2008 Physician Quality Reporting Initiative
Specifications Document

This document contains the complete specifications for the 119 measures that make up the 2008 Physician Quality Reporting Initiative (PQRI). Each measure is assigned a unique number. Measure numbers for 2008 PQRI represent a continuation in numbering from the 2007 PQRI Measures 1 through 74. Gaps in measure numbering reflect those 2007 PQRI measures that are not included for implementation in 2008 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. These specifications will be updated prior to the beginning of the 2008 PQRI reporting period to reflect any additional edits.

The denominator population is defined by certain ICD-9 and CPT Category I codes specified in the measure that are submitted by eligible professionals as part of a claim for covered services under the Medicare Physician Fee Schedule. Some measure coding specifications are adapted as needed for implementation in PQRI in agreement with the measure developer. For example, CPT codes for non-covered services such as preventive visits are not included in the denominator. 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 such as 1P, 2P, or 3P are available to describe medical, patient, system, or other reasons for such exclusion. Where the performance exclusion does not apply, a measure-specific CPT Category II modifier 8P or HCPCS G-code may be used to indicate that the process of care was not provided for a reason not otherwise specified.

To successfully report quality data for a measure under the PQRI program, it is necessary in all circumstances to report numerator coding (CPT Category II code and/or G-code), with or without an applicable CPT Category II code modifier (1P, 2P, 3P, or 8P). 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 or evidence forming the basis or supporting criteria for the measure

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

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

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

This measure is 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 Level > 9.0%
CPT II 3046F: Most recent hemoglobin A1c level > 9.0%

OR

If patient is not eligible for this measure because hemoglobin A1c not performed, report:
Hemoglobin A1c not Performed
Append a reporting modifier (**8P**) to CPT Category II code **3046F** to report circumstances when the patient is not eligible for the measure.

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

OR

Most Recent Hemoglobin A1c Level ≤ 9.0%
CPT II 3044F: Most recent hemoglobin A1c (HbA1c) level < 7.0%
OR
CPT II 3045F: Most recent hemoglobin A1c (HbA1c) level 7.0 to 9.0%

DENOMINATOR:
Patients aged 18 through 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 ≤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 mellitus who had most recent LDL-C level in control (less than 100 mg/dl)

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

This measure is 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 Level < 100 mg/dL
CPT II 3048F: Most recent LDL-C < 100 mg/dL

OR

If patient is not eligible for this measure because LDL-C level not performed, report:
LDL-C Level not Performed
Append a reporting modifier (**8P**) to CPT Category II code **3048F** to report circumstances when the patient is not eligible for the measure.

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

OR

Most Recent LDL-C Level ≥ 100 mg/dL
CPT II 3049F: Most recent LDL-C 100-129 mg/dL
OR
CPT II 3050F: Most recent LDL-C ≥ 130 mg/dL

DENOMINATOR:
Patients aged 18 through 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 mellitus who had most recent blood pressure in control (less than 140/80 mmHg)

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

This measure is 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 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 mmHg

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

Numerator Coding:
Most Recent Blood Pressure Measurement < 140/80 mmHg
Systolic codes
CPT II 3074F: Most recent systolic blood pressure < 130 mmHg
OR
CPT II 3075F: Most recent systolic blood pressure 130 - 139 mmHg
AND
Diastolic code
CPT II 3078F: Most recent diastolic blood pressure less than 80 mmHg
OR

If patient is not eligible for this measure because blood pressure measurement not performed, report:
Blood Pressure Measurement not Performed
Append a reporting modifier (**8P**) to CPT Category II code **2000F** to report circumstances when the patient is not eligible for the measure.

- **8P:** No documentation of blood pressure measurement

OR

Most Recent Blood Pressure Measurement includes a Systolic Value ≥ 140 mmHg
Systolic code
CPT II 3077F: Most recent systolic blood pressure greater than or equal to 140 mmHg
AND
Diastolic codes
CPT II 3078F: Most recent diastolic blood pressure less than 80 mmHg
OR
CPT II 3079F: Most recent diastolic blood pressure 80 - 89 mmHg
OR
CPT II 3080F: Most recent diastolic blood pressure greater than or equal to 90 mmHg

OR

Most Recent Blood Pressure Measurement includes a Diastolic Value ≥ 80 mmHg
Diastolic codes
CPT II 3079F: Most recent diastolic blood pressure 80 - 89 mmHg
OR
CPT II 3080F: Most recent diastolic blood pressure greater than or equal to 90 mmHg
AND
Systolic codes
CPT II 3074F: Most recent systolic blood pressure < 130 mmHg
OR
CPT II 3075F: Most recent systolic blood pressure 130 - 139 mmHg
OR
CPT II 3077F: Most recent systolic blood pressure greater than or equal to 140 mmHg

DENOMINATOR:
Patients aged 18 through 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: 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. There is no diagnosis associated with this measure. This measure is appropriate for use in all non-acute settings (excludes emergency departments and acute care hospitals). This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

This measure is reported using CPT Category II codes:
CPT 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 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 2 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 report 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 code is required to identify patients for denominator inclusion.
CPT 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

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 patients with heart failure and decreased left ventricular systolic function. The left ventricular systolic dysfunction may be determined by quantitative or qualitative assessment, which may be current or historical. Examples of a quantitative or qualitative assessment may include an echocardiogram: 1) that provides a numerical value of left ventricular systolic dysfunction or 2) that uses descriptive terms such as moderately or severely depressed left ventricular dysfunction. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

This measure is 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(s) **OR** the CPT Category II code(s) **with** the modifier. The modifiers allowed for this measure are: 1P- medical reasons, 2P- patient reasons, 3P- system reasons, 8P- reasons not otherwise specified.

NUMERATOR:
Patients who were prescribed ACE inhibitor or ARB therapy

> **Definition:** "Prescribed" includes patients who are currently receiving medication(s) that follow the treatment plan recommended at an encounter during the reporting period, even if the prescription for that medication was ordered prior to the encounter.
>
> ***NUMERATOR NOTE:*** *The correct combination of numerator codes must be reported on the claim form in order to properly report this measure. The "correct combination" of codes may require the submission of multiple numerator codes.*

Numerator Coding:

ACE Inhibitor or ARB Therapy Prescribed

(Two CPT II codes [4009F & 3021F] are required on the claim form to submit this category)

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

(Two CPT II codes [4009F-1P & 3021F] are required on the claim form to submit this category)

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

- **4009F *with* 1P:** Documentation of medical reason(s) for not prescribing angiotensin converting enzyme (ACE) inhibitor or angiotensin receptor blocker (ARB) therapy
- **4009F *with* 2P:** Documentation of patient reason(s) for not prescribing angiotensin converting enzyme (ACE) inhibitor or angiotensin receptor blocker (ARB) therapy
- **4009F *with* 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 is not eligible for this measure because LVEF ≥ 40% or LVEF not performed or documented, report:

Left Ventricular Ejection Fraction (LVEF) ≥ 40%

(One CPT II code [3022F] is required on the claim form to submit this category)

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

(One CPT II code [3021F-8P] is required on the claim form to submit this category)

Append a reporting modifier (**8P**) to CPT Category II code **3021F** to report circumstances when the patient is not eligible for the measure.

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

OR

ACE Inhibitor or ARB Therapy not Prescribed, Reason Not Specified
(Two CPT II codes [4009F-8P & 3021F] are required on the claim form to submit this category)

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.

- **4009F *with* 8P:** Angiotensin converting enzyme (ACE) inhibitor or angiotensin receptor blocker (ARB) therapy was 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 with coronary artery disease seen during the reporting period. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

This measure is 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

> **Definition:** "Prescribed" includes patients who are currently receiving medication(s) that follow the treatment plan recommended at an encounter during the reporting period, even if the prescription for that medication was ordered prior to the encounter.
>
> **Numerator 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) was 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 with prior myocardial infarction (MI) seen during the reporting period. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

This measure is 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

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

Numerator 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 for coronary artery disease* and myocardial infarction and a CPT E/M service code are required to identify patients 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 ß-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 ß-adrenoceptor blocker therapy. Survivors of non-ST-elevation MI. Class IIb – Patients with moderate or severe LV failure or other relative contraindications to ß-adrenoceptor blocker therapy, provided they can be monitored closely. (ACC/AHA)

Although no study has determined if long-term ß-adrenoceptor blocker therapy should be administered to survivors of MI who subsequently have 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 patients with heart failure and decreased left ventricular systolic function. The left ventricular systolic dysfunction may be determined by quantitative or qualitative assessment, which may be current or historical. Examples of a quantitative or qualitative assessment may include an echocardiogram: 1) that provides a numerical value of left ventricular systolic dysfunction or 2) that uses descriptive terms such as moderately or severely depressed left ventricular dysfunction. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

This measure is 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 denominator code(s) and the appropriate numerator G-code.

NUMERATOR:
Patients who were prescribed beta-blocker therapy

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

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

OR

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

OR

If patient is not eligible for this measure because LVEF ≥ 40% or LVEF not performed or documented, report:
Left Ventricular Ejection Fraction (LVEF) ≥ 40%
G8395: 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
G8396: Left ventricular ejection fraction (LVEF) not performed or documented

OR

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

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. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

This measure is reported using G-codes:
ICD-9 diagnosis codes, CPT 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 denominator code(s) and the appropriate numerator 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 for MDD and a CPT code are required to identify patients 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, 99241, 99242, 99243, 99244, 99245, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350

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 either a diagnosis of ischemic stroke or transient ischemic attack (TIA) or intracranial hemorrhage or at least one documented symptom consistent with ischemic stroke or TIA or intracranial hemorrhage that includes 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 or symptom 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. NOTE: Use of symptom codes is limited to those specified in the denominator coding.

This measure is reported using CPT Category II codes:
ICD-9 diagnosis and symptom 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 or symptom codes, CPT procedure codes, and the appropriate CPT Category II code(s) **OR** the CPT Category II code(s) **with** the modifier. The reporting modifier allowed for this measure is: 8P- 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 NOTE:*** *The correct combination of numerator codes must be reported on the claim form in order to properly report this measure. The "correct combination" of codes may require the submission of multiple numerator codes.*
>
> **Numerator Coding:**
> **Presence/Absence of Hemorrhage, Mass Lesion, and Acute Infarction Documented**
> *(Two CPT II codes [3110F & 3111F] are required on the claim form to submit this category)*

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 is not eligible for this measure because CT or MRI of the brain was performed greater than 24 hours after arrival to the hospital, report:
(One CPT II code [3112F] is required on the claim form to submit this category)

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
(Two CPT II codes [3110F-8P & 3111F] are required on the claim form to submit this category)

Append a reporting modifier (**8P**) to CPT Category II code **3110F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

- **3110F *with* 8P:** 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 either a diagnosis of ischemic stroke or TIA or intracranial hemorrhage OR at least one documented symptom consistent with ischemic stroke or TIA or intracranial hemorrhage

Denominator Coding:

For purposes of this measure, the listed symptoms will be considered "documented symptoms consistent" with ischemic stroke or TIA or intracranial hemorrhage. Each of the listed symptoms corresponds to a specific ICD-9 code in the code table below. NOTE: Use of symptom codes is limited to the following:

• Transient visual loss (368.12) • Diplopia (double vision) (368.2) • Vertigo of central origin (386.2) • Transient global amnesia (437.7) • Transient alteration of awareness (780.02) • Lack of coordination (781.3)	• Transient paralysis of limb (781.4) • Facial weakness (781.94) • Disturbance of skin sensation (782.0) • Aphasia (784.3) • Slurred speech (784.5)

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

ICD-9 diagnosis and symptom codes: 368.12, 368.2, 386.2, 431, 433.01, 433.11, 433.21, 433.31, 433.81, 433.91, 434.01, 434.11, 434.91, 435.0, 435.1, 435.2, 435.3, 435.8, 435.9, 437.7, 780.02, 781.3, 781.4, 781.94, 782.0, 784.3, 784.5
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 transient ischemic attack (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 is 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 (e.g., 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 for ischemic stroke or TIA and a CPT procedure code for patients undergoing carotid imaging are required to identify patients 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 system 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 is reported using CPT Category II codes:
ICD-9 diagnosis codes, CPT 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 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, 3P-system 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 or System Reasons
Append a modifier (**1P or 3P**) 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
- **3P:** Documentation of system 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 for primary open-angle glaucoma and a CPT code are required to identify patients for denominator inclusion.
ICD-9 diagnosis codes: 365.01, 365.10, 365.11, 365.12, 365.15
AND
CPT 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 #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 system 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 is reported using CPT Category II codes:
ICD-9 diagnosis codes, CPT 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 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 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, Patient, or System Reasons
Append a modifier (**1P, 2P, or 3P**) 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
- **3P:** Documentation of system 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, 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 for age-related macular degeneration and a CPT code are required to identify patients for denominator inclusion.
ICD-9 diagnosis codes: 362.50, 362.51, 362.52
AND
CPT 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 #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 system 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 is reported using CPT Category II codes:
ICD-9 diagnosis codes, CPT 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 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 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, Patient, or System Reasons
Append a modifier (**1P, 2P, or 3P**) 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
- **3P:** Documentation of system 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 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 for diabetic retinopathy and a CPT code are required to identify patients for denominator inclusion.
ICD-9 diagnosis codes: 362.01, 362.02, 362.03, 362.04, 362.05, 362.06
AND
CPT 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 mellitus regarding the findings of the macular or fundus exam at least once within 12 months

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for all patients with diabetic retinopathy seen during the reporting period. It is anticipated that clinicians who provide the primary management of patients with diabetic retinopathy (in either one or both eyes) will submit this measure. The system 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 is reported using CPT Category II codes and/or G-codes:
ICD-9 diagnosis codes, CPT codes, and patient demographics (age, gender, etc.) are used to identify patients who are included in the measure's denominator. CPT Category II and/or G-codes are used to report the numerator of the measure.

When reporting the measure, submit the listed ICD-9 diagnosis codes, CPT codes, and the appropriate CPT Category II code **AND/OR** G-code **OR** the CPT Category II code **with** the modifier **AND** G-code. The modifiers allowed for this measure are: 2P- patient reasons, 3P- system 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 NOTE:*** *The correct combination of numerator codes must be reported on the claim form in order to properly report this measure. The "correct combination" of codes may require the submission of multiple numerator codes.*

Numerator Coding:

Dilated Macular or Fundus Exam Findings Communicated

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

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

AND

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

OR

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

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

Append a modifier (**2P or 3P**) to CPT Category II code **5010F** to report documented circumstances that appropriately exclude patients from the denominator.

- **5010F *with* 2P:** Documentation of patient reason(s) for not communicating the findings of the dilated macular or fundus exam to the physician who manages the ongoing care of the patient with diabetes
- **5010F *with* 3P:** Documentation of system reason(s) for not communicating the findings of the dilated macular or fundus exam to the physician who manages the ongoing care of the patient with diabetes

AND

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

OR

If patient is not eligible for this measure because patient did not have dilated macular or fundus exam performed, report:

(One G-code [G8398] is required on the claim form to submit this category)

G8398: Dilated macular or fundus exam not performed

OR

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

(One CPT II code & one G-code [5010F-8P & G8397] are required on the claim form to submit this category)

Append a reporting modifier (**8P**) to CPT Category II code **5010F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

- **5010F *with* 8P:** Findings of dilated macular or fundus exam was not communicated to the physician managing the diabetes care, reason not otherwise specified

AND

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

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 for diabetic retinopathy and a CPT code are required to identify patients for denominator inclusion.

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

AND

CPT 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. There is no diagnosis associated with this measure. It is anticipated that clinicians who perform the listed surgical procedures as specified in the denominator coding will submit this measure.

This measure is 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. If multiple surgical procedures were performed on the same date of service and submitted on the same claim form, it is not necessary for the same clinician to submit the CPT Category II code with each procedure. However, if multiple NPIs are reporting this measure on the same claim, each NPI should report the quality data code.

When reporting the measure, 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).
>
> > ***Note:*** *In the event surgery is delayed, as long as the patient is redosed (if clinically appropriate) the numerator coding should be applied.*

Numerator Coding:

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

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

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

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, 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, 47720, 47721, 47740, 47741, 47760, 47765, 47780, 47785, 47800, 47802, 47900
Pancreas	48020, 48100, 48120, 48140, 48145, 48146, 48148, 48150, 48152, 48153, 48154, 48155, 48500, 48510, 48511, 48520, 48540, 48545, 48547, 48548, 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, 35211, 35241, 35271

Cardiothoracic (Pacemaker)	33203, 33206, 33207, 33208, 33212, 33213, 33214, 33215, 33216, 33217, 33218, 33220, 33222, 33223, 33224, 33225, 33226, 33233, 33234, 33235, 33236, 33237, 33238, 33240, 33241, 33243, 33244, 33249, 33254, 33255
Genitourinary Surgery	51550, 51555, 51565, 51570, 51575, 51580, 51585, 51590, 51595, 51596, 51920, 51925, 52450, 52601, 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. There is no diagnosis associated with this measure. It is anticipated that clinicians who perform the listed surgical procedures as specified in the denominator coding will submit this measure.

This measure is 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. If multiple surgical procedures were performed on the same date of service and submitted on the same claim form, it is not necessary for the same clinician to submit the CPT Category II code with each procedure. However, if multiple NPIs are reporting this measure on the same claim, each NPI should report the quality data code.

When reporting the measure, 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.*
>
> > ***Note:*** *In the event surgery is delayed, as long as the patient is redosed (if clinically appropriate) the numerator coding should be applied.*
>
> **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 for 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, 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, 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, 48500, 48510, 48511, 48520, 48540, 48545, 48547, 48548, 48550, 48554, 48556
Abdomen, Peritoneum & Omentum	49000, 49002, 49010, 49180, 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, 33305, 33315, 33321, 33322, 33332, 33335, 33400, 33401, 33403, 33404, 33405, 33406, 33410, 33411, 33413, 33416, 33422, 33425, 33426, 33427, 33430, 33460, 33463, 33464, 33465, 33475, 33496, 33510, 33511, 33512, 33513, 33514, 33516, 33517, 33518, 33519, 33521, 33522, 33523, 33530, 33533, 33534, 33535, 33536, 33542, 33545, 33548, 33572, 35211, 35241, 35271, 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. There is no diagnosis associated with this measure. It is anticipated that clinicians who perform the listed surgical procedures as specified in the denominator coding will submit this measure.

This measure is 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. If multiple surgical procedures were performed on the same date of service and submitted on the same claim form, it is not necessary for the same clinician to submit the CPT Category II code with each procedure. However, if multiple NPIs are reporting this measure on the same claim, each NPI should report the quality data code.

When reporting the measure, submit the listed CPT procedure codes and the appropriate CPT Category II code(s) **OR** the CPT Category II code(s) **with** the modifier. The modifiers allowed for this measure are: 1P- medical reasons, 8P- 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 NOTE:*** *The correct combination of numerator codes must be reported on the claim form in order to properly report this measure. The "correct combination" of codes may require the submission of multiple numerator codes.*

Numerator Coding:

Documentation of order for discontinuation of prophylactic antibiotics (written order, verbal order, or standing order/protocol) within 24 hours of surgical end time
(Two CPT II codes [4049F & 4046F] are required on the claim form to submit this category)

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

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

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

AND

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

OR

If patient is not eligible for this measure because patient did not receive prophylactic antibiotics within specified timeframe, report:
(One CPT II code [4042F] is required on the claim form to submit this category)

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

OR

Prophylactic Antibiotics not Discontinued, Reason not Specified
(Two CPT II codes [4049F-8P & 4046F] are required on the claim form to submit this category)

Append a reporting modifier (**8P**) to CPT Category II code **4049F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

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

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

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, 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, 47720, 47721, 47740, 47741, 47760, 47765, 47780, 47785, 47800, 47802, 47900
Pancreas	48020, 48100, 48120, 48140, 48145, 48146, 48148, 48150, 48152, 48153, 48154, 48155, 48500, 48510, 48511, 48520, 48540, 48545, 48547, 48548, 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. There is no diagnosis associated with this measure. It is anticipated that clinicians who perform the listed surgical procedures as specified in the denominator coding will submit this measure.

This measure is 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. If multiple surgical procedures were performed on the same date of service and submitted on the same claim form, it is not necessary for the same clinician to submit the CPT Category II code with each procedure. However, if multiple NPIs are reporting this measure on the same claim, each NPI should report the quality data code.

When reporting the measure, 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.
>
> **Definition:** Mechanical prophylaxis does not include TED hose.
>
> **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, 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, 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

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 <= 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 on-going care that a fracture occurred and that the patient was or should be tested or treated for osteoporosis

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

This measure is 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 on-going 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 on-going 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 for hip, spine or distal radial fracture and a CPT E/M service code or a CPT procedure code are required to identify patients 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 #28: Aspirin at Arrival for Acute Myocardial Infarction (AMI)

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

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

This measure is reported using CPT Category II codes:
ICD-9 diagnosis codes and CPT E/M service codes are used to identify patients who are included in the measure's denominator. CPT Category II codes are used to report the numerator of the measure.

When reporting the measure, 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, regardless of age, with an emergency department discharge diagnosis of acute myocardial infarction

Denominator Coding:

An ICD-9 diagnosis code for acute myocardial infarction and a CPT E/M service code are required to identify patients for denominator inclusion. The Part B claim form place-of-service field must indicate emergency department.

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

AND

Place of Service Indicator: 23

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 #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 with an order for prophylactic antibiotics will submit this measure.

This measure is 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. Only CPT Category II codes are used to report this 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 Instructions: This measure seeks to identify the timely administration of prophylactic antibiotic. This administration should begin within one hour (if fluoroquinolone or vancomycin, two hours) prior to surgical incision.

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

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

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:** Prophylactic 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 for a parenteral antibiotic order is required to identify patients 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. Part B claims data will be analyzed to determine a hospital stay. If multiple qualifying diagnoses are submitted on the same claim form, only one instance of reporting will be counted. It is anticipated that clinicians who care for patients with a diagnosis of ischemic stroke or intracranial hemorrhage in the hospital setting will submit this measure.

This measure is 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 for ischemic stroke or intracranial hemorrhage and a CPT E/M service code are required to identify patients 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 transient ischemic attack (TIA) who were prescribed antiplatelet therapy at discharge

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

This measure is 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 for ischemic stroke or transient ischemic attack (TIA) and a CPT E/M service code are required to identify patients 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 transient ischemic attack (TIA) with documented permanent, persistent, or paroxysmal atrial fibrillation who were prescribed an anticoagulant at discharge

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

This measure is 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 for ischemic stroke or transient ischemic attack (TIA) and atrial fibrillation and a CPT E/M service code are required to identify patients 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 for all patients under active treatment for ischemic stroke during the reporting period. Part B claims data will be analyzed to determine a hospital stay. If multiple qualifying diagnoses are submitted on the same claim form, only one instance of reporting will be counted. It is anticipated that clinicians who care for patients with a diagnosis of ischemic stroke in the hospital setting will submit this measure.

This measure is 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(s) **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 NOTE:*** *The correct combination of numerator codes must be reported on the claim form in order to properly report this measure. The "correct combination" of codes may require the submission of multiple numerator codes.*
>
> **Numerator Coding:**
> **t-PA Administration or Consideration Documented**
> *(Two CPT II codes [4077F & 1065F] are required on the claim form to submit this category)*
>
> **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 is not eligible for this measure because ischemic stroke symptom onset ≥ 3 hours prior to arrival at hospital, report:
(One CPT II code [1066F] is required on the claim form to submit this category)

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
(Two CPT II codes [4077F-8P & 1065F] are required on the claim form to submit this category)

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.

- **4077F *with* 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 for ischemic stroke and a CPT E/M service code are required to identify patients 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 ≥ 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 for all patients under active treatment for ischemic stroke or intracranial hemorrhage during the reporting period. Part B claims data will be analyzed to determine a hospital stay. If multiple qualifying diagnoses are submitted on the same claim form, only one instance of reporting will be counted. It is anticipated that clinicians who care for patients with a diagnosis of ischemic stroke or intracranial hemorrhage in the hospital setting will submit this measure.

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

Numerator Coding:

Dysphagia Screening Conducted

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

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

(Two CPT II codes [6010F-1P & 6015F] are required on the claim form to submit this category)

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

- **6010F *with* 1P:** Documentation of medical reason(s) for not conducting dysphagia screening prior to taking any foods, fluids or medication by mouth

AND

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

OR

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

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

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

OR

Dysphagia Screening not Conducted, Reason not Specified

(Two CPT II codes [6010F-8P & 6015F] are required on the claim form to submit this category)

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.

- **6010 *with* 8P:** Dysphagia screening was not conducted prior to order for or receipt of any foods, fluids or medication by mouth, reason not otherwise specified

AND

CPT II 6015F: Patient receiving or eligible to receive 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 for ischemic stroke or intracranial hemorrhage and a CPT E/M service code are required to identify patients 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. Part B claims data will be analyzed to determine the hospital discharge. If multiple qualifying diagnoses are submitted on the same claim form, only one instance of reporting will be counted. It is anticipated that clinicians who care for patients with a diagnosis of ischemic stroke or intracranial hemorrhage in the hospital setting will submit this measure.

This measure is 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 for ischemic stroke or intracranial hemorrhage and a CPT E/M service code are required to identify patients 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 #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. There is no diagnosis associated with this measure. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

This measure is reported using G-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 denominator code(s) and the appropriate numerator G-code.

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

Definitions:

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

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

OR

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

OR

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

DENOMINATOR:
All female patients aged 65 years and older

Denominator Coding:
A CPT E/M service code is required to identify patients for denominator inclusion.
CPT E/M service codes: 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215

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

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

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

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

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

BMD testing should be performed on:

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

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

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

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

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

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

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

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

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

*Measure #40: 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. If multiple fractures occurring on the same date of service are submitted on the same claim form, only one instance of reporting will be counted. Claims data will be analyzed to determine unique occurrences. Patients with documentation of prior central DXA measurement or already receiving pharmacologic therapy would automatically meet the intent of this measure. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

This measure is 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

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

Definitions:

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

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

Numerator 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 or 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 for hip, spine or distal radial fracture and a CPT E/M service code or a CPT procedure code are required to identify patients 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 is 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

Definitions:

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

Numerator 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 for osteoporosis and a CPT E/M service code are required to identify patients 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

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)

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

DESCRIPTION:
Percentage of patients aged 18 years and older undergoing isolated coronary artery bypass graft (CABG) surgery using an internal mammary artery (IMA)

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

This measure is 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 performing an internal mammary artery graft for primary, isolated coronary artery bypass graft procedure

OR

IMA Graft not Performed, Reason not Specified
Append a reporting modifier (**8P**) to CPT Category II code **4110F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

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

DENOMINATOR:
Patients with isolated coronary artery bypass graft

Denominator Coding:
A CPT procedure code for isolated coronary artery bypass graft surgery is required to identify patients 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)*

ΩMeasure #44: Preoperative Beta-blocker in Patients with Isolated Coronary Artery Bypass Graft (CABG) Surgery

DESCRIPTION:
Percentage of patients aged 18 years and older undergoing isolated coronary artery bypass (CABG) surgery who received a beta-blocker pre-operatively

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

This measure is 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 isolated coronary artery bypass graft

Denominator Coding:
A CPT procedure code for isolated coronary artery bypass graft surgery is required to identify patients 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. There is no diagnosis associated with this measure. It is anticipated that clinicians who perform the listed surgical procedures as specified in the denominator coding will submit this measure.

This measure is 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. If multiple surgical procedures were performed on the same date of service and submitted on the same claim form, it is not necessary to submit the CPT Category II code with each procedure.

When reporting the measure, submit the listed CPT procedure code and the appropriate CPT Category II code(s) **OR** the CPT Category II code(s) **with** the modifier. The modifiers allowed for this measure are: 1P- medical reasons, 8P- 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 NOTE:*** *The correct combination of numerator codes must be reported on the claim form in order to properly report this measure. The "correct combination" of codes may require the submission of multiple numerator codes.*

Numerator Coding:

Documentation of order for discontinuation of prophylactic antibiotics (written order, verbal order, or standing order/protocol) within 48 hours of surgical end time
(Two CPT II codes [4043F & 4046F] are required on the claim form to submit this category)

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

> ***Note:*** *CPT Category II 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
(Two CPT II codes [4043F-1P & 4046F] are required on the claim form to submit this category)

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

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

AND

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

OR

If patient is not eligible for this measure because patient was not documented to have prophylactic antibiotics given within 4 hours prior to surgical incision, report:
(One CPT II code [4042F] is required on the claim form to submit this category)

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

OR

Prophylactic Antibiotics not Discontinued, Reason not Specified
(Two CPT II codes [4043F-8P & 4046F] are required on the claim form to submit this category)

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

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

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

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 for cardiac surgical procedures for which prophylactic antibiotics are indicated is required to identify patients 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, 33305, 33315, 33321, 33322, 33332, 33335, 33400, 33401, 33403, 33404, 33405, 33406, 33410, 33411, 33413, 33416, 33422, 33425, 33426, 33427, 33430, 33460, 33463, 33464, 33465, 33475, 33496, 33510, 33511, 33512, 33513, 33514, 33516, 33517, 33518, 33519, 33521, 33522, 33523, 33530, 33533, 33534, 33535, 33536, 33542, 33545, 33548, 33572, 35211, 35241, 35271, 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 date during the reporting period. There is no diagnosis associated with this measure. If multiple claims are submitted within 60 days of inpatient discharge, only one instance of reporting will be counted. Part B claims data will be analyzed to determine the inpatient facility discharge date. This measure is appropriate for use in the ambulatory setting only. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding. There are no reporting requirements for this measure if a patient has been seen in an outpatient setting and not discharged from an inpatient facility within 60 days prior to the outpatient visit.

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

Numerator Coding:

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

(Two CPT II codes [1111F & 1110F] are required on the claim form to submit this category)

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 is not eligible for this measure 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

(Two CPT II codes [1111F-8P & 1110F] are required on the claim form to submit this category)

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

- **1111F *with* 8P:** Discharge medications 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 is required to identify patients for denominator inclusion.

CPT E/M service codes: 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215

RATIONALE:

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

CLINICAL RECOMMENDATION STATEMENTS:

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

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

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

1. Based on what occurred in the visit, should any medication that the patient was taking or receiving prior to the visit be discontinued or altered?
2. Based on what occurred in the visit, should any prior medication be suspended pending consultation with the prescriber?
3. Have any new prescriptions been added today?

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

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

*Measure #47: Advance Care Plan

DESCRIPTION:
Percentage of patients aged 65 years and older who have an advance care plan or surrogate decision maker documented in the medical record or documentation in the medical record that an advance care plan was discussed but the patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan 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. There is no diagnosis associated with this measure. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

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

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

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

OR

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

- **8P:** Advance care planning not documented, reason not otherwise specified

DENOMINATOR:
All patients aged 65 years and older

Denominator Coding:
A CPT E/M service code is required to identify patients 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

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

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

Oral statements

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

Instructional advance directives (DNR orders, living wills)

- Written instructions regarding the initiation, continuation, withholding, or withdrawal of particular forms of life-sustaining medical treatment.
- May be revoked or altered at any time by the patient.

- Clinicians who comply with such directives are provided legal immunity for such actions.

Durable power of attorney for health care or health care proxy

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

The National Hospice and Palliative Care Organization provides the Caring Connection web site (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 and is considered a general screening measure. There is no diagnosis associated with this measure. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

This measure is 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 is required to identify patients for denominator inclusion.
CPT E/M service codes: 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215

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 is 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, 788.33, 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

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 is 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, 788.33, 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

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. Do not limit the search for spirometry results to the reporting period. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

This measure is 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 (FEV_1 and FEV_1/FVC)

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

Numerator 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

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 FEV_1/FVC less than 70% and have symptoms who were prescribed an inhaled bronchodilator

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

This measure is 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(s) **OR** the CPT Category II code(s) **with** the modifier. The modifiers allowed for this measure are: 1P- medical reasons, 2P- patient reasons, 3P- system reasons, 8P- reasons not otherwise specified.

NUMERATOR:
Patients who were prescribed an inhaled bronchodilator

> **Definition:** "Prescribed" includes patients who are currently receiving medication(s) that follow the treatment plan recommended at an encounter during the reporting period, even if the prescription for that medication was ordered prior to the encounter.
>
> ***NUMERATOR NOTE:*** *The correct combination of numerator codes must be reported on the claim form in order to properly report this measure. The "correct combination" of codes may require the submission of multiple numerator codes.*
>
> **Numerator Coding:**
> **Patient Prescribed Inhaled Bronchodilator Therapy**
> *(Two CPT II codes [4025F & 3025F] are required on the claim form to submit this category)*
>
> **CPT II 4025F:** Inhaled bronchodilator prescribed
> **AND**
> **CPT II 3025F:** Spirometry test results demonstrate FEV_1/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
(Two CPT II codes [4025F-☒P & 3025F] are required on the claim form to submit this category)

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

- **4025F *with* 1P:** Documentation of medical reason(s) for not prescribing an inhaled bronchodilator
- **4025F *with* 2P:** Documentation of patient reason(s) for not prescribing an inhaled bronchodilator
- **4025F *with* 3P:** Documentation of system reason(s) for not prescribing an inhaled bronchodilator

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

OR

If patient is not eligible for this measure because spirometry results demonstrate $FEV_1/FVC \geq 70\%$ or patient does not have COPD symptoms, report:
Spirometry Results Demonstrate $FEV_1/FVC \geq 70\%$ or Patient Does not Have COPD Symptoms
(One CPT II code [3027F] is required on the claim form to submit this category)

CPT II 3027F: Spirometry test results demonstrate $FEV_1/FVC \geq 70\%$ or patient does not have COPD symptoms
OR
Spirometry Test not Performed or Documented
(One CPT II code [3025F-8P] is required on the claim form to submit this category)

Append a reporting modifier (**8P**) to CPT Category II code **3025F** to report circumstances when the patient is not eligible for the measure.

- **3025F *with* 8P:** Spirometry test not performed or documented

OR

Patient not Documented to have Inhaled Bronchodilator Prescribed, Reason not Specified
(Two CPT II codes [4025F-8P & 3025F] are required on the claim form to submit this category)

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

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

AND
CPT II 3025F: Spirometry test results demonstrate $FEV_1/FVC < 70\%$ with COPD symptoms (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

RATIONALE:
Inhaled bronchodilator therapy is effective in treating and managing the symptoms of COPD, particularly, for those patients with moderate to very severe COPD, and improving a patient's quality of life.

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

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

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

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

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

▲ 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. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

This measure is 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(s) **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 $beta_2$-agonist) or an acceptable alternative treatment (leukotriene modifiers, cromolyn sodium, nedocromil sodium, or sustained-released methylaxanthines)

> **Numerator Instructions:** Documentation of persistent asthma must be present. One method of identifying persistent asthma is at least daily use of short-acting bronchodilators.
>
> **Definition:** "Prescribed" includes patients who are currently receiving medication(s) that follow the treatment plan recommended at an encounter during the reporting period, even if the prescription for that medication was ordered prior to the encounter.
>
> ***NUMERATOR NOTE:*** *The correct combination of numerator codes must be reported on the claim form in order to properly report this measure. The "correct combination" of codes may require the submission of multiple numerator codes.*

Numerator Coding:

Preferred Long-Term Control Medication or Acceptable Alternative Treatment Prescribed

(Two CPT II codes [4015F & 1038F] are required on the claim form to submit this category)

CPT II 4015F: Persistent asthma, preferred long term control medication or acceptable alternative treatment prescribed

AND

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

OR

Preferred Long-Term Control Medication or Acceptable Alternative Treatment not Prescribed for Patient Reasons

(Two CPT II codes [4015F-2P & 1038F] are required on the claim form to submit this category)

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

- **4015F *with* 2P:** Documentation of patient reason(s) for not prescribing either the preferred long-term control medication (inhaled corticosteroid or inhaled corticosteroid with long-acting inhaled $beta_2$-agonist) or an acceptable alternative treatment (leukotriene modifiers, cromolyn sodium, nedocromil sodium, or sustained-released methylaxanthines)

AND

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

OR

If patient is not eligible for this measure because patient does not have persistent asthma, report:

(One CPT II code [1039F] is required on the claim form to submit this category)

CPT II 1039F: Intermittent asthma

OR

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

(Two CPT II codes [4015F-8P & 1038F] are required on the claim form to submit this category)

Append a reporting modifier (**8P**) to CPT Category II code **4015F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

- **4015F *with* 8P:** Persistent asthma, preferred long term control medication or acceptable alternative treatment not prescribed, reason not otherwise specified

AND

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

DENOMINATOR:
All patients aged 5 through 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, 493.91, 493.92
AND
CPT E/M service codes: 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245

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

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

- Step 1: Mild Intermittent Asthma
- No daily medication needed
- Step 2: Mild Persistent Asthma
- *Preferred treatment:* Low-dose inhaled corticosteroids (ICS)
- *Alternative treatment:* Cromolyn, leukotriene modifier, nedocromil, OR sustained-release theophylline
- Step 3: Moderate Persistent Asthma
- *Preferred treatment:* Low-medium dose ICS + long-acting inhaled $beta_2$-agonists (LABA)
- *Alternative treatment:* Increase medium-dose ICS OR low-medium dose ICS and either leukotriene modifier or theophylline (If needed, may increase ICS within medium-dose range in either treatment)
- Step 4: Severe Persistent Asthma
- *Preferred treatment:* High-dose ICS + LABA AND, if needed, corticosteroid tablets or syrup long-term

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

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

*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 a 12-lead electrocardiogram (ECG) performed

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

This measure is 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 a 12-lead ECG performed

Numerator Coding:
12-Lead ECG Performed
CPT II 3120F: 12-Lead ECG Performed

OR

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

- **1P:** Documentation of medical reason(s) for not performing a 12-Lead ECG
- **2P:** Documentation of patient reason(s) for not performing a 12-Lead ECG

OR

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

- **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 diagnosis code for non-traumatic chest pain and a CPT E/M service code are required to identify patients for denominator inclusion. The Part B claim form place-of-service field must indicate emergency department.
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
AND
Place of Service Indicator: 23

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

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

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

- 12-lead ECG (Rule)
- IV access, supplemental oxygen, cardiac monitor, serum cardiac markers (e.g., CKMB), CXR, nitrates, management of 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 a 12-lead ECG performed

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

This measure is 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 a 12-lead ECG performed

Numerator Coding:
12-Lead ECG Performed
CPT II 3120F: 12-Lead ECG Performed

OR

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

- **1P:** Documentation of medical reason(s) for not performing a 12-Lead ECG
- **2P:** Documentation of patient reason(s) for not performing a 12-Lead ECG

OR

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

- **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 diagnosis code for syncope and a CPT E/M service code are required to identify patients for denominator inclusion. The Part B claim form place-of-service field must indicate emergency department.
ICD-9 diagnosis codes: 780.2
AND
CPT E/M service codes: 99281, 99282, 99283, 99284, 99285, 99291
AND
Place of Service Indicator: 23

RATIONALE:
12-lead ECG can occasionally pick up potentially life-threatening conditions such as pre-excitation syndromes, prolonged QT syndromes, or Brugada's syndrome in otherwise healthy appearing young adults. 12-lead ECG testing is performed inconsistently, even in high risk patients; the largest study to date of 12-lead ECG testing variation in ED syncope visits using a 9 year national sample illustrated that 12-lead ECG testing was documented in only 59% of ED syncope visits.

CLINICAL RECOMMENDATION STATEMENTS:
Obtain a standard 12-lead ECG in patients with syncope when history and physical examination do not reveal a diagnosis. (ACEP) (Level A)

- A patient with normal 12-lead ECG has a low likelihood of dysrhythmias as a cause of syncope.
- Abnormal 12-lead ECG has been associated as being the most important predictor of serious outcomes and a multivariate predictor for arrhythmia or death within 1 year after the syncopal episode.

*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. Each unique occurrence is defined as a 45-day period from onset of community-acquired bacterial pneumonia. Claims data will be analyzed to determine unique occurrences. All patients 18 years and older with a diagnosis of community acquired bacterial pneumonia should have documentation in the medical record of having vital signs recorded and reviewed. It is anticipated that clinicians who provide care in the emergency department or office setting will submit this measure. Clinicians utilizing the critical care code must indicate the emergency department place-of-service code in order to be counted in the measure's denominator.

This measure is 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 for community-acquired bacterial pneumonia and a CPT E/M service code are required to identify patients 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*

** Clinicians utilizing the critical care code must indicate the emergency department place-of-service (23) on the Part B claim form in order to report this measure.*

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. Each unique occurrence is defined as a 45-day period from onset of community-acquired bacterial pneumonia. Claims data will be analyzed to determine unique occurrences. All patients 18 years and older with a diagnosis of community-acquired bacterial pneumonia 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. Clinicians utilizing the critical care code must indicate the emergency department place-of-service code in order to be counted in the measure's denominator.

This measure is 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. Clinicians utilizing the critical care code must indicate the emergency department place-of-service code in order to be counted in the measure's denominator.

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 for community-acquired bacterial pneumonia and a CPT E/M service code are required to identify patients 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*

** Clinicians utilizing the critical care code must indicate the emergency department place-of-service (23) on the Part B claim form in order to report this measure.*

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. Each unique occurrence is defined as a 45-day period from onset of community-acquired bacterial pneumonia. Claims data will be analyzed to determine unique occurrences. All patients 18 years and older with a diagnosis of community acquired bacterial pneumonia should have documentation in the medical record of having mental status assessed. It is anticipated that clinicians who provide care in the emergency department or office setting will submit this measure. Clinicians utilizing the critical care code must indicate the emergency department place-of-service code in order to be counted in the measure's denominator.

This measure is 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 for community-acquired bacterial pneumonia and a CPT E/M service code are required to identify patients 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*

** Clinicians utilizing the critical care code must indicate the emergency department place-of-service (23) on the Part B claim form in order to report this measure.*

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. Each unique occurrence is defined as a 45-day period from onset of community-acquired bacterial pneumonia. Claims data will be analyzed to determine unique occurrences. All patients 18 years and older with a diagnosis of community acquired bacterial pneumonia should have documentation in the medical record of having an appropriate empiric antibiotic prescribed. It is anticipated that clinicians who provide care in the emergency department or office setting will submit this measure. Clinicians utilizing the critical care code must indicate the emergency department place-of-service code in order to be counted in the measure's denominator.

This measure is 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

Definitions:

- Appropriate empiric antibiotic for treatment of community-acquired bacterial pneumonia (CAP) should include any medication from one of the following four drug classes: Fluoroquinolones, Macrolides, Doxycycline, Beta Lactam with Macrolide or Doxycycline (as defined by current ATS/IDSA guidelines).
- "Prescribed" includes patients who are currently receiving medication(s) that follow the treatment plan recommended at an encounter during the reporting period, even if the prescription for that medication was ordered prior to the encounter.

Numerator 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 for community-acquired bacterial pneumonia and a CPT E/M service code are required to identify patients 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*

** Clinicians utilizing the critical care code must indicate the emergency department place-of-service (23) on the Part B claim form in order to report this measure.*

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 #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 with asthma seen during the reporting period. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

This measure is 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, reason not otherwise specified

DENOMINATOR:
All patients aged 5 through 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, 493.91, 493.92
AND
CPT E/M service codes: 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245

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 prescribed or dispensed an antibiotic prescription on or within 3 days of the initial date of service

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

This measure is 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 not dispensed an antibiotic prescription on or within 3 days of the initial date of service

Numerator Instructions: For performance, the measure will be calculated as the number of patients for whom antibiotics were neither prescribed nor dispensed over the number of patients in the denominator (patients aged 3 months through 18 years with URI). A higher score indicates appropriate treatment of patients with URI (e.g., the proportion for whom antibiotics *were not* prescribed or dispensed).

Numerator Coding:
Antibiotic not Prescribed or Dispensed
CPT II 4124F: Antibiotic neither prescribed nor dispensed

OR

Antibiotic Prescribed or Dispensed for Medical Reasons
Append a modifier (**1P**) to CPT Category II code **4120F** to report documented circumstances that appropriately exclude patients from the denominator.

- **1P:** Documentation of medical reason(s) for prescribing or dispensing antibiotic

OR

Antibiotic Prescribed or Dispensed
CPT II 4120F: Antibiotic prescribed or dispensed

DENOMINATOR:
All patients aged 3 months through 18 years with a diagnosis of upper respiratory infection

Denominator Coding:
An ICD-9 diagnosis code for upper respiratory infection (URI) and a CPT E/M service code are required to identify patients 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

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

This measure is 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(s) **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 NOTE:*** *The correct combination of numerator codes must be reported on the claim form in order to properly report this measure. The "correct combination" of codes may require the submission of multiple numerator codes.*
>
> **Numerator Coding:**
> **Group A Streptococcus Test Performed and Antibiotic Prescribed**
> *(Two CPT II codes [3210F & 4120F] are required on the claim form to submit this category)*
>
> **CPT II 3210F:** Group A Strep Test Performed
> **AND**
> **CPT II 4120F:** Antibiotic prescribed or dispensed

OR

Group A Streptococcus Test not Performed for Medical Reasons
(Two CPT II codes [3210F-1P & 4120F] are required on the claim form to submit this category)

Append a modifier (**1P**) to CPT Category II codes **3210F** to report documented circumstances that appropriately exclude patients from the denominator.

- **3210F *with* 1P:** Documentation of medical reason(s) for not Performing Group A Strep Test

AND
CPT II 4120F: Antibiotic prescribed or dispensed

OR

If patient is not eligible for this measure because patient was not prescribed antibiotics, report:
(One CPT II code [4124F] is required on the claim form to submit this category)

CPT II 4124F: Antibiotic neither prescribed nor dispensed

OR

Group A Streptococcus Test not Performed, Reason not Specified
(Two CPT II codes [3210F-8P & 4120F] are required on the claim form to submit this category)

Append a reporting modifier (**8P**) to CPT Category II code **3210F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

- **3210F *with* 8P:** Group A Strep Test not Performed, reason not otherwise specified

AND
CPT II 4120F: Antibiotic prescribed or dispensed

DENOMINATOR:
All patients aged 2 through 18 years with a diagnosis of pharyngitis

Denominator Coding:
An ICD-9 diagnosis code for pharyngitis and a CPT E/M service code are required to identify patients 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

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 is 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 for Myelodysplastic Syndrome (MDS) or acute leukemias (not in remission) and a CPT E/M service code are required to identify patients 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 all MDS patients seen during the reporting period, regardless of when the documentation of iron stores occurs. It is anticipated that clinicians who provide services for patients with the diagnosis of myelodysplastic syndromes will submit this measure.

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

Numerator Coding:
Documentation of Iron Stores Prior to Initiating Erythropoietin Therapy Performed
(Two CPT II codes [3160F & 4090F] are required on the claim form to submit this category)

CPT II 3160F: Documentation of iron stores prior to initiating erythropoietin therapy
AND
CPT II 4090F: Patient receiving erythropoietin therapy

OR

Documentation of Iron Stores Prior to Initiating Erythropoietin Therapy not Performed for System Reasons
(Two CPT II codes [3160F-3P & 4090F] are required on the claim form to submit this category)

Append a modifier (**3P**) to CPT Category II code **3160F** to report documented circumstances that appropriately exclude patients from the denominator.

- **3160F *with* 3P:** Documentation of system reason(s) for not documenting iron stores prior to initiating erythropoietin therapy

AND
CPT II 4090F: Patient receiving erythropoietin therapy

OR

If patient is not eligible for this measure because patient is not receiving erythropoietin therapy, report:
(One CPT II code [4095F] is required on the claim form to submit this category)

CPT II 4095F: Patient not receiving erythropoietin therapy

OR

Documentation of Iron Stores Prior to Initiating Erythropoietin Therapy not Performed, Reason not Specified
(Two CPT II codes [3160F-8P & 4090F] are required on the claim form to submit this category)

Append a reporting modifier (**8P**) to CPT Category II code **3160F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

- **3160F *with* 8P:** Iron stores prior to initiating erythropoietin therapy not documented, reason not otherwise specified

AND
CPT II 4090F: Patient receiving erythropoietin therapy

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 for Myelodysplastic Syndrome (MDS) and a CPT E/M service code are required to identify patients 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 hypoproductive macrocytic anemia, often associated with suboptimal elevation of serum Epo levels. Iron repletion needs to be verified before instituting Epo therapy (Category 2A Recommendation). (NCCN)

♣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 the 12-month reporting period

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

This measure is 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 the 12 month reporting period

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 for Multiple Myeloma (MM), not in remission, and a CPT E/M service code are required to identify patients 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 is 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 for chronic lymphocytic leukemia, not in remission, and a CPT E/M service code are required to identify patients 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 female patients aged 18 years and older with Stage IC through IIIC, estrogen receptor (ER) or progesterone receptor (PR) positive breast cancer who were prescribed tamoxifen or aromatase inhibitor (AI) during the 12-month reporting period

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for all female patients with breast cancer seen during the reporting period. It is anticipated that clinicians who treat female patients with Stage IC through IIIC, estrogen receptor (ER) or progesterone receptor (PR) positive breast cancer will submit this measure.

This measure is 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 tamoxifen or aromatase inhibitor (AI) during the 12 month reporting period

> ***NUMERATOR NOTE:*** *The correct combination of numerator codes must be reported on the claim form in order to properly report this measure. The "correct combination" of codes may require the submission of multiple numerator codes.*
>
> **Numerator Coding:**
> **Tamoxifen or Aromatase Inhibitor Prescribed**
> *(Three CPT II codes [4179F & 33☒☒F & 3315F] are required on the claim form to submit this category)*
>
> **CPT II 4179F:** Tamoxifen or aromatase inhibitor (AI) prescribed
> **AND**

CPT II 3305F: AJCC Cancer Stage IC, documented
OR
CPT II 3306F: AJCC Cancer Stage IIA, documented
OR
CPT II 3307F: AJCC Cancer Stage IIB, documented
OR
CPT II 3308F: AJCC Cancer Stage IIC, documented
OR
CPT II 3309F: AJCC Cancer Stage IIIA, documented
OR
CPT II 3310F: AJCC Cancer Stage IIIB, documented
OR
CPT II 3311F: AJCC Cancer Stage IIIC, documented

AND
CPT II 3315F: Estrogen receptor (ER) or progesterone receptor (PR) positive breast cancer

OR

Tamoxifen or Aromatase Inhibitor not Prescribed for Medical, Patient, or System Reasons
(Three CPT II codes [4179F-⊠P & 33⊠⊠F & 3315F] are required on the claim form to submit this category)

Append a modifier (**1P, 2P, or 3P**) to CPT Category II code **4179F** to report documented circumstances that appropriately exclude patients from the denominator

- **4179F *with* 1P:** Documentation of medical reason(s) for not prescribing tamoxifen or aromatase inhibitor (eg, patient's disease has progressed to metastatic; patient is receiving a gonadotropin-releasing hormone analogue, patient has received oophorectomy, patient is receiving radiation or chemotherapy, patient's diagnosis date was ≥ 5 years from reporting date)
- **4179F *with* 2P:** Documentation of patient reason(s) for not prescribing tamoxifen or aromatase inhibitor (eg, patient refusal)
- **4179F *with* 3P:** Documentation of system reason(s) for not prescribing tamoxifen or aromatase inhibitor (eg, patient is currently enrolled in a clinical trial)

AND

CPT II 3305F: AJCC Cancer Stage IC, documented
OR
CPT II 3306F: AJCC Cancer Stage IIA, documented
OR
CPT II 3307F: AJCC Cancer Stage IIB, documented
OR
CPT II 3308F: AJCC Cancer Stage IIC, documented

OR
CPT II 3309F: AJCC Cancer Stage IIIA, documented
OR
CPT II 3310F: AJCC Cancer Stage IIIB, documented
OR
CPT II 3311F: AJCC Cancer Stage IIIC, documented

AND
CPT II 3315F: Estrogen receptor (ER) or progesterone receptor (PR) positive breast cancer

OR

If patient is not eligible for this measure because patient is not stage IC through IIIC breast cancer, report:
Patient not Stage IC through IIIC Breast Cancer
(One CPT II code [33⊠⊠F] is required on the claim form to submit this category)

CPT II 3302F: AJCC Cancer Stage 0, documented
OR
CPT II 3303F: AJCC Cancer Stage IA, documented
OR
CPT II 3304F: AJCC Cancer Stage IB, documented
OR
CPT II 3312F: AJCC Cancer Stage IVA, documented
OR
CPT II 3313F: AJCC Cancer Stage IVB, documented
OR
CPT II 3314F: AJCC Cancer Stage IVC, documented

OR

If patient is not eligible for this measure because patient is estrogen receptor (ER) and progesterone receptor (PR) negative, report:
Patient is Estrogen Receptor (ER) and Progesterone Receptor (PR) Negative
(One CPT II code [3316F] is required on the claim form to submit this category)

CPT II 3316F: Estrogen receptor (ER) and progesterone receptor (PR) negative breast cancer

OR

If patient is not eligible for this measure because cancer stage is not documented, report:
Cancer Stage not Documented
(One CPT II code [3305F-8P] is required on the claim form to submit this category)

Append a reporting modifier (**8P**) to CPT Category II code **3305F** to report circumstances when the patient is not eligible for the measure.
Note: 3305F-8P is being used to indicate that there is no cancer stage documented.

- **3305F *with* 8P:** No documentation of cancer stage

OR

Tamoxifen or Aromatase Inhibitor not Prescribed, Reason not Specified
(Three CPT II codes [4179F-8P & 33⊠⊠F & 3315F] are required on the claim form to submit this category)

Append a reporting modifier (**8P**) to CPT Category II code **4179F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

- **4179F *with* 8P:** Tamoxifen or aromatase inhibitor not prescribed, reason not otherwise specified

AND

CPT II 3305F: AJCC Cancer Stage IC, documented
OR
CPT II 3306F: AJCC Cancer Stage IIA, documented
OR
CPT II 3307F: AJCC Cancer Stage IIB, documented
OR
CPT II 3308F: AJCC Cancer Stage IIC, documented
OR
CPT II 3309F: AJCC Cancer Stage IIIA, documented
OR
CPT II 3310F: AJCC Cancer Stage IIIB, documented
OR
CPT II 3311F: AJCC Cancer Stage IIIC, documented

AND
CPT II 3315F: Estrogen receptor (ER) or progesterone receptor (PR) positive breast cancer

DENOMINATOR:
All female patients aged 18 years and older with Stage IC through IIIC, estrogen receptor (ER) or progesterone receptor (PR) positive breast cancer

Denominator Coding:
An ICD-9 diagnosis code for breast cancer and a CPT E/M service code are required to identify patients 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

RATIONALE:
Despite evidence suggesting the role of adjuvant endocrine therapy in lowering the risk of tumor recurrence, many female patients who should be receiving this therapy are not. This measure assesses whether patients with a certain stage of breast cancer (IC through IIIC) and ER/PR+ are currently receiving the therapy. There are allowable medical, patient, and system reasons to document instances in which a woman with stage IC through IIIC, ER/PR+ may not be a candidate for the therapy. Note: the reporting/managing physician does not need to have actually written the prescription; however the reporting/managing physician must verify that the patient already has been prescribed the hormonal therapy by another physician.

CLINICAL RECOMMENDATION STATEMENTS:
Adjuvant therapy for postmenopausal women with hormone receptor–positive breast cancer should include an aromatase inhibitor in order to lower the risk of tumor recurrence. Aromatase inhibitors are appropriate as initial treatment for women with contraindications to tamoxifen. For all other postmenopausal women, treatment options include 5 years of aromatase inhibitors treatment or sequential therapy consisting of tamoxifen (for either 2 to 3 years or 5 years) followed by aromatase inhibitors for 2 to 3, or 5 years (ASCO guidelines include narrative rankings). (ASCO)

Patients intolerant of aromatase inhibitors should receive tamoxifen. Women with hormone receptor–negative tumors should not receive adjuvant endocrine therapy (ASCO guidelines include narrative rankings). (ASCO)

Patients with invasive breast cancers that are estrogen or progesterone receptor positive should be considered for adjuvant endocrine therapy regardless of patient age, lymph node status, or whether or not adjuvant chemotherapy is to be administered (Category 2A). (NCCN)

The most firmly established adjuvant endocrine therapy is tamoxifen for both premenopausal and postmenopausal women. Prospective, randomized trials demonstrate that the optimal duration of tamoxifen appears to be five years. In patients receiving both tamoxifen and chemotherapy, chemotherapy should be given first, followed by sequential tamoxifen. Several studies have evaluated aromatase inhibitors in the treatment of postmenopausal women with early-stage breast cancer (Category 2A). (NCCN)

¥ Measure #72: Chemotherapy for Stage III Colon Cancer Patients

DESCRIPTION:
Percentage of patients aged 18 years and older with Stage IIIA through IIIC colon cancer who are prescribed or who have received adjuvant chemotherapy during the 12-month reporting period

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for all patients with colon cancer seen during the reporting period. It is anticipated that clinicians who treat patients with Stage IIIA through IIIC colon cancer will submit this measure.

This measure is 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 are prescribed or who have previously received adjuvant chemotherapy* during the 12 month reporting period

> **Definition:** *According to current NCCN guidelines, the following therapies are recommended: 5-fluorouracil/leucovorin or capecitabine, or 5-fluorouracil/leucovorin/ oxaliplatin
>
> ***NUMERATOR NOTE:*** *The correct combination of numerator codes must be reported on the claim form in order to properly report this measure. The "correct combination" of codes may require the submission of multiple numerator codes.*
>
> **Numerator Coding:**
> **Adjuvant Chemotherapy Prescribed or Previously Received**
> *(Two CPT II codes [4180F & 33⊠⊠F] are required on the claim form to submit this category)*
>
> **CPT II 4180F:** Adjuvant chemotherapy prescribed or previously received for Stage IIIA through Stage IIIC colon cancer
> **AND**
>
> **CPT II 3309F:** AJCC Cancer Stage IIIA, documented
> **OR**
> **CPT II 3310F:** AJCC Cancer Stage IIIB, documented
> **OR**

CPT II 3311F: AJCC Cancer Stage IIIC, documented

OR

Adjuvant Chemotherapy <u>not</u> Prescribed or Previously Received for Medical, Patient, or System Reasons
(Two CPT II codes [4180F-⊠P & 33⊠⊠F] are required on the claim form to submit this category)

Append a modifier (**1P, 2P, or 3P**) to CPT Category II code **4180F** to report documented circumstances that appropriately exclude patients from the denominator.

- **4180F *with* 1P:** Documentation of medical reason(s) for not prescribing adjuvant chemotherapy (eg, medical comorbidities, diagnosis date more than 5 years prior to the current visit date; patient's cancer has metastasized; medical contraindication/allergy, poor performance status)
- **4180F *with* 2P:** Documentation of patient reason(s) for not prescribing adjuvant chemotherapy (eg, patient refusal)
- **4180F *with* 3P:** Documentation of system reason(s) for not prescribing adjuvant chemotherapy (eg, patient is currently enrolled in a clinical trial that precludes prescription of chemotherapy)

<u>AND</u>

CPT II 3309F: AJCC Cancer Stage IIIA, documented
<u>OR</u>
CPT II 3310F: AJCC Cancer Stage IIIB, documented
<u>OR</u>
CPT II 3311F: AJCC Cancer Stage IIIC, documented

OR

If patient is not eligible for this measure because patient is not stage IIIA through IIIC colon cancer, report:
Patient <u>not</u> Stage IIIA through IIIC Colon Cancer
(One CPT II code [33⊠⊠F] is required on the claim form to submit this category)

CPT II 3302F: AJCC Cancer Stage 0, documented
<u>OR</u>
CPT II 3303F: AJCC Cancer Stage IA, documented
<u>OR</u>
CPT II 3304F: AJCC Cancer Stage IB, documented
<u>OR</u>
CPT II 3305F: AJCC Cancer Stage IC, documented
<u>OR</u>
CPT II 3306F: AJCC Cancer Stage IIA, documented
<u>OR</u>
CPT II 3307F: AJCC Cancer Stage IIB, documented
<u>OR</u>

CPT II 3308F: AJCC Cancer Stage IIC, documented
OR
CPT II 3312F: AJCC Cancer Stage IVA, documented
OR
CPT II 3313F: AJCC Cancer Stage IVB, documented
OR
CPT II 3314F: AJCC Cancer Stage IVC, documented

OR

If patient is not eligible for this measure because cancer stage is not documented, report:
Cancer Stage not Documented
(One CPT II code [3309F-8P] is required on the claim form to submit this category)

Append a reporting modifier (**8P**) to CPT Category II code **3309F** to report circumstances when the patient is not eligible for the measure.
Note: 3309F-8P is being used to indicate that there is no cancer stage documented.

- **3309F *with* 8P:** No documentation of cancer stage

OR

Adjuvant Chemotherapy not Prescribed or Previously Received, Reason not Specified
(Two CPT II codes [4180F-8P & 33⊠⊠F] are required on the claim form to submit this category)

Append a reporting modifier (**8P**) to CPT Category II code **4180F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

- **4180F *with* 8P:** Adjuvant chemotherapy not prescribed or previously received, reason not otherwise specified

AND

CPT II 3309F: AJCC Cancer Stage IIIA, documented
OR
CPT II 3310F: AJCC Cancer Stage IIIB, documented
OR
CPT II 3311F: AJCC Cancer Stage IIIC, documented

DENOMINATOR:
All patients aged 18 years and older with Stage IIIA through IIIC colon cancer

Denominator Coding:
An ICD-9 diagnosis code for colon cancer and a CPT E/M service code are required to identify patients 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

RATIONALE:
Patients with Stage IIIA through Stage IIIC colon cancer do not always receive the recommended treatment of adjuvant chemotherapy. This measure is intended to determine whether and how often chemotherapy is administered. The specific chemotherapy drugs specified in this measure reflect the most current guidelines of the National Comprehensive Cancer Network.

CLINICAL RECOMMENDATION STATEMENTS:
Following primary surgical treatment, the panel recommends six months of 5-fluorouracil/leucovorin capecitabine, or 5-fluorouracil/leucovorin/oxaliplatin as adjuvant chemotherapy for patients with stage III (T1-4, N1-2, M0) colon cancer (Category 2A). (NCCN)

♥ Measure #73: Plan for Chemotherapy Documented Before Chemotherapy Administered

DESCRIPTION:
Percentage of patients, regardless of age, with a diagnosis of breast, colon, or rectal cancer who are receiving intravenous chemotherapy for whom the planned chemotherapy regimen (which includes, at a minimum: drug(s) prescribed, dose, and duration) is documented prior to the initiation of a new treatment regimen

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for patients with breast, colon, or rectal cancer seen during the reporting period. It is anticipated that clinicians who treat patients with breast, colon, or rectal cancer who are receiving intravenous chemotherapy administration will submit this measure.

This measure is reported using CPT Category II codes:
ICD-9 diagnosis codes, CPT E/M service codes and CPT procedure codes are used to identify patients who are included in the measure's denominator. CPT Category II codes are used to report the numerator of the measure.

When reporting the measure, submit the listed ICD-9 diagnosis codes, CPT E/M service codes, CPT procedure codes, and the appropriate CPT Category II codes **OR** the CPT Category II code(s) **with** the modifier. The modifier allowed for this measure is: 8P- reasons not otherwise specified. There are no allowable performance exclusions for this measure.

NUMERATOR:
Patients for whom the planned chemotherapy regimen (which includes, at a minimum: drug(s) prescribed, dose, and duration) is documented prior to the initiation of a new treatment regimen

Numerator Coding:
Plan for Chemotherapy Documented
CPT II 0519F: Planned chemotherapy regimen, including at a minimum: drug(s) prescribed, dose, and duration, documented prior to initiation of a new treatment regimen

OR

Plan for Chemotherapy not Documented, Reason not Specified
Append a reporting modifier (**8P**) to CPT Category II code **0519F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

- **8P:** Plan for chemotherapy not documented, reason not otherwise specified

DENOMINATOR:
All patients, regardless of age, with a diagnosis of breast, colon, or rectal cancer who are receiving intravenous chemotherapy

Denominator Coding:
An ICD-9 diagnosis code for breast, colon, or rectal cancer, a CPT E/M service code and a CPT procedure code for intravenous chemotherapy administration are required to identify patients 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, 154.0, 154.1, 154.2, 154.3, 154.8, 174.0, 174.1, 174.2, 174.3, 174.4, 174.5, 174.6, 174.8, 174.9
AND
CPT E/M service codes: 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215
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

RATIONALE:
A detailed plan for the chemotherapy regimen is a critical component of ensuring high quality care for patients. There are no exclusions for this measure.

CLINICAL RECOMMENDATION STATEMENTS:
American Society of Clinical Oncology, "Chemotherapy Treatment Summary," (www.asco.org/treatmentsummary) specifies that a treatment plan should include the following information about the planned chemotherapy regimen:

- Chemotherapy regimen and starting dosages
- Duration of treatment and number of planned cycles (ASCO)

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 provide 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 denominator code(s) and the appropriate numerator 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.

Definition: 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 through 70 years with invasive breast cancer

Denominator Coding:
An ICD-9 diagnosis code for invasive breast cancer and a CPT E/M service code are required to identify patients 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.

▲ Measure #75: Prevention of Ventilator-Associated Pneumonia – Head Elevation

DESCRIPTION:
Percentage of ICU patients aged 18 years and older who receive mechanical ventilation and who had an order on the first ventilator day for head of bed elevation (30-45 degrees)

INSTRUCTIONS:
This measure is to be reported once for each episode of care for all critically ill patients seen during the reporting period. There is no diagnosis associated with this measure. An individual patient may have multiple ICU episodes during the same hospitalization. This measure should be reported for each new episode of care, even those that occur during the same hospitalization.
Situations that define an episode include the following:

1) The first instance 99291 is used (e.g., admission to the ICU or a new episode of critical care)
2) Upon readmission to the ICU from another unit (e.g., discharged to a step-down unit, then readmitted to ICU due to complications)
3) *Upon reintubation or intubation any time following admission to the ICU

*The following is an example: For the patient initially admitted to the ICU, not receiving ventilation, CPT II 4169F (see coding below) would be reported. There may be instances when a critically ill patient is not ventilated at the initial instance of 99291; if the patient's status changes during the episode, requiring ventilation, a second CPT II code (4168F) indicating that the patient is receiving ventilation should be reported; finally, if head of bed elevation is ordered, report CPT II code 4167F.

It is anticipated that clinicians who provide care in the ICU will submit this measure. Clinicians utilizing the critical care code in the emergency department will not be included in this measure.

This measure is 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(s) **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 an order on the first ventilator day for head of bed elevation (30-45 degrees)

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

Numerator Coding:

Order for Head of Bed Elevation (30-45 degrees) on First Ventilator Day

(Two CPT II codes [4167F & 4168F] are required on the claim form to submit this category)

CPT II 4167F: Head of bed elevation (30-45 degrees) on first ventilator day ordered

AND

CPT II 4168F: Patient receiving care in the intensive care unit (ICU) and receiving mechanical ventilation, 24 hours or less

OR

Head of Bed Elevation (30-45 Degrees) not Ordered on First Ventilator Day for Medical Reasons

(Two CPT II codes [4167F-1P & 4168F] are required on the claim form to submit this category)

Append a modifier (**1P**) to CPT Category II code **4167F** to report documented circumstances that appropriately exclude patients from the denominator.

- **4167F *with* 1P:** Documentation of medical reason(s) for not ordering head of bed elevation (30-45 degrees) on the first ventilator day

AND

CPT II 4168F: Patient receiving care in the intensive care unit (ICU) and receiving mechanical ventilation, 24 hours or less

OR

CPT II 4169F: Report if patient is not eligible for this measure because patient is not receiving ICU care or not receiving mechanical ventilation.

OR

Head of Bed Elevation (30-45 Degrees) not Ordered on First Ventilator Day, Reason not Specified

(Two CPT II codes [4167F-8P & 4168F] are required on the claim form to submit this category)

Append a reporting modifier (**8P**) to CPT Category II code **4167F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

- **4167F *with* 8P:** Head of bed elevation (30-45 degrees) not ordered on first ventilator day, reason not otherwise specified

AND

CPT II 4168F: Patient receiving care in the intensive care unit (ICU) and receiving mechanical ventilation, 24 hours or less

DENOMINATOR:

All patients aged 18 years and older receiving care in the ICU who receive mechanical ventilation

Definition: For the purposes of this measure, mechanical ventilation may include pressure or volume preset ventilators for assisted or controlled breathing OR continuous positive airway pressure ventilation (CPAP).

Denominator Coding:
An E/M service code is required to identify patients for denominator inclusion.
CPT E/M service code: 99291*

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

RATIONALE:
Mechanically ventilated patients are at high risk for aspiration pneumonia. Elevation of the head of the bed has been shown to reduce the risk of aspiration.

Existing hospital-level measures for this topic were consulted and, to the extent feasible, harmonization between physician- and hospital-level measurement was achieved.

CLINICAL RECOMMENDATION STATEMENTS:
Patients should be kept in the semirecumbent position (30–45°) rather than supine to prevent aspiration, especially when receiving enteral feeding. (ATS/IDSA) (Level I)

In the absence of medical contraindication(s), elevate at an angle of 30-45 degrees the head of the bed of a patient at high risk for aspiration pneumonia (e.g., a person receiving mechanically assisted ventilation or who has an enteral tube in place). (CDC) (Category I)

▲ Measure #76: Prevention of Catheter-Related Bloodstream Infections (CRBSI) – Central Venous Catheter Insertion Protocol

DESCRIPTION:
Percentage of patients, regardless of age, who undergo central venous catheter (CVC) insertion for whom CVC was inserted with all elements of maximal sterile barrier technique (cap AND mask AND sterile gown AND sterile gloves AND a large sterile sheet AND hand hygiene AND 2% chlorhexidine for cutaneous antisepsis) followed

INSTRUCTIONS:
This measure is to be reported each time a CVC insertion is performed during the reporting period. There is no diagnosis associated with this measure. It is anticipated that clinicians who perform CVC insertion will submit this measure.

This measure is reported using CPT Category II codes:
CPT procedure codes are used to identify patients who are included in the measure's denominator. CPT Category II codes are used to report the numerator of the measure.

When reporting the measure, 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 for whom central venous catheter (CVC) was inserted with all elements of maximal sterile barrier technique (cap AND mask AND sterile gown AND sterile gloves AND a large sterile sheet AND hand hygiene AND 2% chlorhexidine for cutaneous antisepsis) followed

Definition: For purposes of this measure, maximal sterile barrier technique during CVC insertion is defined to include use of: cap AND mask AND sterile gown AND sterile gloves AND a large sterile sheet AND hand hygiene AND 2% chlorhexidine for cutaneous antisepsis.

Numerator Coding:
All Elements of Maximal Sterile Barrier Technique Followed
CPT II 6030F: All elements of maximal sterile barrier technique including: cap AND mask AND sterile gown AND sterile gloves AND a large sterile sheet AND hand hygiene AND 2% chlorhexidine for cutaneous antisepsis, followed

OR

All Elements of Maximal Sterile Barrier Technique not Followed for Medical Reasons
Append a modifier (**1P**) to CPT Category II code **6030F** to report documented circumstances that appropriately exclude patients from the denominator.

- **1P:** Documentation of medical reason(s) for not following all elements of maximal sterile barrier technique during CVC insertion (including CVC insertion performed on emergency basis)

OR

All Elements of Maximal Sterile Barrier Technique not Followed, Reason not Specified

Append a reporting modifier (**8P**) to CPT Category II code **6030F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

- **8P:** All elements of maximal sterile barrier technique including: cap AND mask AND sterile gown AND sterile gloves AND a large sterile sheet AND hand hygiene AND 2% chlorhexidine for cutaneous antisepsis, not followed reason not otherwise specified

DENOMINATOR:

All patients, regardless of age, who undergo CVC insertion

Denominator Coding:

A CPT procedure code for CVC insertion or replacement is required to identify patients for denominator inclusion.

CPT procedure codes: 36555, 36556, 36557, 36558, 36560, 36561, 36563, 36565, 36566, 36568, 36569, 36570, 36571, 36578, 36580, 36581, 36582, 36583, 36584, 36585

RATIONALE:

Catheter-related bloodstream infection is a costly complication of central venous catheter insertion, but may be avoided with routine use of aseptic technique during catheter insertion. This measure is constructed to require that *all* of the listed elements of aseptic technique are followed and documented.

Existing hospital-level measures for this topic were consulted and, to the extent feasible, harmonization between physician- and hospital-level measurement was achieved.

CLINICAL RECOMMENDATION STATEMENTS:

Maximal sterile barrier precautions during catheter insertion: Use aseptic technique including the use of a cap, mask, sterile gown, sterile gloves, and a large sterile sheet, for the insertion of CVCs (including PICCS) or guidewire exchange. (CDC/MMWR) (Category IA)

Hand hygiene: Observe proper hand-hygiene procedures either by washing hands with conventional antiseptic-containing soap and water or with waterless alcohol-based gels or foams. Observe hand hygiene before and after palpating catheter insertion sites, as well as before and after inserting, replacing, accessing, repairing, or dressing an intravascular catheter. Palpation of the insertion site should not be performed after the application of antiseptic, unless aseptic technique is maintained. Use of gloves does not obviate the need for hand hygiene. (CDC/MMWR) (Category IA)

Cutaneous antisepsis: Disinfect clean skin with an appropriate antiseptic before catheter insertion and during dressing changes. Although a 2% chlorhexidine-based preparation is preferred, tincture of iodine, an iodophor, or 70% alcohol can be used. (CDC/MMWR) (Category IA)

*Measure #77: Assessment of GERD Symptoms in Patients Receiving Chronic Medication for GERD

DESCRIPTION:
Percentage of patients aged 18 years and older with the diagnosis of gastroesophageal reflux disease (GERD) who have been prescribed continuous proton pump inhibitor (PPI) or histamine H_2 receptor antagonist (H_2RA) therapy who received an annual assessment of their GERD symptoms after 12 months of therapy

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

This measure is 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 and denominator 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(s) **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 an annual assessment of their GERD symptoms after 12 months of therapy

> ***NUMERATOR NOTE:*** *The correct combination of numerator codes must be reported on the claim form in order to properly report this measure. The "correct combination" of codes may require the submission of multiple numerator codes.*
>
> **Numerator Coding:**
> **GERD Symptoms Assessed**
> *(Two CPT II codes [1118F & 4185F] are required on the claim form to submit this category)*
>
> **CPT II 1118F:** GERD symptoms assessed after 12 months of therapy
> **AND**
> **CPT II 4185F:** Continuous (12-months) therapy with proton pump inhibitor (PPI) or histamine H2 receptor antagonist (H_2RA) received

OR

GERD Symptoms not Assessed for Medical Reasons
(Two CPT II codes [1118F-1P & 4185F] are required on the claim form to submit this category)

Append a modifier (**1P**) to CPT Category II code **1118F** to report documented circumstances that appropriately exclude patients from the denominator

- **1118F *with* 1P:** Documentation of medical reason(s) for not assessing GERD symptoms

AND
CPT II 4185F: Continuous (12-months) therapy with proton pump inhibitor (PPI) or histamine H2 receptor antagonist (H_2RA) received

OR

If patient is not eligible for this measure because patient was not prescribed continuous medication therapy, report:
(One CPT II code [4186F] is required on the claim form to submit this category)

CPT II 4186F: No continuous (12-months) therapy with either proton pump inhibitor (PPI) or histamine H_2 receptor antagonist (H_2RA) received

OR

GERD Symptoms not Assessed, Reason not Specified
(Two CPT II codes [1118F-8P & 4185F] are required on the claim form to submit this category)

Append a reporting modifier (**8P**) to CPT Category II code **1118F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

- **1118F *with* 8P:** GERD symptoms not assessed after 12 months of therapy, reason not otherwise specified

AND
CPT II 4185F: Continuous (12-months) therapy with proton pump inhibitor (PPI) or histamine H2 receptor antagonist (H_2RA) received

DENOMINATOR:
All patients aged 18 years and older with a diagnosis of GERD who have been prescribed continuous proton pump inhibitor (PPI) or histamine H_2 receptor antagonist (H_2RA) therapy

Definition: Continuous medication therapy is defined as any patient receiving proton pump inhibitor (PPI) or histamine H_2 receptor antagonist (H_2RA) therapy lasting 12 months or more to treat GERD.

Denominator Coding:
An ICD-9 diagnosis code for gastroesophageal reflux disease 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:
Many patients with GERD remain on medication therapy for years, and experts suspect that not all patients are being reassessed on a regular basis to determine whether the medication is still needed. This measure attempts to capture whether or not a patient on chronic medication have their GERD symptoms are assessed at least annually. Research indicates that patients on chronic therapy are able to have their dose modified or reduced based on the presence or absence of symptoms.

CLINICAL RECOMMENDATION STATEMENTS:
Because GERD is a chronic condition, continuous therapy to control symptoms and prevent complications is appropriate. (ACG)

Nonresponders to adequate trials of drug therapy, particularly PPI therapy, should have their symptoms reassessed, undergo endoscopy if it was not previously done, and be considered for additional diagnostic work-up. (VHA/DOD)

Inadequate response to a 4- to 8-week course of standard-dose PPI may indicate longer treatment is needed, more severe disease, or incorrect diagnosis. If there is an adequate response to a course of standard-dose PPI (the recommended duration of therapy for PPIs in the treatment of GERD is 4 to 8 weeks), extend treatment with either the same or double dose of PPI. (VHA/DOD)

▲Measure #78: Vascular Access for Patients Undergoing Hemodialysis

DESCRIPTION:
Percentage of patients aged 18 years and older with a diagnosis of end stage renal disease (ESRD) and receiving hemodialysis who have a functioning AV fistula OR patients who are referred for an AV fistula at least once during the 12-month reporting period

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for ESRD patients receiving hemodialysis seen during the reporting period. It is anticipated that clinicians providing care for patients with ESRD will submit this measure.

This measure is reported using CPT Category II 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. 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, G-codes and the appropriate CPT Category II code(s) **OR** the CPT Category II code(s) **with** the modifier. The modifiers allowed for this measure are: 1P- medical reasons, 2P- patient reasons, 8P- reasons not otherwise specified.

NUMERATOR:
Patients who have a functioning AV fistula OR patients who are referred for AV fistula at least once during the 12 month reporting period

> ***NUMERATOR NOTE:*** *The correct combination of numerator codes must be reported on the claim form in order to properly report this measure. The "correct combination" of codes may require the submission of multiple numerator codes.*
>
> **Numerator Coding:**
> **Patient with Functioning AV Fistula**
> *(One CPT II code [4052F] is required on the claim form to submit this category)*
>
> **CPT II 4052F:** Hemodialysis via functioning arterio-venous (AV) fistula
>
> **OR**
>
> **Patient Referred for AV Fistula**
> *(Two CPT II codes [4051F & 4054F] are required on the claim form to submit this category)*
>
> **CPT II 4051F:** Referred for an arterio-venous (AV) fistula
> **AND**
> **CPT II 4054F:** Hemodialysis via catheter

OR

Patient not Referred for AV Fistula for Medical or Patient Reasons
(Two CPT II codes [4051F-1P & 4054F] are required on the claim form to submit this category)

Append a modifier (**1P or 2P**) to CPT Category II code **4051F** to report documented circumstances that appropriately exclude patients from the denominator.

- **4051F *with* 1P:** Documentation of medical reason(s) for not referring for an AV fistula (e.g., documentation of a functioning AV graft)
- **4051F *with* 2P:** Documentation of patient reason(s) for not referring for an AV fistula

AND
CPT II 4054F: Hemodialysis via catheter

OR

If patient is not eligible for this measure because patient has a functioning arterio-venous (AV) graft, report:
(One CPT II code [4053F] is required on the claim form to submit this category)

CPT II 4053F: Hemodialysis via functioning arterio-venous (AV) graft

OR

Patient not Referred for AV Fistula, Reason not Specified
(Two CPT II codes [4051F-8P & 4054F] are required on the claim form to submit this category)

Append a reporting modifier (**8P**) to CPT Category II codes **4051F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

- **4051F *with* 8P:** Patient was not referred for an AV fistula, reason not otherwise specified

AND
CPT II 4054F: Hemodialysis via catheter

DENOMINATOR:
All patients aged 18 years and older with a diagnosis of ESRD and receiving hemodialysis

Denominator Coding:
An ICD-9 diagnosis code for ESRD and a G-code or CPT procedure code for hemodialysis are required to identify patients for denominator inclusion.
ICD-9 diagnosis codes: 585.6
AND
CPT procedure codes or G-codes: 90935, 90937, G0314, G0315, G0316, G0317, G0318, G0319

RATIONALE:

A functioning AV fistula is the preferred delivery method for hemodialysis. This measure assesses two components: 1) whether patients have a functioning AV fistula, or 2) if not, was the patient referred for an AV fistula or permanent vascular access at least once during the reporting year. This measure captures actions that are within a nephrologist's control (e.g., referral) rather than simply measuring the percentage of patients who have an AV fistula.

CLINICAL RECOMMENDATION STATEMENTS:

Patients should have a functional permanent access at the initiation of dialysis therapy. A fistula should be placed at least 6 months before the anticipated start of HD treatments. This timing allows for access evaluation and additional time for revision to ensure a working fistula is available at initiation of dialysis therapy. (B) A graft should, in most cases, be placed at least 3 to 6 weeks before the anticipated start of HD therapy. Some newer graft materials may be cannulated immediately after placement. (B) A peritoneal dialysis (PD) catheter ideally should be placed at least 2 weeks before the anticipated start of dialysis treatments. A backup HD access does not need to be placed in most patients. A PD catheter may be used as a bridge for a fistula in "appropriate" patients. (B) (KDOQI™)

▲Measure #79: Influenza Vaccination in Patients with End Stage Renal Disease (ESRD)

DESCRIPTION:
Percentage of patients aged 18 years and older with a diagnosis of ESRD and receiving dialysis who received the influenza immunization during the flu season (September through February)

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for ESRD patients receiving dialysis seen during the reporting period. This measure is intended to determine whether or not ESRD patients receiving dialysis received or had an order for influenza immunization during the flu season. It is anticipated that clinicians providing care for patients with ESRD will submit this measure.

This measure is reported using CPT Category II 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. 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, G-codes, and the appropriate CPT Category II code **OR** the CPT Category II code **with** the modifier. The modifiers allowed for this measure are: 1P- medical reasons, 2P- patient reasons, 3P- system reasons, 8P- reasons not otherwise specified.

NUMERATOR:
Patients who received the influenza immunization during the flu season (September through February)

Numerator Coding:
Influenza Immunization Received
CPT II 4037F: Influenza immunization ordered or administered

OR

Influenza Immunization not Received for Medical, Patient, or System Reasons
Append a modifier (**1P, 2P, or 3P**) to CPT Category II code **4037F** to report documented circumstances that appropriately exclude patients from the denominator.

- **1P:** Documentation of medical reason(s) for patient not receiving the influenza immunization
- **2P:** Documentation of patient reason(s) for patient not receiving the influenza immunization
- **3P:** Documentation of system reason(s) for patient not receiving the influenza immunization

OR

Influenza Immunization not Received, Reason not Specified
Append a reporting modifier (**8P**) to CPT Category II code **4037F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

- **8P:** Influenza immunization not ordered or administered, reason not otherwise specified

DENOMINATOR:
All patients aged 18 years and older with a diagnosis of ESRD and receiving dialysis

Denominator Coding:
An ICD-9 diagnosis code for ESRD and a G-code or CPT procedure code for dialysis are required to identify patients for denominator inclusion.
ICD-9 diagnosis codes: 585.6
AND
CPT procedure codes or G-codes: 90935, 90937, 90945, 90947, G0314, G0315, G0316, G0317, G0318, G0319, G0322, G0323, G0326, G0327

RATIONALE:
Infectious disease is a common cause of death in late-stage kidney disease patients. Immunizing this high risk population is therefore critical to increasing patient well-being and potentially reducing morbidity and mortality. Despite its importance, a review of Medicare billing data has indicated that the ESRD population had a less than 50% immunization rate for the years 1997 to 1998 and 1998 to 1999.

CLINICAL RECOMMENDATION STATEMENTS:
Annual influenza vaccine is recommended for all persons aged 65 and older and persons in selected high-risk groups. (B recommendation) (USPSTF)

Vaccination is recommended for the following persons who are at increased risk for complications from influenza: adults and children who have required regular medical follow-up or hospitalization during the preceding year because of chronic metabolic diseases (including diabetes mellitus), renal dysfunction, hemoglobinopathies, or immunosuppression (including immunosuppression caused by medications or by human immunodeficiency virus [HIV]); (CDC).

▲Measure #80: Plan of Care for ESRD Patients with Anemia

DESCRIPTION:
Percentage of patient calendar months during the 12-month reporting period in which patients aged 18 years and older with a diagnosis of end stage renal disease (ESRD) who are receiving dialysis have a Hgb ≥ 11g/dL OR have a Hgb < 11 g/dL with a documented plan of care for anemia

INSTRUCTIONS:
This measure is to be reported a minimum of once per calendar month for ESRD patients receiving dialysis seen during the reporting period. It is anticipated that clinicians providing care for patients with ESRD will submit this measure.

This measure is reported using CPT Category II 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. 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, G-codes and the appropriate CPT Category II code(s) **OR** the CPT Category II code(s) **with** the modifier. The modifier allowed for this measure is: 8P- reasons not otherwise specified. There are no allowable performance exclusions for this measure.

NUMERATOR:
Number of patient calendar months during which patients have a Hgb ≥ 11 g/dL OR have a Hgb < 11 g/dL with a documented plan of care for anemia

> ***NUMERATOR NOTE:*** *The correct combination of numerator codes must be reported on the claim form in order to properly report this measure. The "correct combination" of codes may require the submission of multiple numerator codes.*
>
> **Numerator Coding:**
> **Patient has Hemoglobin Level ≥ 11 g/dL**
> *(One CPT II code [32⊠⊠F] is required on the claim form to submit this category)*
>
> **CPT II 3279F:** Hemoglobin level greater than or equal to 13 g/dL
> **OR**
> **CPT II 3280F:** Hemoglobin level 11 g/dL to 12.9 g/dL
>
> **OR**

Patient has Hemoglobin < 11 g/dL with a Documented Plan of Care
(Two CPT II codes [3281F & 0516F] are required on the claim form to submit this category)

CPT II 3281F: Hemoglobin less than 11 g/dL
AND
CPT II 0516F: Anemia plan of care documented

OR

Hemoglobin Level not Performed or Documented:
(Two CPT II codes [3279F] are required on the claim form to submit this category)

Append a reporting modifier (**8P**) to CPT Category II code **3279F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

- **3279F *with* 8P:** Hemoglobin level was not performed or documented, reason not otherwise specified

OR

Patient has Hemoglobin Level < 11 g/dL without a Documented Plan of Care, Reason Not Specified
(Two CPT II codes [0516F-8P & 3281F] are required on the claim form to submit this category)

Append a reporting modifier (**8P**) to CPT Category II codes **0516F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

- **0516F *with* 8P:** Anemia plan of care not documented, reason not otherwise specified

AND
CPT II 3281F: Hemoglobin less than 11g/dL

DENOMINATOR:
Calendar months during which all patients aged 18 years and older with a diagnosis of ESRD are receiving dialysis

Denominator Coding:
An ICD-9 diagnosis code for ESRD and a G-code or CPT procedure code for dialysis are required to identify patients for denominator inclusion.
ICD-9 diagnosis codes: 585.6
AND
CPT procedure codes or G-codes: 90935, 90937, 90945, 90947, G0314, G0315, G0316, G0317, G0318, G0319, G0322, G0323, G0326, G0327

RATIONALE:
Anemia is a common comorbidity in patients with kidney disease, increasing in likelihood as kidney function declines. The goal of this measure is to identify anemia and develop a treatment plan

which is vital to “improve patient quality of life, to improve the various physiological abnormalities associated with anemia, to decrease morbidity, to decrease hospitalization, and to improve patient survival.”

CLINICAL RECOMMENDATION STATEMENTS:

Hb testing should be carried out in all patients with CKD, regardless of stage or cause (Opinion). Hb levels should be measured at least annually (Opinion). In patients with CKD, Hb should be 11.0 g/dL or greater (Moderately Strong Recommendation). (KDOQI™)

▲Measure #81: Plan of Care for Inadequate Hemodialysis in ESRD Patients

DESCRIPTION:
Percentage of patient calendar months during the 12-month reporting period in which patients aged 18 years and older with a diagnosis of end stage renal disease (ESRD) receiving hemodialysis have a Kt/V ≥ 1.2 OR patients who have a Kt/V < 1.2 with a documented plan of care for inadequate hemodialysis

INSTRUCTIONS:
This measure is to be reported a minimum of once per calendar month for ESRD patients receiving hemodialysis seen during the reporting period. It is anticipated that clinicians providing care for patients with ESRD will submit this measure.

This measure is reported using CPT Category II 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. 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, G-codes, and the appropriate CPT Category II code(s) **OR** the CPT Category II code(s) **with** the modifier. The modifier allowed for this measure is: 8P- reasons not otherwise specified. There are no allowable performance exclusions for this measure.

NUMERATOR:
Number of patient calendar months during which patients have a Kt/V ≥1.2 OR have Kt/V <1.2 with a documented plan of care for inadequate hemodialysis

> **Definition:** A documented plan of care may include checking for adequacy of the AV access, increasing the blood flow, increasing the dialyzer size, increasing the time of dialysis sessions, adjusting dialysis prescription, or documenting residual renal function.
>
> ***NUMERATOR NOTE:*** *The correct combination of numerator codes must be reported on the claim form in order to properly report this measure. The "correct combination" of codes may require the submission of multiple numerator codes.*
>
> **Numerator Coding:**
> **Kt/V ≥ 1.2**
> *(One CPT II code [30⊠⊠F] is required on the claim form to submit this category)*
>
> **CPT II 3083F:** Kt/V equal to or greater than 1.2 and less than 1.7 (Clearance of urea (Kt)/volume(V))
> **OR**
> **CPT II 3084F:** Kt/V ≥1.7 (Clearance of urea (Kt)/volume(V))
>
> **OR**

Kt/V < 1.2 with a Documented Plan of Care
(Two CPT II codes [3082F & 0505F] are required on the claim form to submit this category)

CPT II 3082F: Kt/V **<** 1.2 (Clearance of urea (Kt)/volume(V))
AND
CPT II 0505F: Hemodialysis plan of care documented

OR

Kt/V Measurement not Performed or Documented:
(One CPT II code [3084F-8P] is required on the claim form to submit this category)

Append a reporting modifier (**8P**) to CPT Category II code **3084F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified

- **3084F *with* 8P:** Kt/V was not performed or documented, reason not otherwise specified

OR

Patient has Kt/V < 1.2 without a Documented Plan of Care, Reason not Specified
(Two CPT II codes [0505F-8P & 3082F] are required on the claim form to submit this category)

Append a reporting modifier (**8P**) to CPT Category II codes **0505F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

- **0505F *with* 8P:** Hemodialysis plan of care not documented, reason not otherwise specified

AND
CPT II 3082F: Kt/V **<** 1.2 (Clearance of urea (Kt)/volume(V))

DENOMINATOR:
Calendar months for all patients aged 18 years and older with a diagnosis of ESRD who are receiving hemodialysis

Denominator Coding:
An ICD-9 diagnosis code for ESRD and a G-code or CPT procedure code for hemodialysis are required to identify patients for denominator inclusion.
ICD-9 diagnosis codes: 585.6
AND
CPT procedure codes or G-codes: 90935, 90937, G0314, G0315, G0316, G0317, G0318, G0319

RATIONALE:

Patients receiving hemodialysis must be monitored (by assessing Kt/V) regularly to ensure that their dialysis dose is sufficient. A patient receiving hemodialysis whose Kt/V level is less than 1.2 is not receiving optimal dialysis. This measure assesses whether the treating physician addressed the low Kt/V level. A plan of care (action defined as checking for adequacy of the AV access, increasing the blood flow, increasing the dialyzer size, or increasing the time of dialysis sessions) should be documented by the physician for every time Kt/V is less than 1.2.

CLINICAL RECOMMENDATION STATEMENTS:

Quantifying HD is the first step toward assessment of its adequacy. Fortunately, the intermittent rapid decrease in urea concentration during HD allows a relatively easy measurement of the dose. The delivered dose of HD should be measured at regular intervals no less than monthly(A). (KDOQI™)

The minimally adequate dose of HD given 3 times per week to patients with K_r less than 2 mL/min/1.73 m^2 should be an spKt/V (excluding RKF) of 1.2 per dialysis. For treatment times less than 5 hours, an alternative minimum dose is a URR of 65% (A). The target dose for HD given 3 times per week with K_r less than 2 mL/min/1.73 m^2 should be an spKt/V of 1.4 per dialysis not including RKF, or URR of 70% (A). (KDOQI™)

▲Measure #82: Plan of Care for Inadequate Peritoneal Dialysis

DESCRIPTION:
Percentage of patients aged 18 years and older with a diagnosis of end stage renal disease (ESRD) receiving peritoneal dialysis who have a Kt/V ≥ 1.7 OR patients who have a Kt/V < 1.7 with a documented plan of care for inadequate peritoneal dialysis at least three times during the 12-month reporting period

INSTRUCTIONS:
This measure is to be reported up to three times per reporting year for ESRD patients receiving peritoneal dialysis during the entire reporting period and seen during the reporting period.
This measure should be reported according to the following frequency, depending on the number of months during the reporting period a patient is receiving peritoneal dialysis:

- 1-4 months- report once during the reporting period
- 5-8 months- report twice during the reporting period
- 9-12 months- report three times during the reporting period

It is anticipated that clinicians providing care for patients with ESRD will submit this measure.

This measure is reported using CPT Category II 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. 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, G-codes, and the appropriate CPT Category II code(s) **OR** the CPT Category II code(s) **with** the modifier. The modifier allowed for this measure is: 8P- reasons not otherwise specified. There are no allowable performance exclusions for this measure.

NUMERATOR:
Patients who have a Kt/V ≥1.7 OR have a Kt/V <1.7 with a documented plan of care for inadequate peritoneal dialysis at least three times during the 12 month reporting period

> **Definition:** A documented plan of care may include assessing for non-adherence with the peritoneal prescription, sampling, and collection; assessing for error in the peritoneal dialysis prescription and/or inadequate monitoring of the delivered dose; performing peritoneal equilibrium testing; assessing for inadequate patient education; increasing the exchange volume; increasing the number of exchanges per 24 hours; assessing for modality (CAPD or CCPD).
>
> ***NUMERATOR NOTE:*** *The correct combination of numerator codes must be reported on the claim form in order to properly report this measure. The "correct combination" of codes may require the submission of multiple numerator codes.*

Numerator Coding:

Kt/V ≥ 1.7

(One CPT II code [3084F] is required on the claim form to submit this category)

CPT II 3084F: Kt/V ≥1.7 (Clearance of urea (Kt)/volume(V))

OR

Kt/V < 1.7 with a Documented Plan of Care

(Two CPT II codes [30☒☒F & 0507F] are required on the claim form to submit this category)

CPT II 3083F: Kt/V equal to or greater than 1.2 and less than 1.7 (Clearance of urea (Kt)/volume(V))

OR

CPT II 3082F: Kt/V < 1.2 (Clearance of urea (Kt)/volume(V))

AND

CPT II 0507F: Peritoneal dialysis plan of care documented

OR

Kt/V not Performed or Documented

(One CPT II code [3084F-8P] is required on the claim form to submit this category)

Append a reporting modifier (**8P**) to CPT Category II code **3084F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified

- **3084F *with* 8P:** Kt/V was not performed or documented, reason not otherwise specified

OR

Patient has Kt/V < 1.7 without a Documented Plan of Care, Reason not Specified

(Two CPT II codes [0507F-8P & 30☒☒F] are required on the claim form to submit this category)

Append a reporting modifier (**8P**) to CPT Category II codes **0507F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

- **0507F *with* 8P:** Peritoneal dialysis plan of care not documented, reason not otherwise specified

AND

CPT II 3082F: Kt/V < 1.2 (Clearance of urea (Kt)/volume(V))

OR

CPT II 3083F: Kt/V equal to or greater than 1.2 and less than 1.7 (Clearance of urea (Kt)/volume(V))

DENOMINATOR:
All patients aged 18 years and older with a diagnosis of ESRD receiving peritoneal dialysis

Denominator Coding:
An ICD-9 diagnosis code for ESRD and a G-code or CPT procedure code for peritoneal dialysis are required to identify patients for denominator inclusion.
ICD-9 diagnosis codes: 585.6
AND
CPT procedure codes or G-codes: 90945, 90947, G0322, G0323, G0326, G0327

RATIONALE:
Patients receiving peritoneal dialysis must be monitored (by assessing Kt/V) regularly to ensure that their dialysis dose is sufficient. A patient receiving peritoneal dialysis whose Kt/V level is less than 1.7 is not receiving optimal dialysis. This measure assesses whether the treating physician addressed the low Kt/V level. A plan of care (may include assessing for non-adherence with the peritoneal prescription, sampling, and collection; assessing for error in the peritoneal dialysis prescription and/or inadequate monitoring of the delivered dose; performing peritoneal equilibrium testing; assessing for inadequate patient education; increasing the exchange volume; or increasing the number of exchanges per 24 hours) should be documented by the physician for every time Kt/V is less than 1.7.

CLINICAL RECOMMENDATION STATEMENTS:
Total solute clearance (residual kidney and peritoneal, in terms of Kt/V_{urea}) should be measured within the first month after initiating dialysis therapy and at least once every 4 months thereafter (B). (KDOQI™)

For patients with residual kidney function (considered to be significant when urine volume is > 100 mL/d): The minimal "delivered" dose of total small-solute clearance should be a total (peritoneal and kidney) Kt/V_{urea} of at least 1.7 per week (B).

For patients without RKF (considered insignificant when urine volume is ≤ 100 mL/d): The minimal "delivered" dose of total small-solute clearance should be a peritoneal Kt/V_{urea} of at least 1.7 per week measured within the first month after starting dialysis therapy and at least once every 4 months thereafter (B). (KDOQI™)

▲Measure #83: Testing of Patients with Chronic Hepatitis C (HCV) for Hepatitis C Viremia

DESCRIPTION:
Percentage of patients aged 18 years and older with a diagnosis of hepatitis C seen for an initial evaluation who had HCV RNA testing ordered or previously performed

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

This measure is 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(s) **OR** the CPT Category II code(s) **with** the modifier. The modifiers allowed for this measure are: 1P- medical reasons, 2P- patient reasons, 8P- reasons not otherwise specified.

NUMERATOR:
Patients for whom HCV RNA testing was ordered or previously performed

> ***NUMERATOR NOTE:*** *The correct combination of numerator codes must be reported on the claim form in order to properly report this measure. The "correct combination" of codes may require the submission of multiple numerator codes.*
>
> **Numerator Coding:**
> **RNA Testing Ordered or Results Documented**
> *(Two CPT II codes [3265F & 1119F] are required on the claim form to submit this category)*
>
> **CPT II 3265F:** Ribonucleic acid (RNA) testing for Hepatitis C viremia ordered or results documented
> **AND**
> **CPT II 1119F:** Initial evaluation for condition

OR

> **RNA Testing not Ordered or Results not Documented for Medical or Patient Reasons**
> *(Two CPT II codes [3265F-☒P & 1119F] are required on the claim form to submit this category)*
>
> Append a modifier (**1P or 2P**) to CPT Category II code **3265F** to report documented circumstances that appropriately exclude patients from the denominator.

- **3265F *with* 1P:** Documentation of medical reason(s) for not ordering or performing RNA testing for HCV
- **3265F *with* 2P:** Documentation of patient reason(s) for not ordering or performing RNA testing for HCV

AND
CPT II 1119F: Initial evaluation for condition

OR

If patient is not eligible for this measure because the patient is seen for a subsequent evaluation for condition, report:
(One CPT II code [1121F] is required on the claim form to submit this category)

CPT II 1121F: Subsequent evaluation for condition

OR

RNA Testing not Ordered or Results not Documented, Reason not Specified
(Two CPT II codes [3265F-8P & 1119F] are required on the claim form to submit this category)

Append a reporting modifier (**8P**) to CPT Category II code **3265F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

- **3265F *with* 8P:** RNA testing for HCV was not ordered or results not documented, reason not otherwise specified

AND
CPT II 1119F: Initial evaluation for condition

DENOMINATOR:
All patients aged 18 years and older with a diagnosis of hepatitis C seen for initial evaluation

Denominator Coding:
An ICD-9 diagnosis code for hepatitis C and a CPT E/M service code are required to identify patients for denominator inclusion.
ICD-9 diagnosis codes: 070.51, 070.54, 070.70
AND
CPT E/M service codes: 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245

RATIONALE:
HCV RNA testing is needed to establish and confirm diagnosis of chronic hepatitis C. HCV is an RNA virus of the Flaviviridae family. HCV replicates preferentially in hepatocytes but is not directly cytopathic, leading to persistent infection. During chronic infection, HCV RNA reaches high levels, generally ranging from 10^5 to 10^7 international units (IU)/mL, but the levels can fluctuate widely. However, within the same individual, RNA levels are usually relatively stable. (NIH)

After initial exposure, HCV RNA can be detected in blood within 1 to 3 weeks and is present at the onset of symptoms.

Antibodies to HCV are detected by enzyme immunoassay (EIA) in only 50 to 70 percent of patients at the onset of symptoms, increasing to more than 90 percent after 3 months.

The clinical utility of serial HCV viral levels in a patient is predicated on continued use of the same specific quantitative assay that was used in the initial determination of the viral level. While there is little correlation between disease severity or disease progression with the absolute level of HCV RNA, quantitative determination of the HCV level provides important information on the likelihood of response to treatment in patients undergoing antiviral therapy.

CLINICAL RECOMMENDATION STATEMENTS:

HCV ribonucleic acid (RNA) testing should be performed in:

a. patients with a positive anti-HCV test (Grade II-2);
b. patients for whom antiviral treatment is being considered, using a quantitative assay (Grade II-2);
c. patients with unexplained liver disease whose anti-HCV test is negative and who are immunocompromised or suspected of having acute HCV infection (Grade II-2). (AASLD)

The diagnosis of chronic hepatitis C infection is often suggested by abnormalities in ALT levels and is established by EIA followed by confirmatory determination of HCV RNA. (NIH)

▲Measure #84: Initial Hepatitis C RNA Testing

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

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for all patients with a diagnosis of chronic hepatitis C seen during the reporting period. This measure is intended to reflect the quality of services provided for patients with chronic hepatitis C who are receiving antiviral treatment. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

This measure is 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(s) **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 for whom quantitative HCV RNA testing was performed within 6 months prior to initiation of treatment

> ***NUMERATOR NOTE:*** *The correct combination of numerator codes must be reported on the claim form in order to properly report this measure. The "correct combination" of codes may require the submission of multiple numerator codes.*
>
> **Numerator Coding:**
> **RNA Testing Performed within Six Months**
> *(Two CPT II codes [3218F & 4150F] are required on the claim form to submit this category)*
>
> **CPT II 3218F:** RNA testing for Hepatitis C documented as performed within six months prior to initiation of antiviral treatment for Hepatitis C
> **AND**
> **CPT II 4150F:** Patient receiving antiviral treatment for Hepatitis C

OR

RNA Testing not Performed within Six Months for Medical Reason
(Two CPT II codes [3218F-1P & 4150F] are required on the claim form to submit this category)

Append a modifier (**1P)** to CPT Category II code **3218F** to report documented circumstances that appropriately exclude patients from the denominator.

- **3218F *with* 1P:** Documentation of medical reason(s) for not performing RNA testing within six months prior to initiation of antiviral treatment for Hepatitis C

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

OR

If patient is not eligible for this measure because patient is not receiving antiviral treatment, report:
(One CPT II code [4151F] is required on the claim form to submit this category)

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

OR

RNA Testing not Performed within Six Months, Reason not Specified
(Two CPT II codes [3218F-8P & 4150F] are required on the claim form to submit this category)
Append a reporting modifier (**8P**) to CPT Category II code **3218F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

- **3218F *with* 8P:** RNA testing for Hepatitis C was not documented as performed within six months prior to initiation of antiviral treatment for Hepatitis C, reason not otherwise specified

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

DENOMINATOR:
All patients aged 18 years and older with a diagnosis of chronic hepatitis C who are receiving antiviral treatment

Denominator Coding:
An ICD-9 diagnosis code for chronic hepatitis C and a CPT E/M service code are required to identify patients for denominator inclusion.
ICD-9 diagnosis codes: 070.54
AND
CPT E/M service codes: 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245

RATIONALE:
Establish baseline level against which to monitor virologic response and indicate likelihood of response. The clinical utility of serial HCV viral levels in a patient is predicated on continued use of the same specific quantitative assay that was used in the initial determination of the viral level. While there is little correlation between disease severity or disease progression with the absolute level of HCV RNA, quantitative determination of the HCV level provides important information on the likelihood of response to treatment in patients undergoing antiviral therapy. (NIH)

CLINICAL RECOMMENDATION STATEMENTS:
HCV RNA testing should be performed in patients with a positive anti-HCV test (Grade II-2), patients for whom antiviral treatment is being considered, using a quantitative assay (Grade II-2), patients with unexplained liver disease whose anti-HCV test is negative and patients who are immune compromised or suspected of having acute HCV infection (Grade II-2). AASLD)

All candidates for antiviral therapy should be tested for HCV RNA with a quantitative amplification assay, which provides both a baseline level against which to monitor virologic response and a prognostic indicator of the likelihood of response. AGA)

The diagnosis of chronic hepatitis C infection is often suggested by abnormalities in ALT levels and is established by EIA followed by confirmatory determination of HCV RNA. NIH)

▲Measure #85: HCV Genotype Testing Prior to Therapy

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

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for all patients with a diagnosis of chronic hepatitis C seen during the reporting period. This measure is intended to reflect the quality of services provided for patients with chronic hepatitis C who are receiving antiviral treatment. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

This measure is reported using CPT Category II codes and/or 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. CPT Category II codes and/or 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 CPT Category II code **AND/OR** G-code **OR** the CPT Category II code **with** the modifier **AND** G-code. There are no allowable performance exclusions for this measure.

NUMERATOR:
Patients for whom HCV genotype testing was performed prior to initiation of treatment

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

Numerator Coding:
Hepatitis C Genotype Testing Performed
(One CPT II code & one G-code [3266F & G8459] are required on the claim form to submit this category)

CPT II 3266F: Hepatitis C genotype testing documented as performed prior to initiation of antiviral treatment for hepatitis C
AND
G8459: Clinician documented that patient is receiving antiviral treatment for Hepatitis C

OR

If patient is not eligible for this measure because patient is not receiving antiviral treatment, report:
(One G-code [G8458] is required on the claim form to submit this category)

G8458: Clinician documented that patient is not an eligible candidate for genotype testing; patient not receiving antiviral treatment for Hepatitis C

OR

Genotype Testing not Performed, Reason not Specified
(One CPT II code & one G-code [3266F-8P & G8459] are required on the claim form to submit this category)

Append a reporting modifier (**8P**) to CPT Category II code **3266F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

- **3266F *with* 8P:** Hepatitis C genotype testing was not documented as performed prior to initiation of antiviral treatment for Hepatitis C, reason not otherwise specified

AND
G8459: Clinician documented that patient is receiving antiviral treatment for Hepatitis C

DENOMINATOR:
All patients aged 18 years and older with a diagnosis of chronic hepatitis C who are receiving antiviral treatment

Denominator Coding:
An ICD-9 diagnosis code for chronic hepatitis C and a CPT E/M service code are required to identify patients for denominator inclusion.
ICD-9 diagnosis codes: 070.54
AND
CPT E/M service codes: 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245

RATIONALE:
To guide treatment decisions regarding duration of therapy and likelihood of response. There are 6 HCV genotypes and more than 50 subtypes. These genotypes differ by as much as 31 to 34 percent in their nucleotide sequences, whereas subtypes differ by 20 to 23 percent based on full-length genomic sequence comparisons. Genotype determinations influence treatment decisions. Patients with genotypes 2 or 3 have better response rates to re-treatment than those with genotype 1. (NIH)

CLINICAL RECOMMENDATION STATEMENTS:
HCV genotype should be determined in all HCV-infected persons prior to treatment in order to determine the duration of therapy and likelihood of response (Grade I). (AASLD)

Information on the genotype of the virus is important to guide treatment decisions. Genotype 1, most commonly found in the United States, is less amenable to treatment than genotypes 2 or 3. (NIH)

All candidates for antiviral therapy should be tested for HCV RNA with a quantitative amplification assay and should be tested for HCV genotype. (AGA)

▲Measure #86: Consideration for Antiviral Therapy in HCV Patients

DESCRIPTION:
Percentage of patients aged 18 years and older with a diagnosis of chronic hepatitis C who were considered for peginterferon and ribavirin therapy within the 12-month reporting period

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

This measure is 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 considered for peginterferon and ribavirin therapy within the 12 month reporting period

Numerator Coding:
Peginterferon and Ribavirin Therapy Considered or Prescribed
CPT II 4152F: Documentation that combination peginterferon and ribavirin therapy considered
OR
CPT II 4153F: Combination peginterferon and ribavirin therapy prescribed

OR

Peginterferon and Ribavirin Therapy not Considered or Prescribed, Reason not Specified
Append a reporting modifier (**8P**) to CPT Category II code **4152F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

- **8P:** Combination peginterferon and ribavirin therapy was not considered or prescribed, reason not otherwise specified

DENOMINATOR:
All patients aged 18 years and older with a diagnosis of chronic hepatitis C

Denominator Coding:
An ICD-9 diagnosis code for chronic hepatitis C and a CPT E/M service code are required to identify patients for denominator inclusion.
ICD-9 diagnosis codes: 070.54
AND
CPT E/M service codes: 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245

RATIONALE:
Assure that antiviral therapy is considered for all patients with confirmed Hepatitis C.

The current standard of care for the treatment of previously untreated patients with chronic hepatitis C is combination pegylated interferon (PEG-IFN) alfa by subcutaneous injection once a week and oral ribavirin daily. For patients with contraindications to ribavirin but who have indications for antiviral therapy, PEG-IFN represents the best available treatment. (AGA)

Current contraindications to therapy include decompensated cirrhosis, pregnancy, uncontrolled depression or severe mental illness, active substance abuse in the absence of concurrent participation in a drug treatment program, advanced cardiac or pulmonary disease, severe cytopenias, poorly controlled diabetes, retinopathy, seizure disorders, immunosuppressive treatment, autoimmune diseases, or other inadequately controlled comorbid conditions.(AGA)

CLINICAL RECOMMENDATION STATEMENTS:
The treatment of choice is peginterferon plus ribavirin (Grade I). (AASLD)

The current standard of care for the treatment of previously untreated patients with chronic hepatitis C is combination pegylated interferon (PEG-IFN) alfa by subcutaneous injection once a week and oral ribavirin daily. For patients with contraindications to ribavirin but who have indications for antiviral therapy, PEG-IFN represents the best available treatment. (Category I)(AGA summ) Current contraindications to therapy include decompensated cirrhosis, pregnancy, uncontrolled depression or severe mental illness, active substance abuse in the absence of concurrent participation in a drug treatment program, advanced cardiac or pulmonary disease, severe cytopenias, poorly controlled diabetes, retinopathy, seizure disorders, immunosuppressive treatment, autoimmune diseases, or other inadequately controlled comorbid conditions (Category I). (AGA)

Combination therapy results in better treatment responses than monotherapy, but the highest response rates have been achieved with pegylated interferon in combination with ribavirin. (NIH)

▲Measure #87: HCV RNA Testing at Week 12 of Therapy

DESCRIPTION:
Percentage of patients aged 18 years and older with a diagnosis of chronic hepatitis C who are receiving antiviral treatment for whom quantitative HCV RNA testing was performed at 12 weeks from the initiation of antiviral treatment

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for all patients with a diagnosis of chronic hepatitis C seen during the reporting period. This measure is intended to reflect the quality of services provided for patients with chronic hepatitis C who are receiving antiviral treatment. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

This measure is reported using CPT Category II codes and/or 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. CPT Category II codes and/or 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 CPT Category II code **AND/OR** G-code **OR** the CPT Category II code **with** the modifier **AND** G-code. The modifiers allowed for this measure are: 1P- medical reasons, 2P- patient reasons, 8P- reasons not otherwise specified.

NUMERATOR:
Patients for whom quantitative HCV RNA testing was performed at 12 weeks from the initiation of antiviral treatment

> **Definition:** Patients for whom testing was performed between 11-13 weeks from the initiation of antiviral treatment will meet the numerator for this measure.
>
> ***NUMERATOR NOTE:*** *The correct combination of numerator codes must be reported on the claim form in order to properly report this measure. The "correct combination" of codes may require the submission of multiple numerator codes.*
>
> **Numerator Coding:**
> **Hepatitis C Quantitative RNA Testing at 12 weeks**
> *(One CPT II code & one G-code [3220F & G8461] are required on the claim form to submit this category)*
>
> **CPT II 3220F:** Hepatitis C quantitative RNA testing documented as performed at 12 weeks from initiation of antiviral treatment
> **AND**
> **G8461:** Patient receiving antiviral treatment for Hepatitis C

OR

Hepatitis C Quantitative RNA Testing not Performed at 12 Weeks
(One CPT II code & one G-code [3220F-1P & G8461] are required on the claim form to submit this category)

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

- **3220F *with* 1P:** Documentation of medical reason(s) for not performing quantitative HCV RNA at 12 weeks from initiation of antiviral treatment
- **3220F *with* 2P:** Documentation of patient reason(s) for not performing quantitative HCV RNA at 12 weeks from initiation of antiviral treatment

AND
G8461: Patient receiving antiviral treatment for Hepatitis C

OR

If patient is not eligible for this measure because patient is not receiving antiviral treatment, report:
(One G-code [G8460] is required on the claim form to submit this category)

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

OR

Hepatitis C Quantitative RNA Testing not Performed at 12 Weeks, Reason not Specified
(One CPT II code & one G-code [3220-8P & G8461] are required on the claim form to submit this category)

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

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

AND
G8461: Patient receiving antiviral treatment for Hepatitis C

DENOMINATOR:
All patients aged 18 years and older with a diagnosis of chronic hepatitis C who are receiving antiviral treatment

Denominator Coding:
An ICD-9 diagnosis code for chronic hepatitis C and a CPT E/M service code are required to identify patients for denominator inclusion.
ICD-9 diagnosis codes: 070.54
AND
CPT E/M service codes: 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245

RATIONALE:
Monitor effectiveness of antiviral therapy. An early virologic response (EVR), during the first 12 weeks of therapy, is a valuable clinical milestone. In the absence of an EVR, the likelihood of an SVR is 0–3%. If the only goal of therapy is to achieve an SVR, therapy can be discontinued after 12 weeks if an EVR is not achieved. Potentially, histologic benefit can accrue even in the absence of an SVR; therefore, some authorities treat beyond 12 weeks even in patients who have not achieved an EVR. For documentation of a virologic response at the end of therapy (end-of-treatment response) or an SVR ≥ 6 months after completing therapy, a more sensitive quantitative assay with a lower limit of ≤ 50 IU/mL, if available, or a qualitative HCV RNA assay is recommended.

CLINICAL RECOMMENDATION STATEMENTS:
Baseline and 12-week monitoring of HCV RNA levels should be performed with the same quantitative amplification assay. An early virologic response (EVR), defined as a ≥ 2-$\log_{10}$ reduction in HCV RNA levels during the first 12 weeks of therapy, is a valuable clinical milestone (Category I). (AGA)

Clinical and virologic monitoring during therapy should be conducted at intervals ranging from once a month to once every 3 months. Frequent hematologic monitoring is necessary to identify marked anemia, neutropenia, and thrombocytopenia; monitoring of thyroid stimulating hormone level is indicated to identify hypothyroidism or hyperthyroidism (Category I). (AGA)

▲Measure #88: Hepatitis A and B Vaccination in Patients with HCV

DESCRIPTION:
Percentage of patients aged 18 years and older with a diagnosis of hepatitis C who were recommended to receive or who have received hepatitis A vaccination or who have documented immunity to hepatitis A AND who were recommended to receive or have received hepatitis B vaccination or who have documented immunity to hepatitis B

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

This measure is 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 codes **with** the modifier. The modifiers allowed for this measure are: 1P- medical reasons, 8P- reasons not otherwise specified.

NUMERATOR:
Patients who were recommended to receive or who have received hepatitis A vaccination or who have documented immunity to hepatitis A AND who were recommended to receive or who have received hepatitis B vaccination or who have documented immunity to hepatitis B

Numerator Instructions: Two CPT II codes are required for successful reporting.
Report one code for Hepatitis A Vaccine series and one code for Hepatitis B Vaccine series

Hepatits A Numerator Coding:
Hepatitis A Vaccine Recommended or Previously Received or Patient Has Documented Immunity
CPT II 4154F: Hepatitis A vaccine series recommended
OR
CPT II 4155F: Hepatitis A vaccine series previously received
OR
CPT II 3215F: Patient has documented immunity to Hepatitis A

OR

Hepatitis A Vaccine not Recommended for Medical Reasons
Append a modifier (**1P**) to CPT Category II code **4154F** to report documented circumstances that appropriately exclude patients from the denominator.

- **1P:** Documentation of medical reason(s) for not recommending or administering hepatitis A vaccine series

OR

Hepatitis A Vaccine not Recommended, Reason not Specified
Append a reporting modifier (**8P**) to CPT Category II code **4154F** to report circumstances when an action described in a measure's numerator is not performed and the reason is not otherwise specified.

- **8P:** Hepatitis A Vaccine not recommended, reason not otherwise specified

AND

Hepatitis B Numerator Coding:
Hepatitis B Vaccine Recommended or Previously Received or Patient Has Documented Immunity
CPT II 4156F: Hepatitis B vaccine series recommended
OR
CPT II 4157F: Hepatitis B vaccine series previously received
OR
CPT II 3216F: Patient has documented immunity to Hepatitis B

OR

Hepatitis B Vaccine not Recommended for Medical Reasons
Append a modifier (**1P**) to CPT Category II code **4156F** to report documented circumstances that appropriately exclude patients from the denominator.

- **1P:** Documentation of medical reason(s) for not recommending or administering hepatitis B vaccine series

OR

Hepatitis B Vaccine not Recommended, Reason not Specified
Append a reporting modifier (**8P**) to CPT Category II code **4156F** to report circumstances when an action described in a measure's numerator is not performed and the reason is not otherwise specified.

- **8P:** Hepatitis B Vaccine not recommended, reason not otherwise specified

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

Denominator Coding:
An ICD-9 diagnosis code for hepatitis C and a CPT service code are required to identify patients for denominator inclusion.
ICD-9 diagnosis codes: 070.51, 070.54, 070.70
AND
CPT E/M service codes: 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245

RATIONALE:
Assure that hepatitis A and hepatitis B vaccinations are recommended/received except for cases of documented medical reasons. These vaccinations decrease the potential for a patient acquiring for hepatitis A and hepatitis B which would contribute to further liver damage.

CLINICAL RECOMMENDATION STATEMENTS:
All patients with chronic hepatitis C should be vaccinated against hepatitis A, and seronegative persons with risk factors for hepatitis B virus (HBV) should be vaccinated against hepatitis B. (NIH)

Persons in whom the diagnosis of hepatitis C is established are candidates for hepatitis A and hepatitis B vaccines. (AGA)

▲Measure #89: Counseling Patients with HCV Regarding Use of Alcohol

DESCRIPTION:
Percentage of patients aged 18 years and older with a diagnosis of hepatitis C who received education regarding the risk of alcohol consumption at least once within the 12-month reporting period

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

This measure is 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 received education regarding the risk of alcohol consumption at least once within the 12 month reporting period

Numerator Coding:
Education Regarding Risk of Alcohol Consumption
CPT II 4158F: Patient education regarding risk of alcohol consumption performed

OR

Education Regarding Risk of Alcohol Consumption not Performed, Reason not Specified
Append a reporting modifier (**8P**) to CPT Category II code **4158F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

- **8P:** Patient education regarding risk of alcohol consumption not performed, reason not otherwise specified

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

Denominator Coding:
An ICD-9 diagnosis code for hepatitis C and a CPT E/M service code are required to identify patients for denominator inclusion.
ICD-9 diagnosis codes: 070.51, 070.54, 070.70
AND
CPT E/M service codes: 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245

RATIONALE:
Minimize progression of liver disease. Higher levels of alcohol promote the development of progressive liver disease, with strong evidence for the detrimental effects of 30 g/day in men (~ equivalent to 2 beers, 2 glasses of wine, or 2 mixed drinks) and 20 g/day in women. Lower amounts of alcohol also may increase the risk of liver damage associated with HCV (NIH)

CLINICAL RECOMMENDATION STATEMENTS:
Higher levels of alcohol use play an important role in promoting the development of progressive liver disease, with strong evidence for the detrimental effects of 30 g/day in men (~ equivalent to 2 beers, 2 glasses of wine, or 2 mixed drinks) and 20 g/day in women. Lower amounts of alcohol also may increase the risk of liver damage associated with HCV. (NIH)

Abstinence should be recommended before and during antiviral treatment in alcoholic persons, and treatment of alcohol abuse should be linked with efforts to treat hepatitis C in alcoholic patients. A safe level of alcohol consumption in patients with hepatitis C has not been established (Category II-1b). (AGA)

▲Measure #90 Counseling of Patients Regarding Use of Contraception Prior to Starting Antiviral Therapy

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

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for all patients with a diagnosis of chronic hepatitis C seen during the reporting period. This measure is intended to reflect the quality of services provided for patients with chronic hepatitis C who are receiving antiviral treatment. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

This measure is reported using CPT Category II codes and/or 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. CPT Category II codes and/or 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 CPT Category II code **AND/OR** G-code **OR** the CPT Category II code **with** the modifier **AND** G-code. The modifiers allowed for this measure are: 1P- medical reasons, 8P- reasons not otherwise specified.

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

> ***NUMERATOR NOTE:*** *The correct combination of numerator codes must be reported on the claim form in order to properly report this measure. The "correct combination" of codes may require the submission of multiple numerator codes.*
>
> **Numerator Coding:**
> **Education Regarding Contraception Received**
> *(One CPT II code & one G-code [4159F & G8463] are required on the claim form to submit this category)*
>
> **CPT II 4159F:** Counseling regarding contraception received prior to initiation of antiviral treatment
> **AND**
> **G8463:** Patient receiving antiviral treatment for Hepatitis C documented

OR

Education Regarding Contraception not Received for Medical Reason
(One CPT II code & one G-code [4159F-1P & G8463] are required on the claim form to submit this category)

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

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

AND
G8463: Patient receiving antiviral treatment for Hepatitis C documented

OR

If patient is not eligible for this measure because patient is not receiving antiviral treatment, report:
(One G-code [G8462] is required on the claim form to submit this category)

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

OR

Education Regarding Contraception not Received, Reason not Specified
(One CPT II code & one G-code [4159F-8P & G8463] are required on the claim form to submit this category)

Append a reporting modifier (**8P**) to CPT Category II code **4159F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

- **4159F *with* 8P:** Counseling regarding contraception not received prior to initiation of antiviral treatment, reason not otherwise specified

AND
G8463: Patient receiving antiviral treatment for Hepatitis C documented

DENOMINATOR:
All women aged 18 through 44 years and all men aged 18 years and older with a diagnosis of chronic hepatitis C who are receiving antiviral treatment

Denominator Coding:
An ICD-9 diagnosis code for chronic hepatitis C and a CPT E/M service code are required to identify patients for denominator inclusion.
ICD-9 diagnosis codes: 070.54
AND
CPT E/M service codes: 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245

RATIONALE:
Ribavirin is contraindicated in pregnancy. Therefore, counseling regarding strict precautions and contraception in women of childbearing age and their sexual partners and in HCV-infected men with female partners of childbearing age needs to be provided to those receiving treatment for chronic hepatitis C prior to the initiation of treatment. Although this measure is only captures data related to counseling prior to therapy it should be subsequently re-enforced during treatment and for a period of 6 months after treatment.

CLINICAL RECOMMENDATION STATEMENTS:
Because of the concern of birth defects from the use of ribavirin, it is imperative that persons who receive the drug use strict contraception methods both during treatment and for a period of 6 months after treatment. (AASLD)

Ribavirin is contraindicated in pregnancy, necessitating strict precautions and contraception in women of childbearing age and their sexual partners and in HCV-infected men with female partners of childbearing age. (AGA)

▲Measure #91: Acute Otitis Externa (AOE): Topical Therapy

DESCRIPTION:
Percentage of patients aged 2 years and older with a diagnosis of AOE who were prescribed topical preparations

INSTRUCTIONS:
This measure is to be reported once for each occurrence of AOE during the reporting period. Each unique occurrence is defined as a 30-day period from onset of AOE. Claims data will be analyzed to determine unique occurrences. If multiple claims are submitted within that 30-day period, only one instance of reporting will be counted. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

This measure is 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 appropriate 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 topical preparations

Numerator Coding:
Topical Preparations (including OTC) for Acute Otitis Externa (AOE) Prescribed
CPT II 4130F: Topical preparations (including OTC) prescribed for acute otitis externa

OR

Topical Preparations (including OTC) for Acute Otitis Externa (AOE) not Prescribed for Medical Reasons or Patient Reasons
Append a modifier (**1P or 2P**) to CPT Category II code **4130F** to report documented circumstances that appropriately exclude patients from the denominator.

- **1P:** Documentation of medical reason(s) for not prescribing topical preparations (including OTC) for acute otitis externa
- **2P:** Documentation of patient reason(s) for not prescribing topical preparations (including OTC) for acute otitis externa

OR

Topical Preparations (including OTC) for Acute Otitis Externa (AOE) not Prescribed, Reason not Specified

Append a reporting modifier (**8P**) to CPT Category II code **4130F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

- **8P:** Topical preparations (including OTC) for acute otitis externa (AOE) not prescribed, reason not otherwise specified

DENOMINATOR:

All patients aged 2 years and older with a diagnosis of AOE

Denominator Coding:

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

ICD-9 diagnosis codes: 380.10, 380.11, 380.12, 380.13, 380.22

AND

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

RATIONALE:

Topical preparations should be used to treat AOE as they are active against the most common bacterial pathogens in AOE, Pseudomonas aeruginosa and Staphylococcus aureus. Topical preparations have demonstrated efficacy in the treatment of AOE with resolution in about 65-90% of patients.

CLINICAL RECOMMENDATION STATEMENTS:

Clinicians should use topical preparations for initial therapy of diffuse, uncomplicated AOE. (Recommendation based on randomized controlled trials with minor limitations and a preponderance of benefit over harm. [Aggregate evidence quality – Grade B]) (AAO-HNSF)

▲Measure #92: Acute Otitis Externa (AOE): Pain Assessment

DESCRIPTION:
Percentage of patient visits for those patients aged 2 years and older with a diagnosis of AOE with assessment for auricular or periauricular pain

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

This measure is 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 appropriate 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:
Patient visits with assessment for auricular or periauricular pain

Numerator Coding:
Auricular or Periauricular Pain Assessed
CPT II 1116F: Auricular or periauricular pain assessed

OR

Auricular or Periauricular Pain not Assessed for Medical Reasons
Append a modifier (**1P**) to CPT Category II code **1116F** to report documented circumstances that appropriately exclude patients from the denominator.

- **1P:** Documentation of medical reason(s) for not assessing auricular or periauricular pain

OR

Auricular or Periauricular Pain not Assessed, Reason not Specified
Append a reporting modifier (**8P**) to CPT Category II code **1116F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

- **8P:** Auricular or periauricular pain not assessed, reason not otherwise specified

DENOMINATOR:
All patient visits for those patients aged 2 years and older with a diagnosis of AOE

Denominator Coding:
An ICD-9 diagnosis code for AOE and a CPT E/M service code are required to identify patients for denominator inclusion.
ICD-9 diagnosis codes: 380.10, 380.11, 380.12, 380.13, 380.22
AND
CPT E/M service codes: 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245

RATIONALE:
Pain relief is a major goal in the management of AOE. Frequent use of analgesics is often necessary to permit patients to achieve comfort, rest, and to resume normal activities. Ongoing assessment of the severity of discomfort is essential for proper management.

CLINICAL RECOMMENDATION STATEMENTS:
The management of diffuse AOE should include an assessment of pain. The clinician should recommend analgesic treatment based on the severity of pain. (Strong recommendation based on well-designed randomized trials with a preponderance of benefit over harm. [Aggregate evidence quality – Grade B]) (AAO-HNSF)

▲Measure #93: Acute Otitis Externa (AOE): Systemic Antimicrobial Therapy – Avoidance of Inappropriate Use

DESCRIPTION:
Percentage of patients aged 2 years and older with a diagnosis of AOE who were not prescribed systemic antimicrobial therapy

INSTRUCTIONS:
This measure is to be reported once for each occurrence of AOE during the reporting period. Each unique occurrence is defined as a 30-day period from onset of AOE. Claims data will be analyzed to determine unique occurrences. If multiple claims are submitted within that 30-day period, only one instance of reporting will be counted. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

This measure is 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 appropriate 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 not prescribed systemic antimicrobial therapy

Numerator Instructions: For performance, the measure will be calculated as the number of patients for whom systemic antimicrobial therapy was not prescribed over the number of patients in the denominator (patients aged 2 years and older with acute otitis externa). A higher score indicates appropriate treatment of patients with AOE (e.g., the proportion for whom systemic antimicrobials *were not* prescribed).

Numerator Coding:
Systemic Antimicrobial Therapy not Prescribed
CPT II 4132F: Systemic antimicrobial therapy not prescribed

OR

Systemic Antimicrobial Therapy Prescribed for Medical Reasons
Append a modifier (**1P**) to CPT Category II code **4131F** to report documented circumstances that appropriately exclude patients from the denominator.

- **1P:** Documentation of medical reason(s) for prescribing systemic antimicrobial therapy

OR

Systemic Antimicrobial Therapy Prescribed
CPT II 4131F: Systemic antimicrobial therapy prescribed

DENOMINATOR:
All patients aged 2 years and older with a diagnosis of AOE

Denominator Coding:
An ICD-9 diagnosis code for AOE and a CPT E/M service code are required to identify patients for denominator inclusion.
ICD-9 diagnosis codes: 380.10, 380.11, 380.12, 380.13, 380.22
AND
CPT E/M service codes: 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245

RATIONALE:
Despite their limited utility, many patients with AOE receive systemic antimicrobial therapy, often in addition to topical therapy. "There are no data on the efficacy of systemic therapy with the use of appropriate antibacterials and stratified by severity of the infection. Moreover, orally administered antibiotics have significant adverse effects that include rashes, vomiting, diarrhea, allergic reactions, altered nasopharyngeal flora, and development of bacterial resistance." The use of systemic antimicrobial therapy to treat AOE should be limited only to those clinical situations in which it is indicated.

CLINICAL RECOMMENDATION STATEMENTS:
Systemic antimicrobial therapy should not be used unless there is extension outside the ear canal or the presence of specific host factors that would indicate a need for systemic therapy. (Recommendation based on randomized controlled trials with minor limitations and a preponderance of benefit over harm. [Aggregate evidence quality – Grade B]) (AAO-HNSF)

▲Measure #94: Otitis Media with Effusion (OME): Diagnostic Evaluation – Assessment of Tympanic Membrane Mobility

DESCRIPTION:
Percentage of patient visits for those patients aged 2 months through 12 years with a diagnosis of OME with assessment of tympanic membrane mobility with pneumatic otoscopy or tympanometry

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

This measure is 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 appropriate 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:
Patient visits with assessment of tympanic membrane mobility with pneumatic otoscopy or tympanometry

Numerator Coding:
Tympanic Membrane Mobility Assessed
CPT II 2035F: Tympanic membrane mobility assessed with pneumatic otoscopy or tympanometry

OR

Tympanic Membrane Mobility not Assessed for Medical or Patient Reasons
Append a modifier (**1P or 2P**) to CPT Category II code **2035F** to report documented circumstances that appropriately exclude patients from the denominator.

- **1P:** Documentation of medical reason(s) for not assessing tympanic membrane mobility with pneumatic otoscopy or tympanometry
- **2P:** Documentation of patient reason(s) for not assessing tympanic membrane mobility with pneumatic otoscopy or tympanometry

OR

Tympanic Membrane Mobility not Assessed, Reason not Specified
Append a reporting modifier (**8P**) to CPT Category II code **2035F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

- **8P:** Tympanic membrane mobility not assessed with pneumatic otoscopy or tympanometry, reason not otherwise specified

DENOMINATOR:
All patient visits for those patients aged 2 months through 12 years with a diagnosis of OME

Denominator Coding:
An ICD-9 diagnosis code for OME and a CPT E/M service code are required to identify patients for denominator inclusion.
ICD-9 diagnosis codes: 381.10, 381.19, 381.20, 381.29, 381.3, 381.4
AND
CPT E/M service codes: 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245

RATIONALE:
Correctly diagnosing middle ear effusion is essential for proper management. OME is often characterized by a cloudy tympanic membrane with distinctly impaired mobility which can best be determined with pneumatic otoscopy or tympanometry.

CLINICAL RECOMMENDATION STATEMENTS:
Clinicians should use pneumatic otoscopy as the primary diagnostic method for OME. OME should be distinguished from AOM. (Strong Recommendation based on systematic review of cohort studies and preponderance of benefit over harm. [Aggregate evidence quality – Grade A])
Tympanometry can be used to confirm the diagnosis of OME. (Option based on cohort studies and a balance of benefit and harm. [Aggregate evidence quality – Grade B]) (AAFP/AAO-HNSF/AAP)

▲Measure #95: Otitis Media with Effusion (OME): Hearing Testing

DESCRIPTION:
Percentage of patients aged 2 months through 12 years with a diagnosis of OME who received tympanostomy tube insertion who had a hearing test performed within 6 months prior to tympanostomy tube insertion

INSTRUCTIONS:
This measure is to be reported each time a tympanostomy tube insertion procedure is performed during the reporting period for children. It is anticipated that clinicians who perform the tympanostomy tube insertion for children 2 months through 12 years of age with a diagnosis of OME will submit this measure.

This measure is reported using CPT Category II codes:
ICD-9 diagnosis codes, CPT procedure 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 appropriate ICD-9 diagnosis codes, CPT procedure 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, 3P- system reasons, 8P- reasons not otherwise specified.

NUMERATOR:
Patients who had a hearing test performed within 6 months prior to tympanostomy tube insertion

Numerator Coding:
Hearing Test Performed within 6 Months Prior to Tympanostomy Tube Insertion
CPT II 3230F: Documentation that hearing test was performed within 6 months prior to tympanostomy tube insertion

OR

Hearing Test not Performed within 6 Months Prior to Tympanostomy Tube Insertion for Medical or System Reasons
Append a modifier (**1P or 3P**) to CPT Category II code **3230F** to report documented circumstances that appropriately exclude patients from the denominator.

- **1P:** Documentation of medical reason(s) for not performing hearing test within 6 months prior to tympanostomy tube insertion
- **3P:** Documentation of system reason(s) for not performing hearing test within 6 months prior to tympanostomy tube insertion

OR

Hearing Test not Performed within 6 Months Prior to Tympanostomy Tube Insertion, Reason not Specified

Append a reporting modifier (**8P**) to CPT Category II code **3230F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

- **8P:** Hearing test not performed within 6 months prior to tympanostomy tube insertion, reason not otherwise specified

DENOMINATOR:

All patients aged 2 months through 12 years with a diagnosis of OME who received tympanostomy tube insertion

Denominator Coding:

An ICD-9 diagnosis code for OME, a CPT procedure code for tympanostomy tube insertion, and a CPT E/M service code are required to identify patients for denominator inclusion.

ICD-9 diagnosis codes: 381.10, 381.19, 381.20, 381.29, 381.3, 381.4

AND

CPT procedure codes: 69433, 69436

AND

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

RATIONALE:

OME is often accompanied by hearing loss which can impair early language acquisition, especially in severe cases which often necessitate tympanostomy tube insertion. Therefore, it is imperative that any patient for whom tympanostomy tube insertion is indicated have their hearing tested.

CLINICAL RECOMMENDATION STATEMENTS:

Hearing testing is recommended when OME persists for 3 months or longer, or at any time that language delay, learning problems, or a significant hearing loss is suspected in a child with OME. (Recommendation based on cohort studies and preponderance of benefit over risk. [Aggregate evidence quality – Grade B and C]) (AAFP/AAO-HNSF/AAP)

▲Measure #96: Otitis Media with Effusion (OME): Antihistamines or Decongestants – Avoidance of Inappropriate Use

DESCRIPTION:
Percentage of patients aged 2 months through 12 years with a diagnosis of OME who were not prescribed/recommended either antihistamines or decongestants

INSTRUCTIONS:
This measure is to be reported once for each occurrence of OME in children seen during the reporting period. Each unique occurrence is defined as a 90-day period from onset of OME. Claims data will be analyzed to determine unique occurrences. If multiple claims are submitted within that 90-day period, only one instance of reporting will be counted. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

This measure is 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 appropriate ICD-9 diagnosis codes, 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 not prescribed/recommended either antihistamines or decongestants

Numerator Instructions: For performance, the measure will be calculated as the number of patients for whom antihistamines or decongestants were neither prescribed nor recommended over the number of patients in the denominator (patients aged 2 months through 12 years with a diagnosis of OME). A higher score indicates appropriate treatment of patients with OME (e.g., the proportion for whom antihistamines or decongestants *were neither* prescribed *nor* recommended).

Numerator Coding:
Antihistamines or Decongestants not Prescribed or Recommended
CPT II 4134F: Antihistamines or decongestants neither prescribed nor recommended

OR

Antihistamines or Decongestants Prescribed or Recommended for Medical Reasons
Append a modifier (**1P**) to CPT Category II code **4133F** to report documented circumstances that appropriately exclude patients from the denominator.

- **1P:** Documentation of medical reason(s) for prescribing or recommending antihistamines or decongestants

OR

Antihistamines or Decongestants Prescribed or Recommended
CPT II 4133F: Antihistamines or decongestants prescribed or recommended

DENOMINATOR:
All patients aged 2 months through 12 years with a diagnosis of OME

Denominator Coding:
An ICD-9 diagnosis code for OME and a CPT E/M service code are required to identify patients for denominator inclusion.
ICD-9 diagnosis codes: 381.10, 381.19, 381.20, 381.29, 381.3, 381.4
AND
CPT E/M service codes: 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245

RATIONALE:
OME usually resolves spontaneously with indications for therapy only if the condition is persistent and clinically significant benefits can be achieved. No data exists to support antihistamines and decongestants in treating OME. As a result, physicians should not prescribe or recommend the over-the-counter use of these medications.

CLINICAL RECOMMENDATION STATEMENTS:
Antihistamines and decongestants are ineffective for OME and are not recommended for treatment. (Recommendation based on systematic review of randomized, controlled trials and preponderance of harm over benefit. [Aggregate evidence quality – Grade A]) (AAFP/AAO-HNSF/AAP)

▲Measure #97: Otitis Media with Effusion (OME): Systemic Antimicrobials – Avoidance of Inappropriate Use

DESCRIPTION:
Percentage of patients aged 2 months through 12 years with a diagnosis of OME who were not prescribed systemic antimicrobials

INSTRUCTIONS:
This measure is to be reported once for each occurrence of OME in children seen during the reporting period. Each unique occurrence is defined as a 90-day period from onset of OME. Claims data will be analyzed to determine unique occurrences. If multiple claims are submitted within that 90-day period, only one instance of reporting will be counted. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

This measure is 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 appropriate ICD-9 diagnosis codes, 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 not prescribed systemic antimicrobials

Numerator Instructions: For performance, the measure will be calculated as the number of patients for whom systemic antimicrobial therapy was not prescribed over the number of patients in the denominator (patients aged 2 months through 12 years with a diagnosis of OME). A higher score indicates appropriate treatment of patients with OME (e.g., the proportion for whom systemic antimicrobial therapy was *not* prescribed).

Systemic Antimicrobial Therapy not Prescribed
CPT II 4132F: Systemic antimicrobial therapy not prescribed

OR

Systemic Antimicrobial Therapy Prescribed for Medical Reasons
Append a modifier (**1P**) to CPT Category II code **4131F** to report documented circumstances that appropriately exclude patients from the denominator.

- **1P:** Documentation of medical reason(s) for prescribing systemic antimicrobial therapy

OR

Systemic Antimicrobial Therapy Prescribed
CPT II 4131F: Systemic antimicrobial therapy prescribed

DENOMINATOR:
All patients aged 2 months through 12 years with a diagnosis of OME

Denominator Coding:
An ICD-9 diagnosis code for OME and a CPT E/M service code are required to identify patients for denominator inclusion.
ICD-9 diagnosis codes: 381.10, 381.19, 381.20, 381.29, 381.3, 381.4
AND
CPT E/M service codes: 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245

RATIONALE:
OME usually resolves spontaneously with indications for therapy only if the condition is persistent and clinically significant benefits can be achieved. Antimicrobials have no proven long-term effectiveness and have potential adverse effects.

CLINICAL RECOMMENDATION STATEMENTS:
Antimicrobials and corticosteroids do not have long-term efficacy and are not recommended for routine management. (Recommendation based on systematic review of randomized, controlled trials and preponderance of harm over benefit. [Aggregate evidence quality – Grade A]) (AAFP/AAO-HNSF/AAP)

▲Measure #98: Otitis Media with Effusion (OME): Systemic Corticosteroids – Avoidance of Inappropriate Use

DESCRIPTION:
Percentage of patients aged 2 months through 12 years with a diagnosis of OME who were not prescribed systemic corticosteroids

INSTRUCTIONS:
This measure is to be reported once for each occurrence of OME in children seen during the reporting period. Each unique occurrence is defined as a 90-day period from onset of OME. Claims data will be analyzed to determine unique occurrences. If multiple claims are submitted within that 90-day period, only one instance of reporting will be counted. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

This measure is 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 appropriate ICD-9 diagnosis codes, 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 not prescribed systemic corticosteroids

Numerator Instructions: For performance, the measure will be calculated as the number of patients for whom systemic corticosteroids were neither prescribed nor recommended over the number of patients in the denominator (patients aged 2 months through 12 years with a diagnosis of OME). A higher score indicates appropriate treatment of patients with OME (e.g., the proportion for whom systemic corticosteroids were *not* prescribed).

Systemic Corticosteroids not Prescribed
CPT II 4136F: Systemic corticosteroids not prescribed

OR

Systemic Corticosteroids Prescribed for Medical Reasons
Append a modifier (**1P**) to CPT Category II code **4135F** to report documented circumstances that appropriately exclude patients from the denominator.

- **1P:** Documentation of medical reason(s) for prescribing systemic corticosteroids

OR

Systemic Corticosteroids Prescribed
CPT II 4135F: Systemic corticosteroids prescribed

DENOMINATOR:
All patients aged 2 months through 12 years with a diagnosis of OME

Denominator Coding:
An ICD-9 diagnosis code for OME and a CPT E/M service code are required to identify patients for denominator inclusion.
ICD-9 diagnosis codes: 381.10, 381.19, 381.20, 381.29, 381.3, 381.4
AND
CPT E/M service codes: 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245

RATIONALE:
OME usually resolves spontaneously with indications for therapy only if the condition is persistent and clinically significant benefits can be achieved. Systemic steroids have no proven long-term effectiveness and have potential adverse effects.

CLINICAL RECOMMENDATION STATEMENTS:
Antimicrobials and corticosteroids do not have long-term efficacy and are not recommended for routine management. (Recommendation based on systematic review of randomized, controlled trials and preponderance of harm over benefit. [Aggregate evidence quality – Grade A]) (AAFP/AAO-HNSF/AAP)

€ Measure #99: Breast Cancer Patients who have a pT and pN Category and Histologic Grade for Their Cancer

DESCRIPTION:
Percentage of breast cancer resection pathology reports that include the pT category (primary tumor), the pN category (regional lymph nodes), and the histologic grade

INSTRUCTIONS:
This measure is to be reported each time a breast cancer resection surgical pathology examination is performed during the reporting period for breast cancer patients. It is anticipated that clinicians who examine breast tissue specimens following resection in a laboratory or institution will submit this measure.

This measure is reported using CPT Category II codes:
ICD-9 diagnosis codes and CPT procedure codes are used to identify patients who are included in the measure's denominator. CPT Category II codes are used to report the numerator of the measure.

When reporting the measure, submit the appropriate 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:
Reports that include the pT category, the pN category and the histologic grade

Numerator Coding:
pT Category, pN Category and Histologic Grade Documented
CPT II 3260F: pT category (primary tumor), pN category (regional lymph nodes), and histologic grade documented in pathology report

OR

pT Category, pN Category and Histologic Grade not Documented for Medical Reasons
Append a modifier (**1P**) to CPT Category II code **3260F** to report documented circumstances that appropriately exclude patients from the denominator.

- **1P:** Documentation of medical reason(s) for not including pT category, pN category, and histologic grade in the pathology report (e.g., re-excision without residual tumor; non-carcinomas)

OR

pT Category, pN Category and Histologic Grade not Documented, Reason not Specified
Append a reporting modifier (**8P**) to CPT Category II code **3260F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

- **8P:** pT category, pN category, and histologic grade was not documented in pathology report, reason not otherwise specified

DENOMINATOR:
All breast cancer resection pathology reports (excluding biopsies)

Denominator Coding:
An ICD-9 diagnosis code for breast cancer and a CPT procedure code are required to identify patients 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, 175.0, 175.9
AND
CPT procedure codes: 88307, 88309

RATIONALE:
Therapeutic decisions for breast cancer management are stage driven and cannot be made without a complete set of pathology descriptors. Incomplete cancer resection pathology reports may result in misclassification of patients, rework and delays, and suboptimal management. The College of American Pathologists (CAP) has produced evidence-based checklists of essential pathologic parameters that are recommended to be included in cancer resection pathology reports. These checklists have been endorsed as a voluntary standard by National Quality Forum (NQF) and are considered the reporting standard by the Commission on Cancer (CoC) of the American College of Surgeons (ACS).

The CAP recently conducted a structured audit of breast cancer pathology report adequacy at 86 institutions. Overall, 35% of eligible reports were missing at least one of the ten CAP-recommended breast cancer elements. Cancer Care Ontario (CCO) conducted a similar study in 2005 and found that 25% of breast cancer pathology reports did not include all of the information required by the CAP standards.

While the exact percentage of breast cancer resection pathology reports that are missing the pT category, the pN category and the histologic grade is unknown, these are essential elements in breast cancer treatment decisions and should be included in every pathology report when possible.

CLINICAL RECOMMENDATION STATEMENTS:
Patient management and treatment guidelines promote an organized approach to providing quality care. The (American College of Surgeons Commission on Cancer) CoC requires that 90% of pathology reports that include a cancer diagnosis contain the scientifically validated data elements outlined in the surgical case summary checklist of the College of American Pathologists (CAP) publication Reporting on Cancer Specimens. (ACSCoC)

All invasive breast carcinomas, with the exception of medullary carcinoma should be graded. The grading system used must be specified in the report; the Nottingham combined histologic grade (Elston-Ellis modification of Scarff-Bloom-Richardson grading system) is recommended. Within each stage grouping there is a relation between histologic grade and outcome. (CAP)

TNM staging information is included in factors proven to be of prognostic import and useful in clinical patient management.(CAP)

€ Measure #100: Colorectal Cancer Patients who have a pT and pN Category and Histologic Grade for Their Cancer

DESCRIPTION:
Percentage of colon and rectum cancer resection pathology reports that include the pT category (primary tumor), the pN category (regional lymph nodes) and the histologic grade

INSTRUCTIONS:
This measure is to be reported each time a colorectal cancer resection surgical pathology examination is performed during the reporting period for colorectal cancer patients. It is anticipated that clinicians who examine colorectal tissue specimens following resection in a laboratory or institution will submit this measure.

This measure is reported using CPT Category II codes:
ICD-9 diagnosis codes and CPT procedure codes are used to identify patients who are included in the measure's denominator. CPT Category II codes are used to report the numerator of the measure.

When reporting the measure, submit the appropriate 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:
Reports that include the pT category, the pN category and the histologic grade

Numerator Coding:
pT Category, pN Category and Histologic Grade Documented
CPT II 3260F: pT category (primary tumor), pN category (regional lymph nodes), and histologic grade documented in pathology report

OR

pT Category, pN Category and Histologic Grade not Documented for Medical Reasons
Append a modifier (**1P**) to CPT Category II code **3260F** to report documented circumstances that appropriately exclude patients from the denominator.

- **1P:** Documentation of medical reason(s) for not including pT category, pN category and histologic grade in the pathology report (e.g., non-carcinomas; anal canal)

OR

pT Category, pN Category and Histologic Grade not Documented, Reason not Specified
Append a reporting modifier (**8P**) to CPT Category II code **3260F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

- **8P:** pT category, pN category and histologic grade was not documented in the pathology report, reason not otherwise specified

DENOMINATOR:
All colon and rectum cancer resection pathology reports

Denominator Coding:
An ICD-9 diagnosis code for colon or rectum cancer and a CPT procedure code are required to identify patients 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, 154.0, 154.1, 154.8
AND
CPT procedure codes: 88309

RATIONALE:
Therapeutic decisions for colorectal cancer management are stage driven and cannot be made without a complete set of pathology descriptors. Incomplete cancer resection pathology reports may result in misclassification of patients, rework and delays, and suboptimal management. The College of American Pathologists (CAP) has produced evidence-based checklists of essential pathologic parameters that are recommended to be included in cancer resection pathology reports. These checklists have been endorsed as a voluntary standard by National Quality Forum (NQF) and are considered the reporting standard by the Commission on Cancer (CoC) of the American College of Surgeons (ACS).

The CAP recently conducted a structured audit of colorectal cancer pathology report adequacy at 86 institutions. Overall, 34% of eligible reports were missing at least one of the ten CAP-recommended colorectal cancer elements. Cancer Care Ontario (CCO) conducted a similar study in 2005 and found that 31% of colorectal cancer pathology reports did not include all of the information required by the CAP standards.

While the exact percentage of colorectal cancer resection pathology reports that are missing the pT category, the pN category and the histologic grade is unknown, these are essential elements in colorectal cancer treatment decisions and should be included in every pathology report when possible.

CLINICAL RECOMMENDATION STATEMENTS:
Patient management and treatment guidelines promote an organized approach to providing quality care. The American College of Surgeons Committee on Cancer (CoC) requires that 90% of pathology reports that include a cancer diagnosis contain the scientifically validated data elements outlined in the surgical case summary checklist of the College of American Pathologists (CAP) publication Reporting on Cancer Specimens.(ACSCoC)

Surgical resection is the primary therapy for most colorectal carcinomas, and the most important prognostic indicators are related to the pathologic findings in the resection specimen. The anatomic extent of disease is by far the most important prognostic factor in colorectal cancer. Pathologic staging depends on pathologic documentation of the anatomic extent of disease, whether or not the primary tumor has been completely removed. If a biopsied tumor is not resected for any reason

(e.g., when technically unfeasible) and if the highest T and N categories or the M1 category of the tumor can be confirmed microscopically, the criteria for pathologic classification and staging have been satisfied without total removal of the primary cancer.(CAP)

▲ Measure #101: Appropriate Initial Evaluation of Patients with Prostate Cancer

DESCRIPTION:
Percentage of patients, regardless of age, with prostate cancer receiving interstitial prostate brachytherapy, OR external beam radiotherapy to the prostate, OR radical prostatectomy, OR cryotherapy with documented evaluation of prostate-specific antigen (PSA), AND primary tumor (T) stage, AND Gleason score

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for patients with prostate cancer seen during the reporting period. It is anticipated that clinicians who perform interstitial prostate brachytherapy, external beam radiotherapy, radical prostatectomy, or cryotherapy will submit this measure.

This measure is reported using CPT Category II codes:
ICD-9 diagnosis codes and CPT procedure codes are used to identify patients who are included in the measure's denominator. CPT Category II codes are used to report the numerator of the measure.

When reporting the measure, submit the appropriate 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 documented evaluation of prostate-specific antigen (PSA), AND primary tumor (T) stage, AND Gleason score

Numerator Coding:
Prostate-specific Antigen (PSA), Primary Tumor (T) Stage, and Gleason Score Documented
CPT II 3268F: Prostate-specific antigen (PSA), AND primary tumor (T) stage, AND Gleason score documented prior to initiation of treatment

OR

Prostate-specific Antigen (PSA), Primary Tumor (T) Stage, and Gleason Score not Documented for Medical Reasons
Append a modifier (**1P**) to CPT Category II code **3268F** to report documented circumstances that appropriately exclude patients from the denominator.

- **1P:** Documentation of medical reason(s) for not documenting prostate-specific antigen (PSA), AND primary tumor (T) stage, AND Gleason score prior to initiation of treatment

OR

Prostate-specific Antigen (PSA), Primary Tumor (T) Stage, and Gleason Score not Documented, Reason not Specified

Append a reporting modifier (**8P**) to CPT Category II code **3268F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

- **8P:** Prostate-specific antigen (PSA), AND primary tumor (T) stage, AND Gleason score not documented prior to initiation of treatment, reason not otherwise specified

DENOMINATOR:

All patients, regardless of age, with prostate cancer receiving interstitial prostate brachytherapy, OR external beam radiotherapy to the prostate, OR radical prostatectomy, OR cryotherapy

Denominator Coding:

An ICD-9 diagnosis code for prostate cancer and a CPT procedure code for patients receiving interstitial prostate brachytherapy, external beam radiotherapy, radical prostatectomy, or cryotherapy are required to identify patients for denominator inclusion.

ICD-9 diagnosis code: 185

AND

CPT E/M procedure codes: 55810, 55812, 55815, 55840, 55842, 55845, 55866, 55873, 77411, 77412, 77413, 77414, 77416, 77418, 77776, 77777, 77778, 77784

RATIONALE:

The initial assessment of all prostate cancer patients should include the three evaluations required in this measure.

CLINICAL RECOMMENDATION STATEMENTS:

Tumor characteristics, including PSA level and changes such as velocity and doubling time, Gleason score, and tumor stage, are predictive of cancer outcomes. Using PSA, Gleason score, and tumor stage, risk strata have been defined that are significantly associated with PSA recurrence and cancer specific mortality. (AUA)

The combination of Gleason score, PSA level, and stage can effectively stratify patients into categories associated with different probabilities of achieving a cure. In addition to considering the probability of cure, the choice of initial treatment is highly influenced by estimated life expectancy, comorbidities, potential therapy side effects, and patient preference. (NCCN)
(Category 2A)

▲ Measure #102: Inappropriate Use of Bone Scan for Staging Low-Risk Prostate Cancer Patients

DESCRIPTION:
Percentage of patients, regardless of age, with a diagnosis of prostate cancer at low risk of recurrence receiving interstitial prostate brachytherapy, OR external beam radiotherapy to the prostate, OR radical prostatectomy, OR cryotherapy who did *not* have a bone scan performed at any time since diagnosis of prostate cancer

INSTRUCTIONS:
This measure is to be reported each time a patient with prostate cancer receives interstitial prostate brachytherapy, external beam radiotherapy, radical prostatectomy, or cryotherapy procedure during the reporting period. It is anticipated that clinicians who perform the listed procedures as specified in the denominator coding will submit this measure.

This measure is reported using CPT Category II codes:
ICD-9 diagnosis codes and CPT procedure codes are used to identify patients who are included in the measure's denominator. CPT Category II codes are used to report the numerator of the measure.

When reporting the measure, submit the appropriate ICD-9 diagnosis codes, CPT procedure codes, and the appropriate CPT Category II code(s) **OR** the CPT Category II code(s) **with** the modifier. The modifiers allowed for this measure are: 1P- medical reasons, 3P- system reasons, 8P- reasons not otherwise specified.

NUMERATOR:
Patients who did *not* have a bone scan performed at any time since diagnosis of prostate cancer

Definitions:
Risk strata definitions:

- Low Risk: PSA ≤10 mg/dL; AND Gleason score 6 or less; AND clinical stage T1c or T2a[2]
- Intermediate Risk: PSA >10 to 20 mg/dL; OR Gleason score 7; OR clinical stage T2b, and not qualifying for high risk[2]
- High Risk: PSA > 20 mg/dL; OR Gleason score 8 to 10; OR clinical stage T2c or greater; and not qualifying for very high risk[2]

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

Numerator Coding:

Bone Scan not Performed

(Two CPT II codes [3270F & 3271F] are required on the claim form to submit this category)

CPT II 3270F: Bone scan not performed prior to initiation of treatment nor at any time since diagnosis of prostate cancer

AND

CPT II 3271F: Low risk of recurrence, prostate cancer

OR

Bone Scan Performed for Medical or System Reasons

(Two CPT II codes [3269F-☒P & 3271F] are required on the claim form to submit this category)

Append a modifier (**1P or 3P**) to CPT Category II code **3269F** to report documented circumstances that appropriately exclude patients from the denominator.

- **3269F *with* 1P:** Documentation of medical reason(s) for performing a bone scan (including documented pain, salvage therapy, other medical reasons)
- **3269F *with* 3P:** Documentation of system reason(s) for performing a bone scan (including bone scan ordered by someone other than reporting physician)

AND

CPT II 3271F: Low risk of recurrence, prostate cancer

OR

If patient is not eligible for this measure because the risk of recurrence is intermediate, high or not determined, report:

(One CPT II code [32☒☒F] is required on the claim form to submit this category)

Intermediate Risk of Recurrence

CPT II 3272F: Intermediate risk of recurrence, prostate cancer

OR

High Risk of Recurrence

CPT II 3273F: High risk of recurrence, prostate cancer

OR

Risk of Recurrence not Determined

CPT II 3274F: Prostate cancer risk of recurrence not determined or neither low, intermediate nor high

OR

Bone Scan Performed
(Two CPT II codes [3269F & 3271F] are required on the claim form to submit this category)

CPT II 3269F: Bone scan performed prior to initiation of treatment or at any time since diagnosis of prostate cancer
AND
CPT II 3271F: Low risk of recurrence, prostate cancer

DENOMINATOR:
All patients, regardless of age, with a diagnosis of prostate cancer at low risk of recurrence receiving interstitial prostate brachytherapy, OR external beam radiotherapy to the prostate, OR radical prostatectomy, OR cryotherapy

Denominator Coding:
An ICD-9 diagnosis code for prostate cancer and a CPT procedure code for patients receiving interstitial prostate brachytherapy, external beam radiotherapy to the prostate, radical prostatectomy, or cryotherapy are required to identify patients for denominator inclusion.
ICD-9 diagnosis code: 185
AND
CPT procedure codes: 55810, 55812, 55815, 55840, 55842, 55845, 55866, 55873, 77411, 77412, 77413, 77414, 77416, 77418, 77776, 77777, 77778, 77784

RATIONALE:
A bone scan is generally not required for staging prostate cancer in men with a low risk of recurrence. This measure is written as a negative measure so that the performance goal is 100%, consistent with the other measures for this condition.

CLINICAL RECOMMENDATION STATEMENTS:
Routine use of a bone scan is not required for staging asymptomatic men with clinically localized prostate cancer when their PSA is equal to or less than 20.0 ng/mL. (AUA)

Patients with a life expectancy > 5 years or symptomatic:
- A bone scan is appropriate for T1 to T2 disease in the presence of a PSA greater than 20 ng/mL, Gleason score of 8 or higher, clinical stage of T3 to T4, or symptomatic disease.
- Patients at higher risk of metastatic disease may undergo pelvic computed tomography (CT) or magnetic resonance imaging (MRI) scanning with possible fine-needle aspiration of enlarged lymph nodes or staging lymph node dissection. Nomograms or risk tables may be used to identify patients with a higher likelihood of having metastatic disease. If the nomogram indicates a probability of lymph node involvement greater than 20% or if the patient is stage T3 or T4, this is recommended as a threshold for doing a staging CT scan or MRI evaluation.

For all other patients, no additional imaging is required for staging. (NCCN) (Category 2A)

▲ Measure #103: Review of Treatment Options in Patients with Clinically Localized Prostate Cancer

DESCRIPTION:
Percentage of patients, regardless of age, with clinically localized prostate cancer AND receiving interstitial prostate brachytherapy, OR external beam radiotherapy to the prostate, OR radical prostatectomy, OR cryotherapy who received counseling on, at a minimum, the following treatment options for clinically localized disease: active surveillance, AND interstitial prostate brachytherapy, AND external beam radiotherapy, AND radical prostatectomy

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for patients with prostate cancer receiving interstitial prostate brachytherapy, external beam radiotherapy to the prostate, radical prostatectomy, or cryotherapy procedure during the reporting period. It is anticipated that clinicians who perform interstitial prostate brachytherapy, external beam radiotherapy to the prostate, radical prostatectomy, or cryotherapy will submit this measure.

This measure is reported using CPT Category II codes:
ICD-9 diagnosis codes and CPT procedure codes are used to identify patients who are included in the measure's denominator. CPT Category II codes are used to report the numerator of the measure.

When reporting the measure, submit the appropriate 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 received counseling on, at a minimum, the following treatment options for clinically localized disease: active surveillance, AND interstitial prostate brachytherapy, AND external beam radiotherapy, AND radical prostatectomy

Numerator Coding:
Counseling on Treatment Options for Clinically Localized Prostate Cancer Provided
CPT II 4163F: Patient counseling at a minimum on all of the following treatment options for clinically localized prostate cancer: active surveillance, AND interstitial prostate brachytherapy, AND external beam radiotherapy, AND radical prostatectomy, provided prior to initiation of treatment

OR

Counseling on Treatment Options for Clinically Localized Prostate Cancer not Provided for Medical Reasons
Append a modifier (**1P**) to CPT Category II code **4163F** to report documented circumstances that appropriately exclude patients from the denominator.

- **1P:** Documentation of medical reason(s) for not counseling patient at a minimum on all of the following treatment options for clinically localized prostate cancer: active surveillance, AND interstitial prostate brachytherapy, AND external beam radiotherapy, AND radical prostatectomy, (ie, salvage therapy)

OR

Counseling on Treatment Options for Clinically Localized Prostate Cancer not Provided, Reason not Specified
Append a reporting modifier (**8P**) to CPT Category II code **4163F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

- **8P:** Patient was not provided counseling at a minimum on all of the following treatment options for clinically localized prostate cancer: active surveillance, AND interstitial prostate brachytherapy, AND external beam radiotherapy, AND radical prostatectomy, reason not otherwise specified

DENOMINATOR:
All patients, regardless of age, with clinically localized prostate cancer AND receiving interstitial prostate brachytherapy, OR external beam radiotherapy to the prostate, OR radical prostatectomy, OR cryotherapy

Denominator Coding:
An ICD-9 diagnosis code for clinically localized prostate cancer without a secondary malignant neoplasm diagnosis of a specified site (respiratory, digestive, and of other specified sites) and a CPT procedure code for patients receiving interstitial prostate brachytherapy, external beam radiotherapy, radical prostatectomy, or cryotherapy are required to identify patients for denominator inclusion.
ICD-9 diagnosis code: 185
WITHOUT
ICD-9 diagnosis codes: 197.0, 197.1, 197.2, 197.3, 197.4, 197.5, 197.6, 197.7, 197.8, 198.0, 198.1, 198.2, 198.3, 198.4, 198.5, 198.6, 198.7, 198.81, 198.82, 198.89

AND
CPT procedure codes: 55810, 55812, 55815, 55840, 55842, 55845, 55866, 55873, 77261, 77262, 77263

RATIONALE:
To enable each prostate cancer patient with clinically localized disease to make an informed choice among treatment options, he should receive counseling on at least the four interventions listed in this measure. Additional treatment options may be offered, but fewer data are available to support their effectiveness.

CLINICAL RECOMMENDATION STATEMENTS:

A patient with clinically localized prostate cancer should be informed about the commonly accepted initial interventions including, at a minimum, active surveillance, radiotherapy (external beam and interstitial), and radical prostatectomy. A discussion of the estimates for benefits and harms of each intervention should be offered to the patient. (AUA) (Standard)

▲ Measure #104: Adjuvant Hormonal Therapy for High-Risk Prostate Cancer Patients

DESCRIPTION:
Percentage of patients, regardless of age, with a diagnosis of prostate cancer at high risk of recurrence receiving external beam radiotherapy to the prostate who were prescribed adjuvant hormonal therapy (GnRH agonist or antagonist)

INSTRUCTIONS:
This measure is to be reported once per episode of radiation therapy for all patients with prostate cancer who receive external beam radiotherapy during the reporting period. Claims data will be analyzed to determine unique episodes of radiation therapy. It is anticipated that clinicians who perform external beam radiotherapy to the prostate will submit this measure.

This measure is reported using CPT Category II codes and/or G-codes:
ICD-9 diagnosis codes and CPT procedure codes are used to identify patients who are included in the measure's denominator. CPT Category II codes and/or G-codes are used to report the numerator of the measure.

When reporting the measure, submit the listed ICD-9 diagnosis codes, CPT procedure codes and the appropriate CPT Category II code **AND/OR** G-code **OR** the CPT Category II code **with** the modifier **AND** G-code. The modifiers allowed for this measure are: 1P- medical reasons, 2P- patient reasons, 8P- reasons not otherwise specified.

NUMERATOR:
Patients who were prescribed adjuvant hormonal therapy (GnRH [gonadotropin-releasing hormone] agonist or antagonist)

Definitions:
Risk strata definitions:

- Low Risk: PSA ≤ 10 mg/dL; AND Gleason score 6 or less; AND clinical stage T1c or T2a[2]
- Intermediate Risk: PSA > 10 to 20 mg/dL; OR Gleason score 7; OR clinical stage T2b, and not qualifying for high risk[2]
- High Risk: PSA > 20 mg/dL; OR Gleason score 8 to 10; OR clinical stage T2c or greater; and not qualifying for very high risk[2]

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

Numerator Coding:

Adjuvant Hormonal Therapy Prescribed/Administered

(One CPT II code & one G-code [4164F & G8465] are required on the claim form to submit this category)

CPT II 4164F: Adjuvant (ie, in combination with external beam radiotherapy to the prostate for prostate cancer) hormonal therapy (GnRH [gonadotropin-releasing hormone] agonist or antagonist) prescribed/administered

AND

G8465: High risk of recurrence of prostate cancer

OR

Adjuvant Hormonal Therapy not Prescribed/Administered for Medical or Patient Reasons

(One CPT II code & one G-code [4164F-1P & G8465] are required on the claim form to submit this category)

Append a modifier (**1P or 2P**) to CPT Category II code **4164F** to report documented circumstances that appropriately exclude patients from the denominator.

- **4164F *with* 1P:** Documentation of medical reason(s) for not prescribing/administering adjuvant (ie, in combination with external beam radiotherapy to the prostate for prostate cancer) hormonal therapy (GnRH [gonadotropin-releasing hormone] agonist or antagonist)
- **4164F *with* 2P:** Documentation of patient reason(s) for not prescribing/administering adjuvant (ie, in combination with external beam radiotherapy to the prostate for prostate cancer) hormonal therapy (GnRH [gonadotropin-releasing hormone] agonist or antagonist)

AND

G8465: High risk of recurrence of prostate cancer

OR

If patient is not eligible for this measure because the risk of recurrence is low, intermediate or not determined, report:

(One G-code [G8464] is required on the claim form to submit this category)

G8464: Clinician documented that prostate cancer patient is not an eligible candidate for adjuvant hormonal therapy; Low or intermediate risk of recurrence OR risk of recurrence not determined

OR

Adjuvant Hormonal Therapy not Prescribed/Administered, Reason not Specified
(One CPT II code & one G-code [4164F-8P & G8465] are required on the claim form to submit this category)

Append a reporting modifier (**8P**) to CPT Category II code **4164F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

- **4164F *with* 8P:** Patients who were not prescribed/administered adjuvant (ie, in combination with external beam radiotherapy for prostate cancer) hormonal therapy (GnRH [gonadotropin-releasing hormone] agonist or antagonist), reason not otherwise specified

AND
G8465: High risk of recurrence of prostate cancer

DENOMINATOR:
All patients, regardless of age, with a diagnosis of prostate cancer at high risk of recurrence receiving external beam radiotherapy to the prostate

Denominator Coding:
An ICD-9 diagnosis code for prostate cancer and a CPT procedure code for patients receiving external beam radiotherapy are required to identify patients for denominator inclusion.
ICD-9 diagnosis code: 185
AND
CPT procedure codes: 77407, 77408, 77409, 77411, 77412, 77413, 77414, 77416, 77418

RATIONALE:
If receiving external beam radiotherapy, prostate cancer patients with a high risk of recurrence should also be prescribed hormonal therapy, which has been shown to increase the effectiveness of the radiotherapy.

CLINICAL RECOMMENDATION STATEMENTS:
High risk patients who are considering specific treatment options should be informed of findings of recent high quality clinical trials, including that: for those considering external beam radiotherapy, use of hormonal therapy combined with conventional radiotherapy may prolong survival. (AUA) (Standard)

Men with prostate cancer that is clinically localized stage T3a, with Gleason score of 8 to 10, or PSA level greater than 20 ng/mL are categorized by the NCCN panel to be at high risk of recurrence after definitive therapy. Note that patients with multiple adverse factors may be shifted into the very high-risk category. Hormonal therapy (e.g., androgen ablation) plus external-beam RT is recommended. (NCCN) (Category 1)

▲ Measure #105: Three-dimensional Radiotherapy for Patients with Prostate Cancer

DESCRIPTION:
Percentage of patients, regardless of age, with prostate cancer receiving external beam radiotherapy to the prostate *only* (no metastases) who receive 3D-CRT or IMRT

INSTRUCTIONS:
This measure is to be reported each time an external beam radiotherapy procedure is performed during the reporting period for prostate cancer patients. It is anticipated that clinicians who perform external beam radiotherapy to the prostate will submit this measure.

This measure is reported using CPT Category II codes:
ICD-9 diagnosis codes and CPT procedure codes are used to identify patients who are included in the measure's denominator. CPT Category II codes are used to report the numerator of the measure.

When reporting the measure, submit the appropriate ICD-9 diagnosis codes, CPT procedure codes, and the appropriate CPT Category II code(s) **OR** the CPT Category II code(s) **with** the modifier. The modifier allowed for this measure is: 8P- reasons not otherwise specified. There are no allowable performance exclusions for this measure.

NUMERATOR:
Patients who receive three-dimensional conformal radiotherapy (3D-CRT) or intensity modulated radiation therapy (IMRT)

> ***NUMERATOR NOTE:*** *The correct combination of numerator codes must be reported on the claim form in order to properly report this measure. The "correct combination" of codes may require the submission of multiple numerator codes.*
>
> **Numerator Coding:**
> **3D-CRT or IMRT Received**
> *(Two CPT II codes [4165F & 4200F] are required on the claim form to submit this category)*
> **CPT II 4165F:** Three-dimensional conformal radiotherapy (3D-CRT) or intensity modulated radiation therapy (IMRT) received
> **AND**
> **CPT II 4200F:** External beam radiotherapy to prostate only

OR

> **If patient is not eligible for this measure because the 3D-CRT or IMRT is to region(s) other than the prostate only, report:**
> *(One CPT II code [4201F] is required on the claim form to submit this category)*
>
> **CPT II 4201F:** External beam radiotherapy for prostate cancer to region(s) other than prostate only

OR

3D-CRT or IMRT not Received, Reason not Specified
(Two CPT II codes [4165F-8P & 4200F] are required on the claim form to submit this category)

Append a reporting modifier (**8P**) to CPT Category II code **4165F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

- **4165F *with* 8P:** Patients who did not receive three-dimensional conformal radiotherapy (3D-CRT) or intensity modulated radiation therapy (IMRT), reason not otherwise specified

AND
CPT II 4200F: External beam radiotherapy to prostate only

DENOMINATOR:
All patients, regardless of age, with prostate cancer receiving external beam radiotherapy to the prostate *only* (no metastases)

Denominator Coding:
An ICD-9 diagnosis code for clinically localized prostate cancer without a secondary malignant neoplasm diagnosis of a specified site (respiratory, digestive, and of other specified sites) and a CPT procedure code for patients receiving external beam radiotherapy are required to identify patients for denominator inclusion.
ICD-9 diagnosis code: 185
WITHOUT
ICD-9 diagnosis codes: 197.0, 197.1, 197.2, 197.3, 197.4, 197.5, 197.6, 197.7, 197.8, 198.0, 198.1, 198.2, 198.3, 198.4, 198.5, 198.6, 198.7, 198.81, 198.82, 198.89

AND
CPT procedure codes: 77401, 77402, 77403, 77404, 77406, 77407, 77408, 77409, 77411, 77412, 77413, 77414, 77416, 77418

RATIONALE:
Current, computer-aided radiotherapy techniques improve the precision of the irradiation of cancerous tissue and should be employed for all patients receiving external beam radiotherapy to the prostate.

CLINICAL RECOMMENDATION STATEMENTS:
Three-dimensional CRT or intensity-modulated radiation therapy (IMRT) techniques should be employed over conventional techniques. These techniques use computer software to integrate CT images of the patients' internal anatomy in the treatment position, which allows the volume receiving the high radiation dose to "conform" more exactly to the shape of the tumor. Three-dimensional CRT has reduced both acute and late normal tissue toxicity in patients with prostate cancer and allows higher cumulative doses to be delivered with a lower risk of late effects. (NCCN) (Category 2A)

▲ Measure #106: Patients who have Major Depression Disorder who meet DSM IV Criteria

DESCRIPTION:
Percentage of patients aged 18 years and older with a new diagnosis or recurrent episode of major depressive disorder (MDD) who met the DSM-IV™ criteria during the visit in which the new diagnosis or recurrent episode was identified during the measurement period

INSTRUCTIONS:
This measure is to be reported once for each occurrence of a new diagnosis or recurrent episode of MDD occurring prior to or during the reporting period. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding. An occurrence of a new diagnosis or recurrent episode of MDD will be identified through the submission of CPT II code 3093F for an individual patient. The CPT II code for diagnostic evaluation should be reported once until remission occurs. At the time of remission, CPT II code 3092F should be reported to indicate the current occurrence of MDD has been resolved.

This measure is 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(s) **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 with documented evidence that they met the DSM-IV™ criteria [At least 5 elements (must include: 1) depressed mood or 2) loss of interest or pleasure) with symptom duration of 2 weeks or longer] during the visit in which the new diagnosis or recurrent episode was identified.

> **Definition:** DSM-IV™ criteria includes presence of depressed mood, marked diminished interest/pleasure, significant weight loss or weight gain, insomnia or hypersomnia, psychomotor agitation or retardation, fatigue or loss of energy, feelings of worthlessness, diminished ability to concentrate and recurrent suicidal ideation.
>
> ***NUMERATOR NOTE:*** *The correct combination of numerator codes must be reported on the claim form in order to properly report this measure. The "correct combination" of codes may require the submission of multiple numerator codes.*

Numerator Coding:

DSM-IV™ Criteria for Major Depressive Disorder Documented

(Two CPT II codes [1040F & 3093F] are required on the claim form to submit this category)

CPT II 1040F: DSM-IV™ criteria for major depressive disorder documented at the initial evaluation

AND

CPT II 3093F: Documentation of new diagnosis of initial or recurrent episode of major depressive disorder

OR

If patient is not eligible for this measure because MDD is in remission, report: Major depressive disorder, in remission

(One CPT II code [3092F] is required on the claim form to submit this category)

CPT II 3092F: Major depressive disorder, in remission

OR

DSM-IV™ Criteria for Major Depressive Disorder not Documented, Reason not Specified

(Two CPT II codes [1040F-8P & 3093F] are required on the claim form to submit this category)

Append a reporting modifier (**8P**) to CPT Category II code **1040F** 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.

- **1040F *with* 8P:** DSM-IV™ criteria for major depressive disorder not documented at the initial evaluation, reason not otherwise specified

AND

CPT II 3093F: Documentation of new diagnosis of initial or recurrent episode of major depressive disorder

DENOMINATOR:

All patients aged 18 years and older with a new diagnosis or recurrent episode of MDD

Denominator Coding:

An ICD-9 diagnosis code for major depressive disorder and a CPT E/M service code are required to identify patients 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

AND

CPT E/M service codes: 90801, 90802, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245

RATIONALE:

Thorough assessment of depressive symptoms sets the basis for accurate diagnosis and treatment of major depressive disorder.

CLINICAL RECOMMENDATION STATEMENTS:

Successful treatment of patients with major depressive disorder is promoted by a thorough assessment of the patient. (APA; Level I Recommendation)

A. At least five of the following symptoms have been present during the same 2-week period and represent a change from previous functioning; at least one of the symptoms is either 1) depressed mood or 2) loss of interest or pleasure (do not include symptoms that are clearly due to general medical condition or mood-incongruent delusions or hallucinations).

1. Depressed mood most of the day, nearly every day as indicated by either subjective report (e.g., feels sad or empty) or observation made by others (e.g., appears tearful)
2. Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation made by others)
3. Significant weight loss when not dieting or weight gain (e.g., a change of more than 5% body weight in a month), or decrease in appetite nearly every day
4. Insomnia or hypersomnia nearly every day
5. Psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down)
6. Fatigue or loss of energy nearly every day
7. Feelings of worthlessness or excessive inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick)
8. Diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or observed by others)
9. Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or specific plan for committing suicide

B. The symptoms do not meet criteria for a mixed episode

C. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning

D. The symptoms are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., hypothyroidism)

E. The symptoms are not better accounted for by bereavement, i.e., after the loss of a loved one, the symptoms persist for longer than 2 months or are characterized by marked functional impairment, morbid preoccupation with worthlessness, suicidal ideation, psychotic symptoms, or psychomotor retardation. (DSM-IV)

▲ Measure #107: Patients who have Major Depression Disorder who are Assessed for Suicide Risks

DESCRIPTION:
Percentage of patients aged 18 years and older with a new diagnosis or recurrent episode of major depressive disorder (MDD) who had a suicide risk assessment completed at each visit during the measurement period

INSTRUCTIONS:
This measure is to be reported at each visit for a new diagnosis or recurrent episode of MDD, for patients seen individually or as a group, during the reporting period. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding. An occurrence of a new diagnosis or recurrent episode of MDD will be identified through the submission of G-code G8467 for an individual patient. The CPT II code for suicide risk assessment should be reported at each visit until remission occurs. At the time of remission, G-code G8466 should be reported to indicate the current occurrence of MDD has been resolved.

This measure is reported using CPT Category II codes and/or 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. CPT Category II codes and/or 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 CPT Category II code **AND/OR** G-code **OR** the CPT Category II code **with** the modifier **AND** G-code. The reporting modifier allowed for this measure is: 8P- reasons not otherwise specified. There are no allowable performance exclusions for this measure.

NUMERATOR:
Patients who had suicide risk assessment completed at each visit

> ***NUMERATOR NOTE:*** *The correct combination of numerator codes must be reported on the claim form in order to properly report this measure. The "correct combination" of codes may require the submission of multiple numerator codes.*
>
> **Numerator Coding:**
> **Suicide Risk Assessed**
> *(One CPT II code & one G-code [3085F & G8467] are required on the claim form to submit this category)*
>
> **CPT II 3085F:** Suicide risk assessed
> **AND**
> **G8467:** Documentation of new diagnosis of initial or recurrent episode of major depressive disorder

OR

If patient is not eligible for this measure because MDD is in remission, report:
(One G-code [G8466] is required on the claim form to submit this category)

G8466: Clinician documented that patient is not an eligible candidate for suicide risk assessment; major depressive disorder, in remission

OR

Suicide Risk not Assessed, Reason not Specified
(One CPT II code & one G-code [3085F-8P & G8467] are required on the claim form to submit this category)

Append a reporting modifier (**8P**) to CPT Category II code **3085F** 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.

- **3085F *with* 8P:** Suicide risk not assessed, reason not otherwise specified

AND

G8467: Documentation of new diagnosis of initial or recurrent episode of major depressive disorder

DENOMINATOR:

All patients aged 18 years and older with a new diagnosis or recurrent episode of MDD

Denominator Coding:

An ICD-9 diagnosis code for major depressive disorder and a CPT E/M service code are required to identify patients 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

AND

CPT E/M service codes: 90801, 90802, 90804, 90805, 90806, 90807, 90808, 90809, 90810, 90811, 90812, 90813, 90814, 90815, 90845, 90847, 90849, 90853, 90857, 90862, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245

RATIONALE:

Research has shown that patients with major depressive disorder are at a high risk for suicide, which makes this assessment an important aspect of care that should be assessed at each visit.

CLINICAL RECOMMENDATION STATEMENTS:

Successful treatment of patients with major depressive disorder is promoted by a thorough assessment of the patient. (APA; Level I Recommendation)

Psychiatric management consists of a broad array of interventions and activities that should be instituted by psychiatrists for all patients with major depressive disorder. (APA; Level I Recommendation)

The components of an evaluation for suicide risk should include:
1) An assessment of the presence of suicidal or homicidal ideation, intent, or plans

2) Access to means for suicide and the lethality of those means
3) Presence of psychotic symptoms, command hallucinations, or severe anxiety
4) Presence of alcohol or substance abuse
5) History of seriousness of previous attempts
6) Family history or recent exposure to suicide (APA)

♦Measure #108: Disease Modifying Anti-Rheumatic Drug Therapy in Rheumatoid Arthritis

DESCRIPTION:
Percentage of patients aged 18 years and older who were diagnosed with rheumatoid arthritis and were prescribed, dispensed, or administered at least one ambulatory prescription for a disease modifying anti-rheumatic drug (DMARD)

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 care for patients with a diagnosis of rheumatoid arthritis will submit this measure.

This measure is 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 can be 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 codes allowed for this measure are: 1P- medical reasons, 8P- reasons not otherwise specified.

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

> **Definition:** "Prescribed" includes patients who are currently receiving medication(s) that follow the treatment plan recommended at an encounter during the reporting period, even if the prescription for that medication was ordered prior to the encounter.
>
> **Numerator Coding:**
> **DMARD Prescribed, Dispensed, or Administered**
> **CPT II 4187F:** Disease modifying anti-rheumatic drug therapy prescribed, dispensed, or administered

OR

> **DMARD not Prescribed, Dispensed, or Administered for Medical Reasons**
> Append a modifier (**1P**) to CPT Category II code **4187F** to report documented circumstances that appropriately exclude patients from the denominator.
>
> - **1P:** Documentation of medical reason(s) for not prescribing, dispensing, or administering disease modifying anti-rheumatic drug therapy

OR

DMARD not Prescribed, Dispensed, or Administered, Reason not Specified
Append a reporting modifier (**8P**) to CPT Category II code **4187F** to report circumstances when the action described in the numerator is not performed and the reason is no otherwise specified.

- **8P:** Disease modifying anti-rheumatic drug therapy was not prescribed, dispensed, or administered, reason not otherwise specified

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

Denominator Coding:
An ICD-9 diagnosis code for rheumatoid arthritis and a CPT E/M service code are required to identify patients for denominator inclusion.
ICD-9 diagnosis codes: 714.0, 714.1, 714.2, 714.81
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, 99455, 99456

RATIONALE:
Arthritis and other rheumatic conditions comprise the leading cause of disability among adults in the United States, and the cost of this public health burden is expected to increase as the U.S. population ages. Rheumatoid arthritis (RA) affects 1 percent of the adult population. Although the course of RA in individual patients is highly variable, most patients with persistent RA develop progressive functional limitation and physical disability. In addition, there is excess mortality and decreased survival among patients with persistent RA compared with the general population. While the prevalence of RA is low, the associated costs are very high over the lifetime of the affected person. Costs of RA amount to approximately 1 percent of the U.S. Gross National Product.

RA is a chronic autoimmune disorder often characterized by progressive joint destruction and multi-system involvement. RA affects approximately 2.5 million Americans, disproportionately women. There is no cure; consequently, the goal of treatment is to slow the progression of disease, thereby delaying or preventing joint destruction, relieving pain and maintaining functional capacity. RA pain is often most effectively managed in the long term by altering the natural history of the active progressive disease with DMARDs, but analgesics and anti-inflammatory drugs also have an important place in pain management.

CLINICAL RECOMMENDATION STATEMENTS:
RA should be treated as early as possible with DMARDs to control symptoms and delay disease progression.
Good Practice Point: All patients with persistent inflammatory joint disease (> 6–8 weeks duration) already receiving simple analgesics and NSAIDs should be considered for referral for specialist rheumatology opinion and DMARD therapy, preferably within 12 weeks.
Early DMARD therapy in RA is important to maintain function and reduce later disability.
DMARD therapy should be sustained in inflammatory disease in order to maintain disease suppression.

American College of Rheumatology (ACR) Subcommittee on Rheumatoid Arthritis Guidelines: Guidelines for ***the Management of Rheumatoid Arthritis.*** The majority of patients with newly diagnosed RA should be started on DMARD therapy within three months of diagnosis. All patients with RA are candidates for DMARD therapy. Although NSAIDs and glucocorticoids may alleviate symptoms, joint damage may continue to occur and progress.

Initiation of DMARD therapy should not be delayed beyond three months for any patient with an established diagnosis who, despite adequate treatment with NSAIDs, has ongoing joint pain, significant morning stiffness or fatigue, active synovitis, persistent elevation of the ESR or CRP level or radiographic joint damage. For any untreated patient with persistent synovitis and joint damage, DMARD treatment should be started promptly to prevent or slow further damage.
(ACR: Wherever possible, guidelines are evidence-based. However, because significant gaps in knowledge still exist, some recommendations are based on best practices and a consensus of the committee.)
American College of Rheumatology Subcommittee of Rheumatoid Arthritis. Guidelines for the Management of Rheumatoid Arthritis: 2002 Update. *Arthritis Rheum.* 2002;46:328-346.

Scottish Intercollegiate Guidelines Network: ***Management of Early Rheumatoid Arthritis.***
There is clear evidence from placebo-controlled trials that DMARDs reduce symptoms in RA (as measured by joint pain, swelling and tenderness, and duration and severity of morning stiffness). DMARDs also improve global well being, as assessed by both patients and physicians. It is becoming increasingly clear that DMARDs should be introduced as soon as possible. Protracted benefit may be achieved in RA patients if appropriate DMARD therapy is introduced early.
Scottish Intercollegiate Guidelines Network. Management of Early Rheumatoid Arthritis. 2000. www.sign.ac.uk

▲ Measure #109: Patients with Osteoarthritis who have an Assessment of Their Pain and Function

DESCRIPTION:
Percentage of patient visits for patients aged 21 years and older with a diagnosis of osteoarthritis (OA) with assessment for function and pain

INSTRUCTIONS:
This measure is to be reported at each visit occurring during the reporting period for patients with osteoarthritis seen during the reporting period. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

This measure is 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:
Patient visits with assessment for level of function and pain documented

Numerator Coding:
Osteoarthritis Symptoms and Functional Status Assessed
CPT II 1006F: Osteoarthritis symptoms and functional status assessed (may include the use of a standardized scale or the completion of an assessment questionnaire, such as an SF-36, AAOS Hip & Knee Questionnaire)

OR

Osteoarthritis Symptoms and Functional Status not Assessed, Reason not Specified
Append a reporting modifier (**8P**) to CPT Category II code **1006F** to 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:** Osteoarthritis symptoms and functional status not assessed, reason not otherwise specified

DENOMINATOR:
All patient visits for patients aged 21 years and older with a diagnosis of OA

Denominator Coding:
An ICD-9 diagnosis code for osteoarthritis and a CPT E/M service code are required to identify patients for denominator inclusion.
ICD-9 diagnosis codes: 715.00, 715.04, 715.09, 715.10, 715.11, 751.12, 715.13, 715.14, 715.15, 715.16, 715.17, 715.18, 715.20, 715.21, 715.22, 715.23, 715.24, 715.25, 715.26, 715.27, 715.28, 715.30, 715.31, 715.32, 715.33, 715.34, 715.35, 715.36, 715.37, 715.38, 715.80, 715.89, 715.90, 715.91, 715.92, 715.93, 715.94, 715.95, 715.96, 715.97, 715.98
AND
CPT E/M service codes: 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245

RATIONALE:
Osteoarthritis can be a debilitating condition. An assessment of patient symptoms and functional status is important as it serves as the basis for making treatment modifications, which in turn, assists in improving the patient's quality of life.

CLINICAL RECOMMENDATION STATEMENTS:
Because pain is a major cause of disability in people with arthritis, assessment of functional status should be included in the pain assessment. When selecting a functional status measure, consideration should be given to the cognitive-developmental abilities of the person, the type of practice setting, the domains of function to be assessed, and the time and resources needed to complete the assessment. (APS; B Recommendation)

Any persistent pain that has an impact on physical function, psychosocial function, or other aspects of quality of life should be recognized as a significant problem. (AGA; IIA Recommendation)

Control of pain and maintenance of activity correlate well with satisfactory quality of life. (AAOS)

▲ Measure #110: Influenza Vaccination for Patients ≥ 50 Years Old

DESCRIPTION:
Percentage of patients aged 50 years and older who received an influenza immunization during the flu season (September through February)

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for patients seen during the reporting period. This measure is intended to determine whether or not all patients aged 50 years and older received or had an order for influenza immunization during the flu season. There is no diagnosis associated with this measure. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

This measure is reported using G-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 denominator code(s) and the appropriate numerator G-code.

NUMERATOR:
Patients who received an influenza immunization during the flu season (September through February)

Numerator Coding:
Influenza Immunization Administered
G8482: Influenza immunization was ordered or administered

OR

Influenza Immunization not Administered for Documented Reasons
G8483: Influenza immunization was not ordered or administered for reasons documented by clinician

OR

Influenza Immunization not Administered, Reason not Specified
G8484: Influenza immunization was not ordered or administered, reason not specified

DENOMINATOR:
All patients aged 50 years and older

Denominator Coding:
A CPT E/M service code is required to identify patients for denominator inclusion.
CPT E/M service codes: 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245

RATIONALE:
Influenza vaccination has shown to decrease hospitalizations for influenza, especially for those with risk factors, however annual influenza vaccination rates remain low.

CLINICAL RECOMMENDATION STATEMENTS:
Annual influenza immunization is recommended for all groups who are at increased risk for complications from influenza including persons aged ≥ 50 years. (CDC, USPSTF)

♦Measure #111: Pneumonia Vaccination for Patients 65 Years and Older

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

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for patients seen during the reporting period. There is no diagnosis associated with this measure. Performance for this measure is not limited to the reporting period. This measure may be reported by clinicians who perform the quality actions described in the measure based on services provided and the measure-specific denominator coding.

This measure is 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 have ever received a pneumococcal vaccination

Numerator Coding:
Pneumonia Vaccination Administered or Previously Received
CPT II 4040F: Pneumococcal vaccine administered or previously received

OR

Pneumonia Vaccination not Administered or Previously Received for Medical Reasons
Append a modifier (**1P**) to CPT Category II code **4040F** to report documented circumstances that appropriately exclude patients from the denominator.

- **1P:** Documentation of medical reason(s) for not administering or previously receiving pneumococcal vaccination

OR

Pneumonia Vaccination not Administered or Previously Received, Reason not Specified
Append a reporting modifier (**8P**) to CPT Category II code **4040F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

- **8P:** Pneumococcal vaccine was not administered or previously received, reason not otherwise specified

DENOMINATOR:
All patients 65 years and older

Denominator Coding:
A CPT E/M service code is required to identify patients for denominator inclusion.
CPT E/M Codes: 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99218, 99219, 99220, 99241, 99242, 99243, 99244, 99245, 99356, 99357

RATIONALE:
The elderly have a much higher mortality from community-acquired pneumonia due to increased risk factors such as comorbidities, an increase in the number of medications taken and weaknesses or disease of lung tissue. Pneumonia accounts for an estimated 20 percent of nosocomial infections among the elderly, second only to urinary tract infections. The disease burden is large for older adults and the potential for prevention is high. (Ely, E., 1997)

Drugs such as penicillin were once effective in treating these infections; but the disease has become more resistant, making treatment of pneumococcal infections more difficult. This makes prevention of the disease through vaccination even more important. (CDC. National Immunization Program—*Pneumococcal Disease.,* 2005)

CLINICAL RECOMMENDATION STATEMENTS:
The U.S. Preventive Services Task Force's *Guide to Clinical Preventive Services* recommends pneumococcal vaccine for all immunocompetent individuals who are 65 and older or otherwise at increased risk for pneumococcal disease. Routine revaccination is not recommended, but may be appropriate in immunocompetent individuals at high risk for morbidity and mortality from pneumococcal disease (e.g., persons ≥ 75 years of age or with severe chronic disease) who were vaccinated more than five years previously. Medicare Part B fully covers the cost of the vaccine and its administration every five years. (United States Preventive Services Task Force, 1998)

Pneumococcal infection is a common cause of illness and death in the elderly and persons with certain underlying conditions. In 1998, an estimated 3,400 adults aged ≥ 65 years died as a result of invasive pneumococcal disease. Pneumococcal infection accounts for more deaths than any other vaccine-preventable bacterial disease. (CDC, 2002; Pneumococcal Pneumonia, NIAID Fact Sheet, December 2004.)

One of the *Healthy People 2010* objectives is to increase pneumococcal immunization levels for the noninstitutionalized, high-risk populations to at least 90 percent (objective no. 14.29). While the percent of persons 65 years and older receiving the pneumococcal vaccine has increased, it still remains considerably below the *Health People 2010* objective. According to the National Health Interview Survey (NHIS), which is used to track performance on year 2010 objectives, in 1998 only 46 percent of adults age 65 years and older report receiving the vaccine. The figure was 45 percent based on the 1997 Behavioral Risk Factor Surveillance System (BRFSS) survey. (National Center for Health Statistics., 2005; CDC, 1997)
A particular strength of this measure is that it provides an opportunity to compare performance against national, state and/or regional benchmarks, which are collected through nationally organized and administered surveys.

At the physician practice level where a patient survey may not be feasible, data collection on pneumonia vaccination status through chart abstraction is a viable option.

♦Measure #112: Screening Mammography

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

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for female patients seen during the reporting period. There is no diagnosis associated with this measure. Breast cancer screening is to be performed at least once within 24 months prior to the date of service. Performance for this measure is not limited to the reporting period. This measure may be reported by clinicians who perform the quality actions described in the measure based on services provided and the measure-specific denominator coding.

This measure is 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 had a mammogram at least once within 24 months

Numerator Coding:
Mammogram Performed
CPT II 3014F: Screening mammography results documented and reviewed

OR

Mammogram not Performed for Medical Reasons
Append a modifier (**1P**) to the above CPT Category II code **3014F** to report documented circumstances that appropriately exclude patients from the denominator

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

OR

Mammogram not Performed, Reason not Specified
Append a reporting modifier (**8P**) to CPT Category II code **3014F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

- **8P:** Screening mammography results were not documented and reviewed, reason not otherwise specified

DENOMINATOR:
All female patients aged 40 through 69 years

Denominator Coding:
A CPT E/M service code is required to identify patients for denominator inclusion.
CPT E/M service codes: 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245

RATIONALE:
Breast cancer ranks as the second leading cause of death in women. For women 40 to 49 years of age mammography can reduce mortality by 17 percent. (AMA, 2003)

CLINICAL RECOMMENDATION STATEMENT:
The U.S. Preventive Services Task Force (USPSTF) recommends screening mammography, with or without clinical breast examination (CBE), every 1-2 years for women aged 40 and older. (USPSTF, 2002)

- The USPSTF found fair evidence that mammography screening every 12-33 months significantly reduces mortality from breast cancer. Evidence is strongest for women aged 50-69, the age group generally included in screening trials. (USPSTF, 2002)
- For women aged 40-49, the evidence that screening mammography reduces mortality from breast cancer is weaker, and the absolute benefit of mammography is smaller, than it is for older women. Most, but not all, studies indicate a mortality benefit for women undergoing mammography at ages 40-49, but the delay in observed benefit in women younger than 50 makes it difficult to determine the incremental benefit of beginning screening at age 40 rather than at age 50. (USPSTF, 2002)
- The absolute benefit is smaller because the incidence of breast cancer is lower among women in their 40s than it is among older women. (USPSTF, 2002)

The USPSTF concluded that the evidence is also generalizable to women aged 70 and older (who face a higher absolute risk for breast cancer) if their life expectancy is not compromised by comorbid disease. The absolute probability of benefits of regular mammography increases along a continuum with age, whereas the likelihood of harms from screening (false-positive results and unnecessary anxiety, biopsies, and cost) diminishes from ages 40-70. The balance of benefits and potential harms, therefore, grows more favorable as women age. The precise age at which the potential benefits of mammography justify the possible harms is a subjective choice. (USPSTF, 2002)

American Cancer Society: Yearly Mammograms starting at age 40 and continuing for as long as a woman is in good health. (Smith, 2003)

American College of Preventative Medicine (ACPM):

- Low-risk women (no family history, familial cancer syndrome, or prior cancer). There is inadequate evidence for or against mammography screening of women under the age of 50. Women between the ages of 50-69 should have annual or biennial, high-quality, two-view mammography. Women aged 70 and older should continue undergoing

mammography screening provided their health status permits breast cancer treatment. (Ferrini, 1996)

- Higher-risk women: Women with a family history of pre-menopausal breast cancer in a first-degree relative or those with a history of breast and/or gynecologic cancer may warrant more aggressive screening. Women with these histories often begin screening at an earlier age, although there is no direct evidence of effectiveness to support this practice. The future availability of genetic screening may define new recommendations for screening high-risk women. (Ferrini, 1996)

The American Medical Association (AMA), the American College of Obstetricians and Gynecologists (ACOG), and the American College of Radiology (ACR), all support screening with mammography and CBE beginning at age 40. (AMA, 1999; ACOG, 2000; Feig, 1998)

The Canadian Task Force on Preventive Health Care (CTFPHC), and the American Academy of Family Physicians (AAFP), recommends beginning mammography for average-risk women at age 50. (Canadian Task Force on the Periodic Health Examination, 1999; AAFP, 2005)
AAFP recommends that mammography in high-risk women begin at age 40, and recommends that all women aged 40-49 be counseled about the risks and benefits of mammography before making decisions about screening. (AAFP, 2005)

♦Measure #113: Colorectal Cancer Screening

DESCRIPTION:
Percentage of patients aged 50 through 80 years who received the appropriate colorectal cancer screening

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for patients seen during the reporting period. There is no diagnosis associated with this measure. Performance for this measure is not limited to the reporting period. This measure may be reported by clinicians who perform the quality actions described in the measure based on services provided and the measure-specific denominator coding.

This measure is 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 had at least one or more screenings for colorectal cancer during or prior to the reporting period

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

- Fecal occult blood test (FOBT) during the reporting period
- Flexible sigmoidoscopy during the reporting period or the four years prior to the reporting period
- Double contrast barium enema (DCBE) or air contrast barium enema during the reporting period or the four years prior to the reporting period
- Colonoscopy during the reporting period or the nine years prior to the reporting period

Numerator Coding:
Colorectal Cancer Screening:
CPT II 3017F: Colorectal cancer screening results documented and reviewed

OR

Colorectal Cancer Screening not Performed for Medical Reasons
Append a modifier (**1P**) to CPT Category II code **3017F** to report documented circumstances that appropriately exclude patients from the denominator

- **1P:** Documentation of medical reason(s) for not performing a colorectal cancer screening

OR

Colorectal Cancer Screening not Performed, Reason not Specified
Append a reporting modifier (**8P**) to CPT Category II code **3017F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

- **8P:** Colorectal cancer screening results were not documented and reviewed, reason not otherwise specified

DENOMINATOR:
All patients aged 50 through 80 years

Denominator Coding:
A CPT E/M service code is required to identify patients for denominator inclusion.
CPT E/M service codes: 99201, 99202, 99203, 99204, 99205, 99211, 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

RATIONALE:
Colorectal cancer is the second leading cause of cancer-related death in the United States. There were an estimated 135,400 new cases and 56,700 deaths from the disease during 2001 (http://www.cancer.org/downloads/STT/F&F2001.pdf). Colorectal cancer (CRC) places significant economic burden on the society as well with treatment costs over $6.5 billion per year and, among malignancies, is second only to breast cancer at $6.6 billion per year. (Schrag, 1999).

Colorectal cancer screening can detect pre-malignant polyps and early stage cancers. Unlike other screening tests that only detect disease, colorectal cancer screening can guide removal of pre-malignant polyps, which in theory can prevent development of colon cancer. Four tests are currently available for screening: fecal occult blood testing (FOBT), flexible sigmoidoscopy, colonoscopy, and double contrast barium enema.

CLINICAL RECOMMENDATION STATEMENTS:
During the past decade, compelling evidence has accumulated that systematic screening of the population can reduce mortality from colorectal cancer. Three randomized, controlled trials demonstrated that fecal occult blood testing (FOBT), followed by complete diagnostic evaluation of the colon for a positive test, reduced colorectal cancer mortality (Hardcastle et al., 1996; Mandel & Oken, 1998; Kronborg; 1996). One of these randomized trials (Mandel et al., 1993) compared annual FOBT screening to biennial FOBT screening, and found that annual screening resulted in greater reduction in colorectal cancer mortality. Two case control studies have provided evidence that sigmoidoscopy reduces colorectal cancer mortality (Selby et al., 1992; Newcomb et al., 1992). Approximately 75% of all colorectal cancers arise sporadically (Stephenson et al., 1991). Part of the effectiveness of colorectal cancer screening is mediated by the removal of the precursor lesion—an adenomatous polyp (Vogtelstein et al., 1988). It has been shown that removal of polyps in a population can reduce the incidence of colorectal cancer (Winawer, 1993). Colorectal screening may also lower mortality by allowing detection of cancer at earlier stages, when treatment is more effective (Kavanaugh, 1998).

Because of the accumulated evidence, broad consensus has emerged about the virtue of screening individuals aged 50 years or older for colorectal cancer. In 1996, the U.S. Preventive

Services Task Force (USPSTF) published guidelines that recommended screening all persons aged 50 and older for colorectal cancer by annual FOBT or sigmoidoscopy (at unspecified periodicity) or both (USPSTF, 1997). In February 1997, clinical practice recommendations were issued by an interdisciplinary task force originally convened by the Agency for Health Care Policy and Research (AHCPR; the agency has since been renamed the Agency for Healthcare Research and Quality) and supported by a consortium of professional organizations including the American Gastroenterological Association (Winawer, 1997). The American Cancer Society (ACS) has recommended screening for colorectal cancer since 1980 and recently updated its guidelines in January, 2002 (Smith et al., 2002). These updated guidelines recommend colorectal cancer screening starting at age 50 for all persons at average risk of developing colorectal cancer using one of five options for screening: (1) annual FOBT; (2) flexible sigmoidoscopy every 5 years; (3) annual FOBT plus flexible sigmoidoscopy every 5 years; (4) double contrast barium enema (DCBE) every five years; or (5) colonoscopy every 10 years.

The USPSTF released its updated recommendations for colorectal cancer screening in July 2002. The USPSTF strongly recommends that clinicians screen men and women 50 years of age or older for colorectal cancer (A recommendation). The USPSTF found good evidence for FOBT screening, fair evidence for sigmoidoscopy (alone or in combination with FOBT), and no direct evidence for colonoscopy or double contrast barium enema. The USPSTF found insufficient evidence to recommend new technologies, such as virtual colonoscopy. The recommended periodicity is annually for FOBT, every 5 years for sigmoidoscopy and double contrast barium enema, and every 10 years for colonoscopy. FOBT is the only test for which direct evidence on periodicity exists. The intervals for the other tests are based on their sensitivity and the natural course of the disease.

▲ Measure #114: Inquiry Regarding Tobacco Use

DESCRIPTION:
Percentage of patients aged 18 years or older who were queried about tobacco use one or more times within 24 months

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for all patients seen during the reporting period. Tobacco use is to be queried at least once within 24 months prior to the date of service. There is no diagnosis associated with this measure. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

This measure is 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 code **with** the modifier. The modifier allowed for this measure is: 8P- reasons not otherwise specified. There are no allowable performance exclusions for this measure.

NUMERATOR:
Patients who were queried about tobacco use one or more times within 24 months

> ***NUMERATOR NOTE:*** *The correct combination of numerator codes must be reported on the claim form in order to properly report this measure. The "correct combination" of codes may require the submission of multiple numerator codes.*
>
> **Numerator Coding:**
> **Tobacco Use Assessed**
> *(Two CPT II codes [1000F & 10☒☒F] are required on the claim form to submit this category)*
>
> **CPT II 1000F:** Tobacco use assessed
> **AND**
>
> **CPT II 1034F:** Current tobacco smoker
> **OR**
> **CPT II 1035F:** Current smokeless tobacco user
> **OR**
> **CPT II 1036F:** Current tobacco non-user

OR

Tobacco Use not Assessed, Reason not Specified
(One CPT II code [1000F-8P] is required on the claim form to submit this category)

Append a reporting modifier (**8P**) to CPT Category II code **1000F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

- **1000F *with* 8P:** Tobacco use not assessed, reason not otherwise specified

DENOMINATOR:
All patients aged 18 years and older

Denominator Coding:
A CPT E/M service code is required to identify patients for denominator inclusion.
CPT E/M service codes: 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215

RATIONALE:
Tobacco use is one of the leading causes of many preventable diseases, however, not all individuals are screened for tobacco use.

CLINICAL RECOMMENDATION STATEMENTS:
Periodic screening for tobacco use is recommended for all patients. (US Department of Health and Human Services, USPSTF)

Tobacco cessation counseling is recommended for all patients who smoke. (USPSTF)

♦Measure #115: Advising Smokers to Quit

DESCRIPTION:
Percentage of patients aged 18 years and older and are smokers who received advice to quit smoking

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for all patients (whether or not they use tobacco) seen during the reporting period. There is no diagnosis associated with this measure. This measure is appropriate for use in all healthcare settings. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

This measure is reported using G-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 denominator code(s) and the appropriate numerator G-code.

NUMERATOR:
Patients who received advice to quit smoking

> ***NUMERATOR NOTE:*** *The correct combination of numerator codes must be reported on the claim form in order to properly report this measure. The "correct combination" of codes may require the submission of multiple numerator codes.*
>
> **Numerator Coding:**
> **Identify Tobacco Smokers Receiving Cessation Intervention**
> *(Two G-codes [G8455 & G8402] are required on the claim form to submit this category)*
>
> **G8455:** Current tobacco smoker
> **AND**
> **G8402:** Tobacco (smoke) use cessation intervention, counseling
>
> **OR**
>
> **If patient is not eligible for this measure because patient is a smokeless tobacco user or a non tobacco user, report:**
> *(One G-code [G84⊠⊠F] is required on the claim form to submit this category)*
>
> **Smokeless Tobacco User**
> **G8456:** Current smokeless tobacco user
> **OR**
> **Tobacco Non-User**
> **G8457:** Tobacco non-user

OR

Tobacco Smokers not Advised to Quit, Reason not Specified
(Two G-codes [G8455 & G8403] are required on the claim form to submit this category)

G8455: Current tobacco smoker
AND
G8403: Tobacco (smoke) use cessation intervention not counseled

DENOMINATOR:
All patients aged 18 years and older

Denominator Coding:
A CPT E/M service code is required to identify patients for denominator inclusion.
CPT E/M service codes: 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99217, 99218, 99219, 99220, 99241, 99242, 99243, 99244, 99245

RATIONALE:
Interventions to control smoking are strategically important because smoking is the leading preventable cause of death in the United States, clinical interventions are known to be effective in increasing cessation rates, and quitting smoking has been shown to improve health outcomes (Fiore, 2000)

CLINICAL RECOMMENDATION STATEMENTS:
The Clinical Practice Guidelines: Treating tobacco use and dependence published by USDHHS Public Health Service (Fiore, 2002) provide convincing empirical support for providing advice to and assistance with quitting smoking for patients who smoke. Specifically, these guidelines recommend:

1) repeated advice and support at all or most visits, and
2) delivery of cessation assistance and follow-up at all or most visits.

There have been more than 12 million premature deaths attributable to smoking since the first published Surgeon General's report on smoking and health in 1964. Smoking remains the leading preventable cause of premature death in the United States.

Nearly every organ in the body is affected by smoking (USDHHS, 2004). Smoking causes many diseases and reduces the health of smokers in general. The list of diseases caused by smoking has been expanded to include abdominal aortic aneurysm, acute myeloid leukemia, cataract, cervical cancer, kidney cancer, pancreatic cancer, pneumonia, periodontitis, and stomach cancer (USDHHS, 2004).

In the US in 2003, 45.4 million adults (21.6 percent) were current smokers—24.1 percent of men and 19.2 percent of women (CDC, 2005a). An estimated 70% of these smokers said they wanted to quit (CDC, 2005a).

An estimated 45.9 million adults were former smokers in 2003, representing 50.3 percent of those who had ever smoked (CDC, 2005a). For the second consecutive year, more adults had quit than were still smoking. A large number of clinical trials have demonstrated the effectiveness of

counseling in increasing cessation rates, and the effectiveness of bupropion and NRT has been demonstrated (Fiore, 2000). A meta-analysis of 7 studies found that physician advice to quit is associated with a 30% increase in cessation rates (Fiore, 2000). Counseling and medication are each associated with a doubling of cessation rates (Fiore, 2000).

♦Measure #116: Inappropriate Antibiotic Treatment for Adults with Acute Bronchitis

DESCRIPTION:
Percentage of adults aged 18 through 64 years with a diagnosis of acute bronchitis who were not prescribed or dispensed an antibiotic prescription on or within 3 days of the initial date of service

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

This measure is 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 were not prescribed or dispensed antibiotics on or within 3 days of the initial date of service

> **Numerator Instructions:** For performance, the measure will be calculated as the number of patients for whom antibiotics were neither prescribed nor dispensed on or within 3 days of the initial date of service over the number of patients in the denominator (patients aged 18 through 64 years with acute bronchitis). A higher score indicates appropriate treatment of patients with acute bronchitis (e.g., the proportion for whom antibiotics *were not* prescribed or dispensed on or three days after the initial date of service).
>
> **Numerator Coding:**

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

Description	Prescription		
5-aminosalicylates	• sulfasalazine		
Amebicides	• metronidazole		
Aminoglycosides	• amikacin • gentamicin	• kanamycin • neomycin	• streptomycin • tobramycin
Aminopenicillins	• amoxicillin	• ampicillin	
Antipseudomonal penicillins	• piperacillin	• ticarcillin	
Beta-lactamase inhibitors	• amoxicillin-clavulanate • ampicillin-sulbactam	• piperacillin-tazobactam	• ticarcillin-clavulanate
First generation cephalosporins	• cefadroxil	• cephalexin	

	• cefazolin	• cephradine	
Fourth generation cephalosporins	• cefepime		
Ketolides	• telithromycin		
Lincomycin derivatives	• clindamycin	• lincomycin	
Macrolides	• azithromycin • clarithromycin	• erythromycin • erythromycin ethylsuccinate	• erythromycin lactobionate • erythromycin stearate
Miscellaneous antibiotics	• aztreonam • chloramphenicol • dalfopristin-quinupristin	• daptomycin • erythromycin-sulfisoxazole • linezolid	• metronidazole
Sulfamethoxazole-trimethoprim DS	• doxycycline	• sulfamethoxazole-trimethoprim	• vancomycin
Natural penicillins	• penicillin G benzathine-procaine • penicillin G potassium	• penicillin G procaine • penicillin G sodium	• penicillin V potassium
Penicillinase resistant penicillins	• dicloxacillin	• nafcillin	• oxacillin
Quinolones	• ciprofloxacin • gatifloxacin • gemifloxacin	• levofloxacin • lomefloxacin • moxifloxacin	• Norfloxacin • ofloxacin • sparfloxacin
Rifamycin derivatives	• rifampin		
Second generation cephalosporin	• cefaclor • cefotetan	• cefoxitin • cefprozil	• cefuroxime • loracarbef
Sulfonamides	• sulfadiazine • sulfamethoxazole-trimethoprim		• sulfisoxazole
Tetracyclines	• doxycycline	• minocycline	• tetracycline
Third generation cephalosporins	• cefdinir • cefixime • cefoperazone	• cefotaxime • ceftazidime	• ceftibuten • ceftriaxone
Urinary anti-infectives	• fosfomycin • nitrofurantoin • nitrofurantoin macrocrystals	• nitrofurantoin macrocrystals-monohydrate • trimethoprim	

Antibiotic not Prescribed or Dispensed
CPT II 4124F: Antibiotic neither prescribed nor dispensed

OR

Antibiotic Prescribed or Dispensed for Medical Reasons
Append a modifier (**1P**) to CPT Category II code **4120F** to report documented circumstances that appropriately exclude patients from the denominator.

- **1P:** Documentation of medical reason(s) for prescribing or dispensing antibiotic

OR

Antibiotic Prescribed or Dispensed
CPT II 4120F: Antibiotic prescribed or dispensed

DENOMINATOR:
All patients aged 18 through 64 years with a diagnosis of acute bronchitis

Denominator Coding:
An ICD-9 diagnosis code for acute bronchitis and a CPT E/M service code are required to identify patients for denominator inclusion.
ICD-9 diagnosis codes: 466.0
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, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350

RATIONALE:
Antibiotics are commonly misused and overused for a number of viral respiratory conditions where antibiotic treatment is not clinically indicated. (Scott J.G., D. Cohen, B. Dicicco-Bloom, 2001) About 80 percent of antibiotics prescribed for acute respiratory infections in adults are unnecessary, according to CDC prevention guidelines. In adults, antibiotics are most often (65–80 percent) prescribed for acute bronchitis, despite its viral origin. The misuse and overuse of antibiotics contributes to antibiotic drug resistance, which is of public health concern due to the diminished efficacy of antibiotics against bacterial infections, particularly in sick patients and the elderly. (Austin D.J., K.G. Kristinsson, R.M. Anderson, 1999, Patterson, JE, 2001, Cohen ML, 1992, Lipsitch M, 2001)

A HEDIS measure that highlights inappropriate antibiotic prescribing in adults for a common respiratory condition will help to raise awareness among clinicians and patients about inappropriate antibiotic use. Antibiotics are most often inappropriately prescribed in adults with acute bronchitis. This measure builds on an existing HEDIS measure targeting inappropriate antibiotic prescribing for children with upper respiratory infection (common cold), where antibiotics are also most often inappropriately prescribed. (Chandran R., 2001, Gonzales R., J.F. Steiner, et al., 1999)

CLINICAL RECOMMENDATION STATEMENTS:
Clinical guidelines do not support antibiotic treatment of otherwise healthy adults with acute bronchitis due to the viral origin of acute bronchitis. Patients with chronic bronchitis, COPD or other chronic comorbidity may be treated with antibiotics and are therefore excluded from the measure denominator. (Gonzales R., D.C. Malone, J.H. Maselli, et al, 2001)

♦Measure #117: Dilated Eye Exam in Diabetic Patient

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

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

This measure is reported using CPT Category II codes:
ICD-9 diagnosis codes, CPT 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 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 had a dilated eye exam for diabetic retinal disease at least once within 12 months

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

Numerator Coding:
Dilated Eye Exam Performed by an Eye Care Professional
CPT II 2022F: Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed
OR
CPT II 2024F: Seven standard field stereoscopic photos with interpretation by an ophthalmologist or optometrist documented and reviewed
OR
CPT II 2026F: Eye imaging validated to match diagnosis from seven standard field stereoscopic photos results documented and reviewed
OR
CPT II 3072F: Low risk for retinopathy (no evidence of retinopathy in the prior year)

OR

Dilated Eye Exam not Performed, Reason not Specified
Append a reporting modifier (**8P**) to CPT Category II code **2022F or 2024F or 2026F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

- **8P:** Dilated eye exam was not performed, reason not otherwise specified

DENOMINATOR:
All patients aged 18 through 75 years with a diagnosis of diabetes

Denominator Coding:
An ICD-9 diagnosis code for diabetes and a CPT 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, 357.2, 362.01, 362.02, 362.03, 362.04, 362.05, 362.06, 362.07, 366.41, 648.00, 648.01, 648.02, 648.03, 648.04
AND
CPT codes: 92002, 92004, 92012, 92014, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99217, 99218, 99219, 99220, 99241, 99242, 99243, 99244, 99245, 99455, 99456

RATIONALE:
Examination of the eyes is the first step in the treatment of any existing or developing conditions related to retinopathy and the first step in the prevention of blindness.

CLINICAL RECOMMENCATION STATEMENTS:
AACE/ACE, ADA, and American Academy of Ophthalmology (AAO): Recommend that a dilated eye examination be performed on patients with diabetes during an initial assessment and at least annually thereafter. (AACE/ACE, 2002; ADA, 2004; AAO, 1998; Hammond, 1998)

American Association of Clinical Endocrinologists and American College of Endocrinology (AACE/ACE): Recommend that the annual eye examination be performed as part of a retinal module. The module includes test of visual acuity (Snellen chart); funduscopic examination and intraocular pressure (IOP) test. The AACE/ACE recommends that diabetic patients should be under the care of an ophthalmologist experienced in the management of diabetic retinopathy. AACE/ACE further believes that a dilated eye exam should only be done by an MD/DO. (AACE/ACE, 2002)

American Diabetes Association (ADA): Patients with type 1 diabetes should have an initial dilated and comprehensive eye examination by an ophthalmologist or optometrist within 3-5 years after the onset of diabetes. In general evaluation for diabetic eye disease is not necessary before 10 years of age. However, some evidence suggests that the prepubertal duration of diabetes may be important in the development of microvascular complications; therefore, clinical judgment should be used when applying these recommendations to individual patients. (Level of Evidence: B)

Patients with type 2 diabetes should have an initial dilated and comprehensive eye examination by an ophthalmologist or optometrist shortly after diabetes diagnosis. (Level of Evidence: B)

Subsequent examinations for type 1 and type 2 diabetic patients should be repeated annually by an ophthalmologist or optometrist who is knowledgeable and experienced in diagnosing the presence of diabetic retinopathy and is aware of its management. Examination will be required more frequently if retinopathy is progressing. This follow-up interval is recommended recognizing that there are limited data addressing this issue. (Level of Evidence: B)

Seven standard field stereoscopic 30° fundus photography is an accepted method for examining diabetic retinopathy. (ADA, 2004)

American Academy of Ophthalmology (AAO): Recommends that diabetic patients should be under the care of an ophthalmologist experienced in the management of diabetic retinopathy. Ophthalmologists with specialized knowledge and experience in managing the disease are best able to detect and treat serious disease. Stereoscopic photographs offer an advantage over nonstereoscopic photographs, and the traditional “seven stereo fields” provide the most complete coverage. (AAO, 1998; Hammond, 1996)

American Geriatrics Society (AGS): Dilated eye examinations should be performed every two years at a minimum, and more often if there are additional risk factors for diabetic eye disease or evidence of age-related eye disease. (CHF/AGS, 2003)

▲ Measure #118: Angiotensin-Converting Enzyme Inhibitor (ACE) or Angiotensin Receptor Blocker (ARB) Therapy for Patients with Coronary Artery Disease and Diabetes and/or Left Ventricular Systolic Dysfunction (LVSD)

DESCRIPTION:
Percentage of patients aged 18 years and older with a diagnosis of coronary artery disease (CAD) who also have diabetes mellitus and/or 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 patients with CAD seen during the reporting period. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

There are two reporting options for this measure:
(1) Patients who are 18 years and older with a diagnosis of CAD who also have LVSD who are prescribed ACE Inhibitor or ARB therapy
OR
(2) Patients who are 18 years and older with a diagnosis of CAD who are also diabetic who are prescribed ACE Inhibitor or ARB therapy.

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 denominator code(s) and the appropriate numerator G-code.

REPORTING OPTION 1: For patients with CAD and LVSD
NUMERATOR:
Patients who were prescribed ACE inhibitor or ARB therapy

> **Numerator Instructions:** The LVSD 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 LVSD or 2) that uses descriptive terms such as moderately or severely depressed left ventricular dysfunction.
>
> **Numerator Coding:**
> **ACE Inhibitor or ARB Therapy Prescribed**
> **G8468:** Angiotensin converting enzyme (ACE) inhibitor or angiotensin receptor blocker (ARB) therapy prescribed for patients with a left ventricular ejection fraction (LVEF) <40% or documentation of moderately or severely depressed left ventricular systolic function

OR

ACE Inhibitor or ARB Therapy not Prescribed for Documented Reasons
G8469: Clinician documented that patient with a left ventricular ejection fraction (LVEF) <40% or documentation of moderately or severely depressed left ventricular systolic function was not an eligible candidate for angiotensin converting enzyme (ACE) inhibitor or angiotensin receptor blocker (ARB) therapy

OR

If patient is not eligible for this measure because LVEF ≥ 40% or LVEF not performed or documented, report:
Left Ventricular Ejection Fraction (LVEF) ≥ 40%
G8470: Patient with 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
G8471: Left ventricular ejection fraction (LVEF) was not performed or documented

OR

ACE Inhibitor or ARB Therapy not Prescribed for Patients with LVSD, Reason not Specified
G8472: Angiotensin converting enzyme (ACE) inhibitor or angiotensin receptor blocker (ARB) therapy not prescribed for patients with a left ventricular ejection fraction (LVEF) <40% or documentation of moderately or severely depressed left ventricular systolic function, reason not specified

DENOMINATOR:
All CAD patients aged 18 years and older who also have a diagnosis of LVSD

Denominator Coding:
An ICD-9 diagnosis code for CAD and a CPT E/M service code are required to identify patients for denominator inclusion.
ICD-9 diagnosis codes for CAD**:** 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, 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, 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

OR

REPORTING OPTION 2: For patients with CAD and diabetes
NUMERATOR:
Patients who were prescribed ACE inhibitor or ARB therapy

Numerator Coding:

ACE Inhibitor or ARB Therapy Prescribed
G8473: Angiotensin converting enzyme (ACE) inhibitor or angiotensin receptor blocker (ARB) therapy prescribed

OR

ACE Inhibitor or ARB Therapy not Prescribed for Documented Reasons
G8474: Angiotensin converting enzyme (ACE) inhibitor or angiotensin receptor blocker (ARB) therapy not prescribed for reasons documented by the clinician

OR

ACE Inhibitor or ARB Therapy not Prescribed, Reason not Specified
G8475: Angiotensin converting enzyme (ACE) inhibitor or angiotensin receptor blocker (ARB) therapy not prescribed, reason not specified

DENOMINATOR:
All CAD patients aged 18 years and older who also have a diagnosis of diabetes

Denominator Coding:
ICD-9 diagnosis codes for CAD and diabetes and a CPT E/M service code are required to identify patients for denominator inclusion.
ICD-9 diagnosis codes for CAD**:** 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, 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
ICD-9 diagnosis codes for diabetes**:** 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: 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:
In the absence of contraindications, ACE inhibitors or ARBs are recommended for patients with coronary artery disease; especially those with diabetes and /or left ventricular systolic dysfunction. ACE inhibitors and ARBs have shown to decrease morbidity and mortality, including significant reductions in the occurrence of myocardial infarction, stroke, and diabetic complications.

CLINICAL RECOMMENDATION STATEMENTS:
ACE inhibitor use is recommended in all patients with CAD who also have diabetes and/or left ventricular systolic dysfunction. (ACC/AHA)

ACE inhibitor use is also recommended in patients with CAD or other vascular disease. (ACC/AHA)

In ST elevation myocardial infarction (STEMI) patients who tolerate ACE inhibitors, an angiotensin receptor blocker (ARB) can be useful as an alternative to ACE inhibitors in the long-term management of STEMI patients, provided there are either clinical or radiological signs of heart failure or LVEF less than 0.40. (ACC/AHA)

♦Measure #119: Urine Screening for Microalbumin or Medical Attention for Nephropathy in Diabetic Patients

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

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

This measure is reported using CPT Category II codes:
ICD-9 diagnosis codes, CPT 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 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 have a nephropathy screening during at least one office visit within 12 months

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

Numerator Coding:
Nephropathy Screening Performed
CPT II 3060F: Positive microalbuminuria test result documented and reviewed
OR
CPT II 3061F: Negative microalbuminuria test result documented and reviewed
OR
CPT II 3062F: Positive macroalbuminuria test result documented and reviewed
OR
CPT II 3066F: Documentation of treatment for nephropathy (eg, patient receiving dialysis, patient being treated for ESRD, CRF, ARF, or renal insufficiency, any visit to a nephrologist)
OR
CPT II 4009F: Angiotensin converting enzyme (ACE) inhibitor or angiotensin receptor blocker (ARB) therapy prescribed

OR

Nephropathy Screening not Performed, Reason not Specified
Append a reporting modifier (**8P**) to CPT Category II code **3060F or 3061F or 3062F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

- **8P:** Nephropathy screening was not performed, reason not otherwise specified

DENOMINATOR:
All patients aged 18 through 75 years of age with the diagnosis of diabetes

Denominator Coding:
An ICD-9 diagnosis code for diabetes and a CPT 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, 357.2, 362.01, 362.02, 362.03, 362.04, 362.05, 362.06, 362.07, 648.00, 648.01, 648.02, 648.03, 648.04
AND
CPT codes: 92002, 92004, 92012, 92014, 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99217, 99218, 99219, 99220, 99241, 99242, 99243, 99244, 99245, 99455, 99456

RATIONALE:
Nephropathy is a frequent complication of renal disease for both type 1 and type 2 diabetes and often ends in end-stage renal disease (ESRD) (ADA, 2002). Of all people with diabetes, 10-21% have nephropathy (ADA 2002).

CLINICAL RECOMENNDATION STATEMENTS:
American Association of Clinical Endocrinologists and American College of Endocrinology (AACE/ACE): Recommends that the initial assessment should include a urinalysis, test for microalbuminuria and creatinine clearance. The renal complication module should be performed annually and includes a test for microalbuminuria and creatinine clearance (AACE/ACE, 2002).

American Diabetes Association (ADA): A test for the presence of microalbumin should be performed at diagnosis in patients with type 2 diabetes. Microalbuminuria rarely occurs with short duration of type 1 diabetes; therefore, screening in individuals with type 1 diabetes should begin after 5 years' disease duration (Level of Evidence: E). However, some evidence suggests that the prepubertal duration of diabetes may be important in the development of microvascular complications; therefore, clinical judgment should be exercised when individualizing these recommendations. Because of the difficulty in precise dating of the onset of type 2 diabetes, such screening should begin at the time of diagnosis. After the initial screening and in the absence of previously demonstrated microalbuminuria, a test for the presence of microalbumin should be performed annually (ADA, 2004).

Screening for microalbuminuria can be performed by three methods:

1) measurement of the albumin-to-creatinine ratio in a random spot collection

2) 24-h collection with creatinine, allowing the simultaneous measurement of creatinine clearance

3) timed (e. g. 4-h or overnight) collection – the analysis of a spot sample for the albumin-to-creatinine ratio is strongly recommended.

The role of annual microalbuminuria assessment is less clear after diagnosis of microalbuminuria and institution of angiotensin-converting enzyme (ACE) inhibitor or angiotensin receptor blocker (ARB) therapy and blood pressure control. Many experts recommend continued surveillance to assess both response to therapy and progression of disease.

National Kidney Foundation (NKF): Individuals at increased risk, but found not to have chronic kidney disease, should be advised to follow a program of risk factor reduction, if appropriate, and undergo repeat periodic evaluation (NKF, 2003).

A comparative analysis of recommendations and evidence in diabetes guidelines from 13 countries (including the American Diabetes Association and Canadian Medical Association) found there was agreement among the guidelines that ACE inhibitors should be recommended to patients with hypertension and renal disease (Burgers, 2002).

The ADA also recommends that for the treatment of both micro- and macroalbuminurua, ARBs should be used except during pregnancy (ADA, 2005).

▲ Measure #120: ACE Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy in Patients with CKD

DESCRIPTION:
Percentage of patients aged 18 years and older with a diagnosis of advanced chronic kidney disease (CKD) (stage 4 or 5, not receiving Renal Replacement Therapy [RRT]), and hypertension and proteinuria who were prescribed angiotensin converting enzyme (ACE) inhibitor or angiotensin receptor blocker (ARB) therapy during the 12-month reporting period

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for patients with CKD seen during the reporting period. It is anticipated that clinicians providing care for patients with CKD will submit this measure.

This measure may 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 appropriate denominator code(s) and the appropriate numerator G-code.

NUMERATOR:
Patients who were prescribed ACE inhibitor or ARB therapy during the 12 month reporting period

Numerator Coding:
ACE Inhibitor or ARB Therapy Prescribed
G8479: Clinician prescribed angiotensin converting enzyme (ACE) inhibitor or angiotensin receptor blocker (ARB) therapy

OR

ACE Inhibitor or ARB Therapy not Prescribed for Documented Reasons
G8480: Clinician documented that patient was not an eligible candidate for angiotensin converting enzyme (ACE) inhibitor or angiotensin receptor blocker (ARB) therapy

OR

ACE Inhibitor or ARB Therapy not Prescribed, Reason not Specified
G8481: Clinician did not prescribe angiotensin converting enzyme (ACE) inhibitor or angiotensin receptor blocker (ARB) therapy, reason not specified

DENOMINATOR:
All patients aged 18 years and older with the diagnosis of advanced CKD (stage 4 or 5, not receiving RRT) and hypertension and proteinuria

Denominator Coding:
An ICD-9 diagnosis code for CKD, hypertension, and proteinuria, and a CPT E/M service code are required to identify patients for denominator inclusion.
ICD-9 diagnosis codes for CKD**:** 585.4, 585.5
AND
ICD-9 diagnosis codes for hypertension**:** 401.0, 401.1, 401.9, 402.00, 402.01, 402.10, 402.11, 402.90, 402.91, 403.00, 403.01, 403.10, 403.11, 403.90, 403.91, 404.00, 404.01, 404.02, 404.03, 404.10, 404.11, 404.12, 404.13, 404.90, 404.91, 404.92, 404.93
AND
ICD-9 diagnosis codes for proteinuria**:** 791.0
AND
CPT E/M service codes: 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245

RATIONALE:
Evidence has shown that use of ACE inhibitors and ARBs as antihypertensive therapy is effective, and may help slow the progression of CKD. These drugs help control hypertension and decrease proteinuria. However, data shows that only approximately one-third of patients with CKD are treated with an ACE inhibitor or an ARB.

Process/goal of care to be improved: Percentage of pts on ACEI or ARB and thereby slowing progression of CKD.

CLINICAL RECOMMENDATION STATEMENTS:
If a patient has GFR ≤ 30 ml/min/1.73m² and hypertension, then s/he should receive an ACE inhibitor or an ARB as a first-line agent (Grade C). (RPA 2002)

ACE inhibitors and ARBs can be used safely in most patients with CKD. ACE Inhibitors and ARBs should be used at moderate to high doses, as used in clinical trials (Grade A). (NKF 2004)

ACE inhibitors and ARBs have not been tested in all types of CKD. Where tested, ACE inhibitors and ARBs have generally similar effects on blood pressure, urine protein excretion, and slowing the progression of kidney disease (Strength of Recommendation: STRONG). (NKF 2004)

▲ Measure #121: Chronic Kidney Disease (CKD): Laboratory Testing (Calcium, Phosphorus, Intact Parathyroid Hormone (iPTH) and Lipid Profile)

DESCRIPTION:
Percentage of patients aged 18 years and older with a diagnosis of advanced CKD (stage 4 or 5, not receiving Renal Replacement Therapy [RRT]), who had the following laboratory testing ordered at least once during the 12-month reporting period: serum levels of calcium, phosphorus and intact PTH, and lipid profile

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for patients with CKD seen during the reporting period. It is anticipated that clinicians providing care for patients with CKD will submit this measure.

This measure may 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, 8P- reasons not otherwise specified.

NUMERATOR:
Patients who had the following laboratory testing ordered at least once during the 12 month reporting period: serum levels of calcium, phosphorus and intact PTH, and lipid profile

Numerator Coding:
Serum Levels of Calcium, Phosphorus, Intact Parathyroid Hormone (iPTH) and Lipid Profile Ordered
CPT II 3278F: Serum levels of calcium, phosphorus, intact Parathyroid Hormone (iPTH) and lipid profile ordered

OR

Serum Levels of Calcium, Phosphorus, Intact Parathyroid Hormone (iPTH) and Lipid Profile not Ordered for Medical or Patient Reasons
Append a modifier (**1P or 2P**) to CPT Category II code **3278F** to report documented circumstances that appropriately exclude patients from the denominator

- **1P:** Documentation of medical reason(s) for not ordering serum levels of calcium, phosphorus, intact Parathyroid Hormone (iPTH) and lipid profile
- **2P:** Documentation of patient reason(s) for not ordering serum levels of calcium, phosphorus, intact Parathyroid Hormone (iPTH) and lipid profile

OR

Serum Levels of Calcium, Phosphorus, Intact Parathyroid Hormone (iPTH) and Lipid Profile not Ordered, Reason not Specified

Append a reporting modifier (**8P**) to CPT Category II code **3278F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

- **8P:** Serum levels of calcium, phosphorus, intact Parathyroid Hormone (iPTH) and lipid profile not ordered, reason not otherwise specified

DENOMINATOR:

All patients aged 18 years and older with the diagnosis of advanced CKD (stage 4 or 5, not receiving RRT)

Denominator Coding:

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

ICD-9 diagnosis codes: 585.4, 585.5

AND

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

RATIONALE:

Bone disease is a common complication of chronic kidney disease. Patients with CKD should be monitored for calcium and phosphate imbalances and secondary hyperparathyroidism. Disturbances in mineral and bone metabolism are prevalent in CKD and are an important cause of morbidity, decrease in quality of life, and extraskeletal calcification that has been associated with increased CV mortality (taken verbatim from Definition, evaluation, and classification of renal osteodystrophy: a position statement from the Kidney Disease: Improving Global Outcomes (KDIGO), Moe, et al, Kidney Int, 2006; 69:1945-53). Gaps: USRDS 2006 data show that less than 30% of Medicare (and less than 20% of EGHP) pts receive Ca, Phos, PTH measures within a year.

Process/goal of care to be improved: identification of abnormalities mineral and bone metabolism that relate to increased morbidity and mortality.

CLINICAL RECOMMENDATION STATEMENTS:

Serum levels of calcium, phosphorus, and intact plasma parathyroid hormone (PTH) should be measured in all patients with CKD and GFR < 60 ml/min/1.73m². (Evidence) (NKF 2003)

If a patient has GFR ≤ 30 ml/min/1.73m², then s/he should have his/her serum calcium and phosphorus measured at least every three months, and iPTH levels measured at least once. (Grade B) (RPA 2002)

Patients with CKD should be considered in the “highest-risk” group for CVD for implementing recommendations for pharmacological therapy, irrespective of cause of CKD. (Grade A) (NKF 2004)

All adults and adolescents with CKD should be evaluated for dyslipidemias. (Grade B) (NKF 2003)

For adults and adolescents with CKD, the assessment of dyslipidemias should include a complete fasting lipid profile with total cholesterol, LDL, HDL, and triglycerides. (Grade B) (NKF 2003)

▲ Measure #122: Chronic Kidney Disease (CKD): Blood Pressure Management

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

INSTRUCTIONS:
This measure is to be reported at each visit for patients with a diagnosis of CKD seen during the reporting period. It is anticipated that clinicians providing care for patients with CKD will submit this measure.

This measure is reported using G-codes and/or 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. G-codes and/or 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 G-code **AND/OR** CPT Category II code **OR** the CPT Category II code **with** the modifier **AND** G-code. The reporting modifier allowed for this measure is: 8P- reasons not otherwise specified. There are no allowable performance exclusions for this measure.

NUMERATOR:
Patients visits with blood pressure <130/80 mmHg OR ≥130/80 mmHg with a documented plan of care

Definition: A documented plan of care should include one or more of the following: recheck blood pressure at specified future date; initiate or alter pharmacologic therapy; initiate or alter non-pharmacologic therapy; documented review of patient's home blood pressure log which indicates that patient's blood pressure is or is not well controlled.

Numerator Instructions: If multiple blood pressure measurements are taken at a single visit, use the most recent measurement taken at that visit.

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

Numerator Coding:
Patient Visits with Blood Pressure < 130/80 mmHg
(One G-code [G8476] is required on the claim form to submit this category)

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

OR

Blood Pressure Plan of Care Documented for Patient Visits with Systolic Blood Pressure ≥ 130 mmHG and/or Diastolic Blood Pressure ≥ 80 mmHg (If either systolic blood pressure is ≥ 130 mmHg OR diastolic blood pressure is ≥ 80 mmHg, patient requires a plan of care)
(One G-code & one CPT II code [G8477 & 0513F] are required on the claim form to submit this category)

G8477: Most recent blood pressure has a systolic measurement of ≥130 mmHg and/or a diastolic measurement of ≥80 mmHg
AND
CPT II 0513F: Elevated blood pressure plan of care documented

OR

Blood Pressure Measurement not Performed
(One G-code [G8478] is required on the claim form to submit this category)

G8478: Blood pressure measurement not performed or documented, reason not specified

OR

Elevated Blood Pressure Plan of Care not Documented for Patient Visits with Systolic Blood Pressure ≥ 130 mmHg and/or Diastolic Blood Pressure ≥ 80 mmHg, Reason not Specified
(One CPT II code & one G-code [0513F-8P & G8477] are required on the claim form to submit this category)

Append a reporting modifier (**8P**) to CPT Category II code **0513F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

- **0513F *with* 8P:** No documentation of elevated blood pressure plan of care, reason not otherwise specified

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

DENOMINATOR:
All visits for patients aged 18 years and older with the diagnosis of advanced CKD (stage 4 or 5, not receiving RRT)

Denominator Coding:
An ICD-9 diagnosis code for CKD and a CPT E/M service code are required to identify patients for denominator inclusion.
ICD-9 diagnosis codes: 585.4, 585.5
AND
CPT E/M service codes: 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245

RATIONALE:

Identification of hypertension in patients with CKD is an essential part of management of the disease. Hypertension is common in patients with CKD, and if hypertension is left untreated, it will speed the progression of the disease. Recent research has shown that during office visits, approximately 20% to 30% of CKD patients do not have their blood pressure measured. Additionally, if the CKD patient is has an anemia/ESA visit, they are even less likely to have their blood pressure measured. In these patients, recent research has shown that 75% do not have their blood pressure measured at an anemia/ESA visit. Patients with CKD should have their blood pressure measured at each office visit so that changes can be identified and treatment initiated as soon as it is necessary. Blood pressure control is important in slowing the progression of chronic kidney disease. By slowing the progression of the disease, quality of life is improved for the patient, and it results in a longer period of time before a patient requires renal replacement therapy. Patients with chronic kidney disease should have a lower target blood pressure (< 130/80) than other patients with hypertension.

CLINICAL RECOMMENDATION STATEMENTS:

Blood pressure should be measured at each health encounter. (Grade A) (NKF 2004)

If a patient has GFR ≤ 30 ml/min/1.73m2, then his/her blood pressure should be checked with every clinic visit. (Grade A) (RPA 2002)
If a patient has a GFR ≤ 30 ml/min/1.73m², and if blood pressure is determined to be elevated (systolic > 130 mmHg OR diastolic > 80 mmHg), then s/he should receive intensified antihypertensive therapy (Grade B). (RPA, 2002)

Patients with CKD should be considered in the “highest-risk” group for CVD for implementing recommendations for pharmacological therapy, irrespective of cause of CKD (Grade A). (NKF, 2004)

Target blood pressure for CVD risk reduction in CKD and diabetic/nondiabetic kidney disease should be < 130/80 mmHg (Grade B). (NKF, 2004)

▲ Measure #123: Chronic Kidney Disease (CKD): Plan of Care: Elevated Hemoglobin for Patients Receiving Erythropoiesis-Stimulating Agents (ESA)

DESCRIPTION:
Percentage of patient calendar months during the 12-month reporting period in which patients aged 18 years and older with a diagnosis of advanced CKD (stage 4 or 5, not receiving Renal Replacement Therapy [RRT]), receiving ESA therapy, have a hemoglobin < 13 g/dL OR patients whose hemoglobin is ≥ 13 g/dL and have a documented plan of care

INSTRUCTIONS:
This measure is to be reported a minimum of once per calendar month for all patients with a diagnosis of CKD seen during the reporting period. The most recent quality code submitted will be used for performance calculation. It is anticipated that clinicians providing care for patients with CKD will submit this measure.

This measure may 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 modifier allowed for this measure is: 8P- reasons not otherwise specified. There are no allowable performance exclusions for this measure.

NUMERATOR:
Number of patient calendar months during which patients with a hemoglobin level of < 13 g/dL OR patients whose hemoglobin level is ≥ 13 g/dL have a documented plan of care

> **Definition:** A documented plan of care should include reducing the ESA dose and repeating hemoglobin at a specified future date.
>
> ***NUMERATOR NOTE:*** *The correct combination of numerator codes must be reported on the claim form in order to properly report this measure. The "correct combination" of codes may require the submission of multiple numerator codes.*
>
> **Numerator Coding:**
> **Hemoglobin level < 13 g/dL**
> *(Two CPT II codes [3281F & 4171F] are required on the claim form to submit this category)*
>
> **CPT II 3281F:** Hemoglobin level less than 11 g/dL
> **OR**
> **CPT II 3280F:** Hemoglobin level 11 g/dL to 12.9 g/dL
>
> **AND**

CPT II 4171F: Patient receiving Erythropoiesis-Stimulating Agent (ESA) therapy

OR

Hemoglobin level ≥ 13 g/dL with a Documented Plan of Care
(Three CPT II codes [3279F & 0514F & 4171F] are required on the claim form to submit this category)

CPT II 3279F: Hemoglobin level greater than or equal to 13 g/dL
AND
CPT II 0514F: Plan of care for elevated hemoglobin level documented for patient receiving Erythropoiesis-Stimulating Agent (ESA) therapy
AND
CPT II 4171F: Patient receiving Erythropoiesis-Stimulating Agent (ESA) therapy

OR

If patient is not eligible for this measure because, patient was not receiving erythropoiesis-stimulating agent (ESA) therapy, report:
(One CPT II code [4172F] is required on the claim form to submit this category)

CPT II 4172F: Patient not receiving Erythropoiesis-Stimulating Agent (ESA) therapy

OR

Hemoglobin Level Measurement not Performed
(Two CPT II codes [3281F-8P & 4171F] are required on the claim form to submit this category)

Append a reporting modifier (**8P**) to CPT Category II code **3281F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

- **3281F *with* 8P:** Hemoglobin level measurement not documented, reason not otherwise specified

AND
CPT II 4171F: Patient receiving Erythropoiesis-Stimulating Agent (ESA) therapy

OR

Plan of Care for Elevated Hemoglobin Level not Documented for Patient Receiving Erythropoiesis-Stimulating Agent (ESA) Therapy, Reason not Specified
(Three CPT II codes [0514F-8P & 3279F & 4171F] are required on the claim form to submit this category)

Append a reporting modifier (**8P**) to CPT Category II code **0514F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

- **0514F *with* 8P:** Plan of care for elevated hemoglobin level not documented for patient receiving Erythropoiesis-Stimulating Agent (ESA) therapy, reason not otherwise specified

AND
CPT II 3279F: Hemoglobin level greater than or equal to 13 g/dL
AND
CPT II 4171F: Patient receiving Erythropoiesis-Stimulating Agent (ESA) therapy

DENOMINATOR:
Calendar months for all patients aged 18 years and older with the diagnosis of advanced CKD (stage 4 or 5, not receiving RRT), receiving ESA therapy

Denominator Coding:
An ICD-9 diagnosis code for CKD and a CPT E/M service code are required to identify patients for denominator inclusion.
ICD-9 diagnosis codes: 585.4, 585.5
AND
CPT E/M service codes: 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245

RATIONALE:
The clinical recommendation regarding Hb levels for CKD patients receiving ESA therapy is that Hb level should generally be in the range of 11.0 to 12.0 g/dL. Additionally, these patients should also have their Hb level checked at least monthly. Given that Hb levels vary for each patient due to numerous factors, it is necessary to monitor Hb level closely in order to make the individualized treatment decisions required in maintaining Hb level in the target range. There is no evidence of benefit from ESA therapy when Hb levels are maintained at greater than 13.0 g/dL. Maintaining Hb at higher levels may result in potential harm to the patient, as well as incur unjustified cost. Evidence linking increased risks for patients with CKD and higher Hb levels were for target Hb levels greater than 13.0g/dL (CHOIR/CREATE). The intention of this measure is not to suggest that the goal of ESA treatment is to reach an achieved Hb of 13.0 g/dL. Rather, as a patient safety measures, it is to realize that patients who reach Hb levels higher than 13.0 g/dL are at increased risk for adverse events, and that these elevated Hb levels need to be addressed by adjusting ESA dosage.

CLINICAL RECOMMENDATION STATEMENTS:
The frequency of HB monitoring in patients treated with ESAs should be at least monthly. (Opinion) (NKF 2006)

The Hb target is the intended aim of ESA therapy for the individual patient with CKD. In clinical practice, achieved Hb results vary considerably from Hb target.

- Selection of the Hb target and selection of the Hb level at which ESA therapy is initiated in the individual patient should include consideration of potential benefits (including improvement in the quality of life and avoidance of transfusion) and potential harms (including the risk of life-threatening adverse events). (Clinical Practice Recommendation) (NKF 2007)
- In dialysis and nondialysis patients with CKD receiving ESA therapy, the selected Hb target should generally be in the range of 11.0 to 12.0 g/dL. (Clinical Practice Recommendation) (NKF 2007)

- In dialysis and nondialysis patients with CKD receiving ESA therapy, the Hb target should not be greater than 13.0 g/dL. (Clinical Practice Guideline; Moderately Strong Evidence) (NKF, 2007)

The initial ESA dose and the ESA dose adjustments should be determined by the patient's Hb level, the target Hb level, the observed rate of increase in Hb level, and clinical circumstances. (Opinion) (NKF 2006)

ESA doses should be decreased, but not necessarily held, when a downward adjustment of Hb level is needed. (Opinion) (NKF 2006)

♠Measure #124: HIT - Adoption/Use of Health Information Technology (Electronic Health Records)

DESCRIPTION:
Documents whether provider has adopted and is using health information technology. To qualify, the provider must have adopted a qualified electronic medical record (EMR). For the purpose of this measure, a qualified EMR can either be a Certification Commission for Healthcare Information Technology (CCHIT) certified EMR or, if not CCHIT certified, the system must be capable of all of the following:

- Generating a medication list
- Generating a problem list
- Entering laboratory tests as discrete searchable data elements

INSTRUCTIONS:
This measure is to be reported at each visit occurring during the reporting period for patients seen during the reporting period. There is no diagnosis associated with this measure. This measure may be reported by clinicians who have adopted and are using health information technology.

This measure is reported using G-codes:
CPT E/M codes, CPT service codes, CPT procedure codes, HCPCS D-codes and HCPCS G-codes are used to identify patients who are included in the measure's denominator. G-codes are used to report the numerator of the measure.

When reporting the measure, submit the appropriate denominator code(s) and the appropriate numerator G-code.

NUMERATOR:
Patient encounter documentation substantiates use of certified/qualified EMR

Definitions:
Health Information Technology (HIT) – A system that incorporates both computer hardware and software that deals with the storage, retrieval, sharing, and use of health care information, data, and knowledge for communication and decision making.
CCHIT – The Certification Commission for Healthcare Information Technology (www.cchit.org) – an independent, nonprofit organization that has been recognized by the federal government as an official certification body for electronic health record products.
Discrete searchable data elements – Laboratory data that can be recorded in predefined fields in predefined formats within the EMR that allow for reports to be generated, such as trends of a specific element over time. This cannot be easily done if data is entered via a free text format or by merely scanning a report into the EMR.

Numerator Coding:
Encounter Documented Using CCHIT Certified or Qualified EMR
G8447: Patient encounter was documented using a CCHIT certified EMR
OR

G8448: Patient encounter was documented using a non-CCHIT certified EMR. To qualify, the system must be capable of all of the following:

- Generating a medication list
- Generating a problem list
- Entering laboratory tests as discrete searchable data elements

OR

Encounter not Documented Using CCHIT Certified or Qualified EMR for System Reasons

G8449: Patient encounter was not documented using an EMR due to system reasons such as, the system being inoperable at the time of the visit. Use of this code implies that an EMR is in place and generally available

DENOMINATOR:

All patients aged 18 years and older

Denominator Coding:

A CPT service code, CPT E/M code, HCPCS D-code or HCPCS G-code is required to identify patients for denominator inclusion.

CPT service codes, CPT E/M codes, HCPCS D-codes or HCPCS G-codes: 90801, 90802, 90804, 90805, 90806, 90807, 90808, 90809, 92002, 92004, 92012, 92014, 96150, 96151, 96152, 97001, 97002, 97003, 97004, 97750, 97802, 97803, 97804, 98940, 98941, 98942, 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, D7140, D7210, G0101, G0108, G0109, G0270, G0271

RATIONALE:

The need for clinical information systems to provide high-quality, safe care is a well recognized fact, as publicized by Dr. Ed Wagner in his Chronic Care Model. A comprehensive clinical information system can enhance the care of individual patients by:

- Providing timely reminders about needed services
- Summarizing data to track and plan care
- Identifying groups of patients needing additional care
- Facilitating performance monitoring and quality improvement efforts

While it is preferable to encourage adoption of CCHIT certified EMRs, it became apparent during measure field testing that CCHIT certified EMRs are not currently available for all provider settings and specialty groups that may report this measure. Therefore, additional numerator coding was added to enable providers who have adopted a non-CCHIT certified product, which meets a set of standards, to also report this measure. The following is an excerpt taken from the CCHIT website:

The 2006 Ambulatory EHR Criteria represent basic requirements that the Commission and its Workgroups believe are appropriate for many common ambulatory care settings. CCHIT acknowledges that these Criteria may not be suitable for settings such as behavioral health, emergency departments, or specialty practices and our current certification makes no representation for these. Purchasers should not interpret a lack of CCHIT Certification as being of

significance for specialties and domains not yet addressed by CCHIT Criteria. (excerpt from www.cchit.org)

Evidence Supporting the Criterion of the Quality Measure:

Overall Evidence Grading: SORT Strength of Recommendation B: considerable patient-oriented evidence, i.e., re: better patient care management, higher patient satisfaction, reduction of adverse drug events, better quality performance, and improved patient safety, but not consistently high quality evidence

Committee on Quality Health Care in America (2001). Crossing the Quality Chasm: A new health system for the 21st century. Washington, D.C., National Academy Press.

This report explains the difficulty managing a patient's care using a written medical record, which can be cumbersome to navigate through, as well as illegible. Not only would an EMR be consistent and legible, it can provide reminders and prompts, allowing better management of patient care. In addition, patients who can access their provider using e-mail can have their needs met more quickly and cost effectively.

Study quality level 2 (limited-quality patient-oriented evidence)

Hillestad, R., et al. (2005). "Can electronic medical record systems transform health care? Potential health benefits, savings and costs." Health Affairs 24(5): 1103-1117.

This article concludes that two-thirds of the approximately 8 million adverse drug events that occur in the outpatient setting would be avoided through the widespread use of computerized physician order entry (CPOE).

Study quality level 2 (limited-quality patient-oriented evidence)

Jha, A. K., et al. (2003). "Effect of the transformation of the Veterans Affairs Health Care System on quality of care." NEJM 348(22): 2218-2227.

The Veterans Health Administration medical system uses an EMR system-wide. The authors attribute the VHA's superior quality performance in part to "an emphasis on the use of information technology."

Study quality level 2 (limited-quality patient-oriented evidence)

Middleton, B. (2005). The value of health information technology in clinical practice. Pennsylvania eHealth Initiative, Harrisburg.

This article highlights the impact that various components of HIT and EMR will have on improving patient safety. Additionally, Dr. Middleton enumerates the cost benefits of ambulatory computerized physician order entry (ACPOE).

Study quality level 2 (limited-quality patient-oriented evidence)

Mitchell, E., Sullivan, F. (2001). "A descriptive feast but an evaluative famine: systematic review of published articles on primary care computing during 1980-1997." BMJ 322(7281): 279-282.

This older systematic review documents the value of using ECI in a variety of primary care situations.

Study quality level 2 (limited-quality patient-oriented evidence; systematic review but older)

♠Measure #125: HIT - Adoption/Use of e-Prescribing

DESCRIPTION:
Documents whether provider has adopted a qualified e-Prescribing system and the extent of use in the ambulatory setting. To qualify this system must be capable of **ALL** of the following:

- Generating a complete active medication list incorporating electronic data received from applicable pharmacy drug plan(s) if available
- Selecting medications, printing prescriptions, electronically transmitting prescriptions, and conducting all safety checks (defined below)
- Providing information related to the availability of lower cost, therapeutically appropriate alternatives (if any)
- Providing information on formulary or tiered formulary medications, patient eligibility, and authorization requirements received electronically from the patient's drug plan

INSTRUCTIONS:
This measure is to be reported at each visit occurring during the reporting period for patients seen during the reporting period. There is no diagnosis associated with this measure. This measure may be reported by clinicians who have adopted a qualified e-Prescribing system.

This measure is reported using G-codes:
CPT E/M codes, CPT service codes and HCPCS G-codes are used to identify patients who are included in the measure's denominator. G-codes are used to report the numerator of the measure.

When reporting the measure, submit the appropriate denominator code(s) and the appropriate numerator G-code.

NUMERATOR:
A qualified e-Prescribing system has been adopted capable of generating a medication list and selecting/printing/transmitting/performing safety checks of prescriptions

Definitions:
Qualified e-Prescribing system – an e-Prescribing system that is capable of **ALL** of the following:

- Generating a complete active medication list incorporating electronic data received from applicable pharmacy drug plan(s) if available
- Selecting medications, printing prescriptions, electronically transmitting prescriptions, and conducting all safety checks (defined below)
- Providing information related to the availability of lower cost, therapeutically appropriate alternatives (if any)
- Providing information on formulary or tiered formulary medications, patient eligibility, and authorization requirements received electronically from the patient's drug plan

e-Prescribing – Entering a prescription for a medication into an automated data entry system that generates a prescription electronically instead of handwriting the prescription on paper

Safety checks – Automated prompts that offer the provider information on the drug being prescribed, potentially inappropriate dose or route of administration of a drug, drug-drug interactions, allergy concerns, or warnings and cautions

Numerator Coding:

Prescriptions Generated via Qualified e-Prescribing System

G8443: All prescriptions created during the encounter were generated using a qualified e-Prescribing system

OR

Qualified e-Prescribing System Available, Prescription(s) not Generated or not Generated Via Qualified e-Prescribing System for System/Patient Reasons

G8445: No prescriptions were generated during the encounter. Provider does have access to a qualified e-Prescribing system

OR

G8446: Some or all prescriptions generated during the encounter were handwritten or phoned in due to one of the following: required by state law, patient request, or qualified e-Prescribing system being temporarily inoperable

DENOMINATOR:

All patients aged 18 years and older

Denominator Coding:

A CPT service code, CPT E/M code, or G-code is required to identify patients for denominator inclusion.

CPT service codes, CPT E/M codes, or HCPCS G-codes: 90801, 90802, 90804, 90805, 90806, 90807, 90808, 90809, 92002, 92004, 92012, 92014, 96150, 96151, 96152, 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, G0101, G0108, G0109

RATIONALE:

Automation of the ambulatory prescribing process has many potential benefits including:

- Patient safety through computerized transmission of legible prescriptions directly to the pharmacy and checks for harmful interactions.
- Patient satisfaction in a process that results in fewer errors and less waiting time
- Avoidance of unnecessary phone calls for clarification between Providers and Pharmacies.
- Easier data collection of physician prescribing patterns and improved formulary compliance for Health plans, pharmacy benefit managers and employers.

Evidence Supporting the Criterion of the Quality Measure:

Overall Evidence Grading: SORT Strength of Recommendation B: considerable patient-oriented evidence, i.e., re: reduction of adverse drug events, reduction of unnecessary utilization, and improved patient safety, but not consistently high quality evidence

Corley, S. T. (2003). "Electronic prescribing: a review of costs and benefits." Topics in Health Information Management 24(1): 29-38.

Corley estimated cost savings from reduction of adverse drug events following implementation of electronic prescribing.

Study quality level 2 (limited-quality patient-oriented evidence)

Hillestad, R., et al. (2005). "Can electronic medical record systems transform health care? Potential health benefits, savings and costs." Health Affairs 24(5): 1103-1117.

This article concludes that two-thirds of the approximately 8 million adverse drug events that occur in the outpatient setting would be avoided through the widespread use of computerized order entry (CPOE).

Study quality level 2 (limited-quality patient-oriented evidence)

Kohn, L., et al. (1999). To err is human: Building a safer health system. Washington, D.C., National Academy Press.

This report concluded, from a case analysis, that there is supporting evidence to show that adverse drug events (ADE) resulted in an increase in physician office and emergency department visits, and of those physician office visits, more than 50% were "judged to be unnecessary and potentially avoidable." Additionally, the report stated, "Physicians do not routinely screen for potential drug interactions, even when medication history information is readily available."

Study quality level 2 (limited-quality patient-oriented evidence)

Middleton, B. (2005). The value of health information technology in clinical practice. Pennsylvania eHealth Initiative, Harrisburg.

Dr. Middleton discusses the value of ambulatory computerized order entry (ACPOE). A model was developed based on data derived from HIT implementation in the Partners Healthcare System. When applied nationally, this model predicts a potential savings of $44 billion and the prevention of 2 million adverse drug events per year.

Study quality level 2 (limited-quality patient-oriented evidence)

Shekelle, P., Morton, S., Keeler, E. (2006). Costs and benefits of health information technology. Evidence Report/Technology Assessment, AHRQ. 132.

Electronic prescribing is widely believed to improve accuracy of the prescription process and thereby reduce potential for medical errors and increase health care quality. Shekelle et al. observe that EMRs with electronic prescribing improve patient safety by reducing adverse drug events in the inpatient setting.

Study quality level 2 (limited-quality patient-oriented evidence)

♪Measure #126: Diabetic Foot and Ankle Care, Peripheral Neuropathy: Neurological Evaluation

DESCRIPTION:
Percentage of patients aged 18 years and older with a diagnosis of diabetes mellitus who had a neurological examination of their lower extremities

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

This measure is reported using G-codes:
ICD-9 diagnosis codes, CPT 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 denominator code(s) and the appropriate numerator G-code.

NUMERATOR:
Patients who had a lower extremity neurological exam performed at least once within 12 months

Definition: A lower extremity neurological exam consists of a documented evaluation of motor and sensory abilities including reflexes, vibratory, proprioception, sharp/dull and 5.07 filament detection.

Numerator Coding:
Lower Extremity Neurological Exam Performed
G8404: Lower extremity neurological exam performed and documented

OR

Lower Extremity Neurological Exam not Performed for Documented Reasons
G8406: Clinician documented that patient was not an eligible candidate for lower extremity neurological exam measure

OR

Lower Extremity Neurological Exam not Performed
G8405: Lower extremity neurological exam not performed

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

Denominator Coding:
An ICD-9 diagnosis code for diabetes mellitus and a CPT 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
AND
CPT codes: 10060, 10061, 10180, 11000, 11040, 11041, 11042, 11043, 11044, 11055, 11056, 11057, 11719, 11720, 11721, 11730, 11740, 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

RATIONALE:
Foot ulceration is the most common single precursor to lower extremity amputations among persons with diabetes. Treatment of infected foot wounds accounts for up to one-quarter of all inpatient hospital admissions for people with diabetes in the United States. Peripheral sensory neuropathy in the absence of perceived trauma is the primary factor leading to diabetic foot ulcerations. Approximately 45-60% of all diabetic ulcerations are purely neuropathic. Other forms of neuropathy may also play a role in foot ulcerations. Motor neuropathy resulting in anterior crural muscle atrophy or intrinsic muscle wasting can lead to foot deformities such as foot drop, equinus, and hammertoes. In people with diabetes, 22.8% have foot problems -- such as amputations and numbness -- compared with 10% of nondiabetics. Over the age of 40 years old, 30% of people with diabetes have loss of sensation in their feet.

CLINCAL RECOMMENDATION STATEMENTS:
Recognizing important risk factors and making a logical, treatment-oriented assessment of the diabetic foot requires a consistent and thorough diagnostic approach using a common language. Without such a method, the practitioner is more likely to overlook vital information and to pay inordinate attention to less critical points in the evaluation. A useful examination will involve identification of key risk factors and assignment into appropriate risk category. Only then can an effective treatment plan be designed and implemented. (ACFAS/ACFAOM Clinical Practice Guidelines)

♪Measure #127: Diabetic Foot and Ankle Care, Ulcer Prevention: Evaluation of Footwear

DESCRIPTION:
Percentage of patients aged 18 years and older with a diagnosis of diabetes mellitus who were evaluated for proper footwear and sizing

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

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 appropriate denominator code(s) and the appropriate numerator G-code.

NUMERATOR:
Patients who were evaluated for proper footwear and sizing at least once within 12 months

> **Definition:** Evaluation for proper footwear includes a foot examination documenting the vascular, neurological, dermatological, and structural/biomechanical findings. The foot should be measured using a standard measuring device and counseling on appropriate footwear should be based on risk categorization.
>
> **Numerator Coding:**
> **Footwear Evaluation Performed**
> **G8410:** Footwear evaluation performed and documented
>
> **OR**
>
> **Footwear Evaluation not Performed for Documented Reasons**
> **G8416:** Clinician documented that patient was not an eligible candidate for footwear evaluation measure
>
> **OR**
>
> **Footwear Evaluation not Performed**
> **G8415:** Footwear evaluation was not performed

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

Denominator Coding:
An ICD-9 diagnosis code for diabetes mellitus and a CPT 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
AND
CPT codes: 10060, 10061, 10180, 11000, 11040, 11041, 11042, 11043, 11044, 11055, 11056, 11057, 11719, 11720, 11721, 11730, 11740, 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

RATIONALE:
Foot ulceration is the most common single precursor to lower extremity amputations among persons with diabetes. Shoe trauma, in concert with loss of protective sensation and concomitant foot deformity, is the leading event precipitating foot ulceration in persons with diabetes. Treatment of infected foot wounds accounts for up to one-quarter of all inpatient hospital admissions for people with diabetes in the United States. Peripheral sensory neuropathy in the absence of perceived trauma is the primary factor leading to diabetic foot ulcerations. Approximately 45-60% of all diabetic ulcerations are purely neuropathic. In people with diabetes, 22.8% have foot problems -- such as amputations and numbness -- compared with 10% of nondiabetics. Over the age of 40 years old, 30% of people with diabetes have loss of sensation in their feet.

CLINCAL RECOMMENDATION STATEMENTS:
The multifactorial etiology of diabetic foot ulcers is evidenced by the numerous pathophysiologic pathways that can potentially lead to this disorder. Among these are two common mechanisms by which foot deformity and neuropathy may induce skin breakdown in persons with diabetes. The first mechanism of injury refers to prolonged low pressure over a bony prominence (i.e., bunion or hammertoe deformity). This generally causes wounds over the medial, lateral, and dorsal aspects of the forefoot and is associated with tight or ill-fitting shoes. (ACFAS/ACFAOM Clinical Practice Guidelines)

♠Measure #128: Universal Weight Screening and Follow-Up

DESCRIPTION:
Percentage of patients aged 65 years and older with a calculated Body Mass Index (BMI) within the past six months or during the current visit that is documented in the medical record and if the most recent BMI is ≥ 30 or < 22, a follow-up plan is documented

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for patients seen during the reporting period. The most recent quality code submitted will be used for performance calculation. There is no diagnosis associated with this measure. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding. BMI measured and documented in the medical record may be reported if done in the provider's office/facility or if BMI calculation within the past six months is documented in outside medical records obtained by the provider. The documentation of a follow up plan should be based on the most recently calculated BMI.

This measure is reported using G-codes:
CPT procedure codes, CPT E/M codes, CPT service codes, HCPCS D-codes, HCPCS 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 appropriate denominator code(s) and the appropriate numerator G-code.

NUMERATOR:
Patients with BMI calculated within the past six months or during the current visit and a follow up plan documented if the BMI is ≥ 30 or < 22

Definitions:
BMI – Body Mass Index (BMI) is a number calculated from a person's weight and height. BMI provides a reliable indicator of body fatness for most people and is used to screen for weight categories that may lead to health problems. BMI is calculated by dividing a person's weight (in kilograms) by his/her height (in meters, squared). BMI can also be calculated by multiplying weight (in pounds) by 705, then dividing by height (in inches) twice. A simpler method to calculate the BMI involves the use of a chart. The weight is plotted on one axis and the height is plotted on the other axis. The BMI can then be read where the two points intersect. See http://www.healthdiscovery.net/links/calculators/body_massindex_chart.htm for an example of a widely available BMI chart.
Calculated BMI – Requires that both the height and weight are actually measured. Values merely reported by the patient cannot be used.
Follow-up plan – Proposed outline of treatment to be conducted as a result of abnormal BMI measurement. Such follow-up can include documentation of a future appointment, education, referral, prescription/administration of medications/dietary supplements, etc.

Not eligible for BMI measurement – Patients can be considered not eligible in the following situations:

- If the patient already is diagnosed as over or under weight and there is documentation in the medical record that the weight problem is being managed by another provider
- If the patient has a terminal illness
- If the patient refuses BMI measurement
- If there is any other reason documented in the medical record by the provider explaining why BMI measurement was not appropriate
- Patient is in an urgent or emergent medical situation where time is of the essence and to delay treatment would jeopardize the patient's health status

Numerator Coding:

BMI Calculated, No Follow-up Plan Needed or BMI Calculated, Follow-up Plan Documented

G8420: BMI < 30 AND ≥ 22 was calculated and documented

OR

G8417: BMI ≥ 30 was calculated and a follow-up plan was documented in the medical record

OR

G8418: BMI < 22 was calculated and a follow-up plan was documented in the medical record

OR

Patient not Eligible for BMI Calculation for Documented Reasons

G8422: Patient not eligible for BMI calculation

OR

BMI not Performed and/or Calculated BMI ≥ 30 or < 22, Follow-up Plan not Documented, Reason not Specified

G8421: BMI not calculated

OR

G8419: BMI ≥ 30 OR < 22 was calculated, but no follow-up plan documented in the medical record

DENOMINATOR:

Patients aged 65 years and older

Denominator Coding:

A CPT procedure code, CPT service code, CPT E/M code, HCPCS D-code or HCPCS G-code is required to identify patients for denominator inclusion.

CPT procedure codes, CPT service codes, CPT E/M codes, HCPCS D-codes or HCPCS G-codes: 00140, 00142, 00170, 00400, 00402, 00810, 00832, 00851, 00910, 00920, 01380, 01382, 01400, 01732, 01810, 01820, 01829, 90801, 90802, 90804, 90805, 90806, 90807, 90808, 90809, 92002, 92004, 92012, 92014, 97001, 97003, 97802, 97803, 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, D7140, D7210, G0101, G0108, G0270

RATIONALE:
Of the Medicare population, 37 percent are overweight and 18 percent are obese, the economic impact of which has been estimated at $117 billion in the U.S. Additionally, elderly patients with unintentional weight loss are at higher risk for infection, depression and death. Older people have special nutritional needs due to age and disease processes and professionals of all disciplines need to help older individuals modify their nutritional status, thereby improving quality of life (American Dietetic Association, Nutrition Screening Initiative, 2002).

CLINICAL RECOMMENDATION STATEMENTS:
The USPSTF recommends that clinicians screen all adult patients for obesity and offer intensive counseling and behavioral interventions to promote sustained weight loss for obese adults. (Level of Evidence = B, USPSTF)

The clinical guideline for obesity recommends assessment of BMI at each encounter (National Heart, Lung and Blood Institute).

Validated measure of nutrition status serves as an indicator of over-nourishment and under-nourishment. Nutrition Screening Initiative: "Nutrition Interventions Manual for Professionals Caring for Older Americans," 2002 (Co-sponsored by American Dietetic Association (ADA), AAFP and National Council on Aging, Inc.).

The NSI-suggested BMI range is 22-27 (values outside this range indicate overweight or underweight for elderly) Nutrition Screening Initiative: "Nutrition Interventions Manual for Professionals Caring for Older Americans," 2002 (Co-sponsored by American Dietetic Association (ADA), AAFP and National Council on Aging, Inc.).

Interventions can be grouped into six primary categories: Social Services, Oral Health, Mental Health, Medication Use, Nutritional Education and Counseling, and Nutritional Support. For further detail on any of the potential interventional strategies, see the Nutritional Interventions Manual for Professionals Caring for Older Americans, 2002. Nutrition Screening Initiative: "Nutrition Interventions Manual for Professionals Caring for Older Americans," 2002 (Co-sponsored by American Dietetic Association (ADA), AAFP and National Council on Aging, Inc.).

Evidence Supporting the Criterion of Quality Measure:
Overall Evidence Grading: SORT Strength of Recommendation B: considerable patient-oriented evidence, i.e., re: improved clinical outcomes, including improved blood pressure, lipid levels, and glucose metabolism, decreased diabetes incidence, and reduced mortality, but not consistently high quality evidence

Callee, E. E., Thun, M.J., Petrelli, J.M., Rodriquez, C., Heath, C.W., Jr. (1999). "Body-mass index and mortality in a prospective cohort of U.S. adults." New England Journal of Medicine 341: 1097-1105.

> BMI of less than 22 kg per m^2 in women and less than 23.5 kg per m^2 in men is associated with increased mortality.
> Study quality level 2 (limited-quality patient-oriented evidence)

Corrada, M. M., et al. (2006). "Association of body mass index and weight change with all-cause mortality in the elderly." American Journal of Epidemiology 163(10): 938-949.

The study explored the relation of BMI and weight change to all-cause mortality in the elderly. Results highlight the influence on older-age mortality risk of being underweight or obese later in life.

Study quality level 2 (limited-quality patient-oriented evidence)

Flegal, K. M., et al. (2005). "Excess deaths associated with underweight, overweight, and obesity." JAMA 293: 1861-1867.

This study sought to estimate deaths associated with underweight (BMI < 18.5), overweight (BMI 25 to < 30), and obesity (BMI ≥ 30) in the United States in 2000. Underweight was associated with 33,746 excess deaths. Underweight and obesity, particularly higher levels of obesity, were associated with increased mortality relative to the normal weight category.

Study quality level 2 (limited-quality patient-oriented evidence)

Jain, M. G., et al. (2005). "Body mass index and mortality in women: Follow-up of the Canadian national breast screening study cohort." International Journal of Obesity 29: 792-797.

A study designed to examine the relationship between obesity and all-cause mortality in women confirms the association of high BMI with increased all-cause mortality in women.

Study quality level 2 (limited-quality patient-oriented evidence)

McTigue, K. M., et al. (2003). "Screening and interventions for obesity in adults: Summary of the evidence for the U.S. preventive services task force." Annals of Internal Medicine 139(11): 933-949.

This meta-analysis concludes that counseling and pharmacotherapy can promote modest sustained weight loss, improving clinical outcomes. Weight reduction improved blood pressure, lipid levels, and glucose metabolism and decreased diabetes incidence.

Study quality level 1 (good-quality patient-oriented evidence)

♠Measure #129: Universal Influenza Vaccine Screening and Counseling

DESCRIPTION:
Percentage of patients aged 50 years and older who were screened and counseled about the influenza vaccine during the months of January, February, March, October, November, and December

INSTRUCTIONS:
This measure is to be reported at each visit occurring during the months of January, February, March, October, November, and December during the reporting period for patients seen during the reporting period. There is no diagnosis associated with this measure. This measure may be reported by non-MD/DO clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

This measure is reported using G-codes:
CPT E/M codes, CPT service codes, CPT procedure codes, HCPCS 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 appropriate denominator code(s) and the appropriate numerator G-code.

NUMERATOR:
Patients screened and counseled about the influenza vaccine

Definitions:
Screening – Testing done on people at risk of developing a certain disease, even if they have no symptoms. Screening tests can predict the likelihood of someone having or developing a particular disease. This measure looks for the test being done in the practitioner's office that is filing the code.
Counseling – Providing information or advice related to the applicable measure such as including ways to stay healthy, implementing lifestyle modifications, and/or improving health status. In this measure, the advice constitutes recommendation to receive vaccine unless contraindicated. For more information on flu vaccine, see: http://www.cdc.gov/flu/professionals/vaccination.

Numerator Coding:
Influenza Vaccine Screening Performed, Status Current or Counseling Provided
G8423: Documented that patient was screened and either influenza vaccination status is current or patient was counseled

OR

Influenza Vaccine Screening and/or Counseling not Performed, Patient not Appropriate
G8426: Documented that patient was not appropriate for screening and/or counseling about the influenza vaccine (e.g., allergy to eggs)

OR

Influenza Vaccine Screening not Performed and/or Counseling not Provided, Reason not Specified
G8424: Influenza vaccine status was not screened
OR
G8425: Influenza vaccine status screened, patient not current and counseling was not provided

DENOMINATOR:
Patients aged 50 years and older and dates of service in January, February, March, October, November, and December

Denominator Coding:
A CPT procedure code, CPT service code, CPT E/M code, or HCPCS G-code is required to identify patients for denominator inclusion.
CPT procedure codes, CPT service codes, CPT E/M codes, or HCPCS G-codes:
00140, 00142, 00170, 00400, 00402, 00810, 00832, 00851, 00910, 00920, 01380, 01382, 01400, 01732, 01810, 01820, 01829, 97802, 97803, 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, G0101, G0108, G0270

RATIONALE:
In the United States, epidemics of influenza typically occur during the winter months and have been associated with an average of approximately 36,000 deaths per year during 1990-1999. The CDC reported that although the target coverage set by Healthy People 2010 is 90 percent for annual influenza immunization, in 2002 national statistics demonstrated rates of only 66 percent. This measure focuses on the CDC's Advisory Committee on Immunization Practices (ACIP) revised recommendation of annual influenza vaccination for all persons age 50 and over, with a reminder to providers that they should routinely offer influenza vaccine to patients throughout the influenza season. (see MMWR 2006 citation below)

CLINICAL RECOMMENDATION STATEMENTS:
ACIP recommends annual influenza vaccination for persons aged 50 or older.

In order not to duplicate resources, the task force did not update their 1996 immunization recommendations and cites the CDC recommendations above, noting that ACIP's methods used to review evidence may differ from those used by USPSTF.

Evidence Supporting the Criterion of Quality Measure:
Overall Evidence Grading: SORT Strength of Recommendation B: considerable patient-oriented evidence, i.e., re: improved immunization rates, and decreased morbidity and mortality associated with influenza, but not consistently high quality evidence

Ashby-Hughes, B., et al. (1999). "Provider endorsement: The strongest cue in prompting high-risk adults to receive influenza and pneumococcal immunizations." Clinical Excellence for Nurse Practitioners 3(2): 97 - 104.

Provider recommendation was the most important reason adults received immunization. This study suggests that practitioner endorsement can significantly decrease the morbidity and mortality associated with flu and pneumonia by improving immunization rates.
Study quality level 2 (limited-quality patient-oriented evidence)

CDC (2006). "Prevention and control of influenza: Recommendations of the advisory committee on immunization practices (ACIP)." MMWR 55(RR10): 1 - 42.

Includes recommendations for administration for annual influenza vaccine for persons age 50 and older. Reminds providers that they should routinely offer influenza vaccine through the influenza season.
Study quality level 2 (limited-quality patient-oriented evidence)

Mayo, A. M., Cobler, S. (2004). "Flu vaccines and patient decision-making: What we need to know." Journal of American Academy of Nurse Practitioners 16(9): 402-410.

Recommending flu vaccine, offering vaccine in convenient locations free of charge, and discussing perceived barriers with patients may increase vaccinations among high-risk patients.
Study quality level 2 (limited-quality patient-oriented evidence)

Nichol, K. L., et al. (1996). "Factors associated with influenza and pneumococcal vaccination behavior among high-risk adults." Journal of Geriatric Internal Medicine 11: 673-677.

Emphasis on provider recommendations and the knowledge and attitudes of patients may enhance flu and pneumococcal vaccination rates, even in the context of organized vaccination programs.
Study quality level 2 (limited-quality patient-oriented evidence)

Postema, A. S., et al. (2000). "Adult immunization programs in nontraditional settings: Quality standards and guidance for program evaluation." MMWR Recommendation Report 49(RR-1): 1 - 13.

This report from CDC's National Vaccine Advisory Committee recognizes that immunization programs in nontraditional settings might enhance the capacity of the health care system to effectively deliver vaccine to adults by increasing the number and types of sites where adults can receive vaccine
Study quality level 2 (limited-quality patient-oriented evidence)

♠Measure #130: Universal Documentation and Verification of Current Medications in the Medical Record

DESCRIPTION:
Percentage of patients aged 18 years and older with written provider documentation that current medications with dosages (includes prescription, over-the-counter, herbals, vitamin/mineral/dietary [nutritional] supplements) were verified with the patient or authorized representative

INSTRUCTIONS:
This measure is to be reported at each visit occurring during the reporting period for patients seen during the reporting period. There is no diagnosis associated with this measure. This measure may be reported by non-MD/DO clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

This measure is reported using G-codes:
CPT service codes, CPT procedure codes, HCPCS 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 appropriate denominator code(s) and the appropriate numerator G-code.

NUMERATOR:
Verification of patient's current medications with dosages is documented

Definitions:
Authorized representative – A person who is acting on the patient's behalf and who does not have a conflict of interest with the patient, when the patient is temporarily or permanently unable to act for himself or herself. This person should have the patient's best interests at heart and should be reasonably expected to act in a manner that is protective of the person and the rights of the patient. Preferably, this individual is appointed by the patient.
Not eligible – A patient is not eligible if one or more of the following condition(s) exist:
- Patient refuses to participate
- Patient is in an urgent or emergent medical situation where time is of the essence and to delay treatment would jeopardize the patient's health status
- Patient cognitively impaired and no authorized representative available

Current medications – All medications (includes prescription, over-the-counter, herbals, vitamin/mineral/dietary [nutritional] supplements) a patient may be taking routinely and/or on a PRN basis

Numerator Coding:

Current Medication Verification Documented

G8427: Written provider documentation was obtained confirming that current medications with dosages (includes prescription, over-the-counter, herbals, vitamin/mineral/dietary [nutritional] supplements) were verified with the patient or authorized representative or patient assessed and is not currently on any medications.

OR

Current Medications not Documented, Patient not Eligible

G8430: Documentation that patient is not eligible for medication assessment

OR

Current Medications not Documented and/or Patient Verification not Documented, Reason not Specified

G8428: Current medications with dosages (includes prescription, over-the-counter, herbals, vitamin/mineral/dietary [nutritional] supplements) were documented without documented patient verification

OR

G8429: Incomplete or no documentation that patient's current medications with dosages (includes prescription, over-the-counter, herbals, vitamin/mineral/dietary [nutritional] supplements) were assessed

DENOMINATOR:

Patients aged 18 years and older

Denominator Coding:

A CPT procedure code, CPT service code, or HCPCS G-code is required to identify patients for denominator inclusion.

CPT procedure codes, CPT service codes, or HCPCS G-codes: 00140, 00142, 00170, 00400, 00402, 00810, 00832, 00851, 00910, 00920, 01380, 01382, 01400, 01732, 01810, 01820, 01829, 90801, 90802, 96116, 96150, 96152, 97001, 97002, 97003, 97004, 97802, 97803, G0101, G0108, G0270

RATIONALE:

Adverse drug events (ADEs) are one of the leading causes of hospitalizations and deaths in the U.S., with 13% of ADEs occurring in patients with a prior or documented allergy/reaction to the reactive drug. Using a medication list in the office setting promotes patient safety and reduces medical errors, both by improving documentation in general and, specifically, by improving communication between patients and providers.

CLINICAL RECOMMENDATION STATEMENTS:

In addition, as part of its efforts to promote patient safety and reduce the growing incidence of medical errors in the office setting, the Institute for Healthcare Improvement created a recommended medication list for patients and their families to carry with them to medical appointments to help providers reconcile medications during medical visits. [Institute for Healthcare Improvement. Medication List For Patients and Families. Massachusetts Coalition for the Prevention of Medical Error (in collaboration with the Massachusetts Medical Society), www.ihi.org/IHI/Topics/OfficePractices/Access/Tools]

Evidence Supporting the Criterion of Quality Measure:

Overall Evidence Grading: SORT Strength of Recommendation B: considerable patient-oriented evidence, i.e., re: improved patient safety, reduced adverse drug events, reduced hospitalizations and death, and reduced costs, but not consistently high quality evidence

Ghandi, T., et al. (2000). "Drug complications in outpatients." Journal of General Internal Medicine 15: 149-154.

A total of 75% of office visits to primary care providers involve the initiation or continuation of drug therapy and estimates of the proportion of outpatients experiencing an ADE per year range from 5-35%, with 13% of events occurring in patients with a prior or documented allergy/reaction to the causative drug. There is need for improved physician-patient communication and documentation of medications in the outpatient setting.
Study quality level 2 (limited-quality patient-oriented evidence)

Gurwitz, J., et al. (2003). "Incidence and preventability of adverse drug events among older persons in the ambulatory setting." JAMA 289: 1107-1116.

ADEs were identified as one of the most serious concerns regarding medication use in older persons cared for in the ambulatory setting. The authors recommend prevention strategies that target the prescribing and monitoring stages of pharmaceutical care and interventions focused on improving patient compliance and monitoring of prescribed medications.
Study quality level 2 (limited-quality patient-oriented evidence)

Kaufman, D., et al. (2002). "Recent patterns of medication use in the ambulatory adult population of the United States." JAMA 287: 337 - 344.

ADEs are among the leading cause of hospitalizations and death in the U.S. The substantial overlap between use of prescription medicine and use of herbals/supplements raises concerns about unintended interactions. Therefore, the authors recommend documentation of usage patterns to provide a basis for improving the safety of medication use.
Study quality level 2 (limited-quality patient-oriented evidence)

Simmonds, M. (2000). "Anesthetists' records of pre-operative assessment." Clinical Performance and Quality Health Care 8(1): 22-27.

Previous anesthesia, drug history, and allergies were recorded in only one to two-thirds of patient charts, thus identifying this as an opportunity for improvement, given the safety and subsequent cost implications.
Study quality level 2 (limited-quality patient-oriented evidence)

Wilson, I. B., et al. (2007). "Physician-patient communication about prescription medications non-adherence." Journal of General Internal Medicine 22(1).

There is a wide communication gap between physicians and elderly patients: one-third of all seniors surveyed and 24% of those with three or more chronic conditions did not talk to their doctors about all of their medicines in the past 12 months.
Study quality level 2 (limited-quality patient-oriented evidence)

♠Measure #131: Pain Assessment Prior to Initiation of Patient Therapy

DESCRIPTION:
Percentage of patients aged 18 years and older with documentation of a pain assessment (if pain is present, including location, intensity and description) through discussion with the patient or through use of a standardized tool on each initial evaluation prior to initiation of therapy

INSTRUCTIONS:
This measure is to be reported for each initial evaluation occurring during the reporting period for patients seen during the reporting period. There is no diagnosis associated with this measure. This measure may be reported by non-MD/DO clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

This measure is reported using G-codes:
CPT 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 denominator code(s) and the appropriate numerator G-code.

NUMERATOR:
Patient's pain assessment prior to initiation of treatment is documented

Definitions:
Standardized tool – A standardized tool is a test or measure administered and scored in a consistent manner and supported by psychometric literature. Examples of tools for pain assessment include, but are not limited to, Multidimensional Pain Score and McGill Pain Questionnaire.
Not eligible – A patient is not eligible if the following condition(s) exist:

- Patient refuses to participate
- Severe mental and/or physical incapacity where the person is unable to express himself/herself in a manner understood by others. For example, cases where pain cannot be accurately assessed through use of nationally recognized standardized pain assessment tools
- Situations where the patient's motivation to improve may impact the accuracy of results of nationally recognized standardized pain assessment tools
- Patient is in an urgent or emergent situation where time is of the essence and to delay treatment would jeopardize the patient's health status

Numerator Coding:
Pain Assessment Documented
G8440: Documentation of pain assessment (including location, intensity and description) prior to initiation of treatment or documentation of the absence of pain as a result of assessment

OR

Pain Assessment not Documented, Patient not Eligible
G8442: Documentation that patient is not eligible for pain assessment

OR

Pain Assessment not Documented, Reason not Specified
G8441: No documentation of pain assessment (including location, intensity and description) prior to initiation of treatment

DENOMINATOR:
Patients aged 18 years and older

Denominator Coding:
A CPT service code is required to identify patients for denominator inclusion.
CPT service codes: 90801, 90802, 96116, 96150, 97001, 97003, 98940, 98941, 98942

RATIONALE:
The multidisciplinary pain management team is the optimal method for delivery of comprehensive treatment to patients in pain. Thus, it is essential for therapists to assess pain prior to initiation of therapy. Pain is the most common symptom for which the general population seeks health care, with chronic pain costing the U.S. $100 billion per year in lost worker productivity and health costs.

CLINICAL RECOMMENDATION STATEMENTS:
The Institute for Clinical Systems Improvement (ICSI) supports that the intensity of pain should be assessed prior to the initiation of appropriate treatment and continually reassessed throughout the duration of treatment.

Reducing the intensity of the pain by just 25% has been shown to achieve a 50% improvement in functional status (Flor, Fydrich, & Turk, 1992. *Evidence Grade = A*).

Older adults with persistent pain commonly experience an increase in pain intensity with movement and, as a result, will limit the activities or movements that exacerbate the pain (e.g., stair climbing or walking) (Davis, Hiemenz, & White, 2002; Duong et al., 2005. *Evidence Grade = C*).

A multidisciplinary approach to diagnosis and treatment of pain is the preferred method of delivering health care to patients with chronic pain of any etiology due to the complexity of diagnosis and management. (International Association for the Study of Pain (IASP). Task Force on Guidelines for Desirable Characteristics for Pain Treatment Facilities, Level N/A).

Evidence Supporting the Criterion of Quality Measure:
Overall Evidence Grading: SORT Strength of Recommendation B: considerable patient-oriented evidence, i.e., re: improved diagnosis and treatment, improved pain management, and improved outcomes, but not consistently high quality evidence

Bloch, R. (2004). "Rehabilitation medicine approach to cancer pain." Cancer Investigation 22(6): 944-948.

Treatment of cancer pain may benefit from interventions focusing on function and physical and occupational therapy may all be needed to help manage cancer pain, especially

insofar as pain may result not only from the cancer itself but also from immobility and debilitation. Therefore assessment of the patient is important in addressing the source of pain.
Study quality level 2 (limited-quality patient-oriented evidence)

Loeser, J. D. (2007). "Task force on guidelines for desirable characteristics for pain treatment facilities." Retrieved May 16, 2007, from www.iasp-pain.org.
The task force on guidelines for desirable characteristics for pain treatment facilities recommends the multidisciplinary approach to diagnosis and treatment as the preferred method of delivering health care to patients with chronic pain of any etiology. It further recommends evaluation and treatment by non-medical health care providers, i.e., therapists, given that medical treatments have already failed many patients in pain.
Study quality level 2 (limited-quality patient-oriented evidence)

Schunk, C., et al. (2000). "Pain outcomes: Measurement and application to the American physical therapy association guide to physical therapy practice." Orthopaedic Physical Therapy Clinics of North America 9(1): 89 - 97.
Pain is a viable factor in physical therapy and should be included in outcome measurement. The American Physical Therapy Association Guide to Physical Therapy Practice includes the parameter of pain as an element of patient management. The appropriate tool depends on the practice setting and the patient population served.
Study quality level 2 (limited-quality patient-oriented evidence)

Shannon, E. (2002). "Reflections on clinical practice by occupational therapists working in multidisciplinary pain management programs in the UK and the USA." Australian Occupational Therapy Journal 49(1).
All patients with chronic pain should be appropriately evaluated before treatment is implemented, with a multidisciplinary approach to diagnosis and treatment the preferred method of delivering health care to patients with chronic pain of any etiology.
Study quality level 2 (limited-quality patient-oriented evidence)

Starke, A. (2005). "Managing the elusive beast of chronic pain: A challenge for PTs." PT magazine: 11.
Pain causes more adult disability than any other condition in the U.S. There are many components to treatment of chronic pain, assessment being a critical component.
Study quality level 2 (limited-quality patient-oriented evidence)

♠Measure #132: Patient Co-Development of Treatment Plan/Plan of Care

DESCRIPTION:
Percentage of patients aged 18 years and older identified as having actively participated in the development of the treatment plan/plan of care. Appropriate documentation includes signature of the practitioner and either co-signature of the patient or documented verbal agreement obtained from the patient or, when necessary, an authorized representative

INSTRUCTIONS:
This measure is to be reported at least one time for each unique episode of care for patients seen during the reporting period. For the purpose of this measure, a unique episode of care is defined by the care given for each unique diagnosis (ICD-9 code) during the reporting period. This measure may be reported by non-MD/DO clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

This measure is reported using G-codes:
CPT 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 denominator code(s) and the appropriate numerator G-code.

NUMERATOR:
Patient's active participation in development of treatment plan/plan of care is documented

Definitions:
Unique episode of care – For the purpose of this measure is defined by each unique ICD-9 code billed in combination with an appropriate CPT service code during the reporting period. Multiple diagnoses on a claim form will count as one episode.
Active participation – Patient involvement in discussions, decisions, objectives determination, and goal setting to the extent that the patient is a co-author of, and responds affirmatively to, the care plan/treatment plan.
Care plan/treatment plan – A roadmap or course of action involving input and approval from the patient.
Authorized representative – A person who is acting on the patient's behalf and who does not have a conflict of interest with the patient, when the patient is temporarily or permanently unable to act for himself or herself, but not against the patient's wishes. This person should have the patient's best interests at heart and should be reasonably expected to act in a manner that is protective of the person and the rights of the patient. Preferably, this individual is appointed by the patient.
Not eligible – A patient is not eligible if one or more of the following conditions exist:

- Patient refuses to participate.
- Patient is in an urgent or emergent health or crisis situation where time is of the essence and to delay treatment would jeopardize the patient's health status.

- Episode of care began either prior to or extends beyond reporting period and Treatment Plan/Plan of Care was co-developed outside reporting period.

Numerator Coding:

Active Participation Documented

G8437: Documentation of clinician and patient involvement with the development of a treatment plan/plan of care including signature by the practitioner and either a co-signature by the patient or documented verbal agreement obtained from the patient or, when necessary, an authorized representative

OR

Active Participation not Documented, Patient not Eligible

G8439: Documentation that patient is not eligible for co-developing a treatment plan/plan of care including signature by the practitioner and either a co-signature by the patient or documented verbal agreement obtained from the patient or, when necessary, an authorized representative

OR

Active Participation not Documented, Reason not Specified

G8438: No documentation of clinician and patient involvement with the development of a treatment plan/plan of care including signature by the practitioner and either a co-signature by the patient or documented verbal agreement obtained from the patient or, when necessary, an authorized representative

DENOMINATOR:

Patients aged 18 years and older

Denominator Coding:

A CPT service code is required to identify patients for denominator inclusion.

CPT service codes: 90801, 90802, 90804, 90805, 90806, 90807, 90808, 90809, 96116, 96150, 96151, 96152, 97001, 97002, 97003, 97004, 97802, 97803, G0270

RATIONALE:

Collaborative interventions involving both client and care provider are significantly more acceptable and likely to produce follow through than directive approaches. This is consistent with the findings of Ed Wagner's "The Chronic Care Model," which states that evidence-based change concepts foster productive interactions between informed patients who take an active part in their care and providers with resources and expertise.

CLINICAL RECOMMENDATION STATEMENTS:

The Siskin Hospital for Physical Rehabilitation states that patients' basic treatment plan and initial goals should include input and agreement of the patient before treatment begins, while the Scottish Intercollegiate Guidelines Network (SIGN) suggests that patients and their caregivers should have an early, active role in the multidisciplinary rehabilitation team.

The Institute for Clinical Systems Improvement (ICSI) recommends that patients and their families should be educated and actively engaged as to diagnosis, prognosis, and treatment options, while the National Collaborating Center for Mental Health recommends that health care professionals

should make all efforts necessary to ensure that a patient can give meaningful and properly informed consent before treatment is initiated.

The 2005 Standards of Practice for Occupational Therapy recommends in Standard III, 1: An occupational therapist has overall responsibility for the development, documentation, and implementation of the occupational therapy intervention based on the evaluation, client goals, current best evidence, and clinical reasoning (American Occupational Therapy Association).

A 2001 American Psychiatric Association guideline states that treatment of patients with borderline personality disorders should be a collaborative process between patient and clinician and that patient preference is an important factor to consider in developing an individual treatment plan (APA).

The 2004 Department of Defense (DoD) and Department of Veterans Affairs (VHA) guideline states that treatment options for persons with psychoses should be presented and discussed with the person/legal guardian and then proceed with treatment if the person/legal guardian consents (DoD and VHA).

Institute for Clinical Systems Improvement 1995 guideline suggests that providers should recognize that it is a sign of progress when a patient becomes more ready to change a health-related behavior (ICSI).

In a Substance Abuse and Mental Health Services Administration 2005 guideline for substance abuse treatment for persons with co-occurring disorders, motivational interviewing was cited as being proven effective in helping clients clarify goals and commit to change (SAMHSA).

Evidence Supporting the Criterion of Quality Measure:

Overall Evidence Grading: SORT Strength of Recommendation B: considerable patient-oriented evidence, i.e., re: e.g., improved treatment outcomes, e.g., improved follow through with recommendations and improved follow-up percent days abstinent; increased patient satisfaction; and reduced costs, but not consistently high quality evidence

Amrhein, P. C., et al. (2003). "Client commitment language during motivational interviewing predicts drug use outcomes." Journal of Consulting and Clinical Psychology 71(862 - 878).

> Motivational interview sessions revealed commitment strength language during a change plan was more common among maintainers and changers and was predictive of follow-up percent days abstinent.
> Study quality level 2 (limited-quality patient-oriented evidence)

Geller, J., et al. (2003). "Collaborative versus directive interventions in the treatment of eating disorders: Implications for care providers." Professional Psychology: Research and Practice 34: 406 - 413.

> Clients and care providers related collaborative interventions as being significantly more acceptable and likely to produce follow through with recommendations than directive approaches.
> Study quality level 2 (limited-quality patient-oriented evidence)

Ruback, S., et al. (2005). "Motivational interviewing: a systematic review and meta-analysis." The British Journal of General Practice 55(513): 305 - 312.

Motivational interviewing in a scientific setting outperforms traditional advice giving in the treatment of a broad range of behavioral problems and diseases.

Study quality level 2 (limited-quality patient-oriented evidence)

Swenson, et al. (2004). "Patient-centered communication: do patients really prefer it?" Journal of General Internal Medicine 19(11).

A randomized study revealed that 82% of participants < 30 years old, 68% of participants aged 30-59; 55% of participants aged > 59 preferred patient-centered communication. Additionally 76% of participants with post-college education, 73% of participants with some college education, and 49% of participants with a high school education preferred patient-centered communication.

Study quality level 2 (limited-quality patient-oriented evidence)

Wagner, E. H. (1998). "Chronic disease management: What will it take to improve care for chronic illness?" Effective Clinical Practice 1: 2-4.

The chronic care model identifies the essential elements of a health care system that encourage high-quality chronic disease care. These elements are the community, the health system, self-management support, delivery system design, decision support and clinical information systems. Evidence-based change concepts under each element, in combination, foster productive interactions between informed patients who take an active part in their care and providers with resources and expertise. The model can be applied to a variety of chronic illnesses, health care settings and target populations. The bottom line is healthier patients, more satisfied providers, and cost savings.

Study quality level 2 (limited-quality patient-oriented evidence)

♠Measure #133: Screening for Cognitive Impairment

DESCRIPTION:
Percentage of patients aged 65 years and older who have documentation of results of a screening for cognitive impairment using a standardized tool

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

This measure is reported using G-codes:
CPT 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 denominator code(s) and the appropriate numerator G-code.

NUMERATOR:
Patient's screening for cognitive impairment is documented

Definitions:
Screening – Testing done on people at risk of developing a certain disease, even if they have no symptoms. Screening tests can predict the likelihood of someone having or developing a particular disease. This measure looks for the test being done in the practitioner's office that is filing the code.
Standardized tool – An assessment tool that has been appropriately normalized and validated for the population in which it is used. Some examples of cognitive impairment screening tools include: Clinical Dementia Rating Scale, Mini Mental Status Examination (MMSE), Global Deterioration Scale, Short Portable Mental Status Questionnaire, Clock Drawing Test, Modified MMSE, Mini-Cog, Hopkins Verbal Learning Test, and 7-Minute Screen.
Cognitive impairment – Impairment of mental activities associated with thinking, learning, and memory.
Not eligible/not appropriate – A patient is not eligible/not appropriate if one or more of the following conditions exist:

- Patient refuses to participate
- Patient is in an urgent or emergent situation where time is of the essence and to delay treatment would jeopardize the patient's health status
- Patient was referred with a diagnosis of cognitive impairment
- Patient has been participating in on-going treatment with screening of cognitive impairment in a preceding reporting period

- Patient is not appropriate for cognitive impairment screening due to physical capacity

Numerator Coding:
Screening for Cognitive Impairment Documented
G8434: Documentation of cognitive impairment screening using a standardized tool

OR

Screening for Cognitive Impairment not Documented, Patient not Eligible/not Appropriate
G8436: Patient not eligible/not appropriate for cognitive impairment screening

OR

Screening for Cognitive Impairment not Documented, Reason not Specified
G8435: No documentation of cognitive impairment screening using a standardized tool

DENOMINATOR:
Patients aged 65 years and older

Denominator Coding:
A CPT service code is required to identify patients for denominator inclusion.
CPT service codes: 90801, 90802, 96150, 97003

RATIONALE:
As many as 6.8 million people in the U.S. have dementia, and at least 1.8 million of those are severely affected. The U.S. Preventive Services Task Force (USPSTF) reported that Alzheimer's Disease and cerebrovascular ischemia (vascular dementia) are the two most common causes of dementia, with estimated economic costs of Alzheimer's Disease (AD) in the U.S. totaling at least $100 billion annually. The National Institute of Neurological Disorders and Stroke contends that accurate diagnosis of dementia is important for patients and their families because it allows early treatment of symptoms.

CLINICAL RECOMMENDATION STATEMENTS:
The American Psychiatric Association (APA) states that the core of the treatment of demented patients is psychiatric management, through psychiatric, neurological, and general medical evaluations of the nature and cause of cognitive deficits, while the American Academy of Neurology (AAN) states there is good evidence to support the use of general cognitive screening instruments.

Evidence Supporting the Criterion of Quality Measure:
Overall Evidence Grading: SORT Strength of Recommendation B: considerable patient-oriented evidence, i.e., re: improved early detection and initiation of treatment for dementia that may delay further progression; reduced iatrogenic illness, unnecessary workups driven by vague symptoms, and inappropriate and costly utilization of hospital and emergency room care; and improved outcomes, but not consistently high quality evidence

American Academy of Neurology (AAN)

A guideline revised in 2004 includes the identification and monitoring of Mild Cognitive Impairment (MCI) patients for progression to Alzheimer's disease. It also states there is good evidence to support the use of general cognitive screening instruments.

In a second guideline developed in 2001, it states that general cognitive screening instruments, which include the Mini Mental Status Exam (MMSE), Kokmen Short Test of Mental Status, the 7-Minute Screen, or the Memory Impairment Screen, are useful for the detection of dementia when used in patient populations with an elevated prevalence of cognitive impairment either due to age or presence of memory dysfunction.

A third guideline developed in 2001 on the early detection of dementia included a review of the evidence on mild cognitive impairment. It reported that studies indicated that individuals characterized as being cognitively impaired, but not meeting clinical criteria for Alzheimer's disease (mild cognitive impairment), have a high risk of progressing to dementia or Alzheimer's disease. It further reported that, if the figures for incident Alzheimer's disease from the general population are used, one could see that the rates range from 0.2% in the 65-69 year age group to 3.9% in the 85-89 year age group. Finally, it reported that studies of mild cognitive impairment indicate that the rate of progression to dementia or Alzheimer's disease is between 6% and 25% per year.
Study quality level 2 (limited-quality patient-oriented evidence)

Geriatric Nursing Academic Institution

This 2003 guideline, developed by a group of nursing experts from across the country as a part of the Nurses Improving Care for Health System Elders (NICHE) Project, supports the use of standardized instruments for cognitive testing.
Study quality level 2 (limited-quality patient-oriented evidence)

Chow, T. W. (2001). "Quality indicators for dementia in vulnerable community dwelling and hospitalized elders." Annals of Internal Medicine 135: 668-676.

A review of 30 quality indicators for dementia resulted in 14 being judged to be valid by the expert panel process. These included five dealing with dementia screening and diagnosis. The cognitive and functional screening indicator states that, if a vulnerable elder is admitted to the hospital or is new to a physician practice, the multidimensional assessment of cognitive ability and assessment of functional status should be documented because screening for dementia can lead to early detection and initiation of treatment that may delay further progression.
Study quality level 2 (limited-quality patient-oriented evidence)

National Chronic Care Consortium (2003). Tools for the early identification, assessment and treatment for people with Alzheimer's disease and dementia. Bloomington, National Chronic Care Networks for Alzheimer's Disease initiative.

Dementia is very prevalent among the elderly, but is often overlooked even by skilled clinicians. Unrecognized dementia may lead to iatrogenic illness, unnecessary workups driven by vague symptoms, inappropriate and costly utilization of hospital and emergency room care, and poor outcomes. Improving our ability to recognize dementia is a key first step toward improving this widespread situation. The Chronic Care Networks for

Alzheimer's disease early identification process uses two tools to identify people who may have dementia and should receive a full assessment. These tools include education and awareness materials/triggers and a family questionnaire.
Study quality level 2 (limited-quality patient-oriented evidence)

Kawas, C. H. (2006). "Alzheimer's and dementia in the oldest-old: A century of challenges." Current Alzheimer Research 3(5): 411-419.

Alzheimer's disease (AD) is the most common type of dementia in the U.S. and much of the world with rates increasing exponentially from age 65. Increases in life expectancy in the last century have resulted in a large number of people living to old age and will result in a quadrupling of AD cases by the middle of the century. Preventing or delaying the onset of AD could have a huge impact in the number of cases expected to develop. The oldest-old are the fastest growing segment of the population and are estimated to account for 12% of the population over 65.

Study quality level 2 (limited-quality patient-oriented evidence)

♠Measure #134: Screening for Clinical Depression

DESCRIPTION:
Percentage of patients aged 18 years and older screened for clinical depression using a standardized tool

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

This measure is reported using G-codes:
CPT 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 denominator code(s) and the appropriate numerator G-code.

NUMERATOR:
Patient's screening for clinical depression is documented

Definitions:
Screening – Testing done on people at risk of developing a certain disease, even if they have no symptoms. Screening tests can predict the likelihood of someone having or developing a particular disease. This measure looks for the test being done in the practitioner's office that is filing the code.
Standardized tool – An assessment tool that has been appropriately normalized and validated for the population in which it is used. Some examples of depression screening tools include: Patient Health Questionnaire (PHQ9), Beck Depression Inventory (BDI or BDI-II), Center for Epidemiologic Studies Depression Scale (CES-D), Depression Scale (DEPS), Duke Anxiety-Depression Scale (DADS), Geriatric Depression Scale (GDS), GDS - Short Version, Hopkins Symptom Checklist (HSCL), The Zung Self-Rating Depression Scale (SDS), and Cornell Scale Screening (this is a screening tool which is used in situations where the patient has cognitive impairment and is administered through the caregiver).
Not eligible/not appropriate – A patient is not eligible if one or more of the following conditions exist:

- Patient refuses to participate
- Patient is in an urgent or emergent situation where time is of the essence and to delay treatment would jeopardize the patient's health status
- Situations where the patient's motivation to improve may impact the accuracy of results of nationally recognized standardized depression assessment tools. For example: certain court appointed cases

- Patient was referred with a diagnosis of depression
- Patient has been participating in on-going treatment with screening of clinical depression in a preceding reporting period
- Severe mental and/or physical incapacity where the person is unable to express himself/herself in a manner understood by others. For example: cases such as delirium or severe cognitive impairment, where depression cannot be accurately assessed through use of nationally recognized standardized depression assessment tools

Numerator Coding:

Screening for Clinical Depression Documented

G8431: Documentation of clinical depression screening using a standardized tool

OR

Screening for Clinical Depression not Documented, Patient not Eligible/Appropriate

G8433: Patient not eligible/not appropriate for clinical depression screening

OR

Screening for Clinical Depression not Documented, Reason not Specified

G8432: No documentation of clinical depression screening using a standardized tool

DENOMINATOR:

Patients aged 18 years and older

Denominator Coding:

A CPT service code is required to identify patients for denominator inclusion.

CPT service codes: 90801, 90802, 90804, 90805, 90806, 90807, 90808, 90809, 97003

RATIONALE:

Major depression was the fourth leading cause of worldwide disease in 1990, with estimated direct and indirect costs to American businesses ranging from $36.2 to $80 billion annually. The U.S. Preventive Services Task Force compared the effects of integrated recognition and management depression screening programs with "usual care" in community primary care practices, and the results showed significantly improved patient outcomes.

CLINICAL RECOMMENDATION STATEMENTS:

USPSTF recommends screening adults for depression in clinical practices that have systems in place to assure accurate diagnosis, effective treatment, and follow-up. Small benefits have been observed in studies that simply feed back screening results to clinicians. Larger benefits have been observed in studies in which the communication of screening results is coordinated with effective follow-up and treatment. (Evidence: B)

The Canadian Task Force on Preventive Health Care used the rigorous USPSTF 2002 systematic review to update their recommendations regarding depression screening. The Canadian task force arrived at the same practice recommendations as USPSTF (available at www.ctfphc.org).

Evidence Supporting the Criterion of Quality Measure:

Overall Evidence Grading: SORT Strength of Recommendation B: considerable patient-oriented evidence, i.e., re: improved recognition and diagnosis of depression, and improved depression outcomes, but not consistently high quality evidence

Ell, K. (2006). "Depression care for the elderly: Reducing barriers to evidence based practice." Home Health Care Services Quarterly 25: 115 - 148.

This review provides an overview of evidence identifying use of health services for depression, effective interventions, barriers to depression care, strategies to reduce barriers, and translating research into practice. There is strong empirical support for implementing strategies to improve depression care for older adults, and there is recent encouraging evidence from Medicare data that older adults may be more willing to seek and accept antidepressant treatment.

Study quality level 2 (limited-quality patient-oriented evidence)

Hickie, I. B., et al. (2002). "Screening for depression in general practice and related medical settings." The Medical Journal of Australia 177: S111-116.

This meta-analysis included reviews found by searching MEDLINE, Cochrane, and other databases. It found that screening increases the recognition and diagnosis of depression and, when integrated with a commitment to provide coordinated and prompt follow-up of diagnosis and treatment, clinical outcomes are improved.

Study quality level 1 (good quality patient-oriented evidence)

Kirkcaldy, R. D., Tynes, L.L. (2006). "Depression screening in a VA primary care clinic." Psychiatric Services 57: 1694 - 1696.

In 1998, the U.S. Department of Veterans Affairs (VA) mandated annual depression screening at all VA primary care clinics. This article reports on an evaluation of the screening program. Findings establish benchmarks for screening administration.

Study quality level 2 (limited-quality patient-oriented evidence)

Pignone, M. P., et al. (2002). "Screening for depression in adults: A summary of the evidence for the U.S. preventive services task force." Annals of Internal Medicine 136: 765-776.

This study aims to clarify whether screening adults for depression in primary care settings improves recognition, treatment, and clinical outcomes. It concludes that, compared with usual care, screening for depression can improve outcomes, particularly when screening is coupled with system changes that help ensure adequate treatment and follow-up.

Study quality level 2 (limited-quality patient-oriented evidence)

Sherman, S. E., et al. (2004). "Improving recognition of depression in primary care: A study of evidence-based quality improvement." Joint Commission Journal on Quality and Patient Safety 30(2).

Implemented at a VA ambulatory care center, this evidence-based QI intervention led to profound and lasting changes in primary care providers' recognition of depression or depressive symptoms.

Study quality level 2 (limited-quality patient-oriented evidence)

* The following notice applies to each of the measures that contain an asterisk (*) before the title:

Physician Performance Measures (Measures) and related data specifications, developed by the American Medical Association (AMA) in collaboration with the Physician Consortium for Performance Improvement (the Consortium) and the National Committee for Quality Assurance (NCQA) pursuant to government sponsorship under subcontract 6205-05-054 with Mathematica Policy Research, Inc. under contract 500-00-0033 with Centers for Medicare & Medicaid Services.

These performance Measures are not clinical guidelines and do not establish a standard of medical care, and have not been tested for all potential applications.

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2007 PQRI Measure Specifications Retired Effective January 1, 2008	
Measure #	**Measure Title**
13	Age-Related Macular Degeneration: Age-Related Eye Disease Study (AREDS) Prescribed/Recommended
15	Cataracts: Assessment of Visual Functional Status
16	Cataracts: Documentation of Pre-Surgical Axial Length, Corneal Power Measurement and Method of Intraocular Lens Power Calculation
17	Cataracts: Pre-Surgical Dilated Fundus Evaluation
25	Melanoma: Patient Medical History
26	Melanoma: Complete Physical Skin Examination
27	Melanoma: Counseling on Self-Examination
29	Beta-Blocker at Time of Arrival for Acute Myocardial Infarction (AMI)
37	Dialysis Dose in End Stage Renal Disease (ESRD) Patients
38	Hematocrit Level in End Stage Renal Disease (ESRD) Patients
42	Osteoporosis: Counseling for Vitamin D, Calcium Intake, and Exercise
60	Gastroesophageal Reflux Disease (GERD): Assessment for Alarm Symptoms
61	Gastroesophageal Reflux Disease (GERD): Upper Endoscopy for Patients with Alarm Symptoms
62	Gastroesophageal Reflux Disease (GERD): Biopsy for Barrett's Esophagus
63	Gastroesophageal Reflux Disease (GERD): Barium Swallow- Inappropriate Use