dipyridamole/Aggrenox)

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.

- **8P:** Oral antiplatelet therapy (eg, aspirin, clopidogrel/Plavix, or combination of aspirin and dipyridamole/Aggrenox) not prescribed, reason not otherwise specified

DENOMINATOR:

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

Denominator Coding:

An ICD-9 diagnosis code for coronary artery disease and a CPT E/M service code are required to identify patients for denominator inclusion.

ICD-9 diagnosis codes: 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

CPT E/M service codes: 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99238, 99239, 99241, 99242, 99243, 99244, 99245, 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

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.

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)

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

DESCRIPTION:

Percentage of patients aged 18 years and older with a diagnosis of coronary artery disease and prior myocardial infarction (MI) who were prescribed beta-blocker therapy

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 coronary artery disease with prior myocardial infarction (MI) will submit this measure.

This measure can be reported using CPT Category II codes:

ICD-9 diagnosis codes, CPT E/M service codes, and patient demographics (age, gender, etc.) 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, submit the listed ICD-9 diagnosis codes, CPT E/M service 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- reasons not otherwise specified.

NUMERATOR:

Patients who were prescribed beta-blocker therapy

Numerator Coding:

Beta-blocker Therapy Prescribed

CPT II 4006F: Beta-blocker therapy prescribed

OR

Beta-blocker Therapy not Prescribed for Medical, Patient, or System Reasons

Append a modifier (**1P, 2P, or 3P**) to CPT Category II code **4006F** to report documented circumstances that appropriately exclude patients from the denominator.

- **1P:** Documentation of medical reason(s) for not prescribing beta-blocker therapy
- **2P:** Documentation of patient reason(s) for not prescribing beta-blocker therapy
- **3P:** Documentation of system reason(s) for not prescribing beta-blocker therapy

OR

Beta-blocker Therapy not Prescribed, Reason Not Specified

Append a reporting modifier (**8P**) to CPT Category II code **4006F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

- **8P:** Beta-blocker therapy was not prescribed, reason not otherwise specified

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 Coding:

An ICD-9 diagnosis code to identify patients with a diagnosis of coronary artery disease* and a diagnosis of myocardial infarction and a CPT E/M service code are required for denominator inclusion.

ICD-9 diagnosis codes: 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, V45.81, V45.82, 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

Patients who had a prior MI at any time

ICD-9 diagnosis codes: 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

CPT E/M service codes: 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99238, 99239, 99241, 99242, 99243, 99244, 99245, 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.*

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 β -adrenoceptor blocker therapy. Treatment should begin within a few days of the event (if not initiated acutely) and continue indefinitely. Class IIa – Low-risk patients without a clear contraindication to β -adrenoceptor blocker therapy. Survivors of non-ST-elevation MI. Class IIb –

Patients with moderate or severe LV failure or other relative contraindications to β -adrenoceptor blocker therapy, provided they can be monitored closely. (ACC/AHA)

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

▲Measure #8: Heart Failure: Beta-blocker Therapy for Left Ventricular Systolic Dysfunction

DESCRIPTION:

Percentage of patients aged 18 years and older with a diagnosis of heart failure who also have left ventricular systolic dysfunction (LVSD) 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 the primary management of patients with heart failure and decreased left ventricular systolic function. The left ventricular systolic dysfunction may be determined by quantitative or qualitative assessment. 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 dysfunction. It is anticipated that clinicians who provide primary management of patients with heart failure will submit this measure.

This measure can be reported using CPT Category II codes:

ICD-9 diagnosis codes, CPT E/M service codes, and patient demographics (age, gender, etc.) 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, submit the listed ICD-9 diagnosis codes, CPT E/M service 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- reasons not otherwise specified.

NUMERATOR:

Patients who were prescribed beta-blocker therapy

Numerator Coding:

Beta-blocker Therapy Prescribed

CPT II 4006F: Beta blocker therapy prescribed

AND

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

OR

Beta-blocker Therapy not Prescribed for Medical, Patient, or System Reasons

Append a modifier (**1P**, **2P**, or **3P**) to Category II code **4006F** to report documented circumstances that appropriately exclude patients from the denominator.

- **1P:** Documentation of medical reason(s) for not prescribing beta-blocker therapy
- **2P:** Documentation of patient reason(s) for not prescribing beta-blocker therapy
- **3P:** Documentation of system reason(s) for not prescribing beta-blocker therapy

AND

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

OR

If patient does not meet denominator inclusion because:

Left ventricular ejection fraction (LVEF) \geq 40%:

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

OR

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

Append a reporting modifier (**8P**) to CPT Category II code **3021F** to report circumstances when the action described does not meet denominator inclusion and the reason is not otherwise specified.

- **8P:** Left ventricular ejection fraction (LVEF) was not performed or documented, reason not otherwise specified

OR

Beta-blocker Therapy not Prescribed, Reason Not Specified

Append a reporting modifier (**8P**) to CPT Category II code **4006F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

- **8P:** Beta-blocker therapy was not prescribed, reason not otherwise specified

AND

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

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 Coding:

An ICD-9 diagnosis code for heart failure and a CPT E/M service code are required to identify patients for denominator inclusion.

ICD-9 diagnosis codes: 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

CPT E/M service codes: 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 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

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)

◆Measure #9: Antidepressant Medication During Acute Phase for Patients with New Episode of Major Depression

DESCRIPTION:

Percentage of patients aged 18 years and older diagnosed with new episode of major depressive disorder (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. It is anticipated that clinicians who provide the primary management of patients with major depressive disorder (MDD) will submit this measure.

This measure can be reported using G-codes:

ICD-9 diagnosis codes, CPT E/M service codes, and patient demographics (age, gender, etc.) 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, submit the listed ICD-9 diagnosis codes, CPT E/M service codes, and the appropriate G-code.

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: A "new episode" is defined as a 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 Coding:

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

DENOMINATOR:

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

Denominator Coding:

An ICD-9 diagnosis code to identify patients with a diagnosis of major depression and a CPT E/M service code are required for denominator inclusion.

ICD-9 diagnosis codes: 296.20, 296.21, 296.22, 296.23, 296.24, 296.30, 296.31, 296.32, 296.33, 296.34, 298.0, 300.4, 309.1, 311

AND

CPT E/M service codes: 90801, 90802, 90804, 90805, 90806, 90807, 90808, 90809, 90862, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215

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.

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*

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

DESCRIPTION:

Percentage of final reports for CT or MRI studies of the brain performed within 24 hours of arrival to the hospital for patients aged 18 years and older with the diagnosis of ischemic stroke or TIA or intracranial hemorrhage that include documentation of the presence or absence of each of the following: hemorrhage and mass lesion and acute infarction

INSTRUCTIONS:

This measure is to be reported each time a CT or MRI is performed in a hospital or outpatient setting during the reporting period for patients with a diagnosis of ischemic stroke, TIA, or intracranial hemorrhage. 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.

This measure can be reported using CPT Category II codes:

ICD-9 diagnosis codes, CPT procedure codes, and patient demographics (age, gender, etc.) 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, submit the listed ICD-9 diagnosis codes, CPT procedure 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.

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

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

Numerator Coding:

Presence/Absence of Hemorrhage, Mass Lesion, and Acute Infarction Documented

CPT II 3110F: Presence or absence of hemorrhage and mass lesion and acute infarction documented in final CT or MRI report

AND

CPT II 3111F: CT or MRI of the brain performed within 24 hours of arrival to the hospital

OR

If patient does not meet denominator inclusion because CT or MRI of the brain was performed greater than 24 hours after arrival to the hospital, report:

CPT II 3112F: CT or MRI of the brain performed greater than 24 hours after arrival to the hospital

OR

Presence/Absence of Hemorrhage, Mass Lesion, and Acute Infarction not Documented, Reason Not Specified

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.

- **8P:** Presence or absence of hemorrhage and mass lesion and acute infarction was not documented in final CT or MRI report, reason not otherwise specified

AND

CPT II 3111F: CT or MRI of the brain within 24 hours of arrival to the hospital

DENOMINATOR:

All final reports for CT or MRI studies of the brain performed within 24 hours of arrival to the hospital for patients aged 18 years and older with a diagnosis of ischemic stroke or TIA or intracranial hemorrhage

Denominator Coding:

An ICD-9 diagnosis code to identify patients with a diagnosis of ischemic stroke or TIA or intracranial hemorrhage and a CPT procedure code for patients undergoing CT or MRI of the brain are required for denominator inclusion.

ICD-9 diagnosis codes: 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

AND

CPT procedure codes: 0042T, 70450, 70460, 70470, 70551, 70552, 70553

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, on which initial treatment decisions will be based.

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)

***Measure #11: Stroke and Stroke Rehabilitation: Carotid Imaging Reports**

DESCRIPTION:

Percentage of final reports for carotid imaging studies (neck MR angiography [MRA], neck CT angiography [CTA], neck duplex ultrasound, carotid angiogram) performed for patients aged 18 years and older with the diagnosis of ischemic stroke or TIA 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 patients with a diagnosis of ischemic stroke or TIA. It is anticipated that clinicians who provide the physician component of diagnostic imaging studies for patients with stroke or TIA in the hospital or outpatient setting will submit this measure.

This measure can be reported using CPT Category II codes:

ICD-9 diagnosis codes, CPT procedure codes, and patient demographics (age, gender, etc.) 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, submit the listed ICD-9 diagnosis codes, CPT procedure 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- reasons not otherwise specified.

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 (eg, for duplex ultrasound studies, velocity parameters that correlate the residual internal carotid lumen with methods based on the distal internal carotid lumen)

Numerator Coding:

Reference to Measurements of Distal Internal Carotid Diameter as the Denominator for Stenosis Measurement Documented

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 for Medical Reasons

Append a modifier (**1P**) to CPT Category II code **3100F** to report documented circumstances that appropriately exclude patients from the denominator.

- **1P:** Documentation of medical reason(s) for not including direct or indirect reference to measurements of distal internal carotid diameter

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.

- **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

DENOMINATOR:

All final reports for carotid imaging studies (neck MR angiography [MRA], neck CT angiography [CTA], neck duplex ultrasound, carotid angiogram) performed for patients aged 18 years and older with a diagnosis of ischemic stroke or TIA

Denominator Coding:

An ICD-9 diagnosis code to identify patients with a diagnosis of ischemic stroke or TIA and a CPT procedure code for patients undergoing carotid imaging are required for denominator inclusion.

ICD-9 diagnosis codes: 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

CPT procedure codes: 70498, 70547, 70548, 70549, 75660, 75662, 75665, 75671, 75676, 75680, 93880, 93882

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:

For patients with symptomatic atherosclerotic carotid stenosis >70%, as defined using the NASCET criteria, the value of carotid endarterectomy (CEA) has been clearly established from the results of 3 major prospective randomized trials: the NASCET, the European Carotid Surgery Trial (ECST), and the Veterans Affairs Cooperative Study Program. Among symptomatic patients with TIAs or minor strokes and high-grade carotid stenosis, each trial showed impressive relative and absolute risk reductions for those randomized to surgery. For patients with carotid stenosis <50%, these trials showed that there was no significant benefit of surgery. (Sacco, ASA, 2006)

It is important to consider that the degree of carotid stenosis in ECST was measured differently than that in NASCET. The degree of carotid stenosis is significantly higher if calculated by the

NASCET rather than the ECST method. In summary, it appears that patients with a recent TIA or nondisabling stroke with ipsilateral carotid stenosis benefit from surgery if the stenosis is >50% as measured by the NASCET method; however, this benefit appears to be less pronounced in women. Recently symptomatic patients with >70% stenosis as measured by the NASCET method can expect a far greater benefit from carotid endarterectomy. (Albers, AHA, 1999)

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

DESCRIPTION:

Percentage of patients aged 18 years and older with a diagnosis of primary open-angle glaucoma (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. The medical reason exclusion may be used if a clinician is asked to report on this measure but is not the clinician providing the primary management for primary open-angle glaucoma.

This measure can be reported using CPT Category II codes:

ICD-9 diagnosis codes, CPT procedure codes, and patient demographics (age, gender, etc.) 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, submit the listed ICD-9 diagnosis codes, CPT procedure 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- reasons not otherwise specified.

NUMERATOR:

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

Numerator Coding:

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.

- **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.

- **8P:** Optic nerve head evaluation was not performed, reason not otherwise specified

DENOMINATOR:

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

Denominator Coding:

An ICD-9 diagnosis code to identify patients with a diagnosis of primary open-angle glaucoma and a CPT code are required for denominator inclusion. The CPT code may be a CPT procedure code for ophthalmologic services or a CPT E/M service code.

ICD-9 diagnosis codes: 365.01, 365.10, 365.11, 365.12, 365.15

AND

CPT procedure codes: 92002, 92004, 92012, 92014, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245

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).

***Measure #13: Age-Related Macular Degeneration: Age-Related Eye Disease Study (AREDS) Prescribed/Recommended**

DESCRIPTION:

Percentage of patients aged 50 years and older with a diagnosis of age-related macular degeneration who had AREDS prescribed/recommended 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. The medical reason exclusion may be used if a clinician is asked to report on this measure but is not the clinician providing the primary management for age-related macular degeneration.

This measure can be reported using CPT Category II codes:

ICD-9 diagnosis codes, CPT procedure codes, and patient demographics (age, gender, etc.) 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, submit the listed ICD-9 diagnosis codes, CPT procedure 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- reasons not otherwise specified.

NUMERATOR:

Patients with who had AREDS prescribed/recommended within 12 months

Definition: Medical record must include documentation of the term "AREDS" if it is recommended. If it is prescribed, it must specify the AREDS formulation.

Numerator Coding:

AREDS Prescribed/Recommended

CPT II 4007F: Age-Related Eye Disease Study (AREDS) formulation prescribed or recommended

OR

AREDS not Prescribed/Recommended for Medical Reasons

Append a modifier (**1P**) to CPT Category II code **4007F** to report documented circumstances that appropriately exclude patients from the denominator.

- **1P:** Documentation of medical reason(s) for not prescribing or recommending the AREDS formulation (eg mild AMD, patient does not meet criteria for antioxidant vitamin or mineral supplements as outlined in the AREDS study, patient smokes)

OR

AREDS not Prescribed/Recommended, Reason Not Specified

Append a reporting modifier (**8P**) to CPT Category II code **4007F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

- **8P:** Age-Related Eye Disease Study (AREDS) formulation was not prescribed or recommended, reason not otherwise specified

DENOMINATOR:

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

Denominator Coding:

An ICD-9 diagnosis code to identify patients with a diagnosis of age-related macular degeneration and a CPT code are required for denominator inclusion. The CPT code may be a CPT procedure code for ophthalmologic services or a CPT E/M service code.

ICD-9 diagnosis codes: 362.50, 362.51, 362.52

AND

CPT procedure codes: 92002, 92004, 92012, 92014, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245

RATIONALE:

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 (Age-Related Eye Disease Study Research Group, 2001). 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:

According to the American Academy of Ophthalmology, 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, 2005).

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

DESCRIPTION:

Percentage of patients aged 50 years and older with a diagnosis of age-related macular degeneration 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. The medical reason exclusion may be used if a clinician is asked to report on this measure but is not the clinician providing the primary management for age-related macular degeneration.

This measure can be reported using CPT Category II codes:

ICD-9 diagnosis codes, CPT procedure codes, and patient demographics (age, gender, etc.) 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, submit the listed ICD-9 diagnosis codes, CPT procedure 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- reasons not otherwise specified.

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.

Numerator Coding:

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.

- **1P:** Documentation of medical reason(s) for not performing a dilated macular examination
- **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.

- **8P:** Dilated macular exam was not performed, including documentation of the presence or absence of macular thickening or hemorrhage AND the level of macular degeneration severity, reason not otherwise specified

DENOMINATOR:

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

Denominator Coding:

An ICD-9 diagnosis code to identify patients with a diagnosis of age-related macular degeneration and a CPT code are required for denominator inclusion. The CPT code may be a CPT procedure code for ophthalmologic services or a CPT E/M service code.

ICD-9 diagnosis codes: 362.50, 362.51, 362.52

AND

CPT procedure codes: 92002, 92004, 92012, 92014, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245

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 exists on the frequency or absence of regular examinations of the macula when patients are under the care of an ophthalmologist for AMD, parallel data for key structural assessments for glaucoma and cataract and diabetic retinopathy suggest that significant gaps are likely.

CLINICAL RECOMMENDATION STATEMENTS:

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

***Measure #15: Cataracts: Assessment of Visual Functional Status**

DESCRIPTION:

Percentage of patients aged 18 years and older with a diagnosis of cataracts who were assessed for visual functional status 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 cataracts (in either one or both eyes) will submit this measure. The medical reason exclusion may be used if a clinician is asked to report on this measure but is not the clinician providing the primary management for cataracts.

This measure can be reported using CPT Category II codes:

ICD-9 diagnosis codes, CPT procedure codes, and patient demographics (age, gender, etc.) 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, submit the listed ICD-9 diagnosis codes, CPT procedure 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- reasons not otherwise specified.

NUMERATOR:

Patients who were assessed for visual functional status during one or more office visits within 12 months

Definition: Documentation in medical record of visual functional status must include: documentation that patient is operating well with vision or not operating well with vision based on discussion with the patient **OR** documentation of use of a standardized scale or completion of an assessment questionnaire (e.g., VF-14, ADVS [Activities of Daily Vision Scale], VFQ [Visual Function Questionnaire]).

Numerator Coding:

Visual Functional Status Assessed

CPT II 1055F: Visual functional status assessed

OR

Visual Functional Status not Assessed for Medical Reasons

Append a modifier (**1P**) to CPT Category II code **1055F** to report documented circumstances that appropriately exclude patients from the denominator.

- **1P:** Documentation of medical reason(s) for not assessing patient's visual functional status

OR

Visual Functional Status not Assessed, Reason Not Specified

Append a reporting modifier (**8P**) to CPT Category II code **1055F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

- **8P:** Visual functional status was not assessed, reason not otherwise specified

DENOMINATOR:

All patients aged 18 years and older with a diagnosis of cataracts

Denominator Coding:

An ICD-9 diagnosis code to identify patients with a diagnosis of cataracts and a CPT procedure code for ophthalmologic services are required for denominator inclusion.

ICD-9 diagnosis codes: 366.00, 366.01, 366.02, 366.03, 366.04, 366.09, 366.10, 366.11, 366.12, 366.13, 366.14, 366.15, 366.16, 366.17, 366.19, 366.20, 366.22, 366.34, 366.41, 366.42, 366.43, 366.45, 366.46

AND

CPT procedure codes: 92002, 92004, 92012, 92014, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245

RATIONALE:

The primary reason for cataract surgery is to improve the patient's visual functional status and quality of life, since there is no scientific threshold for measures such as visual acuity when cataract surgery is or is not indicated on a population basis. Data indicate that actual measured performance on important activities varies linearly with visual acuity and contrast sensitivity, two visual parameters directly affected by cataracts (West, 2002). The impact of such decrements varies from person to person. As such, it is vital to assess functioning related to vision prior to cataract surgery. Outcomes of cataract surgery, such as patient satisfaction, have been found to vary directly with the degree of pre-operative impairment (Schein, 1995; Tielsch, 1995).

CLINICAL RECOMMENDATION STATEMENTS:

According to the American Academy of Ophthalmology, the initial physical examination should include visual acuity, refraction, ocular alignment and motility, pupil reactivity and function, IOP measurement, external examination, slit-lamp biomicroscopy, evaluation of the fundus through dilated pupil, assessment of general and mental health. (Level A:III Recommendation) (AAO, 2005)

***Measure #16: Cataracts: Documentation of Pre-Surgical Axial Length, Corneal Power Measurement and Method of Intraocular Lens Power Calculation**

DESCRIPTION:

Percentage of patients aged 18 years and older who had cataract surgery who had the pre-surgical axial length, corneal power measurement and method of intraocular lens power calculation performed and documented within 6 months prior to the procedure

INSTRUCTIONS:

This measure is to be reported each time a cataract surgery (in either one or both eyes) with intraocular lens (IOL) placement is performed during the reporting period. It is anticipated that clinicians who perform the cataract procedure will submit this measure.

This measure can be reported using CPT Category II codes:

CPT procedure codes and patient demographics (age, gender, etc.) 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, submit the listed CPT procedure 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- reasons not otherwise specified.

NUMERATOR:

Patients who had the pre-surgical axial length, corneal power measurement and method of intraocular lens power calculation documented as performed within 6 months prior to the procedure.

Numerator Coding:

Pre-surgical Measurements and Intraocular Lens Power Calculation Method Performed and Documented

CPT II 3073F: Pre-surgical (cataract) axial length, corneal power measurement and method of intraocular lens power calculation documented (must be performed within six months prior to surgery).

OR

Pre-surgical Measurements and Intraocular Lens Power Calculation Method not Performed and Documented for Medical Reasons

Append a modifier (**1P**) to CPT Category II code **3073F** to report documented circumstances that appropriately exclude patients from the denominator.

- **1P:** Documentation of medical reason(s) for not performing the pre-surgical (cataract) axial length, corneal power measurement and method of intraocular lens power calculation

OR

Pre-surgical Measurements and Intraocular Lens Power Calculation Method not Performed and Documented, Reason Not Specified

Append a reporting modifier (**8P**) to CPT Category II code **3073F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

- **8P:** Pre-surgical (cataract) axial length, corneal power measurement and method of intraocular lens power calculation was not documented (must be performed within six months prior to surgery), reason not otherwise specified

DENOMINATOR:

All patients aged 18 years and older who had cataract surgery

Denominator Coding:

A CPT procedure code is required to identify patients who underwent cataract surgery (in either one or both eyes) with IOL placement for denominator inclusion.

CPT procedure codes (without modifier 55): 66982, 66983, 66984

RATIONALE:

An important outcome of cataract surgery is improved visual function and attainment of the patient's desired refractive outcome. 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. These data are not always documented in the patient record (McGlynn, 2003). Further, there are various methods to measure axial length and corneal power, and different lens calculation formula that can be used. The rationale for documenting these measurements and IOL power calculation formula used is to help increase the likelihood of achieving an appropriate postoperative refractive target, and to be able to review potential causes of any postoperative refractive surprises (postoperative refraction does not equal the plan/targeted refraction).

CLINICAL RECOMMENDATION STATEMENTS:

Achieving the targeted postoperative refraction requires measuring axial length accurately, determining corneal power, and using the most appropriate IOL power formula. (AAO).

***Measure #17: Cataracts: Pre-Surgical Dilated Fundus Evaluation**

DESCRIPTION:

Percentage of patients aged 18 years and older who had cataract surgery who had a dilated fundus evaluation performed within six months prior to the procedure

INSTRUCTIONS:

This measure is to be reported each time a cataract surgery (in either one or both eyes) with or without intraocular lens (IOL) placement is performed during the reporting period. It is anticipated that clinicians who perform the cataract procedure will submit this measure.

This measure can be reported using CPT Category II codes:

CPT procedure codes and patient demographics (age, gender, etc.) 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, CPT procedure codes and the appropriate CPT Category II code **OR** the CPT Category II code **with** the modifier. The modifiers allowed for this measure are: 2P- patient reasons, 8P- reasons not otherwise specified.

NUMERATOR:

Patients who had a dilated fundus evaluation performed within six months prior to the procedure

Numerator Coding:

Pre-surgical Dilated Fundus Evaluation Performed

CPT II 2020F: Dilated fundus evaluation performed within six months prior to cataract surgery

OR

Pre-surgical Dilated Fundus Evaluation not Performed for Patient Reasons

Append a modifier (**2P**) to CPT Category II code **2020F** to report documented circumstances that appropriately exclude patients from the denominator.

- **2P:** Documentation of patient reason(s) for not performing a dilated fundus evaluation

OR

Pre-surgical Dilated Fundus Evaluation not Performed, Reason Not Specified

Append a reporting modifier (**8P**) to CPT Category II code **2020F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

- **8P:** Dilated fundus evaluation was not performed within six months prior to cataract surgery, reason not otherwise specified

DENOMINATOR:

All patients aged 18 years and older who had cataract surgery

Denominator Coding:

A CPT procedure code is required to identify patients who underwent cataract surgery (in either one or both eyes) with or without IOL placement for denominator inclusion.

CPT procedure codes (without modifier 55): 66840, 66850, 66852, 66920, 66930, 66940, 66982, 66983, 66984

RATIONALE:

All patients undergoing cataract surgery should have a comprehensive eye examination prior to the scheduled procedure, with particular attention to the presence of other ocular conditions that may impact the advisability and expected outcomes of surgery. The presence of a dilated fundus examination is often lacking in pre-operative assessments (Lee, 1996). In addition, the outcomes of cataract surgery are significantly impacted by the presence or absence of comorbid ocular conditions (Schein, 1995; Tielsch, 1995; Mangione, 1995).

CLINICAL RECOMMENDATION STATEMENTS:

The initial physical examination should include visual acuity, refraction, ocular alignment and motility, pupil reactivity and function, IOP measurement, external examination, slit-lamp biomicroscopy, evaluation of the fundus through dilated pupil, assessment of general and mental health. (Level A:III Recommendation) (AAO, 2001)

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

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. The medical reason exclusion may be used if a clinician is asked to report on this measure but is not the clinician providing the primary management for diabetic retinopathy.

This measure can be reported using CPT Category II codes:

ICD-9 diagnosis codes, CPT procedure codes, and patient demographics (age, gender, etc.) 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, submit the listed ICD-9 diagnosis codes, CPT procedure 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- reasons not otherwise specified.

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

Definition: Medical record must include: Documentation of the level of severity of retinopathy (e.g., background diabetic retinopathy, proliferative diabetic retinopathy, nonproliferative diabetic retinopathy) AND documentation of whether macular edema was present or absent

Numerator Coding:

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.

- **1P:** Documentation of medical reason(s) for not performing a dilated macular or fundus examination
- **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.

- **8P:** Dilated macular or fundus exam was not performed, including documentation of the presence or absence of macular edema AND level of severity of retinopathy, reason not otherwise specified

DENOMINATOR:

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

Denominator Coding:

An ICD-9 diagnosis code to identify patients with a diagnosis of diabetic retinopathy and a CPT code are required for denominator inclusion. The CPT code may be a CPT procedure code for ophthalmologic services or a CPT E/M service code.

ICD-9 diagnosis codes: 362.01, 362.02, 362.03, 362.04, 362.05, 362.06

AND

CPT procedure codes: 92002, 92004, 92012, 92014, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245

RATIONALE:

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

CLINICAL RECOMMENDATION STATEMENTS:

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)

***Measure #19: Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care**

DESCRIPTION:

Percentage of patients aged 18 years and older with a diagnosis of diabetic retinopathy who had a dilated macular or fundus exam performed with documented communication to the physician who manages the ongoing care of the patient with diabetes 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 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. The medical reason exclusion may be used if a clinician is asked to report on this measure but is not the clinician providing the primary management for diabetic retinopathy.

This measure can be reported using CPT Category II codes:

ICD-9 diagnosis codes, CPT procedure codes, and patient demographics (age, gender, etc.) 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, submit the listed ICD-9 diagnosis codes, CPT procedure 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- reasons not otherwise specified.

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 Coding:

Dilated Macular or Fundus Exam Findings Communicated

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

AND

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

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

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

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

AND

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

If patient does not meet denominator inclusion because:

Patient did not have dilated macular or fundus exam performed:

Append a reporting modifier (**8P**) to CPT Category II code **2021F** to report circumstances when the action described does not meet denominator inclusion and the reason is not otherwise specified.

- **8P:** Dilated macular or fundus exam not performed, including documentation of the presence or absence of macular edema AND level of severity of retinopathy, reason not otherwise specified

OR

Dilated Macular or Fundus Exam Findings not Communicated, Reason Not Specified

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.

- **8P:** Findings of dilated macular or fundus exam was not communicated to the physician managing the diabetes care, reason not otherwise specified

AND

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.

DENOMINATOR:

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

Denominator Coding:

An ICD-9 diagnosis code to identify patients with a diagnosis of diabetic retinopathy and a CPT code are required for denominator inclusion. The CPT code may be a CPT procedure code for ophthalmologic services or a CPT E/M service code.

ICD-9 diagnosis codes: 362.01, 362.02, 362.03, 362.04, 362.05, 362.06

AND

CPT procedure codes: 92002, 92004, 92012, 92014, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245

RATIONALE:

The physician that manages the ongoing care of the patient with diabetes should be aware of the patient's dilated eye examination and severity of retinopathy to manage the 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)

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

DESCRIPTION:

Percentage of surgical patients aged 18 years and older undergoing procedures with the indications for prophylactic parenteral antibiotics, who have an order for prophylactic 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 antibiotics. It is anticipated that clinicians who perform the listed surgical procedures will submit this measure.

This measure can be reported using CPT Category II codes:

CPT procedure codes and patient demographics (age, gender, etc.) 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, submit the listed CPT procedure code and the appropriate CPT Category II code OR the CPT Category II code with the modifier. The modifiers allowed for this measure are: 1P- medical reasons, 8P- reasons not otherwise specified.

NUMERATOR:

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

Numerator Coding:

Table 1A: The antimicrobial drugs listed below are considered prophylactic antibiotics for the purposes of this measure.

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

CPT II 4047F: Documentation of order for prophylactic 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 antibiotic has been given within one hour prior to the surgical incision (or start of procedure when no incision is required)

CPT II 4048F: Documentation that prophylactic antibiotic was given within one hour (if fluoroquinolone or vancomycin, two hours) prior to surgical incision (or start of procedure when no incision is required)

OR

Order for Prophylactic Antibiotic not Given for Medical Reasons

Append a modifier (**1P**) to CPT Category II code **4047F** to report documented circumstances that appropriately exclude patients from the denominator.

- **1P:** Documentation of medical reason(s) for not ordering 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 or Administration of Prophylactic Antibiotic not Given, Reason Not Specified

Append a reporting modifier (**8P**) to CPT Category II code **4047F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

- **8P:** Antibiotics were not ordered 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

DENOMINATOR:

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

Denominator Coding:

A CPT procedure code for surgical procedures for which prophylactic antibiotics are indicated is required to identify patients for denominator inclusion.

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, 27758, 27759, 27766, 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, 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, 43324, 43325, 43326, 43330, 43331, 43340, 43341, 43350, 43351, 43352, 43360, 43361, 43400, 43401, 43405, 43410, 43415, 43420, 43425, 43496
Stomach	43500, 43501, 43502, 43510, 43520, 43600, 43605, 43610, 43611, 43620, 43621, 43622, 43631, 43632, 43633, 43634, 43640, 43641, 43653, 43800, 43810, 43820, 43825, 43830, 43831, 43832, 43840, 43842, 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, 45170, 45190, 45500, 45505, 45520, 45540, 45541, 45550, 45560, 45562, 45563, 45800, 45805, 45820, 45825
Hepatic Surgery	47133, 47135, 47136, 47140, 47141, 47142
Biliary Surgery	47420, 47425, 47460, 47480, 47560, 47561, 47570, 47600,

	47605, 47610, 47612, 47620, 47700, 47701, 47711, 47712, 47715, 47719, 47720, 47721, 47740, 47741, 47760, 47765, 47780, 47785, 47800, 47802, 47900
Pancreas	48020, 48100, 48120, 48140, 48145, 48146, 48148, 48150, 48152, 48153, 48154, 48155, 48160, 48500, 48510, 48511, 48520, 48540, 48545, 48547, 48548, 48550, 48554, 48556
Abdomen, Peritoneum, & Omentum	49215, 49568
Renal Transplant	50300, 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, 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, 35021, 35211, 35216, 35241, 35246, 35271, 35276, 35311
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, 52612, 52614, 52620, 52630, 52647, 52648, 54401, 54405, 54406, 54408, 54410, 54415, 54416, 55801, 55810, 55812, 55815, 55821, 55831, 55840, 55842, 55845
General Thoracic Surgery	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, 35481, 35526, 37616, 38381, 38746, 38747, 39000, 39010, 39200, 39220, 39545, 39561, 60521, 60522, 64746
Foot & Ankle	27702, 27703, 27704, 27870, 28192, 28193, 28293, 28296, 28299, 28300, 28306, 28307, 28308, 28309, 28310, 28320, 28322, 28415, 28420, 28445, 28465, 28485, 28505, 28525, 28531, 28555, 28585, 28615, 28645, 28675, 28705, 28715, 28725, 28730, 28735, 28737, 28740, 28750, 28755, 28760

RATIONALE:

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

CLINICAL RECOMMENDATION STATEMENTS:

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

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

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

DESCRIPTION:

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

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. It is anticipated that clinicians who perform the listed surgical procedures will submit this measure.

This measure can be reported using CPT Category II codes:

CPT procedure codes and patient demographics (age, gender, etc.) 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, submit the listed CPT procedure 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- reasons not otherwise specified.

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 Coding:

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.

- **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.

- **8P:** Order for cefazolin OR cefuroxime for antimicrobial prophylaxis was not documented, reason not otherwise specified

DENOMINATOR:

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

Denominator Coding:

A CPT procedure code for surgical procedures with indications of first or second generation cephalosporin prophylactic antibiotic is required to identify patients for denominator inclusion.

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, 27758, 27759, 27766, 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, 35636, 35637, 35638, 35642, 35645, 35646, 35647, 35650, 35651, 35654, 35656, 35661, 35663, 35665, 35666, 35671, 36830
Spleen and Lymph Nodes	38100, 38101, 38115, 38120
Esophagus	43045, 43100, 43101, 43107, 43108, 43112, 43113, 43116, 43117, 43118, 43121, 43122, 43123, 43124, 43130, 43135,

	43280, 43300, 43305, 43310, 43312, 43313, 43320, 43324, 43325, 43326, 43330, 43331, 43340, 43341, 43350, 43351, 43352, 43360, 43361, 43400, 43401, 43405, 43410, 43415, 43420, 43425, 43496
Stomach	43500, 43501, 43502, 43510, 43520, 43600, 43605, 43610, 43611, 43620, 43621, 43622, 43631, 43632, 43633, 43634, 43640, 43641, 43651, 43652, 43653, 43800, 43810, 43820, 43825, 43830, 43831, 43832, 43840, 43842, 43843, 43845, 43846, 43847, 43848, 43850, 43855, 43860, 43865, 43870, 43880
Small Intestine	44005, 44010, 44020, 44021, 44025, 44050, 44055, 44100, 44110, 44111, 44120, 44125, 44126, 44127, 44130, 44132, 44133, 44135, 44136
Hepatic Surgery	47133, 47135, 47136, 47140, 47141, 47142
Biliary Surgery	47420, 47425, 47460, 47480, 47490, 47510, 47511, 47525, 47530, 47560, 47561, 47570, 47600, 47605, 47610, 47612, 47620, 47630, 47700, 47701, 47711, 47712, 47715, 47719, 47720, 47721, 47740, 47741, 47760, 47765, 47780, 47785, 47800, 47802, 47900
Pancreas	48001, 48020, 48100, 48102, 48120, 48140, 48145, 48146, 48148, 48150, 48152, 48153, 48154, 48155, 48160, 48500, 48510, 48511, 48520, 48540, 48545, 48547, 48548, 48550, 48554, 48556
Abdomen, Peritoneum & Omentum	49000, 49002, 49010, 49180, 49200, 49201, 49215
Renal Transplant	50300, 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
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, 33300, 33305, 33310, 33315, 33320, 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, 35021, 35211, 35216, 35241,

	35246, 35271, 35276, 35311, 35820
Cardiothoracic (Pacemaker)	33203, 33254, 33255
General Thoracic Surgery	19272, 21627, 21632, 21740, 21750, 21805, 21825, 31760, 31766, 31770, 31775, 31786, 31805, 32035, 32036, 32095, 32100, 32110, 32120, 32124, 32140, 32141, 32150, 32200, 32215, 32220, 32225, 32310, 32320, 32402, 32440, 32442, 32445, 32480, 32482, 32484, 32486, 32488, 32491, 32500, 32501, 32540, 32601, 32602, 32603, 32604, 32605, 32606, 32650, 32651, 32652, 32653, 32654, 32655, 32656, 32657, 32658, 32659, 32660, 32661, 32662, 32663, 32664, 32665, 32800, 32810, 32815, 32900, 32905, 32906, 32940, 33020, 33025, 33030, 33031, 33050, 33300, 33310, 33320, 34051, 35021, 35216, 35246, 35276, 35311, 35481, 35526, 37616, 38381, 38746, 38747, 39000, 39010, 39200, 39220, 39545, 39561, 60521, 60522, 64746
Foot & Ankle	27702, 27703, 27704, 27870, 28192, 28193, 28293, 28296, 28299, 28300, 28306, 28307, 28308, 28309, 28310, 28320, 28322, 28415, 28420, 28445, 28465, 28485, 28505, 28525, 28531, 28555, 28585, 28615, 28645, 28675, 28705, 28715, 28725, 28730, 28735, 28737, 28740, 28750, 28755, 28760

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.)

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)

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

DESCRIPTION:

Percentage of non-cardiac surgical patients aged 18 years and older undergoing procedures with the indications for prophylactic antibiotics AND who received a prophylactic antibiotic, who have an order for discontinuation of prophylactic 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 antibiotics. It is anticipated that clinicians who perform the listed surgical procedures will submit this measure.

This measure can be reported using CPT Category II codes:

CPT procedure codes and patient demographics (age, gender, etc.) are used to identify patients who are included in the denominator. CPT Category II codes are used to report the numerator of the measure.

When reporting the measure, submit the listed CPT procedure 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- reasons not otherwise specified.

NUMERATOR:

Non-cardiac surgical patients who have an order for discontinuation of prophylactic 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 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 documentation that prophylactic antibiotic was discontinued within 24 hours of surgical end time.

Numerator Coding:

Documentation of order for discontinuation of prophylactic antibiotics (written order, verbal order, or standing order/protocol) within 24 hours of surgical end time

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 Antibiotics not Discontinued for Medical Reasons

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

- **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 does not meet denominator inclusion because patient did not receive prophylactic antibiotics within specified timeframe, report:

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

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.

- **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

DENOMINATOR:

All non-cardiac surgical patients undergoing procedures with the indications for prophylactic antibiotics AND who received a prophylactic antibiotic.

Denominator Instructions: 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 Coding:

A CPT procedure code for non-cardiac surgical procedures for which prophylactic antibiotics are indicated is required to identify patients for denominator inclusion.

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, 27758, 27759, 27766, 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, 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, 43324, 43325, 43326, 43330, 43331, 43340, 43341, 43350, 43351, 43352, 43360, 43361, 43400, 43401, 43405, 43410, 43415, 43420, 43425, 43496
Stomach	43500, 43501, 43502, 43510, 43520, 43600, 43605, 43610, 43611, 43620, 43621, 43622, 43631, 43632, 43633, 43634, 43640, 43641, 43653, 43800, 43810, 43820, 43825, 43830, 43831, 43832, 43840, 43842, 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, 45170, 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, 47719, 47720, 47721, 47740, 47741, 47760, 47765, 47780, 47785, 47800, 47802, 47900
Pancreas	48020, 48100, 48120, 48140, 48145, 48146, 48148, 48150, 48152, 48153, 48154, 48155, 48160, 48500, 48510, 48511, 48520, 48540, 48545, 48547, 48548, 48550, 48554, 48556
Abdomen, Peritoneum, & Omentum	49215, 49568
Renal Transplant	50300, 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 (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	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, 35481, 35526, 37616, 38381, 38746, 38747, 39000, 39010, 39200, 39220, 39545, 39561, 60521, 60522, 64746
Foot & Ankle	27702, 27703, 27704, 27870, 28192, 28193, 28293, 28296, 28299, 28300, 28306, 28307, 28308, 28309, 28310, 28320, 28322, 28415, 28420, 28445, 28465, 28485, 28505, 28525, 28531, 28555, 28585, 28615, 28645, 28675, 28705, 28715, 28725, 28730, 28735, 28737, 28740, 28750, 28755, 28760

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)

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

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

DESCRIPTION:

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

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. It is anticipated that clinicians who perform the listed surgical procedures will submit this measure.

This measure can be reported using CPT Category II codes:

CPT procedure codes and patient demographics (age, gender, etc.) 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, submit the listed CPT procedures 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- reasons not otherwise specified.

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.

Numerator Coding:

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 is ordered or VTE prophylaxis is 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** above to report documented circumstances that appropriately exclude patients from the denominator.

- **1P:** Documentation of medical reason(s) for patient not receiving any form of VTE prophylaxis (LMWH, LDUH, adjusted-dose warfarin, fondaparinux or mechanical prophylaxis) within 24 hours prior to incision time or 24 hours after surgery end time

OR

VTE Prophylaxis not Ordered, Reason Not Specified

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

- **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

DENOMINATOR:

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

Denominator Coding:

A CPT procedure code for surgical procedures for which VTE prophylaxis is indicated is required to identify patients for denominator inclusion.

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
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, 39502, 39503, 39520, 39530, 39531, 39540, 39541, 39545, 39560, 39561, 43020, 43030, 43045, 43100, 43101, 43107, 43108, 43112, 43113, 43116, 43117, 43118, 43121, 43122, 43123, 43124, 43130, 43135, 43280, 43300, 43305, 43310, 43312, 43313, 43314, 43320, 43324, 43325, 43326, 43330, 43331, 43340, 43341, 43350, 43351, 43352, 43360, 43361, 43400, 43401, 43405, 43410, 43415, 43420, 43425, 43496, 43500, 43501, 43502, 43510, 43520, 43605, 43610, 43611, 43620, 43621, 43622, 43631, 43632, 43633, 43634, 43640, 43641, 43644, 43645, 43651, 43652, 43653, 43770, 43771, 43772, 43773, 43774, 43800, 43810, 43820, 43825, 43830, 43832, 43840, 43842, 43843, 43845, 43846, 43847, 43848, 43850, 43855, 43860, 43865, 43870, 43880, 43886, 43887, 43888, 44005, 44010, 44020, 44021, 44025, 44050, 44055, 44110, 44111, 44120, 44125, 44126, 44127, 44130, 44140, 44141, 44143, 44144, 44145, 44146, 44147, 44150, 44151, 44155, 44156, 44157, 44158, 44160, 44180, 44186, 44187, 44188, 44202, 44204, 44205, 44206, 44207, 44208, 44210, 44211, 44212, 44227, 44300, 44310, 44312, 44314, 44316, 44320, 44322, 44340, 44345, 44346, 44602, 44603, 44604, 44605, 44615, 44620, 44625, 44626, 44640, 44650, 44660, 44661, 44680, 44700, 44800, 44820, 44850, 44900, 44950, 44960, 44970, 45000, 45020, 45100, 45108, 45110, 45111, 45112, 45113, 45114, 45116, 45119, 45120, 45121, 45123, 45126, 45130, 45135, 45136, 45150, 45160, 45170, 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, 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, 49200,
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	49201, 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
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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 nonmajor 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 \leq 3,400 U once daily (both Grade 1A).

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

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

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

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

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

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

***Measure #24: Osteoporosis: Communication with the Physician Managing Ongoing Care Post Fracture**

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 ongoing 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. 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 ongoing care that the fracture occurred and that the patient was or should be tested or treated for osteoporosis. 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. It is anticipated that clinicians who treat the hip, spine or distal radial fracture will submit this measure.

This measure can be reported using CPT Category II codes:

ICD-9 diagnosis codes, CPT E/M service codes, CPT procedure codes, and patient demographics (age, gender, etc.) 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, submit the listed ICD-9 diagnosis codes, CPT E/M service codes, CPT procedure 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- reasons not otherwise specified.

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.

Numerator Coding:

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.

- **1P:** Documentation of medical reason(s) for not communicating with physician managing ongoing care of patient that a fracture occurred and that the patient was or should be tested or treated for osteoporosis
- **2P:** Documentation of patient reason(s) for not communicating that a fracture occurred and that the patient was or should be tested or treated for osteoporosis with physician managing ongoing care of patient

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.

- **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

DENOMINATOR:

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

Denominator Coding:

An ICD-9 diagnosis code and a CPT E/M service code or a CPT procedure code to identify patients with a recent fracture of the hip, spine or distal radius are required for denominator inclusion.

ICD-9 diagnosis codes: 733.12, 733.13, 733.14, 805.00, 805.01, 805.02, 805.03, 805.04, 805.05, 805.06, 805.07, 805.08, 805.10, 805.11, 805.12, 805.13, 805.14, 805.15, 805.16, 805.17, 805.18, 805.2, 805.4, 805.6, 805.8, 813.40, 813.41, 813.42, 813.44, 813.45, 813.50, 813.51, 813.52, 813.54, 820.00, 820.01, 820.02, 820.03, 820.09, 820.10, 820.11, 820.13, 820.20, 820.21, 820.22, 820.8, 820.9

AND

CPT E/M service codes: 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245

OR

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

RATIONALE:

Patients who experience fragility fractures should either be treated or screened for the presence of osteoporosis. Although the fracture may be treated by the orthopedic surgeon, the testing and/or treatment is likely to be under the responsibility of the physician providing on-going care. It is important the physician providing on-going care for the patient be made aware the patient has sustained a non-traumatic fracture. There is a high degree of variability and consensus by experts of what constitutes a fragility fracture and predictor of an underlying problem of osteoporosis. The

work group determined that only those fractures, which have the strongest consensus and evidence that they are predictive of osteoporosis, should be included in the measure at this time. We anticipate that the list of fractures will expand as further evidence is published supporting the inclusion of other fractures.

CLINICAL RECOMMENDATION STATEMENTS:

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

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

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

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

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

***Measure #25: Melanoma: Patient Medical History**

DESCRIPTION:

Percentage of patients with either a current diagnosis of cutaneous melanoma or a history of cutaneous melanoma who had a medical history taken that included being asked if they have any new or changing moles 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. It is anticipated that clinicians who provide services for the primary treatment or follow-up of cutaneous melanoma or primary management of patients with a history of cutaneous melanoma will submit this measure.

This measure can be reported using CPT Category II codes:

ICD-9 diagnosis codes, CPT E/M service codes, and patient demographics (age, gender, etc.) 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, submit the listed ICD-9 diagnosis codes, CPT E/M service 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- reasons not otherwise specified.

NUMERATOR:

Patients who had a medical history taken that included being asked if they have any new or changing moles at least once within 12 months

Numerator Coding:

Medical History with Review of New or Changing Moles Documented

CPT II 1050F: History obtained regarding new or changing moles

OR

Medical History with Review of New or Changing Moles not Completed for Medical, Patient, or System Reasons

Append a modifier (**1P**, **2P**, or **3P**) to CPT Category II code **1050F** to report documented circumstances that appropriately exclude patients from the denominator.

- **1P:** Documentation of medical reason(s) for not asking about presence of new or changing moles.
- **2P:** Documentation of patient reason(s) for not asking about presence of new or changing moles.
- **3P:** Documentation of system reason(s) for not asking about presence of new or changing moles.

OR

Medical History with Review of New or Changing Moles not Completed, Reason Not Specified

Append a reporting modifier (**8P**) to CPT Category II code **1050F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

- **8P:** History was not obtained regarding new or changing moles, reason not otherwise specified

DENOMINATOR:

All patients with either a current diagnosis of cutaneous melanoma or a history of cutaneous melanoma

Denominator Coding:

An ICD-9 diagnosis code and a CPT E/M service code to identify patients with either a current diagnosis of cutaneous melanoma or a history of cutaneous melanoma are required for denominator inclusion.

ICD-9 diagnosis codes: 172.0, 172.1, 172.2, 172.3, 172.4, 172.5, 172.6, 172.7, 172.8, 172.9, V10.82

AND

CPT E/M service codes: 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245

RATIONALE:

While there are not widely available data documenting a gap in care for whether a history was taken, consensus exists among practicing dermatologists that there is room for improvement regarding physicians asking patients about new or changing moles. Early detection of additional primary melanomas is the goal of follow-up care. The majority of recurrences are discovered by the patient or family member.

CLINICAL RECOMMENDATION STATEMENTS:

The results of routine interval history and physical examination should direct the need for laboratory tests and imaging studies. (AAD)

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. (NCCN)

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)

***Measure #26: Melanoma: Complete Physical Skin Examination**

DESCRIPTION:

Percentage of patients with either a current diagnosis of cutaneous melanoma or a history of cutaneous melanoma who had a complete physical skin exam performed 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. Patients with either a current diagnosis or history of cutaneous melanoma should receive a complete physical skin exam at least once within 12 months. It is anticipated that clinicians who provide primary treatment or follow-up for melanoma or primary management of patients with a history of cutaneous melanoma will submit this measure.

This measure can be reported using CPT Category II codes:

ICD-9 diagnosis codes, CPT E/M service codes, and patient demographics (age, gender, etc.) 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, submit the listed ICD-9 diagnosis codes, CPT E/M service 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- reasons not otherwise specified.

NUMERATOR:

Patients who had a complete physical skin exam performed at least once within 12 months

Numerator Coding:

Complete Physical Skin Exam Documented

CPT II 2029F: Complete physical skin exam performed

OR

Complete Physical Skin Exam not Performed for Medical, Patient, or System Reasons

Append a modifier (**1P**, **2P**, or **3P**) to CPT Category II code **2029F** to report documented circumstances that appropriately exclude patients from the denominator.

- **1P:** Documentation of medical reason(s) for not performing a complete physical skin exam
- **2P:** Documentation of patient reason(s) for not performing a complete physical skin exam
- **3P:** Documentation of system reason(s) for not performing a complete physical skin exam

OR

Complete Physical Skin Exam not Performed, Reason Not Specified

Append a reporting modifier (**8P**) to CPT Category II code **2029F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

- **8P:** Complete physical skin exam was not performed, reason not otherwise specified

DENOMINATOR:

All patients with either a current diagnosis of cutaneous melanoma or a history of cutaneous melanoma

Denominator Coding:

An ICD-9 diagnosis code and a CPT E/M service code to identify patients with either a current diagnosis of cutaneous melanoma or a history of cutaneous melanoma are required for denominator inclusion.

ICD-9 diagnosis codes: 172.0, 172.1, 172.2, 172.3, 172.4, 172.5, 172.6, 172.7, 172.8, 172.9, V10.82

AND

CPT E/M service codes: 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245

RATIONALE:

A complete skin examination should be performed to identify recurrences of melanoma; the genital area may be excluded per patient preference. Published literature suggests that a complete skin exam performed by a physician may result in identification of a second melanoma at an earlier stage, which positively impacts life expectancy and cost effectiveness, when compared with other screening strategies.

CLINICAL RECOMMENDATION STATEMENTS:

Routine interval follow-up physical examinations are recommended at least annually. (AAD)

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. (NCCN)

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)

***Measure #27: Melanoma: Counseling on Self-Examination**

DESCRIPTION:

Percentage of patients with either a current diagnosis of cutaneous melanoma or a history of cutaneous melanoma who were counseled at least once within 12 months to perform a self-examination for new or changing moles

INSTRUCTIONS:

This measure is to be reported a minimum of once per reporting period for patients seen during the reporting period. Patients with either a current diagnosis or history of cutaneous melanoma should be counseled at least once within 12 months to perform self-examination. It is anticipated that clinicians who provide primary treatment or follow-up for melanoma or primary management of patients with a history of cutaneous melanoma will submit this measure.

This measure can be reported using CPT Category II codes:

ICD-9 diagnosis codes, CPT E/M service codes, and patient demographics (age, gender, etc.) 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, submit the listed ICD-9 diagnosis codes, CPT E/M service 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- reasons not otherwise specified.

NUMERATOR:

Patients who were counseled at least once within 12 months, to perform self-examination for new or changing moles

Numerator Coding:

Patient Counseling to Perform Self-Examination Documented

CPT II 5005F: Patient counseled on self-examination for new or changing moles

OR

Patient Counseling to Perform a Self-Examination not Performed for Medical, Patient, or System Reasons

Append a modifier (**1P**, **2P**, or **3P**) to CPT Category II code **5005F** to report documented circumstances that appropriately exclude patients from the denominator.

- **1P:** Documentation of medical reason(s) for not counseling patient to perform self-examination for new or changing moles
- **2P:** Documentation of patient reason(s) for not counseling patient to perform self-examination for new or changing moles
- **3P:** Documentation of system reason(s) for not counseling patient to perform self-examination for new or changing moles

OR

Patient Counseling to Perform a Self-Examination not Performed, Reason Not Specified

Append a reporting modifier (**8P**) to CPT Category II code **5005F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

- **8P:** Patient was not counseled on self-examination for new or changing moles, reason not otherwise specified

DENOMINATOR:

All patients with either a current diagnosis of melanoma or a history of cutaneous melanoma

Denominator Coding:

An ICD-9 diagnosis code and a CPT E/M service code to identify patients with either a current diagnosis of cutaneous melanoma or a history of cutaneous melanoma are required for denominator inclusion.

ICD-9 diagnosis codes: 172.0, 172.1, 172.2, 172.3, 172.4, 172.5, 172.6, 172.7, 172.8, 172.9, V10.82

AND

CPT E/M service codes: 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245

RATIONALE:

Significant opportunity exists to increase rates of patient self-examination. Educating patients to perform self-examinations will lead to earlier detection of secondary sites of melanoma.

CLINICAL RECOMMENDATION STATEMENTS:

Patient education on self-examination of the skin and lymph nodes is recommended. (AAD)

All patients should be taught self-examination because many recurrences are found by patients themselves at home rather than by clinicians in the clinic. (BAD)

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

DESCRIPTION:

Percentage of patients 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.

This measure can be reported using CPT Category II codes:

ICD-9 diagnosis codes, CPT E/M service codes, and patient demographics (age, gender, etc.) 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, submit the listed ICD-9 diagnosis codes, CPT E/M service 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- reasons not otherwise specified.

NUMERATOR:

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

Numerator Coding:

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.

- **1P:** Documentation of medical reason(s) for not receiving or taking aspirin within 24 hours before emergency department arrival or during emergency department stay
- **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.

- **8P:** Aspirin was not received within 24 hours before emergency department arrival or during emergency department stay, reason not otherwise specified

DENOMINATOR:

All patients with an emergency department discharge diagnosis of acute myocardial infarction

Denominator Coding:

An ICD-9 emergency department discharge diagnosis code and a CPT E/M service code to identify patients with a diagnosis of AMI are required for denominator inclusion.

ICD-9 diagnosis codes: 410.01, 410.11, 410.21, 410.31, 410.41, 410.51, 410.61, 410.71, 410.81, 410.91

AND

CPT E/M service codes: 99281, 99282, 99283, 99284, 99285, 99291

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)

Measure #29: Beta-Blocker at Time of Arrival for Acute Myocardial Infarction (AMI)

DESCRIPTION:

Percentage of patients with a diagnosis of AMI who had documentation of receiving beta-blocker within 24 hours before or after hospital arrival

INSTRUCTIONS:

This measure is to be reported once during a hospital stay for each occurrence of an AMI during the reporting period. Patients should receive beta-blocker therapy upon initial arrival if clinically appropriate. However, the timeframe for this measure includes the entire 24 hour period from the time of presentation. This construct is consistent with the hospital performance measure. This measure is intended to reflect the quality of services provided for the initial, primary management of patients with acute myocardial infarction in the hospital inpatient setting. It is anticipated that clinicians who provide services in the hospital inpatient setting will submit this measure.

This measure can be reported using G-codes:

ICD-9 diagnosis codes, CPT E/M service codes, and patient demographics (age, gender, etc.) 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, submit the listed ICD-9 diagnosis codes, CPT E/M service codes, and the appropriate G-code.

NUMERATOR:

Acute myocardial infarction patients who received beta blocker within 24 hours before or after hospital arrival

Numerator Coding:

Beta-blocker Received

G8009: Acute myocardial infarction: patient documented to have received beta-blocker at arrival

OR

Beta-blocker not Received for Documented Reasons

G8011: Clinician documented that acute myocardial infarction patient was not an eligible candidate for beta-blocker at arrival measure

OR

Beta-blocker not Received

G8010: Acute myocardial infarction: patient not documented to have received beta-blocker at arrival

DENOMINATOR:

Patients with acute myocardial infarction who present to hospital inpatient setting or are hospitalized

Denominator Coding:

An ICD-9 diagnosis code and a CPT E/M service code to identify patients with acute myocardial infarction are required for denominator inclusion.

ICD-9 diagnosis codes: 410.01, 410.11, 410.21, 410.31, 410.41, 410.51, 410.61, 410.71, 410.81, 410.91

AND

CPT E/M service codes: 99218, 99219, 99220, 99221, 99222, 99223, 99234, 99235, 99236, 99291, 99292

RATIONALE:

The early use of beta blockers in patients with acute myocardial infarction reduces mortality and morbidity (ISIS-1, 1986; Goldstein, 1996; and MIAMI, 1985) and has demonstrated effectiveness in a wide range of AMI patients (Krumholz, 1998). National guidelines strongly recommend early beta blockers for patients hospitalized with AMI (Braunwald, 2002 and Antman, 2004). Despite these recommendations, beta blockers remain under-utilized in eligible older patients hospitalized with AMI. (Jencks, 2000)

CLINICAL RECOMMENDATIONS:

Long-Term Beta-blocker Therapy Recommendations in Survivors of Myocardial Infarction (ACC/AHA Revised Recommendations, 1999)

Class IIa

2. Survivors of non–ST-elevation MI.

Class IIb

1. Patients with moderate or severe LV failure or other relative contraindication to β -adrenoceptor blocker therapy, provided patients can be monitored closely.

Class III

No recommendation

When citing this document, the American College of Cardiology and the American Heart Association request that the following citation format be used: Ryan TJ, Antman EM, Brooks NH, Califf RM, Hillis LD, Hiratzka LF, Rapaport E, Riegel B, Russell RO, Smith EE III, Weaver WD. 1999 update: ACC/AHA guidelines for the management of patients with acute myocardial infarction: executive summary and recommendations: a report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines (Committee on Management of Acute Myocardial Infarction). *Circulation*. 1999;100:1016–1030.

***Measure #30: Perioperative Care: Timing of Prophylactic Antibiotic – Administering Physician**

DESCRIPTION:

Percentage of surgical patients aged 18 and older who have an order for a 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) for whom administration of prophylactic antibiotic 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 a procedure is performed during the reporting period for patients who undergo surgical procedures with an order for prophylactic antibiotics. It is anticipated that clinicians who provide anesthesia care for surgical procedures will submit this measure.

This measure can be reported using CPT Category II codes:

A CPT Category II code and patient demographics (age, gender, etc.) 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, submit the appropriate CPT Category II code **OR** the CPT Category II code **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.

NUMERATOR:

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

Numerator Coding:

Table 2A: The antimicrobial drugs listed below are considered prophylactic antibiotics for the purposes of this measure.

<ul style="list-style-type: none">• Ampicillin/sulbactam• Aztreonam• Cefazolin• Cefmetazole• Cefotetan• Cefoxitin	<ul style="list-style-type: none">• Cefuroxime• Ciprofloxacin• Clindamycin• Ertapenem• Erythromycin base• Gatifloxacin	<ul style="list-style-type: none">• Gentamicin• Levofloxacin• Metronidazole• Moxifloxacin• Neomycin• Vancomycin
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Prophylactic Antibiotic Given

CPT II 4048F: Documentation that prophylactic antibiotic was given within one hour (if fluoroquinolone or vancomycin, two hours) prior to surgical incision (or start of procedure when no incision is required)

OR

Prophylactic Antibiotic not Given, 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.

- **8P:** Antibiotic was not 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

DENOMINATOR:

All surgical patients aged 18 years and older who have an order for a 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)

Denominator Instructions: For denominator inclusion, 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).

Denominator Coding:

A CPT Category II code to identify patients who have an order for a parenteral antibiotic is required for denominator inclusion.

CPT II 4047F: Documentation of order for prophylactic 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)

RATIONALE:

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

CLINICAL RECOMMENDATION STATEMENTS:

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

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

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

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. 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.

This measure can be reported using CPT Category II codes:

ICD-9 diagnosis codes, CPT E/M service codes, and patient demographics (age, gender, etc.) 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, submit the listed ICD-9 diagnosis codes, CPT E/M service 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- reasons not otherwise specified.

NUMERATOR:

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

Definition: For purposes of this measure, 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 Coding:

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.

- **1P:** Documentation of medical reason(s) for not receiving DVT Prophylaxis by end of hospital day 2, including physician documentation that patient is ambulatory
- **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.

- **8P:** Deep vein thrombosis (DVT) prophylaxis was not received by end of hospital day 2, reason not otherwise specified

Denominator:

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

Denominator Coding:

An ICD-9 diagnosis code to identify patients with a diagnosis of ischemic stroke or intracranial hemorrhage and a CPT E/M service code are required for denominator inclusion.

ICD-9 diagnosis codes: 431, 433.01, 433.11, 433.21, 433.31, 433.81, 433.91, 434.01, 434.11, 434.91

AND

CPT E/M service codes: 99221, 99222, 99223, 99251, 99252, 99253, 99254, 99255, 99291

RATIONALE:

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

CLINICAL RECOMMENDATION STATEMENTS:

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, we recommend prophylactic low-dose subcutaneous heparin or low-molecular-weight heparins or heparinoid. (Grade 1A) In patients with an acute ICH, we recommend 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)

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

DESCRIPTION:

Percentage of patients aged 18 years and older with a diagnosis of ischemic stroke or 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. 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.

This measure can be reported using CPT Category II codes:

ICD-9 diagnosis codes, CPT E/M service codes, and patient demographics (age, gender, etc.) 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, submit the listed ICD-9 diagnosis codes, CPT E/M service 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- reasons not otherwise specified.

NUMERATOR:

Patients who were prescribed antiplatelet therapy at discharge

Definition: Antiplatelet therapy: aspirin, combination of aspirin and extended-release dipyridamole, clopidogrel, ticlopidine

Numerator Coding:

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.

- **1P:** Documentation of medical reason(s) for not prescribing oral antiplatelet therapy at discharge
- **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.

- **8P:** Oral antiplatelet therapy was not prescribed at discharge, reason not otherwise specified

DENOMINATOR:

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

Denominator Coding:

An ICD-9 diagnosis code to identify patients with a diagnosis of ischemic stroke or transient ischemic attack (TIA) and a CPT E/M service code are required for denominator inclusion.

ICD-9 diagnosis codes: 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

CPT E/M service codes: 99238, 99239, 99251, 99252, 99253, 99254, 99255

RATIONALE:

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

CLINICAL RECOMMENDATION STATEMENTS:

We recommend 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)

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

DESCRIPTION:

Percentage of patients aged 18 years and older with a diagnosis of ischemic stroke or 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.

This measure can be reported using CPT Category II codes:

ICD-9 diagnosis codes, CPT E/M service codes, and patient demographics (age, gender, etc.) 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, submit the listed ICD-9 diagnosis codes, CPT E/M service 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- reasons not otherwise specified.

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

Numerator Coding:

Anticoagulant Prescribed

CPT II 4075F: Anticoagulant therapy prescribed at discharge

OR

Anticoagulant Prescription not Received for Medical or Patient Reasons

Append a modifier (**1P** or **2P**) to CPT Category II code **4075F** to report documented circumstances that appropriately exclude patients from the denominator.

- **1P:** Documentation of medical reason(s) for not prescribing anticoagulant therapy at discharge

- **2P:** Documentation of patient reason(s) for not prescribing anticoagulant therapy at discharge

OR

Anticoagulant Prescription not Received, Reason Not Specified

Append a reporting modifier (**8P**) to CPT Category II code **4075F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

- **8P:** Anticoagulant therapy was not prescribed at discharge, reason not otherwise specified

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 Coding:

An ICD-9 diagnosis code to identify patients with a diagnosis of ischemic stroke or transient ischemic attack (TIA) and atrial fibrillation and a CPT E/M service code are required for denominator inclusion.

ICD-9 diagnosis codes: 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

ICD-9 diagnosis code: 427.31

AND

CPT E/M service codes: 99238, 99239, 99251, 99252, 99253, 99254, 99255

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)

We recommend 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)

***Measure #34: Stroke and Stroke Rehabilitation: Tissue Plasminogen Activator (t-PA)
Considered**

DESCRIPTION:

Percentage of patients aged 18 years and older with a diagnosis of ischemic stroke whose time from symptom onset to arrival is less than 3 hours who were considered for t-PA administration

INSTRUCTIONS:

This measure is to be reported during each hospital stay when a patient is under active treatment for ischemic stroke during the reporting period. It is anticipated that clinicians who care for patients with a diagnosis of ischemic stroke in the hospital setting will submit this measure.

This measure can be reported using CPT Category II codes:

ICD 9 diagnosis codes, CPT E/M service codes, and patient demographics (age, gender, etc.) 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, submit the listed ICD-9 diagnosis codes, CPT E/M service 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.

NUMERATOR:

Patients who were considered for t-PA administration (given t-PA or documented reasons for patient not being a candidate for therapy)

Definition: For purposes of this measure, patients "considered for t-PA administration" includes patients to whom t-PA was given or patients for whom reasons for not being a candidate for t-PA therapy are documented.

Numerator Coding:

t-PA Administration or Consideration Documented

CPT II 4077F: Documentation that tissue plasminogen activator (t-PA) administration was considered

AND

CPT II 1065F: Ischemic stroke symptom onset of less than 3 hours prior to arrival

OR

If patient does not meet denominator inclusion because ischemic stroke symptom onset \geq 3 hours prior to arrival at hospital, report:

CPT II 1066F: Ischemic stroke symptom onset greater than or equal to 3 hours prior to arrival

OR

t-PA Administration or Consideration not Documented, Reason Not Specified

Append a reporting modifier (**8P**) to CPT Category II code **4077F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

- **8P:** Tissue plasminogen activator (t-PA) administration was not considered, reason not otherwise specified

AND

CPT II 1065F: Ischemic stroke symptom onset of less than 3 hours prior to arrival

DENOMINATOR:

All patients aged 18 years and older with the diagnosis of ischemic stroke whose time from symptom onset to arrival is less than 3 hours.

Denominator Coding:

An ICD-9 diagnosis code to identify patients with a diagnosis of ischemic stroke and a CPT E/M service code are required for denominator inclusion.

ICD-9 diagnosis codes: 433.01, 433.11, 433.21, 433.31, 433.81, 433.91, 434.01, 434.11, 434.91

AND

CPT E/M service codes: 99221, 99222, 99223, 99251, 99252, 99253, 99254, 99255, 99291

RATIONALE:

Patients who arrive at the hospital within 3 hours of stroke symptom onset should be considered for t-PA therapy.

CLINICAL RECOMMENDATION STATEMENTS:

We recommend administration of IV tPA 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 minutes for eligible patients, provided that treatment is initiated within 3 hours of clearly defined symptom onset. We recommend strict adherence to eligibility criteria for the use of IV tPA based on the NINDS trial protocol. (Inclusion Criteria: Age \geq 18 years, clinical diagnosis of stroke with a clinically meaningful neurologic deficit, clearly defined time of onset of $<$ 180 minutes before treatment, and a baseline CT showing no evidence of intracranial hemorrhage. (Albers, ACCP, 2001) (Grade 1A)

Intravenous rtPA (0.9 mg/kg, maximum dose 90 mg) is strongly recommended for carefully selected patients who can be treated within 3 hours of onset of ischemic stroke. (Adams, ASA, 2003) (Grade A)

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

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 when a patient is under active treatment for ischemic stroke or intracranial hemorrhage during the reporting period. 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.

This measure can be reported using CPT Category II codes:

ICD-9 diagnosis codes, CPT E/M service codes, and patient demographics (age, gender, etc.) 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, submit the listed ICD-9 diagnosis codes, CPT E/M service 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- reasons not otherwise specified.

NUMERATOR:

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

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 Instructions: For purposes of this measure, patients "who receive any food, fluids or medication by mouth" may be identified by the absence of an NPO (nothing by mouth) order

Numerator Coding:

Dysphagia Screening Conducted

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 food, fluids or medication by mouth

OR

Dysphagia Screening not Conducted for Medical Reasons

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

- **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 food, fluids or medication by mouth

OR

If patient does not meet denominator inclusion because patient is NPO, report:

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

OR

Dysphagia Screening not Conducted, Reason Not Specified

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.

- **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 food, fluids or medication by mouth

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 Coding:

An ICD-9 diagnosis code to identify patients with a diagnosis of ischemic stroke or intracranial hemorrhage and a CPT E/M service code are required for denominator inclusion.

ICD-9 diagnosis codes: 431, 433.01, 433.11, 433.21, 433.31, 433.81, 433.91, 434.01, 434.11, 434.91

AND

CPT E/M service codes: 99221, 99222, 99223, 99251, 99252, 99253, 99254, 99255

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)

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

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 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 intracranial hemorrhage in the hospital setting will submit this measure.

This measure can be reported using CPT Category II codes:

ICD-9 diagnosis codes, CPT E/M service codes, and patient demographics (age, gender, etc.) 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, submit the listed ICD-9 diagnosis codes, CPT E/M service 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- reasons not otherwise specified. There are no allowable performance exclusions for this measure.

NUMERATOR:

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

Definition: For purposes of this measure, "consideration of rehabilitation services" includes an order for rehabilitation services or documentation that rehabilitation was not indicated.

Numerator Coding:

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.

- **8P:** Rehabilitation services were not considered, reason not otherwise specified

DENOMINATOR:

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

Denominator Coding:

An ICD-9 diagnosis code to identify patients with a diagnosis of ischemic stroke or intracranial hemorrhage and a CPT E/M service code are required for denominator inclusion.

ICD-9 diagnosis codes: 431, 433.01, 433.11, 433.21, 433.31, 433.81, 433.91, 434.01, 434.11, 434.91

AND

CPT E/M service codes: 99238, 99239, 99251, 99252, 99253, 99254, 99255

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)

Measure #37: Dialysis Dose in End Stage Renal Disease (ESRD) Patients

DESCRIPTION:

Percentage of patients aged 18 years and older with a diagnosis of end-stage renal disease undergoing hemodialysis with a documented urea reduction ratio (URR) value greater than or equal to 65% (or a single-pool Kt/V greater than or equal to 1.2)

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. It is anticipated that clinicians who provide the primary management of end stage renal disease will submit this measure.

This measure can be reported using G-codes:

ICD-9 diagnosis codes, CPT procedure codes, G-codes, and patient demographics (age, gender, etc.) 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, submit the listed ICD-9 diagnosis codes, CPT procedure codes, and the appropriate G-code(s).

NUMERATOR:

Hemodialysis patients with a documented URR value greater than or equal to 65% (or a Kt/V greater than or equal to 1.2)

Numerator Coding:

URR Value \geq 65% Documented

G8075: End-stage renal disease patient with documented dialysis dose of URR greater than or equal to 65% (or Kt/V greater than or equal to 1.2)

OR

URR Value not Documented for Documented Reasons

G8077: Clinician documented that end-stage renal disease patient was not an eligible candidate for URR or Kt/V measure

OR

URR Value < 65% Documented

G8076: End-stage renal disease patient with documented dialysis dose of URR less than 65% (or Kt/V less than 1.2)

OR

URR Value not Documented

G8388: End-stage renal disease patient with URR OR Kt/V value not documented, but otherwise eligible for measure

DENOMINATOR:

Patients aged 18 years and older with a diagnosis of end-stage renal disease undergoing hemodialysis

Denominator Coding:

An ICD-9 diagnosis code for end stage renal disease diagnosis and a G-code or a CPT procedure code for hemodialysis are required to identify patients for denominator inclusion.

ICD-9 diagnosis code: 585.6

AND

G-codes: G0314, G0315, G0316, G0317, G0318, G0319, G0322, G0323, G0326, G0327

OR

CPT procedure codes: 90935, 90937

RATIONALE:

The dialysis care team should routinely measure and monitor the delivered dose of hemodialysis.

CLINICAL RECOMMENDATION STATEMENTS:

The dialysis care team should routinely measure and monitor the delivered dose of hemodialysis (K/DOQI)

The delivered dose of hemodialysis should be measured at least once a month in all adult and pediatric hemodialysis patients. The frequency of measurement of the delivered dose of hemodialysis should be increased when:

1. Patients are noncompliant with their hemodialysis prescriptions (missed treatments, late for treatments, early sign-off from hemodialysis treatments, etc..)
2. Frequent problems are noted in delivery of the prescribed dose of hemodialysis (such as variably poor blood flows, or treatment interruptions because of hypotension or angina pectoris).
3. Wide variability in urea kinetic modeling results is observed in the absence of prescription changes.
4. The hemodialysis prescription is modified. (K/DOQI)

The dialysis care team should deliver a Kt/V of at least 1.2 (single-pool, variable volume) for adult hemodialysis patients. (K/DOQI)

Measure #38: Hematocrit Level in End Stage Renal Disease (ESRD) Patients

DESCRIPTION:

Percentage of patients aged 18 years and older with a diagnosis of end-stage renal disease undergoing hemodialysis with a documented hematocrit value greater than or equal to 33 (or a hemoglobin value greater than or equal to 11)

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. It is anticipated that clinicians who provide the primary management of end stage renal disease will submit this measure.

This measure can be reported using G-codes:

ICD-9 diagnosis codes, CPT procedure codes, G-codes, and patient demographics (age, gender, etc.) 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, submit the listed ICD-9 diagnosis codes, CPT procedure codes, and the appropriate G-code(s).

NUMERATOR:

Hemodialysis patients with a hematocrit greater than or equal to 33 (or a hemoglobin greater than or equal to 11)

Numerator Coding:

Hematocrit Value \geq 33 Documented

G8078: End-stage renal disease patient with documented hematocrit greater than or equal to 33 (or hemoglobin greater than or equal to 11)

OR

Hematocrit Value not Documented for Documented Reasons

G8080: Clinician documented that end-stage renal disease patient was not an eligible candidate for hematocrit (hemoglobin) measure

OR

Hematocrit Value $<$ 33 Documented

G8079: End-stage renal disease patient with documented hematocrit less than 33 (or hemoglobin less than 11)

OR

Hematocrit Value not Documented

G8387: End-stage renal disease patient with a hematocrit OR hemoglobin not documented

DENOMINATOR:

Patients aged 18 years and older with a diagnosis of end-stage renal disease undergoing hemodialysis

Denominator Coding:

An ICD-9 diagnosis code for end stage renal disease diagnosis and a G-code or a CPT procedure code for hemodialysis are required to identify patients for denominator inclusion.

ICD-9 diagnosis code: 585.6

AND

G-codes: G0314, G0315, G0316, G0317, G0318, G0319, G0322, G0323, G0326, G0327

OR

CPT procedure codes: 90935, 90937

RATIONALE:

Anemia usually develops during the course of chronic kidney disease and may be associated with adverse outcomes.

CLINICAL RECOMMENDATION STATEMENTS:

Patients with glomerular filtration rate (GFR) <60 mL/min/1.73 m² should be evaluated for anemia. The evaluation should include measurement of hemoglobin level. (K/DOQI)

Anemia in chronic kidney disease should be evaluated and treated-see K/DOQI Clinical Practice Guidelines for Anemia of Chronic Kidney Disease

Available data permit the description of mean levels of hemoglobin (with wide standard deviations) at different levels of GFR and support the following recommendations. Physicians treating patients with chronic kidney disease should:

- Follow hemoglobin levels over time in all individuals with chronic kidney disease and expect some degree of decline over time as kidney function worsens
- Evaluate anemia in all patients with GFR <60 mL/min/1.73 m²
- Assess the relationship of anemia to the patient's symptoms and findings and the impact of anemia on the patient's comorbid conditions and other complications of decreased kidney function
- As in anemia from any cause, treatments appropriate to the etiology of the anemia (iron or other supplement deficiency) should be implemented. The issues of timing of intervention and specific target of hemoglobin are beyond the scope of this guideline.

These recommendations are consistent with published K/DOQI Clinical Practice Guidelines on Anemia of Chronic Kidney Disease. While there are no "normal"/expected values of hemoglobin at any specific level of GFR, available data suggest that individual patients do trend toward a fall in hemoglobin as kidney function declines. The characterization of severity of anemia for any individual with chronic kidney disease should be made in light of changes in hemoglobin from previous levels. The decline in hemoglobin is most likely associated with a reduction in erythropoietin effectiveness or production, which accompanies the decline in GFR(K/DOQI)

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

DESCRIPTION:

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

INSTRUCTIONS:

This measure is to be reported a minimum of once during the 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. It is anticipated that clinicians who provide primary care or care for treatment of fracture or osteoporosis will submit this measure.

This measure can be reported using CPT Category II codes:

CPT E/M service codes and patient demographics (age, gender, etc.) 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, submit the listed CPT E/M service 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- reasons not otherwise specified.

NUMERATOR:

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

Definition: 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).

Numerator Coding:

Central DXA Measurement Ordered or Performed 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

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

OR

Central DXA Measurement not Ordered or Performed or Pharmacologic Therapy not Prescribed for Medical, Patient, or System Reasons

Append a modifier (**1P**, **2P**, or **3P**) to CPT Category II code **3096F** or **3095F** or **4005F** to report documented circumstances that appropriately exclude patients from the denominator.

- **1P:** Documentation of medical reason(s) for not ordering or performing a central dual energy X-ray absorptiometry (DXA) measurement or not prescribing pharmacologic therapy for osteoporosis
- **2P:** Documentation of patient reason(s) for not ordering or performing central dual energy X-ray absorptiometry (DXA) measurement or not prescribing pharmacologic therapy for osteoporosis
- **3P:** Documentation of system reason(s) for not ordering or performing central dual energy X-ray absorptiometry (DXA) measurement or not prescribing pharmacologic therapy for osteoporosis

OR

Central DXA Measurement not Ordered or Performed or Pharmacologic Therapy not Prescribed, Reason Not Specified

Append a reporting modifier (**8P**) to CPT Category II code **3096F** or **3095F** or **4005F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

- **8P:** Central dual energy X-ray absorptiometry (DXA) measurement was not ordered or performed and a pharmacologic therapy for osteoporosis was not prescribed, reason not otherwise specified

DENOMINATOR:

All female patients aged 65 years and older

Denominator Coding:

A CPT E/M service code is required to identify female patients aged 65 years and older who were seen by a clinician for denominator inclusion.

CPT E/M service codes: 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99387, 99397, 99401, 99402, 99403, 99404

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 nonuse of estrogen replacement, to screen younger women may identify high-risk women. (B Recommendation) (USPSTF)

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

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

BMD testing should be performed on:

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

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

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

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

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

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

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

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

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

***Measure #40: Osteoporosis: Management Following Fracture**

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. 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. Patients with documentation of prior central DXA measurement or already receiving pharmacologic therapy would automatically meet the intent of this measure. It is anticipated that clinicians who manage the primary or ongoing care for osteoporosis or osteoporosis related fracture(s) will submit this measure.

This measure can be reported using CPT Category II codes:

ICD-9 diagnosis codes, CPT E/M service codes, CPT procedure codes, and patient demographics (age, gender, etc.) 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, submit the listed ICD-9 diagnosis codes, CPT E/M service codes, CPT procedure 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- reasons not otherwise specified.

NUMERATOR:

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

Definition: 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).

Numerator Coding:

Central DXA Measurement Ordered or Performed 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

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

OR

Central DXA Measurement not Ordered or Performed or Pharmacologic Therapy not Prescribed for Medical, Patient, or System Reasons

Append a modifier (**1P, 2P, or 3P**) to CPT Category II codes **3096F or 3095F or 4005F** to report documented circumstances that appropriately exclude patients from the denominator.

- **1P:** Documentation of medical reason(s) for not ordering or performing a central dual energy X-ray absorptiometry (DXA) measurement or not prescribing pharmacologic therapy for osteoporosis
- **2P:** Documentation of patient reason(s) for not ordering or performing a central dual energy X-ray absorptiometry (DXA) measurement or not prescribing pharmacologic therapy for osteoporosis
- **3P:** Documentation of system reason(s) for not ordering or performing a central dual energy X-ray absorptiometry (DXA) measurement or not prescribing pharmacologic therapy for osteoporosis

OR

Central DXA Measurement not Ordered or Performed or Pharmacologic Therapy not Prescribed, Reason Not Specified

Append a reporting modifier (**8P**) to CPT Category II code **3096F or 3095F or 4005F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

- **8P:** Central dual energy X-ray absorptiometry (DXA) measurement was not ordered or performed and a pharmacologic therapy for osteoporosis was not prescribed, reason not otherwise specified

DENOMINATOR:

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

Denominator Coding:

An ICD-9 diagnosis code and a CPT E/M service code or CPT procedure code are required to identify patients with a recent fracture of the hip, spine, or distal radius for denominator inclusion.

ICD-9 diagnosis codes: 733.12, 733.13, 733.14, 805.00, 805.01, 805.02, 805.03, 805.04, 805.05, 805.06, 805.07, 805.08, 805.10, 805.11, 805.12, 805.13, 805.14, 805.15, 805.16, 805.17, 805.18, 805.2, 805.4, 805.6, 805.8, 813.40, 813.41, 813.42, 813.44, 813.45, 813.50, 813.51, 813.52, 813.54, 820.00, 820.01, 820.02, 820.03, 820.09, 820.10, 820.11, 820.13, 820.20, 820.21, 820.22, 820.8, 820.9

AND

CPT E/M service codes: 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245

OR

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

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 (NQF)

***Measure #41: Osteoporosis: Pharmacologic Therapy**

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.

This measure can be reported using CPT Category II codes:

ICD-9 diagnosis codes, CPT E/M service codes, and patient demographics (age, gender, etc.) 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, submit the listed ICD-9 diagnosis codes, CPT E/M service 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- reasons not otherwise specified.

NUMERATOR:

Patients who were prescribed pharmacologic therapy within 12 months

Definition: 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).

Numerator Coding:

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.

- **1P:** Documentation of medical reason(s) for not prescribing pharmacologic therapy for osteoporosis
- **2P:** Documentation of patient reason(s) for not prescribing pharmacologic therapy for osteoporosis

- **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.

- **8P:** Pharmacologic therapy for osteoporosis was not prescribed, reason not otherwise specified

DENOMINATOR:

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

Denominator Coding:

An ICD-9 diagnosis code to identify patients with osteoporosis and a CPT E/M service code are required for denominator inclusion.

ICD-9 diagnosis codes: 733.00, 733.01, 733.02, 733.03, 733.09

AND

CPT E/M service codes: 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99386, 99387, 99396, 99397, 99401, 99402, 99403, 99404

RATIONALE:

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

CLINICAL RECOMMENDATION STATEMENTS:

Agents approved by the FDA for osteoporosis prevention and/or treatment include (in alphabetical order) bisphosphonates (alendronate, ibandronate, risedronate), salmon calcitonin, estrogen, raloxifene, and teriparatide. All act by reducing bone resorption, except for teriparatide, which has anabolic effects on bone. Although estrogen is not approved for treatment of osteoporosis, there is level 1 evidence for its efficacy in reducing vertebral fractures, nonvertebral fractures, and hip fractures. Level 1 evidence of efficacy in reducing the risk of vertebral fractures is available for all the agents approved for treatment of osteoporosis (bisphosphonates, calcitonin, raloxifene, and teriparatide). Prospective trials have demonstrated the effectiveness of bisphosphonates and teriparatide in reducing the risk of nonvertebral fractures (level 1), but only bisphosphonates have been shown to reduce the risk of hip fractures in prospective controlled trials (level 1). (AACE)

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

***Measure #42: Osteoporosis: Counseling for Vitamin D, Calcium Intake, and Exercise**

DESCRIPTION:

Percentage of patients, regardless of age, with a diagnosis of osteoporosis who are either receiving both calcium and vitamin D or have been counseled regarding both calcium and vitamin D intake, and exercise 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. Patients with a diagnosis of osteoporosis should be receiving both calcium and vitamin D or had counseling regarding their use and counseled on exercise. It is anticipated that clinicians who provide services for patients with the diagnosis of osteoporosis will submit this measure.

This measure can be reported using CPT Category II codes:

ICD-9 diagnosis codes, CPT E/M service codes, and patient demographics (age, gender, etc.) 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, submit the listed ICD-9 diagnosis codes, CPT E/M service 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- reasons not otherwise specified.

NUMERATOR:

Patients who are either receiving both calcium and vitamin D or have been counseled for both calcium and vitamin D intake, and exercise at least once within 12 months

Numerator Coding:

Calcium and Vitamin D Received or Counseling Regarding Calcium Vitamin D Use, and Exercise

CPT II 4019F: Documentation of receipt of counseling on exercise AND either both calcium and vitamin D use or counseling regarding both calcium and vitamin D use

OR

Calcium and Vitamin D not Received or no Counseling Regarding Calcium, Vitamin D Use, and Exercise for Medical Reasons

Append a modifier (**1P**) to the CPT Category II code **4019F** to report documented circumstances that appropriately exclude patients from the denominator.

- **1P:** Documentation of medical reason(s) for patient not receiving both calcium and vitamin D or and not needing counseling regarding both calcium and vitamin D intake, and exercise (e.g., patient has dementia and is unable to receive counseling)

OR

Calcium and Vitamin D not Received or no Counseling Regarding Calcium, Vitamin D Use, and Exercise, Reason Not Specified

Append a reporting modifier (**8P**) to CPT Category II code **4019F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

- **8P:** Receipt of counseling on exercise AND either both calcium and vitamin D use or counseling regarding both calcium and vitamin D use was not documented, reason not otherwise specified

DENOMINATOR:

All patients, regardless of age, with the diagnosis of osteoporosis

Denominator Coding:

An ICD-9 diagnosis code to identify patients with osteoporosis and a CPT E/M service code are required for denominator inclusion.

ICD-9 diagnosis codes: 733.00, 733.01, 733.02, 733.03, 733.09

AND

CPT E/M service codes: 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99385, 99386, 99387, 99395, 99396, 99397, 99401, 99402, 99403, 99404

RATIONALE:

Vitamin D and calcium and exercise are important in the treatment of osteoporosis.

CLINICAL RECOMMENDATION STATEMENTS:

Promote a diet with adequate calcium content (500 to 1,000 mg/day). Promote adequate vitamin D intake (at least 400 IU/day; as much as 800 IU/day in the elderly). (AACE)

Advocate regular weight-bearing exercise. Minimize risk of falls and injuries with gait and balance training. (AACE)

Advise all patients to obtain an adequate intake of dietary calcium (at least 1200 mg per day, including supplements if necessary) and vitamin D (400 to 800 IU per day for individuals at risk of deficiency). (NQF)

Advise patients to engage in weight-bearing and muscle-strengthening exercise reduce the risk of falls and fractures. (NQF)

Supplementation with both calcium and vitamin D (plain or activated form) should be required for glucocorticoid-treated patients. (ACR)

All patients require education regarding the importance of lifestyle changes (e.g., regular exercise, smoking cessation) as well as vitamin D and calcium supplementation. (Level D Evidence) (ACR)

All patients require education regarding Vitamin D and calcium supplementation. (AGA)

All patients should receive education on the importance of lifestyle changes (e.g., engaging in regular weight-bearing exercise, quitting smoking, avoiding excessive alcohol intake). (Level D Evidence) (AGA)

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

DESCRIPTION:

Percentage of patients undergoing coronary artery bypass graft (CABG) surgery using an internal mammary artery (IMA)

INSTRUCTIONS:

This measure is to be reported each time a procedure is performed during the reporting period for patients who undergo isolated coronary artery bypass graft (CABG) procedures. It is anticipated that clinicians who provide services for CABG will submit this measure. This measure is intended to reflect the quality of the surgical services provided for CABG patients. This measure does not include patients undergoing a repeat CABG surgery.

This measure can be reported using CPT Category II codes:

CPT procedure codes and patient demographics (age, gender, etc.) 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, submit the listed CPT procedure 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- reasons not otherwise specified.

NUMERATOR:

Patient who received an IMA coronary artery bypass graft

Numerator Coding:

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.

- **1P:** Documentation of medical reason(s) for not utilizing 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.

- **8P:** Internal mammary artery graft not utilized for primary, isolated coronary artery bypass graft procedure, reason not otherwise specified

DENOMINATOR:

Patients with coronary artery bypass graft

Denominator Coding:

A CPT procedure code to identify patients who underwent a coronary artery bypass graft surgery is required for denominator inclusion.

CPT procedure codes: 33510, 33511, 33512, 33513, 33514, 33516, 33517, 33518, 33519, 33521, 33522, 33523, 33533, 33534, 33535, 33536

RATIONALE:

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

CLINICAL RECOMMENDATION STATEMENTS:

Class I

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

Measure #44: Pre-Operative Beta-blocker in Patients with Isolated Coronary Artery Bypass Graft (CABG) Surgery

DESCRIPTION:

Percentage of patients undergoing coronary artery bypass (CABG) surgery who received a beta-blocker pre-operatively

INSTRUCTIONS:

This measure is to be reported at each time a procedure is performed during the reporting period for patients who undergo coronary artery bypass graft (CABG) procedures. It is anticipated that clinicians who provide services for CABG will submit this measure. The timeframe for this measure includes the entire 24 hour period before the incision time.

This measure can be reported using CPT Category II codes:

CPT procedure codes and patient demographics (age, gender, etc.) 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, submit the listed CPT procedure 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- reasons not otherwise specified.

NUMERATOR:

Patients undergoing CABG with documented pre-operative beta-blocker

Numerator Coding:

Pre-operative Beta-blocker Received

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

OR

Pre-operative 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.

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

OR

Pre-operative 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.

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

DENOMINATOR:

Patients with coronary artery bypass graft

Denominator Coding:

A CPT procedure code to identify patients who underwent a coronary artery bypass graft surgery is required for denominator inclusion.

CPT procedure codes: 33510, 33511, 33512, 33513, 33514, 33516, 33517, 33518, 33519, 33521, 33522, 33523, 33533, 33534, 33535, 33536

RATIONALE:

In patients at risk of cardiovascular complications in a variety of medical conditions, beta blockers have 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.

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

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. It is anticipated that clinicians who perform the listed surgical procedures will submit this measure.

This measure can be reported using CPT Category II codes:

CPT procedure codes and patient demographics (age, gender, etc.) 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, submit the listed CPT procedure code and the appropriate CPT Category II codes **OR** the CPT Category II code(s) **with** the modifier. The modifiers allowed for this measure are: 1P- medical reasons, 8P- reasons not otherwise specified.

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 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 documentation that prophylactic antibiotic was discontinued within 48 hours of surgical end time.

Numerator Coding:

Documentation of order for discontinuation of prophylactic antibiotics (written order, verbal order, or standing order/protocol) within 48 hours of surgical end time

CPT II 4043F: Documentation that an order was given to discontinue prophylactic antibiotics within 48 hours of surgical end time, cardiac procedure

Note: CPT Category II codes 4043F may be provided for documentation that antibiotic discontinuation was ordered or that antibiotic discontinuation was accomplished. Report CPT Category II code 4043F if antibiotics were discontinued within 48 hours.

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

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

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

AND

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

OR

If patient does not meet denominator inclusion because patient was not documented to have prophylactic antibiotics given within 4 hours prior to surgical incision, report:

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

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.

- **8P:** An order was not given to discontinue prophylactic antibiotics within 48 hours of surgical end time, 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

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: 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 Coding:

A CPT procedure code to identify all cardiac surgical patients who underwent a procedure is required for denominator inclusion.

CPT procedure codes (Cardiac surgical procedure codes for which prophylactic antibiotics are indicated for denominator inclusion):

SURGICAL PROCEDURE	CPT CODE
Cardiothoracic Surgery	33120, 33130, 33140, 33141, 33202, 33250, 33251, 33256, 33261, 33300, 33305, 33310, 33315, 33320, 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, 35021, 35211, 35216, 35241, 35246, 35271, 35276, 35311, 35820

RATIONALE:

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

CLINICAL RECOMMENDATION STATEMENTS:

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

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

***Measure #46: Medication Reconciliation**

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 office visit occurring within 60 days of each inpatient facility discharge during the reporting period. This measure is appropriate for use in the ambulatory setting only. It is anticipated that clinicians who provide primary on-going care will submit this measure when a patient is seen in the office within 60 days following discharge from any inpatient facility. If a patient has not been discharged within the 60-day timeframe from an inpatient facility, there are no reporting requirements for this measure.

This measure can be reported using CPT Category II codes:

CPT E/M service codes and patient demographics (age, gender, etc.) 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, submit the listed CPT E/M service codes and the appropriate CPT Category II codes **OR** the CPT Category II codes **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.

NUMERATOR:

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

Definition: The medical record must indicate that 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 Coding:

Documentation of Reconciliation of Discharge Medication with Current Medication List in the Medical Record

CPT II 1111F: Discharge medications reconciled with the current medication list in outpatient medical record

AND

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

OR

If patient does not meet denominator inclusion because patient was not discharged from an inpatient facility within the last 60 days, do not report any CPT Category II codes. There are no reporting requirements in this case.

OR

Discharge Medication not Reconciled with Current Medication List in the Medical Record, Reason Not Specified

Append a reporting modifier (**8P**) to CPT Category II code **1111F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

- **8P:** Discharge medications were not reconciled with the current medication list in outpatient medical record, reason not otherwise specified

AND

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

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

Denominator Coding:

A CPT E/M service code to identify patients who were seen in the office by the clinician providing on-going care is required for denominator inclusion.

CPT E/M service codes: 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99387, 99397, 99401, 99402, 99403, 99404

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. (IH)

***Measure #47: Advance Care Plan**

DESCRIPTION:

Percentage of patients aged 65 years and older with documentation of a surrogate decision-maker or advance care plan in the medical record

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 all healthcare settings. It is anticipated that clinicians who provide primary care services for the patient will submit this measure.

This measure can be reported using CPT Category II codes:

CPT E/M service codes and patient demographics (age, gender, etc.) 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, submit the listed CPT E/M service codes and the appropriate CPT Category II code **OR** the CPT Category II code **with** the modifier. The modifiers allowed for this measure are: 2P- patient reasons, 8P- reasons not otherwise specified.

NUMERATOR:

Patients with documentation of a surrogate decision maker or advance care plan in the medical record

Numerator Coding:

Surrogate Decision Maker or Advance Care Plan Documented

CPT II 1080F: Surrogate decision maker or advance care plan documented in the medical record

OR

Surrogate Decision Maker or Advance Directive not Documented for Patient Reasons

Append a modifier (**2P**) to CPT Category II code **1080F** to report documented circumstances that appropriately exclude patients from the denominator.

- **2P:** Documentation of patient reason(s) for no documentation of a surrogate decision maker or advance care plan in the medical record (eg, patient does not wish to discuss advance care planning)

OR

Surrogate Decision Maker or Advance Directive not Documented, Reason Not Specified

Append a reporting modifier (**8P**) to CPT Category II code **1080F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

- **8P:** Surrogate decision maker or advance care plan not documented in the medical record, reason not otherwise specified

DENOMINATOR:

All patients aged 65 years and older

Denominator Coding:

A CPT E/M service code to identify patients aged 65 years and older who were seen by the clinician is required for denominator inclusion.

CPT E/M service codes: 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99218, 99219, 99220, 99221, 99222, 99223, 99231, 99232, 99233, 99234, 99235, 99236, 99281, 99282, 99283, 99284, 99285, 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, 99387, 99397, 99401, 99402, 99403, 99404

RATIONALE:

It is essential that the patient's wishes regarding medical treatment be established as much as possible prior to incapacity.

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 (www.caringinfo.org). This web site provides resources and information on end-of-life care, including a national repository of state by state advance directives.

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

DESCRIPTION:

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

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 primary care for the patient will submit this measure.

This measure can be reported using CPT Category II codes:

CPT E/M service codes and patient demographics (age, gender, etc.) 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, submit the listed CPT E/M service 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- reasons not otherwise specified.

NUMERATOR:

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

Definition: Urinary incontinence is defined as any involuntary leakage of urine.

Numerator Coding:

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.

- **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.

- **8P:** Presence or absence of urinary incontinence not assessed, reason not otherwise specified

DENOMINATOR:

All female patients aged 65 years and older

Denominator Coding:

A CPT E/M service code to identify patients aged 65 years and older who were seen by the clinician is required for denominator inclusion.

CPT E/M service codes: 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99387, 99397, 99401, 99402, 99403, 99404

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)

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

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.

This measure can be reported using CPT Category II codes:

ICD-9 diagnosis codes, CPT E/M service codes, and patient demographics (age, gender, etc.) 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, submit the listed ICD-9 diagnosis codes, CPT E/M service 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- reasons not otherwise specified. There are no allowable performance exclusions for this measure.

NUMERATOR:

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

Numerator Coding:

Urinary Incontinence Characterized

CPT II 1091F: Urinary incontinence characterized (eg frequency, volume, timing, type of symptoms, how bothersome)

OR

Urinary Incontinence not Characterized, Reason Not 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.

- **8P:** Urinary incontinence not characterized (eg frequency, volume, timing, type of symptoms, how bothersome), reason not otherwise specified

DENOMINATOR:

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

Denominator Coding:

An ICD-9 diagnosis code for urinary incontinence and a CPT E/M service code are required to identify patients for denominator inclusion.

ICD-9 diagnosis codes: 307.6, 625.6, 788.30, 788.31, 788.32, 788.33, 788.34, 788.35, 788.36, 788.37, 788.38, 788.39

AND

CPT E/M service codes: 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99387, 99397, 99401, 99402, 99403, 99404

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)

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

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.

This measure can be reported using CPT Category II codes:

ICD-9 diagnosis codes, CPT E/M service codes, and patient demographics (age, gender, etc.) 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, submit the listed ICD-9 diagnosis codes, CPT E/M service 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- reasons not otherwise specified. There are no allowable performance exclusions for this measure.

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 Coding:

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.

- **8P:** Urinary incontinence plan of care not documented, reason not otherwise specified

DENOMINATOR:

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

Denominator Coding:

An ICD-9 diagnosis code for urinary incontinence and a CPT E/M service code are required to identify patients for denominator inclusion.

ICD-9 diagnosis codes: 307.6, 625.6, 788.30, 788.31, 788.32, 788.33, 788.34, 788.35, 788.36, 788.37, 788.38, 788.39

AND

CPT E/M service codes: 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99387, 99397, 99401, 99402, 99403, 99404

RATIONALE:

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

CLINICAL RECOMMENDATION STATEMENTS:

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

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

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

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

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

DESCRIPTION:

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

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. It is anticipated that clinicians who provide primary care services for the patient will submit this measure.

This measure can be reported using CPT Category II codes:

ICD-9 diagnosis codes, CPT E/M service codes, and patient demographics (age, gender, etc.) 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, submit the listed ICD-9 diagnosis code, CPT E/M service 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- reasons not otherwise specified.

NUMERATOR:

Patients with documented spirometry results in the medical record (FEV₁ and FEV₁/FVC)

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

Numerator Coding:

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.

- **1P:** Documentation of medical reason(s) for not documenting and reviewing spirometry results
- **2P:** Documentation of patient reason(s) for not documenting and reviewing spirometry results
- **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.

- **8P:** Spirometry results not documented and reviewed, reason not otherwise specified

DENOMINATOR:

All patients aged 18 and older with a diagnosis of COPD

Denominator Coding:

An ICD-9 diagnosis code for COPD and a CPT E/M service code are required to identify patients for denominator inclusion.

ICD-9 diagnosis codes: 491.0, 491.1, 491.20, 491.21, 491.22, 491.8, 491.9, 492.0, 492.8, 496

AND

CPT E/M service codes: 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99385, 99386, 99387, 99395, 99396, 99397, 99401, 99402, 99403, 99404

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)

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)

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

DESCRIPTION:

Percentage of patients aged 18 years and older with a diagnosis of COPD and who have an FEV₁/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. It is anticipated that clinicians who provide primary care services for the patient will submit this measure.

This measure can be reported using CPT Category II codes:

ICD-9 diagnosis codes, CPT E/M service codes, and patient demographics (age, gender, etc.) 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, submit the listed ICD-9 diagnosis codes, CPT E/M service 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- reasons not otherwise specified.

NUMERATOR:

Patients who were prescribed an inhaled bronchodilator

Numerator Coding:

Patient Prescribed Inhaled Bronchodilator Therapy

CPT II 4025F: Inhaled bronchodilator prescribed

AND

CPT II 3025F: Spirometry test results demonstrate FEV₁/FVC < 70% with COPD symptoms (eg, dyspnea, cough/sputum, wheezing)

OR

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

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

- **1P:** Documentation of medical reason(s) for not prescribing an inhaled bronchodilator
- **2P:** Documentation of patient reason(s) for not prescribing an inhaled bronchodilator
- **3P:** Documentation of system reason(s) for not prescribing an inhaled bronchodilator

AND

CPT II 3025F: Spirometry test results demonstrate FEV₁/FVC < 70% with COPD symptoms (eg, dyspnea, cough/sputum, wheezing)

OR

If patient does not meet denominator inclusion because:

Spirometry results demonstrate $FEV_1/FVC \geq 70\%$ or patient does not have COPD symptoms:

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:

Append a reporting modifier (**8P**) to CPT Category II code **3025F** to report circumstances when the action described does not meet denominator inclusion and the reason is not otherwise specified.

- **8P:** Spirometry test results not performed or documented, reason not otherwise specified

OR

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

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.

- **8P:** Inhaled bronchodilator not prescribed, reason not otherwise specified

AND

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

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 Coding:

An ICD-9 diagnosis code for COPD and a CPT E/M service code are required to identify patients for denominator inclusion.

ICD-9 diagnosis codes: 491.0, 491.1, 491.20, 491.21, 491.22, 491.8, 491.9, 492.0, 492.8, 496

AND

CPT E/M service codes: 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99385, 99386, 99387, 99395, 99396, 99397, 99401, 99402, 99403, 99404

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 FEV₁ 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)

▲Measure #53: Asthma: Pharmacologic Therapy

DESCRIPTION:

Percentage of patients aged 5 through 40 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. It is anticipated that clinicians who provide primary care services for the patient will submit this measure.

This measure can be reported using CPT Category II codes:

ICD-9 diagnosis codes, CPT E/M service codes, and patient demographics (age, gender, etc.) 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, submit the listed ICD-9 diagnosis codes, CPT E/M service 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: 2P- patient reasons, 8P- reasons not otherwise specified.

NUMERATOR:

Patients who were prescribed *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 methylxanthines)

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

Numerator Coding:

Preferred Long-Term Control Medication or Acceptable Alternative Treatment Prescribed

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

Append a modifier (**2P**) to CPT Category II code **4015F** to report documented circumstances that appropriately exclude patients from the denominator.

- **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 methylxanthines)

AND

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

OR

If patient does not meet denominator inclusion because patient does not have persistent asthma, report:

CPT II 1039F: Intermittent Asthma

OR

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

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.

- **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)

DENOMINATOR:

All patients aged 5 to 40 years with a diagnosis of mild, moderate, or severe persistent asthma

Denominator Coding:

An ICD-9 diagnosis code for asthma and a CPT E/M service code are required to identify patients for denominator inclusion.

ICD-9 diagnosis codes: 493.00, 493.01, 493.02, 493.10, 493.11, 493.12, 493.20, 493.21, 493.22, 493.81, 493.82, 493.90, 493.92

AND

CPT E/M service codes: 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99383, 99384, 99385, 99386, 99393, 99394, 99395, 99396, 99401, 99402, 99403, 99404

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 Beta₂ 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 beta2-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)

***Measure #54: Electrocardiogram Performed for Non-Traumatic Chest Pain**

DESCRIPTION:

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

INSTRUCTIONS:

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

This measure can be reported using CPT Category II codes:

ICD-9 diagnosis codes, CPT E/M service codes, and patient demographics (age, gender, etc.) 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, submit the listed ICD-9 diagnosis codes, CPT E/M service 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- reasons not otherwise specified.

NUMERATOR:

Patients who had an ECG performed

Numerator Coding:

ECG Performed

CPT II 3120F: 12-Lead ECG performed

OR

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.

- **1P:** Documentation of medical reason(s) for not performing an ECG
- **2P:** Documentation of patient reason(s) for not performing an ECG

OR

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.

- **8P:** 12-Lead ECG not performed, reason not otherwise specified

DENOMINATOR:

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

Denominator Coding:

An ICD-9 emergency department discharge diagnosis code and a CPT E/M service code to identify patients with a diagnosis of non-traumatic chest pain are required for denominator inclusion.

ICD-9 diagnosis codes: 413.0, 413.1, 413.9, 786.50, 786.51, 786.52, 786.59

AND

CPT E/M service codes: 99281, 99282, 99283, 99284, 99285, 99291

RATIONALE:

All patients in the age group for which CAD/ACS is part of the differential diagnosis, should have an 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:

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

***Measure #55: Electrocardiogram Performed for Syncope**

DESCRIPTION:

Percentage of patients aged 60 years and older with an emergency department discharge diagnosis of syncope who had an 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. Patients who experienced syncope should have documentation in the medical record of having an ECG performed. It is anticipated that clinicians who provide care in the emergency department will submit this measure.

This measure can be reported using CPT Category II codes:

ICD-9 diagnosis codes, CPT E/M service codes, and patient demographics (age, gender, etc.) 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, submit the listed ICD-9 diagnosis codes, CPT E/M service 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- reasons not otherwise specified.

NUMERATOR:

Patients who had an ECG performed

Numerator Coding:

ECG Performed

CPT II 3120F: 12-Lead ECG performed

OR

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.

- **1P:** Documentation of medical reason(s) for not performing an ECG
- **2P:** Documentation of patient reason(s) for not performing an ECG

OR

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.

- **8P:** 12-Lead ECG not performed, reason not otherwise specified

DENOMINATOR:

All patients aged 60 years and older with an emergency department discharge diagnosis of syncope

Denominator Coding:

An ICD-9 discharge diagnosis code and a CPT E/M service code to identify patients with a diagnosis of syncope are required for denominator inclusion.

ICD-9 diagnosis codes: 780.2

AND

CPT E/M service codes: 99281, 99282, 99283, 99284, 99285, 99291

RATIONALE:

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. ECG testing is performed inconsistently, even in high risk patients; the largest study to date of ECG testing variation in ED syncope visits using a 9 year national sample illustrated that 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 ECG has a low likelihood of dysrhythmias as a cause of syncope
- Abnormal 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

***Measure #56: Vital Signs for Community-Acquired Bacterial Pneumonia**

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. 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.

This measure can be reported using CPT Category II codes:

ICD-9 diagnosis codes, CPT E/M service codes, and patient demographics (age, gender, etc.) 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, submit the listed ICD-9 diagnosis codes, CPT E/M service 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- reasons not otherwise specified. There are no allowable performance exclusions for this measure.

NUMERATOR:

Patients with vital signs (temperature, pulse, respiratory rate, and blood pressure) documented and reviewed

Definition: Medical record 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 Coding:

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.

- **8P:** Vital signs (temperature, pulse, respiratory rate, and blood pressure) not documented and reviewed, reason not otherwise specified

DENOMINATOR:

All patients aged 18 years and older with a diagnosis of community-acquired bacterial pneumonia

Denominator Coding:

An ICD-9 diagnosis code and a CPT E/M service code to identify patients with a diagnosis of community-acquired bacterial pneumonia are required for denominator inclusion.

ICD-9 diagnosis codes: 481, 482.0, 482.1, 482.2, 482.30, 482.31, 482.32, 482.39, 482.40, 482.41, 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

CPT E/M service codes: 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99281, 99282, 99283, 99284, 99285, 99291

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 dehydrations and mental status). (ATS) (Level II Evidence)

***Measure #57: Assessment of Oxygen Saturation for Community-Acquired Bacterial Pneumonia**

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. All patients 18 years and older with a diagnosis of community-acquired bacterial pneumonia would 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.

This measure can be reported using CPT Category II codes:

ICD-9 diagnosis codes, CPT E/M service codes, and patient demographics (age, gender, etc.) 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, submit the listed ICD-9 diagnosis codes, CPT E/M service 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- reasons not otherwise specified.

NUMERATOR:

Patients with oxygen saturation documented and reviewed

Definition: Medical record 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 Coding:

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.

- **1P:** Documentation of medical reason(s) for not documenting and reviewing oxygen saturation
- **2P:** Documentation of patient reason(s) for not documenting and reviewing oxygen saturation

- **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.

- **8P:** Oxygen saturation results not documented and reviewed, reason not otherwise specified

DENOMINATOR:

All patients aged 18 years and older with a diagnosis of community-acquired bacterial pneumonia

Denominator Coding:

An ICD-9 diagnosis code and a CPT E/M service code to identify patients with a diagnosis of community-acquired bacterial pneumonia are required for denominator inclusion.

ICD-9 diagnosis codes: 481, 482.0, 482.1, 482.2, 482.30, 482.31, 482.32, 482.39, 482.40, 482.41, 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

CPT E/M service codes: 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99281, 99282, 99283, 99284, 99285, 99291

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 dehydrations 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)

***Measure #58: Assessment of Mental Status for Community-Acquired Bacterial Pneumonia**

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. 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.

This measure can be reported using CPT Category II codes:

ICD-9 diagnosis codes, CPT E/M service codes, and patient demographics (age, gender, etc.) 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, submit the listed ICD-9 diagnosis codes, CPT E/M service 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- reasons not otherwise specified. There are no allowable performance exclusions for this measure.

NUMERATOR:

Patients for whom mental status was assessed

Definition: Medical record may include documentation by clinician that patient's mental status was noted (e.g., patient is oriented or disoriented).

Numerator Coding:

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.

- **8P:** Mental status not assessed, reason not otherwise specified

DENOMINATOR:

All patients aged 18 years and older with a diagnosis of community-acquired bacterial pneumonia

Denominator Coding:

An ICD-9 diagnosis code and a CPT E/M service code to identify patients with a diagnosis of community-acquired bacterial pneumonia are required for denominator inclusion.

ICD-9 diagnosis codes: 481, 482.0, 482.1, 482.2, 482.30, 482.31, 482.32, 482.39, 482.40, 482.41, 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

CPT E/M service codes: 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99281, 99282, 99283, 99284, 99285, 99291

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 dehydrations and mental status). (ATS) (Level II Evidence)

***Measure #59: Empiric Antibiotic for Community-Acquired Bacterial Pneumonia**

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. 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.

This measure can be reported using CPT Category II codes:

ICD-9 diagnosis codes, CPT E/M service codes, and patient demographics (age, gender, etc.) 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, submit the listed ICD-9 diagnosis codes, CPT E/M service 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- reasons not otherwise specified.

NUMERATOR:

Patients with appropriate empiric antibiotic prescribed

Definition: 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).

Numerator Coding:

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.

- **1P:** Documentation of medical reason(s) for not prescribing appropriate empiric antibiotic
- **2P:** Documentation of patient reason(s) for not prescribing appropriate empiric antibiotic
- **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.

- **8P**: Appropriate empiric antibiotic not prescribed, reason not otherwise specified

DENOMINATOR:

All patients aged 18 years and older with the diagnosis of community-acquired bacterial pneumonia

Denominator Coding:

An ICD-9 diagnosis code and a CPT E/M service code to identify patients with a diagnosis of community-acquired bacterial pneumonia are required for denominator inclusion.

ICD-9 diagnosis codes: 481, 482.0, 482.1, 482.2, 482.30, 482.31, 482.32, 482.39, 482.40, 482.41, 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

CPT E/M service codes: 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99281, 99282, 99283, 99284, 99285, 99291

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)

***Measure #60: Gastroesophageal Reflux Disease (GERD): Assessment for Alarm Symptoms**

DESCRIPTION:

Percentage of patients aged 18 years and older with a diagnosis of GERD, seen for an initial evaluation, who were assessed for the presence or absence of the following alarm symptoms: involuntary weight loss, dysphagia, and GI bleeding

INSTRUCTIONS:

This measure is to be reported once for all GERD patients seen during the reporting period. Patients seen for an initial evaluation of GERD should have documentation in the medical record of the presence or absence of alarm symptoms. If the initial evaluation of GERD occurred prior to the reporting period, report the proper CPT Category II code with modifier indicated in the numerator coding indicating this is not the initial evaluation. It is anticipated that clinicians who provide care for patients with GERD will submit this measure.

This measure can be reported using CPT Category II codes:

ICD-9 diagnosis codes, CPT E/M service codes, and patient demographics (age, gender, etc.) 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, submit the listed ICD-9 diagnosis code, CPT E/M service 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- reasons not otherwise specified.

NUMERATOR:

Patients who were assessed for the presence or absence of the following alarm symptoms: involuntary weight loss, dysphagia, and GI bleeding

Numerator Coding:

Alarm Symptoms Assessed

CPT II 1070F: Alarm symptoms (involuntary weight loss, dysphagia, or gastrointestinal bleeding) assessed; none present

OR

CPT II 1071F: Alarm symptoms (involuntary weight loss, dysphagia, or gastrointestinal bleeding) assessed; one or more present

OR

Alarm Symptoms not Assessed for Medical Reasons

Append a modifier (**1P**) to CPT Category II code **1070F** or **1071F** to report documented circumstances that appropriately exclude patients from the denominator.

- **1P:** Documentation of medical reason(s) for not documenting presence or absence of alarm symptoms

OR

If patient does not meet denominator inclusion because the initial evaluation of GERD occurred prior to the reporting period, report:

Append a reporting modifier (**8P**) to CPT Category II code **1070F** to report that this visit is not the initial evaluation for GERD

OR

Alarm Symptoms not Assessed, Reason Not Specified

Append a reporting modifier (**8P**) to CPT Category II code **1071F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

- **8P:** Alarm symptoms (involuntary weight loss, dysphagia, or gastrointestinal bleeding) not assessed, reason not otherwise specified

DENOMINATOR:

All patients aged 18 years and older with the diagnosis of GERD, seen for an initial evaluation

Denominator Coding:

An ICD-9 diagnosis code for GERD and a CPT E/M service code are required to identify patients for denominator inclusion.

ICD-9 diagnosis codes: 530.10, 530.11, 530.12, 530.19, 530.81

AND

CPT E/M service codes: 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245

RATIONALE:

To determine a treatment plan for a patient with GERD, the physician should assess and document whether or not the patient has alarm symptoms. These symptoms are suggestive of possible cancer, and should be addressed with further diagnostic testing when present. Data are not readily available as to whether or not physicians are routinely assessing for alarm signs at the initial evaluation of a patient with GERD.

CLINICAL RECOMMENDATION STATEMENTS:

Further diagnostic testing (including endoscopy, proton pump inhibitor (PPI) trial, ambulatory pH monitoring, or other tests) is recommended in the following:

- Patients with *alarm symptoms* (referral for further testing should be immediate). Alarm symptoms are those that suggest cancer. Alarm symptoms include dysphagia, odynophagia, weight loss, hematemesis, black or bloody stools, chest pain, or choking (acid reflux causing coughing, hoarseness, or shortness of breath). (VHA,2003)

Alarm features should be sought in all patients presenting with dyspepsia. If alarm features are present, endoscopy should be performed (suggested time frames for urgency of endoscopy are provided with each of the alarm features listed). (ICSI) (Class A, C)

***Measure #61: Gastroesophageal Reflux Disease (GERD): Upper Endoscopy for Patients with Alarm Symptoms**

DESCRIPTION:

Percentage of patients aged 18 years and older with a diagnosis of GERD, seen for an initial evaluation, with at least one alarm symptom who were either referred for upper endoscopy or had an upper endoscopy performed

INSTRUCTIONS:

This measure is to be reported once for all GERD patients seen during the reporting period. Patients seen for an initial evaluation of GERD and at least one alarm symptom will be referred for upper endoscopy or have an upper endoscopy performed. If the initial evaluation of GERD occurred prior to the reporting period, report the proper CPT II Category II code with modifier indicated in the numerator coding indicating this is not the initial evaluation. It is anticipated that clinicians who provide care for patients with GERD will submit this measure.

This measure can be reported using CPT Category II codes:

ICD-9 diagnosis codes, CPT E/M service codes, and patient demographics (age, gender, etc.) 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, submit the listed ICD-9 diagnosis codes, CPT E/M service 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- reasons not otherwise specified.

NUMERATOR:

Patients who were either referred for an upper endoscopy or had an upper endoscopy performed

Definition: Alarm symptoms for GERD include involuntary weight loss, dysphagia, and GI bleeding.

Numerator Coding:

Endoscopy Performed or Patient Referred for Upper Endoscopy

CPT II 3130F: Upper gastrointestinal endoscopy performed

OR

CPT II 3132F: Documentation of referral for upper gastrointestinal endoscopy

AND

CPT II 1071F: Alarm symptoms (involuntary weight loss, dysphagia, or gastrointestinal bleeding) assessed; one or more present

OR

Upper Endoscopy not Performed or Patient not Referred for Upper Endoscopy for Medical, Patient, or System Reasons

Append a modifier (**1P**, **2P**, or **3P**) to one of the above CPT Category II codes **3130F** or **3132F** to report documented circumstances that appropriately exclude patients from the denominator.

- **1P**: Documentation of medical reason(s) for not referring for or not performing an upper gastrointestinal endoscopy
- **2P**: Documentation of patient reason(s) for not referring for or not performing an upper gastrointestinal endoscopy
- **3P**: Documentation of system reason(s) for not referring for or not performing an upper gastrointestinal endoscopy

AND

CPT II 1071F: Alarm symptoms (involuntary weight loss, dysphagia, or gastrointestinal bleeding) assessed; one or more present

OR

If patient does not meet denominator inclusion because:

Patient does not have alarm symptoms:

Report CPT II 1070F: Alarm symptoms (involuntary weight loss, dysphagia, or gastrointestinal bleeding) assessed; none present

OR

If patient does not meet denominator inclusion because:

Initial evaluation of GERD occurred prior to the reporting period:

Append a reporting modifier (**8P**) to CPT Category II code **1071F** to report that this visit is not the initial evaluation of GERD

OR

Upper Endoscopy not Performed or Patient not Referred for Upper Endoscopy, Reason Not Specified

Append a reporting modifier (**8P**) to CPT Category II code **3130F** or **3132F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

- **8P**: Referral for or completion of an upper gastrointestinal endoscopy was not documented, reason not otherwise specified

AND

CPT II 1071F: Alarm symptoms (involuntary weight loss, dysphagia, or gastrointestinal bleeding) assessed; one or more present

DENOMINATOR:

All patients aged 18 years and older with a diagnosis of GERD, seen for an initial evaluation, with documentation of at least one alarm symptom (*involuntary weight loss, dysphagia, or GI bleeding*)

Denominator Coding:

An ICD-9 diagnosis code for GERD and a CPT E/M service code are required to identify patients for denominator inclusion.

ICD-9 diagnosis codes: 530.10, 530.11, 530.12, 530.19, 530.81

AND

CPT E/M service codes: 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245

RATIONALE:

This measure addresses the issue of when to perform an upper endoscopy by assessing whether an upper endoscopy was done for a patient with at least one alarm symptom. Alarm symptoms could indicate cancer, and further imaging is needed to rule out the diagnosis of cancer or other conditions.

CLINICAL RECOMMENDATION STATEMENTS:

Further diagnostic testing (including upper endoscopy, proton pump inhibitor (PPI) trial, ambulatory pH monitoring, or other tests) is recommended in the following:

- Patients with *alarm symptoms* (referral for further testing should be immediate). Alarm symptoms are those that suggest cancer. Alarm symptoms include dysphagia, odynophagia, weight loss, hematemesis, black or bloody stools, chest pain, or choking (acid reflux causing coughing, hoarseness, or shortness of breath). (VHA,2003)

Send patients with dyspepsia plus one of the following alarm features for urgent endoscopic evaluation. Suggested time frames for the urgency of endoscopy are provided with each of the alarm features listed. (ICSI) (Class A, C)

- Melena (*within 1 day if ill*)
- Hematemesis (*within 1 day if ill*)
- Persistent vomiting (*7-10 days*)
- Anemia (*7-10 days*)
- Acute onset of total dysphagia (*within 1 day*)
- Weight loss greater than 5% (involuntary) (*7-10 days*)

***Measure #62: Gastroesophageal Reflux Disease (GERD): Biopsy for Barrett's Esophagus**

DESCRIPTION:

Percentage of patients aged 18 years and older with a diagnosis of GERD or heartburn whose upper endoscopy report indicates a suspicion of Barrett's esophagus who had a forceps esophageal biopsy performed

INSTRUCTIONS:

This measure is to be reported each time an upper endoscopy is performed during the reporting period for patients with a diagnosis of GERD or heartburn. Patients with a diagnosis of GERD or heartburn, and whose endoscopy report indicates suspicion of Barrett's esophagus should have a forceps esophageal biopsy performed. It is anticipated that clinicians who perform the upper endoscopy will submit this measure.

This measure can be reported using CPT Category II codes:

ICD-9 diagnosis codes, CPT procedure codes, and patient demographics (age, gender, etc.) 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, submit the listed ICD-9 diagnosis codes, CPT procedure 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- reasons not otherwise specified.

NUMERATOR:

Patients who had a forceps esophageal biopsy performed

Numerator Coding:

Esophageal Biopsy Performed

CPT II 3150F: Forceps esophageal biopsy performed

AND

CPT II 3140F: Upper gastrointestinal endoscopy report indicates suspicion of Barrett's esophagus

OR

Esophageal Biopsy not Performed for Medical Reasons

Append a modifier (**1P**) to CPT Category II codes **3150F** to report documented circumstances that appropriately exclude patients from the denominator.

- **1P:** Documentation of medical reason(s) for not performing an esophageal biopsy

AND

CPT II 3140F: Upper gastrointestinal endoscopy report indicates suspicion of Barrett's esophagus

OR

If patient does not meet denominator inclusion because there is no suspicion of Barrett's esophagus, report:

CPT II 3141F: Upper gastrointestinal endoscopy report indicates no suspicion of Barrett's esophagus

OR

Esophageal Biopsy not Performed, Reason Not Specified

Append a reporting modifier (**8P**) to CPT Category II code **3150F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

- **8P:** Forceps esophageal biopsy not performed, reason not otherwise specified

AND

CPT II 3140F: Upper gastrointestinal endoscopy report indicates suspicion of Barrett's esophagus

DENOMINATOR:

All patients aged 18 years and older with a diagnosis of GERD or heartburn whose upper endoscopy report indicates a suspicion of Barrett's esophagus

Denominator Coding:

An ICD-9 diagnosis code to identify patients with GERD or heartburn and a CPT procedure code for upper endoscopy are required for denominator inclusion.

ICD-9 diagnosis codes: 530.10, 530.11, 530.12, 530.19, 530.81, 787.1

AND

CPT procedure codes: 43200, 43201, 43202, 43216, 43217, 43228, 43234, 43235, 43236, 43239, 43250, 43251, 43258

RATIONALE:

The official diagnosis of Barrett's esophagus is made by a pathologist. Therefore, if Barrett's esophagus is suspected upon endoscopic examination, a biopsy should be performed by the endoscopist and sent to pathology for diagnosis.

CLINICAL RECOMMENDATION STATEMENTS:

Endoscopy is the technique of choice used to identify suspected Barrett's esophagus and to diagnose complications of GERD. Biopsy must be added to confirm the presence of Barrett's epithelium and to evaluate for dysplasia. (ACG, 2005) (Level III)

***Measure #63: Gastroesophageal Reflux Disease (GERD): Barium Swallow- Inappropriate Use**

DESCRIPTION:

Percentage of patients aged 18 years and older with a diagnosis of GERD, seen for an initial evaluation, who did not have a barium swallow test ordered

INSTRUCTIONS:

This measure is to be reported once for all GERD patients seen during the reporting period. Patients being seen for an initial evaluation of GERD should not receive a barium swallow test. If the initial evaluation of GERD occurred prior to the reporting period, report the proper CPT Category II with modifier indicated in the numerator coding indicating this is not the initial evaluation. It is anticipated that clinicians who provide care for patients with GERD will submit this measure.

This measure can be reported using CPT Category II codes:

ICD-9 diagnosis codes, CPT E/M service codes, and patient demographics (age, gender, etc.) 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, submit the listed ICD-9 diagnosis codes, CPT E/M service 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.

NUMERATOR:

Patients who did not have a barium swallow test ordered.

Numerator Instructions: This is an overuse measure. For performance, the numerator will be calculated as the difference between patients in the denominator and patients for whom a CPT Category II code was reported for barium swallow test *ordered*. A higher score indicates appropriate treatment of patients with GERD (i.e., the proportion for whom a barium swallow test *was not* ordered).

Numerator Coding:

Barium Swallow Test *Ordered*

CPT II 3142F: Barium swallow test ordered

OR

Barium Swallow Test *Ordered* for Medical Reasons

Append a modifier (**1P**) to CPT Category II code **3142F** to report documented circumstances that appropriately exclude patients from the denominator.

- **1P:** Documentation of medical reason(s) for ordering a barium swallow test

OR

If patient does not meet denominator inclusion because the initial evaluation of GERD occurred prior to the reporting period, report:

Append a reporting modifier (**8P**) to CPT Category II code **3200F** to report that this visit is not the initial evaluation of GERD

OR

Barium Swallow Test not Ordered

CPT II 3200F: Barium swallow test not ordered

DENOMINATOR:

All patients aged 18 years and older seen for an initial evaluation of GERD

Denominator Coding:

An ICD-9 diagnosis code to identify patients with a diagnosis of GERD and a CPT E/M service code are required for denominator inclusion.

ICD-9 diagnosis codes: 530.10, 530.11, 530.12, 530.19, 530.81

AND

CPT E/M service codes: 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245

RATIONALE:

This measure was written as an avoidance measure so that the performance goal is 100%, consistent with the other measures.

CLINICAL RECOMMENDATION STATEMENTS:

Barium radiology has limited usefulness in the diagnosis of GERD and thus is not recommended. (UMHS, 2002) (Grade B)

▲Measure #64: Asthma Assessment

DESCRIPTION:

Percentage of patients aged 5 through 40 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 seen during the reporting period. It is anticipated that clinicians who provide primary care services for the patient with a diagnosis of asthma will submit this measure.

This measure can be reported using CPT Category II codes:

ICD-9 diagnosis codes, CPT E/M service codes, and patient demographics (age, gender, etc.) 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, submit the listed ICD-9 diagnosis codes, CPT E/M service 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- reasons not otherwise specified. There are no allowable performance exclusions for this measure.

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 Coding:

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.

- **8P:** Asthma symptoms not evaluated (includes physician documentation of numeric frequency of symptoms or patient completion of an asthma assessment tool/survey/questionnaire), reason not otherwise specified

DENOMINATOR:

All patients aged 5-40 years with a diagnosis of asthma

Denominator Coding:

An ICD-9 diagnosis code for asthma and a CPT E/M service code are required to identify patients for denominator inclusion.

ICD-9 diagnosis codes: 493.00, 493.01, 493.02, 493.10, 493.11, 493.12, 493.20, 493.21, 493.22, 493.81, 493.82, 493.90, 493.92

AND

CPT E/M service codes: 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99383, 99384, 99385, 99386, 99393, 99394, 99395, 99396, 99401, 99402, 99403, 99404

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)

◆Measure #65: Appropriate Treatment for Children with Upper Respiratory Infection (URI)

DESCRIPTION:

Percentage of children aged 3 months through 18 years with a diagnosis of upper respiratory infection (URI) who were not dispensed an antibiotic prescription on or 3 days after the episode date

INSTRUCTIONS:

This measure is to be reported once for each occurrence of upper respiratory infection during the reporting period. It is anticipated that clinicians who provide care to all patients 3 months–18 years of age with a diagnosis of upper respiratory infection would have documentation of having appropriate treatment will submit this measure.

This measure can be reported using CPT Category II codes:

ICD-9 diagnosis codes, CPT E/M service codes, and patient demographics (age, etc.) 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, submit the listed ICD-9 diagnosis codes, CPT E/M service 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.

NUMERATOR:

Patients who were dispensed an antibiotic prescription on or three days after the episode date

Numerator Instructions: For performance, the numerator will be calculated as the difference between patients in the denominator and patients for whom a CPT Category II code was reported for antibiotic prescribed or dispensed. A higher score indicates appropriate treatment of children with URI (eg., the proportion for whom antibiotics *were not* prescribed).

Numerator Coding:

Antibiotic Prescribed or Dispensed

CPT II 4120F: Antibiotic prescribed or dispensed

OR

Antibiotic Prescribed or Dispensed for Medical Reasons

Append a modifier (**1P**) to CPT Category II code **4124F** to report documented circumstances that appropriately exclude patients from the denominator.

- **1P:** Documentation of medical reason(s) for prescribing or dispensing antibiotic

OR

Antibiotic not Prescribed or Dispensed

CPT II 4124F: Antibiotic neither prescribed nor dispensed

DENOMINATOR:

All patients aged 3 months–18 years with a diagnosis of upper respiratory infection

Denominator Coding:

An ICD-9 diagnosis code to identify patients with a diagnosis of upper respiratory infection (URI) and a CPT E/M service code for an outpatient visit are required for denominator inclusion.

ICD-9 diagnosis codes: 460, 465.0, 465.8, 465.9

AND

CPT E/M service codes: 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99217, 99218, 99219, 99220, 99241, 99242, 99243, 99244, 99245, 99382, 99383, 99384, 99385, 99392, 99393, 99394, 99395, 99401, 99402, 99403, 99404, 99411, 99412, 99420, 99429, 99499

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.

◆Measure #66: Appropriate Testing for Children with Pharyngitis

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. This measure is intended to reflect the quality of services provided for the primary management of patients with pharyngitis and were dispensed an antibiotic. It is anticipated that clinicians who provide care to all patients 2 through 18 years of age with a diagnosis of pharyngitis will submit this measure.

This measure can be reported using CPT Category II codes:

ICD-9 diagnosis codes, CPT E/M service codes, and patient demographics (age, gender, etc.) 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, submit the listed ICD-9 diagnosis codes, CPT E/M service 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- reasons not otherwise specified.

NUMERATOR:

Patients who were dispensed an antibiotic and who received a group A streptococcus (strep) test for the episode

Numerator Coding:

Group A Streptococcus Test Performed and Antibiotic Prescribed

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

Append a modifier (**1P**) to CPT Category II codes **3210F** to report documented circumstances that appropriately exclude patients from the denominator.

- **1P:** Documentation of medical reason(s) for not Performing Group A Strep Test

AND

CPT II 4120F: Antibiotic prescribed or dispensed

OR

If patient does not meet denominator inclusion because patient was not prescribed antibiotics, report:

CPT II 4124F: Antibiotic neither prescribed nor dispensed

OR

Group A Streptococcus test not Performed, Reason Not Specified

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.

- **8P**: Group A Strep Test not Performed, reason not otherwise specified

AND

CPT II 4120F: Antibiotic prescribed or dispensed

DENOMINATOR:

All patients aged 2–18 years with a diagnosis of pharyngitis

Denominator Coding:

An ICD-9 diagnosis code to identify patients with a diagnosis of pharyngitis and a CPT E/M service code for an outpatient visit are required for denominator inclusion.

ICD-9 diagnosis codes: 034.0, 462, 463

AND

CPT E/M service codes: 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99217, 99218, 99219, 99220, 99241, 99242, 99243, 99244, 99245, 99382, 99383, 99384, 99385, 99392, 99393, 99394, 99395, 99401, 99402, 99403, 99404, 99411, 99412, 99420, 99429, 99499

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)

♣Measure #67: Myelodysplastic Syndrome (MDS) and Acute Leukemias: Baseline Cytogenetic Testing Performed on Bone Marrow

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.

This measure can be reported using CPT Category II codes:

ICD-9 diagnosis codes, CPT E/M service codes, and patient demographics (age, gender, etc.) 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, submit the listed ICD-9 diagnosis codes, CPT E/M service 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- reasons not otherwise specified.

NUMERATOR:

Patients who had baseline cytogenetic testing performed on bone marrow

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

Numerator Coding:

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.

- **1P:** Documentation of medical reason(s) for not performing baseline cytogenetic testing on bone marrow (e.g., no liquid bone marrow or fibrotic marrow)
- **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)

- **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.

- **8P:** Cytogenetic testing not performed on bone marrow at time of diagnosis or prior to initiating treatment, reason not otherwise specified

DENOMINATOR:

All patients aged 18 years and older with a diagnosis of MDS or an acute leukemia

Denominator Coding:

An ICD-9 diagnosis code to identify patients with a diagnosis of Myelodysplastic Syndrome (MDS) or acute leukemias (not in remission) and a CPT E/M service code are required for denominator inclusion.

ICD-9 diagnosis codes: 204.00, 205.00, 206.00, 207.00, 207.20, 208.00, 238.72, 238.73, 238.74, 238.75

AND

CPT E/M service codes: 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245

RATIONALE:

For MDS:

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

For acute leukemias:

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

CLINICAL RECOMMENDATION STATEMENTS:

For MDS:

Bone marrow aspiration 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)

♣Measure #68: Myelodysplastic Syndrome (MDS): Documentation of Iron Stores in Patients Receiving Erythropoietin Therapy

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 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.

This measure can be reported using CPT Category II codes:

ICD-9 diagnosis codes, CPT E/M service codes, and patient demographics (age, gender, etc.) 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, submit the listed ICD-9 diagnosis codes, CPT E/M service 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: 3P- system reasons, 8P- reasons not otherwise specified.

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
- For the purpose of this measure erythropoietin therapy includes the following medications: epoetin and darbepoetin

Numerator Coding:

Documentation of Iron Stores Prior to Initiating Erythropoietin Therapy Performed

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

Append a modifier (**3P**) to CPT Category II code **3160F** to report documented circumstances that appropriately exclude patients from the denominator.

- **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 does not meet denominator inclusion because patient is not receiving erythropoietin therapy, report:

CPT II 4095F: Patient not receiving erythropoietin therapy

OR

Documentation of Iron Stores Prior to Initiating Erythropoietin Therapy not Performed, Reason Not Specified

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.

- **8P:** Iron stores prior to initiating erythropoietin therapy not documented, reason not otherwise specified

AND

CPT II 4090F: Patient receiving erythropoietin therapy

Denominator:

All patients aged 18 years and older with a diagnosis of MDS who are receiving erythropoietin therapy

Denominator Coding:

An ICD-9 diagnosis code to identify patients with a diagnosis of Myelodysplastic Syndrome (MDS) and a CPT E/M service code are required for denominator inclusion.

ICD-9 diagnosis codes: 238.72, 238.73, 238.74, 238.75

AND

CPT E/M service codes: 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245

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 hypoproliferative 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)

♣Measure #69: Multiple Myeloma: Treatment with Bisphosphonates

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 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 services for the patients with the diagnosis of multiple myeloma will submit this measure.

This measure can be reported using CPT Category II codes:

ICD-9 diagnosis codes, CPT E/M service codes, and patient demographics (age, gender, etc.) 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, submit the listed ICD-9 diagnosis codes, CPT E/M service 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- reasons not otherwise specified.

NUMERATOR:

Patients who were prescribed or received intravenous bisphosphonate therapy within 12 months

Definition: For the purpose of this measure bisphosphonate therapy includes the following medications: pamidronate and zoledronate

Numerator Coding:

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.

- **1P:** Documentation of medical reason(s) for not prescribing bisphosphonates
- **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.

- **8P:** Bisphosphonate therapy, intravenous, not ordered or received, reason not otherwise specified

DENOMINATOR:

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

Denominator Coding:

An ICD-9 diagnosis code to identify patients with a diagnosis of Multiple Myeloma (MM) and a CPT E/M service code are required for denominator inclusion.

ICD-9 diagnosis code: 203.00

AND

CPT E/M service codes: 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245

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)

♣Measure #70: Chronic Lymphocytic Leukemia (CLL) : Baseline Flow Cytometry

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.

This measure can be reported using CPT Category II codes:

ICD-9 diagnosis codes, CPT E/M service codes, and patient demographics (age, gender, etc.) 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, submit the listed ICD-9 diagnosis codes, CPT E/M service 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- reasons not otherwise specified.

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 Coding:

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.

- **1P:** Documentation of medical reason(s) for not performing baseline flow cytometry studies
- **2P:** Documentation of patient reason(s) for not performing baseline flow cytometry studies
- **3P:** Documentation of system reason(s) for not performing baseline flow cytometry studies

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.

- **8P:** Flow cytometry studies not performed at time of diagnosis or prior to initiating treatment, reason not otherwise specified

DENOMINATOR:

All patients aged 18 years and older with a diagnosis of CLL

Denominator Coding:

An ICD-9 diagnosis code to identify patients with a diagnosis of chronic lymphocytic leukemia (not in remission) and a CPT E/M service code are required for denominator inclusion.

ICD-9 diagnosis code: 204.10

AND

CPT E/M service codes: 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245

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)

Measure #71: Hormonal Therapy for Stage IC-III, ER/PR Positive Breast Cancer

DESCRIPTION:

Percentage of Stage IC-III, estrogen receptor (ER) or progesterone receptor (PR) positive, female breast cancer patients aged 18 years and older who are receiving tamoxifen or aromatase inhibitor (AI) at the time of the visit

INSTRUCTIONS:

This measure is to be reported a minimum of once per reporting period for all female breast cancer patients seen during the reporting period. It is anticipated that clinicians who treat patients with breast cancer will submit this measure. The reporting clinician is not required to have written the initial prescription.

This measure is reported using G-codes:

ICD-9 diagnosis codes, CPT E/M service codes, and patient demographics (age, gender, etc..) 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, submit the listed ICD-9 diagnosis codes, CPT E/M service codes, and the appropriate G-code.

NUMERATOR:

Patients receiving tamoxifen or AIs and have Stage 1C-III, ER/PR positive breast cancer

Numerator Coding:

Tamoxifen or Aromatase Inhibitor Documented or Prescribed

G8381: For patients with ER or PR positive, Stage IC-III breast cancer, clinician documented or prescribed that the patient is receiving tamoxifen or aromatase inhibitor

OR

Tamoxifen or Aromatase Inhibitor not Documented or Prescribed for Documented Reasons

G8376: Clinician documentation that breast cancer patient was not eligible for tamoxifen or aromatase inhibitor therapy measure

OR

Tamoxifen or Aromatase Inhibitor not Documented or Prescribed

G8380: For patients with ER or PR positive, Stage IC-III breast cancer, clinician did not document that the patient received or was prescribed tamoxifen or aromatase inhibitor

DENOMINATOR:

All female patients aged 18 years and older with breast cancer

Denominator Coding:

An ICD-9 diagnosis code to identify patients with a diagnosis of breast cancer and a CPT E/M service code are required for denominator inclusion.

ICD-9 diagnosis codes: 174.0, 174.1, 174.2, 174.3, 174.4, 174.5, 174.6, 174.8, 174.9

AND

CPT E/M service codes: 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99218, 99219, 99220, 99221, 99222, 99223, 99231, 99232, 99233, 99234, 99235, 99236, 99241, 99242, 99243, 99244, 99245, 99251, 99252, 99253, 99254, 99255

RATIONALE:

Based on results from multiple large randomized trials, adjuvant therapy for women with hormone receptor-positive breast cancer should include hormonal therapy in order to lower the risk of tumor recurrence.

CLINICAL RECOMMENDATION STATEMENTS:

American Society of Clinical Oncology, *Use of Aromatase Inhibitors As Adjuvant Therapy for Postmenopausal Women With Hormone Receptor-Positive Breast Cancer*

<http://www.asco.org/portal/site/ASCO/menuitem.c543a013502b2a89de912310320041a0/?vgnextoid=e64ef314170d8010VgnVCM100000ed730ad1RCRD&vgnnextfmt=default>

National Comprehensive Cancer Network *Breast Cancer* guideline recommendations for stage IC-III, ER/PR positive cancer: BINV-G, BINV-5, BINV-6, BINV-9.

http://www.nccn.org/professionals/physician_gls/default.asp

Measure #72: Chemotherapy for Stage III Colon Cancer Patients

DESCRIPTION:

Percentage of stage III colon cancer patients aged 18 through 80 years who were prescribed chemotherapy

INSTRUCTIONS:

This measure is to be reported once per reporting period for all colon cancer patients seen during the reporting period. It is anticipated that clinicians who treat patients with colon cancer will submit this measure. Neoadjuvant and adjuvant chemotherapy should be reported. The reporting clinician is not required to have written the initial prescription; 'prescribed' can include managing treatment started by another clinician.

This measure is reported using G-codes:

ICD-9 diagnosis codes, CPT E/M service codes, and patient demographics (age, gender, etc..) 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, submit the listed ICD-9 diagnosis codes, CPT E/M service codes, and the appropriate G-code.

NUMERATOR:

Patients who received chemotherapy and have Stage III colon cancer

Numerator Coding:

Chemotherapy Documented as Received or Prescribed

G8372: Chemotherapy documented as received or prescribed for Stage III colon cancer patients

OR

Chemotherapy not Documented as Received or Prescribed for Documented Reasons

G8377: Clinician documentation that colon cancer patient is not eligible for the chemotherapy measure

OR

Chemotherapy not Documented as Received or Prescribed

G8371: Chemotherapy documented as not received or prescribed for Stage III colon cancer patients

DENOMINATOR:

All patients aged 18 to 80 years with colon cancer

Denominator Coding:

An ICD-9 diagnosis code to identify patients with a diagnosis of colon cancer and a CPT E/M service code are required for denominator inclusion.

ICD-9 diagnosis codes: 153.0, 153.1, 153.2, 153.3, 153.4, 153.5, 153.6, 153.7, 153.8, 153.9

AND

CPT E/M service codes: 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99218, 99219, 99220, 99221, 99222, 99223, 99231, 99232, 99233, 99234, 99235, 99236, 99241, 99242, 99243, 99244, 99245, 99251, 99252, 99253, 99254, 99255

RATIONALE:

Direct evidence from randomized controlled trials supports the use of adjuvant chemotherapy for patients with stage III colon cancer.

CLINICAL RECOMMENDATION STATEMENTS:

National Comprehensive Cancer Network *Colon Cancer* guideline recommendations for stage III cancer: COL-4.

http://www.nccn.org/professionals/physician_gls/default.asp

Measure #73: Plan for Chemotherapy Documented Before Chemotherapy Administered

DESCRIPTION:

Percentage of cancer patients for whom a plan for the amount of chemotherapy to be given was documented before the chemotherapy was administered

INSTRUCTIONS:

This measure is to be reported once per chemotherapy regimen received for each cancer patient who is administered chemotherapy during the reporting period. It is anticipated that clinicians who treat patients with cancer will submit this measure.

This measure is reported using G-codes:

ICD-9 diagnosis codes, CPT E/M service codes, CPT procedure codes, and patient demographics (age, gender, etc..) 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, submit the listed ICD-9 diagnosis codes, CPT E/M service codes, CPT procedure codes, and the appropriate G-code. There are no allowable exclusions for this measure.

NUMERATOR:

Patients for whom a chemotherapy plan is documented

Definition: A plan for the amount of chemotherapy to be given must include doses and time intervals.

Numerator Coding:

Chemotherapy Plan Documented

G8373: Chemotherapy plan documented prior to chemotherapy administration

OR

Chemotherapy Plan not Documented

G8374: Chemotherapy plan not documented prior to chemotherapy administration

DENOMINATOR:

All cancer patients who were administered IV chemotherapy

Denominator Coding:

An ICD-9 diagnosis code to identify patients with a diagnosis of cancer receiving chemotherapy as indicated by a chemotherapy administration CPT procedure code and a CPT E/M service code are required for denominator inclusion.

ICD-9 diagnosis codes: 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, 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, 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, 200.80, 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, 202.80, 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, 203.10, 203.11, 203.80, 203.81, 204.00, 204.01, 204.10, 204.11, 204.20, 204.21, 204.80, 204.81, 204.90, 204.91, 205.00, 205.01, 205.10, 205.11, 205.20, 205.21, 205.30, 205.31, 205.80, 205.81, 205.90, 205.91, 206.00, 206.01, 206.10, 206.11, 206.20, 206.21, 206.80, 206.81, 206.90, 206.91, 207.00, 207.01, 207.10, 207.11, 207.20, 207.21, 207.80, 207.81, 208.00, 208.01, 208.10, 208.11, 208.20, 208.21, 208.80, 208.81, 208.90, 208.91, 210.0, 210.1, 210.2, 210.3, 210.4, 210.5, 210.6, 210.7, 210.8, 210.9, 211.0, 211.1, 211.2, 211.3, 211.4, 211.5, 211.6, 211.7, 211.8, 211.9, 212.0, 212.1, 212.2, 212.3, 212.4, 212.5, 212.6, 212.7, 212.8, 212.9, 213.0, 213.1, 213.2, 213.3, 213.4, 213.5, 213.6, 213.7, 213.8, 213.9,

214.0, 214.1, 214.2, 214.3, 214.4, 214.8, 214.9, 215.0, 215.2, 215.3, 215.4, 215.5, 215.6, 215.7, 215.8, 215.9, 216.0, 216.1, 216.2, 216.3, 216.4, 216.5, 216.6, 216.7, 216.8, 216.9, 217, 218.0, 218.1, 218.2, 218.9, 219.0, 219.1, 219.8, 219.9, 220, 221.0, 221.1, 221.2, 221.8, 221.9, 222.0, 222.1, 222.2, 222.3, 222.4, 222.8, 222.9, 223.0, 223.1, 223.2, 223.3, 223.81, 223.89, 223.9, 224.0, 224.1, 224.2, 224.3, 224.4, 224.5, 224.6, 224.7, 224.8, 224.9, 225.0, 225.1, 225.2, 225.3, 225.4, 225.8, 225.9, 226, 227.0, 227.1, 227.3, 227.4, 227.5, 227.6, 227.8, 227.9, 228.00, 228.01, 228.02, 228.03, 228.04, 228.09, 228.1, 229.0, 229.8, 229.9, 230.0, 230.1, 230.2, 230.3, 230.4, 230.5, 230.6, 230.7, 230.8, 230.9, 231.0, 231.1, 231.2, 231.8, 231.9, 232.0, 232.1, 232.2, 232.3, 232.4, 232.5, 232.6, 232.7, 232.8, 232.9, 233.0, 233.1, 233.2, 233.3, 233.4, 233.5, 233.6, 233.7, 233.9, 234.0, 234.8, 234.9, 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, 238.79, 238.8, 238.9, 239.0, 239.1, 239.2, 239.3, 239.4, 239.5, 239.6, 239.7, 239.8, 239.9

AND

CPT procedure codes: 96401, 96402, 96405, 96406, 96409, 96411, 96413, 96415, 96416, 96417, 96420, 96422, 96423, 96425, 96440, 96445, 96450, 96521, 96522, 96523, 96542, 96549

AND

CPT E/M service codes: 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99218, 99219, 99220, 99221, 99222, 99223, 99231, 99232, 99233, 99234, 99235, 99236, 99241, 99242, 99243, 99244, 99245, 99251, 99252, 99253, 99254, 99255

RATIONALE:

A documented plan for chemotherapy treatment is important for promoting adherence to evidence based care, improving safety, and enhancing coordination among providers.

CLINICAL RECOMMENDATION STATEMENTS:

Data from the NICCQ study and QOPI demonstrate room for improvement in chemotherapy planning documentation prior to chemotherapy administration.

- NICCQ: Malin JL SE, Epstein AM, Adams J, Emanuel EJ, Kahn, K: Results of the National Initiative for Cancer Care Quality: How can we improve the quality of cancer care in the United States. J Clin Oncol 24:626-634, 2006
<http://www.jco.org/cgi/content/abstract/24/4/626>
- Breast cancer: chemotherapy treatment plan documented 63% overall, range 44-78% across 5 MSAs
- Colon cancer: chemotherapy treatment plan documented 53% overall, range 50-71% across 5 MSAs

Measure #74: Radiation Therapy Recommended for Invasive Breast Cancer Patients Who Have Undergone Breast Conserving Surgery

DESCRIPTION:

Percentage of invasive female breast cancer patients aged 18 through 70 years old who have undergone breast conserving surgery and who have received recommendation for radiation therapy within 12 months of the first office visit

INSTRUCTIONS:

This measure is to be reported a minimum once per reporting period for female breast cancer patients at the time of the initial office visit. It is anticipated that clinicians who care for patients with invasive breast cancer and radiation therapy will submit this measure.

This measure is reported using G-codes:

ICD-9 diagnosis codes, CPT E/M service codes, and patient demographics (age, gender, etc.) 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, submit the appropriate ICD-9 diagnosis codes, CPT E/M service codes, and the appropriate G-code.

NUMERATOR:

Female patients with invasive breast cancer patients aged 18 to 70 years old who have undergone breast conserving surgery and who then receive recommendation for radiation therapy within 12 months of the first office visit.

Numerator Instruction: The numerator code should be reported at the time of radiation therapy services.

Definitions: Radiation therapy may include external beam radiation or brachytherapy.

Numerator Coding:

Radiation Therapy Recommended

G8379: Documentation of radiation therapy recommended within 12 months of first office visit

OR

Radiation Therapy not Recommended for Documented Reasons

G8378: Clinician documentation that patient was not an eligible candidate for radiation therapy measure

OR

Radiation Therapy not Recommended

G8383: No documentation of radiation therapy recommended within 12 months of first office visit

DENOMINATOR:

All female patients aged 18 to 70 years with invasive breast cancer

Denominator Coding:

An ICD-9 diagnosis code to identify patients with a diagnosis of invasive breast cancer and a CPT E/M service code are required for denominator inclusion.

ICD-9 diagnosis codes: 174.0, 174.1, 174.2, 174.3, 174.4, 174.5, 174.6, 174.8, 174.9

AND

CPT E/M service codes: 99241, 99242, 99243, 99244, 99245

RATIONALE:

Data from multiple large randomized trials have demonstrated that the addition of radiation after breast conserving surgery in patients with invasive breast cancer lowers the risk of local recurrence. The Oxford meta-analysis of these studies (Peto, et. al., Lancet, 2006) has also detected an improvement in overall survival with the use of radiation therapy in this setting.

CLINICAL RECOMMENDATION STATEMENTS:

National Comprehensive Cancer Network *Breast Cancer* guideline recommendations v2.2006, BINV-2. http://www.nccn.org/professionals/physician_gls/default.asp

The National Quality Forum is in the process of approving the National Voluntary Consensus Standards for Diagnosis and Treatment of Breast and Colon Cancer which includes a measure at the facility level for radiation therapy for patients who have had breast conserving surgery for accountability purposes.

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