This manual contains the measure specifications for the 153 measures that make up the 2009 Physician Quality Reporting Initiative (PQRI). Each measure is assigned a unique number. Measure numbers for 2009 PQRI represent a continuation in numbering from the 2008 PQRI measures 1 through 134. Gaps in measure numbering reflect those PQRI measures that are not included for implementation in 2009 PQRI. For the 2008 PQRI measures which are continuing for 2009 PQRI, measure specifications have been updated prior to the beginning of the 2009 PQRI program. In addition to the measure specifications manual, please refer to the "2009 PQRI Implementation Guide" for additional information essential in helping eligible professionals (EPs) understand and submit measures. This document can be found at: http://www.cms.hhs.gov/PQRI/15_MeasuresCodes.asp#TopOfPage.

<u>Note:</u> Structural measure #124 "Health Information Technology (HIT): Adoption/Use of Electronic Health Records (EHR)" remains in PQRI 2009. However, PQRI 2008 structural measure #125, "HIT – Adoption/Use of e-Prescribing" has been removed from the PQRI program because it is authorized under a different incentive program for 2009 and has separately published specifications at the following website: http://www.cms.hhs.gov/PQRI/03 EPrescribingIncentiveProgram.asp#TopOfPage.

Eligible Professionals

EPs submitting billable services on Part B claims for allowable Medicare Physician Fee Schedule (PFS) charges may report the quality action for selected PQRI quality measure(s). Providers not defined as EPs in the Tax Relief and Health Care Act of 2006 or the Medicare Improvements for Patients and Providers Act of 2008 are not eligible to participate in PQRI. A list of EPs can be found on the PQRI website at: http://www.cms.hhs.gov/PQRI/10_EligibleProfessionals.asp#TopOfPage.

Reporting Options, Frequency, and Performance Timeframes

Three reporting options are available for 2009 PQRI: claims-based, registry, and measures groups, which are identified within each measure specification. The measure specifications contained in this manual are intended for claims-based and registry reporting of individual measures. Measure specifications for measures groups reporting are included in a separate manual, "2009 PQRI Measures Groups Specifications Manual," which can be found at: http://www.cms.hhs.gov/PQRI/15_MeasuresCodes.asp#TopOfPage.

The measure instructions limit the frequency of reporting necessary in certain circumstances, such as for patients with chronic illness for whom a particular process of care is provided only periodically. Each individual EP participating in 2009 PQRI should report according to the frequency and timeframe listed within each measure specification.

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

Quality measures consist of a numerator and a denominator that permit the calculation of the percentage of a defined patient population that receive a particular process of care or achieve a particular outcome. The denominator population is defined by certain ICD-9-CM diagnosis, CPT Category I, and HCPCS codes specified in the measure that are submitted by EPs as part of a claim for <u>covered services</u> under the PFS. If the specified denominator codes for a measure are not included on the patient's claim (for the same date of service) as submitted by the individual EP, then the patient does not fall into the denominator population, and the PQRI measure does not apply to the patient. Some measure 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. Also, the denominators for measures groups have been modified to provide common denominator codes for all measures within the group.

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

If the patient does fall into the denominator population, the applicable QDC(s) (CPT Category II codes or G-codes) that defines the numerator should be submitted to satisfactorily report quality data for a measure under the PQRI program. Where a patient falls into the denominator but the measure specifications define circumstances in which a patient may be excluded, CPT Category II code modifiers such as 1P, 2P, 3P, and 8P are available to describe medical, patient, system, or other reasons for performance exclusion. Where the performance exclusion does not apply, a measure-specific CPT Category II reporting modifier 8P or HCPCS G-code may be used to indicate that the process of care was not provided for a reason not otherwise specified. Instructions specific to each measure provide additional reporting information.

Measure Specification Format

Measure title Reporting option available for each measure (claims-based, registry, or measures group) 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

Table of Contents	Page
Introduction	1
Table of 2009 PQRI Measure Numbers, Measure Titles, Reporting Options, and Page Numbers	4
List of Retired PQRI Measure Specifications	10
2009 PQRI Measure Specifications for Claims and Registry	12
Symbol and Copyright Information	437

Measure Number	Measure Title	Reporting Options	Page
1	Diabetes Mellitus: Hemoglobin A1c Poor Control in Diabetes Mellitus	C, R, MG	12
2	Diabetes Mellitus: Low Density Lipoprotein (LDL-C) Control in Diabetes Mellitus	C, R, MG	15
3	Diabetes Mellitus: High Blood Pressure Control in Diabetes Mellitus	C, R, MG	17
5	Heart Failure: Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD)	C, R	20
6	Coronary Artery Disease (CAD): Oral Antiplatelet Therapy Prescribed for Patients with CAD	C, R	23
7	Coronary Artery Disease (CAD): Beta-Blocker Therapy for CAD Patients with Prior Myocardial Infarction (MI)	R	26
8	Heart Failure: Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)	C, R	29
9	Major Depressive Disorder (MDD): Antidepressant Medication During Acute Phase for Patients with MDD	C, R	32
10	Stroke and Stroke Rehabilitation: Computed Tomography (CT) or Magnetic Resonance Imaging (MRI) Reports	C, R	35
11	Stroke and Stroke Rehabilitation: Carotid Imaging Reports	C, R	38
12	Primary Open Angle Glaucoma (POAG): Optic Nerve Evaluation	C, R	41
14	Age-Related Macular Degeneration (AMD): Dilated Macular Examination	C, R	43
18	Diabetic Retinopathy: Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy	C, R	45
19	Diabetic Retinopathy: Communication with the Physician Managing On-going Diabetes Care	C, R	48
20	Perioperative Care: Timing of Antibiotic Prophylaxis – Ordering Physician	C, R, MG	51
21	Perioperative Care: Selection of Prophylactic Antibiotic – First OR Second Generation Cephalosporin	C, R, MG	57
22	Perioperative Care: Discontinuation of Prophylactic Antibiotics (Non-Cardiac Procedures)	C, R, MG	61
23	Perioperative Care: Venous Thromboembolism (VTE) Prophylaxis (When Indicated in ALL Patients)	C, R, MG	66
24	Osteoporosis: Communication with the Physician Managing On-going Care Post- Fracture	C, R	72
28	Aspirin at Arrival for Acute Myocardial Infarction (AMI)	C, R	75
30	Perioperative Care: Timing of Prophylactic Antibiotics – Administering Physician	C, R	77
31	Stroke and Stroke Rehabilitation: Deep Vein Thrombosis Prophylaxis (DVT) for Ischemic Stroke or Intracranial Hemorrhage	C, R	81
32	Stroke and Stroke Rehabilitation: Discharged on Antiplatelet Therapy	C, R	84
33	Stroke and Stroke Rehabilitation: Anticoagulant Therapy Prescribed for Atrial Fibrillation at Discharge	R	86
34	Stroke and Stroke Rehabilitation: Tissue Plasminogen Activator (t-PA) Considered	C, R	88
35	Stroke and Stroke Rehabilitation: Screening for Dysphagia	C, R	91
36	Stroke and Stroke Rehabilitation: Consideration of Rehabilitation Services	C, R	94

Measure Number	Measure Title	Reporting Options	Page
39	Screening or Therapy for Osteoporosis for Women Aged 65 Years and Older	C, R, MG	96
40	Osteoporosis: Management Following Fracture	C, R	99
41	Osteoporosis: Pharmacologic Therapy	C, R	103
43	Coronary Artery Bypass Graft (CABG): Use of Internal Mammary Artery (IMA) in Patients with Isolated CABG Surgery	C, R, MG	106
44	Coronary Artery Bypass Graft (CABG): Preoperative Beta-Blocker in Patients with Isolated CABG Surgery	C, R, MG	108
45	Perioperative Care: Discontinuation of Prophylactic Antibiotics (Cardiac Procedures)	C, R	110
46	Medication Reconciliation: Reconciliation After Discharge from an Inpatient Facility	R	113
47	Advance Care Plan	C, R	116
48	Urinary Incontinence: Assessment of Presence or Absence of Urinary Incontinence in Women Aged 65 Years and Older	C, R, MG	119
49	Urinary Incontinence: Characterization of Urinary Incontinence in Women Aged 65 Years and Older	C, R	121
50	Urinary Incontinence: Plan of Care for Urinary Incontinence in Women Aged 65 Years and Older	C, R	123
51	Chronic Obstructive Pulmonary Disease (COPD): Spirometry Evaluation	C, R	125
52	Chronic Obstructive Pulmonary Disease (COPD): Bronchodilator Therapy	C, R	127
53	Asthma: Pharmacologic Therapy	C, R	130
54	12-Lead Electrocardiogram (ECG) Performed for Non-Traumatic Chest Pain	C, R	133
55	12-Lead Electrocardiogram (ECG) Performed for Syncope	C, R	135
56	Community-Acquired Pneumonia (CAP): Vital Signs	C, R	137
57	Community-Acquired Pneumonia (CAP): Assessment of Oxygen Saturation	C, R	139
58	Community-Acquired Pneumonia (CAP): Assessment of Mental Status	C, R	141
59	Community-Acquired Pneumonia (CAP): Empiric Antibiotic	C, R	143
64	Asthma: Asthma Assessment	C, R	146
65	Treatment for Children with Upper Respiratory Infection (URI): Avoidance of Inappropriate Use	C, R	148
66	Appropriate Testing for Children with Pharyngitis	C, R	150
67	Myelodysplastic Syndrome (MDS) and Acute Leukemias: Baseline Cytogenetic Testing Performed on Bone Marrow	C, R	153
68	Myelodysplastic Syndrome (MDS): Documentation of Iron Stores in Patients Receiving Erythropoietin Therapy	C, R	156
69	Multiple Myeloma: Treatment with Bisphosphonates	C, R	159
70	Chronic Lymphocytic Leukemia (CLL): Baseline Flow Cytometry	C, R	162
71	Breast Cancer: Hormonal Therapy for Stage IC-IIIC Estrogen Receptor/ Progesterone Receptor (ER/PR) Positive Breast Cancer	C, R	164
72	Colon Cancer: Chemotherapy for Stage III Colon Cancer Patients	C, R	169
76	Prevention of Catheter-Related Bloodstream Infections (CRBSI): Central Venous Catheter (CVC) Insertion Protocol	C, R	172

Measure Number	Measure Title	Reporting Options	Page
79	End Stage Renal Disease (ESRD): Influenza Immunization in Patients with ESRD	C, R	175
81	End Stage Renal Disease (ESRD): Plan of Care for Inadequate Hemodialysis in ESRD Patients	R	177
82	End Stage Renal Disease (ESRD): Plan of Care for Inadequate Peritoneal Dialysis	R	179
83	Hepatitis C: Testing for Chronic Hepatitis C – Confirmation of Hepatitis C Viremia	C, R	181
84	Hepatitis C: Ribonucleic Acid (RNA) Testing Before Initiating Treatment	C, R	184
85	Hepatitis C: HCV Genotype Testing Prior to Treatment	C, R	187
86	Hepatitis C: Antiviral Treatment Prescribed	C, R	190
87	Hepatitis C: HCV Ribonucleic Acid (RNA) Testing at Week 12 of Treatment	C, R	193
89	Hepatitis C: Counseling Regarding Risk of Alcohol Consumption	C, R	196
90	Hepatitis C: Counseling Regarding Use of Contraception Prior to Antiviral Therapy	C, R	198
91	Acute Otitis Externa (AOE): Topical Therapy	C, R	201
92	Acute Otitis Externa (AOE): Pain Assessment	C, R	203
93	Acute Otitis Externa (AOE): Systemic Antimicrobial Therapy – Avoidance of Inappropriate Use	C, R	205
94	Otitis Media with Effusion (OME): Diagnostic Evaluation – Assessment of Tympanic Membrane Mobility	C, R	207
95	Otitis Media with Effusion (OME): Hearing Testing	C, R	209
99	Breast Cancer Resection Pathology Reporting: pT Category (Primary Tumor) and pN Category (Regional Lymph Nodes) with Histologic Grade	C, R	211
100	Colorectal Cancer Resection Pathology Reporting: pT Category (Primary Tumor) and pN Category (Regional Lymph Nodes) with Histologic Grade	C, R	214
102	Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low-Risk Prostate Cancer Patients	C, R	217
104	Prostate Cancer: Adjuvant Hormonal Therapy for High-Risk Prostate Cancer Patients	C, R	220
105	Prostate Cancer: Three-Dimensional (3D) Radiotherapy	C, R	223
106	Major Depressive Disorder (MDD): Diagnostic Evaluation	C, R	226
107	Major Depressive Disorder (MDD): Suicide Risk Assessment	C, R	230
108	Rheumatoid Arthritis (RA): Disease Modifying Anti-Rheumatic Drug (DMARD)Therapy	C, R, MG	232
109	Osteoarthritis (OA): Function and Pain Assessment	C, R	235
110	Preventive Care and Screening: Influenza Immunization for Patients ≥ 50 Years Old	C, R, MG	237
111	Preventive Care and Screening: Pneumonia Vaccination for Patients 65 Years and Older	C, R, MG	239
112	Preventive Care and Screening: Screening Mammography	C, R, MG	242
113	Preventive Care and Screening: Colorectal Cancer Screening	C, R, MG	245
114	Preventive Care and Screening: Inquiry Regarding Tobacco Use	C, R, MG	248
115	Preventive Care and Screening: Advising Smokers to Quit	C, R, MG	250

Measure Number	Measure Title	Reporting Options	Page
116	Antibiotic Treatment for Adults with Acute Bronchitis: Avoidance of Inappropriate Use	C, R	253
117	Diabetes Mellitus: Dilated Eye Exam in Diabetic Patient	C, R, MG	256
118	Coronary Artery Disease (CAD): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Patients with CAD and Diabetes and/or Left Ventricular Systolic Dysfunction (LVSD)	C, R	259
119	Diabetes Mellitus: Urine Screening for Microalbumin or Medical Attention for Nephropathy in Diabetic Patients	C, R, MG	263
121	Chronic Kidney Disease (CKD): Laboratory Testing (Calcium, Phosphorus, Intact Parathyroid Hormone (iPTH) and Lipid Profile)	C, R, MG	266
122	Chronic Kidney Disease (CKD): Blood Pressure Management	C, R, MG	269
123	Chronic Kidney Disease (CKD): Plan of Care – Elevated Hemoglobin for Patients Receiving Erythropoiesis-Stimulating Agents (ESA)	C, R, MG	272
124	Health Information Technology (HIT): Adoption/Use of Electronic Health Records (EHR)	C, R	276
126	Diabetes Mellitus: Diabetic Foot and Ankle Care, Peripheral Neuropathy – Neurological Evaluation	C, R	279
127	Diabetes Mellitus: Diabetic Foot and Ankle Care, Ulcer Prevention – Evaluation of Footwear	C, R	282
128	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow- Up	C, R, MG	284
130	Documentation and Verification of Current Medications in the Medical Record	C, R	289
131	Pain Assessment Prior to Initiation of Patient Therapy and Follow-Up	C, R	292
134	Screening for Clinical Depression and Follow-Up Plan	C, R	295
135	Chronic Kidney Disease (CKD): Influenza Immunization	C, R, MG	298
136	Melanoma: Follow-Up Aspects of Care	C, R	300
137	Melanoma: Continuity of Care – Recall System	C, R	303
138	Melanoma: Coordination of Care	C, R	306
139	Cataracts: Comprehensive Preoperative Assessment for Cataract Surgery with Intraocular Lens (IOL) Placement	C, R	309
140	Age-Related Macular Degeneration (AMD): Counseling on Antioxidant Supplement	C, R	312
141	Primary Open-Angle Glaucoma (POAG): Reduction of Intraocular Pressure (IOP) by 15% OR Documentation of a Plan of Care	C, R	315
142	Osteoarthritis (OA): Assessment for Use of Anti-Inflammatory or Analgesic Over- the-Counter (OTC) Medications	C, R	319
143	Oncology: Medical and Radiation – Pain Intensity Quantified	C, R	321
144	Oncology: Medical and Radiation – Plan of Care for Pain	C, R	325
145	Radiology: Exposure Time Reported for Procedures Using Fluoroscopy	C, R	327
146	Radiology: Inappropriate Use of "Probably Benign" Assessment Category in Mammography Screening	C, R	330
147	Nuclear Medicine: Correlation with Existing Imaging Studies for All Patients Undergoing Bone Scintigraphy	C, R	332

Measure Number	Measure Title	Reporting Options	Page
148	Back Pain: Initial Visit	MG	335
149	Back Pain: Physical Exam	MG	340
150	Back Pain: Advice for Normal Activities	MG	343
151	Back Pain: Advice Against Bed Rest	MG	346
152	Coronary Artery Disease (CAD): Lipid Profile in Patients with CAD	C, R	349
153	Chronic Kidney Disease (CKD): Referral for Arteriovenous (AV) Fistula	C, R, MG	351
154	Falls: Risk Assessment	C, R	354
155	Falls: Plan of Care	C, R	358
156	Oncology: Radiation Dose Limits to Normal Tissues	C, R	360
157	Thoracic Surgery: Recording of Clinical Stage for Lung Cancer and Esophageal Cancer Resection	C, R	362
158	Endarterectomy: Use of Patch During Conventional Endarterectomy	C, R	364
159	HIV/AIDS: CD4+ Cell Count or CD4+ Percentage	R	366
160	HIV/AIDS: Pneumocystis Jiroveci Pneumonia (PCP) Prophylaxis	R	368
161	HIV/AIDS: Adolescent and Adult Patients with HIV/AIDS Who Are Prescribed Potent Antiretroviral Therapy	R	370
162	HIV/AIDS: HIV RNA Control After Six Months of Potent Antiretroviral Therapy	R	375
163	Diabetes Mellitus: Foot Exam	C, R, MG	378
164	Coronary Artery Bypass Graft (CABG): Prolonged Intubation (Ventilation)	R	380
165	Coronary Artery Bypass Graft (CABG): Deep Sternal Wound Infection Rate	R	382
166	Coronary Artery Bypass Graft (CABG): Stroke/Cerebrovascular Accident (CVA)	R	384
167	Coronary Artery Bypass Graft (CABG): Postoperative Renal Insufficiency	R	386
168	Coronary Artery Bypass Graft (CABG): Surgical Re-exploration	R	388
169	Coronary Artery Bypass Graft (CABG): Antiplatelet Medications at Discharge	R	390
170	Coronary Artery Bypass Graft (CABG): Beta-Blockers Administered at Discharge	R	392
171	Coronary Artery Bypass Graft (CABG): Lipid Management and Counseling	R	394
172	Hemodialysis Vascular Access Decision-Making by Surgeon to Maximize Placement of Autogenous Arterial Venous (AV) Fistula	C, R	396
173	Preventive Care and Screening: Unhealthy Alcohol Use – Screening	C, R	398
174	Pediatric End Stage Renal Disease (ESRD): Plan of Care for Inadequate Hemodialysis	R	400
175	Pediatric End Stage Renal Disease (ESRD): Influenza Immunization	C, R	402
176	Rheumatoid Arthritis (RA): Tuberculosis Screening	C, R, MG	405
177	Rheumatoid Arthritis (RA): Periodic Assessment of Disease Activity	C, R, MG	409
178	Rheumatoid Arthritis (RA): Functional Status Assessment	C, R, MG	411
179	Rheumatoid Arthritis (RA): Assessment and Classification of Disease Prognosis	C, R, MG	413
180	Rheumatoid Arthritis (RA): Glucocorticoid Management	C, R, MG	416
181	Elder Maltreatment Screen and Follow-Up Plan	C, R	419
182	Functional Outcome Assessment in Chiropractic Care	C, R	423
183	Hepatitis C: Hepatitis A Vaccination in Patients with HCV	C, R	427
184	Hepatitis C: Hepatitis B Vaccination in Patients with HCV	C, R	429

Measure Number	Measure Title	Reporting Options	Page
185	Endoscopy & Polyp Surveillance: Colonoscopy Interval for Patients with a History of Adenomatous Polyps – Avoidance of Inappropriate Use	C, R	431
186	Wound Care: Use of Compression System in Patients with Venous Ulcers	C, R	434

List of Retired PQRI Measure Specifications			
Measure #	Measure Title	Retirement Effective Date	
4	Screening for Future Fall Risk	January 1, 2009	
13	Age-Related Macular Degeneration: Age-Related Eye Disease Study (AREDS) Prescribed/Recommended	January 1, 2008	
15	Cataracts: Assessment of Visual Functional Status	January 1, 2008	
16	Cataracts: Documentation of Pre-Surgical Axial Length, Corneal Power Measurement and Method of Intraocular Lens Power Calculation	January 1, 2008	
17	Cataracts: Pre-Surgical Dilated Fundus Evaluation	January 1, 2008	
25	Melanoma: Patient Medical History	January 1, 2008	
26	Melanoma: Complete Physical Skin Examination	January 1, 2008	
27	Melanoma: Counseling on Self-Examination	January 1, 2008	
29	Beta-Blocker at Time of Arrival for Acute Myocardial Infarction (AMI)	January 1, 2008	
37	Dialysis Dose in End Stage Renal Disease (ESRD) Patients	January 1, 2008	
38	Hematocrit Level in End Stage Renal Disease (ESRD) Patients	January 1, 2008	
42	Osteoporosis: Counseling for Vitamin D, Calcium Intake, and Exercise	January 1, 2008	
60	Gastroesophageal Reflux Disease (GERD): Assessment for Alarm Symptoms	January 1, 2008	
61	Gastroesophageal Reflux Disease (GERD): Upper Endoscopy for Patients with Alarm Symptoms	January 1, 2008	
62	Gastroesophageal Reflux Disease (GERD): Biopsy for Barrett's Esophagus	January 1, 2008	
63	Gastroesophageal Reflux Disease (GERD): Barium Swallow- Inappropriate Use	January 1, 2008	
73	Plan for Chemotherapy Documented Before Chemotherapy Administered	January 1, 2009	
74	Radiation Therapy Recommended for Invasive Breast Cancer Patients who Have undergone Breast Conserving Surgery	January 1, 2009	
75	Prevention of Ventilator-Associated Pneumonia – Head Elevation	January 1, 2009	

List of Retired PQRI Measure Specifications			
Measure #	Measure Title	Retirement Effective Date	
77	Assessment of GERD Symptoms in Patients Receiving Chronic Medication for GERD	January 1, 2009	
78	Vascular Access for Patients Undergoing Hemodialysis	January 1, 2009	
80	End Stage Renal Disease (ESRD): Plan of Care for ESRD Patients with Anemia	January 1, 2009	
88	Hepatitis C: Hepatitis A and B Vaccination in Patients with HCV	January 1, 2009	
96	Otitis Media with Effusion (OME): Antihistamines or Decongestants – Avoidance of Inappropriate Use	January 1, 2009	
97	Otitis Media with Effusion (OME): Systemic Antimicrobials – Avoidance of Inappropriate Use	January 1, 2009	
98	Otitis Media with Effusion (OME): Systemic Corticosteroids – Avoidance of Inappropriate Use	January 1, 2009	
101	Appropriate Initial Evaluation of Patients with Prostate Cancer	January 1, 2009	
103	Prostate Cancer: Review of Treatment Options in Patients with Clinically Localized Prostate Cancer	January 1, 2009	
120	Chronic Kidney Disease (CKD): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy	January 1, 2009	
125	Health Information Technology (HIT): Adoption/Use of Medication Electronic Prescribing (e-Prescribing) Refer to new Electronic Prescribing (e-prescribing) incentive program	January 1, 2009	
129	Universal Influenza Vaccine Screening and Counseling	January 1, 2009	
132	Patient Co-Development of Treatment Plan/Plan of Care	January 1, 2009	
133	Screening for Cognitive Impairment	January 1, 2009	

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

2009 PQRI REPORTING OPTIONS: CLAIMS-BASED, REGISTRY, MEASURES GROUP

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

Measure Reporting via Claims:

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

When reporting the measure via claims, submit the listed ICD-9-CM diagnosis codes, CPT codes, G-codes, and the appropriate CPT Category II code **OR** the CPT Category II code **with** the modifier. The reporting modifier allowed for this measure is: 8P- reason not otherwise specified. All measure-specific coding should be reported ON THE SAME CLAIM.

NUMERATOR:

Patients with most recent hemoglobin A1c level > 9.0%

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

Numerator Quality-Data Coding Options for Reporting Satisfactorily: Most Recent Hemoglobin A1c Level > 9.0% CPT II 3046F: Most recent hemoglobin A1c level > 9.0%

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.

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

Most Recent Hemoglobin A1c Level $\leq 9.0\%$

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 Criteria (Eligible Cases):

Patients aged 18 through 75 years on date of encounter **AND**

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

<u>AND</u>

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

RATIONALE:

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

CLINICAL RECOMMENDATION STATEMENTS:

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

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

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

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

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

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

2009 PQRI REPORTING OPTIONS: CLAIMS-BASED, REGISTRY, MEASURES GROUP

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

Measure Reporting via Claims:

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

When reporting the measure via claims, submit the listed ICD-9-CM diagnosis codes, CPT codes, G-codes, and the appropriate CPT Category II code **OR** the CPT Category II code **with** the modifier. The reporting modifier allowed for this measure is: 8P- reason not otherwise specified. All measure-specific coding should be reported ON THE SAME CLAIM.

NUMERATOR:

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

<u>Numerator Quality-Data Coding Options for Reporting Satisfactorily:</u> Most Recent LDL-C Level < 100 mg/dL CPT II 3048F: Most recent LDL-C < 100 mg/dL

If patient is not eligible for this measure because LDL-C level not performed, report: LDL-C Level <u>not</u> Performed

Append a reporting modifier (8P) to CPT Category II code 3048F to report circumstances when the patient is not eligible for the measure.

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

<u> 0R</u>

Most Recent LDL-C Level \geq 100 mg/dL CPT II 3049F: Most recent LDL-C 100-129 mg/dL <u>OR</u> CPT II 3050F: Most recent LDL-C \geq 130 mg/dL

DENOMINATOR:

Patients aged 18 through 75 years with the diagnosis of diabetes

Denominator Criteria (Eligible Cases):

Patients aged 18 through 75 years on date of encounter **AND**

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

<u>and</u>

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

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: Diabetes Mellitus: High Blood Pressure Control in Diabetes Mellitus

2009 PQRI REPORTING OPTIONS: CLAIMS-BASED, REGISTRY, MEASURES GROUP

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

Measure Reporting via Claims:

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

When reporting the measure via claims, submit the listed ICD-9-CM diagnosis codes, CPT codes, G-codes, and the appropriate CPT Category II codes <u>**OR**</u> the CPT Category II code <u>**with**</u> the modifier. The reporting modifier allowed for this measure is: 8P- reason not otherwise specified. All measure-specific coding should be reported ON THE SAME CLAIM.

NUMERATOR:

Patients whose most recent blood pressure < 140/80 mmHg

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

Numerator Quality-Data Coding Options for Reporting Satisfactorily: Most Recent Blood Pressure Measurement Performed Systolic codes (Select one (1) code from this section): CPT II 3074F: Most recent systolic blood pressure < 130 mmHg OR CPT II 3075F: Most recent systolic blood pressure 130 - 139 mmHg OR CPT II 3077F: Most recent systolic blood pressure ≥ 140 mmHg AND *Diastolic code* (Select one (1) code from this section):

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

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

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

If patient is not eligible for this measure because blood pressure measurement not performed, report 2000F-8P:

Blood Pressure Measurement <u>not</u> Performed

Append a reporting modifier (8P) to CPT Category II code 2000F to report circumstances when the patient is not eligible for the measure.

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

DENOMINATOR:

Patients aged 18 through 75 years with the diagnosis of diabetes

Denominator Criteria (Eligible Cases):

Patients aged 18 through 75 years on date of encounter **AND**

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

<u>AND</u>

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

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)

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

2009 PQRI REPORTING OPTIONS: CLAIMS-BASED, REGISTRY

DESCRIPTION:

Percentage of patients aged 18 years and older with a diagnosis of heart failure and LVSD who were prescribed ACE inhibitor or ARB therapy

INSTRUCTIONS:

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

Measure Reporting via Claims:

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

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

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

<u>Numerator Quality-Data Coding Options for Reporting Satisfactorily:</u> ACE Inhibitor or ARB Therapy Prescribed

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

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

<u>and</u>

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

ACE Inhibitor or ARB Therapy <u>not</u> Prescribed for Medical, Patient, or System Reasons

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

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

<u>and</u>

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 \ge 40% or LVEF not performed or documented, report:

Left Ventricular Ejection Fraction (LVEF) $\ge 40\%$

(One CPT II code [3022F] is required on the claim form to submit this numerator option) **CPT II 3022F:** Left ventricular ejection fraction (LVEF) \ge 40% or documentation as normal or mildly depressed left ventricular systolic function

Left Ventricular Ejection Fraction (LVEF) not Performed or Documented

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

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 numerator option)

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 <u>not</u> prescribed, reason not otherwise specified

<u>and</u>

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

DENOMINATOR:

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

Denominator Criteria (Eligible Cases):

Patients aged \geq 18 years on date of encounter **AND**

Diagnosis for heart failure (line-item ICD-9-CM): 402.01, 402.11, 402.91, 404.01, 404.03, 404.11, 404.13, 404.91, 404.93, 428.0, 428.1, 428.20, 428.21, 428.22, 428.23, 428.30, 428.31, 428.32, 428.33, 428.40, 428.41, 428.42, 428.43, 428.9

<u>and</u>

Patient encounter during reporting period (CPT): 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)

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

2009 PQRI REPORTING OPTIONS: CLAIMS-BASED, REGISTRY

DESCRIPTION:

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

INSTRUCTIONS:

This measure is to be reported a minimum of <u>once per reporting period</u> 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.

Measure Reporting via Claims:

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

When reporting the measure via claims, submit the listed ICD-9-CM diagnosis codes, CPT codes, and the appropriate CPT Category II code <u>**OR**</u> the CPT Category II code <u>**with**</u> the modifier. The modifiers allowed for this measure are: 1P- medical reasons, 2P- patient reasons, 3P- system reasons, 8P- reason not otherwise specified. All measure-specific coding should be reported ON THE SAME CLAIM.

NUMERATOR:

Patients who were prescribed oral antiplatelet therapy

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

Definition:

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

Numerator Quality-Data Coding Options for Reporting Satisfactorily: Oral Antiplatelet Therapy Prescribed CPT II 4011F: Oral antiplatelet therapy prescribed

Oral Antiplatelet Therapy <u>not</u> Prescribed for Medical, Patient, or System Reasons Append a modifier (1P, 2P or 3P) to Category II code 4011F to report documented

circumstances that appropriately exclude patients from the denominator.

- **4011F** *with* **1P:** Documentation of medical reason(s) for not prescribing oral antiplatelet therapy
- **4011F** *with* **2P**: Documentation of patient reason(s) for not prescribing oral antiplatelet therapy
- **4011F** *with* **3P**: Documentation of system reason(s) for not prescribing oral antiplatelet therapy

Oral Antiplatelet Therapy not Prescribed, Reason not Specified

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

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

DENOMINATOR:

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

Denominator Criteria (Eligible Cases):

Patients aged \geq 18 years on date of encounter **AND**

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

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

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

2009 PQRI REPORTING OPTIONS: REGISTRY ONLY

DESCRIPTION:

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

INSTRUCTIONS:

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

Measure Reporting via Registry Only:

ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure. Do not report this measure via claims.

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 Options:

Beta-blocker therapy prescribed

Beta-blocker therapy <u>not</u> prescribed for medical reason **OR**

Beta-blocker therapy <u>not</u> prescribed for patient reason **OR**

Beta-blocker therapy not prescribed for system reason

Beta-blocker therapy <u>not</u> prescribed, reason not 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 Criteria (Eligible Cases):

Patients aged \geq 18 years on date of encounter **AND**

Diagnosis for CAD* (line-item ICD-9-CM): 410.00*, 410.01*, 410.02*, 410.10*, 410.11*, 410.12*, 410.20*, 410.21*, 410.22*, 410.30*, 410.31*, 410.32*, 410.40*, 410.41*, 410.42*, 410.50*, 410.51*, 410.52*, 410.60*, 410.61*, 410.62*, 410.70*, 410.71*, 410.72*, 410.80*, 410.81*, 410.82*, 410.90*, 410.91*, 410.92*, 411.0, 411.1, 411.81, 411.89, 412*, 413.0, 413.1, 413.9, 414.00, 414.01, 414.02, 414.03, 414.04, 414.05, 414.06, 414.07, 414.8, 414.9, V45.81, V45.81

<u>and</u>

Diagnosis for MI – includes patient that had a prior MI at any time

(line-item ICD-9-CM): 410.00, 410.01, 410.02, 410.10, 410.11, 410.12, 410.20, 410.21, 410.22, 410.30, 410.31, 410.32, 410.40, 410.41, 410.42, 410.50, 410.51, 410.52, 410.60, 410.61, 410.62, 410.70, 410.71, 410.72, 410.80, 410.81, 410.82, 410.90, 410.91, 410.92, 412

<u>and</u>

Patient encounter during reporting period CPT: 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

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

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 ßadrenoceptor 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 satisfactorily undergone revascularization, there is no reason to believe that these agents act differently in coronary patients who have undergone revascularization. (ACC/AHA)

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

2009 PQRI REPORTING OPTIONS: CLAIMS-BASED, REGISTRY

DESCRIPTION:

Percentage of patients aged 18 years and older with a diagnosis of heart failure who also have LVSD and who were prescribed beta-blocker therapy

INSTRUCTIONS:

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

Measure Reporting via Claims:

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

When reporting the measure via claims, submit the listed ICD-9-CM diagnosis codes, CPT codes, and the appropriate numerator G-code. All measure-specific coding should be reported ON THE SAME CLAIM.

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.

<u>Numerator Quality-Data Coding Options for Reporting Satisfactorily:</u> 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

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 \ge 40% or LVEF not performed or documented, report:

Left Ventricular Ejection Fraction (LVEF) $\ge 40\%$

(One G-code [G839x] is required on the claim form to submit this numerator option) **G8395:** Left ventricular ejection fraction (LVEF) \ge 40% or documentation as normal or mildly depressed left ventricular systolic function

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 Criteria (Eligible Cases):

Patients aged \geq 18 years on date of encounter

AND

Diagnosis for heart failure (line-item ICD-9-CM): 402.01, 402.11, 402.91, 404.01, 404.03, 404.11, 404.13, 404.91, 404.93, 428.0, 428.1, 428.20, 428.21, 428.22, 428.23, 428.30, 428.31, 428.32, 428.33, 428.40, 428.41, 428.42, 428.43, 428.9

<u>and</u>

Patient encounter during the reporting period (CPT): 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: Major Depressive Disorder (MDD): Antidepressant Medication During Acute Phase for Patients with MDD

2009 PQRI REPORTING OPTIONS: CLAIMS-BASED, REGISTRY

DESCRIPTION:

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

INSTRUCTIONS:

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

Measure Reporting via Claims:

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

When reporting the measure via claims, submit the listed ICD-9-CM diagnosis codes, CPT codes, and the appropriate numerator G-code. All measure-specific coding should be reported ON THE SAME CLAIM.

NUMERATOR:

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

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

Definition:

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

<u>Numerator Quality-Data Coding Options for Reporting Satisfactorily:</u> 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

Acute Treatment with Antidepressant Medication <u>not</u> 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

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 Criteria (Eligible Cases):

Patients aged \geq 18 years on date of encounter **AND**

Diagnosis for MDD (line-item ICD-9-CM): 296.20, 296.21, 296.22, 296.23, 296.24, 296.25, 296.30, 296.31, 296.32, 296.33, 296.34, 296.35, 298.0, 300.4, 309.0, 309.1, 311 **AND**

Patient encounter during the reporting period (CPT): 90801, 90802, 90804, 90805, 90806, 90807, 90808, 90809, 90810, 90811, 90812, 90813, 90814, 90815, 90821, 90823, 90823, 90824, 90829, 90845, 90849, 90853, 90857, 90862, 99078, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, 99510

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

2009 PQRI REPORTING OPTIONS: CLAIMS-BASED, REGISTRY

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 <u>each time</u> 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. In the event the CT or MRI is performed in an outpatient imaging center, this satisfies the clinical action described in CPT II 3111F. Arrival at the outpatient imaging center where the CT or MRI study is being performed will be considered as "arrival to the hospital". It is anticipated that clinicians who provide the physician component of diagnostic imaging studies for patients with stroke, TIA, or intracranial hemorrhage in the hospital or outpatient setting will submit this measure. **Note:** Use of symptom codes is limited to those specified in the denominator coding.

Measure Reporting via Claims:

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

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

NUMERATOR:

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

Numerator Instructions: Studies (CT or MRI) performed at an outpatient imaging center within 24 hours will be considered as "arrival to the hospital".

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

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

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

(Two CPT II codes [3110F & 3111F] are required on the claim form to submit this numerator option)

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

<u>AND</u>

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

<u> 0R</u>

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

<u> 0R</u>

Presence/Absence of Hemorrhage, Mass Lesion, and Acute Infarction <u>not</u> Documented, Reason not Specified

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

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

3110F *with* **8P**: Presence or absence of hemorrhage and mass lesion and acute infarction was <u>not</u> documented in final CT or MRI report, reason not otherwise specified

<u>AND</u>

CPT II 3111F: CT or MRI of the brain performed 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 Criteria (Eligible Cases):

Patients aged \geq 18 years on date of encounter AND

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-CM code in the code table below.
Note: Use of symptom codes is limited to the following:

Diagnosis for ischemic stroke or TIA or intracranial hemorrhage – including symptom codes (line-item ICD-9-CM): 368.12, 368.2, 386.2, 431, 433.01, 433.11, 433.21, 433.31, 433.81, 433.91, 434.01, 434.11, 434.91, 435.0, 435.1, 435.2, 435.3, 435.8, 435.9, 437.7, 780.02, 781.3, 781.4, 781.94, 782.0, 784.3, 784.5

Patient encounter during the reporting period (CPT): 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

2009 PQRI REPORTING OPTIONS: CLAIMS-BASED, REGISTRY

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 <u>each time</u> 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.

Measure Reporting via Claims:

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

When reporting the measure via claims, submit the listed ICD-9-CM diagnosis codes, CPT codes, and the appropriate CPT Category II code <u>**OR**</u> the CPT Category II code <u>**with**</u> the modifier. The modifiers allowed for this measure are: 1P- medical reasons, 8P- reason not otherwise specified. All measure-specific coding should be reported ON THE SAME CLAIM.

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 <u>residual</u> internal carotid lumen with methods based on the <u>distal</u> internal carotid lumen)

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

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

Measurements of Distal Internal Carotid Diameter <u>not</u> 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. **3100F** *with* **1P**: Documentation of medical reason(s) for not including direct or indirect reference to measurements of distal internal carotid diameter

Measurements of Distal Internal Carotid Diameter \underline{not} Referenced, Reason not Specified

Append a reporting modifier (8P) to CPT Category II code 3100F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

3100F *with* **8P**: Carotid image study report did <u>not</u> 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 Criteria (Eligible Cases):

ICD-9-CM 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 <u>AND</u> Patient encounter during the reporting period (CPT): 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)

Version 3.0

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

2009 PQRI REPORTING OPTIONS: CLAIMS-BASED, REGISTRY

DESCRIPTION:

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

INSTRUCTIONS:

This measure is to be reported a minimum of <u>once per reporting period</u> 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.

Measure Reporting via Claims:

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

When reporting the measure via claims, submit the listed ICD-9-CM diagnosis codes, CPT codes, and the appropriate CPT Category II code <u>**OR**</u> the CPT Category II code <u>**with**</u> the modifier. The modifiers allowed for this measure are: 1P- medical reasons, 3P- system reasons, 8P- reason not otherwise specified. All measure-specific coding should be reported ON THE SAME CLAIM.

NUMERATOR:

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

<u>Numerator Quality-Data Coding Options for Reporting Satisfactorily:</u> Optic Nerve Head Evaluation Performed

CPT II 2027F: Optic nerve head evaluation performed

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.

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

2027F *with* **3P**: Documentation of system reason(s) for not performing an optic nerve head evaluation

<u> 0R</u>

Optic Nerve Head Evaluation not Performed, Reason not Specified

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

2027F *with* 8P: Optic nerve head evaluation was <u>not</u> performed, reason not otherwise specified

DENOMINATOR:

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

Denominator Criteria (Eligible Cases):

Patients aged \geq 18 years on date of encounter **AND**

Diagnosis for primary open-angle glaucoma (line-item ICD-9-CM): 365.01, 365.10, 365.11, 365.12, 365.15

<u>AND</u>

Patient encounter during the reporting period (CPT): 92002, 92004, 92012, 92014, 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

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 (AMD): Dilated Macular Examination

2009 PQRI REPORTING OPTIONS: CLAIMS-BASED, REGISTRY

DESCRIPTION:

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

INSTRUCTIONS:

This measure is to be reported a minimum of <u>once per reporting period</u> 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.

Measure Reporting via Claims:

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

When reporting the measure via claims, submit the listed ICD-9-CM diagnosis codes, CPT codes, and the appropriate CPT Category II code <u>**OR**</u> the CPT Category II code <u>**with**</u> the modifier. The modifiers allowed for this measure are: 1P- medical reasons, 2P- patient reasons, 3P- system reasons, 8P- reason not otherwise specified. All measure-specific coding should be reported ON THE SAME CLAIM.

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

<u>Numerator Quality-Data Coding Options for Reporting Satisfactorily:</u> 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

Dilated Macular Examination <u>not</u> **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.

- **2019F** *with* **1P:** Documentation of medical reason(s) for not performing a dilated macular examination
- **2019F** *with* **2P**: Documentation of patient reason(s) for not performing a dilated macular examination
- **2019F** *with* **3P:** Documentation of system reason(s) for not performing a dilated macular examination

<u> 0R</u>

Dilated Macular Examination not Performed, Reason not Specified

Append a reporting modifier (8P) to CPT Category II code 2019F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

2019F with 8P: Dilated macular exam was not performed, reason not otherwise specified

DENOMINATOR:

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

Denominator Criteria (Eligible Cases):

Patients aged \geq 50 years on date of encounter

<u>AND</u>

Diagnosis for age-related macular degeneration (line-item ICD-9-CM): 362.50, 362.51, 362.52

<u>AND</u>

Patient encounter during the reporting period (CPT): 92002, 92004, 92012, 92014, 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

RATIONALE:

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

CLINICAL RECOMMENDATION STATEMENTS:

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

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

2009 PQRI REPORTING OPTIONS: CLAIMS-BASED, REGISTRY

DESCRIPTION:

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

INSTRUCTIONS:

This measure is to be reported a minimum of <u>once per reporting period</u> 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.

Measure Reporting via Claims:

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

When reporting the measure via claims, submit the listed ICD-9-CM diagnosis codes, CPT codes, and the appropriate CPT Category II code <u>**OR**</u> the CPT Category II code <u>**with**</u> the modifier. The modifiers allowed for this measure are: 1P- medical reasons, 2P- patient reasons, 3P- system reasons, 8P- reason not otherwise specified. All measure-specific coding should be reported ON THE SAME CLAIM.

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, non-proliferative diabetic retinopathy) AND documentation of whether macular edema was present or absent

<u>Numerator Quality-Data Coding Options for Reporting Satisfactorily:</u> 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

Macular or Fundus Exam <u>not</u> 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.

- **2021F** *with* **1P:** Documentation of medical reason(s) for not performing a dilated macular or fundus examination
- **2021F** *with* **2P**: Documentation of patient reason(s) for not performing a dilated macular or fundus examination
- **2021F** *with* **3P**: Documentation of system reason(s) for not performing a dilated macular or fundus examination

Macular or Fundus Exam not Performed, Reason not Specified

Append a reporting modifier (8P) to CPT Category II code 2021F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

2021F *with* 8P: Dilated macular or fundus exam was <u>not</u> performed reason not otherwise specified

DENOMINATOR:

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

Denominator Criteria (Eligible Cases):

Patients aged ≥ 18 years on date of encounter <u>AND</u> Diagnosis for diabetic retinopathy (line-item ICD-9-CM): 362.01, 362.02, 362.03, 362.04, 362.05, 362.06 <u>AND</u> Detine to encounter the encounting of (CDT): 00000, 00004, 00040, 00044

Patient encounter during the reporting period (CPT): 92002, 92004, 92012, 92014, 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

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 On-going Diabetes Care

2009 PQRI REPORTING OPTIONS: CLAIMS-BASED, REGISTRY

DESCRIPTION:

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

INSTRUCTIONS:

This measure is to be reported a minimum of <u>once per reporting period</u> for <u>all</u> 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.

Measure Reporting via Claims:

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

When reporting the measure via claims, submit the listed ICD-9-CM diagnosis codes, CPT codes, and the appropriate CPT Category II code <u>AND/OR</u> G-code <u>OR</u> the CPT Category II code <u>with</u> the modifier <u>AND</u> G-code. The modifiers allowed for this measure are: 2P- patient reasons, 3P- system reasons, 8P- reason not otherwise specified. All measure-specific coding should be reported ON THE SAME CLAIM.

NUMERATOR:

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

Definition:

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

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

<u>Numerator Quality-Data Coding Options for Reporting Satisfactorily:</u> Dilated Macular or Fundus Exam Findings Communicated

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

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

<u>AND</u>

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

Dilated Macular or Fundus Exam Findings <u>not</u> Communicated for Patient or System Reasons

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

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

<u>and</u>

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

OR

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

(One G-code [G8398] is required on the claim form to submit this numerator option) **G8398:** Dilated macular or fundus exam not performed

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

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

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

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

<u>and</u>

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 Criteria (Eligible Cases):

Patients aged ≥ 18 years on date of encounter <u>AND</u> Diagnosis for diabetic retinopathy (line-item ICD-9-CM): 362.01, 362.02, 362.03, 362.04, 362.05, 362.06 <u>AND</u> Patient encounter during the reporting period (CPT): 92002, 92004, 92012, 92014, 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

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

2009 PQRI REPORTING OPTIONS: CLAIMS-BASED, REGISTRY, MEASURES GROUP

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 <u>each time</u> 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 <u>clinicians who perform the listed</u> <u>surgical procedures</u> as specified in the denominator coding will submit this measure.

Measure Reporting via Claims:

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

When reporting the measure via claims, submit the listed CPT codes, and the appropriate CPT Category II code **OR** the CPT Category II code **with** the modifier. The modifiers allowed for this measure are: 1P- medical reasons, 8P- reason not otherwise specified. All measure-specific coding should be reported ON THE SAME CLAIM.

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 <u>has</u> been given within one hour (if fluoroquinolone or vancomycin, two hours) prior to the surgical incision (or start of 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 Quality-Data Coding Options for Reporting Satisfactorily:

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

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

Documentation that Prophylactic Antibiotic <u>has</u> 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)

Order for Prophylactic Antibiotic <u>not</u> 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.

4047F *with* **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)

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.

4047F *with* **8P:** Prophylactic antibiotics were <u>not</u> 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 Criteria (Eligible Cases):

Patients aged \geq 18 years on date of encounter **AND**

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

SURGICAL PROCEDURE	CPT CODE
Integumentary	15734, 15738, 19260, 19271, 19272, 19301, 19302,
	19303, 19304, 19305, 19306, 19307, 19361, 19364,
	19366, 19367, 19368, 19369
Le Fort Fractures	21346, 21347, 21348, 21422, 21423, 21432, 21433,
	21435, 21436
Mandibular Fracture	21454, 21461, 21462, 21465, 21470
Spine	22325, 22612, 22630, 22800, 22802, 22804, 63030,
	63042
Hip Reconstruction	27125, 27130, 27132, 27134, 27137, 27138
Trauma (Fractures)	27235, 27236, 27244, 27245, 27269, 27758, 27759,
	27766, 27769, 27792, 27814
Knee Reconstruction	27440, 27441, 27442, 27443, 27445, 27446, 27447
Laryngectomy	31360, 31365, 31367, 31368, 31370, 31375, 31380,
	31382, 31390, 31395
Vascular	33877, 33880, 33881, 33883, 33886, 33891, 34800,
	34802, 34803, 34804, 34805, 34825, 34830, 34831,
	34832, 34900, 35081, 35091, 35102, 35131, 35141,
	35151, 35601, 35606, 35612, 35616, 35621, 35623,
	35626, 35631, 35632, 35633, 35634, 35636, 35637,
	35638, 35642, 35645, 35646, 35647, 35650, 35651,
	35654, 35656, 35661, 35663, 35665, 35666, 35671,
Culson and Lymph Nadaa	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, 43134
	43116, 43117, 43118, 43121, 43122, 43123, 43124, 43130, 43135, 43300, 43305, 43310, 43312, 43313,
	43130, 43135, 43300, 43303, 43310, 43312, 43313, 43320, 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, 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,
	44000, 44010, 44020, 44021, 44030, 44030, 44100,
	44120, 44125, 44126, 44127, 44130, 44132, 44133,

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

Condictle and sig (Decomposition)	
Cardiothoracic (Pacemaker)	33203, 33206, 33207, 33208, 33212, 33213, 33214,
	33215, 33216, 33217, 33218, 33220, 33222, 33223,
	33224, 33225, 33226, 33233, 33234, 33235, 33236,
	33237, 33238, 33240, 33241, 33243, 33244, 33249,
	33254, 33255
Genitourinary Surgery	51550, 51555, 51565, 51570, 51575, 51580, 51585,
	51590, 51595, 51596, 51920, 51925, 52450, 52601,
	52630, 52647, 52648, 52649, 54401, 54405, 54406,
	54408, 54410, 54415, 54416, 55801, 55810, 55812,
	55815, 55821, 55831, 55840, 55842, 55845
General Thoracic Surgery	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, 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

2009 PQRI REPORTING OPTIONS: CLAIMS-BASED, REGISTRY, MEASURES GROUP

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 <u>each time</u> 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 <u>clinicians who perform the listed surgical procedures</u> as specified in the denominator coding will submit this measure.

Measure Reporting via Claims:

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

When reporting the measure via claims, submit the listed CPT codes, and the appropriate CPT Category II code <u>**OR**</u> the CPT Category II code <u>**with**</u> the modifier. The modifiers allowed for this measure are: 1P- medical reasons, 8P- reason not otherwise specified. All measure-specific coding should be reported ON THE SAME CLAIM.

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 <u>given</u>.

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

<u>Numerator Quality-Data Coding Options for Reporting Satisfactorily:</u> 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 <u>ordered</u> or antibiotic <u>given</u>. <i>Report CPT Category II code* **4041F** *if cefazolin OR cefuroxime was given for antimicrobial prophylaxis.*

<u> 0R</u>

Order for First or Second Generation Cephalosporin <u>not</u> Ordered for Medical Reasons

Append a modifier (**1P**) to CPT Category II code **4041F** to report documented circumstances that appropriately exclude patients from the denominator.

4041F *with* **1P:** Documentation of medical reason(s) for not ordering cefazolin OR cefuroxime for antimicrobial prophylaxis

Order for First or Second Generation Cephalosporin <u>not</u> Ordered, Reason not Specified

Append a reporting modifier (8P) to CPT Category II code 4041F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

4041F *with* **8P:** Order for cefazolin OR cefuroxime for antimicrobial prophylaxis was <u>not</u> 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 Criteria (Eligible Cases):

Patients aged \geq 18 years on date of encounter

AND

Patient encounter during the reporting period (CPT): Listed below are surgical procedures with indications for first or second generation cephalosporin prophylactic antibiotic.

SURGICAL PROCEDURE	CPT CODE
Integumentary	15734, 15738, 19260, 19271, 19272, 19301, 19302,
	19303, 19304, 19305, 19306, 19307, 19361, 19364,
	19366, 19367, 19368, 19369
Spine	22325, 22612, 22630, 22800, 22802, 22804, 63030,
	63042
Hip Reconstruction	27125, 27130, 27132, 27134, 27137, 27138
Trauma (Fractures)	27235, 27236, 27244, 27245, 27269, 27758, 27759,
	27766, 27769, 27792, 27814
Knee Reconstruction	27440, 27441, 27442, 27443, 27445, 27446, 27447
Vascular	33877, 33880, 33881, 33883, 33886, 33891, 34800,
	34802, 34803, 34804, 34805, 34825, 34830, 34831,

	34832, 34900, 35081, 35091, 35102, 35131, 35141,
	35151, 35601, 35606, 35612, 35616, 35621, 35623,
	35626, 35631, 35632, 35633, 35634, 35636, 35637,
	35638, 35642, 35645, 35646, 35647, 35650, 35651,
	35654, 35656, 35661, 35663, 35665, 35666, 35671,
	36830
Spleen and Lymph Nodes	38115
Esophagus	43045, 43100, 43101, 43107, 43108, 43112, 43113,
Loophagao	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,
Otawa a k	43401, 43405, 43410, 43415, 43420, 43425, 43496
Stomach	43500, 43501, 43502, 43510, 43520, 43605, 43610,
	43611, 43620, 43621, 43622, 43631, 43632, 43633,
	43634, 43640, 43641, 43653, 43800, 43810, 43820,
	43825, 43830, 43831, 43832, 43840, 43843, 43845,
	43846, 43847, 43848, 43850, 43855, 43860, 43865,
	43870
Small Intestine	44005, 44010, 44020, 44021, 44050, 44055, 44100,
	44120, 44125, 44126, 44127, 44130, 44132, 44133,
	44135, 44136
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 &	49215, 49568
Omentum	
Renal Transplant	50300, 50320, 50340, 50360, 50365, 50370, 50380
Neurological Surgery	22524, 22554, 22558, 22600, 22612, 22630, 35301,
	61154, 61312, 61313, 61315, 61510, 61512, 61518,
	61548, 61697, 61700, 61750, 61751, 61867, 62223,
	62230, 63015, 63020, 63030, 63042, 63045, 63047,
	63056, 63075, 63081, 63267, 63276
Cardiothoracic Surgery	33120, 33130, 33140, 33141, 33202, 33250, 33251,
	33256, 33261, 33305, 33315, 33321, 33322, 33332,
	33335, 33400, 33401, 33403, 33404, 33405, 33406,
	33410, 33411, 33413, 33416, 33422, 33425, 33426, 33407, 33420, 33460, 33462, 33464, 33465, 33475
	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
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, 39000, 39010, 39200, 39220, 39545, 39561,
60521, 60522, 64746
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)

2009 PQRI REPORTING OPTIONS: CLAIMS-BASED, REGISTRY, MEASURES GROUP

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 <u>each time</u> 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 <u>clinicians who perform the listed surgical procedures</u> as specified in the denominator coding will submit this measure.

Measure Reporting via Claims:

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

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

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 for "one time" IV dose orders) OR documentation that prophylactic antibiotic <u>was</u> discontinued within 24 hours of surgical end time.

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

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Documentation of Order for Discontinuation of Prophylactic Antibiotics (written order, verbal order, or standing order/protocol) Within 24 Hours of Surgical End Time

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

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

Note: *CPT* Category II code **4049F** is provided for documentation that antibiotic discontinuation was <u>ordered</u> or that antibiotic discontinuation was <u>accomplished</u>. 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

Prophylactic Antibiotics not Discontinued for Medical Reasons

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

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

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

<u>AND</u>

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

Prophylactic Antibiotics not Discontinued, Reason not Specified

(Two CPT II codes [4049F-8P & 4046F] are required on the claim form to submit this numerator option)

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

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

<u>AND</u>

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 Criteria (Eligible Cases):

Patients aged \geq 18 years on date of encounter

<u>AND</u>

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

SURGICAL PROCEDURE	CPT CODE
Integumentary	15734, 15738, 19260, 19271, 19272, 19301, 19302,
	19303, 19304, 19305, 19306, 19307, 19361, 19364,
	19366, 19367, 19368, 19369
Le Fort Fractures	21346, 21347, 21348, 21422, 21423, 21432, 21433,
	21435, 21436
Mandibular Fracture	21454, 21461, 21462, 21465, 21470
Spine	22325, 22612, 22630, 22800, 22802, 22804, 63030,
	63042
Hip Reconstruction	27125, 27130, 27132, 27134, 27137, 27138
Trauma (Fractures)	27235, 27236, 27244, 27245, 27269, 27758, 27759,
	27766, 27769, 27792, 27814
Knee Reconstruction	27440, 27441, 27442, 27443, 27445, 27446, 27447
Laryngectomy	31360, 31365, 31367, 31368, 31370, 31375, 31380,
	31382, 31390, 31395
Vascular	33877, 33880, 33881, 33883, 33886, 33891, 34800,
	34802, 34803, 34804, 34805, 34825, 34830, 34831,
	34832, 34900, 35081, 35091, 35102, 35131, 35141,
	35151, 35601, 35606, 35612, 35616, 35621, 35623,
	35626, 35631, 35632, 35633, 35634, 35636, 35637,
	35638, 35642, 35645, 35646, 35647, 35650, 35651,
	35654, 35656, 35661, 35663, 35665, 35666, 35671,
	36830
Glossectomy	41130, 41135, 41140, 41145, 41150, 41153, 41155
Esophagus	43045, 43100, 43101, 43107, 43108, 43112, 43113,
	43116, 43117, 43118, 43121, 43122, 43123, 43124,
	43130, 43135, 43300, 43305, 43310, 43312, 43313,
	43320, 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, 43653, 43800, 43810, 43820,
43825, 43830, 43831, 43832, 43840, 43843, 43845,
43846, 43847, 43848, 43850, 43855, 43860, 43865,
43870
44005, 44010, 44020, 44021, 44050, 44055, 44100,
44120, 44125, 44126, 44127, 44130, 44132, 44133,
44135, 44136
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
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
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
48020, 48100, 48120, 48140, 48145, 48146, 48148,
48150, 48152, 48153, 48154, 48155, 48500, 48510,
48511, 48520, 48540, 48545, 48547, 48548, 48550,
48554, 48556
49215, 49568
50300, 50320, 50340, 50360, 50365, 50370, 50380
58150, 58152, 58180, 58200, 58210, 58260, 58262,
58263, 58267, 58270, 58275, 58280, 58285, 58290,
58291, 58292, 58293, 58294
61520, 61526, 61530, 61591, 61595, 61596, 61598,
61606, 61616, 61618, 61619, 69720, 69955, 69960,
69970
69930
22524, 22554, 22558, 22600, 22612, 22630, 35301,
61154, 61312, 61313, 61315, 61510, 61512, 61518,
61548, 61697, 61700, 61750, 61751, 61867, 62223
61548, 61697, 61700, 61750, 61751, 61867, 62223, 62230, 63015, 63020, 63030, 63042, 63045, 63047,
62230, 63015, 63020, 63030, 63042, 63045, 63047,

Cardiotharaaia	22002 22006 22007 22000 22010 22012 22014
Cardiothoracic	33203, 33206, 33207, 33208, 33212, 33213, 33214,
(Pacemaker)	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, 33202, 33300, 33310, 33320, 33321, 33322,
	34051, 35021, 35211, 35216, 35241, 35246, 35271,
	35276, 35311, 35481, 35526, 37616, 38381, 38746,
	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)

2009 PQRI REPORTING OPTIONS: CLAIMS-BASED, REGISTRY, MEASURES GROUP

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 <u>each time</u> 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 <u>clinicians who perform the listed</u> <u>surgical procedures</u> as specified in the denominator coding will submit this measure.

Measure Reporting via Claims:

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

When reporting the measure via claims, submit the listed CPT codes, and the appropriate CPT Category II code <u>**OR**</u> the CPT Category II code <u>**with**</u> the modifier. The modifiers allowed for this measure are: 1P- medical reasons, 8P- reason not otherwise specified. All measure-specific coding should be reported ON THE SAME CLAIM.

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.

<u>Numerator Quality-Data Coding Options for Reporting Satisfactorily:</u> 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 <u>ordered</u> or VTE prophylaxis <u>given</u>. If VTE prophylaxis is given, report 4044F.

<u> 0R</u>

VTE Prophylaxis not Ordered for Medical Reasons

Append a modifier (**1P**) to CPT Category II code **4044F** to report documented circumstances that appropriately exclude patients from the denominator.

4044F *with* **1P:** Documentation of medical reason(s) for patient not receiving any form of VTE prophylaxis (LMWH, LDUH, adjusted-dose warfarin, fondaparinux or mechanical prophylaxis) within 24 hours prior to incision time or 24 hours after surgery end time

VTE Prophylaxis not Ordered, Reason not Specified

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

4044F *with* **8P:** Order was <u>not</u> 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 Criteria (Eligible Cases):

Patients aged \geq 18 years on date of encounter **AND**

Patient encounter during the reporting period (CPT): Listed below are surgical procedures for which VTE prophylaxis is indicated.

SURGICAL PROCEDURE	CPT CODE
Neurological Surgery	22558, 22600, 22612, 22630, 61313, 61510,
	61512, 61518, 61548, 61697, 61700, 62230,
	63015, 63020, 63047, 63056, 63081, 63267,
	63276
Hip Reconstruction	27125, 27130, 27132, 27134, 27137, 27138
Knee Reconstruction	27440, 27441, 27442, 27443, 27445, 27446,
	27447
Genitourinary Surgery	50020, 50220, 50225, 50230, 50234, 50236,
	50240, 50320, 50340, 50360, 50365, 50370,
	50380, 50543, 50545, 50546, 50547, 50548,
	50715, 50722, 50725, 50727, 50728, 50760,

	50770, 50780, 50782, 50783, 50785, 50800,
	50810, 50815, 50820, 50947, 50948, 51550,
	51555, 51565, 51570, 51575, 51580, 51585,
	51590, 51595, 51596, 51597, 51800, 51820,
	51900, 51920, 51925, 51960, 55810, 55812,
	55815, 55821, 55831, 55840, 55842, 55845,
	55866
Como e a la sia Commo ma	
Gynecologic Surgery	56630, 56631, 56632, 56633, 56634, 56637,
	56640, 58200, 58210, 58240, 58285, 58951,
	58953, 58954, 58956
Hip Fracture Surgery	27235, 27236, 27244, 27245, 27269
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, 43279, 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, 44123, 44126, 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, 49203, 49204, 49205,
49215, 49220, 49250, 49255, 49320, 49321,
49322, 49323, 49560, 49561, 49565, 49566,
49570, 50320, 50340, 50360, 50365, 50370,
50380, 60200, 60210, 60212, 60220, 60225,
60240, 60252, 60254, 60260, 60270, 60271,
60280, 60281, 60500, 60502, 60505, 60520,
60521, 60522, 60540, 60545, 60600, 60605,
60650

RATIONALE:

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

Additional work is needed to determine if a physician-level measure for VTE prophylaxis can be developed to address individual patient thromboembolic risk factors, in addition to procedural risk, without creating data collection burden. Many of these procedures are done in hospitals and ASCs, but quite a few are performed in the physician's office. There are many reasons for the differences in the site of service, including that breast lesions and breast tissue varies considerably. Some women have a small breast and a small lesion that can be expeditiously treated as a minor office

procedure done in 20 minutes under local anesthesia. In this instance, the evidence for DVT prophylaxis is simply not present. Other patients have small or large lesions located in difficult positions within a dense complex breast. In this instance, the patients have long procedures under general anesthesia. Both of these instances can occur within the same CPT code. It should be noted that the number of medical exclusions for these codes will likely be much higher than other codes to account for the variation in major and minor procedures within the same CPT code. Duration of VTE prophylaxis is not specified in the measure due to varying guideline recommendations for different patient populations.

CLINICAL RECOMMENDATION STATEMENTS:

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

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

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

2009 PQRI REPORTING OPTIONS: CLAIMS-BASED, REGISTRY

DESCRIPTION:

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

INSTRUCTIONS:

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

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

Measure Reporting via Claims:

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

When reporting the measure via claims, submit the listed ICD-9-CM diagnosis codes, CPT codes, and the appropriate CPT Category II code <u>**OR**</u> the CPT Category II code <u>**with**</u> the modifier. The modifiers allowed for this measure are: 1P- medical reasons, 2P- patient reasons, 8P- reason not otherwise specified. All measure-specific coding should be reported ON THE SAME CLAIM.

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 Quality-Data Coding Options for Reporting Satisfactorily: Post Fracture Care Communication Documented

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

Post Fracture Care not Communicated for Medical or Patient Reasons

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

- **5015F** *with* **1P**: Documentation of medical reason(s) for not communicating with physician managing on-going care of patient that a fracture occurred and that the patient was or should be tested or treated for osteoporosis
- **5015F** *with* **2P**: Documentation of patient reason(s) for not communicating with the physician managing on-going care of patient that a fracture occurred and that the patient was or should be tested or treated for osteoporosis

Post Fracture Care not Communicated, Reason not Specified

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

5015F *with* **8P**: <u>No</u> 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 Criteria (Eligible Cases):

Patients aged \geq 50 years on date of encounter **AND**

Diagnosis for hip, spine or distal radial fracture (line-item ICD-9-CM): 733.12, 733.13, 733.14, 805.00, 805.01, 805.02, 805.03, 805.04, 805.05, 805.06, 805.07, 805.08, 805.2, 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, 820.20, 820.21, 820.22, 820.8 **AND**

Patient encounter during the reporting period (CPT) – Service codes: 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245

OR

Patient encounter during the reporting period (CPT) – Procedure codes: 22305, 22310, 22315, 22318, 22319, 22325, 22326, 22327, 22520, 22521, 22523, 22524, 25600, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 25005, 2

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)

2009 PQRI REPORTING OPTIONS: CLAIMS-BASED, REGISTRY

DESCRIPTION:

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

INSTRUCTIONS:

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

Measure Reporting via Claims:

Line-item ICD-9-CM diagnosis codes and CPT codes are used to identify patients who are included in the measure's denominator. CPT Category II codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed ICD-9-CM diagnosis codes, CPT codes, and the appropriate CPT Category II code <u>**OR**</u> the CPT Category II code <u>**with**</u> the modifier. The modifiers allowed for this measure are: 1P- medical reasons, 2P- patient reasons, 8P- reason not otherwise specified. All measure-specific coding should be reported ON THE SAME CLAIM.

NUMERATOR:

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

<u>Numerator Quality-Data Coding Options for Reporting Satisfactorily:</u> 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

<u> 0R</u>

Aspirin <u>not</u> Received or Taken 24 Hours Before Emergency Department Arrival or During Emergency Department Stay for Medical or Patient Reasons

Append a modifier (**1P or 2P**) to CPT Category II code **4084F** to report documented circumstances that appropriately exclude patients from the denominator.

- **4084F** *with* **1P:** Documentation of medical reason(s) for not receiving or taking aspirin within 24 hours before emergency department arrival or during emergency department stay
- **4084F** *with* **2P**: Documentation of patient reason(s) for not receiving or taking aspirin within 24 hours before emergency department arrival or during emergency department stay

Aspirin <u>not</u> Received or Taken 24 Hours Before Emergency Department Arrival or During Emergency Department Stay, Reason not Specified

Append a reporting modifier (8P) to CPT Category II code 4084F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

4084F *with* **8P:** Aspirin was <u>not</u> 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 Criteria (Eligible Cases):

Diagnosis for acute myocardial infarction (line-item ICD-9-CM): 410.01, 410.11, 410.21, 410.31, 410.41, 410.51, 410.61, 410.71, 410.81, 410.91

<u>and</u>

Patient encounter during the reporting period (CPT): 99281, 99282, 99283, 99284, 99285, 99291

<u>and</u>

Place of Service Indicator: 23

(The Part B claim form place of service field must indicate emergency department)

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 Antibiotics – Administering Physician

2009 PQRI REPORTING OPTIONS: CLAIMS-BASED, REGISTRY

DESCRIPTION:

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

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

Measure Reporting via Claims:

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

When reporting the measure via claims, submit the appropriate CPT Category II code <u>OR</u> the appropriate CPT Category II code <u>with</u> the modifier on the same claim containing the anesthesia codes listed in the denominator. The modifiers allowed for this measure are: 1P- medical reasons, 8P- reason not otherwise specified. All measure-specific coding should be reported ON THE SAME CLAIM as the denominator codes.

NUMERATOR:

Surgical patients with an order for a prophylactic antibiotic for whom administration of the 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 Quality-Data Coding Options for Reporting Satisfactorily:

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

NUMERATOR NOTE: Includes instances where the clinician providing anesthesia services orders AND administers the prophylactic antibiotic within the appropriate timeframe, report quality-data code CPT II 4048F.

Documentation that Prophylactic Antibiotic was Given Within Specified Timeframe 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)

Prophylactic Antibiotic <u>not</u> Given for Medical Reasons (eg, contraindicated, patient already receiving antibiotics)

Append a modifier (**1P**) to CPT Category II code **4048F** to report documented circumstances that appropriately exclude patients from the denominator.

4048F *with* **1P:** Documentation of medical reason(s) for not giving antibiotics within one hour (if fluoroquinolone or vancomycin, two hours) prior to the surgical incision (or start of procedure when no incision is required)

OR

If patient is not eligible for this measure because prophylactic antibiotic not ordered, report:

Prophylactic Antibiotic not Ordered

Append a reporting modifier (8P) to CPT Category II code 4047F to report circumstances when the patient is not eligible for the measure.

4047F *with* **8P**: <u>No</u> 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)

Prophylactic Antibiotic Ordered but <u>not</u> Given Within One Hour, Reason not Specified

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

4048F *with* **8P:** Prophylactic antibiotic was <u>not</u> 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 patients aged 18 years and older who require anesthesia services where a prophylactic antibiotic is commonly indicated for associated surgical procedures.

Denominator Criteria (Eligible Cases):

Patients aged \geq 18 years on date of encounter **AND**

Patient encounter during the reporting period (CPT): Anesthesia codes for which prophylactic antibiotics are commonly indicated for associated surgical procedure(s): 00100, 00102, 00103, 00120, 00140, 00145, 00147, 00160, 00162, 00164, 00170, 00172, 00174, 00176, 00190, 00192, 00210, 00211, 00212, 00214, 00215, 00216, 00218, 00220, 00222, 00300, 00320, 00322, 00350, 00352, 00400, 00402, 00404, 00406, 00450, 00452, 00454. 00470. 00472. 00474. 00500. 00528. 00529. 00530. 00532. 00534. 00537. 00539. 00540, 00541, 00542, 00546, 00548, 00550, 00560, 00561, 00562, 00563, 00566, 00567, 00580, 00600, 00604, 00620, 00622, 00625, 00626, 00630, 00632, 00634, 00670, 00700, 00730, 00750, 00752, 00754, 00756, 00770, 00790, 00792, 00794, 00796, 00797, 00800, 00802, 00820, 00830, 00832, 00840, 00844, 00846, 00848, 00851, 00860, 00862, 00864, 00865, 00866, 00868, 00870, 00880, 00882, 00902, 00904, 00906, 00908, 00910, 00912, 00914, 00916, 00918, 00920, 00921, 00922, 00924, 00926, 00928, 00930, 00932, 00934, 00936, 00938, 00940, 00942, 00944, 01120, 01140, 01150, 01170, 01173, 01180, 01190, 01202, 01210, 01212, 01214, 01215, 01230, 01232, 01234, 01250, 01260, 01270, 01272, 01274, 01320, 01360, 01382, 01392, 01400, 01402, 01404, 01430, 01432, 01440, 01442, 01444. 01464. 01470. 01472. 01474. 01480. 01482. 01484. 01486. 01500. 01502. 01520. 01522, 01610, 01622, 01630, 01632, 01634, 01636, 01638, 01650, 01652, 01654, 01656, 01670, 01710, 01712, 01714, 01716, 01732, 01740, 01742, 01744, 01756, 01758, 01760, 01770, 01772, 01780, 01782, 01810, 01829, 01830, 01832, 01840, 01842, 01844, 01850, 01852, 01924, 01925, 01926, 01951, 01952, 01953, 01961, 01962, 01963, 01965, 01966, 01968, 01969

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

2009 PQRI REPORTING OPTIONS: CLAIMS-BASED, REGISTRY

DESCRIPTION:

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

INSTRUCTIONS:

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

Measure Reporting via Claims:

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

When reporting the measure via claims, submit the listed ICD-9-CM diagnosis codes, CPT codes, and the appropriate CPT Category II code <u>**OR**</u> the CPT Category II code <u>**with**</u> the modifier. The modifiers allowed for this measure are: 1P- medical reasons, 2P- patient reasons, 8P- reason not otherwise specified. All measure-specific coding should be reported ON THE SAME CLAIM.

NUMERATOR:

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

Definition:

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

<u>Numerator Quality-Data Coding Options for Reporting Satisfactorily:</u> DVT Prophylaxis Received

CPT II 4070F: Deep Vein Thrombosis (DVT) prophylaxis received by end of hospital day 2

DVT Prophylaxis not Received for Medical or Patient Reasons

Append a modifier (**1P or 2P**) to CPT Category II code **4070F** to report documented circumstances that appropriately exclude patients from the denominator.

4070F *with* **1P:** Documentation of medical reason(s) for not receiving DVT Prophylaxis by end of hospital day 2, including physician documentation that patient is ambulatory

4070F *with* **2P:** Documentation of patient reason(s) for not receiving DVT Prophylaxis by end of hospital day 2

DVT Prophylaxis not Received, Reason not Specified

Append a reporting modifier (8P) to CPT Category II code 4070F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

4070F *with* **8P:** Deep Vein Thrombosis (DVT) prophylaxis was <u>not</u> 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 Criteria (Eligible Cases):

Patients aged \geq 18 years on date of encounter **AND**

Diagnosis for ischemic stroke or intracranial hemorrhage (line-item ICD-9-CM): 431, 433.01, 433.11, 433.21, 433.31, 433.81, 433.91, 434.01, 434.11, 434.91 AND

Patient encounter during the reporting period (CPT): 99221, 99222, 99223, 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, it is recommended prophylactic low-dose subcutaneous heparin or low-molecular-weight heparins or heparinoid. (Grade 1A) In patients with an acute ICH, it is recommended the initial use of intermittent pneumatic compression for the prevention of DVT and PE. (Grade 1C+) In stable patients, we suggest low-dose subcutaneous heparin may be initiated as soon as the second day after the onset of the hemorrhage. (Grade 2C) (Albers, ACCP, 2004)

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

2009 PQRI REPORTING OPTIONS: CLAIMS-BASED, REGISTRY

DESCRIPTION:

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

INSTRUCTIONS:

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

Measure Reporting via Claims:

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

When reporting the measure via claims, submit the listed ICD-9-CM diagnosis codes, CPT codes, and the appropriate CPT Category II code <u>**OR**</u> the CPT Category II code <u>**with**</u> the modifier. The modifiers allowed for this measure are: 1P- medical reasons, 2P- patient reasons, 8P- reason not otherwise specified. All measure-specific coding should be reported ON THE SAME CLAIM.

NUMERATOR:

Patients who were prescribed antiplatelet therapy at discharge

Definitions:

Antiplatelet Therapy – Aspirin, combination of aspirin and extended-release dipyridamole, clopidogrel, ticlopidine

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

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

<u>OR</u>

Antiplatelet Therapy Prescription <u>not</u> Prescribed for Medical or Patient Reasons Append a modifier (**1P or 2P**) to CPT Category II code **4073F** to report documented circumstances that appropriately exclude patients from the denominator.

4073F *with* **1P:** Documentation of medical reason(s) for not prescribing oral antiplatelet therapy at discharge

4073F *with* **2P**: Documentation of patient reason(s) for not prescribing oral antiplatelet therapy at discharge

Antiplatelet Therapy Prescription not Prescribed, Reason not Specified

Append a reporting modifier (8P) to CPT Category II code 4073F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

4073F *with* **8P:** Oral antiplatelet therapy was <u>not</u> 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 Criteria (Eligible Cases):

Patients aged \geq 18 years on date of encounter

<u>and</u>

Diagnosis for ischemic stroke or transient ischemic attack (TIA)

(line-item ICD-9-CM): 433.01, 433.11, 433.21, 433.31, 433.81, 433.91, 434.01, 434.11, 434.91, 435.0, 435.1, 435.2, 435.3, 435.8, 435.9

<u>and</u>

Patient encounter during the reporting period (CPT): 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:

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

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

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

Version 3.0

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

2009 PQRI REPORTING OPTIONS: REGISTRY ONLY

DESCRIPTION:

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

INSTRUCTIONS:

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

Measure Reporting via Registry Only:

ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure. Do not report this measure via claims.

NUMERATOR:

Patients who were prescribed an anticoagulant at discharge

Definitions:

Persistent Atrial Fibrillation – Recurrent atrial fibrillation, not self-terminating or terminated electrically or pharmacologically

Paroxysmal Atrial Fibrillation – Recurrent atrial fibrillation, self-terminating **Permanent Atrial Fibrillation** – Long-standing atrial fibrillation (> 1 year), cardioversion failed or not attempted

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

Numerator Options:

Anticoagulant therapy prescribed at discharge

Anticoagulant therapy \underline{not} prescribed at discharge for medical reason **OR**

Anticoagulant therapy not prescribed at discharge for patient reason

Anticoagulant therapy not prescribed at discharge, reason not 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 Criteria (Eligible Cases):

Patients aged \geq 18 years on date of encounter <u>AND</u> Diagnosis for ischemic stroke or transient ischemic attack (TIA) (line-item ICD-9-CM): 433.01, 433.11, 433.21, 433.31, 433.81, 433.91, 434.01, 434.11, 434.91, 435.0, 435.1, 435.2, 435.3, 435.8, 435.9 <u>AND</u> Diagnosis for atrial fibrillation (line-item ICD-9-CM): 427.31 <u>AND</u> Patient encounter during the reporting period (CPT): 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)

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

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

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

2009 PQRI REPORTING OPTIONS: CLAIMS-BASED, REGISTRY

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 <u>during each hospital stay</u> for <u>all</u> 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.

Measure Reporting via Claims:

Line-item ICD 9 diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. CPT Category II codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed ICD-9-CM diagnosis codes, CPT codes, and the appropriate CPT Category II code(s) **OR** the CPT Category II code(s) **with** the modifier. The reporting modifier allowed for this measure is: 8P- reason not otherwise specified. All measure-specific coding should be reported ON THE SAME CLAIM.

NUMERATOR:

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

Definition:

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

<u>Numerator Quality-Data Coding Options for Reporting Satisfactorily:</u> t-PA Administration or Consideration Documented

(Two CPT II codes [4077F & 1065F] are required on the claim form to submit this numerator option)

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

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

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 numerator option)

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 <u>not</u> considered, reason not otherwise specified

<u>AND</u>

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 Criteria (Eligible Cases):

Patients aged ≥ 18 years on date of encounter <u>AND</u> Diagnosis for ischemic stroke (line-item ICD-9-CM): 433.01, 433.11, 433.21, 433.31, 433.81, 433.91, 434.01, 434.11, 434.91

<u>AND</u>

Patient encounter during the reporting period (CPT): 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:

It is recommended 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. It is

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

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

^{*}Measure #35: Stroke and Stroke Rehabilitation: Screening for Dysphagia

2009 PQRI REPORTING OPTIONS: CLAIMS-BASED, REGISTRY

DESCRIPTION:

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

INSTRUCTIONS:

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

Measure Reporting via Claims:

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

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

NUMERATOR:

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

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

Definition:

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

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

<u>Numerator Quality-Data Coding Options for Reporting Satisfactorily:</u> Dysphagia Screening Conducted

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

CPT II 6010F: Dysphagia screening conducted prior to order for or receipt of any foods, fluids or medication by mouth

<u>AND</u>

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

Dysphagia Screening not Conducted for Medical Reasons

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

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

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

<u>AND</u>

CPT II 6015F: Patient receiving or eligible to receive foods, 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 numerator option) CPT II 6020F: NPO (nothing by mouth) ordered

Dysphagia Screening not Conducted, Reason not Specified

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

Append a reporting modifier (8P) to CPT Category II code 6010F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

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

<u>AND</u>

CPT II 6015F: Patient receiving or eligible to receive foods, 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 Criteria (Eligible Cases):

Patients aged \geq 18 years on date of encounter <u>AND</u> Diagnosis for ischemic stroke or intracranial hemorrhage (line-item ICD-9-CM): 431, 433.01, 433.11, 433.21, 433.31, 433.81, 433.91, 434.01, 434.11, 434.91 <u>AND</u> **Patient encounter during the reporting period (CPT):** 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

2009 PQRI REPORTING OPTIONS: CLAIMS-BASED, REGISTRY

DESCRIPTION:

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

INSTRUCTIONS:

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

Measure Reporting via Claims:

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

When reporting the measure via claims, submit the listed ICD-9-CM diagnosis codes, CPT codes, and the appropriate CPT Category II code <u>**OR**</u> the CPT Category II code <u>**with**</u> the modifier. The reporting modifier allowed for this measure is: 8P- reason not otherwise specified. There are no allowable performance exclusions for this measure. All measure-specific coding should be reported ON THE SAME CLAIM.

NUMERATOR:

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

Definition:

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

<u>Numerator Quality-Data Coding Options for Reporting Satisfactorily:</u> Rehabilitation Services Ordered or Considered

CPT II 4079F: Documentation that rehabilitation services were considered

Rehabilitation Services not Ordered or Considered, Reason not Specified

Append a reporting modifier (8P) to CPT Category II code 4079F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

4079F *with* **8P:** Rehabilitation services were <u>not</u> considered, reason not otherwise specified

DENOMINATOR:

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

Denominator Criteria (Eligible Cases):

Patients aged \geq 18 years on date of encounter <u>AND</u> Diagnosis for ischemic stroke or intracranial hemorrhage (line-item ICD-9-CM): 431, 433.01, 433.11, 433.21, 433.31, 433.81, 433.91, 434.01, 434.11, 434.91 <u>AND</u> Patient encounter during the reporting period (CPT): 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

2009 PQRI REPORTING OPTIONS: CLAIMS-BASED, REGISTRY, MEASURES GROUP

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

Measure Reporting via Claims:

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

When reporting the measure via claims, submit the listed CPT codes, and the appropriate numerator G-code. All measure-specific coding should be reported ON THE SAME CLAIM.

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.

<u>Numerator Quality-Data Coding Options for Reporting Satisfactorily:</u> 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

Central DXA Measurement <u>not</u> 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

Central DXA Measurement <u>not</u> 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 Criteria (Eligible Cases):

Patients aged \geq 65 years on date of encounter <u>AND</u> Patient encounter during the reporting period (CPT): 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

2009 PQRI REPORTING OPTIONS: CLAIMS-BASED, REGISTRY

DESCRIPTION:

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

INSTRUCTIONS:

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

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

Measure Reporting via Claims:

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

When reporting the measure via claims, submit the listed ICD-9-CM diagnosis codes, CPT codes, and the appropriate CPT Category II code <u>**OR**</u> the CPT Category II code <u>**with**</u> the modifier. The modifiers allowed for this measure are: 1P- medical reasons, 2P- patient reasons, 3P- system reasons, 8P- reason not otherwise specified. All measure-specific coding should be reported ON THE SAME CLAIM.

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 Quality-Data Coding Options for Reporting Satisfactorily:

Central DXA Measurement Ordered or Results Documented or Pharmacologic Therapy Prescribed

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

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

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

Central DXA Measurement <u>not</u> Ordered or Results <u>not</u> Documented or Pharmacologic Therapy <u>not</u> Prescribed for Medical, Patient, or System Reasons Append a modifier (1P, 2P or 3P) to CPT Category II codes 3096F <u>or</u> 3095F <u>or</u> 4005F to report documented circumstances that appropriately exclude patients from the denominator.

3096F <u>or</u> **3095F** <u>or</u> **4005F** *with* **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

- **3096F** <u>or</u> **3095F** <u>or</u> **4005F** *with* **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 **3096F** <u>or</u> **3095F** <u>or</u> **4005F** *with* **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

Central DXA Measurement <u>not</u> Ordered or Results <u>not</u> Documented or Pharmacologic Therapy <u>not</u> 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.

3096F <u>or</u> 3095F <u>or</u> 4005F *with* 8P: Central dual energy X-ray absorptiometry (DXA) measurement was <u>not</u> ordered or performed or pharmacologic therapy for osteoporosis was <u>not</u> prescribed, reason not otherwise specified

DENOMINATOR:

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

Denominator Criteria (Eligible Cases):

Patients aged \geq 50 years on date of encounter **AND**

Diagnosis for hip, spine, or distal radial fracture (line-item ICD-9-CM): 733.12, 733.13, 733.14, 805.00, 805.01, 805.02, 805.03, 805.04, 805.05, 805.06, 805.07, 805.08, 805.2, 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, 820.20, 820.21, 820.22, 820.8

<u>and</u>

Patient encounter during the reporting period (CPT) - Service codes: 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245

OR

Patient encounter during the reporting period (CPT) - Procedure codes: 22305, 22310, 22315, 22318, 22319, 22325, 22326, 22327, 22520, 22521, 22523, 22524, 25600, 25605, 25606, 25607, 25608, 25609, 27230, 27232, 27235, 27236, 27238, 27240, 27244, 27245, 27246, 27248

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

2009 PQRI REPORTING OPTIONS: CLAIMS-BASED, REGISTRY

DESCRIPTION:

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

INSTRUCTIONS:

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

Measure Reporting via Claims:

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

When reporting the measure via claims, submit the listed ICD-9-CM diagnosis codes, CPT codes, and the appropriate CPT Category II code <u>**OR**</u> the CPT Category II code <u>**with**</u> the modifier. The modifiers allowed for this measure are: 1P- medical reasons, 2P- patient reasons, 3P- system reasons, 8P- reason not otherwise specified. All measure-specific coding should be reported ON THE SAME CLAIM.

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.

<u>Numerator Quality-Data Coding Options for Reporting Satisfactorily:</u> Pharmacologic Therapy Prescribed

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

<u> 0R</u>

Pharmacologic Therapy <u>not</u> Prescribed for Medical, Patient, or System Reasons Append a modifier (1P, 2P or 3P) to CPT Category II code 4005F to report documented circumstances that appropriately exclude patients from the denominator.

- **4005F** *with* **1P:** Documentation of medical reason(s) for not prescribing pharmacologic therapy for osteoporosis
- **4005F** *with* **2P**: Documentation of patient reason(s) for not prescribing pharmacologic therapy for osteoporosis
- **4005F** *with* **3P:** Documentation of system reason for not prescribing pharmacologic therapy for osteoporosis

Pharmacologic Therapy not Prescribed, Reason not Specified

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

4005F *with* **8P:** Pharmacologic therapy for osteoporosis was <u>not</u> prescribed, reason not otherwise specified

DENOMINATOR:

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

Denominator Criteria (Eligible Cases):

Patients aged ≥ 50 years on date of encounter <u>AND</u> Diagnosis for osteoporosis (line-item ICD-9-CM): 733.00, 733.01, 733.02, 733.03, 733.09 <u>AND</u> Patient encounter during the reporting period (CPT): 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)

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

2009 PQRI REPORTING OPTIONS: CLAIMS-BASED, REGISTRY, MEASURES GROUP

DESCRIPTION:

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

INSTRUCTIONS:

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

Measure Reporting via Claims:

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

When reporting the measure via claims, submit the listed CPT codes, and the appropriate CPT Category II code <u>**OR**</u> the CPT Category II code <u>**with**</u> the modifier. The modifiers allowed for this measure are: 1P- medical reasons, 8P- reason not otherwise specified. All measure-specific coding should be reported ON THE SAME CLAIM.

NUMERATOR:

Patients who received an IMA graft in isolated CABG

<u>Numerator Quality-Data Coding Options for Reporting Satisfactorily:</u> IMA Graft Performed

CPT II 4110F: Internal mammary artery graft performed for primary, isolated coronary artery bypass graft procedure

IMA Graft not Performed for Medical Reasons

Append a modifier (**1P**) to the CPT Category II code **4110F** to report documented circumstances that appropriately exclude patients from the denominator.

4110F *with* **1P**: Documentation of medical reason(s) for not performing an internal mammary artery graft for primary, isolated coronary artery bypass graft procedure

IMA Graft not Performed, Reason not Specified

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

4110F *with* **8P:** Internal mammary artery graft <u>not</u> performed for primary, isolated coronary artery bypass graft procedure, reason not otherwise specified

DENOMINATOR:

All patients undergoing isolated CABG

Denominator Criteria (Eligible Cases):

Patients aged \geq 18 years on date of encounter **AND**

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

RATIONALE:

A major innovation has been the introduction of off-bypass CABG, which has reduced the postprocedure 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 offbypass 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)

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

2009 PQRI REPORTING OPTIONS: CLAIMS-BASED, REGISTRY, MEASURES GROUP

DESCRIPTION:

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

INSTRUCTIONS:

This measure is to be reported <u>each time</u> an isolated CABG procedure is performed during the reporting period. It is anticipated that <u>clinicians who provide services for isolated CABG</u> 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.

Measure Reporting via Claims:

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

When reporting the measure via claims, submit the listed CPT codes, and the appropriate CPT Category II code <u>**OR**</u> the CPT Category II code <u>**with**</u> the modifier. The modifiers allowed for this measure are: 1P- medical reasons, 8P- reason not otherwise specified. All measure-specific coding should be reported ON THE SAME CLAIM.

NUMERATOR:

Patients undergoing isolated CABG who received a beta-blocker within 24 hours prior to surgical incision

<u>Numerator Quality-Data Coding Options for Reporting Satisfactorily:</u> **Preoperative Beta-blocker Received CPT II 4115F:** Beta blocker administered within 24 hours prior to surgical incision

<u> 0R</u>

Preoperative Beta-blocker not Received for Medical Reasons

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

4115F *with* **1P:** Documentation of medical reason(s) for not administering beta blocker within 24 hours prior to surgical incision
Preoperative Beta-blocker not Received, Reason not Specified

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

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

DENOMINATOR:

All patients undergoing isolated CABG

Denominator Criteria (Eligible Cases):

Patients aged \geq 18 years on date of encounter **AND**

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

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

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)

2009 PQRI REPORTING OPTIONS: CLAIMS-BASED, REGISTRY

DESCRIPTION:

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

INSTRUCTIONS:

This measure is to be reported <u>each time</u> 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 <u>clinicians who perform the listed</u> <u>surgical procedures</u> as specified in the denominator coding will submit this measure.

Measure Reporting via Claims:

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

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

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 for "one time" IV dose orders) OR documentation that prophylactic antibiotic was discontinued within 48 hours of surgical end time.

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

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

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

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

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

Note: *CPT* Category II codes **4043F** may be provided for documentation that antibiotic discontinuation within 48 hours was <u>ordered</u> or that antibiotic discontinuation was accomplished.

<u>and</u>

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

Prophylactic Antibiotics not Discontinued for Medical Reasons

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

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

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

<u>and</u>

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

OR

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

Prophylactic Antibiotics not Discontinued, Reason not Specified

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

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

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

<u>AND</u>

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 Criteria (Eligible Cases):

Patients aged \geq 18 years on date of encounter

<u>and</u>

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

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

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: Reconciliation After Discharge from an Inpatient Facility

2009 PQRI REPORTING OPTIONS: REGISTRY ONLY

DESCRIPTION:

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

INSTRUCTIONS:

This measure is to be reported at an outpatient visit occurring within 60 days of <u>each inpatient</u> <u>facility discharge date</u> during the reporting period. This measure is appropriate for use in the ambulatory setting only. There is no diagnosis associated with this measure. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding. This measure is not to be reported unless a patient has been discharged from an inpatient facility within 60 days prior to the outpatient visit.

Measure Reporting via Registry Only:

CPT codes and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure. Do not report this measure via claims.

NUMERATOR:

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

Definition:

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

Numerator Options:

Discharge medications reconciled with the current medication list in outpatient medical record

<u>AND</u>

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

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

Discharge medications not reconciled with the current medication list in outpatient medical record, reason not specified

<u>and</u>

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 Criteria (Eligible Cases):

Patients aged \geq 65 years on date of encounter **AND**

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

RATIONALE:

Medications are often changed while a patient is hospitalized. Continuity between inpatient and ongoing 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

2009 PQRI REPORTING OPTIONS: CLAIMS-BASED, REGISTRY

DESCRIPTION:

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

INSTRUCTIONS:

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

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

Measure Reporting via Claims:

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

When reporting the measure via claims, submit the listed CPT codes, and the appropriate CPT Category II codes <u>**OR**</u> the CPT Category II code(s) <u>with</u> the modifier. The reporting modifier allowed for this measure is: 8P- reason not otherwise specified. There are no allowable performance exclusions for this measure. All measure-specific coding should be reported ON THE SAME CLAIM.

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

Definition:

Documentation that Patient did not Wish or was not able to Name a Surrogate Decision Maker or Provide an Advance Care Plan – May also include, as appropriate, the following: • That the patient's cultural and/or spiritual beliefs preclude a discussion of advance care planning, as it would be viewed as harmful to the patient's beliefs and thus harmful to the physician-patient relationship

<u>Numerator Quality-Data Coding Options for Reporting Satisfactorily:</u> 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

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

Advance Care Planning not Documented, Reason not Specified

Append a reporting modifier (8P) to CPT Category II code 1123F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

1123F with 8P: Advance care planning not documented, reason not otherwise specified

DENOMINATOR:

All patients aged 65 years and older

Denominator Criteria (Eligible Cases):

Patients aged \geq 65 years on date of encounter **AND**

Patient encounter during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99218, 99219, 99220, 99221, 99222, 99223, 99231, 99232, 99233, 99234, 99235, 99236, 99291*, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350

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

RATIONALE:

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

CLINICAL RECOMMENDATION STATEMENTS:

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

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

Instructional advance directives (DNR orders, living wills)

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

Durable power of attorney for health care or health care proxy

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

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

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

2009 PQRI REPORTING OPTIONS: CLAIMS-BASED, REGISTRY, MEASURES GROUP

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

Measure Reporting via Claims:

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

When reporting the measure via claims, submit the listed CPT codes, and the appropriate CPT Category II code <u>**OR**</u> the CPT Category II code <u>**with**</u> the modifier. The modifiers allowed for this measure are: 1P- medical reasons, 8P- reason not otherwise specified. All measure-specific coding should be reported ON THE SAME CLAIM.

NUMERATOR:

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

Definition: Urinary Incontinence – Any involuntary leakage of urine.

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

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

<u> 0R</u>

Presence or Absence of Urinary Incontinence <u>not</u> Assessed, Reason not Specified Append a reporting modifier (8P) to CPT Category II code 1090F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

1090F *with* **8P:** Presence or absence of urinary incontinence <u>not</u> assessed, reason not otherwise specified

DENOMINATOR:

All female patients aged 65 years and older

Denominator Criteria (Eligible Cases):

Patients aged \geq 65 years on date of encounter **AND**

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

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: Urinary Incontinence: Characterization of Urinary Incontinence in Women Aged 65 Years and Older

2009 PQRI REPORTING OPTIONS: CLAIMS-BASED, REGISTRY

DESCRIPTION:

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

INSTRUCTIONS:

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

Measure Reporting via Claims:

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

When reporting the measure via claims, submit the listed ICD-9-CM diagnosis codes, CPT codes, and the appropriate CPT Category II code <u>**OR**</u> the CPT Category II code <u>**with**</u> the modifier. The reporting modifier allowed for this measure is: 8P- reason not otherwise specified. There are no allowable performance exclusions for this measure. All measure-specific coding should be reported ON THE SAME CLAIM.

NUMERATOR:

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

<u>Numerator Quality-Data Coding Options for Reporting Satisfactorily:</u> 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.

1091F *with* **8P**: Urinary incontinence <u>not</u> 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 Criteria (Eligible Cases):

Patients aged ≥ 65 years on date of encounter <u>AND</u> Diagnosis for urinary incontinence (line-item ICD-9-CM): 307.6, 625.6, 788.30, 788.31, 788.33, 788.34, 788.35, 788.36, 788.37, 788.38, 788.39 <u>AND</u> Patient encounter during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 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

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: Urinary Incontinence: Plan of Care for Urinary Incontinence in Women Aged 65 Years and Older

2009 PQRI REPORTING OPTIONS: CLAIMS-BASED, REGISTRY

DESCRIPTION:

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

INSTRUCTIONS:

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

Measure Reporting via Claims:

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

When reporting the measure via claims, submit the listed ICD-9-CM diagnosis codes, CPT codes, and the appropriate CPT Category II code <u>**OR**</u> the CPT Category II code <u>**with**</u> the modifier. The reporting modifier allowed for this measure is: 8P- reason not otherwise specified. There are no allowable performance exclusions for this measure. All measure-specific coding should be reported ON THE SAME CLAIM.

NUMERATOR:

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

Definition:

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

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

Plan of Care for Urinary Incontinence <u>not</u> Documented, Reason not Specified Append a reporting modifier (8P) to CPT Category II code 0509F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

0509F *with* **8P:** Urinary incontinence plan of care <u>not</u> documented, reason not otherwise specified

DENOMINATOR:

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

Denominator Criteria (Eligible Cases):

Patients aged \geq 65 years on date of encounter

AND

Diagnosis for urinary incontinence (line-item ICD-9-CM): 307.6, 625.6, 788.30, 788.31, 788.33, 788.34, 788.35, 788.36, 788.37, 788.38, 788.39

<u>and</u>

Patient encounter during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 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

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)

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

2009 PQRI REPORTING OPTIONS: CLAIMS-BASED, REGISTRY

DESCRIPTION:

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

INSTRUCTIONS:

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

Measure Reporting via Claims:

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

When reporting the measure via claims, submit the listed ICD-9-CM diagnosis code, CPT codes, and the appropriate CPT Category II code <u>**OR**</u> the CPT Category II code <u>**with**</u> the modifier. The modifiers allowed for this measure are: 1P- medical reasons, 2P- patient reasons, 3P- system reasons, 8P- reason not otherwise specified. All measure-specific coding should be reported ON THE SAME CLAIM.

NUMERATOR:

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

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

<u>Numerator Quality-Data Coding Options for Reporting Satisfactorily:</u> Spirometry Results Documented

CPT II 3023F: Spirometry results documented and reviewed

Spirometry Results <u>not</u> Documented for Medical, Patient, or System Reasons Append a modifier (1P, 2P or 3P) to CPT Category II code 3023F to report documented

circumstances that appropriately exclude patients from the denominator.

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

- **3023F** *with* **2P**: Documentation of patient reason(s) for not documenting and reviewing spirometry results
- **3023F** *with* **3P:** Documentation of system reason(s) for not documenting and reviewing spirometry results

<u>OR</u>

Spirometry Results not Documented, Reason not Specified

Append a reporting modifier (8P) to CPT Category II code 3023F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

3023F *with* **8P:** Spirometry results <u>not</u> documented and reviewed, reason not otherwise specified

DENOMINATOR:

All patients aged 18 and older with a diagnosis of COPD

Denominator Criteria (Eligible Cases):

Patients aged ≥ 18 years on date of encounter <u>AND</u> **Diagnosis for COPD (line-item ICD-9-CM):** 491.0, 491.1, 491.20, 491.21, 491.22, 491.8, 491.9, 492.0, 492.8, 496 AND

<u>AND</u>

Patient encounter during the reporting period (CPT): 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)

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

2009 PQRI REPORTING OPTIONS: CLAIMS-BASED, REGISTRY

DESCRIPTION:

Percentage of patients aged 18 years and older with a diagnosis of COPD and who have an FEV₁/FVC less than 70% and have symptoms who were prescribed an inhaled bronchodilator

INSTRUCTIONS:

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

Measure Reporting via Claims:

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

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

NUMERATOR:

Patients who were prescribed an inhaled bronchodilator

Definition:

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

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

<u>Numerator Quality-Data Coding Options for Reporting Satisfactorily:</u> Patient Prescribed Inhaled Bronchodilator Therapy

(*Two CPT II codes [4025F & 3025F] are required on the claim form to submit this numerator option*) **CPT II 4025F:** Inhaled bronchodilator prescribed

AND

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

Patient <u>not</u> Documented to have Inhaled Bronchodilator Prescribed for Medical, Patient, or System Reasons

(Two CPT II codes [4025F-xP & 3025F] are required on the claim form to submit this numerator option)

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

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

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

<u>and</u>

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

OR

If patient is not eligible for this measure because spirometry results demonstrate FEV₁/FVC \geq 70% or patient does not have COPD symptoms, report: Spirometry Results Demonstrate FEV₁/FVC \geq 70% or Patient Does <u>not</u> Have COPD Symptoms

(One CPT II code [3027F] is required on the claim form to submit this numerator option) CPT II 3027F: Spirometry test results demonstrate $FEV_1/FVC \ge 70\%$ or patient does not have COPD symptoms

Spirometry Test not Performed or Documented

(One CPT II code [3025F-8P] is required on the claim form to submit this numerator option)

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

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

Patient <u>not</u> Documented to have Inhaled Bronchodilator Prescribed, Reason not Specified

(Two CPT II codes [4025F-8P & 3025F] are required on the claim form to submit this numerator option)

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

4025F *with* **8P:** Inhaled bronchodilator <u>not</u> prescribed, reason not otherwise specified <u>AND</u>

CPT II 3025F: Spirometry test results demonstrate FEV₁/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 FEV₁/FVC <70% and have symptoms (e.g., dyspnea, cough/sputum, wheezing)

Denominator Criteria (Eligible Cases):

Patients aged \geq 18 years on date of encounter <u>AND</u> Diagnosis for COPD (line-item ICD-9-CM): 491.0, 491.1, 491.20, 491.21, 491.22, 491.8, 491.9, 492.0, 492.8, 496 <u>AND</u> Patient encounter during the reporting period (CPT): 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 FEV₁ than either alone and does not produce evidence of tachyphylaxis over 90 days of treatment. (Evidence A) (NHLBI/WHO)

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

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

A Measure #53: Asthma: Pharmacologic Therapy

2009 PQRI REPORTING OPTIONS: CLAIMS-BASED, REGISTRY

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 <u>once per reporting period</u> for <u>all</u> asthma patients seen during the reporting period. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

Measure Reporting via Claims:

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

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

NUMERATOR:

Patients who were prescribed *either* the preferred long-term control medication (inhaled corticosteroid or inhaled corticosteroid with long-acting inhaled beta₂-agonist) or an acceptable alternative treatment (leukotriene modifiers, cromolyn sodium, nedocromil sodium, or sustained-released 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 code(s) must be reported on the claim form in order to properly report this measure. The "correct combination" of codes may require the submission of multiple numerator codes.

<u>Numerator Quality-Data Coding Options for Reporting Satisfactorily:</u> Preferred Long-Term Control Medication or Acceptable Alternative Treatment Prescribed

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

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

<u>AND</u>

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

Preferred Long-Term Control Medication or Acceptable Alternative Treatment <u>not</u> Prescribed for Patient Reasons

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

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

4015F *with* **2P**: Documentation of patient reason(s) for not prescribing either the preferred long-term control medication (inhaled corticosteroid or inhaled corticosteroid with long-acting inhaled beta2-agonist) or an acceptable alternative treatment (leukotriene modifiers, cromolyn sodium, nedocromil sodium, or sustained-released methylaxanthines)

AND

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

OR

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

(One CPT II code [1039F] is required on the claim form to submit this numerator option) CPT II 1039F: Intermittent asthma

Preferred Long-Term Control Medication or Acceptable Alternative Treatment <u>not</u> Prescribed, Reason not Specified

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

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

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

<u>AND</u>

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 Criteria (Eligible Cases):

Patients aged 5 through 40 years on date of encounter AND

Diagnosis for asthma (line-item ICD-9-CM): 493.00, 493.01, 493.02, 493.10, 493.11, 493.12, 493.20, 493.21, 493.22, 493.81, 493.82, 493.90, 493.91, 493.92

<u>and</u>

Patient encounter during the reporting period (CPT): 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 Beta₂ Agonists (LABA) are recommended in combination with Inhaled Corticosteroids.

CLINICAL RECOMMENDATION STATEMENTS:

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

Step 1: Mild Intermittent Asthma

• No daily medication needed

Step 2: Mild Persistent Asthma

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

Step 3: Moderate Persistent Asthma

- Preferred treatment: Low-medium dose ICS + long-acting inhaled beta₂-agonists (LABA)
- *Alternative treatment:* Increase medium-dose ICS OR low-medium dose ICS and either leukotriene modifier or theophylline (If needed, may increase ICS within medium-dose range in either treatment)

Step 4: Severe Persistent Asthma

• *Preferred treatment:* High-dose ICS + LABA AND, if needed, corticosteroid tablets or syrup long-term

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

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

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

2009 PQRI REPORTING OPTIONS: CLAIMS-BASED, REGISTRY

DESCRIPTION:

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

INSTRUCTIONS:

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

Measure Reporting via Claims:

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

When reporting the measure via claims, submit the listed ICD-9-CM diagnosis codes, CPT codes, and the appropriate CPT Category II code <u>**OR**</u> the CPT Category II code <u>**with**</u> the modifier. The modifiers allowed for this measure are: 1P- medical reasons, 2P- patient reasons, 8P- reason not otherwise specified. All measure-specific coding should be reported ON THE SAME CLAIM.

NUMERATOR:

Patients who had a 12-lead ECG performed

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

<u> 0R</u>

12-Lead ECG not Performed for Medical or Patient Reasons

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

<u> 0R</u>

12-Lead ECG not Performed, Reason not Specified

Append a reporting modifier (8P) to CPT Category II code 3120F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

3120F with 8P: 12-Lead ECG not performed, reason not otherwise specified

DENOMINATOR:

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

Denominator Criteria (Eligible Cases):

Patients aged \geq 40 years on date of encounter <u>AND</u> Diagnosis for non-traumatic chost pain (line-

Diagnosis for non-traumatic chest pain (line-item ICD-9-CM): 413.0, 413.1, 413.9, 786.50, 786.51, 786.52, 786.59

<u>and</u>

Patient encounter during the reporting period (CPT): 99281, 99282, 99283, 99284, 99285, 99291

<u>and</u>

Place of Service Indicator: 23

(The Part B claim form place of service field must indicate emergency department)

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: 12-Lead Electrocardiogram (ECG) Performed for Syncope

2009 PQRI REPORTING OPTIONS: CLAIMS-BASED, REGISTRY

DESCRIPTION:

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

INSTRUCTIONS:

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

Measure Reporting via Claims:

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

When reporting the measure via claims, submit the listed ICD-9-CM diagnosis codes, CPT codes, and the appropriate CPT Category II code <u>**OR**</u> the CPT Category II code <u>**with**</u> the modifier. The modifiers allowed for this measure are: 1P- medical reasons, 2P- patient reasons, 8P- reason not otherwise specified. All measure-specific coding should be reported ON THE SAME CLAIM.

NUMERATOR:

Patients who had a 12-lead ECG performed

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

12-Lead ECG not Performed for Medical or Patient Reasons

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

12-Lead ECG not Performed, Reason not Specified

Append a reporting modifier (8P) to CPT Category II code 3120F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

3120F with 8P: 12-Lead ECG not performed, reason not otherwise specified

DENOMINATOR:

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

Denominator Criteria (Eligible Cases):

Patients aged ≥ 60 years on date of encounter <u>AND</u> Diagnosis for syncope (line-item ICD-9-CM): 780.2 <u>AND</u> Patient encounter during the reporting period (CPT): 99281, 99282, 99283, 99284, 99285, 99291 <u>AND</u> Place of Service Indicator: 23

(The Part B claim form place of service field must indicate emergency department)

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: Community-Acquired Pneumonia (CAP): Vital Signs

2009 PQRI REPORTING OPTIONS: CLAIMS-BASED, REGISTRY

DESCRIPTION:

Percentage of patients aged 18 years and older with a diagnosis of community-acquired bacterial pneumonia with vital signs documented and reviewed

INSTRUCTIONS:

This measure is to be reported once for <u>each occurrence</u> 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 <u>clinicians who provide care in the emergency</u> <u>department or office setting</u> will submit this measure. Clinicians utilizing the critical care code must indicate the emergency department place of service code in order to be counted in the measure's denominator.

Measure Reporting via Claims:

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

When reporting the measure via claims, submit the listed ICD-9-CM diagnosis codes, CPT codes, and the appropriate CPT Category II code <u>**OR**</u> the CPT Category II code <u>**with**</u> the modifier. The reporting modifier allowed for this measure is: 8P- reason not otherwise specified. There are no allowable performance exclusions for this measure. All measure-specific coding should be reported ON THE SAME CLAIM.

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

<u>Numerator Quality-Data Coding Options for Reporting Satisfactorily:</u> Vital Signs Documented and Reviewed

CPT II 2010F: Vital signs (temperature, pulse, respiratory rate, and blood pressure) documented and reviewed

Vital Signs not Documented and Reviewed, Reason not Specified

Append a reporting modifier (8P) to CPT Category II code 2010F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

2010F *with* **8P:** Vital signs (temperature, pulse, respiratory rate, and blood pressure) <u>not</u> documented and reviewed, reason not otherwise specified

DENOMINATOR:

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

Denominator Criteria (Eligible Cases):

Patients aged \geq 18 years on date of encounter **AND**

Diagnosis for community-acquired bacterial pneumonia (line-item ICD-9-CM): 481, 482.0, 482.1, 482.2, 482.30, 482.31, 482.32, 482.39, 482.40, 482.41, 482.42, 482.49, 482.81, 482.82, 482.83, 482.84, 482.89, 482.9, 483.0, 483.1, 483.8, 485, 486, 487.0 **AND**

Patient encounter during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99281, 99282, 99283, 99284, 99285, 99291*, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350

* Clinicians utilizing the critical care code (99291) must indicate the emergency department place of service (23) on the Part B claim form in order to report this measure.

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: Community-Acquired Pneumonia (CAP): Assessment of Oxygen Saturation

2009 PQRI REPORTING OPTIONS: CLAIMS-BASED, REGISTRY

DESCRIPTION:

Percentage of patients aged 18 years and older with a diagnosis of community-acquired bacterial pneumonia with oxygen saturation documented and reviewed

INSTRUCTIONS:

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

Measure Reporting via Claims:

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

When reporting the measure via claims, submit the listed ICD-9-CM diagnosis codes, CPT codes, and the appropriate CPT Category II code <u>**OR**</u> the CPT Category II code <u>**with**</u> the modifier. The modifiers allowed for this measure are: 1P- medical reasons, 2P- patient reasons, 3P- system reasons, 8P- reason not otherwise specified. Clinicians utilizing the critical care code must indicate the emergency department place of service code in order to be counted in the measure's denominator. All measure-specific coding should be reported ON THE SAME CLAIM.

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 Quality-Data Coding Options for Reporting Satisfactorily:

Oxygen Saturation Documented and Reviewed

CPT II 3028F: Oxygen saturation results documented and reviewed (includes assessment through pulse oximetry or arterial blood gas measurement)

Oxygen Saturation <u>not</u> Documented and Reviewed for Medical, Patient, or System Reasons

Append a modifier (**1P**, **2P** or **3P**) to CPT Category II code **3028F** to report documented circumstances that appropriately exclude patients from the denominator.

3028F *with* **1P:** Documentation of medical reason(s) for not documenting and reviewing oxygen saturation

- **3028F** *with* **2P:** Documentation of patient reason(s) for not documenting and reviewing oxygen saturation
- **3028F** *with* **3P:** Documentation of system reason(s) for not documenting and reviewing oxygen saturation

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Oxygen Saturation not Documented and Reviewed, Reason not Specified

Append a reporting modifier (8P) to CPT Category II code 3028F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

3028F *with* **8P:** Oxygen saturation results <u>not</u> documented and reviewed, reason not otherwise specified

DENOMINATOR:

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

Denominator Criteria (Eligible Cases):

Patients aged \geq 18 years on date of encounter **AND**

Diagnosis for community-acquired bacterial pneumonia (line-item ICD-9-CM): 481, 482.0, 482.1, 482.2, 482.30, 482.31, 482.32, 482.39, 482.40, 482.41, 482.42, 482.49, 482.81, 482.82, 482.83, 482.84, 482.89, 482.9, 483.0, 483.1, 483.8, 485, 486, 487.0 **AND**

Patient encounter during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99281, 99282, 99283, 99284, 99285, 99291*, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350

* Clinicians utilizing the critical care code (99291) must indicate the emergency department place of service (23) on the Part B claim form in order to report this measure.

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: Community-Acquired Pneumonia (CAP): Assessment of Mental Status

2009 PQRI REPORTING OPTIONS: CLAIMS-BASED, REGISTRY

DESCRIPTION:

Percentage of patients aged 18 years and older with a diagnosis of community-acquired bacterial pneumonia with mental status assessed

INSTRUCTIONS:

This measure is to be reported once for <u>each occurrence</u> 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 <u>clinicians who provide care in the emergency department or office setting</u> will submit this measure. Clinicians utilizing the critical care code must indicate the emergency department place of service code in order to be counted in the measure's denominator.

Measure Reporting via Claims:

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

When reporting the measure via claims, submit the listed ICD-9-CM diagnosis codes, CPT codes, and the appropriate CPT Category II code <u>**OR**</u> the CPT Category II code <u>**with**</u> the modifier. The reporting modifier allowed for this measure is: 8P- reason not otherwise specified. There are no allowable performance exclusions for this measure. All measure-specific coding should be reported ON THE SAME CLAIM.

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 Quality-Data Coding Options for Reporting Satisfactorily:

Mental Status Assessed

CPT II 2014F: Mental status assessed

Mental Status not Assessed, Reason not Specified

Append a reporting modifier (8P) to CPT Category II code 2014F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

2014F with 8P: Mental status not assessed, reason not otherwise specified

DENOMINATOR:

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

Denominator Criteria (Eligible Cases):

Patients aged \geq 18 years on date of encounter **AND**

Diagnosis for community-acquired bacterial pneumonia (line-item ICD-9-CM): 481, 482.0, 482.1, 482.2, 482.30, 482.31, 482.32, 482.39, 482.40, 482.41, 482.42, 482.49, 482.81, 482.82, 482.83, 482.84, 482.89, 482.9, 483.0, 483.1, 483.8, 485, 486, 487.0 **AND**

Patient encounter during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99281, 99282, 99283, 99284, 99285, 99291*, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350

* Clinicians utilizing the critical care code (99291) must indicate the emergency department place of service (23) on the Part B claim form in order to report this measure.

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: Community-Acquired Pneumonia (CAP): Empiric Antibiotic

2009 PQRI REPORTING OPTIONS: CLAIMS-BASED, REGISTRY

DESCRIPTION:

Percentage of patients aged 18 years and older with a diagnosis of community-acquired bacterial pneumonia with an appropriate empiric antibiotic prescribed

INSTRUCTIONS:

This measure is to be reported once for <u>each occurrence</u> 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 <u>clinicians who provide care in the emergency</u> <u>department or office setting</u> will submit this measure. Clinicians utilizing the critical care code must indicate the emergency department place of service code in order to be counted in the measure's denominator.

Measure Reporting via Claims:

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

When reporting the measure via claims, submit the listed ICD-9-CM diagnosis codes, CPT codes, and the appropriate CPT Category II code <u>**OR**</u> the CPT Category II code <u>**with**</u> the modifier. The modifiers allowed for this measure are: 1P- medical reasons, 2P- patient reasons, 3P- system reasons, 8P- reason not otherwise specified. All measure-specific coding should be reported ON THE SAME CLAIM.

NUMERATOR:

Patients with appropriate empiric antibiotic prescribed

Definitions:

Appropriate Empiric Antibiotic – For treatment of community-acquired bacterial pneumonia (CAP) should include any medication from one of the following four drug classes: Fluoroquinolones, Macrolides, Doxycycline, Beta Lactam with Macrolide or Doxycycline (as defined by current ATS/IDSA guidelines).

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

Numerator Quality-Data Coding Options for Reporting Satisfactorily: Appropriate Empiric Antibiotic Prescribed CPT II 4045F: Appropriate empiric antibiotic prescribed

Appropriate Empiric Antibiotic <u>not</u> Prescribed for Medical, Patient, or System Reasons

Append a modifier (**1P**, **2P or 3P**) to CPT Category II code **4045F** to report documented circumstances that appropriately exclude patients from the denominator.

4045F *with* **1P**: Documentation of medical reason(s) for not prescribing appropriate empiric antibiotic

- **4045F** *with* **2P**: Documentation of patient reason(s) for not prescribing appropriate empiric antibiotic
- **4045F** *with* **3P:** Documentation of system reason(s) for not prescribing appropriate empiric antibiotic

OR

Appropriate Empiric Antibiotic not Prescribed, Reason not Specified

Append a reporting modifier (8P) to CPT Category II code 4045F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

4045F *with* **8P:** Appropriate empiric antibiotic <u>not</u> prescribed, reason not otherwise specified

DENOMINATOR:

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

Denominator Criteria (Eligible Cases):

Patients aged \geq 18 years on date of encounter **AND**

Diagnosis for community-acquired bacterial pneumonia (line-item ICD-9-CM):

481, 482.0, 482.1, 482.2, 482.30, 482.31, 482.32, 482.39, 482.40, 482.41, 482.42, 482.49, 482.81, 482.82, 482.83, 482.84, 482.89, 482.9, 483.0, 483.1, 483.8, 485, 486, 487.0 AND

Patient encounter during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99281, 99282, 99283, 99284, 99285, 99291*, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350

* Clinicians utilizing the critical care code (99291) must indicate the emergency department place of service (23) on the Part B claim form in order to report this measure.

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)

Ameasure #64: Asthma: Asthma Assessment

2009 PQRI REPORTING OPTIONS: CLAIMS-BASED, REGISTRY

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 <u>once per reporting period</u> for patients with asthma seen during the reporting period. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

Measure Reporting via Claims:

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

When reporting the measure via claims, submit the listed ICD-9-CM diagnosis codes, CPT codes, and the appropriate CPT Category II code <u>**OR**</u> the CPT Category II code <u>**with**</u> the modifier. The reporting modifier allowed for this measure is: 8P- reason not otherwise specified. There are no allowable performance exclusions for this measure. All measure-specific coding should be reported ON THE SAME CLAIM.

NUMERATOR:

Patients who were evaluated during at least one office visit within 12 months for the frequency (numeric) of daytime and nocturnal asthma symptoms

Numerator Instructions: To be counted in calculation of this measure, symptom frequency must be numerically quantified. Measure may also be met by clinician documentation or patient completion of an asthma assessment tool/survey/questionnaire. Assessment tool may include the Quality Metric Asthma Control Test[™], National Asthma Education & Prevention Program (NAEPP) Asthma Symptoms, and Peak Flow Diary.

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Asthma Symptom Frequency Evaluated CPT II 1005F: Asthma symptoms evaluated (includes physician documentation of numeric frequency of symptoms or patient completion of an asthma assessment

tool/survey/questionnaire)

Asthma Symptom Frequency not Evaluated, Reason not Specified

Append a reporting modifier (8P) to CPT Category II code 1005F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

1005F with 8P: Asthma symptoms not evaluated, reason not otherwise specified

DENOMINATOR:

All patients aged 5 through 40 years with a diagnosis of asthma

Denominator Criteria (Eligible Cases):

Patients aged 5 through 40 years on date of encounter

<u>and</u>

Diagnosis for asthma (line-item ICD-9-CM): 493.00, 493.01, 493.02, 493.10, 493.11, 493.12, 493.20, 493.21, 493.22, 493.81, 493.82, 493.90, 493.91, 493.92

<u>and</u>

Patient encounter during the reporting period (CPT): 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: Treatment for Children with Upper Respiratory Infection (URI): Avoidance of Inappropriate Use

2009 PQRI REPORTING OPTIONS: CLAIMS-BASED, REGISTRY

DESCRIPTION:

Percentage of children aged 3 months through 18 years with a diagnosis of URI who were <u>not</u> <u>prescribed or dispensed</u> an antibiotic prescription on or within 3 days of the initial date of service

INSTRUCTIONS:

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

Measure Reporting via Claims:

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

When reporting the measure via claims, submit the listed ICD-9-CM diagnosis codes, CPT codes, and the appropriate CPT Category II code <u>**OR**</u> the CPT Category II code <u>**with**</u> the modifier. The modifier allowed for this measure is: 1P- medical reasons. All measure-specific coding should be reported ON THE SAME CLAIM.

NUMERATOR:

Patients who were <u>not</u> dispensed an antibiotic prescription on or within 3 days of the initial date of service

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

Numerator Quality-Data Coding Options for Reporting Satisfactorily: Antibiotic <u>not</u> Prescribed or Dispensed CPT II 4124F: Antibiotic neither prescribed nor dispensed

<u>OR</u>

Antibiotic Prescribed or Dispensed for Medical Reasons

Append a modifier (1P) to CPT Category II code 4120F to report documented circumstances that appropriately exclude patients from the denominator.
4120F with 1P: Documentation of medical reason(s) for prescribing or dispensing antibiotic

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 Criteria (Eligible Cases):

Patients aged 3 months through 18 years on date of encounter <u>AND</u> Diagnosis for URI (line-item ICD-9-CM): 460, 465.0, 465.8, 465.9 <u>AND</u> Patient encounter during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 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

2009 PQRI REPORTING OPTIONS: CLAIMS-BASED, REGISTRY

DESCRIPTION:

Percentage of children aged 2 through 18 years with a diagnosis of pharyngitis, who were prescribed an antibiotic and who received a group A streptococcus (strep) test for the episode

INSTRUCTIONS:

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

Measure Reporting via Claims:

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

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

NUMERATOR:

Patients who were dispensed an antibiotic and who received a group A streptococcus (strep) test for the episode

Definition:

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

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

Numerator Quality-Data Coding Options for Reporting Satisfactorily: Group A Streptococcus Test Performed and Antibiotic Prescribed (Two CPT II codes [3210F & 4120F] are required on the claim form to submit this numerator option) **CPT II 3210F:** Group A Strep Test Performed <u>AND</u> **CPT II 4120F:** Antibiotic prescribed or dispensed

<u> 0R</u>

Group A Streptococcus Test not Performed for Medical Reasons

(Two CPT II codes [3210F-1P & 4120F] are required on the claim form to submit this numerator option)

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

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

<u>and</u>

CPT II 4120F: Antibiotic prescribed or dispensed

OR

If patient is not eligible for this measure because patient was not prescribed antibiotics, report:

(One CPT II code [4124F] is required on the claim form to submit this numerator option) CPT II 4124F: Antibiotic neither prescribed nor dispensed

Group A Streptococcus Test not Performed, Reason not Specified

(Two CPT II codes [3210F-8P & 4120F] are required on the claim form to submit this numerator option)

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

3210F *with* **8P:** Group A Strep Test <u>not</u> Performed, reason not otherwise specified <u>AND</u>

CPT II 4120F: Antibiotic prescribed or dispensed

DENOMINATOR:

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

Denominator Criteria (Eligible Cases):

Patients aged 2 through 18 years on date of encounter **AND**

Diagnosis for pharyngitis (line-item ICD-9-CM): 034.0, 462, 463

<u>and</u>

Patient encounter during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 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

2009 PQRI REPORTING OPTIONS: CLAIMS-BASED, REGISTRY

DESCRIPTION:

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

INSTRUCTIONS:

This measure is to be reported a minimum of <u>once per reporting period</u> for patients seen during the reporting period, regardless of when the baseline testing is performed. It is anticipated that clinicians who provide services for patients with the diagnosis of myelodysplastic syndromes or an acute leukemia (not in remission) will submit this measure.

Measure Reporting via Claims:

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

When reporting the measure via claims, submit the listed ICD-9-CM diagnosis codes, CPT codes, and the appropriate CPT Category II code <u>**OR**</u> the CPT Category II code <u>**with**</u> the modifier. The modifiers allowed for this measure are: 1P- medical reasons, 2P- patient reasons, 3P- system reasons, 8P- reason not otherwise specified. All measure-specific coding should be reported ON THE SAME CLAIM.

NUMERATOR:

Patients who had baseline cytogenetic testing performed on bone marrow

Definition:

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

<u>Numerator Quality-Data Coding Options for Reporting Satisfactorily:</u> Baseline Cytogenetic Testing Performed

CPT II 3155F: Cytogenetic testing performed on bone marrow at time of diagnosis or prior to initiating treatment

<u> 0R</u>

Baseline Cytogenetic Testing <u>not</u> Performed for Medical, Patient, or System Reasons

Append a modifier (**1P**, **2P or 3P**) to CPT Category II code **3155F** to report documented circumstances that appropriately exclude patients from the denominator.

- **3155F** *with* **1P:** Documentation of medical reason(s) for not performing baseline cytogenetic testing on bone marrow (e.g., no liquid bone marrow or fibrotic marrow)
- **3155F** *with* **2P:** Documentation of patient reason(s) for not performing baseline cytogenetic testing on bone marrow (e.g., at time of diagnosis receiving palliative care or not receiving treatment as defined above)
- **3155F** *with* **3P:** Documentation of system reason(s) for not performing baseline cytogenetic testing on bone marrow (e.g., patient previously treated by another physician at the time cytogenetic testing performed)

Baseline Cytogenetic Testing not Performed, Reason not Specified

Append a reporting modifier (8P) to CPT Category II code 3155F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

3155F *with* **8P:** Cytogenetic testing <u>not</u> 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 Criteria (Eligible Cases):

Patients aged \geq 18 years on date of encounter

<u>AND</u>

Diagnosis for MDS or acute leukemia – not in remission (line-item ICD-9-CM):

204.00, 204.02, 205.00, 205.02, 206.00, 206.02, 207.00, 207.02, 207.20, 207.22, 208.00, 208.02, 238.72, 238.73, 238.74, 238.75

<u>AND</u>

Patient encounter during the reporting period (CPT): 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

2009 PQRI REPORTING OPTIONS: CLAIMS-BASED, REGISTRY

DESCRIPTION:

Percentage of patients aged 18 years and older with a diagnosis of MDS who are receiving erythropoietin therapy with documentation of iron stores prior to initiating erythropoietin therapy

INSTRUCTIONS:

This measure is to be reported a minimum of <u>once per reporting period</u> for <u>all</u> MDS patients seen during the reporting period, regardless of when the documentation of iron stores occurs. It is anticipated that clinicians who provide services for patients with the diagnosis of myelodysplastic syndromes will submit this measure.

Measure Reporting via Claims:

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

When reporting the measure via claims, submit the listed ICD-9-CM diagnosis codes, CPT codes, and the appropriate CPT Category II code(s) <u>**OR**</u> the CPT Category II code(s) <u>**with**</u> the modifier. The modifiers allowed for this measure are: 3P- system reasons, 8P- reason not otherwise specified. All measure-specific coding should be reported ON THE SAME CLAIM.

NUMERATOR:

Patients with documentation of iron stores prior to initiating erythropoietin therapy

Definitions:

Documentation of Iron Stores – Includes either: bone marrow examination including iron stain OR serum iron measurement by ferritin or serum iron and TIBC **Erythropoietin Therapy** – Includes the following medications: epoetin and darbepoetin for the purpose of this measure

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

<u>Numerator Quality-Data Coding Options for Reporting Satisfactorily:</u> Documentation of Iron Stores Prior to Initiating Erythropoietin Therapy Performed (*Two CPT II codes [3160F & 4090F] are required on the claim form to submit this numerator option*) **CPT II 3160F:** Documentation of iron stores prior to initiating erythropoietin therapy <u>AND</u>

CPT II 4090F: Patient receiving erythropoietin therapy

Documentation of Iron Stores Prior to Initiating Erythropoietin Therapy <u>not</u> Performed for System Reasons

(Two CPT II codes [3160F-3P & 4090F] are required on the claim form to submit this numerator option)

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

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

<u>and</u>

CPT II 4090F: Patient receiving erythropoietin therapy

OR

If patient is not eligible for this measure because patient is not receiving erythropoietin therapy, report:

(One CPT II code [4095F] is required on the claim form to submit this numerator option) CPT II 4095F: Patient not receiving erythropoietin therapy

Documentation of Iron Stores Prior to Initiating Erythropoietin Therapy <u>not</u> Performed, Reason not Specified

(Two CPT II codes [3160F-8P & 4090F] are required on the claim form to submit this numerator option)

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

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

<u>and</u>

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 Criteria (Eligible Cases):

Patients aged ≥ 18 years on date of encounter <u>AND</u> Diagnosis for MDS (line-item ICD-9-CM): 238.72, 238.73, 238.74, 238.75 <u>AND</u>

Patient encounter during the reporting period (CPT): 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

2009 PQRI REPORTING OPTIONS: CLAIMS-BASED, REGISTRY

DESCRIPTION:

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

INSTRUCTIONS:

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

Measure Reporting via Claims:

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

When reporting the measure via claims, submit the listed ICD-9-CM diagnosis codes, CPT codes, and the appropriate CPT Category II code <u>**OR**</u> the CPT Category II code <u>**with**</u> the modifier. The modifiers allowed for this measure are: 1P- medical reasons, 2P- patient reasons, 8P- reason not otherwise specified. All measure-specific coding should be reported ON THE SAME CLAIM.

NUMERATOR:

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

Definitions:

Bisphosphonate Therapy – Includes the following medications: pamidronate and zoledronate

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

<u>Numerator Quality-Data Coding Options for Reporting Satisfactorily:</u> Intravenous Bisphosphonate Therapy Prescribed or Received CPT II 4100F: Bisphosphonate therapy, intravenous, ordered or received

Intravenous Bisphosphonate Therapy <u>not</u> Prescribed or Received for Medical or Patient Reasons

Append a modifier (**1P or 2P**) to CPT Category II code **4100F** to report documented circumstances that appropriately exclude patients from the denominator.

4100F *with* **1P:** Documentation of medical reason(s) for not prescribing bisphosphonates (eg, patients who do not have bone disease, patients with dental disease, patients with renal insufficiency)

4100F *with* **2P**: Documentation of patient reason(s) for not prescribing bisphosphonates

Intravenous Bisphosphonate Therapy not Prescribed, Reason not Specified

Append a reporting modifier (8P) to CPT Category II code 4100F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

4100F *with* **8P:** Bisphosphonate therapy, intravenous, <u>not</u> 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 Criteria (Eligible Cases):

Patients aged ≥ 18 years on date of encounter <u>AND</u> Diagnosis for multiple myeloma – not in remission (line-item ICD-9-CM): 203.00, 203.02 <u>AND</u> Define two events of the new entire meriod (CDT) = 00001, 00000, 00001, 00000

Patient encounter during the reporting period (CPT): 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

2009 PQRI REPORTING OPTIONS: CLAIMS-BASED, REGISTRY

DESCRIPTION:

Percentage of patients aged 18 years and older with a diagnosis of CLL who had baseline flow cytometry studies performed

INSTRUCTIONS:

This measure is to be reported a minimum of <u>once per reporting period</u> for patients seen during the reporting period, regardless of when the baseline flow cytometry studies are performed. It is anticipated that clinicians who provide services for patients with the diagnosis of chronic lymphocytic leukemia, not in remission, will submit this measure.

Measure Reporting via Claims:

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

When reporting the measure via claims, submit the listed ICD-9-CM diagnosis codes, CPT codes, and the appropriate CPT Category II code <u>**OR**</u> the CPT Category II code <u>**with**</u> the modifier. The modifiers allowed for this measure are: 1P- medical reasons, 2P- patient reasons, 3P- system reasons, 8P- reason not otherwise specified. All measure-specific coding should be reported ON THE SAME CLAIM.

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.

<u>Numerator Quality-Data Coding Options for Reporting Satisfactorily:</u> Baseline Flow Cytometry Studies Performed

CPT II 3170F: Flow cytometry studies performed at time of diagnosis or prior to initiating treatment

Baseline Flow Cytometry Studies <u>not</u> Performed for Medical, Patient, or System Reasons

Append a modifier (**1P**, **2P or 3P**) to CPT Category II code **3170F** to report documented circumstances that appropriately exclude patients from the denominator.

- **3170F** *with* **1P:** Documentation of medical reason(s) for not performing baseline flow cytometry studies
- **3170F** *with* **2P**: Documentation of patient reason(s) for not performing baseline flow cytometry studies
- **3170F** *with* **3P:** Documentation of system reason(s) for not performing baseline flow cytometry studies

Baseline Flow Cytometry Studies not Performed, Reason not Specified

Append a reporting modifier (8P) to CPT Category II code 3170F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

3170F *with* **8P:** Flow cytometry studies <u>not</u> 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 Criteria (Eligible Cases):

Patients aged ≥ 18 years on date of encounter <u>AND</u> Diagnosis for CLL – not in remission (line-item ICD-9-CM): 204.10, 204.12 <u>AND</u> Patient encounter during the reporting period (CPT): 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: Breast Cancer: Hormonal Therapy for Stage IC–IIIC Estrogen Receptor/ Progesterone Receptor (ER/PR) Positive Breast Cancer

2009 PQRI REPORTING OPTIONS: CLAIMS-BASED, REGISTRY

DESCRIPTION:

Percentage of female patients aged 18 years and older with Stage IC through IIIC, ER or PR positive breast cancer who were prescribed tamoxifen or aromatase inhibitor (AI) during the 12-month reporting period

INSTRUCTIONS:

This measure is to be reported a minimum of <u>once per reporting period</u> for <u>all</u> female patients with breast cancer seen during the reporting period. Review estrogen receptor (ER) or progesterone receptor (PR) AND breast cancer stage status AND tumor size to determine which quality-data codes should be submitted. It is anticipated that clinicians who treat female breast cancer patients will submit this measure.

Measure Reporting via Claims:

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

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

NUMERATOR:

Patients who were prescribed tamoxifen or aromatase inhibitor (AI) during the 12 month reporting period

Definition:

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

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

<u>Numerator Quality-Data Coding Options for Reporting Satisfactorily:</u> Tamoxifen or Aromatase Inhibitor Prescribed

(Three CPT II codes [4179F & 337x F & 3315F] are required on the claim form to submit this numerator option)

CPT II 4179F: Tamoxifen or aromatase inhibitor (AI) prescribed <u>AND</u>

CPT II 3374F: AJCC Breast Cancer Stage I: TIC (tumor size > 1cm to 2cm), documented **OR**

CPT II 3376F: AJCC Breast Cancer Stage II, documented OR

CPT II 3378F: AJCC Breast Cancer Stage III, documented

<u>AND</u>

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

Tamoxifen or Aromatase Inhibitor <u>not</u> Prescribed for Medical, Patient, or System Reasons

(Three CPT II codes [4179F-xP & 337xF & 3315F] are required on the claim form to submit this numerator option)

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

- **4179F** *with* **1P:** Documentation of medical reason(s) for not prescribing tamoxifen or aromatase inhibitor (eg, patient's disease has progressed to metastatic; patient is receiving a gonadotropin-releasing hormone analogue, patient has received oophorectomy, patient is receiving radiation or chemotherapy, patient's diagnosis date was ≥ 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)

<u>AND</u>

CPT II 3374F: AJCC Breast Cancer Stage I: T1C (tumor size > 1cm to 2cm), documented **OR**

CPT II 3376F: AJCC Breast Cancer Stage II, documented

CPT II 3378F: AJCC Breast Cancer Stage III, documented

<u>and</u>

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

If patient is not eligible for this measure because patient is not stage IC through IIIC breast cancer, report:

Patient not Stage IC through IIIC Breast Cancer

(One CPT II code [33xxF] is required on the claim form to submit this numerator option) **Note:** If reporting a code from the category below (3370F or 3372F or 3380F), it is not necessary to report the patient's ER/PR status.

CPT II 3370F: AJCC Breast Cancer Stage 0, documented **OR**

CPT II 3372F: AJCC Breast Cancer Stage I: T1 mic, T1a or T1b (tumor size < 1cm), documented

CPT II 3380F: AJCC Breast Cancer Stage IV, documented

OR

If patient is not eligible for this measure because patient is estrogen receptor (ER) and progesterone receptor (PR) negative, report:

Patient is Estrogen Receptor (ER) and Progesterone Receptor (PR) Negative (One CPT II code [3316F] is required on the claim form to submit this numerator option) Note: If reporting code 3316F, it is not necessary to report the patient's AJCC Cancer Stage.

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

OR

If patient is not eligible for this measure because the cancer stage is not documented OR the ER/PR is not documented, report:

Cancer Stage not Documented OR ER/PR not Documented

(One CPT II code [33xxF-8P] is required on the claim form to submit this numerator option) Append a reporting modifier (8P) to CPT Category II codes 3370F or 3316F to report circumstances when the patient is not eligible for the measure.

3370F *with* 8P: <u>No</u> documentation of cancer stage OR

3316F *with* **8P:** <u>No</u> documentation of estrogen receptor (ER) and progesterone receptor (PR) status

<u> 0R</u>

Tamoxifen or Aromatase Inhibitor not Prescribed, Reason not Specified

(Three CPT II codes [4179F-8P & 337xF & 3315F] are required on the claim form to submit this numerator option)

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

4179F *with* **8P:** Tamoxifen or aromatase inhibitor <u>not</u> prescribed, reason not otherwise specified

<u>and</u>

CPT II 3374F: AJCC Breast Cancer Stage: TIC (tumor size > 1cm to 2cm), documented **OR**

CPT II 3376F: AJCC Breast Cancer Stage II, documented

CPT II 3378F: AJCC Breast Cancer Stage III, documented

<u>AND</u>

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 Criteria (Eligible Cases):

Patients aged \geq 18 years on date of encounter **AND**

Diagnosis for breast cancer (line-item ICD-9-CM): 174.0, 174.1, 174.2, 174.3, 174.4, 174.5, 174.6, 174.8, 174.9

<u>and</u>

Patient encounter during the reporting period (CPT): 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: Colon Cancer: Chemotherapy for Stage III Colon Cancer Patients

2009 PQRI REPORTING OPTIONS: CLAIMS-BASED, REGISTRY

DESCRIPTION:

Percentage of patients aged 18 years and older with Stage IIIA through IIIC colon cancer who are referred for adjuvant chemotherapy, prescribed adjuvant chemotherapy, or have previously received adjuvant chemotherapy within the 12-month reporting period

INSTRUCTIONS:

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

Measure Reporting via Claims:

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

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

NUMERATOR:

Patients who are referred for adjuvant chemotherapy, prescribed adjuvant chemotherapy, or who have previously received adjuvant chemotherapy within the 12 month reporting period

Definitions:

Adjuvant Chemotherapy – According to current NCCN guidelines, the following therapies are recommended: 5-fluorouracil/leucovorin or capecitabine, or 5-fluorouracil/leucovorin/oxaliplatin

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

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

<u>Numerator Quality-Data Coding Options for Reporting Satisfactorily:</u> Adjuvant Chemotherapy Referred, Prescribed or Previously Received

(Two CPT II codes [4180F & 3388F] are required on the claim form to submit this numerator option)

CPT II 4180F: Adjuvant chemotherapy referred, prescribed or previously received for Stage IIIA through Stage IIIC colon cancer

<u>AND</u>

CPT II 3388F: AJCC Colon Cancer Stage III, documented

Adjuvant Chemotherapy <u>not</u> Referred, Prescribed or Previously Received for Medical, Patient, or System Reasons

(Two CPT II codes [4180F-xP & 3388F] are required on the claim form to submit this numerator option)

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

- **4180F** *with* **1P:** Documentation of medical reason(s) for not referring for or prescribing adjuvant chemotherapy (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 referring for or prescribing adjuvant chemotherapy (eg, patient refusal)
- **4180F** *with* **3P:** Documentation of system reason(s) for not referring for or prescribing adjuvant chemotherapy (eg, patient is currently enrolled in a clinical trial that precludes prescription of chemotherapy)

<u>AND</u>

CPT II 3388F: AJCC Colon Cancer Stage III, documented

OR

If patient is not eligible for this measure because patient is not stage III colon cancer, report:

Patient not Stage III Colon Cancer

(One CPT II code [33xxF] is required on the claim form to submit this numerator option) CPT II 3382F: AJCC Colon Cancer Stage 0, documented <u>OR</u>

CPT II 3384F: AJCC Colon Cancer Stage I, documented **OR**

CPT II 3386F: AJCC Colon Cancer Stage II, documented **OR**

CPT II 3390F: AJCC Colon Cancer Stage IV, documented

If patient is not eligible for this measure because cancer stage is not documented, report:

Cancer Stage not Documented

(One CPT II code [3382F-8P] is required on the claim form to submit this category) Append a reporting modifier (8P) to CPT Category II code 3382F to report circumstances when the patient is not eligible for the measure.

3382F with 8P: No documentation of cancer stage

<u> 0R</u>

Adjuvant Chemotherapy <u>not</u> Referred, Prescribed or Previously Received, Reason not Specified

(Two CPT II codes [4180F-8P & 3388F] are required on the claim form to submit this numerator option)

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

4180F *with* **8P:** Adjuvant chemotherapy <u>not</u> prescribed or previously received, reason not otherwise specified

<u>and</u>

CPT II 3388F: AJCC Colon Cancer Stage III, documented

DENOMINATOR:

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

Denominator Criteria (Eligible Cases):

Patients aged ≥ 18 years on date of encounter <u>AND</u> Diagnosis for colon cancer (line-item ICD-9-CM): 153.0, 153.1, 153.2, 153.3, 153.4, 153.5, 153.6, 153.7, 153.8, 153.9

<u>AND</u>

Patient encounter during the reporting period (CPT): 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)

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

2009 PQRI REPORTING OPTIONS: CLAIMS-BASED, REGISTRY

DESCRIPTION:

Percentage of patients, regardless of age, who undergo CVC insertion for whom CVC was inserted with all elements of maximal sterile barrier technique [cap AND mask AND sterile gown AND sterile gloves AND a large sterile sheet AND hand hygiene AND 2% chlorhexidine for cutaneous antisepsis (or acceptable alternative antiseptics per current guideline)] followed

INSTRUCTIONS:

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

Measure Reporting via Claims:

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

When reporting the measure via claims, submit the listed CPT codes, and the appropriate CPT Category II code <u>**OR**</u> the CPT Category II code <u>**with**</u> the modifier. The modifiers allowed for this measure are: 1P- medical reasons, 8P- reason not otherwise specified. All measure-specific coding should be reported ON THE SAME CLAIM.

NUMERATOR:

Patients for whom central venous catheter (CVC) was inserted with all elements of maximal sterile barrier technique [cap AND mask AND sterile gown AND sterile gloves AND a large sterile sheet AND hand hygiene AND 2% chlorhexidine for cutaneous antisepsis (or acceptable alternative antiseptics, per current guideline)] followed

Definition:

Maximal Sterile Barrier Technique during CVC Insertion – Includes use of <u>all</u> of the following: Cap AND mask AND sterile gown AND sterile gloves AND a large sterile sheet AND hand hygiene AND 2% chlorhexidine for cutaneous antisepsis (or acceptable alternative antiseptics, per current guideline).

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

All Elements of Maximal Sterile Barrier Technique Followed

CPT II 6030F: All elements of maximal sterile barrier technique including: cap AND mask AND sterile gown AND sterile gloves AND a large sterile sheet AND hand hygiene AND 2% chlorhexidine for cutaneous antisepsis (or acceptable alternative antiseptics, per current guideline), followed

All Elements of Maximal Sterile Barrier Technique not Followed for Medical Reasons Append a modifier (1P) to CPT Category II code 6030F to report documented circumstances that appropriately exclude patients from the denominator. 6030F with 1P: Documentation of medical reason(s) for not following all elements of maximal sterile barrier technique during CVC insertion (including CVC insertion performed on emergency basis)

All Elements of Maximal Sterile Barrier Technique <u>not</u> Followed, Reason not Specified

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

6030F *with* **8P:** All elements of maximal sterile barrier technique including: cap AND mask AND sterile gown AND sterile gloves AND a large sterile sheet AND hand hygiene AND 2% chlorhexidine for cutaneous antisepsis (or acceptable alternative antiseptics, per current guideline), <u>not</u> followed, reason not otherwise specified

DENOMINATOR:

All patients, regardless of age, who undergo CVC insertion

Denominator Criteria (Eligible Cases):

Patient encounter during the reporting period (CPT): 36555, 36556, 36557, 36558, 36560, 36561, 36563, 36565, 36566, 36568, 36569, 36570, 36571, 36578, 36580, 36581, 36582, 36583, 36584, 36585, 93503

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)

A Measure #79: End Stage Renal Disease (ESRD): Influenza Immunization in Patients with ESRD

2009 PQRI REPORTING OPTIONS: CLAIMS-BASED, REGISTRY

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 <u>once per reporting period</u> 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 (September through February). It is anticipated that clinicians providing care for patients with ESRD will submit this measure.

Measure Reporting via Claims:

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

When reporting the measure via claims, submit the listed ICD-9-CM diagnosis codes, CPT codes, G-codes, and the appropriate CPT Category II code <u>**OR**</u> the CPT Category II code <u>**with**</u> the modifier. The modifiers allowed for this measure are: 1P- medical reasons, 2P- patient reasons, 3P- system reasons, 8P- reason not otherwise specified. All measure-specific coding should be reported ON THE SAME CLAIM.

NUMERATOR:

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

<u>Numerator Quality-Data Coding Options for Reporting Satisfactorily:</u> Influenza Immunization Received

CPT II 4037F: Influenza immunization ordered or administered

Influenza Immunization <u>not</u> 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.

- **4037F** *with* **1P:** Documentation of medical reason(s) for patient not receiving the influenza immunization
- **4037F** *with* **2P:** Documentation of patient reason(s) for patient not receiving the influenza immunization
- **4037F** *with* **3P:** Documentation of system reason(s) for patient not receiving the influenza immunization

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.

4037F *with* **8P:** Influenza immunization <u>not</u> ordered or administered, reason not otherwise specified

DENOMINATOR:

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

Denominator Criteria (Eligible Cases):

Patients aged \geq 18 years on date of encounter <u>AND</u> Diagnosis for ESRD (line-item ICD-9-CM): 585.6 <u>AND</u> Patient encounter during the reporting period (CPT or HCPCS): 90935, 90937, 90945, 90947, 90957, 90958, 90959, 90960, 90961, 90962, 90965, 90966, 90969, 90970

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).

A Measure #81: End Stage Renal Disease (ESRD): Plan of Care for Inadequate Hemodialysis in ESRD Patients

2009 PQRI REPORTING OPTIONS: REGISTRY ONLY

DESCRIPTION:

Percentage of calendar months during the 12-month reporting period in which patients aged 18 years and older with a diagnosis of ESRD receiving hemodialysis have a Kt/V \ge 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 <u>each calendar month</u> hemodialysis is performed on ESRD patients seen during the reporting period. It is anticipated that clinicians providing care for patients with ESRD will submit this measure.

Measure Reporting via Registry Only:

ICD-9-CM diagnosis codes, CPT codes, G-codes, and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure. Do not report this measure via claims.

NUMERATOR:

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

Definition:

Documented Plan of Care – May include checking for adequacy of the AV access, increasing the blood flow, increasing the dialyzer size, increasing the time of dialysis sessions, adjusting dialysis prescription, or documenting residual renal function.

Numerator Options:

 $Kt/V \ge 1.2$ (Clearance of urea (Kt)/volume(V))

OR

Kt/V < 1.2 (Clearance of urea (Kt)/volume(V)) <u>AND</u> Hemodialysis plan of care documented

Kt/V not performed or documented, reason not specified

OR

Hemodialysis plan of care <u>not</u> documented, reason not specified <u>AND</u> 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 Criteria (Eligible Cases):

Patients aged ≥ 18 years on date of encounter <u>AND</u> Diagnosis for ESRD (line-item ICD-9-CM): 585.6 <u>AND</u> Patient encounter during the reporting period (CPT or HCPCS): 90935, 90937, 90957, 90958, 90959, 90960, 90961, 90962

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). (KDOQITM)

The minimally adequate dose of HD given 3 times per week to patients with K_r less than 2 mL/min/1.73 m² 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 m² should be an spKt/V of 1.4 per dialysis not including RKF, or URR of 70% (A). (KDOQITM)

A Measure #82: End Stage Renal Disease (ESRD): Plan of Care for Inadequate Peritoneal Dialysis

2009 PQRI REPORTING OPTIONS: REGISTRY ONLY

DESCRIPTION:

Percentage of patients aged 18 years and older with a diagnosis of ESRD receiving peritoneal dialysis who have a Kt/V \ge 1.7 OR patients who have a Kt/V < 1.7 with a documented plan of care for inadequate peritoneal dialysis at least three times (every 4 months) during the 12-month reporting period

INSTRUCTIONS:

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

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

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

Measure Reporting via Registry Only:

ICD-9-CM diagnosis codes, CPT codes, G-codes, and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure. Do not report this measure via claims.

NUMERATOR:

Patients who have a Kt/V \geq 1.7 OR have a Kt/V <1.7 with a documented plan of care for inadequate peritoneal dialysis at least three times (every 4 months) during the 12 month reporting period

Definition:

Documented Plan of Care – May include assessing for non-adherence with the peritoneal prescription, sampling, and collection; assessing for error in the peritoneal dialysis prescription and/or inadequate monitoring of the delivered dose; performing peritoneal equilibrium testing; assessing for inadequate patient education; increasing the exchange volume; increasing the number of exchanges per 24 hours; assessing for modality (CAPD or CCPD).

Numerator Options:

Kt/V \geq 1.7 (Clearance of urea (Kt)/volume(V))

Kt/V < 1.7 (Clearance of urea (Kt)/volume(V)) <u>AND</u> Peritoneal dialysis plan of care documented

<u>OR</u>

Kt/V not performed or documented, reason not specified

OR

Peritoneal dialysis plan of care <u>not</u> documented, reason not specified <u>AND</u>

Kt/V < 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 Criteria (Eligible Cases):

Patients aged ≥ 18 years on date of encounter <u>AND</u> Diagnosis for ESRD (line-item ICD-9-CM): 585.6

Diagnosis for ESRD (line-item ICD-9-CM

<u>and</u>

Patient encounter during the reporting period (CPT or HCPCS): 90945, 90947, 90965, 90966, 90969, 90970

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 \leq 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). (KDOQITM)
A Measure #83: Hepatitis C: Testing for Chronic Hepatitis C – Confirmation of Hepatitis C Viremia

2009 PQRI REPORTING OPTIONS: CLAIMS-BASED, REGISTRY

DESCRIPTION:

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

INSTRUCTIONS:

This measure should be reported on the <u>first visit</u> occurring during the reporting period for <u>all</u> patients with a diagnosis of hepatitis C seen during the reporting period. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

Measure Reporting via Claims:

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

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

NUMERATOR:

Patients for whom HCV RNA testing was ordered or previously performed

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

<u>Numerator Quality-Data Coding Options for Reporting Satisfactorily:</u> RNA Testing Ordered or Results Documented

(Two CPT II codes [3265F & 1119F] are required on the claim form to submit this numerator option)

CPT II 3265F: Ribonucleic acid (RNA) testing for Hepatitis C viremia ordered or results documented

<u>and</u>

CPT II 1119F: Initial evaluation for condition

RNA Testing not Ordered or Results not Documented for Medical or Patient Reasons

(Two CPT II codes [3265F-xP & 1119F] are required on the claim form to submit this numerator option)

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

<u>and</u>

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 numerator option) CPT II 1121F: Subsequent evaluation for condition

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 numerator option)

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 <u>not</u> ordered or results <u>not</u> documented, reason not otherwise specified

<u>AND</u>

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 Criteria (Eligible Cases):

Patients aged \geq 18 years on date of encounter **AND**

Diagnosis for hepatitis C (line-item ICD-9-CM): 070.51, 070.54, 070.70 AND

Patient encounter during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 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 10⁵ to 10⁷ 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)

A Measure #84: Hepatitis C: Ribonucleic Acid (RNA) Testing Before Initiating Treatment

2009 PQRI REPORTING OPTIONS: CLAIMS-BASED, REGISTRY

If reporting Measure #84: Hepatitis C: RNA Testing Before Initiating Treatment, also report Measure #85: Hepatitis C HCV Genotype Testing Prior to Treatment.

DESCRIPTION:

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

INSTRUCTIONS:

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

Measure Reporting via Claims:

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

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

NUMERATOR:

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

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

<u>Numerator Quality-Data Coding Options for Reporting Satisfactorily:</u> RNA Testing Performed within Six Months

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

CPT II 3218F: RNA testing for Hepatitis C documented as performed within six months prior to initiation of antiviral treatment for Hepatitis C **AND**

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

RNA Testing not Performed within Six Months for Medical Reason

(Two CPT II codes [3218F-1P & 4150F] are required on the claim form to submit this numerator option)

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

3218F *with* **1P**: Documentation of medical reason(s) for not performing RNA testing within six months prior to initiation of antiviral treatment for Hepatitis C (eg, if patient is first seen by physician after initiation of treatment)

<u>AND</u>

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

OR

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

(One CPT II code [4151F] is required on the claim form to submit this numerator option) **CPT II 4151F:** Patient not receiving antiviral treatment for Hepatitis C

RNA Testing not Performed within Six Months, Reason not Specified

(Two CPT II codes [3218F-8P & 4150F] are required on the claim form to submit this numerator option)

Append a reporting modifier (8P) to CPT Category II code 3218F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

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

<u>and</u>

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 Criteria (Eligible Cases):

Patients aged \geq 18 years on date of encounter <u>AND</u> Diagnosis for chronic hepatitis C (line-item ICD-9-CM): 070.54 <u>AND</u> Patient encounter during the reporting period (CPT): 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)

A Measure #85: Hepatitis C: HCV Genotype Testing Prior to Treatment

2009 PQRI REPORTING OPTIONS: CLAIMS-BASED, REGISTRY

If reporting Measure #85: Hepatitis C HCV Genotype Testing Prior to Treatment, also report Measure #84: Hepatitis C: RNA Testing Before Initiating Treatment.

DESCRIPTION:

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

INSTRUCTIONS:

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

Measure Reporting via Claims:

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

When reporting the measure via claims, submit the listed ICD-9-CM diagnosis codes, CPT codes, and the appropriate CPT Category II code <u>AND/OR</u> G-code <u>OR</u> the CPT Category II code <u>with</u> the modifier <u>AND</u> G-code. The reporting modifier allowed for this measure is: 8P- reason not otherwise specified. All measure-specific coding should be reported ON THE SAME CLAIM.

NUMERATOR:

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

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

<u>Numerator Quality-Data Coding Options for Reporting Satisfactorily:</u> Hepatitis C Genotype Testing Performed

(One CPT II code & one G-code [3266F & G8459] are required on the claim form to submit this numerator option)

CPT II 3266F: Hepatitis C genotype testing documented as performed prior to initiation of antiviral treatment for Hepatitis C

<u>AND</u>

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

<u> 0 R</u>

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

(One G-code [G8458] is required on the claim form to submit this numerator option) G8458: Clinician documented that patient is not an eligible candidate for genotype testing; patient not receiving antiviral treatment for Hepatitis C

<u> 0R</u>

Genotype Testing not Performed, Reason not Specified

(One CPT II code & one G-code [3266F-8P & G8459] are required on the claim form to submit this numerator option)

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

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

<u>AND</u>

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 Criteria (Eligible Cases):

Patients aged ≥ 18 years on date of encounter <u>AND</u> Diagnosis for chronic hepatitis C (line-item ICD-9-CM): 070.54 <u>AND</u> Patient encounter during the reporting period (CPT): 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)

A Measure #86: Hepatitis C: Antiviral Treatment Prescribed

2009 PQRI REPORTING OPTIONS: CLAIMS-BASED, REGISTRY

DESCRIPTION:

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

INSTRUCTIONS:

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

Measure Reporting via Claims:

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

When reporting the measure via claims, submit the listed ICD-9-CM diagnosis codes, CPT codes, and the appropriate CPT Category II code <u>**OR**</u> the CPT Category II code <u>**with**</u> the modifier. The modifiers allowed for this measure are: 1P- medical reasons, 2P- patient reasons, 3P- system reasons, 8P- reason not otherwise specified. All measure-specific coding should be reported ON THE SAME CLAIM.

NUMERATOR:

Patients who were prescribed peginterferon and ribavirin therapy within the 12 month reporting period

Definition:

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

Numerator Quality-Data Coding Options for Reporting Satisfactorily: Peginterferon and Ribavirin Therapy Prescribed

CPT II 4153F: Combination peginterferon and ribavirin therapy prescribed

<u> 0R</u>

Peginterferon and Ribavirin Therapy <u>not</u> Prescribed for Medical, Patient or System Reasons

Append a modifier (**1P**, **2P or 3P**) to CPT Category II code **4153F** to report documented circumstances that appropriately exclude patients from the denominator.

- **4153F** *with* **1P:** Documentation of medical reason(s) for not prescribing peginterferon and ribavarin therapy within 12 month reporting period (eg, patient was not a candidate for therapy, could not tolerate).
- **4153F** *with* **2P**: Documentation of patient reason(s) for not prescribing peginterferon and ribavirin therapy within 12 month reporting period (eg, patient declined).
- **4153F** *with* **3P:** Documentation of system reason(s) for not prescribing peginterferon andribavirin therapy within 12 month reporting period (eg, patient has no insurance coverage, therapy not covered).

Peginterferon and Ribavirin Therapy not Prescribed, Reason not Specified

Append a reporting modifier (8P) to CPT Category II code 4153F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

4153F *with* **8P:** Combination peginterferon and ribavirin therapy was <u>not</u> prescribed, reason not otherwise specified

DENOMINATOR:

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

Denominator Criteria (Eligible Cases): Patients aged ≥ 18 years on date of encounter <u>AND</u> Diagnosis for chronic hepatitis C (line-item ICD-9-CM): 070.54 <u>AND</u> Patient encounter during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245

RATIONALE:

Assure that antiviral therapy is prescribed for all patients with confirmed Hepatitis C.

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

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

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)

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

2009 PQRI REPORTING OPTIONS: CLAIMS-BASED, REGISTRY

DESCRIPTION:

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

INSTRUCTIONS:

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

Measure Reporting via Claims:

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

When reporting the measure via claims, submit the listed ICD-9-CM diagnosis codes, CPT codes, and the appropriate CPT Category II code <u>AND/OR</u> G-code <u>OR</u> the CPT Category II code <u>with</u> the modifier <u>AND</u> G-code. The modifiers allowed for this measure are: 1P- medical reasons, 2P-patient reasons, 8P- reason not otherwise specified. All measure-specific coding should be reported ON THE SAME CLAIM.

NUMERATOR:

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

Definition:

12 Weeks from Initiation – Patients for whom testing was performed between 11-13 weeks from the initiation of antiviral treatment will meet the numerator for this measure.

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

<u>Numerator Quality-Data Coding Options for Reporting Satisfactorily:</u> Hepatitis C Quantitative RNA Testing at 12 weeks

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

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

<u>AND</u>

G8461: Patient receiving antiviral treatment for Hepatitis C

Hepatitis C Quantitative RNA Testing <u>not</u> Performed at 12 Weeks for Medical or Patient Reasons

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

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

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

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

AND

G8461: Patient receiving antiviral treatment for Hepatitis C

OR

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

(One G-code [G8460] is required on the claim form to submit this numerator option) **G8460:** Clinician documented that patient is not an eligible candidate for quantitative RNA testing at week 12; patient not receiving antiviral treatment for Hepatitis C

Hepatitis C Quantitative RNA Testing <u>not</u> Performed at 12 Weeks, Reason not Specified

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

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

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

<u>and</u>

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 Criteria (Eligible Cases):

Patients aged \geq 18 years on date of encounter <u>AND</u> Diagnosis for chronic hepatitis C (line-item ICD-9-CM): 070.54 <u>AND</u> Patient encounter during the reporting period (CPT): 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 \geq 6 months after completing therapy, a more sensitive quantitative assay with a lower limit of \leq 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 -log₁₀ 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)

A Measure #89: Hepatitis C: Counseling Regarding Risk of Alcohol Consumption

2009 PQRI REPORTING OPTIONS: CLAIMS-BASED, REGISTRY

DESCRIPTION:

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

INSTRUCTIONS:

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

Measure Reporting via Claims:

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

When reporting the measure via claims, submit the listed ICD-9-CM diagnosis codes, CPT codes, and the appropriate CPT Category II code <u>**OR**</u> the CPT Category II code <u>**with**</u> the modifier. The reporting modifier allowed for this measure is: 8P- reason not otherwise specified. There are no allowable performance exclusions for this measure. All measure-specific coding should be reported ON THE SAME CLAIM.

NUMERATOR:

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

Definition:

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

Numerator Quality-Data Coding Options for Reporting Satisfactorily: Counseling Regarding Risk of Alcohol Consumption CPT II 4158F: Patient counseled about risks of alcohol use

<u> 0R</u>

Counseling Regarding Risk of Alcohol Consumption <u>not</u> Performed, Reason not Specified

Append a reporting modifier (8P) to CPT Category II code 4158F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

4158F *with* **8P:** Patient counseled about risks of alcohol use <u>not</u> performed, reason not otherwise specified

DENOMINATOR:

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

Denominator Criteria (Eligible Cases): Patients aged ≥ 18 years on date of encounter <u>AND</u> Diagnosis for hepatitis C (line-item ICD-9-CM): 070.51, 070.54, 070.70 <u>AND</u> Patient encounter during the reporting period (CPT): 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)

A Measure #90 Hepatitis C: Counseling Regarding Use of Contraception Prior to Antiviral Therapy

2009 PQRI REPORTING OPTIONS: CLAIMS-BASED, REGISTRY

DESCRIPTION:

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

INSTRUCTIONS:

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

Measure Reporting via Claims:

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

When reporting the measure via claims, submit the listed ICD-9-CM diagnosis codes, CPT codes, and the appropriate CPT Category II code <u>AND/OR</u> G-code <u>OR</u> the CPT Category II code <u>with</u> the modifier <u>AND</u> G-code. The modifiers allowed for this measure are: 1P- medical reasons, 8P- reason not otherwise specified. All measure-specific coding should be reported ON THE SAME CLAIM.

NUMERATOR:

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

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

<u>Numerator Quality-Data Coding Options for Reporting Satisfactorily:</u> Counseling Regarding Contraception Received

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

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

AND

G8463: Patient receiving antiviral treatment for Hepatitis C documented

Counseling Regarding Contraception not Received for Medical Reason

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

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

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

<u>and</u>

G8463: Patient receiving antiviral treatment for Hepatitis C documented

OR

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

(One G-code [G8462] is required on the claim form to submit this numerator option) **G8462:** Clinician documented that patient is not an eligible candidate for counseling regarding contraception prior to antiviral treatment; patient not receiving antiviral treatment for Hepatitis C

Counseling Regarding Contraception not Received, Reason not Specified

(One CPT II code & one G-code [4159F-8P & G8463] are required on the claim form to submit this numerator option)

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

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

<u>AND</u>

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 Criteria (Eligible Cases):

Patients (females aged 18 through 44 years or males aged \geq 18 years) on date of encounter

<u>AND</u>

Diagnosis for chronic hepatitis (line-item ICD-9-CM): 070.54 AND

Patient encounter during the reporting period (CPT): 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 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)

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

2009 PQRI REPORTING OPTIONS: CLAIMS-BASED, REGISTRY

DESCRIPTION:

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

INSTRUCTIONS:

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

Measure Reporting via Claims:

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

When reporting the measure via claims, submit the appropriate ICD-9-CM diagnosis codes, CPT codes, and the appropriate CPT Category II code **OR** the CPT Category II code **with** the modifier. The modifiers allowed for this measure are: 1P- medical reasons, 2P- patient reasons, 8P- reason not otherwise specified. All measure-specific coding should be reported ON THE SAME CLAIM.

NUMERATOR:

Patients who were prescribed topical preparations

Definition:

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

<u>Numerator Quality-Data Coding Options for Reporting Satisfactorily</u>: Topical Preparations Prescribed

CPT II 4130F: Topical preparations (including OTC) prescribed for acute otitis externa

Topical Preparations not Prescribed for Medical or Patient Reasons

Append a modifier (**1P or 2P**) to CPT Category II code **4130F** to report documented circumstances that appropriately exclude patients from the denominator.

4130F *with* **1P:** Documentation of medical reason(s) for not prescribing topical preparations (including OTC) for acute otitis externa

4130F *with* **2P**: Documentation of patient reason(s) for not prescribing topical preparations (including OTC) for acute otitis externa

<u>OR</u>

Topical Preparations not Prescribed, Reason not Specified

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

4130F *with* **8P:** Topical preparations (including OTC) for acute otitis externa (AOE) <u>not</u> prescribed, reason not otherwise specified

DENOMINATOR:

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

Denominator Criteria (Eligible Cases):

Patients aged ≥ 2 years on date of encounter <u>AND</u> Diagnosis for AOE (line-item ICD-9-CM): 380.10, 380.11, 380.12, 380.13, 380.22 <u>AND</u> Patient encounter during the reporting period (CPT): 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)

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

2009 PQRI REPORTING OPTIONS: CLAIMS-BASED, REGISTRY

DESCRIPTION:

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

INSTRUCTIONS:

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

Measure Reporting via Claims:

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

When reporting the measure via claims, submit the appropriate ICD-9-CM diagnosis codes, CPT codes, and the appropriate CPT Category II code **<u>OR</u>** the CPT Category II code **<u>with</u>** the modifier. The modifiers allowed for this measure are: 1P- medical reasons, 8P- reason not otherwise specified. All measure-specific coding should be reported ON THE SAME CLAIM.

NUMERATOR:

Patient visits with assessment for auricular or periauricular pain

<u>Numerator Quality-Data Coding Options for Reporting Satisfactorily:</u> Auricular or Periauricular Pain Assessed

CPT II 1116F: Auricular or periauricular pain assessed

<u> 0R</u>

Auricular or Periauricular Pain not Assessed for Medical Reasons

Append a modifier (**1P**) to CPT Category II code **1116F** to report documented circumstances that appropriately exclude patients from the denominator. **1116F** *with* **1P**: Documentation of medical reason(s) for not assessing auricular or

periauricular pain

Auricular or Periauricular Pain not Assessed, Reason not Specified

Append a reporting modifier (8P) to CPT Category II code 1116F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

1116F *with* **8P:** Auricular or periauricular pain <u>not</u> assessed, reason not otherwise specified

DENOMINATOR:

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

Denominator Criteria (Eligible Cases):

Patients aged ≥ 2 years on date of encounter <u>AND</u> Diagnosis for AOE (line-item ICD-9-CM): 380.10, 380.11, 380.12, 380.13, 380.22 <u>AND</u> Patient encounter during the reporting period (CPT): 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

2009 PQRI REPORTING OPTIONS: CLAIMS-BASED, REGISTRY

DESCRIPTION:

Percentage of patients aged 2 years and older with a diagnosis of AOE who were <u>not prescribed</u> systemic antimicrobial therapy

INSTRUCTIONS:

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

Measure Reporting via Claims:

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

When reporting the measure via claims, submit the appropriate ICD-9-CM diagnosis codes, CPT codes, and the appropriate CPT Category II code <u>**OR**</u> the CPT Category II code <u>**with**</u> the modifier. The modifier allowed for this measure is: 1P- medical reasons. All measure-specific coding should be reported ON THE SAME CLAIM.

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).

<u>Numerator Quality-Data Coding Options for Reporting Satisfactorily:</u> Systemic Antimicrobial Therapy <u>not</u> Prescribed CPT II 4132F: Systemic antimicrobial therapy not prescribed

Systemic Antimicrobial Therapy Prescribed for Medical Reasons
 Append a modifier (1P) to CPT Category II code 4131F to report documented circumstances that appropriately exclude patients from the denominator.
 4131F with 1P: Documentation of medical reason(s) for prescribing systemic antimicrobial therapy

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 Criteria (Eligible Cases):

Patients aged ≥ 2 years on date of encounter <u>AND</u> Diagnosis for AOE (line-item ICD-9-CM): 380.10, 380.11, 380.12, 380.13, 380.22 <u>AND</u>

Patient encounter during the reporting period (CPT): 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)

Version 3.0

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

2009 PQRI REPORTING OPTIONS: CLAIMS-BASED, REGISTRY

DESCRIPTION:

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

INSTRUCTIONS:

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

Measure Reporting via Claims:

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

When reporting the measure via claims, submit the appropriate ICD-9-CM diagnosis codes, CPT codes, and the appropriate CPT Category II code **OR** the CPT Category II code **with** the modifier. The modifiers allowed for this measure are: 1P- medical reasons, 2P- patient reasons, 8P- reason not otherwise specified. All measure-specific coding should be reported ON THE SAME CLAIM.

NUMERATOR:

Patient visits with assessment of tympanic membrane mobility with pneumatic otoscopy or tympanometry

<u>Numerator Quality-Data Coding Options for Reporting Satisfactorily:</u> Tympanic Membrane Mobility Assessed

CPT II 2035F: Tympanic membrane mobility assessed with pneumatic otoscopy or tympanometry

<u> 0R</u>

Tympanic Membrane Mobility <u>not</u> Assessed for Medical or Patient Reasons

Append a modifier (**1P or 2P**) to CPT Category II code **2035F** to report documented circumstances that appropriately exclude patients from the denominator.

2035F *with* **1P:** Documentation of medical reason(s) for not assessing tympanic membrane mobility with pneumatic otoscopy or tympanometry

2035F *with* **2P**: Documentation of patient reason(s) for not assessing tympanic membrane mobility with pneumatic otoscopy or tympanometry

Tympanic Membrane Mobility not Assessed, Reason not Specified

Append a reporting modifier (8P) to CPT Category II code 2035F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

2035F *with* **8P:** Tympanic membrane mobility <u>not</u> 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 Criteria (Eligible Cases):

Patients aged 2 months through 12 years on date of encounter <u>AND</u> Diagnosis for OME (line-item ICD-9-CM): 381.10, 381.19, 381.20, 381.29, 381.3, 381.4 AND

Patient encounter during the reporting period (CPT): 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)

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

2009 PQRI REPORTING OPTIONS: CLAIMS-BASED, REGISTRY

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 <u>each time</u> a tympanostomy tube insertion procedure is performed during the reporting period for children. It is anticipated that <u>clinicians who perform the</u> <u>tympanostomy tube insertion</u> for children 2 months through 12 years of age with a diagnosis of OME will submit this measure.

Measure Reporting via Claims:

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

When reporting the measure via claims, submit the appropriate ICD-9-CM diagnosis codes, CPT codes, and the appropriate CPT Category II code **OR** the CPT Category II code **with** the modifier. The modifiers allowed for this measure are: 1P- medical reasons, 3P- system reasons, 8P- reason not otherwise specified. All measure-specific coding should be reported ON THE SAME CLAIM.

NUMERATOR:

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

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

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 <u>not</u> 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.

3230F *with* **1P**: Documentation of medical reason(s) for not performing hearing test within 6 months prior to tympanostomy tube insertion

3230F *with* **3P:** Documentation of system reason(s) for not performing hearing test within 6 months prior to tympanostomy tube insertion

Hearing Test <u>not</u> 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.

3230F *with* **8P**: Hearing test <u>not</u> 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 Criteria (Eligible Cases):

Patients aged 2 months through 12 years on date of encounter <u>AND</u> Diagnosis for OME (line-item ICD-9-CM): 381.10, 381.19, 381.20, 381.29, 381.3, 381.4 <u>AND</u> Patient encounter during the reporting period (CPT): 69433, 69436

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 #99: Breast Cancer Resection Pathology Reporting: pT Category (Primary Tumor) and pN Category (Regional Lymph Nodes) with Histologic Grade

2009 PQRI REPORTING OPTIONS: CLAIMS-BASED, REGISTRY

DESCRIPTION:

Percentage of breast cancer resection pathology reports that include the pT category (primary tumor), the pN category (regional lymph nodes), and the histologic grade

INSTRUCTIONS:

This measure is to be reported <u>each time</u> a breast cancer resection surgical pathology examination is performed during the reporting period for breast cancer patients. Each unique CPT Category I code submitted on the claim will be counted for denominator inclusion. It is anticipated that <u>clinicians who examine breast tissue specimens following resection</u> in a laboratory or institution will submit this measure. Independent laboratories, using indicator place of service 81, are <u>not</u> included. If the specimen is not primary breast tissue (eg, liver, lung), report only CPT II code 3250F.

Measure Reporting via Claims:

Line-item ICD-9-CM diagnosis codes and CPT codes are used to identify patients who are included in the measure's denominator. CPT Category II codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the appropriate ICD-9-CM diagnosis codes, CPT codes, and the appropriate CPT Category II code **OR** the CPT Category II code **with** the modifier. The modifiers allowed for this measure are: 1P- medical reasons, 8P- reason not otherwise specified. All measure-specific coding should be reported ON THE SAME CLAIM.

NUMERATOR:

Reports that include the pT category, the pN category and the histologic grade

<u>Numerator Quality-Data Coding Options for Reporting Satisfactorily:</u> 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

<u> 0R</u>

pT Category, pN Category and Histologic Grade <u>not</u> Documented for Medical Reasons

Append a modifier (1P) to CPT Category II code 3260F to report documented circumstances that appropriately exclude patients from the denominator.
3260F with 1P: Documentation of medical reason(s) for not including pT category, pN category, and histologic grade in the pathology report (e.g., re-excision

without residual tumor)

If patient is not eligible for this measure because the specimen is not primary breast tissue (eg, liver, lung) report:

CPT II 3250F: Specimen site other than anatomic location of primary tumor

pT Category, pN Category and Histologic Grade \underline{not} Documented, Reason not Specified

Append a reporting modifier (8P) to CPT Category II code 3260F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

3260F *with* **8P:** pT category, pN category, and histologic grade were <u>not</u> documented in pathology report, reason not otherwise specified

DENOMINATOR:

All breast cancer resection pathology reports (excluding biopsies)

Denominator Criteria (Eligible Cases): Diagnosis for breast cancer (line-item ICD-9-CM): 174.0, 174.1, 174.2, 174.3, 174.4, 174.5, 174.6, 174.8, 174.9, 175.0, 175.9 <u>AND</u> Patient encounter during the reporting period (CPT): 88307, 88309 <u>WITHOUT</u> Place of Service Indicator: 81

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 Resection Pathology Reporting: pT Category (Primary Tumor) and pN Category (Regional Lymph Nodes) with Histologic Grade

2009 PQRI REPORTING OPTIONS: CLAIMS-BASED, REGISTRY

DESCRIPTION:

Percentage of colon and rectum cancer resection pathology reports that include the pT category (primary tumor), the pN category (regional lymph nodes) and the histologic grade

INSTRUCTIONS:

This measure is to be reported <u>each time</u> a colorectal cancer resection surgical pathology examination is performed during the reporting period for colorectal cancer patients. Each unique CPT Category I code submitted on the claim will be counted for denominator inclusion. It is anticipated that <u>clinicians who examine colorectal tissue specimens following resection</u> in a laboratory or institution will submit this measure. Independent laboratories, using indicator place of service 81, are not included. If the specimen is not primary colorectal tissue (eg, liver, lung), report only CPT II 3250F.

Measure Reporting via Claims:

Line-item ICD-9-CM diagnosis codes and CPT codes are used to identify patients who are included in the measure's denominator. CPT Category II codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the appropriate ICD-9-CM diagnosis codes, CPT codes, and the appropriate CPT Category II code **OR** the CPT Category II code **with** the modifier. The modifiers allowed for this measure are: 1P- medical reasons, 8P- reason not otherwise specified. All measure-specific coding should be reported ON THE SAME CLAIM.

NUMERATOR:

Reports that include the pT category, the pN category and the histologic grade

<u>Numerator Quality-Data Coding Options for Reporting Satisfactorily:</u> 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

pT Category, pN Category and Histologic Grade <u>not</u> Documented for Medical Reasons

Append a modifier (1P) to CPT Category II code 3260F to report documented circumstances that appropriately exclude patients from the denominator.
3260F with 1P: Documentation of medical reason(s) for not including pT category, pN category and histologic grade in the pathology report (e.g., anal canal)

If patient is not eligible for this measure because the specimen is not primary colorectal tissue (eg, liver, lung) report:

CPT II 3250F: Specimen site other than anatomic location of primary tumor

pT Category, pN Category and Histologic Grade \underline{not} Documented, Reason not Specified

Append a reporting modifier (8P) to CPT Category II code 3260F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

3260F *with* **8P:** pT category, pN category and histologic grade were <u>not</u> documented in the pathology report, reason not otherwise specified

DENOMINATOR:

All colon and rectum cancer resection pathology reports

Denominator Criteria (Eligible Cases):

 Diagnosis for colon or rectum cancer (line-item ICD-9-CM): 153.0, 153.1, 153.2, 153.3, 153.4, 153.5, 153.6, 153.7, 153.8, 153.9, 154.0, 154.1, 154.8

 AND

 Patient encounter during the reporting period (CPT): 88309

 WITHOUT

 Place of Service Indicator: 81

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 CAPrecommended 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)
A Measure #102: Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low-Risk Prostate Cancer Patients

2009 PQRI REPORTING OPTIONS: CLAIMS-BASED, REGISTRY

DESCRIPTION:

Percentage of patients, regardless of age, with a diagnosis of prostate cancer at low risk of recurrence receiving interstitial prostate brachytherapy, OR external beam radiotherapy to the prostate, OR radical prostatectomy, OR cryotherapy who did <u>not</u> have a bone scan performed at any time since diagnosis of prostate cancer

INSTRUCTIONS:

This measure is to be reported <u>once per episode</u> of treatment (i.e., interstitial prostate brachytherapy, OR external beam radiotherapy to the prostate, OR radical prostatectomy, OR cryotherapy) for <u>all</u> patients with prostate cancer who receive interstitial prostate brachytherapy, external beam radiotherapy to the prostate, radical prostatectomy, or cryotherapy during the reporting period. Claims data will be analyzed to determine unique episodes of radiation therapy. Each episode of radiation therapy in an eligible patient receiving external beam radiotherapy to the prostate occurring during the reporting period will be counted when calculating the reporting and performance rates. The PQRI quality-data code needs to be submitted only once during the episode of radiation therapy (e.g., 8 weeks of therapy). It is anticipated that <u>clinicians who perform</u> <u>the listed procedures</u> as specified in the denominator coding will submit this measure.

Measure Reporting via Claims:

Line-item ICD-9-CM diagnosis codes and CPT codes are used to identify patients who are included in the measure's denominator. CPT Category II codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the appropriate ICD-9-CM diagnosis codes, CPT codes, and the appropriate CPT Category II code(s) **<u>OR</u>** the CPT Category II code(s) **<u>with</u>** the modifier. The modifiers allowed for this measure are: 1P- medical reasons, 3P- system reasons. All measure-specific coding should be reported ON THE SAME CLAIM.

NUMERATOR:

Patients who did not have a bone scan performed at any time since diagnosis of prostate cancer

Definitions:

Risk Strata: Low, Intermediate, or High

Low Risk – PSA \leq 10 mg/dL; AND Gleason score 6 or less; AND clinical stage T1c or T2a² **Intermediate Risk** – PSA >10 to 20 mg/dL; OR Gleason score 7; OR clinical stage T2b, and not qualifying for high risk²

High Risk – PSA >20 mg/dL; OR Gleason score 8 to 10; OR clinically localized stage T3a1

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

<u>Numerator Quality-Data Coding Options for Reporting Satisfactorily:</u> Bone Scan not Performed

(Two CPT II codes [3270F & 3271F] are required on the claim form to submit this numerator option)

CPT II 3270F: Bone scan not performed prior to initiation of treatment nor at any time since diagnosis of prostate cancer

<u>and</u>

CPT II 3271F: Low risk of recurrence, prostate cancer

Bone Scan Performed for Medical or System Reasons

(Two CPT II codes [3269F-xP & 3271F] are required on the claim form to submit this numerator option)

Append a modifier (**1P or 3P**) to CPT Category II code **3269F** to report documented circumstances that appropriately exclude patients from the denominator.

3269F *with* **1P:** Documentation of medical reason(s) for performing a bone scan (including documented pain, salvage therapy, other medical reasons)

3269F *with* **3P:** Documentation of system reason(s) for performing a bone scan (including bone scan ordered by someone other than reporting physician)

<u>AND</u>

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 [327xF] is required on the claim form to submit this numerator option) Intermediate Risk of Recurrence

CPT II 3272F: Intermediate risk of recurrence, prostate cancer

High Risk of Recurrence

CPT II 3273F: High risk of recurrence, prostate cancer

<u> 0R</u>

Risk of Recurrence not Determined

CPT II 3274F: Prostate cancer risk of recurrence not determined or neither low, intermediate nor high

Bone Scan Performed

(Two CPT II codes [3269F & 3271F] are required on the claim form to submit this numerator option)

CPT II 3269F: Bone scan performed prior to initiation of treatment or at any time since diagnosis of prostate cancer

<u>AND</u>

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

Note: Only patients with prostate cancer with low risk of recurrence will be counted in the performance denominator of this measure

Denominator Criteria (Eligible Cases):

Diagnosis for prostate cancer (line-item ICD-9-CM): 185 <u>AND</u> Patient encounter during the reporting period (CPT): 55810, 55812, 55815, 55840,

55842, 55845, 55866, 55873, 77411, 77412, 77413, 77414, 77416, 77418, 77427, 77776, 77777, 77778, 7778

RATIONALE:

A bone scan is generally not required for staging prostate cancer in men with a low risk of recurrence and receiving primary therapy. This measure is written as a negative measure so that the performance goal is 100%, consistent with the other measures for this condition.

CLINICAL RECOMMENDATION STATEMENTS:

Routine use of a bone scan is not required for staging asymptomatic men with clinically localized prostate cancer when their PSA is equal to or less than 20.0 ng/mL. (AUA)

Patients with a life expectancy > 5 years or symptomatic:

- A bone scan is appropriate for T1 to T2 disease in the presence of a PSA greater than 20 ng/mL, Gleason score of 8 or higher, clinical stage of T3 to T4, or symptomatic disease.
- Patients at higher risk of metastatic disease may undergo pelvic computed tomography (CT) or magnetic resonance imaging (MRI) scanning with possible fine-needle aspiration of enlarged lymph nodes or staging lymph node dissection. Nomograms or risk tables may be used to identify patients with a higher likelihood of having metastatic disease. If the nomogram indicates a probability of lymph node involvement greater than 20% or if the patient is stage T3 or T4, this is recommended as a threshold for doing a staging CT scan or MRI evaluation.

For all other patients, no additional imaging is required for staging. (NCCN) (Category 2A)

A Measure #104: Prostate Cancer: Adjuvant Hormonal Therapy for High-Risk Prostate Cancer Patients

2009 PQRI REPORTING OPTIONS: CLAIMS-BASED, REGISTRY

DESCRIPTION:

Percentage of patients, regardless of age, with a diagnosis of prostate cancer at high risk of recurrence receiving external beam radiotherapy to the prostate who were prescribed adjuvant hormonal therapy (GnRH agonist or antagonist)

INSTRUCTIONS:

This measure is to be reported <u>once per episode</u> of radiation therapy for <u>all</u> patients with prostate cancer who receive external beam radiotherapy to the prostate during the reporting period. Claims data will be analyzed to determine unique episodes of radiation therapy. Each episode of radiation therapy in an eligible patient receiving external beam radiotherapy to the prostate occurring during the reporting period will be counted when calculating the reporting and performance rates. The PQRI quality-data code needs to be submitted only once during the episode of radiation therapy (e.g., 8 weeks of therapy). It is anticipated that <u>clinicians who perform external beam radiotherapy to the prostate</u> will submit this measure.

Measure Reporting via Claims:

Line-item ICD-9-CM diagnosis codes and CPT codes are used to identify patients who are included in the measure's denominator. CPT Category II codes and/or G-codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed ICD-9-CM diagnosis codes, CPT codes, and the appropriate CPT Category II code <u>AND/OR</u> G-code <u>OR</u> the CPT Category II code <u>with</u> the modifier <u>AND</u> G-code. The modifiers allowed for this measure are: 1P- medical reasons, 2P-patient reasons, 8P- reason not otherwise specified. All measure-specific coding should be reported ON THE SAME CLAIM.

NUMERATOR:

Patients who were prescribed adjuvant hormonal therapy (GnRH [gonadotropin-releasing hormone] agonist or antagonist)

Definitions:

Risk Strata: Low, Intermediate, or High

Low Risk – PSA \leq 10 mg/dL; AND Gleason score 6 or less; AND clinical stage T1c or T2a²

Intermediate Risk – PSA > 10 to 20 mg/dL; OR Gleason score 7; OR clinical stage T2b, and not qualifying for high risk²

High Risk – PSA > 20 mg/dL; OR Gleason score 8 to 10; OR clinically localized stage $T3a^1$

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

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

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Adjuvant Hormonal Therapy Prescribed/Administered

(One CPT II code & one G-code [4164F & G8465] are required on the claim form to submit this numerator option)

CPT II 4164F: Adjuvant (ie, in combination with external beam radiotherapy to the prostate for prostate cancer) hormonal therapy (GnRH [gonadotropin-releasing hormone] agonist or antagonist) prescribed/administered

<u>AND</u>

G8465: High risk of recurrence of prostate cancer

Adjuvant Hormonal Therapy <u>not</u> Prescribed/Administered for Medical or Patient Reasons

(One CPT II code & one G-code [4164F-xP & G8465] are required on the claim form to submit this numerator option)

Append a modifier (**1P or 2P**) to CPT Category II code **4164F** to report documented circumstances that appropriately exclude patients from the denominator.

4164F *with* **1P**: Documentation of medical reason(s) for not prescribing/administering adjuvant hormonal therapy (eg, salvage therapy)

4164F *with* **2P:** Documentation of patient reason(s) for not prescribing/administering adjuvant hormonal therapy

<u>and</u>

G8465: High risk of recurrence of prostate cancer

OR

If patient is not eligible for this measure because the risk of recurrence is low, intermediate or not determined, report:

(One G-code [G8464] is required on the claim form to submit this numerator option) **G8464:** Clinician documented that prostate cancer patient is not an eligible candidate for adjuvant hormonal therapy; Low or intermediate risk of recurrence OR risk of recurrence not determined

Adjuvant Hormonal Therapy not Prescribed/Administered, Reason not Specified

(One CPT II code & one G-code [4164F-8P & G8465] are required on the claim form to submit this numerator option)

Append a reporting modifier (8P) to CPT Category II code 4164F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

4164F *with* **8P:** Patients who were <u>not</u> prescribed/administered adjuvant hormonal therapy, reason not otherwise specified

<u>and</u>

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

Note: Only patients with prostate cancer with high risk of recurrence will be counted in the performance denominator of this measure

Denominator Criteria (Eligible Cases):

Diagnosis for prostate cancer (line-item ICD-9-CM): 185 <u>AND</u> Patient encounter during the reporting period (CPT): 77407, 77408, 77409, 77411, 77412, 77413, 77414, 77416, 77418, 77427

RATIONALE:

If receiving external beam radiotherapy as primary therapy, prostate cancer patients with a high risk of recurrence should also be prescribed hormonal therapy, which has been shown to increase the effectiveness of the radiotherapy.

CLINICAL RECOMMENDATION STATEMENTS:

High risk patients who are considering specific treatment options should be informed of findings of recent high quality clinical trials, including that: for those considering external beam radiotherapy, use of hormonal therapy combined with conventional radiotherapy may prolong survival. (AUA) (Standard)

Men with prostate cancer that is clinically localized stage T3a1, with Gleason score of 8 to 10, or PSA level greater than 20 ng/mL are categorized by the NCCN panel to be at high risk of recurrence after definitive therapy. Note that patients with multiple adverse factors may be shifted into the very high-risk category. Hormonal therapy (e.g., androgen ablation) plus external-beam RT is recommended. (NCCN) (Category 1)

A Measure #105: Prostate Cancer: Three-Dimensional (3D) Radiotherapy

2009 PQRI REPORTING OPTIONS: CLAIMS-BASED, REGISTRY

DESCRIPTION:

Percentage of patients, regardless of age, with a diagnosis of clinically localized prostate cancer receiving external beam radiotherapy as a primary therapy to the prostate with or without nodal irradiation (no metastases; no salvage therapy)

INSTRUCTIONS:

This measure is to be reported <u>once per episode</u> of radiation therapy for <u>all</u> patients with prostate cancer who receive external beam radiotherapy to the prostate during the reporting period. Claims data will be analyzed to determine unique episodes of radiation therapy. Each episode of radiation therapy in an eligible patient receiving external beam radiotherapy to the prostate occurring during the reporting period will be counted when calculating the reporting and performance rates. The PQRI quality-data code needs to be submitted only once during the episode of radiation therapy (e.g., 8 weeks of therapy). It is anticipated that <u>clinicians who perform external beam radiotherapy to the prostate</u> will submit this measure.

Measure Reporting via Claims:

Line-item ICD-9-CM diagnosis codes and CPT codes are used to identify patients who are included in the measure's denominator. CPT Category II codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the appropriate ICD-9-CM diagnosis codes, CPT codes, and the appropriate CPT Category II code(s) **OR** the CPT Category II code(s) **with** the modifier. The reporting modifier allowed for this measure is: 8P- reason not otherwise specified. All measure-specific coding should be reported ON THE SAME CLAIM.

NUMERATOR:

Patients who receive three-dimensional conformal radiotherapy (3D-CRT) or intensity modulated radiation therapy (IMRT)

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

<u>Numerator Quality-Data Coding Options for Reporting Satisfactorily:</u> 3D-CRT or IMRT Received

(Two CPT II codes [4165F & 4200F] are required on the claim form to submit this numerator option)

CPT II 4165F: Three-dimensional conformal radiotherapy (3D-CRT) or intensity modulated radiation therapy (IMRT) received

<u>AND</u>

CPT II 4200F: External beam radiotherapy as primary therapy to the prostate with or without nodal irradiation

If patient is not eligible for this measure because the 3D-CRT or IMRT is to region(s) other than the prostate only, report:

(One CPT II code [4201F] is required on the claim form to submit this numerator option) CPT II 4201F: External beam radiotherapy with or without nodal irradiation as adjuvant or salvage therapy for prostate cancer patient

<u> 0R</u>

3D-CRT or IMRT not Received, Reason not Specified

(Two CPT II codes [4165F-8P & 4200F] are required on the claim form to submit this numerator option)

Append a reporting modifier (8P) to CPT Category II code 4165F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

4165F *with* **8P:** Patients who did <u>not</u> receive three-dimensional conformal radiotherapy (3D-CRT) or intensity modulated radiation therapy (IMRT), reason not otherwise specified

<u>AND</u>

CPT II 4200F: External beam radiotherapy as primary therapy to the prostate with or without nodal irradiation

DENOMINATOR:

All patients, regardless of age, with a diagnosis of clinically localized prostate cancer receiving external beam radiotherapy as primary therapy to the prostate with or without nodal irradiation (no metastases; no salvage therapy)

Denominator Criteria (Eligible Cases):

Diagnosis for clinically localized prostate cancer (line-item ICD-9-CM): 185 <u>WITHOUT</u>

Secondary malignant neoplasm diagnosis of a specified site – respiratory, digestive, and of other specified sites (line-item ICD-9-CM): 197.0, 197.1, 197.2, 197.3, 197.4, 197.5, 197.6, 197.7, 197.8, 198.0, 198.1, 198.2, 198.3, 198.4, 198.5, 198.6, 198.7, 198.81, 198.82, 198.89

<u>AND</u>

Patient encounter during the reporting period (CPT): 77401, 77402, 77403, 77404, 77406, 77407, 77408, 77409, 77411, 77412, 77413, 77414, 77416, 77418, 77427

RATIONALE:

Current, computer-aided radiotherapy techniques improve the precision of the irradiation of cancerous tissue and should be employed for all patients receiving external beam radiotherapy as primary therapy to the prostate.

CLINICAL RECOMMENDATION STATEMENTS:

Three-dimensional CRT or intensity-modulated radiation therapy (IMRT) techniques should be employed over conventional techniques. These techniques use computer software to integrate CT images of the patients' internal anatomy in the treatment position, which allows the volume

receiving the high radiation dose to "conform" more exactly to the shape of the tumor. Threedimensional 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)

A Measure #106: Major Depressive Disorder (MDD): Diagnostic Evaluation

2009 PQRI REPORTING OPTIONS: CLAIMS-BASED, REGISTRY

DESCRIPTION:

Percentage of patients aged 18 years and older with a new diagnosis or recurrent episode of MDD who met the DSM-IV criteria during the visit in which the new diagnosis or recurrent episode was identified during the measurement period

INSTRUCTIONS:

This measure is to be reported a minimum of <u>once per reporting period</u> for all patients with an active diagnosis of major depressive disorder seen during the reporting period, including episodes of MDD that began prior to the reporting period. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

Measure Reporting via Claims:

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

When reporting the measure via claims, submit the listed ICD-9-CM diagnosis codes, CPT codes, and the appropriate CPT Category II code <u>**OR**</u> the CPT Category II code <u>**with**</u> the modifier. The reporting modifier allowed for this measure is: 8P- reason not otherwise specified. There are no allowable performance exclusions for this measure. All measure-specific coding should be reported ON THE SAME CLAIM.

NUMERATOR:

Patients with documented evidence that they met the DSM-IV criteria [At least 5 elements (must include: 1) depressed mood or 2) loss of interest or pleasure) with symptom duration of 2 weeks or longer] during the visit in which the new diagnosis or recurrent episode was identified.

Definitions:

DSM-IV Criteria – Includes presence of depressed mood, marked diminished interest/pleasure, significant weight loss or weight gain, insomnia or hypersomnia, psychomotor agitation or retardation, fatigue or loss of energy, feelings of worthlessness, diminished ability to concentrate and recurrent suicidal ideation. **Remission** – Patient no longer meets DSM-IV criteria

NUMERATOR NOTE: PATIENTS WHOSE EPISODE OF MDD BEGAN PRIOR TO THE CURRENT REPORTING PERIOD: The clinician should report that DSM IV criteria was assessed during the visit in which the new diagnosis or recurrent episode was identified. <u>Numerator Quality-Data Coding Options for Reporting Satisfactorily:</u> DSM-IV Criteria for Major Depressive Disorder Documented CPT II 1040F: DSM-IV criteria for major depressive disorder documented <u>at the initial</u> evaluation

OR

DSM-IV Criteria for Major Depressive Disorder <u>not</u> Documented, Reason not Specified

Append a reporting modifier (8P) to CPT Category II code 1040F report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

1040F *with* **8P:** DSM-IV criteria for major depressive disorder <u>not</u> documented at the initial evaluation, reason not otherwise specified

DENOMINATOR:

All patients aged 18 years and older with a new diagnosis or recurrent episode of MDD

Denominator Criteria (Eligible Cases):

Patients aged \geq 18 years on date of encounter **AND**

Diagnosis for MDD (line-item ICD-9-CM): 296.20, 296.21, 296.22, 296.23, 296.24, 296.30, 296.31, 296.32, 296.33, 296.34

<u>and</u>

Patient encounter during the reporting period (CPT): 90801, 90802, 90804, 90805, 90806, 90807, 90808, 90809, 90810, 90811, 90812, 90813, 90814, 90815, 90845, 90862, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 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)

Diagnostic criteria for 296.20-296.24 – Major Depressive Disorder, Single Episode

- A. Presence of a single Major Depressive Episode.
- B. The Major Depressive Episode is not better accounted for by Schizoaffective Disorder and is not superimposed on Schizophrenia, Schizophreniform Disorder, Delusional Disorder, or Psychotic Disorder Not Otherwise Specified.
- C. There has never been a Manic Episode, a Mixed Episode, or a Hypomanic Episode.

Note: This exclusion does not apply if all of the manic-like, mixed-like, or hypomanic-like episodes are substance or treatment induced or are due to the direct physiological effects of a general medical condition. (DSM IV)

Diagnostic criteria for 296.30-296.34 - Major Depressive Disorder, Recurrent

- A. Presence of two or more Major Depressive Episodes.
 Note: To be considered separate episodes, there must be an interval of at least 2 consecutive months in which criteria are not met for a Major Depressive Episode.
- B. The Major Depressive Episodes are not better accounted for by Schizoaffective Disorder and are not superimposed on Schizophrenia, Schizophreniform Disorder, Delusional Disorder, or Psychotic Disorder Not Otherwise Specified.
- C. There has never been a Manic Episode, a Mixed Episode, or a Hypomanic Episode.

Note: This exclusion does not apply if all of the manic-like, mixed-like, or hypomanic-like episodes are substance or treatment induced or are due to the direct physiological effects of a general medical condition. (DSM IV)

Criteria for Major Depressive Episode

- A. At least five of the following symptoms have been present during the same 2-week period and represent a change from previous functioning; at least one of the symptoms is either 1) depressed mood or 2) loss of interest or pleasure (do not include symptoms that are clearly due to general medical condition or mood-incongruent delusions or hallucinations).
 - 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)
 - 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
 - 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)
 - 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)

A Measure #107: Major Depressive Disorder (MDD): Suicide Risk Assessment

2009 PQRI REPORTING OPTIONS: CLAIMS-BASED, REGISTRY

DESCRIPTION:

Percentage of patients aged 18 years and older with a new diagnosis or recurrent episode of MDD who had a suicide risk assessment completed at each visit during the measurement period

INSTRUCTIONS:

This measure is to be reported at <u>each visit</u> for a new diagnosis or recurrent episode of MDD, for patients seen individually during the reporting period. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

Measure Reporting via Claims:

Line-item ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. CPT Category II code(s) are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed ICD-9-CM diagnosis codes, CPT codes, and the appropriate CPT Category II code(s) **OR** the CPT Category II code **with** the modifier. The reporting modifier allowed for this measure is: 8P- reason not otherwise specified. All measure-specific coding should be reported ON THE SAME CLAIM.

NUMERATOR:

Patients who had suicide risk assessment completed at each visit

Numerator Quality-Data Coding Options for Reporting Satisfactorily: Suicide Risk Assessed CPT II 3085F: Suicide risk assessed

<u> 0R</u>

If patient is not eligible for this measure because MDD is in remission, report: CPT II 3092F: Major depressive disorder, in remission

Suicide Risk not Assessed, Reason not Specified

Append a reporting modifier (8P) to CPT Category II code 3085F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

3085F with 8P: Suicide risk not assessed, reason not otherwise specified

DENOMINATOR:

All patients aged 18 years and older with a new diagnosis or recurrent episode of MDD

Denominator Criteria (Eligible Cases):

Patients aged \geq 18 years on date of encounter

<u>and</u>

Diagnosis for MDD (line-item ICD-9-CM): 296.20, 296.21, 296.22, 296.23, 296.24, 296.30, 296.31, 296.32, 296.33, 296.34

AND

Patient encounter during the reporting period (CPT): 90801, 90802, 90804, 90805, 90806, 90807, 90808, 90809, 90810, 90811, 90812, 90813, 90814, 90815, 90845, 90862, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 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: Rheumatoid Arthritis (RA): Disease Modifying Anti-Rheumatic Drug (DMARD) Therapy

2009 PQRI REPORTING OPTIONS: CLAIMS-BASED, REGISTRY, MEASURES GROUP

DESCRIPTION:

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

INSTRUCTIONS:

This measure is to be reported a minimum of <u>once per reporting period</u> for RA patients seen during the reporting period. It is anticipated that clinicians who provide care for patients with a diagnosis of RA will submit this measure.

Measure Reporting via Claims:

Line-item ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. CPT Category II codes can be used to report the numerator of the measure.

When reporting the measure via claims, submit the listed ICD-9-CM diagnosis codes, CPT codes, and the appropriate CPT Category II code <u>**OR**</u> the CPT Category II code <u>**with**</u> the modifier. The modifier codes allowed for this measure are: 1P- medical reasons, 8P- reason not otherwise specified. All measure-specific coding should be reported ON THE SAME CLAIM.

NUMERATOR:

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

Definitions:

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. **Biologic DMARD Therapy** – Includes Adalimunab, Etanercept, Infliximab, Abatacept, Anakinra and Rituximab

<u>Numerator Quality-Data Coding Options for Reporting Satisfactorily:</u> DMARD Prescribed, Dispensed, or Administered

CPT II 4187F: Disease modifying anti-rheumatic drug therapy prescribed, dispensed, or administered

DMARD <u>not</u> Prescribed, Dispensed, or Administered for Medical Reasons
 Append a modifier (1P) to CPT Category II code 4187F to report documented
 circumstances that appropriately exclude patients from the denominator.
 4187F with 1P: Documentation of medical reason(s) for not prescribing, dispensing, or
 administering disease modifying anti-rheumatic drug therapy

DMARD not Prescribed, Dispensed, or Administered, Reason not Specified

Append a reporting modifier (8P) to CPT Category II code 4187F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

4187F *with* **8P:** Disease modifying anti-rheumatic drug therapy was <u>not</u> prescribed, dispensed, or administered, reason not otherwise specified

DENOMINATOR:

All patients aged 18 years and older with a diagnosis of rheumatoid arthritis (RA)

Denominator Criteria (Eligible Cases): Patients aged ≥ 18 years on date of encounter AND Diagnosis for rheumatoid arthritis (line-item ICD-9-CM): 714.0, 714.1, 714.2, 714.81 AND Patient encounter during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, 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.)

Scottish Intercollegiate Guidelines Network: *Management of Early Rheumatoid Arthritis.* There is clear evidence from placebo-controlled trials that DMARDs reduce symptoms in RA (as measured by joint pain, swelling and tenderness, and duration and severity of morning stiffness). DMARDs also improve global well being, as assessed by both patients and physicians. It is becoming increasingly clear that DMARDs should be introduced as soon as possible. Protracted benefit may be achieved in RA patients if appropriate DMARD therapy is introduced early. Refer to Scottish Intercollegiate Guidelines Network. Management of Early Rheumatoid Arthritis, 2000.

A Measure #109: Osteoarthritis (OA): Function and Pain Assessment

2009 PQRI REPORTING OPTIONS: CLAIMS-BASED, REGISTRY

DESCRIPTION:

Percentage of patient visits for patients aged 21 years and older with a diagnosis of OA with assessment for function and pain

INSTRUCTIONS:

This measure is to be reported at <u>each visit</u> occurring during the reporting period for patients with osteoarthritis seen during the reporting period. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

Measure Reporting via Claims:

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

When reporting the measure via claims, submit the listed ICD-9-CM diagnosis codes, CPT codes, and the appropriate CPT Category II code <u>**OR**</u> the CPT Category II code <u>**with**</u> the modifier. The reporting modifier allowed for this measure is: 8P- reason not otherwise specified. There are no allowable performance exclusions for this measure. All measure-specific coding should be reported ON THE SAME CLAIM.

NUMERATOR:

Patient visits with assessment for level of function and pain documented

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Osteoarthritis Symptoms and Functional Status Assessed

CPT II 1006F: Osteoarthritis symptoms and functional status assessed (may include the use of a standardized scale or the completion of an assessment questionnaire, such as the SF-36, AAOS Hip & Knee Questionnaire)

Osteoarthritis Symptoms and Functional Status not Assessed, Reason not Specified

Append a reporting modifier (8P) to CPT Category II code 1006F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

1006F *with* **8P:** Osteoarthritis symptoms and functional status <u>not</u> assessed, reason not otherwise specified

DENOMINATOR:

All patient visits for patients aged 21 years and older with a diagnosis of OA

Denominator Criteria (Eligible Cases):

Patients aged \geq 21 years on date of encounter **AND**

Diagnosis for OA (line-item ICD-9-CM): 715.00, 715.04, 715.09, 715.10, 715.11, 715.12, 715.13, 715.14, 715.15, 715.16, 715.17, 715.18, 715.20, 715.21, 715.22, 715.23, 715.24, 715.25, 715.26, 715.27, 715.28, 715.30, 715.31, 715.32, 715.33, 715.34, 715.35, 715.36, 715.37, 715.38, 715.80, 715.89, 715.90, 715.91, 715.92, 715.93, 715.94, 715.95, 715.96, 715.97, 715.98

<u>and</u>

Patient encounter during the reporting period (CPT): 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)

A Measure #110: Preventive Care and Screening: Influenza Immunization for Patients \geq 50 Years Old

2009 PQRI REPORTING OPTIONS: CLAIMS-BASED, REGISTRY, MEASURES GROUP

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 <u>once per reporting period</u> for patients seen during the reporting period. This measure is intended to determine whether or not all patients aged 50 years and older received or had an order for influenza immunization during the flu season (September through February). There is no diagnosis associated with this measure. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

Measure Reporting via Claims:

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

When reporting the measure via claims, submit the listed CPT codes, and the appropriate numerator G-code. All measure-specific coding should be reported ON THE SAME CLAIM.

NUMERATOR:

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

<u>Numerator Quality-Data Coding Options for Reporting Satisfactorily:</u> Influenza Immunization Administered

G8482: Influenza immunization was ordered or administered

Influenza Immunization not Administered for Documented Reasons

G8483: Influenza immunization was not ordered or administered for reasons documented by clinician

Influenza Immunization <u>not</u> Administered, Reason not Specified G8484: Influenza immunization was not ordered or administered, reason not specified

DENOMINATOR:

All patients aged 50 years and older

Denominator Criteria (Eligible Cases):

Patients aged \geq 50 years on date of encounter <u>AND</u>

Patient encounter during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99315, 99316, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350

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 \geq 50 years. (CDC, USPSTF)

Measure #111: Preventive Care and Screening: Pneumonia Vaccination for Patients 65 Years and Older

2009 PQRI REPORTING OPTIONS: CLAIMS-BASED, REGISTRY, MEASURES GROUP

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 <u>once per reporting period</u> for patients seen during the reporting period. There is no diagnosis associated with this measure. Performance for this measure is not limited to the reporting period. This measure may be reported by clinicians who perform the quality actions described in the measure based on services provided and the measure-specific denominator coding.

Measure Reporting via Claims:

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

When reporting the measure via claims, submit the listed CPT codes, and the appropriate CPT Category II code <u>**OR**</u> the CPT Category II code <u>**with**</u> the modifier. The modifiers allowed for this measure are: 1P- medical reasons, 8P- reason not otherwise specified. All measure-specific coding should be reported ON THE SAME CLAIM.

NUMERATOR:

Patients who have ever received a pneumococcal vaccination

Numerator Quality-Data Coding Options for Reporting Satisfactorily: Pneumonia Vaccination Administered or Previously Received CPT II 4040F: Pneumococcal vaccine administered or previously received

OR

Pneumonia Vaccination <u>not</u> Administered or Previously Received for Medical Reasons

Append a modifier (**1P**) to CPT Category II code **4040F** to report documented circumstances that appropriately exclude patients from the denominator. **4040F** *with* **1P**: Documentation of medical reason(s) for not administering or previously

receiving pneumococcal vaccination

<u> 0R</u>

Pneumonia Vaccination <u>not</u> Administered or Previously Received, Reason not Specified

Append a reporting modifier (8P) to CPT Category II code 4040F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

4040F *with* **8P:** Pneumococcal vaccine was <u>not</u> administered or previously received, reason not otherwise specified

DENOMINATOR:

All patients 65 years and older

Denominator Criteria (Eligible Cases):

Patients aged \geq 65 years on date of encounter **AND**

Patient encounter during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99218, 99219, 99220, 99241, 99242, 99243, 99244, 99245, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, 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 \geq 75 years of age or with severe chronic disease) who were vaccinated more than five years previously. Medicare Part B fully covers the cost of the vaccine and its administration every five years. (United States Preventive Services Task Force, 1998) Pneumococcal infection is a common cause of illness and death in the elderly and persons with certain underlying conditions. In 1998, an estimated 3,400 adults aged \geq 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 non-institutionalized, high-risk populations to at least 90 percent (objective no. 14.29). While the percent of persons 65 years and older receiving the pneumococcal vaccine has increased, it still remains considerably below the *Health People 2010* objective. According to the National Health Interview Survey (NHIS), which is used to track performance on year 2010 objectives, in 1998 only 46 percent of adults age 65 years and older report receiving the vaccine. The figure was 45 percent based on the 1997 Behavioral Risk Factor Surveillance System (BRFSS) survey. (National Center for Health Statistics., 2005; CDC, 1997)

A particular strength of this measure is that it provides an opportunity to compare performance against national, state and/or regional benchmarks, which are collected through nationally organized and administered surveys.

At the physician practice level where a patient survey may not be feasible, data collection on pneumonia vaccination status through chart abstraction is a viable option.

Measure #112: Preventive Care and Screening: Screening Mammography

2009 PQRI REPORTING OPTIONS: CLAIMS-BASED, REGISTRY, MEASURES GROUP

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 <u>once per reporting period</u> 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.

Measure Reporting via Claims:

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

When reporting the measure via claims, submit the listed CPT codes, and the appropriate CPT Category II code <u>**OR**</u> the CPT Category II code <u>**with**</u> the modifier. The modifiers allowed for this measure are: 1P- medical reasons, 8P- reason not otherwise specified. All measure-specific coding should be reported ON THE SAME CLAIM.

NUMERATOR:

Patients who had a mammogram at least once within 24 months

<u>Numerator Quality-Data Coding Options for Reporting Satisfactorily:</u> Mammogram Performed

CPT II 3014F: Screening mammography results documented and reviewed

Mammogram not Performed for Medical Reasons

Append a modifier (**1P**) to CPT Category II code **3014F** to report documented circumstances that appropriately exclude patients from the denominator. **3014F** *with* **1P**: Documentation of medical reason(s) for not performing a mammogram

(i.e., women who had a bilateral mastectomy or two unilateral mastectomies).

Mammogram not Performed, Reason not Specified

Append a reporting modifier (8P) to CPT Category II code 3014F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

3014F *with* **8P:** Screening mammography results were <u>not</u> documented and reviewed, reason not otherwise specified

DENOMINATOR:

All female patients aged 40 through 69 years

Denominator Criteria (Eligible Cases):

Patients aged 40 through 69 years on date of encounter <u>AND</u> Patient encounter during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 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, twoview 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: Preventive Care and Screening: Colorectal Cancer Screening

2009 PQRI REPORTING OPTIONS: CLAIMS-BASED, REGISTRY, MEASURES GROUP

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 <u>once per reporting period</u> for patients seen during the reporting period. There is no diagnosis associated with this measure. Performance for this measure is not limited to the reporting period. This measure may be reported by clinicians who perform the quality actions described in the measure based on services provided and the measure-specific denominator coding.

Measure Reporting via Claims:

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

When reporting the measure via claims, submit the listed CPT codes, and the appropriate CPT Category II code <u>**OR**</u> the CPT Category II code <u>**with**</u> the modifier. The modifiers allowed for this measure are: 1P- medical reasons, 8P- reason not otherwise specified. All measure-specific coding should be reported ON THE SAME CLAIM.

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

<u>Numerator Quality-Data Coding Options for Reporting Satisfactorily:</u> Colorectal Cancer Screening

CPT II 3017F: Colorectal cancer screening results documented and reviewed

Colorectal Cancer Screening not Performed for Medical Reasons

Append a modifier (1P) to CPT Category II code 3017F to report documented circumstances that appropriately exclude patients from the denominator.
3017F with 1P: Documentation of medical reason(s) for not performing a colorectal cancer screening

Colorectal Cancer Screening not Performed, Reason not Specified

Append a reporting modifier (8P) to CPT Category II code 3017F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

3017F *with* **8P:** Colorectal cancer screening results were <u>not</u> documented and reviewed, reason not otherwise specified

DENOMINATOR:

All patients aged 50 through 80 years

Denominator Criteria (Eligible Cases):

Patients aged 50 through 80 years on date of encounter <u>AND</u>

Patient encounter during the reporting period (CPT): 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

RATIONALE:

Colorectal cancer is the second leading cause of cancer-related death in the United States. There were an estimated 135,400 new cases and 56,700 deaths from the disease during 2001. Colorectal cancer (CRC) places significant economic burden on the society as well with treatment costs over \$6.5 billion per year and, among malignancies, is second only to breast cancer at \$6.6 billion per year (Schrag, 1999).

Colorectal cancer screening can detect pre-malignant polyps and early stage cancers. Unlike other screening tests that only detect disease, colorectal cancer screening can guide removal of pre-malignant polyps, which in theory can prevent development of colon cancer. 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 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.

A Measure #114: Preventive Care and Screening: Inquiry Regarding Tobacco Use

2009 PQRI REPORTING OPTIONS: CLAIMS-BASED, REGISTRY, MEASURES GROUP

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 <u>once per reporting period</u> for <u>all</u> 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.

Measure Reporting via Claims:

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

When reporting the measure via claims, submit the listed CPT service codes, and the appropriate CPT Category II codes <u>**OR**</u> the CPT Category II code <u>**with**</u> the modifier. The reporting modifier allowed for this measure is: 8P- reason not otherwise specified. There are no allowable performance exclusions for this measure. All measure-specific coding should be reported ON THE SAME CLAIM.

NUMERATOR:

Patients who were queried about tobacco use one or more times within 24 months

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

<u>Numerator Quality-Data Coding Options for Reporting Satisfactorily:</u> Tobacco Use Assessed

(Two CPT II codes [1000F & 103xF] are required on the claim form to submit this numerator option) CPT II 1000F: Tobacco use assessed AND

CPT II 1034F: Current tobacco smoker <u>OR</u> CPT II 1035F: Current smokeless tobacco user <u>OR</u> CPT II 1036F: Current tobacco non-user

Tobacco Use not Assessed, Reason not Specified

(One CPT II code [1000F-8P] is required on the claim form to submit this numerator option)

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 Criteria (Eligible Cases):

Patients aged \geq 18 years on date of encounter <u>AND</u>

Patient encounter during the reporting period (CPT): 90801, 90802, 90804, 90805, 90806, 90807, 90808, 90809, 90810, 90811, 90812, 90813, 90814, 90815, 90845, 90862, 96150, 96152, 97003, 97004, 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: Preventive Care and Screening: Advising Smokers to Quit

2009 PQRI REPORTING OPTIONS: CLAIMS-BASED, REGISTRY, MEASURES GROUP

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 <u>once per reporting period</u> for <u>all</u> patients (whether or not they use tobacco) seen during the reporting period. All patients identified as tobacco smokers at any time during the reporting period should be advised to quit. 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.

Measure Reporting via Claims:

CPT codes and patient demographics are used to identify patients who are included in the measure's denominator. CPT Category II and/or G-codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed CPT codes, and the appropriate CPT Category II code <u>AND/OR</u> G-code <u>OR</u> the CPT Category II code <u>with</u> the modifier <u>AND</u> G-code. The reporting modifier allowed for this measure is: 8P- reasons not otherwise specified. All measure-specific coding should be reported ON THE SAME CLAIM.

NUMERATOR:

Patients who received advice to quit smoking

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

<u>Numerator Quality-Data Coding Options for Reporting Satisfactorily:</u> Advising Smoker to Quit

(One G-code and one CPT II code [G8455 & 400xF] are required on the claim form to submit this numerator option)

G8455: Current tobacco smoker AND

CPT II 4000F: Tobacco use cessation intervention, counseling **OR CPT II 4001F:** Tobacco use cessation intervention, pharmacologic therapy

<u> 0R</u>

If patient is not eligible for this measure because patient is a smokeless tobacco user or a non tobacco user, report:

(One G-code [G845x] is required on the claim form to submit this numerator option)

Smokeless Tobacco User

G8456: Current smokeless tobacco user

Tobacco Non-User

G8457: Current tobacco non-user

<u> 0R</u>

Tobacco Smoker not Advised to Quit, Reason not Specified

(One CPT II code and one G-code [4000F-8P & G8455] are required on the claim form to submit this numerator option)

Append a reporting modifier (8P) to CPT Category II code 4000F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

4000F *with* **8P:** Tobacco use cessation intervention <u>not</u> counseled, reason not otherwise specified

<u>and</u>

G8455: Current tobacco smoker

DENOMINATOR:

All patients aged 18 years and older

Denominator Criteria (Eligible Cases):

Patients aged \geq 18 years on date of encounter <u>AND</u> Detient encounter during the reporting paris

Patient encounter during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 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: Antibiotic Treatment for Adults with Acute Bronchitis: Avoidance of Inappropriate Use

2009 PQRI REPORTING OPTIONS: CLAIMS-BASED, REGISTRY

DESCRIPTION:

Percentage of adults aged 18 through 64 years with a diagnosis of acute bronchitis who were <u>not</u> <u>prescribed or dispensed</u> an antibiotic prescription on or within 3 days of the initial date of service

INSTRUCTIONS:

This measure is to be reported at <u>each visit</u> for acute bronchitis during the reporting period. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

Measure Reporting via Claims:

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

When reporting the measure via claims, submit the listed ICD-9-CM diagnosis codes, CPT codes, and the appropriate CPT Category II code <u>**OR**</u> the CPT Category II code <u>**with**</u> the modifier. The modifier allowed for this measure is: 1P- medical reasons. All measure-specific coding should be reported ON THE SAME CLAIM.

NUMERATOR:

Patients who were <u>not</u> prescribed or dispensed antibiotics on or within 3 days of the initial date of service

Numerator Instructions: For performance, the measure will be calculated as the number of patients for whom antibiotics were neither prescribed nor dispensed on or within 3 days of the initial date of service over the number of patients in the denominator (patients aged 18 through 64 years with acute bronchitis). A higher score indicates appropriate treatment of patients with acute bronchitis (e.g., the proportion for whom antibiotics *were not* prescribed or dispensed on or three days after the initial date of service).

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

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

Description		Prescription	
5-aminosalicylates	 sulfasalazine 		
Aminoglycosides	 amikacin gentamicin	kanamycinneomycin	 tobramycin
Aminopenicillins	amoxicillin	ampicillin	

Antipseudomonal penicillins	• piperacillin	• ticarcillin	
Beta-lactamase inhibitors	amoxicillin-clavulanateampicillin-sulbactam	 piperacillin- tazobactam 	• ticarcillin-clavulanate
First generation cephalosporins	cefadroxilcefazolin	cephalexincephradine	
Fourth generation cephalosporins	cefepime		
Ketolides	telithromycin		
Lincomycin derivatives	clindamycin	Iincomycin	
Macrolides	azithromycinclarithromycin	 erythromycin erythromycin ethylsuccinate 	 erythromycin lactobionate erythromycin stearate
Miscellaneous antibiotics	 aztreonam chloramphenicol dalfopristin- quinupristin 	 daptomycin erythromycin- sulfisoxazole linezolid 	metronidazolevancomycin
Sulfamethoxazole- trimethoprim DS	 sulfamethoxazole- trimethoprim 		
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	ciprofloxacingatifloxacingemifloxacin	levofloxacinlomefloxacinmoxifloxacin	Norfloxacinofloxacinsparfloxacin
Rifamycin derivatives	• rifampin		
Second generation cephalosporin	cefaclorcefotetan	cefoxitincefprozil	cefuroximeloracarbef
Sulfonamides	 sulfadiazine sulfamethoxazole-trime 	ethoprim	• sulfisoxazole
Tetracyclines	doxycycline	minocycline	 tetracycline
Third generation	cefdinir	cefotaxime	ceftibuten
cephalosporins	cefditoren	 cefpodoxime 	ceftizoxime
	cefixime	ceftazidime	ceftriaxone
Urinary anti- infectives	 fosfomycin nitrofurantoin nitrofurantoin macrocrystals 	nitrofurantoin macrocitrimethoprim	rystals-monohydrate

Antibiotic <u>not</u> Prescribed or Dispensed CPT II 4124F: Antibiotic neither prescribed nor dispensed

Antibiotic Prescribed or Dispensed for Medical Reasons

Append a modifier (1P) to CPT Category II code 4120F to report documented circumstances that appropriately exclude patients from the denominator.
4120F with 1P: Documentation of medical reason(s) for prescribing or dispensing antibiotic

<u> 0R</u>

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 Criteria (Eligible Cases):

Patients aged 18 through 64 years on date of encounter <u>AND</u>

Diagnosis for acute bronchitis (line-item ICD-9-CM): 466.0 AND

Patient encounter during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99217, 99218, 99219, 99220, 99241, 99242, 99243, 99244, 99245

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 in adults 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: Diabetes Mellitus: Dilated Eye Exam in Diabetic Patient

2009 PQRI REPORTING OPTIONS: CLAIMS-BASED, REGISTRY, MEASURES GROUP

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 <u>once per reporting period</u> for patients with diabetes mellitus seen during the reporting period. This measure may be reported by clinicians who perform the quality actions described in the measure based on services provided and the measure-specific denominator coding.

Measure Reporting via Claims:

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

When reporting the measure via claims, submit the listed ICD-9-CM diagnosis codes, CPT codes, and the appropriate CPT Category II code <u>**OR**</u> the CPT Category II code <u>**with**</u> the modifier. The reporting modifier allowed for this measure is: 8P- reason not otherwise specified. There are no allowable performance exclusions for this measure. All measure-specific coding should be reported ON THE SAME CLAIM.

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 Quality-Data Coding Options for Reporting Satisfactorily:

Dilated Eye Exam Performed by an Eye Care Professional

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

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

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

OR

Dilated Eye Exam not Performed, Reason not Specified

Append a reporting modifier (8P) to CPT Category II code 2022F or 2024F or 2026F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

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

DENOMINATOR:

All patients aged 18 through 75 years with a diagnosis of diabetes

Denominator Criteria (Eligible Cases):

Patients aged 18 through 75 years on date of encounter AND

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

<u>AND</u>

Patient encounter during the reporting period (CPT or HCPCS): 92002, 92004, 92012, 92014, 97802, 97803, 97804, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, G0270, G0271

RATIONALE:

Examination of the eyes is the first step in the treatment of any existing or developing conditions related to retinopathy and the first step in the prevention of blindness.

CLINICAL RECOMMENDATION STATEMENTS:

AACE/ACE, ADA, and American Academy of Ophthalmology (AAO): Recommend that a dilated eye examination be performed on patients with diabetes during an initial assessment and at least annually thereafter. (AACE/ACE, 2002; ADA, 2004; AAO, 1998; Hammond, 1998)

American Association of Clinical Endocrinologists and American College of Endocrinology (AACE/ACE): Recommend that the annual eye examination be performed as part of a retinal module. The module includes test of visual acuity (Snellen chart); funduscopic examination and intraocular pressure (IOP) test. The AACE/ACE recommends that diabetic patients should be under the care of an ophthalmologist experienced in the management of diabetic retinopathy. AACE/ACE further believes that a dilated eye exam should only be done by an MD/DO. (AACE/ACE, 2002)

American Diabetes Association (ADA): Patients with type 1 diabetes should have an initial dilated and comprehensive eye examination by an ophthalmologist or optometrist within 3-5 years after the onset of diabetes. In general evaluation for diabetic eye disease is not necessary before 10 years of age. However, some evidence suggests that the prepubertal duration of diabetes may be important in the development of microvascular complications; therefore, clinical judgment should be used when applying these recommendations to individual patients. (Level of Evidence: B) Patients with type 2 diabetes should have an initial dilated and comprehensive eye examination by an ophthalmologist or optometrist shortly after diabetes diagnosis. (Level of Evidence: B)

Subsequent examinations for type 1 and type 2 diabetic patients should be repeated annually by an ophthalmologist or optometrist who is knowledgeable and experienced in diagnosing the presence of diabetic retinopathy and is aware of its management. Examination will be required more frequently if retinopathy is progressing. This follow-up interval is recommended recognizing that there are limited data addressing this issue. (Level of Evidence: B)

Seven standard field stereoscopic 30° fundus photography is an accepted method for examining diabetic retinopathy. (ADA, 2004)

American Academy of Ophthalmology (AAO): Recommends that diabetic patients should be under the care of an ophthalmologist experienced in the management of diabetic retinopathy. Ophthalmologists with specialized knowledge and experience in managing the disease are best able to detect and treat serious disease. Stereoscopic photographs offer an advantage over nonstereoscopic photographs, and the traditional "seven stereo fields" provide the most complete coverage. (AAO, 1998; Hammond, 1996)

American Geriatrics Society (AGS): Dilated eye examinations should be performed every two years at a minimum, and more often if there are additional risk factors for diabetic eye disease or evidence of age-related eye disease. (CHF/AGS, 2003)

A Measure #118: Coronary Artery Disease (CAD): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Patients with CAD and Diabetes and/or Left Ventricular Systolic Dysfunction (LVSD)

2009 PQRI REPORTING OPTIONS: CLAIMS-BASED, REGISTRY

DESCRIPTION:

Percentage of patients aged 18 years and older with a diagnosis of CAD who also have diabetes mellitus and/or LVSD who were prescribed ACE inhibitor or ARB therapy

INSTRUCTIONS:

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

Measure Reporting via Claims:

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

When reporting the measure via claims, submit the listed CPT codes, and the appropriate numerator G-code. All measure-specific coding should be reported ON THE SAME CLAIM.

There are two reporting criteria for this measure:

(1) Patients who are 18 years and older with a diagnosis of CAD OR

(2) Patients who are 18 years and older with a diagnosis of CAD who are also diabetic

The eligible professional should submit data on one of the reporting criteria, depending on the clinical findings. If patient has CAD (without a diagnosis of Diabetes), use Denominator Reporting Criteria 1. If the patient has CAD and Diabetes, use Denominator Reporting Criteria 2. If a patient has both diabetes and LVSD, the eligible professional may report quality data for Reporting Criteria 2 and this will count as appropriate reporting for this patient.

REPORTING CRITERIA 1: All patients with CAD (without a diagnosis of diabetes)

NUMERATOR:

Patients who were prescribed ACE inhibitor or ARB therapy

Numerator Instructions: It is necessary to determine the LVEF for the patient, either through quantitative or qualitative assessment. Examples of a quantitative or qualitative assessment may include an echocardiogram: 1) that provides a numerical value of LVSD or 2) that uses descriptive terms such as moderately or severely depressed left ventricular

function. If the patient does not have LVSD (as defined by LVEF <40% or moderately or severely depressed left ventricular systolic function), report only G8470. If LVEF was not performed or is not documented, report only G8471.

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.

<u>Numerator Quality-Data Coding Options for Reporting Satisfactorily:</u> 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 \ge 40% or LVEF not performed or documented, report:

Left Ventricular Ejection Fraction (LVEF) $\ge 40\%$

(One G-code [G847x] is required on the claim form to submit this numerator option) **G8470:** Patient with left ventricular ejection fraction (LVEF) \geq 40% or documentation as normal or mildly depressed left ventricular systolic function

Left Ventricular Ejection Fraction (LVEF) <u>not</u> Performed or Documented

G8471: Left ventricular ejection fraction (LVEF) was not performed or documented

ACE Inhibitor or ARB Therapy <u>not</u> 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 (REPORTING CRITERIA 1):

All patients aged 18 years and older with a diagnosis of CAD who also have a diagnosis of LVSD

Denominator Criteria (Eligible Cases):

Patients aged \geq 18 years on date of encounter <u>AND</u>

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

Patient encounter during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 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 CRITERIA 2: Patients with CAD and diabetes

NUMERATOR:

Patients who were prescribed ACE inhibitor or ARB therapy

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

ACE Inhibitor or ARB Therapy Prescribed

G8473: Angiotensin converting enzyme (ACE) inhibitor or angiotensin receptor blocker (ARB) therapy prescribed

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

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 (REPORTING CRITERIA 2):

All patients aged 18 years and older with a diagnosis of CAD who also have a diagnosis of diabetes

Note: If a patient has both diabetes and LVSD, reporting criteria #2 will count as appropriate reporting for this patient.

Denominator Criteria (Eligible Cases):

Patients aged \geq 18 years on date of encounter **AND**

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

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

<u>AND</u>

Patient encounter during the reporting period (CPT): 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: Diabetes Mellitus: Urine Screening for Microalbumin or Medical Attention for Nephropathy in Diabetic Patients

2009 PQRI REPORTING OPTIONS: CLAIMS-BASED, REGISTRY, MEASURES GROUP

DESCRIPTION:

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

INSTRUCTIONS:

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

Measure Reporting via Claims:

Line-item ICD-9-CM diagnosis codes, CPT code, G-codes, and patient demographics are used to identify patients who are included in the measure's denominator. CPT Category II codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed ICD-9-CM diagnosis codes, CPT codes, and the appropriate CPT Category II code **OR** G-code **OR** the CPT Category II code **with** the modifier. The reporting modifier allowed for this measure is: 8P- reason not otherwise specified. There are no allowable performance exclusions for this measure. All measure-specific coding should be reported ON THE SAME CLAIM.

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.

<u>Numerator Quality-Data Coding Options for Reporting Satisfactorily:</u> 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)

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

Nephropathy Screening not Performed, Reason not Specified

Append a reporting modifier (8P) to CPT Category II code 3060F or 3061F or 3062F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

3060F or 3061F or 3062F with 8P: Nephropathy screening was not performed, reason not otherwise specified

DENOMINATOR:

All patients aged 18 through 75 years with the diagnosis of diabetes

Denominator Criteria (Eligible Cases):

Patients aged 18 years through 75 years on date of encounter **AND**

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

<u>AND</u>

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

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).

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 albuminto-creatinine ratio is strongly recommended.

The role of annual microalbuminuria assessment is less clear after diagnosis of microalbuminuria and institution of angiotensin-converting enzyme (ACE) inhibitor or angiotensin receptor blocker (ARB) therapy and blood pressure control. Many experts recommend continued surveillance to assess both response to therapy and progression of disease.

National Kidney Foundation (NKF): Individuals at increased risk, but found not to have chronic kidney disease, should be advised to follow a program of risk factor reduction, if appropriate, and undergo repeat periodic evaluation (NKF, 2003).

A comparative analysis of recommendations and evidence in diabetes guidelines from 13 countries (including the American Diabetes Association and Canadian Medical Association) found there was agreement among the guidelines that ACE inhibitors should be recommended to patients with hypertension and renal disease (Burgers, 2002).

The ADA also recommends that for the treatment of both micro- and macroalbuminuria, ARBs should be used except during pregnancy (ADA, 2005).

A Measure #121: Chronic Kidney Disease (CKD): Laboratory Testing (Calcium, Phosphorus, Intact Parathyroid Hormone (iPTH) and Lipid Profile)

2009 PQRI REPORTING OPTIONS: CLAIMS-BASED, REGISTRY, MEASURES GROUP

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 <u>once per reporting period</u> for patients with advanced CKD seen during the reporting period. It is anticipated that clinicians providing care for patients with advanced CKD will submit this measure.

Measure Reporting via Claims:

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

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

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

<u>Numerator Quality-Data Coding Options for Reporting Satisfactorily:</u> 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 <u>not</u> Ordered for Medical or Patient Reasons

Append a modifier (**1P or 2P**) to CPT Category II code **3278F** to report documented circumstances that appropriately exclude patients from the denominator.

3278F *with* **1P:** Documentation of medical reason(s) for not ordering serum levels of calcium, phosphorus, intact Parathyroid Hormone (iPTH) and lipid profile

3278F *with* **2P:** Documentation of patient reason(s) for not ordering serum levels of calcium, phosphorus, intact Parathyroid Hormone (iPTH) and lipid profile

Serum Levels of Calcium, Phosphorus, Intact Parathyroid Hormone (iPTH) and Lipid Profile <u>not</u> Ordered, Reason not Specified

Append a reporting modifier (8P) to CPT Category II code 3278F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

3278F *with* **8P:** Serum levels of calcium, phosphorus, intact Parathyroid Hormone (iPTH) and lipid profile <u>not</u> 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 Criteria (Eligible Cases):

Patients aged ≥ 18 years on date of encounter <u>AND</u> Diagnosis for stage 4 or 5 CKD (line-item ICD-9-CM): 585.4, 585.5 <u>AND</u> Patient encounter during the reporting period (CPT): 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 $GFR \le 30 \text{ ml/min}/1.73\text{m}^2$, 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)

A Measure #122: Chronic Kidney Disease (CKD): Blood Pressure Management

2009 PQRI REPORTING OPTIONS: CLAIMS-BASED, REGISTRY, MEASURES GROUP

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 <u>each visit</u> for patients with a diagnosis of advanced CKD seen during the reporting period. It is anticipated that clinicians providing care for patients with advanced CKD will submit this measure.

Measure Reporting via Claims:

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

When reporting the measure via claims, submit the listed ICD-9-CM diagnosis codes, CPT codes, and the appropriate G-code <u>AND/OR</u> CPT Category II code <u>OR</u> the CPT Category II code <u>with</u> the modifier <u>AND</u> G-code. The reporting modifier allowed for this measure is: 8P- reason not otherwise specified. There are no allowable performance exclusions for this measure. All measure-specific coding should be reported ON THE SAME CLAIM.

NUMERATOR:

Patients visits with blood pressure <130/80 mmHg OR ≥130/80 mmHg with a documented plan of care

Numerator Instructions: If multiple blood pressure measurements are taken at a single visit, use the most recent measurement taken at that visit.

Definition:

Documented Plan of Care – Should include one or more of the following: recheck blood pressure at specified future date; initiate or alter pharmacologic therapy; initiate or alter non-pharmacologic therapy; documented review of patient's home blood pressure log which indicates that patient's blood pressure is or is not well controlled.

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

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Patient Visits with Blood Pressure < 130/80 mmHg

(One G-code [G8476] is required on the claim form to submit this numerator option) **G8476:** Most recent blood pressure has a systolic measurement of <130 mmHg and a diastolic measurement of <80 mmHg

OR

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

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

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

AND

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

<u> 0R</u>

Blood Pressure Measurement not Performed, Reason not Specified

(One G-code [G8478] is required on the claim form to submit this numerator option) **G8478:** Blood pressure measurement not performed or documented, reason not specified

OR

Elevated Blood Pressure Plan of Care <u>not</u> Documented for Patient Visits with Systolic Blood Pressure \geq 130 mmHg and/or Diastolic Blood Pressure \geq 80 mmHg, Reason not Specified

(One CPT II code & one G-code [0513F-8P & G8477] are required on the claim form to submit this numerator option)

Append a reporting modifier (8P) to CPT Category II code 0513F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

0513F *with* **8P**: <u>No</u> documentation of elevated blood pressure plan of care, reason not otherwise specified

<u>and</u>

G8477: Most recent blood pressure has a systolic measurement of \ge 130 mmHg and/or a diastolic measurement of \ge 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 Criteria (Eligible Cases):

Patients aged \geq 18 years on date of encounter <u>AND</u>

Diagnosis for stage 4 or 5 CKD (line-item ICD-9-CM): 585.4, 585.5 AND

Patient encounter during the reporting period (CPT): 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 \leq 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 \leq 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)

A Measure #123: Chronic Kidney Disease (CKD): Plan of Care – Elevated Hemoglobin for Patients Receiving Erythropoiesis-Stimulating Agents (ESA)

2009 PQRI REPORTING OPTIONS: CLAIMS-BASED, REGISTRY, MEASURES GROUP

DESCRIPTION:

Percentage of calendar months during the 12-month reporting period in which patients aged 18 years and older with a diagnosis of advanced CKD (stage 4 or 5, not receiving Renal Replacement Therapy [RRT]), receiving ESA therapy, have a hemoglobin < 13 g/dL OR patients whose hemoglobin is \geq 13 g/dL and have a documented plan of care

INSTRUCTIONS:

This measure is to be reported <u>each calendar month</u> patients are seen with a diagnosis of advanced CKD (stage 4 or 5) during the reporting period. The most recent quality code submitted will be used for performance calculation. It is anticipated that clinicians providing care for patients with advanced CKD will submit this measure.

Measure Reporting via Claims:

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

When reporting the measure via claims, submit the listed ICD-9-CM diagnosis codes, CPT codes, and the appropriate CPT Category II codes **OR** the CPT Category II code(s) **with** the modifier. The reporting modifier allowed for this measure is: 8P- reason not otherwise specified. All measure-specific coding should be reported ON THE SAME CLAIM.

NUMERATOR:

Number of calendar months during which patients with a hemoglobin level of < 13 g/dL OR patients whose hemoglobin level is \geq 13 g/dL have a documented plan of care

Definition:

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

Numerator Quality-Data Coding Options for Reporting Satisfactorily: Hemoglobin level < 13 g/dL (*Two CPT II codes [328xF & 4171F] are required on the claim form to submit this numerator option*) CPT II 3281F: Hemoglobin level less than 11 g/dL OR

CPT II 3280F: Hemoglobin level 11 g/dL to 12.9 g/dL <u>AND</u> **CPT II 4171F:** Patient receiving Erythropoiesis-Stimulating Agents (ESA) therapy

OR

Hemoglobin level \geq 13 g/dL with a Documented Plan of Care

(Three CPT II codes [3279F & 0514F & 4171F] are required on the claim form to submit this numerator option)

CPT II 3279F: Hemoglobin level greater than or equal to 13 g/dL **AND**

CPT II 0514F: Plan of care for elevated hemoglobin level documented for patient receiving Erythropoiesis-Stimulating Agent (ESA) therapy

<u>AND</u>

CPT II 4171F: Patient receiving Erythropoiesis-Stimulating Agents (ESA) therapy

If patient is not eligible for this measure because, patient was not receiving erythropoiesis-stimulating agent (ESA) therapy, report:

(One CPT II code [4172F] is required on the claim form to submit this numerator option) **CPT II 4172F:** Patient not receiving Erythropoiesis-Stimulating Agents (ESA) therapy

Hemoglobin Level Measurement not Performed, Reason not Specified

(Two CPT II codes [3281F-8P & 4171F] are required on the claim form to submit this numerator option)

Append a reporting modifier (8P) to CPT Category II code 3281F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

3281F *with* **8P:** Hemoglobin level measurement <u>not</u> documented, reason not otherwise specified

<u>and</u>

CPT II 4171F: Patient receiving Erythropoiesis-Stimulating Agents (ESA) therapy

OR

Plan of Care for Elevated Hemoglobin Level <u>not</u> Documented for Patient Receiving Erythropoiesis-Stimulating Agent (ESA) Therapy, Reason not Specified

(Three CPT II codes [0514F-8P & 3279F & 4171F] are required on the claim form to submit this numerator option)

Append a reporting modifier (8P) to CPT Category II code 0514F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

0514F *with* **8P:** Plan of care for elevated hemoglobin level <u>not</u> documented for patient receiving Erythropoiesis-Stimulating Agent (ESA) therapy, reason not otherwise specified

<u>AND</u>

CPT II 3279F: Hemoglobin level greater than or equal to 13 g/dL AND CPT II 4171F: Patient receiving Erythropoiesis-Stimulating Agents (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 Criteria (Eligible Cases):

Patients aged ≥ 18 years on date of encounter <u>AND</u> Diagnosis for stage 4 or 5 CKD (line-item ICD-9-CM): 585.4, 585.5 <u>AND</u> Patient encounter during the reporting period (CPT): 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. 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: Health Information Technology (HIT): Adoption/Use of Electronic Health Records (EHR)

2009 PQRI REPORTING OPTIONS: CLAIMS-BASED, REGISTRY

DESCRIPTION:

Documents whether provider has adopted and is using health information technology. To qualify, the provider must have adopted and be using a certified/qualified EHR

INSTRUCTIONS:

This measure is to be reported at <u>each visit</u> 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 certified/qualified health information technology.

Measure Reporting via Claims:

CPT codes, HCPCS (D- or G-) codes are used to identify patients who are included in the measure's denominator. G-codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed CPT codes, HCPCS codes, and the appropriate numerator G-code. There are no allowable performance exclusions for this measure. All measure-specific coding should be reported ON THE SAME CLAIM.

NUMERATOR:

Patient encounter documentation substantiates use of certified/qualified EHR

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. Basic Privacy and Security Elements – Basic privacy and security elements include the following:

- Ability to audit the date/time and user of each time patient chart printed
- Ability to archive and retrieve health record information

CCHIT – The Certification Commission for Healthcare Information Technology – an independent, nonprofit organization that has been recognized by the federal government as an official certification body for electronic health record products.

Certified/Qualified Electronic Health Record – A certified/qualified EHR can be any of the following:

- Certification Commission for Healthcare Information Technology (CCHIT) certified EHR at the time of measurement
- If CCHIT certification is available (in primary care or a specialty) on or before August 1, 2008, but the system in use is not CCHIT certified, the EHR must meet the following criteria:
 - Ability to manage a medication list

- o Ability to manage a problem list
- Ability to manually enter or electronically receive, store and display laboratory results as discrete searchable data elements
- o Ability to meet basic privacy and security elements

AND

the EHR (above) must be CCHIT certified on or before August 1, 2011, or another CCHIT certified product must be in use for compliance after August 1, 2011

- If CCHIT certification is not available for a specialty on August 1, 2008, the EHR must have the following capabilities to be qualified:
 - o Ability to manage a medication list
 - Ability to manage a problem list
 - Ability to manually enter or electronically receive, store and display laboratory results as discrete searchable data elements
 - o Ability to meet basic privacy and security elements

Note: For providers having CCHIT certified EHR products available (according to specialty) on or before August 1, 2008, an extended time parameter has been placed in this measure of August 1, 2011 in order to allow for a period of time for providers to transition to a CCHIT certified product if necessary. After August 1, 2011, these providers will no longer meet the performance requirement of the measure without a CCHIT certified EHR in use.

Manage a Medication List – Create, maintain and display a patient specific medication list

Manage a Problem List – Create, maintain and display a patient specific problem list **Discrete Searchable Data Elements** – Laboratory data that can be recorded in predefined fields in predefined formats within the EHR 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 EHR.

Numerator Quality-Data Coding Options for Reporting Satisfactorily: Encounter Documented Using Certified/Qualified EHR G8447: Patient encounter was documented using a CCHIT certified EHR OR

G8448: Patient encounter was documented using a gualified (non-CCHIT certified) EHR

DENOMINATOR:

All patient encounters

Denominator Criteria (Eligible Cases):

Patient encounter during the reporting period (CPT or HCPCS): 90801, 90802, 90804, 90805, 90806, 90807, 90808, 90809, 92002, 92004, 92012, 92014, 92541, 92542, 92543, 92544 92548, 92552, 92553, 92555, 92557, 92561, 92562, 92563, 92564, 92565, 92567, 92568, 92569, 92571, 92572, 92575, 92576, 92577, 92579, 92582, 92584, 92585, 92586,

92587, 92588, 92601, 92602, 92603, 92604, 92620, 92621, 92625, 92626, 92627, 92640, 95920, 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. This need was well publicized by Dr. Ed Wagner in his "Chronic Care Model" as one of the key elements to provide high-quality care. To quote from the Improving Chronic Care Web site, "Effective chronic illness care is virtually impossible without information systems that assure ready access to key data on individual patients as well as populations of patients. A comprehensive clinical information system can enhance the care of individual patients by providing timely reminders about needed services and summarized data to track and plan care. At the practice population level, they identify groups of patients needing additional care, as well as facilitate performance monitoring and quality improvement efforts." To be able to take advantage of many of the more advanced applications of health information technology, the facility must first implement an EMR and use it to document patient encounters.

Although some health plans and provider incentive programs do reward facilities for EMR adoption, our analysis did not reveal any established consensus-endorsed measure that measures adoption of technology and defines it in the way described above.

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."*

▲ Measure #126: Diabetes Mellitus: Diabetic Foot and Ankle Care, Peripheral Neuropathy – Neurological Evaluation

2009 PQRI REPORTING OPTIONS: CLAIMS-BASED, REGISTRY

DESCRIPTION:

Percentage of patients aged 18 years and older with a diagnosis of diabetes mellitus who had a neurological examination of their lower extremities within 12 months

INSTRUCTIONS:

This measure is to reported a minimum of <u>once per reporting period</u> for patients with diabetes mellitus seen during the reporting period. Evaluation of neurological status in patients with diabetes to assign risk category and therefore have appropriate foot and ankle care to prevent ulcerations and infections ultimately reduces the number and severity of amputations that occur. Risk categorization and follow up treatment plan should be done according to the following table:

Risk Categorization System:

Category	Risk Profile	Evaluation Frequency
0	Normal	Annual
1	Peripheral Neuropathy (LOPS)	Semi-annual
2	Neuropathy, deformity, and/or PAD	Quarterly
3	Previous ulcer or amputation	Monthly to quarterly

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

Measure Reporting via Claims:

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

When reporting the measure via claims, submit the listed ICD-9-CM diagnosis codes, CPT codes, and the appropriate numerator G-code. All measure-specific coding should be reported ON THE SAME CLAIM.

NUMERATOR:

Patients who had a lower extremity neurological exam performed at least once within 12 months

Definition:

Lower Extremity Neurological Exam – Consists of a documented evaluation of motor and sensory abilities including reflexes, vibratory, proprioception, sharp/dull and 5.07 filament detection.

Numerator Quality-Data Coding Options for Reporting Satisfactorily: Lower Extremity Neurological Exam Performed G8404: Lower extremity neurological exam performed and documented

<u>OR</u>

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

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 Criteria (Eligible Cases):

Patients aged \geq 18 years on date of encounter **AND**

Diagnosis for diabetes (line-item ICD-9-CM): 250.00, 250.01, 250.02, 250.03, 250.10, 250.11, 250.12, 250.13, 250.20, 250.21, 250.22, 250.23, 250.30, 250.31, 250.32, 250.33, 250.40, 250.41, 250.42, 250.43, 250.50, 250.51, 250.52, 250.53, 250.60, 250.61, 250.62, 250.63, 250.70, 250.71, 250.72, 250.73, 250.80, 250.81, 250.82, 250.83, 250.90, 250.91, 250.92, 250.93

<u>and</u>

Patient encounter during the reporting period (CPT): 11040, 11041, 11042, 11043, 11044, 11055, 11056, 11057, 11719, 11720, 11721, 11730, 11740, 97001, 97002, 97802, 97803, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99251, 99252, 99253, 99254, 99255, 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: Diabetes Mellitus: Diabetic Foot and Ankle Care, Ulcer Prevention – Evaluation of Footwear

2009 PQRI REPORTING OPTIONS: CLAIMS-BASED, REGISTRY

DESCRIPTION:

Percentage of patients aged 18 years and older with a diagnosis of diabetes mellitus who were evaluated for proper footwear and sizing

INSTRUCTIONS:

This measure is to reported a minimum of <u>once per reporting period</u> for patients with diabetes mellitus seen during the reporting period. This measure may be reported by non-MD/DO clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

Measure Reporting via Claims:

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

When reporting the measure via claims, submit the listed ICD-9-CM diagnosis codes, CPT codes, and the appropriate numerator G-code. All measure-specific coding should be reported ON THE SAME CLAIM.

NUMERATOR:

Patients who were evaluated for proper footwear and sizing at least once within 12 months

Definition:

Evaluation for Proper Footwear – Includes a foot examination documenting the vascular, neurological, dermatological, and structural/biomechanical findings. The foot should be measured using a standard measuring device and counseling on appropriate footwear should be based on risk categorization.

Numerator Quality-Data Coding Options for Reporting Satisfactorily: Footwear Evaluation Performed G8410: Footwear evaluation performed and documented

OR

Footwear Evaluation not Performed for Documented Reasons

G8416: Clinician documented that patient was not an eligible candidate for footwear evaluation measure

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 Criteria (Eligible Cases):

Patients aged \geq 18 years on date of encounter

<u>and</u>

Diagnosis for diabetes (line-item ICD-9-CM): 250.00, 250.01, 250.02, 250.03, 250.10, 250.11, 250.12, 250.13, 250.20, 250.21, 250.22, 250.23, 250.30, 250.31, 250.32, 250.33, 250.40, 250.41, 250.42, 250.43, 250.50, 250.51, 250.52, 250.53, 250.60, 250.61, 250.62, 250.63, 250.70, 250.71, 250.72, 250.73, 250.80, 250.81, 250.82, 250.83, 250.90, 250.91, 250.92, 250.93

<u>AND</u>

Patient encounter during the reporting period (CPT): 11040, 11041, 11042, 11043, 11044, 11055, 11056, 11057, 11719, 11720, 11721, 11730, 11740, 97001, 97002, 97802, 97803, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99251, 99252, 99253, 99254, 99255, 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: Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up

2009 PQRI REPORTING OPTIONS: CLAIMS-BASED, REGISTRY, MEASURES GROUP

DESCRIPTION:

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

<u>Parameters:</u> Age 65 and older BMI ≥30 or <22 Age 18 – 64 BMI ≥25 or <18.5

INSTRUCTIONS:

This measure is to be reported a minimum of <u>once per reporting period</u> 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.

Measure Reporting via Claims:

CPT codes, HCPCS (D- and G-) codes, and patient demographics are used to identify patients who are included in the measure's denominator. G-codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed CPT codes, HCPCS codes, and the appropriate numerator G-code. All measure-specific coding should be reported ON THE SAME CLAIM.

NUMERATOR:

Patients with BMI calculated within the past six months or during the current visit and a follow-up plan documented if the BMI is outside of parameters

Definitions:

BMI – Body Mass Index (BMI) 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. Example BMI charts are widely available via the internet. **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. **Terminal Illness** – Life expectancy is 6 months or less

Not Eligible/Not Appropriate for BMI Measurement – Patients can be considered not eligible in the following situations:

- There is documentation in the medical record that the patient is over or under weight and is being managed by another provider
- If the patient has a terminal illness
- 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 Quality-Data Coding Options for Reporting Satisfactorily:

BMI Calculated, No Follow-up Plan Needed or BMI Calculated, Follow-up Plan Documented

G8420: Calculated BMI within normal parameters and documented **OR**

G8417: Calculated BMI above the upper parameter and a follow-up plan was documented in the medical record

G8418: Calculated BMI below the lower parameter and a follow-up plan was documented in the medical record

<u>OR</u>

Patient <u>not</u> Eligible for BMI Calculation for Documented Reasons G8422: Patient not eligible for BMI calculation

BMI <u>not</u> Performed and/or Calculated BMI Outside of Normal Parameters, Follow-up Plan <u>not</u> Documented, Reason not Specified

G8421: BMI not calculated

<u> 0R</u>

G8419: Calculated BMI outside normal parameters, no follow-up plan documented in the medical record

DENOMINATOR:

All patients aged 18 years and older

Denominator Criteria (Eligible Cases):

Patients aged \geq 18 years on date of encounter <u>AND</u>

Patient encounter during the reporting period (CPT or HCPCS): 00100, 00102, 00103, 00104, 00120, 00124, 00126, 00140, 00142, 00144, 00145, 00147, 00148, 00160, 00162, 00164. 00170. 00172. 00174. 00176. 00190. 00192. 00210. 00211. 00212. 00214. 00215. 00216, 00218, 00220, 00222, 00300, 00320, 00322, 00326, 00350, 00352, 00400, 00402, 00404. 00406. 00410. 00450. 00452. 00454. 00470. 00472. 00474. 00500. 00520. 00522. 00524, 00528, 00529, 00530, 00532, 00534, 00537, 00539, 00540, 00541, 00542, 00546, 00548, 00550, 00560, 00561, 00562, 00563, 00566, 00567, 00580, 00600, 00604, 00620, 00622, 00625, 00626, 00630, 00632, 00634, 00635, 00640, 00670, 00700, 00702, 00730, 00740. 00750. 00752. 00754. 00756. 00770. 00790. 00792. 00794. 00796. 00797. 00800. 00802, 00810, 00820, 00830, 00832, 00834, 00836, 00840, 00842, 00844, 00846, 00848, 00851,00860, 00862, 00864, 00865, 00866, 00868, 00870, 00872, 00873, 00880, 00882, 00902, 00904, 00906, 00908, 00910, 00912, 00914, 00916, 00918, 00920, 00921, 00922, 00924. 00926. 00928. 00930. 00932. 00934. 00936. 00938. 00940. 00942. 00944. 00948. 00950, 00952, 01112, 01120, 01130, 01140, 01150, 01160, 01170, 01173, 01180, 01190, 01200, 01202, 01210, 01212, 01214, 01215, 01220, 01230, 01232, 01234, 01250, 01260, 01270, 01272, 01274, 01320, 01340, 01360, 01380, 01382, 01390, 01392, 01400, 01402, 01404, 01420, 01430, 01432, 01440, 01442, 01444, 01462, 01464, 01470, 01472, 01474, 01480, 01482, 01484, 01486, 01490, 01500, 01502, 01520, 01522, 01610, 01620, 01622, 01630, 01632, 01634, 01636, 01638, 01650, 01652, 01654, 01656, 01670, 01680, 01682, 01710, 01712, 01714, 01716, 01730, 01732, 01740, 01742, 01744, 01756, 01758, 01760, 01770, 01772, 01780, 01782, 01810, 01820, 01829, 01830, 01832, 01840, 01842, 01844, 01850, 01852, 01860, 01916, 01920, 01922, 01924, 01925, 01926, 01930, 01931, 01932, 01933. 01935. 01936. 01951. 01952. 01953. 01958. 01960. 01961. 01962. 01963. 01965. 01966, 01967, 01968, 01969, 01990, 01991, 01992, 01996, 01999, 90801, 90802, 90804, 90805, 90806, 90807, 90808, 90809, 97001, 97003, 97802, 97803, 98960, 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. Between 1991 and 1998, the prevalence of obesity among persons age 60-69 increased by 45 percent (American Obesity Association).

The economic impact of obesity and its related conditions in the U.S. economy is staggering and has been estimated at about \$117 billion according to the Midcourse Review of Healthy People 2010.

A recent study predicts that by 2020 there will be an 18 percent to 22 percent increase in the prevalence of Americans between the ages of 50 and 69 who have difficulty bathing, dressing or walking across a room if the current rate of weight increase for this age group continues. According to a 1998 survey, only 52 percent of adults age 50 or older reported being asked during routine medical check-ups about physical activity or exercise. The likelihood of being asked about exercise during a routine check-up declined with age (Center for the Advancement of Health, 2004).

Elderly patients with unintentional weight loss are at higher risk for infection, depression and death. The leading causes of involuntary weight loss are depression (especially in residents of long-term care facilities), cancer (lung and gastrointestinal malignancies), cardiac disorders and benign gastrointestinal diseases. Medications that may cause nausea and vomiting, dysphagia, dysgeusia and anorexia have been implicated. Polypharmacy can cause unintended weight loss, as can psychotropic medication reduction (e.g., by unmasking problems such as anxiety). In one study it was found that a BMI of less than 22 kg per m2 in women and less than 23.5 in men is associated with increased mortality. In another study it was found that the optimal BMI in the elderly is 24 to 29 kg per m2. (Huffman, G. B., <u>Evaluation and Treatment of Unintentional Weight Loss in the Elderly</u>, American Family Physician, 2002 Feb, 4:640-650.)

A tremendous gap still exists between our knowledge of malnutrition and its sequelae and our actions in preventing and treating it. To date professionals in various disciplines have applied their own approaches to solving the problem. Yet the causes of malnutrition are multi-factorial and the solutions demand an integration of knowledge and expertise from the many different disciplines involved in geriatric care. Older people have special nutritional needs due to age and disease processes. Professionals of all disciplines need to help older individuals improve their oral health, mental health, medication use, food choices, economic situation, functional status and medical condition and thereby improve both nutritional status and quality of life (American Dietetic Association, Nutrition Screening Initiative, 2002).

A Web search of the National Quality Measures Clearinghouse on the key words of BMI, body mass index, produced three measures, all focused on possible follow-up for overweight and obesity for a broader age range. There were no measures that focused on underweight or a follow-up plan.

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 undernourishment. 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.).
* Measure #130: Documentation and Verification of Current Medications in the Medical Record

2009 PQRI REPORTING OPTIONS: CLAIMS-BASED, REGISTRY

DESCRIPTION:

Percentage of patients aged 18 years and older with a list of current medications with dosages (includes prescription, over-the-counter, herbals, vitamin/mineral/dietary [nutritional] supplements) and verification with the patient or authorized representative is documented by the provider

INSTRUCTIONS:

This measure is to be reported at <u>each visit</u> 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.

Measure Reporting via Claims:

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

When reporting the measure via claims, submit the CPT codes, HCPCS codes, and the appropriate numerator G-code. All measure-specific coding should be reported ON THE SAME CLAIM.

NUMERATOR:

Current medications with dosages and verification with patient or authorized representative is documented by the provider

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 him 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, the patient appoints this individual. 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

Verification – Documentation of acknowledgment by the patient and/or authorized representative or provider that signifies discussion, assessment, or review to confirm accuracy of information.

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

<u>Numerator Quality-Data Coding Options for Reporting Satisfactorily:</u> Current Medications with Dosages AND Verification Documented

G8427: List of current medications with dosages (includes prescription, over-the-counter, herbals, vitamin/mineral/dietary [nutritional] supplements) and verification with the patient or authorized representative documented by the provider

Current Medications with Dosages not Documented, Patient not Eligible

G8430: Provider documentation that patient is not eligible for medication assessment

OR

Current Medications with Dosages Documented, Patient Verification <u>not</u> Documented, Patient not Eligible

G8507: Provider documentation that patient is not eligible for patient verification of current medications

<u> 0R</u>

Current Medications with Dosages Documented, Patient Verification <u>not</u> Documented, Reason not Specified

G8428: Provider documentation of current medications with dosages (includes prescription, over-the-counter, herbals, vitamin/mineral/dietary [nutritional] supplements) without documented patient verification

Current Medications with Dosages not Documented, Reason not Specified

G8429: Incomplete or no provider documentation that the patient's current medications with dosages (includes prescription, over-the-counter, herbals, vitamin/mineral/dietary [nutritional] supplements) were assessed

DENOMINATOR:

All patients aged 18 years and older

Denominator Criteria (Eligible Cases):

Patients aged \geq 18 years on date of encounter **AND**

Patient encounter during the reporting period (CPT or HCPCS): 00100, 00102, 00103, 00104, 00120, 00124, 00126, 00140, 00142, 00144, 00145, 00147, 00148, 00160, 00162, 00164, 00170, 00172, 00174, 00176, 00190, 00192, 00210, 00211, 00212, 00214, 00215, 00216, 00218, 00220, 00222, 00300, 00320, 00322, 00326, 00350, 00352, 00400, 00402, 00404, 00406, 00410, 00450, 00452, 00454, 00470, 00472, 00474, 00500, 00520, 00522, 00524, 00528, 00529, 00530, 00532, 00534, 00537, 00539, 00540, 00541, 00542, 00546, 00548, 00550, 00560, 00561, 00562, 00563, 00566, 00567, 00580, 00600, 00604, 00620, 00622, 00625, 00626, 00630, 00632, 00634, 00635, 00640, 00670, 00700, 00702, 00730, 00740, 00750, 00752, 00754, 00756, 00770, 00790, 00792, 00794, 00796, 00797, 00800, 00802, 00810, 00820, 00832, 00834, 00836, 00840, 00842, 00844, 00846, 00848, 00851,00860, 00862, 00864, 00865, 00866, 00868, 00870, 00872, 00873, 00880, 00882, 00902, 00904, 00906, 00908, 00910, 00912, 00914, 00916, 00918, 00920, 00921, 00922, 00924, 00926, 00928, 00930, 00932, 00934, 00936, 00938, 00940, 00942, 00944, 00948, 00950, 00952, 01112, 01120, 01130, 01140, 01150, 01160, 01170, 01173, 01180, 01190.

01200, 01202, 01210, 01212, 01214, 01215, 01220, 01230, 01232, 01234, 01250, 01260, 01270, 01272, 01274, 01320, 01340, 01360, 01380, 01382, 01390, 01392, 01400, 01402, 01404, 01420, 01430, 01432, 01440, 01442, 01444, 01462, 01464, 01470, 01472, 01474, 01480, 01482, 01484, 01486, 01490, 01500, 01502, 01520, 01522, 01610, 01620, 01622, 01630, 01632, 01634, 01636, 01638, 01650, 01652, 01654, 01656, 01670, 01680, 01682, 01710, 01712, 01714, 01716, 01730, 01732, 01740, 01742, 01744, 01756, 01758, 01760, 01770, 01772, 01780, 01782, 01810, 01820, 01829, 01830, 01832, 01840, 01842, 01844, 01850, 01852, 01860, 01916, 01920, 01922, 01924, 01925, 01926, 01930, 01931, 01932, 01933, 01935, 01936, 01951, 01952, 01953, 01958, 01960, 01961, 01962, 01963, 01965, 01966, 01967, 01968, 01969, 01990, 01991, 01992, 01996, 01999, 90801, 90802, 92002, 92004, 92012, 92014, 92541, 92542, 92543, 92544, 92545, 92547, 92548, 92557, 92567, 92568, 92569, 92585, 92588, 92626, 96116, 96150, 96152, 97001, 97002, 97003, 97004, 97802, 97803, 98960, 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, G0101, G0108, G0270

RATIONALE:

Adverse drug events (ADEs) are one of the leading causes of hospitalizations and deaths in the U.S. Specifically, data suggests that ADEs are an important problem among outpatients, with 13% of events 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.

The need for this measure is important because no similar measure has been identified through review of literature, the AHRQ National Quality Measures Clearinghouse, and relevant specialty society web sites.

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)]

Measure #131: Pain Assessment Prior to Initiation of Patient Therapy and Follow-Up

2009 PQRI REPORTING OPTIONS: CLAIMS-BASED, REGISTRY

DESCRIPTION:

Percentage of patients aged 18 years and older with documentation of a pain assessment (if pain is present, including location, intensity and description) through discussion with the patient including the use of a standardized tool on each qualifying visit prior to initiation of therapy AND documentation of a follow-up plan

INSTRUCTIONS:

This measure is to be reported for <u>each qualifying visit</u> 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.

Measure Reporting via Claims:

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

When reporting the measure via claims, submit the listed CPT codes, and the appropriate numerator G-code. All measure-specific coding should be reported ON THE SAME CLAIM.

NUMERATOR:

Patient's pain assessment prior to initiation of treatment is documented through discussion with the patient including the use of a standardized tool AND a follow-up plan is documented

Definitions:

Qualifying Visit – Meets denominator criteria (age and CPT encounter codes) as listed below.

Standardized Tool – An assessment tool that has been appropriately normalized and validated for the population in which it is used. Examples of tools for pain assessment include, but are not limited to, Multidimensional Pain Score and McGill Pain Questionnaire. **Follow-up Plan** – Proposed outline of treatment to be conducted as a result of pain assessment. Such follow-up must include a reassessment of pain and may include documentation of a future appointment, education, referral, notification or primary care provider, etc.

Not Eligible - A patient is not eligible if the following condition(s) exist:

Pain Assessment

- Patient refuses to participate
- Severe mental and/or physical incapacity where the person is unable to express himself/herself in a manner understood by others. For example, cases where pain cannot be accurately assessed through use of nationally recognized standardized pain assessment tools

• Patient is in an urgent or emergent situation where time is of the essence and to delay treatment would jeopardize the patient's health status

Follow-Up Plan

- Absence of pain on assessment
- Diagnosis/condition/illness if not situationally related to pain

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Pain Assessment Documented AND Follow-Up Plan Documented

G8440: Documentation of pain assessment (including location, intensity and description) prior to initiation of treatment or documentation of the absence of pain as a result of assessment through discussion with the patient including the use of a standardized tool AND a follow-up plan is documented

Pain Assessment not Documented, Patient not Eligible

G8442: Documentation that patient is not eligible for a pain assessment

OR

Pain Assessment Documented, Follow-up Plan not Documented, Patient not Eligible

G8508: Documentation of pain assessment (including location, intensity and description) prior to initiation of treatment or documentation of the absence of pain as a result of assessment through discussion with the patient including the use of a standardized tool; no documentation of a follow-up plan, patient not eligible

<u>OR</u>

Pain Assessment not Documented, Reason not Specified

G8441: No documentation of pain assessment (including location, intensity and description) prior to initiation of treatment

Pain Assessment Documented, Follow-up Plan <u>not</u> Documented, Reason not Specified

G8509: 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 through discussion with the patient including the use of a standardized tool; no documentation of a follow-up plan, reason not specified

DENOMINATOR:

All patients aged 18 years and older

Denominator Criteria (Eligible Cases):

Patients aged \geq 18 years on date of encounter <u>AND</u>

Patient encounter during the reporting period (CPT): 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, and chronic pain due to arthritis, back problems, cancer and other ailments costs the U.S. economy \$100 billion per year in lost worker productivity and health costs.

A search of the National Quality Measures Clearinghouse and relevant specialty society web sites revealed no measures that address pain assessment prior to the initiation of therapy.

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).

The Veterans Health Administration (VHA) and Department of Defense (DoD) in conjunction with the VHA Office of Quality and Performance and a consultant group developed a postoperative pain guideline which provides readily accessible information and evidence-based guidance to a variety of providers, including physicians, dentists, nurses, pharmacists, physical therapists, and psychologists. It highlights deficiencies in our understanding of the pain and recovery processes and how they might guide our choices of postoperative analgesic techniques.

Measure #134: Screening for Clinical Depression and Follow-Up Plan

2009 PQRI REPORTING OPTIONS: CLAIMS-BASED, REGISTRY

DESCRIPTION:

Percentage of patients aged 18 years and older screened for clinical depression using a standardized tool AND follow-up plan documented

INSTRUCTIONS:

This measure is to be reported a minimum of <u>once per reporting period</u> 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.

Measure Reporting via Claims:

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

When reporting the measure via claims, submit the listed CPT codes and the appropriate numerator G-code. All measure-specific coding should be reported ON THE SAME CLAIM.

NUMERATOR:

Patient's screening for clinical depression using a standardized tool AND follow-up plan 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 depression screening tools include: Patient Health Questionnaire (PHQ9), Beck Depression Inventory (BDI or BDI-II), Center for Epidemiologic Studies Depression Scale (CES-D), Depression Scale (DEPS), Duke Anxiety-Depression Scale (DADS), Geriatric Depression Scale (GDS), GDS – Short Version, Hopkins Symptom Checklist (HSCL), The Zung Self-Rating Depression Scale (SDS), and Cornell Scale Screening (this is a screening tool which is used in situations where the patient has cognitive impairment and is administered through the caregiver). **Follow-Up Plan** – Proposed outline of treatment to be conducted as a result of clinical depression screen. Such follow-up must include further evaluation if screen is positive and may include documentation of a future appointment, education, additional evaluation and/or referral to a practitioner who is qualified to diagnose and treat depression, and/or notification of primary care provider.

Not Eligible/Not Appropriate – A patient is not eligible if one or more of the following conditions exist:

- Patient refuses to participate
- Patient is in an urgent or emergent situation where time is of the essence and to delay treatment would jeopardize the patient's health status
- Situations where the patient's motivation to improve may impact the accuracy of results of nationally recognized standardized depression assessment tools. For example: certain court appointed cases
- Patient was referred with a diagnosis of depression
- Patient has been participating in on-going treatment with screening of clinical depression in a preceding reporting period
- Severe mental and/or physical incapacity where the person is unable to express himself/herself in a manner understood by others. For example: cases such as delirium or severe cognitive impairment, where depression cannot be accurately assessed through use of nationally recognized standardized depression assessment tools

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Positive Screen for Clinical Depression, Follow-up Plan Documented

G8431: Positive screen for clinical depression using a standardized tool and a follow-up plan documented

<u> 0R</u>

Negative Screen for Clinical Depression Documented, Patient not Eligible/Appropriate for Follow-up Plan

G8510: Negative screen for clinical depression using standardized tool, patient not eligible/appropriate for follow-up plan documented

<u> 0R</u>

Screening for Clinical Depression <u>not</u> Documented, Patient not Eligible/Appropriate G8433: Screening for clinical depression using a standardized tool not documented, patient not eligible/appropriate

Screening for Clinical Depression <u>not</u> Documented, Reason not Specified

G8432: No documentation of clinical depression screening using a standardized tool **OR**

Screening for Clinical Depression Documented, Follow-Up Plan <u>not</u> Documented, Reason not Specified

G8511: Screen for clinical depression using a standardized tool documented, follow-up plan not documented, reason not specified

DENOMINATOR:

All patients aged 18 years and older

Denominator Criteria (Eligible Cases):

Patients aged \geq 18 years on date of encounter <u>AND</u>

Patient encounter during the reporting period (CPT): 90801, 90802, 90804, 90805, 90806, 90807, 90808, 90809, 92557, 92567, 92568, 92625, 97003

RATIONALE:

The World Health Organization identified major depression as the fourth leading cause of worldwide disease in 1990, causing more disability than either ischemic heart disease or cerebrovascular disease. In primary care settings, the point prevalence of major depression ranges from 5 to 9 percent among adults, and up to 50 percent of depressed patients are not recognized. Depressive disorders are also relatively common in younger persons, with estimated prevalence of 0.8 to 2.0 percent in children and 4.5 percent in adolescents.

U.S. Preventive Services Task Force compared the effects of integrated recognition and management depression screening programs with "usual care" in community primary care practices. Results showed significantly improved patient outcomes.

The National Center for Policy Analysis and the U.S. Surgeons General, among others, estimate the direct and indirect costs of depression to American businesses ranging from \$36.2 billion to \$80 billion annually.

Major depression is " ranked second only to ischemic heart disease in magnitude of disease burden in established market economies" and "is the leading cause of *disability* (measured by the number of years *lived* with a disabling condition) worldwide among persons age 5 and older." Murray CJL, Lopez AD, eds. <u>The Global Burden Of Disease And Injury Series</u>, <u>Volume 1: A</u> <u>Comprehensive Assessment Of Mortality And Disability From Diseases</u>, <u>Injuries</u>, <u>And Risk Factors</u> <u>In 1990 And Projected To 2020</u>. Cambridge, MA: Published by the Harvard School of Public Health on behalf of the World Health Organization and the World Bank, Harvard University Press, 1996.

A search of the literature in PubMed concerning social workers and depression screening showed nothing to indicate that these practitioners are routinely screening their patients for depression.

A search of the National Quality Measures Clearinghouse database found no depression screening measures that address Medicare eligible patients and there was only one measure from the Physician Consortium for Performance Improvement addressing screening for patients aged 18 years and older with suspected major depressive disorder.

CLINICAL RECOMMENDATION STATEMENTS:

USPSTF recommends screening adults for depression in clinical practices that have systems in place to assure accurate diagnosis, effective treatment, and follow-up. Small benefits have been observed in studies that simply feed back screening results to clinicians. Larger benefits have been observed in studies in which the communication of screening results is coordinated with effective follow-up and treatment. (Evidence: B)

The Canadian Task Force on Preventive Health Care used the rigorous USPSTF 2002 systematic review to update their recommendations regarding depression screening. The Canadian task force arrived at the same practice recommendations as USPSTF.

A Measure #135: Chronic Kidney Disease (CKD): Influenza Immunization

2009 PQRI REPORTING OPTIONS: CLAIMS-BASED, REGISTRY, MEASURES GROUP

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 received the influenza immunization during the flu season (September through February)

INSTRUCTIONS:

This measure is to be reported a minimum of <u>once per reporting period</u> for advanced CKD patients seen during the reporting period. This measure is intended to determine whether or not CKD patients received or had an order for an influenza immunization during the flu season (September through February). It is anticipated that clinicians providing care for patients with advanced CKD will submit this measure.

Measure Reporting via Claims:

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

When reporting the measure via claims, submit the listed ICD-9-CM diagnosis code, CPT codes, and the appropriate CPT Category II code <u>**OR**</u> the CPT Category II code <u>**with**</u> the modifier. The modifiers allowed for this measure are: 1P- medical reasons, 2P- patient reasons, 3P- system reasons, 8P- reason not otherwise specified. All measure-specific coding should be reported ON THE SAME CLAIM.

NUMERATOR:

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

Numerator Quality-Data Coding Options for Reporting Satisfactorily: Influenza Immunization Ordered or Administered

CPT II 4037F: Influenza immunization ordered or administered

Influenza Immunization <u>not</u> Ordered or Administered 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.

- **4037F** *with* **1P:** Documentation of medical reason(s) for patient not receiving the influenza immunization
- **4037F** *with* **2P**: Documentation of patient reason(s) for patient not receiving the influenza immunization
- **4037F** *with* **3P:** Documentation of system reason(s) for patient not receiving the influenza immunization

Influenza Immunization not Ordered or Administered, 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.

4037F *with* **8P:** Influenza immunization <u>not</u> ordered or administered, 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 Criteria (Eligible Cases):

Patients aged \geq 18 years on date of encounter <u>AND</u> Diagnosis for stage 4 or 5 CKD (line-item ICD-9-CM): 585.4, 585.5 <u>AND</u> Patient encounter during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245

RATIONALE:

USRDS data shows that Medicare patients with CKD are more likely to receive a flu vaccine versus employer group health plan patients with CKD (0.43 versus 0.08 respectively). Additionally, it is estimated that fewer than 20% of all patients in high risk groups receive a flu vaccine each year. Patients with CKD need to be vaccinated yearly in order to decrease morbidity and mortality related to influenza and its complications.

CLINICAL RECOMMENDATION STATEMENTS:

Vaccination with TIV (trivalent inactivated flu vaccine) is recommended for the following persons who are at increased risk for severe complications from influenza, or at higher risk for influenza-associated clinic, emergency department, or hospital visits: adults and children who have chronic pulmonary (including asthma), cardiovascular (except hypertension), renal, hepatic, hematological, or metabolic disorders (including diabetes mellitus). (CDC, 2007)

In any given year, the optimal time to vaccinate patients cannot be determined because influenza seasons vary in their timing, and more than one outbreak might occur in a single community in a single year. (CDC, 2007)

In general, health-care providers should begin offering vaccination soon after vaccine becomes available and if possible, by October. (CDC, 2007)

Vaccine efforts should continue throughout the season, because the duration of the influenza season varies, and influenza might not occur in certain communities until February or March. The majority of adults have antibody protection against influenza within 2 weeks after vaccination. (CDC, 2007)

^{*}Measure #136: Melanoma: Follow-Up Aspects of Care

2009 PQRI REPORTING OPTIONS: CLAIMS-BASED, REGISTRY

DESCRIPTION:

Percentage of patients, regardless of age, with a new diagnosis of melanoma or a history of melanoma who received all of the following aspects of care within 12 months: (1) patient was asked specifically if he/she had any new or changing moles; AND (2) a complete physical skin examination was performed and the morphology, size, and location of new or changing pigmented lesions were noted; AND (3) patient was counseled to perform a monthly self skin examination

INSTRUCTIONS:

This measure is to be reported a minimum of <u>once per reporting period</u> for melanoma patients seen during the reporting period. It is anticipated that clinicians providing care for patients with melanoma or a history of melanoma will submit this measure.

Measure Reporting via Claims:

Line-item ICD-9-CM diagnosis codes and CPT codes are used to identify patients who are included in the measure's denominator. CPT Category II codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed ICD-9-CM diagnosis code, CPT codes, and the appropriate CPT Category II code <u>**OR**</u> the CPT Category II code <u>**with**</u> the modifier. The modifiers allowed for this measure are: 3P- system reasons, 8P- reason not otherwise specified. All measure-specific coding should be reported ON THE SAME CLAIM.

NUMERATOR:

Patients who received all aspects of care at least once within 12 months

Numerator Instructions: A complete physical skin exam includes: head (including the face), neck, chest (including the axillae), abdomen, back, and extremities. The genitalia (including the groin and buttocks) may also be examined (optional).

Definition:

Follow-up Aspects of Care – Include all of the following (1) patient was asked specifically if he/she had any new or changing moles; AND (2) a complete physical skin examination was performed and the morphology, size, and location of new or changing pigmented lesions were noted; AND (3) patient was counseled to perform a monthly self skin examination.

<u>Numerator Quality-Data Coding Options for Reporting Satisfactorily:</u> Follow-Up Aspects of Care Performed CPT II 0015F: Melanoma follow-up completed

<u> 0R</u>

Follow-Up Aspects of Care <u>not</u> Performed for System Reasons
Append a modifier (3P) to CPT Category II code 0015F to report documented circumstances that appropriately exclude patients from the denominator.
0015F with 3P: Documentation of system reason(s) for not performing the follow-up service (eg, another physician performed this service)

Follow-Up Aspects of Care not Performed, Reason not Specified

Append a reporting modifier (8P) to CPT Category II code 0015F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

0015F *with* 8P: Melanoma follow-up <u>not</u> performed, reason not otherwise specified

DENOMINATOR:

All patients, regardless of age, with a new diagnosis of melanoma or a history of melanoma

Denominator Criteria (Eligible Cases):

Diagnosis for melanoma or history of melanoma (line-item ICD-9-CM): 172.0, 172.1, 172.2, 172.3, 172.4, 172.5, 172.6, 172.7, 172.8, 172.9, V10.82 <u>AND</u> Patient encounter during the reporting period (CPT): 99201, 99202, 99203, 99204,

99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245

RATIONALE:

Early detection of an additional or secondary primary melanoma is an important goal of follow-up care. The majority of additional primary melanomas are discovered by the patient or family member. Educating patients to perform self-examinations will lead to earlier detection of secondary <u>primary</u> sites of melanoma. Only 60% of physicians routinely performed full-body examinations with their high-risk patients.

CLINICAL RECOMMENDATION STATEMENTS:

Skin examination and surveillance at least once a year for life is recommended for all melanoma patients, including those with stage 0 in situ-melanoma. Frequency of dermatologic surveillance should be determined individually, based on risk factors, including skin type, family history, presence of dysplastic nevi, and history of non-melanoma skin cancers. Clinicians should also consider educating patients about monthly self-exam of their skin and lymph nodes. (NCCN)

For patients with stage IA melanoma, a comprehensive H&P (with specific emphasis on the regional nodes and skin) should be performed every 3 to 12 months as clinically indicated. For patients with stage IB-III melanomas, a comprehensive H&P (with emphasis on the regional nodes and skin) should be performed every 3 to 6 months for 3 years; then every 4 to 12 months for 2 years; and annually (at least) thereafter, as clinically indicated. (NCCN) (Level of Evidence – Category 2A)

A structured follow-up program could permit the earlier detection of recurrent disease at a time when it might be more amenable to potentially curative surgical resection. This follow-up would be

particularly appropriate for patients at risk for regional nodal recurrence who have not yet undergone sentinel node biopsy or elective lymph node dissection. (NCCN)

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

^{*}Measure #137: Melanoma: Continuity of Care – Recall System

2009 PQRI REPORTING OPTIONS: CLAIMS-BASED, REGISTRY

DESCRIPTION:

Percentage of patients, regardless of age, with a current diagnosis of melanoma or a history of melanoma who were entered into a recall system with the date for the next complete physical skin examination specified at least once within 12 months

INSTRUCTIONS:

This measure is to be reported a minimum of <u>once per reporting period</u> for melanoma patients seen during the reporting period. It is anticipated that clinicians providing care for patients with melanoma or a history of melanoma will submit this measure.

Measure Reporting via Claims:

Line-item ICD-9-CM diagnosis codes and CPT codes are used to identify patients who are included in the measure's denominator. CPT Category II codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed ICD-9-CM diagnosis code, CPT codes, and the appropriate CPT Category II code **OR** the CPT Category II code **with** the modifier. The modifiers allowed for this measure are: 3P- system reasons, 8P- reason not otherwise specified. All measure-specific coding should be reported ON THE SAME CLAIM.

NUMERATOR:

Patients entered into a recall system with the target date for the next complete physical skin exam specified, at least once within 12 months

Numerator Instructions: To satisfy this measure, the recall system <u>must</u> be linked to a process for notifying patients when their next physical exam is due and <u>must</u> include the following elements at a minimum: patient identifier, patient contact information, cancer diagnosis(es), dates(s) of initial cancer diagnosis (if known), and the target date for the next complete physical exam.

<u>Numerator Quality-Data Coding Options for Reporting Satisfactorily:</u> Recall System Utilized

CPT II 7010F: Patient information entered into a recall system with the target date for the next exam specified

Recall System not Utilized for System Reasons

Append a modifier (**3P**) to CPT Category II code **7010F** to report documented circumstances that appropriately exclude patients from the denominator.

7010F *with* **3P:** Documentation of system reason(s) for not entering patient's information into a recall system (eg, melanoma being monitored by another physician provider)

Recall System not Utilized, Reason not Specified

Append a reporting modifier (8P) to CPT Category II code 7010F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

7010F with 8P: Recall system not utilized, reason not otherwise specified

DENOMINATOR:

All patients, regardless of age, with a current diagnosis of melanoma or a history of melanoma

Denominator Criteria (Eligible Cases):

Diagnosis for melanoma or history of melanoma (line-item ICD-9-CM): 172.0, 172.1, 172.2, 172.3, 172.4, 172.5, 172.6, 172.7, 172.8, 172.9, V10.82 <u>AND</u> Patient encounter during the reporting period (CPT): 99201, 99202, 99203, 99204,

Patient encounter during the reporting period (CPT): 99201, 99202, 99203, 99204 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245

RATIONALE:

Lack of follow-up with providers noted in the Institute of Medicine (IOM) report on patient errors. Follow-up for skin examination and surveillance is an important aspect in the management of patients with a current diagnosis or a history of melanoma. The presence of a recall system, whether it is electronic or paper based, enables providers to ensure that patients receive follow-up appointments in accordance with their individual needs.

CLINICAL RECOMMENDATION STATEMENTS:

Skin examination and surveillance at least once a year for life is recommended for all melanoma patients, including those with stage 0 in situ-melanoma. Frequency of dermatologic surveillance should be determined individually, based on risk factors, including skin type, family history, presence of dysplastic nevi, and history of non-melanoma skin cancers. Clinicians should also consider educating patients about monthly self-exam of their skin and lymph nodes. (NCCN)

For patients with stage IA melanoma, a comprehensive H&P (with specific emphasis on the regional nodes and skin) should be performed every 3 to 12 months as clinically indicated. For patients with stage IB-III melanomas, a comprehensive H&P (with emphasis on the regional nodes and skin) should be performed every 3 to 6 months for 3 years; then every 4 to 12 months for 2 years; and annually (at least) thereafter, as clinically indicated. (NCCN) (Level of Evidence - Category 2A)

Each local skin cancer multi-disciplinary team (LSMDT) and specialist skin cancer multi-disciplinary team (SSMDT) should have at least one skin cancer clinical nurse specialist (CNS) who will play a leading role in supporting patients and carers. There should be equity of access to information and support regardless of where the care is delivered. A checklist may be used by healthcare professionals to remind them to give patients and carers the information they need in an appropriate format for pre-diagnosis, diagnosis, treatment, follow-up, and palliative care. This may also include a copy of the letter confirming the diagnosis and treatment plan sent by the consultant to the general practitioner (GP).

- Provide a rapid referral service for patients who require specialist management through the LSMDT/SSMDT.
- Be responsible for the provision of information, advice, and support for patients managed in primary care and their care givers.
- Maintain a register of all patients treated, whose care should be part of a regular audit presented to the LSMDT/SSMDT.
- Liaise and communicate with all members of the skin cancer site-specific network group.
- Ensure that referring GPs are given prompt and full information about their patients' diagnosis or treatment in line with national standards on communication to GPs of cancer diagnoses.
- Collect data for network-wide audit. (NICE)

^{*}Measure #138: Melanoma: Coordination of Care

2009 PQRI REPORTING OPTIONS: CLAIMS-BASED, REGISTRY

DESCRIPTION:

Percentage of patient visits, regardless of patient age, with a new occurrence of melanoma who have a treatment plan documented in the chart that was communicated to the physician(s) providing continuing care within one month of diagnosis

INSTRUCTIONS:

This measure is to be reported at <u>each visit</u> occurring during the reporting period for melanoma patients seen during the reporting period. It is anticipated that clinicians providing care for patients with melanoma will submit this measure.

Measure Reporting via Claims:

Line-item ICD-9-CM diagnosis codes and CPT codes are used to identify patients who are included in the measure's denominator. CPT Category II code(s) are used to report the numerator of the measure.

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

NUMERATOR:

Patient visits with a treatment plan documented in the chart that was communicated to the physician(s) providing continuing care within one month of diagnosis

Numerator Instructions: A treatment plan should include the following elements: diagnosis, tumor thickness, and plan for surgery or alternate care.

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

<u>Numerator Quality-Data Coding Options for Reporting Satisfactorily:</u> Treatment Plan Communicated

(Two CPT II codes [5050F & 1127F] are required on the claim form to submit this numerator option)

CPT II 5050F: Treatment plan communicated to provider(s) managing continuing care within <u>one</u> month of diagnosis

AND

CPT II 1127F: New episode for condition

<u> 0R</u>

Treatment Plan not Communicated for Patient or System Reasons

(Two CPT II codes [5050F-xP & 1127F] are required on the claim form to submit this numerator option)

Append a modifier (**2P or 3P**) to CPT Category II code **5050F** to report documented circumstances that appropriately exclude patients from the denominator.

5050F *with* **2P**: Documentation of patient reason(s) for not communicating treatment plan (e.g., patients asks that treatment plan not be communicated to the physician(s) providing continuing care)

5050F *with* **3P:** Documentation of system reason(s) for not communicating treatment plan (e.g., patient does not have a primary care physician or referring physician)

<u>and</u>

CPT II 1127F: New episode for condition

OR

If patient is not eligible for this measure because this is a subsequent episode for the condition, report:

(One CPT II code [1128F] is required on the claim form to submit this numerator option) CPT II 1128F: Subsequent episode for condition

Treatment Plan not Communicated, Reason not Specified

(Two CPT II codes [5050F-8P & 1127F] are required on the claim form to submit this numerator option)

Append a reporting modifier (8P) to CPT Category II code 5050F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

5050F *with* 8P: Treatment plan <u>not</u> communicated, reason not otherwise specified <u>AND</u>

CPT II 1127F: New episode for condition

DENOMINATOR:

All visits for patients, regardless of age, diagnosed with a new occurrence of melanoma

Denominator Criteria (Eligible Cases):

Diagnosis for melanoma (line-item ICD-9-CM): 172.0, 172.1, 172.2, 172.3, 172.4, 172.5, 172.6, 172.7, 172.8, 172.9

<u>and</u>

Patient encounter during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245

RATIONALE:

Perceived lack of follow-up with primary care providers which is reinforced in the Institute of Medicine (IOM) report on patient errors. The intention of this measure is to enable the primary care provider to support, facilitate, and coordinate the care of the patient.

CLINICAL RECOMMENDATION STATEMENTS:

Each local skin cancer multi-disciplinary team (LSMDT) and specialist skin cancer multi-disciplinary team (SSMDT) should have at least one skin cancer clinical nurse specialist (CNS) who will play a leading role in supporting patients and carers. There should be equity of access to information and support regardless of where the care is delivered. A checklist may be used by healthcare professionals to remind them to give patients and carers the information they need in an appropriate format for pre-diagnosis, diagnosis, treatment, follow-up, and palliative care. This may also include a copy of the letter confirming the diagnosis and treatment plan sent by the consultant to the general practitioner (GP).

- Provide a rapid referral service for patients who require specialist management through the LSMDT/SSMDT.
- Be responsible for the provision of information, advice, and support for patients managed in primary care and their care givers.
- Maintain a register of all patients treated, whose care should be part of a regular audit presented to the LSMDT/SSMDT.
- Liaise and communicate with all members of the skin cancer site-specific network group.
- Ensure that referring GPs are given prompt and full information about their patients' diagnosis or treatment in line with national standards on communication to GPs of cancer diagnoses.
- Collect data for network-wide audit. (NICE)

*Measure #139: Cataracts: Comprehensive Preoperative Assessment for Cataract Surgery with Intraocular Lens (IOL) Placement

2009 PQRI REPORTING OPTIONS: CLAIMS-BASED, REGISTRY

DESCRIPTION:

Percentage of patients aged 18 years and older with a procedure of cataract surgery with IOL placement who received a comprehensive preoperative assessment of 1) dilated fundus examination; 2) axial length, corneal keratometry measurement, and method of IOL power calculation; and 3) functional or medical indication(s) for surgery prior to the cataract surgery with IOL placement within 12 months prior to cataract surgery

INSTRUCTIONS:

This measure is to be reported <u>each time</u> a cataract surgery with IOL placement is performed during the reporting period. There is no diagnosis associated with this measure. It is anticipated that <u>clinicians who perform the cataract procedure</u> will submit this measure.

Measure Reporting via Claims:

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

When reporting the measure via claims, submit the appropriate CPT code and the appropriate CPT Category II code <u>**OR**</u> the CPT Category II code <u>**with**</u> the modifier. The reporting modifier allowed for this measure is: 8P- reason not otherwise specified. There are no allowable performance exclusions for this measure. All measure-specific coding should be reported ON THE SAME CLAIM.

NUMERATOR:

Patients who received a comprehensive preoperative assessment within 12 months prior to cataract surgery

Definition:

Comprehensive Preoperative Assessment – 1) dilated fundus examination; 2) axial length, corneal keratometry measurement, and method of IOL power calculation; and 3) functional or medical indication(s) for surgery prior to the cataract surgery with IOL placement

Numerator Quality-Data Coding Options for Reporting Satisfactorily: Comprehensive Preoperative Assessment Performed

CPT II 0014F: Comprehensive preoperative assessment performed for cataract surgery with intraocular lens (IOL) placement

<u> 0R</u>

Comprehensive Preoperative Assessment <u>not</u> **Performed, Reason not Specified** Append a reporting modifier (8P) to CPT Category II code 0014F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

0014F *with* **8P:** Comprehensive preoperative assessment <u>not</u> performed for cataract surgery with intraocular lens (IOL) placement, reason not otherwise specified

DENOMINATOR:

All patients aged 18 years and older who had cataract surgery with IOL placement

Denominator Criteria (Eligible Cases): Patients aged ≥ 18 years on date of encounter <u>AND</u> Patient encounter during the reporting period (CPT): 66982, 66983, 66984

RATIONALE:

1. Scientific basis for comprehensive preoperative assessment

In order to ensure that cataract surgery is APPROPRIATE and SAFE to perform, the operating surgeon is obligated to ensure that there is 1) a patient-centered problem that cataract surgery will address and improve (i.e., that there is likely to be an appropriate outcome of surgery); 2) that the safety of the procedure is maximized through appropriate IOL choice to reduce "wrong power IOL" surgery; and 3) that there are no other conditions that would impact either the appropriateness or the safety of surgery through a comprehensive eye examination, including dilation.

The purpose of the comprehensive evaluation of a patient whose chief complaint might be related to a cataract is to determine the presence of a cataract, confirm that a cataract is a significant factor related to the visual impairment and symptoms described by the patient, and exclude or identify other ocular or systemic conditions that might contribute to visual impairment or affect the cataract surgical plan or ultimate outcome.

During the preoperative evaluation, other ocular conditions could be found in the course of fundus evaluation that would lead to identification of possible contraindications for surgery: Surgery for a visually impairing cataract should not be performed under the following circumstances:

- Eyeglasses or visual aids provide vision that meets the patient's needs.
- Surgery will not improve visual function.
- The patient cannot safely undergo surgery because of co-existing medical or ocular conditions.
- Appropriate postoperative care cannot be arranged.

The surgeon should consider the patient's individual desires and needs in selecting an appropriate postoperative refractive target. The axial length can be measured by A-scan ultrasonography using either an applanation (contact) or an immersion (non-contact) technique. Biometry measurement for both eyes is advisable, even if surgery is not planned for the other eye. Formulas for calculating

IOL power rely on keratometry to determine the net refractive contribution of the cornea. These measurements can be obtained through either manual or automated keratometry, or through corneal topography. Latest generation lens calculation formulas should be used in the IOL selection process.

2. Evidence of gap in care.

Results from the Cataract Appropriateness Project from RAND and additional studies for AHCPR at RAND suggest that the gap for a comprehensive preoperative assessment range from 10 to 30+%.

CLINICAL RECOMMENDATION STATEMENTS:

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

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

The primary indication for surgery is visual function that no longer meets the patient's needs and for which cataract surgery provides a reasonable likelihood of improved vision. Functional indications for surgery include documentation that a patient is experiencing difficulty with activities of daily living, such as reading, walking, driving, and performing other visual tasks. This may also include symptoms of anisometropia, glare, starbursts, or color vision abnormalities.

Medical indications for surgery include documentation that the presence of the cataract is contributing to disease (such as primary angle closure) or that removal is necessary for adequate visualization of the fundus. Such medical conditions for a cataract removal include the following:

- Clinically significant anisometropia in the presence of a cataract.
- The lens opacity interferes with optimal diagnosis or management of posterior segment conditions.
- The lens causes inflammation (phacolysis, phacoanaphylaxis).
- The lens induces angle closure (phacomorphic or phacotopic).

*Measure #140: Age-Related Macular Degeneration (AMD): Counseling on Antioxidant Supplement

2009 PQRI REPORTING OPTIONS: CLAIMS-BASED, REGISTRY

DESCRIPTION:

Percentage of patients aged 50 years and older with a diagnosis of AMD and/or their caregiver(s) who were counseled within 12 months on the benefits and/or risks of the Age-Related Eye Disease Study (AREDS) formulation for preventing progression of AMD

INSTRUCTIONS:

This measure is to be reported a minimum of <u>once per reporting period</u> for AMD patients seen during the reporting period. It is anticipated that clinicians who provide the primary management of patients with AMD will submit this measure. 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 AMD.

Measure Reporting via Claims:

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

When reporting the measure via claims, submit the appropriate ICD-9-CM diagnosis code, CPT codes, and the appropriate CPT Category II code **OR** the CPT Category II code **with** the modifier. The modifiers allowed for this measure are: 3P- system reasons, 8P- reason not otherwise specified. All measure-specific coding should be reported ON THE SAME CLAIM.

NUMERATOR:

Patients and/or their caregiver(s) who were counseled within 12 months on the benefits and/or risks of the AREDS formulation for preventing progression of AMD

Numerator Instructions: Counseling can be discussed with all patients with AMD, even those who do not meet the criteria for the AREDS formulation, patients who are smokers (beta-carotene can increase the risk for cancer in these patients) or other reasons why the patient would not meet criteria for AREDS formulation as outlined in the AREDS. The ophthalmologist or optometrist can explain why these supplements are not appropriate for their particular situation. Also, given the purported risks associated with antioxidant use, patients would be informed of the risks and benefits and make their choice based on valuation of vision loss vs. other risks. As such, the measure seeks to educate patients about overuse as well as appropriate use.

<u>Numerator Quality-Data Coding Options for Reporting Satisfactorily:</u> AREDS Counseling Performed

CPT II 4177F: Counseling about the benefits and/or risks of the Age-Related Eye Disease Study (AREDS) formulation for preventing progression of age-related macular degeneration (AMD) provided to patient and/or caregiver(s)

<u> 0R</u>

AREDS Counseling not Performed for System Reasons

Append a modifier (**3P**) to CPT Category II code **4177F** to report documented circumstances that appropriately exclude patients from the denominator.

4177F *with* **3P:** Documentation of system reason(s) for not counseling the patient and/or caregiver(s) on the benefits and/or risks of the AREDS formulation

AREDS Counseling not Performed, Reason not Specified

Append a reporting modifier (8P) to CPT Category II code 4177F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

4177F with 8P: AREDS counseling not performed, reason not otherwise specified

DENOMINATOR:

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

Denominator Criteria (Eligible Cases):

Patients aged ≥ 50 years on date of encounter <u>AND</u> Diagnosis for AMD (line-item ICD-9-CM): 362.50, 362.51, 362.52 <u>AND</u> Patient encounter during the reporting period (CPT): 92002, 92004, 92012, 92014, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337

RATIONALE:

1. Scientific basis for counseling regarding use of AREDS formulation for patients with AMD

Antioxidant vitamins and mineral supplements help to reduce the rate of progression to advanced AMD for those patients with intermediate or advanced AMD in one eye. From the same AREDS study, there is no evidence that the use of antioxidant vitamin and mineral supplements for patients with mild AMD alters the natural history of mild AMD.

At the same time, published meta analyses have raised an issue as to the presence of an elevated mortality risk among patients taking elements similar to parts of the AREDS formulation (and elevated risk among smokers). As such, patients need to know of their individualized risk profile for taking the AREDS formula AND the potential benefits, so that they can make their OWN individual decision as to whether or not to take the AREDS formulation.

This indicator thus seeks to directly enhance the provider-patient relationship to apply the results of level 1 randomized controlled trials (RCTs) in a manner that accommodates the needs of each

individual patient in a patient-centered manner, rather than a paternalistic approach of either recommending or withholding treatment.

2. Evidence of gap in care.

Antioxidant vitamins and mineral supplements help to reduce the rate of progression to advanced AMD for those patients with intermediate or advanced AMD in one eye. From the same AREDS study, there is no evidence that the use of antioxidant vitamin and mineral supplements for patients with mild AMD alters the natural history of mild AMD.

CLINICAL RECOMMENDATION STATEMENTS:

Patients with intermediate AMD or advanced AMD in one eye should be counseled on the use of antioxidant vitamin and mineral supplements as recommended in the Age-related Eye Disease Study (AREDS) reports. (Level A:I Recommendation) (AAO)

TABLE 1 Antioxidant Vitamin and Mineral Supplements Used in the AREDS	
Supplement	Daily Dose (See note below)
Vitamin C	500 mg
Vitamin E	400 IU
Beta-carotene	15 mg (25,000 IU)
Zinc oxide	80 mg
Cupric oxide	2 mg

Note: These doses are not those listed on the commercially available vitamin/mineral supplements because of a change in labeling rules by the U.S. Food and Drug Administration that specifies that the doses must reflect the amounts available at the end of the shelf life.

^{*}Measure #141: Primary Open-Angle Glaucoma (POAG): Reduction of Intraocular Pressure (IOP) by 15% OR Documentation of a Plan of Care

2009 PQRI REPORTING OPTIONS: CLAIMS-BASED, REGISTRY

DESCRIPTION:

Percentage of patients aged 18 years and older with a diagnosis of POAG whose glaucoma treatment has not failed (the most recent IOP was reduced by at least 15% from the pre-intervention level) OR if the most recent IOP was not reduced by at least 15% from the pre-intervention level, a plan of care was documented within 12 months

INSTRUCTIONS:

This measure is to be reported a minimum of <u>once per reporting period</u> for glaucoma patients seen during the reporting period. It is anticipated that clinicians who provide the primary management of patients with POAG will submit this measure. The system reason exclusion may be used if an ophthalmologist or optometrist is asked to report on this measure but is not the ophthalmologist or optometrist providing the primary management for primary open-angle glaucoma.

Measure Reporting via Claims:

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

When reporting the measure via claims, submit the appropriate ICD-9-CM diagnosis code, CPT codes, and the appropriate CPT Category II code(s) <u>**OR**</u> the CPT Category II code <u>with</u> the modifier. The modifiers allowed for this measure are: 3P- system reasons, 8P- reason not otherwise specified. All measure-specific coding should be reported ON THE SAME CLAIM.

NUMERATOR:

Patients whose glaucoma treatment has not failed (the most recent IOP was reduced by at least 15% from the pre-intervention level) OR if the most recent IOP was not reduced by at least 15% from the pre-intervention level a plan of care was documented within 12 months

Definition:

Plan of Care – May include: recheck of IOP at specified time, change in therapy, perform additional diagnostic evaluations, monitoring per patient decisions or unable to achieve due to health system reasons, and/or referral to a specialist

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

<u>Numerator Quality-Data Coding Options for Reporting Satisfactorily:</u> Intraocular Pressure (IOP) Reduced Greater than or Equal to 15% Pre-intervention Level

(One CPT II code [3284F] is required on the claim form to submit this numerator option) CPT II 3284F: Intraocular pressure (IOP) reduced by a value of greater than or equal to 15% from the pre-intervention level

OR

Intraocular Pressure (IOP) Reduced Less than 15% Pre-intervention Level with Plan of Care

(Two CPT II codes [0517F & 3285F] are required on the claim form to submit this numerator option)

CPT II 0517F: Glaucoma plan of care documented

<u>and</u>

CPT II 3285F: Intraocular pressure (IOP) reduced by a value less than 15% from the preintervention level

Glaucoma Plan of Care not Documented for System Reasons

(Two CPT II codes [0517F-3P & 3285F] are required on the claim form to submit this numerator option)

Append a modifier (**3P**) to CPT Category II code **0517F** to report documented circumstances that appropriately exclude patients from the denominator.

0517F *with* **3P:** Glaucoma plan of care not documented for system reason(s) <u>AND</u>

CPT II 3285F: Intraocular pressure (IOP) reduced by a value less than 15% from the preintervention level

<u> 0R</u>

Glaucoma Plan of Care not Documented, Reason not Specified

(Two CPT II codes [0517F-8P & 3285F] are required on the claim form to submit this numerator option)

Append a reporting modifier (8P) to CPT Category II code 0517F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

0517F *with* **8P:** Glaucoma plan of care <u>not</u> documented, reason not otherwise specified <u>AND</u>

CPT II 3285F: Intraocular pressure (IOP) reduced by a value less than 15% from the preintervention level

OR

Intraocular Pressure (IOP) Measurement not Documented, Reason not Specified

(One CPT II code [3284F-8P] is required on the claim form to submit this numerator option)

Append a reporting modifier (8P) to CPT Category II code 3284F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

3284F with 8P: IOP measurement not documented, reason not otherwise specified

DENOMINATOR:

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

Denominator Criteria (Eligible Cases):

Patients aged ≥ 18 years on date of encounter <u>AND</u> Diagnosis for POAG (line-item ICD-9-CM): 365.10, 365.11, 365.12, 365.15 <u>AND</u> Patient encounter during the reporting period (CPT): 92002, 92004, 92012, 92014, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337

RATIONALE:

1. Scientific basis for intraocular pressure (IOP) control as outcomes measure (intermediate)

Analyses of results of several randomized clinical trials all demonstrate that reduction of IOP of at least 18% (EMGT, CIGTS, AGIS, CNTGS) reduces the rate of worsening of visual fields by at least 40%. The various studies, however, achieved different levels of mean IOP lowering in realizing their benefit in patient outcomes, ranging from 18% in the "normal pressure" subpopulation of EMGT to 42% in the CIGTS study. (Level I studies) As such, an appropriate "failure" indicator is to NOT achieve at least a 15% IOP reduction. The rationales for a failure indicator are that 1) the results of different studies can lead experienced clinicians to believe that different levels of IOP reduction are appropriate; 2) to minimize the impact of adverse selection for those patients whose IOPs are more difficult to control; and 3) because each patient's clinical course may require IOP reduction that may vary from 18 to 40+%.

In addition, "...[s]several population based studies have demonstrated that the prevalence of POAG as well as the incidence of POAG, increases as the level of IOP increases. These studies provide strong evidence that IOP plays an important role in the neuropathy of POAG. Furthermore, studies have demonstrated that reduction in the level of IOP lessens the risk of visual field progression in open-angle glaucoma. In addition, treated eyes that have a greater IOP fluctuation are at increased risk of progression.

Intraocular pressure is the intermediate outcome of therapy used by the FDA for approval of new drugs and devices and, as noted above, has been shown to be directly related to ultimate patient outcomes of vision loss. As such, failure to achieve minimal pressure lowering, absent an appropriate plan of care to address the situation, would constitute performance whose improvement would directly benefit patients with POAG.

2. Evidence for gap in care

Based on studies in the literature reviewing documentation of IOP achieved under care, the gap could be as great as 50% or more in the community of ophthalmologists and optometrists treating patients with primary open-angle glaucoma. Based on loose criteria for control, IOP was controlled in 66% of follow-up visits for patients with mild glaucoma and 52% of visits for patients with moderate to severe glaucoma. Another study of a single comprehensive insurance plan suggested that a large proportion of individuals felt to require treatment for glaucoma or suspect glaucoma are falling out of care and are being monitored at rates lower than expected from recommendations of published guidelines.

CLINICAL RECOMMENDATION STATEMENTS:

The initial target pressure selected should be at least 20% lower than the pretreatment IOP, depending upon the clinical findings. Further reduction of the target IOP is often also justified by the severity of existing optic nerve damage, the level of the measured pretreatment IOP, the rapidity with which the damage occurred, and other risk factors. In general, the more advanced the damage, the lower the initial pressure should be (Level A: III Recommendation).

Please note that the American Optometric Association's (AOA) 2002 guideline on Open-angle Glaucoma was not reviewed during the development of this measure prior to the public comment period and therefore is not presented here verbatim. Review of the AOA guideline subsequent to initial measure development indicates that the recommendations in the AOA guideline are consistent with the intent of the measure. As such, the intent of this measure is to have this indicator apply to both optometrists and ophthalmologists (and any other physician who provides glaucoma care); the use of "ophthalmologists" only in the preceding verbatim section reflects the wording in the American Academy of Ophthalmology Preferred Practice pattern.

A Measure #142: Osteoarthritis (OA): Assessment for Use of Anti-Inflammatory or Analgesic Over-the-Counter (OTC) Medications

2009 PQRI REPORTING OPTIONS: CLAIMS-BASED, REGISTRY

DESCRIPTION:

Percentage of patient visits for patients aged 21 years and older with a diagnosis of OA with an assessment for use of anti-inflammatory or analgesic OTC medications

INSTRUCTIONS:

This measure is to be reported at <u>each visit</u> occurring during the reporting period for OA patients seen during the reporting period. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

Measure Reporting via Claims:

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

When reporting the measure via claims, submit the listed ICD-9-CM diagnosis code, CPT codes, and the appropriate CPT Category II code <u>**OR**</u> the CPT Category II code <u>**with**</u> the modifier. The reporting modifier allowed for this measure is: 8P- reason not otherwise specified. There are no allowable performance exclusions for this measure. All measure-specific coding should be reported ON THE SAME CLAIM.

NUMERATOR:

Patient visits with assessment for use of anti-inflammatory or analgesic OTC medications documented

<u>Numerator Quality-Data Coding Options for Reporting Satisfactorily:</u> Assessment for Anti-inflammatory or Analgesic OTC Medications Performed CPT II 1007F: Use of anti-inflammatory or analgesic over-the-counter (OTC) medications for symptom relief assessed

<u> 0R</u>

Assessment for Anti-inflammatory or Analgesic OTC Medications <u>not</u> Performed, Reason not Specified

Append a reporting modifier (8P) to CPT Category II code 1007F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

1007F *with* **8P:** Use of anti-inflammatory or analgesic OTC medications <u>not</u> assessed, reason not otherwise specified

DENOMINATOR:

All visits for patients aged 21 years and older with OA

Denominator Criteria (Eligible Cases):

Patients aged \geq 21 years on date of encounter

AND

Diagnosis for OA (line-item ICD-9-CM): 715.00, 715.04, 715.09, 715.10, 715.11, 715.12, 715.13, 715.14, 715.15, 715.16, 715.17, 715.18, 715.20, 715.21, 715.22, 715.23, 715.24, 715.25, 715.26, 715.27, 715.28, 715.30, 715.31, 715.32, 715.33, 715.34, 715.35, 715.36, 715.37, 715.38, 715.80, 715.89, 715.90, 715.91, 715.92, 715.93, 715.94, 715.95, 715.96, 715.97, 715.98

<u>AND</u>

Patient encounter during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245

RATIONALE:

Management of pain in patients with osteoarthritis is an important aspect of care. Patients who are able to have their pain controlled are more likely to be able to function at their desired level, which leads to improved quality of life.

CLINICAL RECOMMENDATION STATEMENTS:

Initial treatment should include activity modification and trial of analgesic or non-steroidal antiinflammatory medication (NSAID). (AAOS; A Recommendation)

Acetaminophen has been shown to be as effective a pain reliever as NSAIDs in patients with OA of the knee. (AAOS, A Recommendation)

Analgesic and anti-inflammatory medications are important in arthritis pain management, but should be used concurrently with nutritional, physical, educational, and cognitive-behavioral interventions. (APS; A Recommendation)

A Measure #143: Oncology: Medical and Radiation – Pain Intensity Quantified

2009 PQRI REPORTING OPTIONS: CLAIMS-BASED, REGISTRY

This is a two-part measure which is paired with Measure #144: Oncology: Medical and Radiation: Plan of Care for Pain. If pain is present (CPT II code 1125F is submitted), #144 *should* also be reported.

DESCRIPTION:

Percentage of patient visits, regardless of patient age, with a diagnosis of cancer currently receiving chemotherapy or radiation therapy in which pain intensity is quantified

INSTRUCTIONS:

This measure is to be reported at <u>each visit</u> occurring during the reporting period for patients with a diagnosis of cancer who are seen during the reporting period. It is anticipated that clinicians providing care for patients with cancer will submit this measure.

Measure Reporting via Claims:

Line-item ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. CPT Category II code(s) are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed ICD-9-CM diagnosis codes, CPT codes, and the appropriate CPT Category II code(s) <u>**OR**</u> the CPT Category II code(s) <u>**with**</u> the modifier. The reporting modifier allowed for this measure is: 8P- reason not otherwise specified. There are no allowable performance exclusions for this measure. All measure-specific coding should be reported ON THE SAME CLAIM.

NUMERATOR:

Patient visits in which pain intensity was quantified

Numerator Instructions: Pain intensity should be quantified using a standard instrument, such as a 0-10 numeric rating scale, a categorical scale, or the pictorial scale.

Numerator Quality-Data Coding Options for Reporting Satisfactorily: Pain Severity Quantified, Presence of Pain Documented CPT II 1125F: Pain severity quantified; pain present (When CPT II code 1125F is submitted, Measure #144 should also be reported) OR CPT II 1126F: Pain severity quantified; no pain present

Pain Severity not Documented, Reason not Specified

Append a reporting modifier (8P) to CPT Category II code 1125F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

1125F with 8P: Pain severity not documented, reason not otherwise specified

DENOMINATOR:

All patient visits, regardless of patient age, with a diagnosis of cancer currently receiving chemotherapy or radiation therapy

Denominator Criteria (Eligible Cases):

Diagnosis for cancer (line-item ICD-9-CM): 140.0, 140.1, 140.3, 140.4, 140.5, 140.6, 140.8, 140.9, 141.0, 141.1, 141.2, 141.3, 141.4, 141.5, 141.6, 141.8, 141.9, 142.0, 142.1, 142.2, 142.8, 142.9, 143.0, 143.1, 143.8, 143.9, 144.0, 144.1, 144.8, 144.9, 145.0, 145.1, 145.2, 145.3, 145.4, 145.5, 145.6, 145.8, 145.9, 146.0, 146.1, 146.2, 146.3, 146.4, 146.5, 146.6, 146.7, 146.8, 146.9, 147.0, 147.1, 147.2, 147.3, 147.8, 147.9, 148.0, 148.1, 148.2, 148.3, 148.8, 148.9, 149.0, 149.1, 149.8, 149.9, 150.0, 150.1, 150.2, 150.3, 150.4, 150.5, 150.8, 150.9, 151.0, 151.1, 151.2, 151.3, 151.4, 151.5, 151.6, 151.8, 151.9, 152.0, 152.1, 152.2, 152.3, 152.8, 152.9, 153.0, 153.1, 153.2, 153.3, 153.4, 153.5, 153.6, 153.7, 153.8, 153.9, 154.0, 154.1, 154.2, 154.3, 154.8, 155.0, 155.1, 155.2, 156.0, 156.1, 156.2, 156.8, 156.9, 157.0, 157.1, 157.2, 157.3, 157.4, 157.8, 157.9, 158.0, 158.8, 158.9, 159.0, 159.1, 159.8, 159.9, 160.0, 160.1, 160.2, 160.3, 160.4, 160.5, 160.8, 160.9, 161.0, 161.1, 161.2, 161.3, 161.8, 161.9, 162.0, 162.2, 162.3, 162.4, 162.5, 162.8, 162.9, 163.0, 163.1, 163.8, 163.9, 164.0, 164.1, 164.2, 164.3, 164.8, 164.9, 165.0, 165.8, 165.9, 170.0, 170.1, 170.2, 170.3, 170.4, 170.5, 170.6, 170.7, 170.8, 170.9, 171.0, 171.2, 171.3, 171.4, 171.5, 171.6, 171.7, 171.8, 171.9, 172.0, 172.1, 172.2, 172.3, 172.4, 172.5, 172.6, 172.7, 172.8, 172.9, 173.0, 173.1, 173.2, 173.3, 173.4, 173.5, 173.6, 173.7, 173.8, 173.9, 174.0, 174.1, 174.2, 174.3, 174.4, 174.5, 174.6, 174.8, 174.9, 175.0, 175.9, 176.0, 176.1, 176.2, 176.3, 176.4, 176.5, 176.8, 176.9, 179, 180.0, 180.1, 180.8, 180.9, 181, 182.0, 182.1, 182.8, 183.0, 183.2, 183.3, 183.4, 183.5, 183.8, 183.9, 184.0, 184.1, 184.2, 184.3, 184.4, 184.8, 184.9, 185, 186.0, 186.9, 187.1, 187.2, 187.3, 187.4, 187.5, 187.6, 187.7, 187.8, 187.9, 188.0, 188.1, 188.2, 188.3, 188.4, 188.5, 188.6, 188.7, 188.8, 188.9, 189.0, 189.1, 189.2, 189.3, 189.4, 189.8, 189.9, 190.0, 190.1, 190.2, 190.3, 190.4, 190.5, 190.6, 190.7, 190.8, 190.9, 191.0, 191.1, 191.2, 191.3, 191.4, 191.5, 191.6, 191.7, 191.8, 191.9, 192.0, 192.1, 192.2, 192.3, 192.8, 192.9, 193, 194.0, 194.1, 194.3, 194.4, 194.5, 194.6, 194.8, 194.9, 195.0, 195.1, 195.2, 195.3, 195.4, 195.5, 195.8, 196.0, 196.1, 196.2, 196.3, 196.5, 196.6, 196.8, 196.9, 197.0, 197.1, 197.2, 197.3, 197.4, 197.5, 197.6, 197.7, 197.8, 198.0, 198.1, 198.2, 198.3, 198.4, 198.5, 198.6, 198.7, 198.81, 198.82, 198.89, 199.0, 199.1, 199.2, 200.00, 200.01, 200.02, 200.03, 200.04, 200.05, 200.06, 200.07, 200.08, 200.10, 200.11, 200.12, 200.13, 200.14, 200.15, 200.16, 200.17, 200.18, 200.20, 200.21, 200.22, 200.23, 200.24, 200.25, 200.26, 200.27, 200.28, 200.30, 200.31, 200.32, 200.33, 200.34, 200.35, 200.36, 200.37, 200.38, 200.40, 200.41, 200.42, 200.43, 200.44, 200.45, 200.46, 200.47, 200.48; 200.50, 200.51, 200.52, 200.53, 200.54, 200.55, 200.56, 200.57, 200.58, 200.60, 200.61, 200.62, 200.63, 200.64, 200.65, 200.66, 200.67, 200.68, 200.70, 200.71, 200.72, 200.73, 200.74, 200.75, 200.76, 200.77, 200.78, 200.80, 200.81, 200.82, 200.83, 200.84, 200.85, 200.86, 200.87, 200.88, 201.00, 201.01, 201.02, 201.03, 201.04, 201.05, 201.06, 201.07, 201.08, 201.10, 201.11, 201.12, 201.13, 201.14, 201.15, 201.16, 201.17, 201.18, 201.20,

201.21, 201.22, 201.23, 201.24, 201.25, 201.26, 201.27, 201.28, 201.40, 201.41, 201.42, 201.43, 201.44, 201.45, 201.46, 201.47, 201.48, 201.50, 201.51, 201.52, 201.53, 201.54, 201.55, 201.56, 201.57, 201.58, 201.60, 201.61, 201.62, 201.63, 201.64, 201.65, 201.66, 201.67, 201.68, 201.70, 201.71, 201.72, 201.73, 201.74, 201.75, 201.76, 201.77, 201.78, 201.90, 201.91, 201.92, 201.93, 201.94, 201.95, 201.96, 201.97, 201.98, 202.00, 202.01, 202.02, 202.03, 202.04, 202.05, 202.06, 202.07, 202.08, 202.10, 202.11, 202.12, 202.13, 202.14, 202.15, 202.16, 202.17, 202.18, 202.20, 202.21, 202.22, 202.23, 202.24, 202.25, 202.26, 202.27, 202.28, 202.30, 202.31, 202.32, 202.33, 202.34, 202.35, 202.36, 202.37, 202.38, 202.40, 202.41, 202.42, 202.43, 202.44, 202.45, 202.46, 202.47, 202.48, 202.50, 202.51, 202.52, 202.53, 202.54, 202.55, 202.56, 202.57, 202.58, 202.60, 202.61, 202.62, 202.63, 202.64, 202.65, 202.66, 202.67, 202.68, 202.70, 202.71, 202.72, 202.73, 202.74, 202.75, 202.76, 202.77, 202.78, 202.80, 202.81, 202.82, 202.83, 202.84, 202.85, 202.86, 202.87, 202.88, 202.90, 202.91, 202.92, 202.93, 202.94, 202.95, 202.96, 202.97, 202.98, 203.00, 203.01, 203.02, 203.10, 203.11, 203.12, 203.80, 203.81, 203.82, 204.00, 204.01, 204.02, 204.10, 204.11, 204.12, 204.20, 204.21, 204.22, 204.80, 204.81, 204.82, 204.90, 204.91, 204.92, 205.00, 205.01, 205.02, 205.10, 205.11, 205.12, 205.20, 205.21, 205.22, 205.30, 205.31, 205.32, 205.80, 205.81, 205.82, 205.90, 205.91, 205.92, 206.00, 206.01, 206.02, 206.10, 206.11, 206.12, 206.20, 206.21, 206.22, 206.80, 206.81, 206.82, 206.90, 206.91, 206.92, 207.00, 207.01, 207.02, 207.10, 207.11, 207.12, 207.20, 207.21, 207.22, 207.80, 207.81, 207.82, 208.00, 208.01, 208.02, 208.10, 208.11, 208.12, 208.20, 208.21, 208.22, 208.80, 208.81, 208.82, 208.90, 208.91, 208.92, 209.00, 209.01, 209.02, 209.03, 209.10, 209.11, 209.12, 209.13, 209.14, 209.15, 209.16, 209.17, 209.20, 209.21, 209.22, 209.23, 209.24, 209.25, 209.26, 209.27, 209.29, 209.30, 235.0, 235.1, 235.2, 235.3, 235.4, 235.5, 235.6, 235.7, 235.8, 235.9, 236.0, 236.1, 236.2, 236.3, 236.4, 236.5, 236.6, 236.7, 236.90, 236.91, 236.99, 237.0, 237.1, 237.2, 237.3, 237.4, 237.5, 237.6, 237.70, 237.71, 237.72, 237.9, 238.0, 238.1, 238.2, 238.3, 238.4, 238.5, 238.6, 238.71, 238.72, 238.73, 238.74, 238.75, 238.76, 238.77, 238.8, 238.9, 239.0, 239.1, 239.2, 239.3, 239.4, 239.5, 239.6, 239.7, 239.8, 239.9

AND EITHER:

Patient encounter during the reporting period (CPT) - Procedure codes: 77427, 77431, 77432, 77435, 77470

OR

Patient encounter during the reporting period (CPT) - Service codes: 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215

<u>and</u>

Patient encounter during the reporting period (CPT) - Procedure codes: 51720, 96401, 96402, 96405, 96406, 96409, 96411, 96413, 96415, 96416, 96417, 96420, 96422, 96423, 96425, 96440, 96445, 96450, 96521, 96522, 96523, 96542, 96549

RATIONALE:

Inadequate cancer pain management is widely prevalent, harmful to the patient, and costly.

CLINICAL RECOMMENDATION STATEMENTS:

All patients with cancer should be screened during the initial evaluation, at regular intervals, and whenever new therapy is initiated. The standard means for determining how much pain a patient is experiencing relies on a patient's self-report. Severity should be quantified using a 0-10 numerical rating scale, a categorical scale, or the pictorial scale (Wong-Baker Faces Pain Rating Scale). Faces can be used with patients who have difficulty with the above scales, eg, children, the elderly, and patients with language or cultural differences or other communication barriers (Category 2A). (NCCN)

Pain intensity must be quantified, as the algorithm bases therapeutic decisions on a numerical value assigned to the severity of pain. Opioid naïve patients experiencing severe or increasing pain should receive rapid escalating doses of short-acting opioids, a bowel regimen, and Nonopioid analgesics as indicated. Psychosocial support is needed to ensure that patients encountering common barriers to appropriate pain control (eg, fear of addiction or side effects, inability to purchase opioids) or needing additional assistance (eg, depression, rapidly declining functional status) receive appropriate aid. Although pain intensity ratings will be obtained frequently to judge opioid dose increases, a formal reassessment is mandated in 24 hours for severe pain (Category 2A). (NCCN)

Regular, on-going assessment of pain, non-pain symptoms (including but not limited to shortness of breath, nausea, fatigue and weakness, anorexia, insomnia, anxiety, depression, confusion, and constipation), treatment side effects, and functional capacities are documented. Validated instruments, where available, should be used. (NCP)

All patients should be routinely screened for pain, and when it is present, pain intensity should be recorded in highly visible ways that facilitate regular review by health care providers. A standard for pain assessment and documentation should be established in each setting to ensure that pain is recognized, documented, and treated promptly. (APS)
A Measure #144: Oncology: Medical and Radiation – Plan of Care for Pain

2009 PQRI REPORTING OPTIONS: CLAIMS-BASED, REGISTRY

This is a two-part measure which is paired with Measure #143: Oncology: Medical and Radiation: Pain Intensity Quantified. This measure *should* be reported if CPT II code 1125F "Pain severity quantified; pain present" is submitted for Measure #143.

DESCRIPTION:

Percentage of patient visits, regardless of patient age, with a diagnosis of cancer currently receiving chemotherapy or radiation therapy who report having pain with a documented plan of care to address pain

INSTRUCTIONS:

This measure is to be reported at <u>each visit</u> occurring during the reporting period for patients with a diagnosis of cancer and in which pain is present who are seen during the reporting period. It is anticipated that clinicians providing care for patients with cancer will submit this measure.

Measure Reporting via Claims:

All eligible instances when CPT II code 1125F (Pain severity quantified; pain present) is reported in the numerator for Measure #143 make up the denominator for this measure. CPT Category II code(s) are used to report the numerator of the measure.

When CPT II code 1125F is reported with Measure #143, add the appropriate CPT Category II code(s) **OR** the CPT Category II code(s) **with** the modifier. The reporting modifier allowed for this measure is: 8P- reason not otherwise specified. There are no allowable performance exclusions for this measure. All measure-specific coding should be reported ON THE SAME CLAIM.

NUMERATOR:

Patient visits that included a documented plan of care to address pain

Numerator Instructions: A documented plan of care may include: use of opioids, nonopioid analgesics, psychological support, patient and/or family education, referral to a pain clinic, or reassessment of pain at an appropriate time interval.

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Plan of Care for Pain Documented

CPT II 0521F: Plan of care to address pain documented

Plan of Care for Pain not Documented, Reason not Specified

Append a reporting modifier (8P) to CPT Category II code 0521F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

0521F with 8P: Plan of care for pain not documented, reason not otherwise specified

DENOMINATOR:

All patient visits, regardless of age, with a diagnosis of cancer currently receiving chemotherapy or radiation therapy who report having pain

Denominator Criteria (Eligible Cases):

All eligible instances when **CPT II code 1125F** (Pain severity quantified; pain present) is reported in the numerator for Measure #143

RATIONALE:

Inadequate cancer pain management is widely prevalent, harmful to the patient, and costly.

CLINICAL RECOMMENDATION STATEMENTS:

All patients with cancer should be screened during the initial evaluation, at regular intervals, and whenever new therapy is initiated. The standard means for determining how much pain a patient is experiencing relies on a patient's self-report. Severity should be quantified using a 0-10 numerical rating scale, a categorical scale, or the pictorial scale (Wong-Baker Faces Pain Rating Scale). Faces can be used with patients who have difficulty with the above scales, eg, children, the elderly, and patients with language or cultural differences or other communication barriers (Category 2A). (NCCN)

Pain intensity must be quantified, as the algorithm bases therapeutic decisions on a numerical value assigned to the severity of pain. Opioid naïve patients experiencing severe or increasing pain should receive rapid escalating doses of short-acting opioids, a bowel regimen, and Nonopioid analgesics as indicated. Psychosocial support is needed to ensure that patients encountering common barriers to appropriate pain control (eg, fear of addiction or side effects, inability to purchase opioids) or needing additional assistance (eg, depression, rapidly declining functional status) receive appropriate aid. Although pain intensity ratings will be obtained frequently to judge opioid dose increases, a formal reassessment is mandated in 24 hours for severe pain (Category 2A). (NCCN)

For patients whose pain is less than 7 at presentation, the pathways are similar. The main differences include the option to perform the formal pain intensity reassessment less frequently (24-48 hours) and to consider beginning with slower titration of short-acting opioids for patients with moderate pain intensity rating 4-6 or with NSAID or acetaminophen if the patient has mild pain intensity rating from 1 to 0 and is opioid and NSAID-naïve (Category 2A). (NCCN)

Regular, on-going assessment of pain, non-pain symptoms (including but not limited to shortness of breath, nausea, fatigue and weakness, anorexia, insomnia, anxiety, depression, confusion, and constipation), treatment side effects, and functional capacities are documented. Validated instruments, where available, should be used. (NCP)

All patients should be routinely screened for pain, and when it is present, pain intensity should be recorded in highly visible ways that facilitate regular review by health care providers. A standard for pain assessment and documentation should be established in each setting to ensure that pain is recognized, documented, and treated promptly. (APS)

Measure #145: Radiology: Exposure Time Reported for Procedures Using Fluoroscopy

2009 PQRI REPORTING OPTIONS: CLAIMS-BASED, REGISTRY

DESCRIPTION:

Percentage of final reports for procedures using fluoroscopy that include documentation of radiation exposure or exposure time

INSTRUCTIONS:

This measure is to be reported <u>each time</u> fluoroscopy is performed in a hospital or outpatient setting during the reporting period. There is no diagnosis associated with this measure. It is anticipated that <u>clinicians providing the services for procedures using fluoroscopy</u> will submit this measure.

Measure Reporting via Claims:

CPT codes and G-codes are used to identify patients who are included in the measure's denominator. CPT Category II codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed CPT codes, G-codes, and the appropriate CPT Category II code **OR** the CPT Category II code **with** the modifier. The reporting modifier allowed for this measure is: 8P- reason not otherwise specified. There are no allowable performance exclusions for this measure. All measure-specific coding should be reported ON THE SAME CLAIM.

NUMERATOR:

Final reports for procedures using fluoroscopy that include documentation of radiation exposure or exposure time

Numerator Quality-Data Coding Options for Reporting Satisfactorily: Radiation Exposure or Exposure Time Documented in Fluoroscopy Report CPT II 6045F: Radiation exposure or exposure time in final report for procedure using fluoroscopy, documented

<u> 0R</u>

Radiation Exposure or Exposure Time <u>not</u> Documented in Fluoroscopy Report, Reason not Specified

Append a reporting modifier (8P) to CPT Category II code 6045F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

6045F *with* **8P:** Final fluoroscopy report does <u>not</u> include documentation of radiation exposure or exposure time, reason not otherwise specified

DENOMINATOR:

All final reports for procedures using fluoroscopy

Denominator Criteria (Eligible Cases):

Patient encounter during the reporting period (CPT or HCPCS): 0062T, 0075T, 0080T, 24516, 25606, 25651, 26608, 26650, 26676, 26706, 26727, 27235, 27244, 27245, 27506, 27509, 27756, 27759, 28406, 28436, 28456, 28476, 36597, 36598, 37182, 37183, 37184, 37187, 37188, 37210, 43260, 43261, 43262, 43263, 43264, 43265, 43267, 43268, 43269, 43271, 43272, 43752, 44500, 49440, 49441, 49442, 49446, 49450, 49451, 49452, 49460, 49465, 50382, 50384, 50385, 50386, 50387, 50389, 50590, 61623, 62263, 62264, 62280, 62281, 62282, 62318, 62319, 63610, 64510, 64520, 64530, 64561, 64605, 64610, 64620, 64622, 64626, 64680, 64681, 70010, 70015, 70170, 70332, 70370, 70371, 70373, 70390, 71023, 71034, 71040, 71060, 71090, 72240, 72255, 72265, 72270, 72275, 72285, 72291, 72295, 73040, 73085, 73115, 73525, 73542, 73580, 73615, 74190, 74210, 74220, 74230, 74235, 74240, 74241, 74245, 74246, 74247, 74249, 74250, 74251, 74260, 74270, 74280, 74283, 74290, 74291, 74300, 74305, 74320, 74327, 74328, 74329, 74330, 74340, 74355, 74360, 74363, 74400, 74410, 74415, 74420, 74425, 74430, 74440, 74445, 74450, 74455, 74470, 74475, 74480, 74485, 74740, 74742, 75600, 75605, 75625, 75630, 75650, 75658, 75660, 75662, 75665, 75671, 75676, 75680, 75685, 75705, 75710, 75716, 75722, 75724, 75726, 75731, 75733, 75736, 75741, 75743, 75746, 75756, 75790, 75801, 75803, 75805, 75807, 75809, 75810, 75820, 75822, 75825, 75827, 75831, 75833, 75840, 75842, 75860, 75870, 75872, 75880, 75885, 75887, 75889, 75891, 75893, 75894, 75896, 75898, 75900, 75901, 75902, 75940, 75952, 75953, 75954, 75956, 75957, 75958, 75959, 75960, 75961, 75962, 75966, 75970, 75978, 75980, 75982, 75984, 75992, 75994, 75995, 76000, 76001, 76080, 76100, 76101, 76102, 76120, 76150, 76496, 77001, 77002, 77003, 77031, 77053, 77054, 77071, 92611, 93555, 93556, G0106, G0120, G0259, G0260, G0275, G0278, G0365

RATIONALE:

Data suggests that the lifetime risk for cancer can be increased, albeit by a small amount, with frequent or repeated exposure to ionizing radiation, including procedures using fluoroscopy. (NCI, 2002) The BEIR report concluded that "the linear no-threshold model (LNT) provided the most reasonable description of the relation between low-dose exposure to ionizing radiation and the incidence of solid cancers that are induced by ionizing radiation." (NRC, 2006) In order to monitor these long-term effects, the exposure time or radiation dose that a patient receives as a result of the procedure should be measured and recorded in the patient's record.

CLINICAL RECOMMENDATION STATEMENTS:

Radiation dose related information provided by automated dosimetry systems should be recorded in the patient's permanent record for procedures involving more than 10 minutes of fluoroscopic exposure. If automated dosimetry data is not available, fluoroscopic exposure times should be recorded in the patient's medical record for such procedures. (ACR, 2003)

[ACR] should now encourage practices to record actual fluoroscopy time for all fluoroscopic procedures. The fluoroscopy time for various procedures (e.g., upper gastrointestinal, pediatric voiding cystourethrography, diagnostic angiography) should then be compared with benchmark figures...More complete patient radiation dose data should be recorded for all high-dose interventional procedures, such as embolizations, transjugular intrahepatic portosystemic shunts, and arterial angioplasty or stent placement anywhere in the abdomen and pelvis. (Amis et al., ACR, 2007)

Measure & record patient radiation dose:

- Record fluoroscopy time
- Record available measures DAP (dose area product), cumulative dose, skin dose (NCI, 2005)

☐ Measure #146: Radiology: Inappropriate Use of "Probably Benign" Assessment Category in Mammography Screening

2009 PQRI REPORTING OPTIONS: CLAIMS-BASED, REGISTRY

DESCRIPTION:

Percentage of final reports for screening mammograms that are classified as "probably benign"

INSTRUCTIONS:

This measure is to be reported <u>each time</u> a screening mammogram is performed during the reporting period. It is anticipated that <u>clinicians who provide the physician component of diagnostic imaging studies</u> for screening mammograms will submit this measure.

Measure Reporting via Claims:

Line-item ICD-9-CM codes, CPT codes, and G-codes, are used to identify patients who are included in the measure's denominator. CPT Category II codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed ICD-9-CM diagnosis codes, CPT codes, G-codes, and the appropriate CPT Category II codes. All measure-specific coding should be reported ON THE SAME CLAIM.

NUMERATOR:

Final reports classified as "probably benign"

Numerator Instructions: For performance, a lower percentage, with a definitional target approaching 0%, indicates appropriate assessment of screening mammograms (eg, the proportion of screening mammograms that are classified as "probably benign").

The mammogram assessment category (and corresponding CPT Category II **[33xxF]** code) to be reported is the single overall final assessment for the mammographic study. Separate breast assessment categories should not be reported for this measure.

Definition:

"Probably Benign" Classification – MQSA assessment category of "probably benign"; BI-RADS® category 3; or FDA-approved equivalent assessment category

<u>Numerator Quality-Data Coding Options for Reporting Satisfactorily:</u> Mammogram Assessment Category of "Probably Benign" Documented CPT II 3343F: Mammogram assessment category of "probably benign", documented

CPT II 3340F: Mammogram assessment category of "incomplete: need additional imaging evaluation," documented

<u>OR</u>

CPT II 3341F: Mammogram assessment category of "negative", documented **OR**

CPT II 3342F: Mammogram assessment category of "benign", documented OR

CPT II 3344F: Mammogram assessment category of "suspicious", documented **OR**

CPT II 3345F: Mammogram assessment category "highly suggestive of malignancy", documented

CPT II 3350F: Mammogram assessment category of "known biopsy proven malignancy", documented

DENOMINATOR

All final reports for screening mammograms

Denominator Criteria (Eligible Cases): Diagnosis for screening mammogram (line-item ICD-9-CM): V76.11, V76.12 AND Patient encounter during the reporting period (CPT or HCPCS): 77057, G0202

RATIONALE:

Although a mammogram assessment category of "probably benign" is not recommended for use in interpreting screening mammograms, it is associated with up to 11% of screening mammograms and accounts for over 40%–50% of abnormal screening mammograms. (Yasmeen et al., 2003A) Mammogram assessment category of "probably benign" is coupled with a recommendation for short-interval follow-up (typically 6 months), resulting in economic and emotional consequences for the women that receive them.

CLINICAL RECOMMENDATION STATEMENTS:

Do not use Category 3 in interpreting screening examinations. (ACR, 2003)

All the published studies emphasize the need to conduct a complete diagnostic imaging evaluation before making a probably benign (Category 3) assessment; hence it is inadvisable to render such an assessment when interpreting a screening examination. (ACR, 2003)

The use of Category 3, probably benign, is reserved for findings that are almost certainly benign. It must be emphasized that this is NOT an indeterminate category for malignancy, but one that, for mammography, has a less than 2% chance of malignancy (i.e. is almost certainly benign). (ACR, 2003)

Such findings are generally identified on baseline screening or on screening for which previous examinations are unavailable for comparison. Immediate evaluation with additional mammographic views and/or ultrasound is required to render a Category 3, probably benign assessment. (ACR, 2003)

A Measure #147: Nuclear Medicine: Correlation with Existing Imaging Studies for All Patients Undergoing Bone Scintigraphy

2009 PQRI REPORTING OPTIONS: CLAIMS-BASED, REGISTRY

DESCRIPTION:

Percentage of final reports for all patients, regardless of age, undergoing bone scintigraphy that include physician documentation of correlation with existing relevant imaging studies (eg, x-ray, MRI, CT, etc.) that were performed

INSTRUCTIONS:

This measure is to be reported <u>each time</u> bone scintigraphy is performed during the reporting period. There is no diagnosis associated with this measure. It is anticipated <u>clinicians performing</u> <u>the bone scintigraphy study</u> will report on this measure.

Measure Reporting via Claims:

CPT codes are used to identify patients who are included in the measure's denominator. CPT Category II codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed CPT codes, and the appropriate CPT Category II code <u>**OR**</u> the CPT Category II code <u>**with**</u> the modifier. The modifiers allowed for this measure are: 3P- system reason, 8P- reason not otherwise specified. All measure-specific coding should be reported ON THE SAME CLAIM.

NUMERATOR:

Final reports that include physician documentation of correlation with existing relevant imaging studies (eg, x-ray, MRI, CT, etc.)

Definition:

Relevant Imaging Studies – Studies that correspond to the same anatomical region in question.

<u>Numerator Quality-Data Coding Options for Reporting Satisfactorily:</u> Bone Scintigraphy Report Correlated with Existing Studies

CPT II 3570F: Final report for bone scintigraphy study includes correlation with existing relevant imaging studies (eg, x-ray, MRI, CT) corresponding to the same anatomical region in question

Bone Scintigraphy Report not correlated for System Reasons

Append a modifier (**3P**) to CPT Category II code **3570F** to report documented circumstances that appropriately exclude patients from the denominator.

3570F *with* **3P:** Documentation of system reason(s) for not documenting correlation with existing relevant imaging studies in final report (eg, no existing relevant imaging study available, patient did not have a previous relevant imaging study)

Note: Correlative studies are considered to be unavailable if relevant studies (reports and/or actual examination material) from other imaging modalities exist but could not be obtained after reasonable efforts to retrieve the studies are made by the interpreting physician prior to the finalization of the bone scintigraphy report.

<u>OR</u>

Bone Scintigraphy Report not Correlated, Reason not Specified

Append a reporting modifier (8P) to CPT Category II code 3570F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

3570F with 8P: Bone scintigraphy report not correlated, reason not otherwise specified

DENOMINATOR:

All final reports for patients, regardless of age, undergoing bone scintigraphy

Denominator Criteria (Eligible Cases):

Patient encounter during the reporting period (CPT): 78300, 78305, 78306, 78315, 78320

RATIONALE:

Radionuclide bone imaging plays an integral part in tumor staging and management; the majority of bone scans are performed in patients with a diagnosis of malignancy, especially carcinoma of the breast, prostate gland, and lung. This modality is extremely sensitive for detecting skeletal abnormalities, and numerous studies have confirmed that it is considerably more sensitive than conventional radiography for this purpose. However, the specificity of bone scan abnormalities can be low since many other conditions may mimic tumor; therefore, it is important that radionuclide bone scans are correlated with available, relevant imaging studies. Existing imaging studies that are available can help inform the diagnosis and treatment for the patient. Furthermore, correlation with existing radiographs is considered essential to insure that benign conditions are not interpreted as tumor. While there are no formal studies on variations in care in how often correlation with existing studies is not performed, there is significant anecdotal information from physicians practicing in the field that there is a gap in care and that correlation is not occurring frequently when images are available.

Literature suggests that as many as 30% of Radiology reports contain errors, regardless of the imaging modality, Radiologists experience, or time spent in interpretation. Evidence has also suggested that Radiology reports are largely non-standardized and commonly incomplete, vague, untimely, and error-prone and may not serve the needs of referring physicians. Therefore, it is imperative that existing imaging reports be correlated with the Nuclear Medicine bone scintigraphy procedure to ensure proper diagnosis and appropriate patient treatment.

CLINICAL RECOMMENDATION STATEMENTS:

Bone scintigraphic abnormalities should be correlated with appropriate physical examination and imaging studies to ascertain that osseous or soft-tissue abnormalities, which might cause cord or other nerve compression or pathologic fracture in an extremity, are not present. (SNM, 2003)

Relevant radiographs and/or MR imaging of painful sites to exclude cord compression or severe lytic lesions which carry an increased risk of pathologic fracture should be examined by the physician. (SNM, 2003)

Measure #148: Back Pain: Initial Visit

2009 PQRI REPORTING OPTIONS: MEASURES GROUP ONLY - BACK PAIN

DESCRIPTION:

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

INSTRUCTIONS:

REFER TO THE 2009 PQRI MEASURES GROUPS SPECIFICATIONS MANUAL FOR REPORTING OF THIS MEASURE.

NUMERATOR:

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

Definitions:

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

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

OR

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

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

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

- SF-36
- Oswestry Low Back Pain Disability Questionnaire
- Roland-Morris Disability Questionnaire
- Quebec Pain Disability Scale

- Sickness Impact Profile
- Multidimensional Pain Inventory

OR

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

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

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

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

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

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

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

- Sickness Impact Profile
- Multidimensional Pain Inventory

OR

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

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

Episode – Patient with back pain who has not been seen or treated for back pain by any practitioner during the 4 months prior to the first claim for back pain diagnosis. A new episode can either be a recurrence for a patient with prior back pain or a patient with a new onset of back pain.

Initial Visit – First visit to the clinician for an episode of back pain. This measure may be reported by more than one clinician if multiple clinicians evaluate or treat the patient for the back pain episode.

<u>Numerator Quality-Data Coding Options for Reporting Satisfactorily:</u> Back Pain and Function Assessed

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

OR

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

CPT II 0526F: Subsequent visit for episode

Back Pain and Function not Assessed, Reason not Specified

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

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

DENOMINATOR:

Patients aged 18 through 79 years with a diagnosis of back pain at the initial visit to the clinician for the episode

Denominator Criteria (Eligible Cases):

Patients aged 18 through 79 years on date of encounter AND

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

<u>AND</u>

Patient encounter during the reporting period (CPT) - Service codes: 98940, 98941, 98942, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245

OR

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

RATIONALE:

Pain Assessment: The initial assessment should occur with each new episode of pain and should focus on identifying the cause of the pain and developing a pain management plan. Subsequent assessments should evaluate the effectiveness of the plan and, if pain is unrelieved, determine whether the cause is related to the progression of disease, a new cause of pain, or the treatment.

Functional Status: Spinal disorders involve a complex interaction of physiologic, psychological and social factors that are difficult to evaluate through traditional biomedical techniques. As a consequence of this complexity, both clinicians and researchers have acknowledged the evaluation of functional status as essential in the treatment of chronic disabling musculoskeletal conditions because pain and disability are the most important endpoints for patients.

Patient History: Identifying the presence or absence of red flags is necessary to determine if there are signs of serious underlying conditions that require specific treatment.

Assessment of Prior Treatment and Response: Information about the patient's history of back pain and response to previous therapy are important in the care of back problems. A variety of treatments may be appropriate. Failure to respond to treatment may indicate the need to try other approaches.

Employment Status: Investigation of employment status and patient-perceived barriers (psychosocial, workplace, management issues) assists physicians in gaining an understanding of how to best alter a patient's back pain or disability trajectory and encourage return to work or full work status.

CLINICAL RECOMMENDATION STATEMENTS:

Guidelines are consistent in recommendations that diagnostic procedures should focus on the identification of red flags and exclusion of specific diseases.

- American Academy of Orthopedic Surgeons (2002)
- North American Spine Society (2000)
- International Guideline Comparison (2001)
- ICSI (2005)
- University of Michigan Health System (2003)

Measure #149: Back Pain: Physical Exam

2009 PQRI REPORTING OPTIONS: MEASURES GROUP ONLY - BACK PAIN

DESCRIPTION:

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

INSTRUCTIONS:

REFER TO THE 2009 PQRI MEASURES GROUPS SPECIFICATIONS MANUAL FOR REPORTING OF THIS MEASURE.

NUMERATOR:

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

Definitions:

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

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

For patients **<u>without</u>** radicular symptoms, documentation of physical exam must include the following:

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

Episode – Patient with back pain who has not been seen or treated for back pain by any practitioner during the 4 months prior to the first claim for back pain diagnosis. A new episode can either be a recurrence for a patient with prior back pain or a patient with a new onset of back pain.

Initial Visit – First visit to the clinician for an episode of back pain. This measure may be reported by more than one clinician if multiple clinicians evaluate or treat the patient for the back pain episode.

<u>Numerator Quality-Data Coding Options for Reporting Satisfactorily:</u> Physical Exam Performed

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

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

CPT II 0526F: Subsequent visit for episode

Physical Exam not Performed, Reason not Specified

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

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

DENOMINATOR:

Patients aged 18 through 79 years with a diagnosis of back pain at the initial visit to the clinician for the episode

Denominator Criteria (Eligible Cases):

Patients aged 18 through 79 years on date of encounter AND

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

<u>and</u>

Patient encounter during the reporting period (CPT) - Service codes: 98940, 98941, 98942, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245

OR

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

RATIONALE:

The physical exam is an integral component of identifying the source and mechanism of back pain and provides the physician with the information necessary to determine the next steps for diagnosis and treatment.

CLINICAL RECOMMENDATION STATEMENTS:

The types of physical examination and physical tests that are recommended show some variation. Neurologic screening, which is largely based on the straight leg raising test, plays an important role in most guidelines.

Physical exam components may differ by diagnosis or suspected diagnosis. For example, straightleg raise should be performed on patients with sciatica or pseudoclaudication, but may be negative in patients with spinal stenosis.

Measure #150: Back Pain: Advice for Normal Activities

2009 PQRI REPORTING OPTIONS: MEASURES GROUP ONLY - BACK PAIN

DESCRIPTION:

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

INSTRUCTIONS:

REFER TO THE 2009 PQRI MEASURES GROUPS SPECIFICATIONS MANUAL FOR REPORTING OF THIS MEASURE.

NUMERATOR:

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

Definitions:

Episode – Patient with back pain who has not been seen or treated for back pain by any practitioner during the 4 months prior to the first claim for back pain diagnosis. A new episode can either be a recurrence for a patient with prior back pain or a patient with a new onset of back pain.

Initial Visit – First visit to the clinician for an episode of back pain. This measure may be reported by more than one clinician if multiple clinicians evaluate or treat the patient for the back pain episode.

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Advice for Normal Activities Performed

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

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

CPT II 0526F: Subsequent visit for the episode

Advice for Normal Activities not Performed, Reason not Specified

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

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

DENOMINATOR:

Patients aged 18 through 79 years with a diagnosis of back pain at the initial visit to the clinician for the episode

Denominator Criteria (Eligible Cases):

Patients aged 18 through 79 years on date of encounter **AND**

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

<u>AND</u>

Patient encounter during the reporting period (CPT) – Service codes: 98940, 98941, 98942, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245

OR

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

RATIONALE:

In cases of low back pain, patients should be encouraged to maintain or resume their normal activities as early as possible in the course of the symptoms.

For most patients, the best recommendation is a rapid return to normal activities as tolerated and encouraged ambulation. This recommendation must be tempered by consideration of the patient's usual job or life demands. Heavy lifting, trunk twisting and bodily vibrations should be avoided in the acute phase.

CLINICAL RECOMMENDATION STATEMENTS:

Evidence Level: Moderate—important clinical benefit of functional activities on return to work (acute low back pain only).

Acute: Nine RCTs comparing bed rest with other treatments; either no difference was found or bed rest resulted in worse outcomes in pain, functional status, recovery and sick leave. Advice to continue ordinary activity can give equivalent or faster symptomatic recovery from the acute attack and lead to less chronic disability and less time off work.

Chronic: No RCTs for advice to stay active or bed rest.

Guideline Support:

- Clinical Evidence (review) (2004)
- Philadelphia Panel Evidence Based Guidelines (2001)
- Cochrane Review: Bed Rest (2004)
- ICSI
- University of Michigan Health System

Measure #151: Back Pain: Advice Against Bed Rest

2009 PQRI REPORTING OPTIONS: MEASURES GROUP ONLY - BACK PAIN

DESCRIPTION:

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

INSTRUCTIONS:

REFER TO THE 2009 PQRI MEASURES GROUPS SPECIFICATIONS MANUAL FOR REPORTING OF THIS MEASURE.

NUMERATOR:

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

Definitions:

Episode – A patient with back pain who has not been seen or treated for back pain by any practitioner during the 4 months prior to the first claim for back pain diagnosis. A new episode can either be a recurrence for a patient with prior back pain or a patient with a new onset of back pain.

Initial Visit – First visit to the clinician for an episode of back pain. If the patient's initial visit for this episode of back pain occurred prior to the beginning of the reporting period, report that this is a subsequent visit for the episode.

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Advice Against Bed Rest Performed

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

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

CPT II 0526F: Subsequent visit for episode

Advice Against Bed Rest not Performed, Reason not Specified

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

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

DENOMINATOR:

Patients aged 18 through 79 years with a diagnosis of back pain at the initial visit to the clinician for the episode

Denominator Criteria (Eligible Cases):

Patients aged 18 through 79 years on date of encounter **AND**

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

AND

Patient encounter during the reporting period (CPT) – Service codes: 98940, 98941, 98942, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245

OR

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

RATIONALE:

For most patients, the best recommendation is a rapid return to normal activities and avoidance of bed rest. This recommendation must be tempered by consideration of the patient's usual job or life demands. Heavy lifting, trunk twisting and bodily vibrations should be avoided in the acute phase.

CLINICAL RECOMMENDATION STATEMENTS:

Evidence Level: Moderate—important clinical benefit of functional activities on return to work (acute LBP only).

Acute: Nine RCTs comparing bed rest with other treatments; either no difference was found or bed rest resulted in worse outcomes in pain, functional status, recovery and sick leave. Advice to continue ordinary activity can give equivalent or faster symptomatic recovery from the acute attack and lead to less chronic disability and less time off work. Chronic: No RCTs for advice to stay active or bed rest.

Guideline Support:

- Clinical Evidence (review) (2004)
- Philadelphia Panel Evidence Based Guidelines (2001)
- Cochrane Review: Bed Rest (2004)
- ICSI
- University of Michigan Health System

A Measure #152: Coronary Artery Disease (CAD): Lipid Profile in Patients with CAD

2009 PQRI REPORTING OPTIONS: CLAIMS-BASED, REGISTRY

DESCRIPTION:

Percentage of patients aged 18 years and older with a diagnosis of CAD who received at least one lipid profile within 12 months

INSTRUCTIONS:

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

Measure Reporting via Claims:

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

When reporting the measure via claims, submit the listed ICD-9-CM diagnosis codes, CPT codes, and the appropriate CPT Category II codes <u>**OR**</u> the CPT Category II code(s) <u>with</u> the modifier. The reporting modifier allowed for this measure is: 8P- reason not otherwise specified. There are no allowable performance exclusions for this measure. All measure-specific coding should be reported ON THE SAME CLAIM.

NUMERATOR:

Patients who received at least one lipid profile (or ALL component tests)

Numerator Quality-Data Coding Options for Reporting Satisfactorily: Lipid Profile Performed

CPT II 3011F: Lipid panel results documented and reviewed (must include total cholesterol, HDL-C, triglycerides and calculated LDL-C)

Note: If LDL-C could not be calculated due to high triglycerides, count as complete lipid profile and report CPT II 3011F.

Lipid Profile not Performed, Reason not Specified

Append a reporting modifier (8P) to CPT Category II code 3011F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

3011F with 8P: Lipid profile not performed, reason not otherwise specified

DENOMINATOR:

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

Denominator Criteria (Eligible Cases):

Patients aged \geq 18 years on date of encounter **AND**

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

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

Total cholesterol has been linked to the development of adverse ischemic events in patients with established CAD. Most of this risk is due to LDL cholesterol. A lipid profile is recommended in all patients with CAD.

CLINICAL RECOMMENDATION STATEMENTS:

A fasting lipid profile is recommended and should include total cholesterol, high-density lipoprotein cholesterol (HDL-C), calculated low-density lipoprotein cholesterol (LDL-C), and triglycerides. (Class I Recommendation, Level of Evidence: C) (ACC/AHA)

A Measure #153: Chronic Kidney Disease (CKD): Referral for Arteriovenous (AV) Fistula

2009 PQRI REPORTING OPTIONS: CLAIMS-BASED, REGISTRY, MEASURES GROUP

DESCRIPTION:

Percentage of patients aged 18 years and older with the diagnosis of advanced CKD (stage 4 or 5, not receiving Renal Replacement Therapy [RRT]), who were referred for AV fistula at least once during the 12-month reporting period

INSTRUCTIONS:

This measure is to be reported a minimum of <u>once per reporting period</u> for patients with a diagnosis of advanced CKD seen during the reporting period. It is anticipated that clinicians providing care for patients with advanced CKD will submit this measure.

Measure Reporting via Claims:

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

When reporting the measure via claims, submit the listed ICD-9-CM diagnosis codes, CPT codes, and the appropriate CPT Category II code <u>**OR**</u> the CPT Category II code <u>**with**</u> the modifier. The modifiers allowed for this measure are: 1P- medical reasons, 2P- patient reasons, 8P- reason not otherwise specified. All measure-specific coding should be reported ON THE SAME CLAIM.

NUMERATOR:

Patients who were referred for AV fistula at least once during the 12 month reporting period

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

AV Fistula Referred

CPT II 4051F: Referred for an arteriovenous (AV) fistula

<u> 0R</u>

AV Fistula not Referred for Medical or Patient Reasons

Append a modifier (**1P or 2P**) to CPT Category II code **4051F** to report documented circumstances that appropriately exclude patients from the denominator. **4051F** with **1P**: Documentation of medical reason(s) for not referring for an AV fistula **4051F** with **2P**: Documentation of patient reason(s) for not referring for an AV fistula

OR

AV Fistula not Referred, Reason not Specified

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

4051F with 8P: AV fistula not referred, reason not otherwise specified

DENOMINATOR:

All patients aged 18 years and older with the diagnosis of advanced CKD (stage 4 or 5, not receiving RRT)

Denominator Criteria (Eligible Cases):

Patients aged \geq 18 years on date of encounter <u>AND</u> Diagnosis for stage 4 or 5 CKD (line-item ICD-9-CM): 585.4, 585.5 <u>AND</u> Patient encounter during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245

RATIONALE:

For patients who will require dialysis, an AV fistula is the preferred permanent vascular access. Patients who have an AV fistula as their permanent vascular access for dialysis have fewer complications, such as infection. However USRDS data shows that only 35% of male and 15% of female hemodialysis patients have an AV fistula compared to 50% of male and 60% of female hemodialysis patients that have a long-term catheter as their vascular access. By improving the rate of which AV fistulas are used, morbidity and mortality due to complications of other types of permanent vascular access will decrease.

CLINICAL RECOMMENDATION STATEMENTS:

1.3 Patients should have a functional permanent access at the initiation of dialysis therapy.

 1.3.1 A fistula should be placed at least 6 months before the anticipated start of HD treatments. This timing allows for access evaluation and additional time for revision to ensure a working fistula is available at initiation of dialysis therapy. (NKF 2006)

2.1 The order of preference for placement of fistulae in patients with kidney failure who choose HD as their initial mode of KRT should be (in descending order of preference):

- 2.1.1 Preferred: Fistulae (NKF 2006)
 - o 2.1.1.1 A wrist (radiocephalic) primary fistula (NKF 2006)
 - o 2.1.1.2 An elbow (brachiocephalic) primary fistula (NKF 2006)
 - o 2.1.1.3 A transposed brachial basilic vein fistula (NKF 2006)
- 2.1.2 Acceptable: AVG of synthetic or biological material, such as: (NKF 2006)
 - o 2.1.2.1 A forearm loop graft, preferable to a straight configuration
 - o 2.1.2.2 Upper-arm graft
 - 2.1.2.3 Chest wall or "necklace" prosthetic graft or lower-extremity fistula or graft; all upper-arm sites should be exhausted
- 2.1.3 Avoid if possible: Long-term catheters. (NKF 2006)
 - 2.1.3.1 Short-term catheters should be used for acute dialysis and for a limited duration in hospitalized patients. Noncuffed femoral catheters should be used in bed-bound patients only (NKF 2006)
 - 2.1.3.2 Long-term catheters or dialysis port catheter systems should be used in conjunction with a plan for permanent access. Catheters capable of rapid flow rates are preferred. Catheter choice should be based on local experience, goals for use, and cost (NKF 2006)
 - 2.1.3.3 Long-term catheters should not be placed on the same side as a maturing AV access, if possible (NKF 2006)

12/08/2008 Page 352 of 442

- 2.1.4 Patients should be considered for construction of a primary fistula after failure of every dialysis AV access (NKF 2006)
- 8.1.2 The goals for permanent HD access placement should include:
 - 8.1.2.1 Prevalent functional AVF placement rate of greater than 65% of patients. (NKF 2006)
 - 8.1.2.2 Cuffed catheter for permanent dialysis access (eg, not as a bridge) in less than 10% of patients. Long-term catheter access is defined as the use of dialysis catheter for more than three months in the absence of a maturing permanent access – graft of fistula. (NKF 2006)

^{*}Measure # 154: Falls: Risk Assessment

2009 PQRI REPORTING OPTIONS: CLAIMS-BASED, REGISTRY

This is a two-part measure which is paired with Measure #155: Falls: Plan of Care. If the falls risk assessment indicates the patient has documentation of two or more falls in the past year or any fall with injury in the past year (CPT II code 1100F is submitted), #155 *should* also be reported.

DESCRIPTION:

Percentage of patients aged 65 years and older with a history of falls who had a risk assessment for falls completed within 12 months

INSTRUCTIONS:

This measure is to be reported a minimum of <u>once per reporting period</u> for patients seen during the reporting period. There is no diagnosis associated with this measure. This measure is appropriate for use in all non-acute settings (excludes emergency departments and acute care hospitals). This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

Measure Reporting via Claims:

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

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

NUMERATOR:

Patients who had a risk assessment for falls completed within 12 months

Numerator Instructions: All components do not need to be completed during one patient visit, but should be documented in the medical record as having been performed within the past 12 months.

Definitions:

Fall – A sudden, unintentional change in position causing an individual to land at a lower level, on an object, the floor, or the ground, other than as a consequence of sudden onset of paralysis, epileptic seizure, or overwhelming external force.

Risk Assessment – Comprised of balance/gait AND one or more of the following: postural blood pressure, vision, home fall hazards, and documentation on whether medications are a contributing factor or not to falls within the past 12 months.

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

<u>Numerator Quality-Data Coding Options for Reporting Satisfactorily:</u> Risk Assessment for Falls Completed

(Two CPT II codes [3288F & 1100F] are required on the claim form to submit this numerator option)

CPT II 3288F: Falls risk assessment documented

<u>AND</u>

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

Risk Assessment for Falls not Completed for Medical Reasons

(Two CPT II codes [3288F-1P & 1100F] are required on the claim form to submit this numerator option)

Append a modifier (**1P**) to CPT Category II code **3288F** to report documented circumstances that appropriately exclude patients from the denominator.

3288F *with* **1P:** Documentation of medical reason(s) for not completing a risk assessment for falls

<u>and</u>

CPT II 1100F: Patient screened for future fall risk; documentation of two or more falls in the past year or any fall with injury in the past year

OR

If patient is not eligible for this measure because patient has documentation of no falls or only one fall without injury the past year, report:

Patient not at Risk for Falls

(One CPT II code [1101F] is required on the claim form to submit this numerator option) CPT II 1101F: Patient screened for future fall risk; documentation of no falls in the past year or only one fall without injury in the past year

OR

If patient is not eligible for this measure because falls status is not documented, report:

Falls Status not Documented

(One CPT II code [1101F-8P] is required on the claim form to submit this numerator option)

Append a reporting modifier (8P) to CPT Category II code 1101F to report circumstances when the patient is not eligible for the measure.

1101F with 8P: No documentation of falls status

Risk Assessment for Falls not Completed, Reason not Specified

(Two CPT II codes [3288F-8P & 1100F] are required on the claim form to submit this numerator option)

Append a reporting modifier (8P) to CPT Category II code 3288F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

3288F *with* **8P:** Falls risk assessment <u>not</u> completed, reason not otherwise specified <u>AND</u>

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

DENOMINATOR:

All patients aged 65 years and older who have a history of falls

Denominator Criteria (Eligible Cases):

Patients aged \geq 65 years on date of encounter **AND**

Patient encounter during the reporting period (CPT): 97001, 97002, 97003, 97004, 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:

Screening for specific medical conditions may direct the therapy. Although the clinical guidelines and supporting evidence calls for an evaluation of many factors, it was felt that for the purposes of measuring performance and facilitating implementation this initial measure must be limited in scope. For this reason, the work group defined an evaluation of balance and gait as a core component that must be completed on all patients with a history of falls as well as four additional evaluations – at least one of which must be completed within the 12 month period. Data elements required for the measure can be captured and the measure is actionable by the physician.

CLINICAL RECOMMENDATION STATEMENTS:

Older people who present for medical attention because of a fall, or report recurrent falls in the past year, or demonstrate abnormalities of gait and/or balance should be offered a multifactorial falls risk assessment. This assessment should be performed by a health care professional with appropriate skills and experience, normally in the setting of a specialist falls service. This assessment should be part of an individualized, multifactorial intervention. (NICE) (Grade C) Multifactorial assessment may include the following:

- identification of falls history
- assessment of gait, balance and mobility, and muscle weakness
- assessment of osteoporosis risk
- assessment of the older person's perceived functional ability and fear relating to falling
- assessment of visual impairment
- assessment of cognitive impairment and neurological examination
- assessment of urinary incontinence

- assessment of home hazards
- cardiovascular examination and medication review (NICE) (Grade C)

A falls risk assessment should be performed for older persons who present for medical attention because of a fall, report recurrent falls in the past year, report difficulties in walking or balance or fear of falling, or demonstrate unsteadiness or difficulty performing a gait and balance test.

The falls risk evaluation should be performed by a clinician with appropriate skills and experience. [C]

A falls risk assessment is a clinical evaluation that should include the following, but are not limited to:

- a history of fall circumstances
- review of all medications and doses
- evaluation of gait and balance, mobility levels and lower extremity joint function
- examination of vision
- examination of neurological function, muscle strength, proprioception, reflexes, and tests of cortical, extrapyramidal, and cerebellar function
- cognitive evaluation
- screening for depression
- assessment of postural blood pressure
- assessment of heart rate and rhythm
- assessment of heart rate and rhythm, and blood pressure responses to carotid sinus stimulation if appropriate
- assessment of home environment

The falls risks assessment should be followed by direct intervention on the identified risk. [A] (AGS)

^{*}Measure #155: Falls: Plan of Care

2009 PQRI REPORTING OPTIONS: CLAIMS-BASED, REGISTRY

This is a two-part measure which is paired with Measure #154: Falls: Risk Assessment. This measure *should* be reported if CPT II code 1100F "Patient screened for future falls risk; documentation of two or more falls in the past year or any fall with injury in the past year" is submitted for Measure #154.

DESCRIPTION:

Percentage of patients aged 65 years and older with a history of falls who had a plan of care for falls documented within 12 months

INSTRUCTIONS:

This measure is to be reported a minimum of <u>once per reporting period</u> for patients seen during the reporting period. There is no diagnosis associated with this measure. This measure is appropriate for use in all non-acute settings (excludes emergency departments and acute care hospitals). This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

Measure Reporting via Claims:

All eligible instances when CPT II code 1100F (Patient screened for future falls risk; documentation of two or more falls in the past year or any fall with injury in the past year) is reported in the numerator for Measure #154 make up the denominator for this measure. CPT Category II codes are used to report the numerator of the measure.

When CPT II code 1100F is reported with Measure #154, add the appropriate CPT Category II codes <u>**OR**</u> the CPT Category II code(s) <u>with</u> the modifier. The modifiers allowed for this measure are: 1P- medical reasons, 8P- reason not otherwise specified. All measure-specific coding should be reported ON THE SAME CLAIM.

NUMERATOR:

Patients with a plan of care for falls documented within 12 months

Numerator Instructions: All components do not need to be completed during one patient visit, but should be documented in the medical record as having been performed within the past 12 months.

Definitions:

Plan of Care – Must include: 1) consideration of appropriate assistance device AND 2) balance, strength, and gait training.

Consideration of Appropriate Assistance Device – Medical record must include: documentation that an assistive device was provided or considered OR referral for evaluation for an appropriate assistance device

Balance, Strength, and Gait Training – Medical record must include: documentation that balance, strength, and gait training/instructions were provided OR referral to an exercise program, which includes at least one of the three components: balance, strength or gait **Fall** – A sudden, unintentional change in position causing an individual to land at a lower level, on an object, the floor, or the ground, other than as a consequence of sudden onset of paralysis, epileptic seizure, or overwhelming external force

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Plan of Care Documented

CPT II 0518F: Falls plan of care documented

<u> 0R</u>

Plan of Care not Documented for Medical Reasons

Append a modifier (**1P**) to CPT Category II code **0518F** to report documented circumstances that appropriately exclude patients from the denominator. **0518F** *with* **1P**: Documentation of medical reason(s) for no plan of care for falls

<u> 0R</u>

Plan of Care not Documented, Reason not Specified

Append a reporting modifier (8P) to CPT Category II code 0518F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

0518F with 8P: Plan of care not documented, reason not otherwise specified

DENOMINATOR:

All patients aged 65 years and older with a history of falls (history of falls is defined as 2 or more falls in the past year or any fall with injury in the past year)

Denominator Criteria (Eligible Cases):

All eligible instances when **CPT II code 1100F** (Patient screened for future fall risk; documentation of two or more falls in the past year or any fall with injury in the past year) is reported in the numerator for Measure #154.

RATIONALE:

Interventions to prevent future falls should be documented for the patient with 2 or more falls or injurious falls.

CLINICAL RECOMMENDATION STATEMENTS:

Among community-dwelling older persons (i.e., those living in their own homes), multifactorial interventions should include:

- gait training and advice on the appropriate use of assistive devices (Grade B)
- review and modification of medication, especially psychotropic medication (Grade B)
- exercise programs, with balance training as one of the components (Grade B)
- treatment of postural hypotension (Grade B)
- modification of environmental hazards (Grade C)
- treatment for cardiovascular disorders (Grade D) (AGS/BGS/AAOS)

Measure #156: Oncology: Radiation Dose Limits to Normal Tissues

2009 PQRI REPORTING OPTIONS: CLAIMS-BASED, REGISTRY

DESCRIPTION:

Percentage of patients, regardless of age, with a diagnosis of pancreatic or lung cancer receiving 3D conformal radiation therapy with documentation in medical record that radiation dose limits to normal tissues were established prior to the initiation of a course of 3D conformal radiation for a minimum of two tissues

INSTRUCTIONS:

This measure is to be reported a minimum of <u>once per reporting period</u> for patients with a diagnosis of cancer receiving 3D conformal radiation therapy seen during the reporting period. It is anticipated that <u>clinicians providing radiation therapy for patients with cancer</u> will submit this measure.

Measure Reporting via Claims:

Line-item ICD-9-CM diagnosis codes and CPT codes are used to identify patients who are included in the measure's denominator. CPT Category II code(s) are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed ICD-9-CM diagnosis codes, CPT codes, and the appropriate CPT Category II code <u>**OR**</u> the CPT Category II code <u>**with**</u> the modifier. The reporting modifier allowed for this measure is: 8P- reason not otherwise specified. There are no allowable performance exclusions for this measure. All measure-specific coding should be reported ON THE SAME CLAIM.

NUMERATOR:

Patients who had documentation in medical record that radiation dose limits to normal tissues were established prior to the initiation of a course of 3D conformal radiation for a minimum of two tissues

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Radiation Dose Limits to Normal Tissues Established

CPT II 0520F: Radiation dose limits to normal tissues established prior to the initiation of a course of 3D conformal radiation for a minimum of two tissues/organs

<u> 0R</u>

Radiation Dose Limits to Normal Tissues not Established, Reason not Specified

Append a reporting modifier (8P) to CPT Category II code 0520F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

0520F *with* **8P:** Radiation dose limits to normal tissues <u>not</u> established prior to the initiation of a course of 3D conformal radiation for a minimum of two tissues/organs, reason not otherwise specified
DENOMINATOR:

All patients, regardless of age, with a diagnosis of pancreatic or lung cancer who receive 3D conformal radiation therapy

Denominator Criteria (Eligible Cases): Diagnosis for pancreatic or lung cancer (line-item ICD-9-CM): 157.0, 157.1, 157.2, 157.3, 157.4, 157.8, 157.9, 162.0, 162.2, 162.3, 162.4, 162.5, 162.8, 162.9 AND Patient encounter during the reporting period (CPT): 77295

RATIONALE:

Identifying radiation dose limits to normal tissues is an important step in the process of care for patients receiving radiation therapy treatments. Although no specific data is available, in its practice accreditation reviews, the American College of Radiation Oncology has found that radiation dose limits to normal tissues are included in the patient chart less frequently than reviewers expected. While dose constraint specification is an integral part of IMRT, it is not required for 3D conformal radiation therapy. Patients treated with 3D conformal radiation therapy are often subjected to dose levels that exceed normal tissue tolerance, and precise specification of maximum doses to be received by normal tissues represent both an intellectual process for the physician during radiation treatment planning, and a fail-safe point for the treating therapists. In most circumstances where facilities require specification of radiation dose limits to normal tissues prior to initiation of therapy, policies and procedures exist that prohibit exceeding those limits in the absence of written physician approval.

CLINICAL RECOMMENDATION STATEMENTS:

"The cognitive process of treatment planning requires the radiation oncologist to have knowledge of the natural history of the tumor to be treated and to determine the tumor site, its extent, and its relationship with adjacent normal tissues. This process is based on consideration of the history, physician examination, endoscopy, diagnostic imaging, findings at surgery, and histology. When ionizing radiation is to be used, the radiation oncologist must select beam characteristics and/or radionuclide sources, method of delivery, doses, and sequencing with other treatments. The sequencing with other treatments should be coordinated in collaboration with medical and surgical oncologists. The radiation oncologist determines the dose to be delivered to the tumor, limiting doses to critical structures (emphasis added), and the fractionation desired." (ACR 2004) Ω Measure #157: Thoracic Surgery: Recording of Clinical Stage for Lung Cancer and Esophageal Cancer Resection

2009 PQRI REPORTING OPTIONS: CLAIMS-BASED, REGISTRY

DESCRIPTION:

Percentage of surgical patients aged 18 years and older undergoing resection for lung or esophageal cancer who had clinical TNM staging provided prior to surgery

INSTRUCTIONS:

This measure is to be reported <u>each time</u> a major cancer resection of the lung or esophagus is performed. This measure is intended to reflect the quality of services provided for patients undergoing resection for lung or esophageal cancer. The clinical staging of lung and esophageal cancer patients guides the decision-making process when choosing optimal treatment modality which may or may not include surgery. It is anticipated that <u>clinicians who perform the listed</u> <u>surgical procedures with a diagnosis of lung or esophageal cancer</u> will submit this measure.

Measure Reporting via Claims:

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

When reporting the measure via claims, submit the listed CPT codes, and the appropriate numerator G-code. All measure-specific coding should be reported ON THE SAME CLAIM.

NUMERATOR:

Patients undergoing resection for lung and esophageal cancer who had clinical TNM staging provided prior to surgery.

<u>Numerator Quality-Data Coding Options for Reporting Satisfactorily:</u> Clinical TNM Staging Provided

G8518: Clinical stage prior to surgery for lung cancer and esophageal cancer resection was recorded

<u> 0R</u>

Clinical TNM Staging not Provided for Documented Reasons

G8519: Clinician documented that patient was not eligible for clinical stage prior to surgery for lung cancer and esophageal cancer resection measure (**Note:** includes urgent and emergent surgeries)

Clinical TNM Staging not Provided, Reason not Specified

G8520: Clinician stage prior to surgery for lung cancer and esophageal cancer resection was not recorded, reason not specified

DENOMINATOR:

All patients aged 18 years and older undergoing resection for lung or esophageal cancer

Denominator Criteria (Eligible Cases):

Patients aged \geq 18 years on date of encounter

AND

Diagnosis for lung or esophageal cancer (line-item ICD-9-CM): 150.3, 150.4, 150.5, 162.2, 162.3, 162.4, 162.5

<u>and</u>

Patient encounter during the reporting period (CPT): 32440, 32442, 32445, 32480, 32482, 32484, 32486, 32488, 32500, 32503, 32504, 32657, 32663, 43107, 43108, 43112, 43113, 43117, 43118, 43121, 43122, 43123

RATIONALE:

Evaluation of patients with suspected lung cancer and esophageal cancer includes both diagnosis of the primary tumor and evaluation of the extent of disease. The current system for staging lung and esophageal cancer is based on the AJCC TNM classification. The clinical staging of lung and esophageal cancer patients guides the decision-making process when choosing optimal treatment modality which may or may not include surgery. Review of the 5000 lobectomies recorded in the current STS General Thoracic Database identified a significant gap with respect to recording of clinical stage; it was reported in only 80% of patients undergoing resection for lung cancer. Remediation of this process gap should improve quality by reducing inappropriate selection of treatment modalities including surgery.

CLINICAL RECOMMENDATION STATEMENTS:

BTS Guidelines on the selection of patients with lung cancer for surgery, Thorax 2001;56,89-108(February), and National Cancer Institute Web site: Non-Small Cell Lung Cancer PDQ®: Treatment. Available for download at the following address as of 11/3/08 -<u>http://www.cancer.gov/cancertopics/pdq/treatment/non-small-cell-lung/HealthProfessional</u>, page3, and Surgical treatment of esophageal cancer. Manchester (MA): Society for Surgery of the Alimentary Tract (SSAT); 2002. 3 p. ASSESSMENT OF OPERABILITY (Clinical Staging Importance in Lung Cancer)

"Assuming satisfactory performance status, operability in patients with lung cancer depends on the clinical assessment of tumor stage. Preoperative clinical staging (cTNM), as accurately as possible given the limitations of the investigations available, is therefore crucial. Recommendations

1. All patients being considered for surgery should have a plain chest radiograph and a computed tomographic (CT) scan of the thorax including the liver and adrenal glands. [B] 2. Confirmatory diagnostic percutaneous needle biopsy in patients presenting with peripheral lesions is not mandatory in patients who are otherwise fit, particularly if there are previous chest radiographs showing no evidence of a lesion. [B]

3. Patients with mediastinal nodes greater than 1 cm in short axis diameter on the CT scan should undergo biopsy by staging mediastinoscopy, anterior mediastinotomy, or needle biopsy as appropriate. [B]

On the basis of these investigations, cTNM staging should be possible and appropriate surgery undertaken in the light of current knowledge of results.

* Measure #158: Endarterectomy: Use of Patch During Conventional Endarterectomy

2009 PQRI REPORTING OPTIONS: CLAIMS-BASED, REGISTRY

DESCRIPTION:

Percentage of patients aged 18 years and older undergoing conventional (non-eversion) endarterectomy who undergo patch closure of the arteriotomy

INSTRUCTIONS:

This measure is to be reported <u>each time</u> a patient undergoes an endarterectomy procedure during the reporting period. It is anticipated that <u>clinicians who perform the listed surgical procedure</u> as specified in the denominator coding will submit this measure.

Measure Reporting via Claims:

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

When reporting the measure via claims, submit the listed CPT codes, and the appropriate numerator G-code. All measure-specific coding should be reported ON THE SAME CLAIM.

NUMERATOR:

Patients undergoing an elective, conventional CEA who undergo patch closure of the arteriotomy site

Definitions:

Non-Eversion, Conventional CEA – Involves a longitudinal arteriotomy incision with plaque extraction requiring closure of the arteriotomy with or without a patch (vein or synthetic).

Eversion Carotid Endarterectomy – Involves the complete transection of the internal carotid artery at its origin and the removal of the atheroma circumferentially is performed followed by re-implantation of the vessel.

<u>Numerator Quality-Data Coding Options for Reporting Satisfactorily:</u> Conventional CEA with Patch

G8524: Patch closure used for patient undergoing conventional CEA

If patient is not eligible for this measure because a conventional CEA was not performed, report:

G8525: Clinician documented that endarterectomy patient did not receive conventional CEA

<u>OR</u>

Conventional CEA Performed without Patch

G8526: Patch closure not used for patient undergoing conventional CEA, reason not specified

DENOMINATOR:

Patients aged 18 years and older undergoing CEA requiring patch arteriotomy (vein or synthetic)

Denominator Criteria (Eligible Cases):

Patients aged ≥ 18 years on date of encounter <u>AND</u> Patient encounter during the reporting period (CPT): 35301

RATIONALE:

Carotid endarterectomy (CEA) can be performed in the conventional manner, in which a longitudinal arteriotomy is used to expose the plaque for subsequent endarterectomy, or with the eversion technique, in which the artery is transected and everted for plaque removal. With conventional endarterectomy, multiple randomized trials have demonstrated the benefit of patching to reduce postoperative stroke and prevent recurrent stenosis. With conventional endarterectomy, multiple randomized trials have demonstrated the benefit of patching to reduce postoperative stroke and prevent recurrent stenosis. With conventional endarterectomy, multiple randomized trials have demonstrated the benefit of patching to reduce postoperative stroke and prevent recurrent stenosis (Ref 1-10). In a systematic review of this question, Bond et al concluded that patch angioplasty was associated with a reduction of stroke risk (P=.004), ipsilateral stroke (P=.001), stroke or death postoperatively (P=.007) and both perioperative occlusion (P=.0001) and recurrent stenosis during long-term follow-up (P<.0001) (Ref 11). This report concluded that patching should be performed during conventional CEA. There does not appear to be any difference or advantage among various types of patches (autogenous vein, polyester, polytetrafluoroethylene, or bovine pericardium).

Because eversion CEA involves a transverse closure, it does not require patching. In fact a Cochrane review based on multiple randomized studies have shown that eversion CEA is comparable in outcome to conventional CEA with patching in terms of stroke, death, and recurrent stenosis.

CLINICAL RECOMMENDATION STATEMENTS:

There are no current practice guidelines concerning use of patch during conventional CEA, but such guidelines are currently being prepared by the Society for Vascular Surgery. The VSGNNE uses carotid patching during conventional CEA as a quality indicator in its reports to regional centers. A 2007 analysis of nearly 3000 conventional CEAs performed in VSGNNE showed that the use of patching varied from 60% to 100% (mean 90%) among 11 hospitals. This demonstrates potential for improvement even for a group of surgeons where this result is known.

Measure #159: HIV/AIDS: CD4+ Cell Count or CD4+ Percentage

2009 PQRI REPORTING OPTIONS: REGISTRY ONLY

DESCRIPTION:

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

INSTRUCTIONS:

This measure is to be <u>reported twice</u> during the reporting period for patients with HIV/AIDS seen during the reporting period, <u>once during the first half of the year and once in the second half of the year</u>. The measure should be reported twice if there are visits during both halves of the reporting period. Only patients who had at least two visits during the reporting period, with at least 60 days between each visit will be counted in the denominator for this measure. This measure is intended to reflect the quality of services provided for the primary management of patients with HIV/AIDS.

Measure Reporting via Registry Only:

ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure. Do not report this measure via claims.

NUMERATOR:

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

Numerator Options:

CD4+ cell count or CD4+ cell percentage documented as performed

<u> 0R</u>

CD4+ cell count or percentage not documented as performed, reason not specified

DENOMINATOR:

Patients aged 6 months and older with a diagnosis of HIV/AIDS who had at least two medical visits during the measurement year, with at least 60 days between each visit

Denominator Criteria (Eligible Cases):

Patients aged ≥ 6 months on date of encounter <u>AND</u> Diagnosis for HIV/AIDS (line-item ICD-9-CM): 042, 079.53, V08 <u>AND</u> Patient encounters during the reporting period (CPT): 99201, 99202, 99203, 99204,

99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245

RATIONALE:

CD4+ cell counts help to establish monitoring frequency, and are taken into account when establishing a patient's disease stage.

CLINICAL RECOMMENDATION STATEMENTS:

Asymptomatic patients with normal CD4 cell counts and low virus loads can be monitored infrequently, repeating virus load measurements every 3-4 months and CD4 cell counts every 3-6 months. (Level of Evidence: B) (IDSA)

CD4 percentage or count should be measured at the time of diagnosis of HIV infection and at least every 3-4 months thereafter. (DHHS)

Clinicians should measure CD4 cell counts at the time of diagnosis of HIV infection and every 3 to 4 months thereafter. (NYSDOH)

Version 3.0

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

2009 PQRI REPORTING OPTIONS: REGISTRY ONLY

DESCRIPTION:

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

INSTRUCTIONS:

This measure is to be reported a minimum of <u>once per reporting period</u> for patients with HIV/AIDS seen during the reporting period. Only patients who had at least two visits during the reporting period, with at least 60 days between each visit will be counted in the denominator for this measure. This measure is intended to reflect the quality of services provided for the primary management of patients with HIV/AIDS.

Measure Reporting via Registry Only:

ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure. Do not report this measure via claims.

NUMERATOR:

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

Definition:

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

Numerator Options:

Pneumocystis jiroveci pneumonia prophylaxis prescribed within 3 months of low CD4+ cell count or percentage

AND

CD4+ cell count < 200 cells/mm³

<u> 0R</u>

Pneumocystis jiroveci pneumonia prophylaxis <u>not</u> prescribed within 3 months of low CD4+ cell count or percentage for medical reason

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

<u>AND</u>

CD4+ cell count < 200 cells/mm³

CD4+ cell count 200 – 499 cells/mm³ <u>OR</u> CD4+ cell count \geq 500 cells/mm³

<u> 0R</u>

CD4+ cell count not performed, reason not specified

OR

PCP prophylaxis was <u>not</u> prescribed within 3 months of low CD4+ cell count, reason not specified

AND

CD4+ cell count < 200 cells/mm³

DENOMINATOR:

Patients aged 6 years and older with a diagnosis of HIV/AIDS whose CD4+ cell count < 200 cells/mm³, and who had at least two medical visits during the measurement year, with at least 60 days between each visit

Denominator Criteria (Eligible Cases):

Patients aged \geq 6 years on date of encounter <u>AND</u> Diagnosis for HIV/AIDS (line-item ICD-9-CM): 042, 079.53, V08 <u>AND</u> Patient encounters during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245

RATIONALE:

Although advances in the management of HIV and AIDS diseases have been made, Pneumocystis carinii pneumonia (PCP) remains an important complication and cause of morbidity. Without PCP prophylaxis, patients with HIV/AIDS are at increased risk of developing PCP, especially when CD4 cell counts fall 200 cells/mm³ to 250 cells/mm³ (Kaplan, 1998; Phair, 1990). PCP prophylaxis is very effective and has been demonstrated to prolong life.

CLINICAL RECOMMENDATION STATEMENTS:

HIV-infected adults and adolescents, including pregnant women and those on HAART, should receive chemoprophylaxis against PCP if they have a CD4+T lymphocyte count of <200/mL or a history of oropharyngeal candidiasis. (USPH/IDSA, 2002)

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

2009 PQRI REPORTING OPTIONS: REGISTRY ONLY

DESCRIPTION:

Percentage of patients with a diagnosis of HIV/AIDS aged 13 years and older: who have a history of a nadir CD4+ cell count below 350/mm³ or who have a history of an AIDS-defining condition, regardless of CD4+ cell count; or who are pregnant, regardless of CD4+ cell count or age, who were prescribed potent antiretroviral therapy

INSTRUCTIONS:

This measure is to be reported a minimum of <u>once per reporting period</u> for patients with HIV/AIDS seen during the reporting period. Only patients who had at least two visits during the reporting period, with at least 60 days between each visit will be counted in the denominator for this measure. This measure is intended to reflect the quality of services provided for the primary management of patients with HIV/AIDS.

Measure Reporting via Registry Only:

ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure. Do not report this measure via claims.

There are two reporting criteria for this measure:

(1) Patients who are aged 13 years and older with a diagnosis of HIV/AIDS who have a history of a nadir CD4+ cell count below 350/mm³ or who have a history of an AIDS-defining condition, regardless of CD4+ cell count.

(2) Patients with a diagnosis of HIV/AIDS and who are pregnant, regardless of CD4+ cell count or age

Eligible professionals should submit data on one set of reporting criteria, depending on the clinical findings. If patient has HIV/AIDS (without a diagnosis of pregnancy) and a history of a nadir CD4+ cell count below 350/mm³ or a history of AIDS-defining condition, use Denominator Reporting Criteria 1. If the patient has HIV/AIDS and pregnant, use Denominator Reporting Criteria 2. If the patient can be included in both criteria, the eligible professional may report quality data for either reporting criteria and this will count as appropriate reporting for this patient.

REPORTING CRITERIA 1: For all patients with HIV/AIDS (without a diagnosis of pregnancy)

NUMERATOR:

Patients who were prescribed potent antiretroviral therapy

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

Definitions:

Potent Antiretroviral Therapy – Potent antiretroviral therapy is described as any antiretroviral therapy that has demonstrated optimal efficacy and results in durable suppression of HIV as shown by prior clinical trials. For potent antiretroviral therapy recommendations, refer to current DHHS guidelines available for download at the following address as of 11/3/08 - http://www.aids.gov.

AIDS-defining Condition – Conditions included in the 1993 AIDS surveillance case definition:

- Candidiasis of bronchi, trachea, or lungs;
- Candidiasis, esophageal;
- Cervical cancer, invasive;
- Coccidiodomycosis, disseminated or extrapulmonary;
- Cryptococcosis, extrapulmonary;
- Crytosporidiosis, chronic intestinal (greater than 1 month's duration);
- Cytomegalovirus disease (other than liver, spleen, or nodes);
- Cytomegalovirus retinitis (with loss of vision);
- Encephalopathy, HIV-related;
- Herpes simplex: chronic ulcer(s) (greater than 1 month's duration);
- Bronchitis, pneumonitis, or esophagitis;
- Histoplasmosis, disseminated or extrapulmonary;
- Isosporiasis, chronic intestinal (greater than 1 month's duration);
- Kaposi's sarcoma;
- Lymphoma, Burkitt's (or equivalent term);
- Lymphoma, immunoblastic (or equivalent term);
- Lymphoma, primary, of brain;
- Mycobacterium avium complex or M. kansasii, disseminated or extrapulmonary;
- Mycobacterium tuberculosis, any site (pulmonary or extrapulmonary);
- Mycobacterium, other species or unidentified species, disseminated or extrapulmonary;
- Pneumocystis carinii pneumonia;
- Pneumonia, recurrent;
- Progressive multifocal leukoencephalopathy;
- Salmonella septicemia, recurrent;
- Toxoplasmosis of brain;
- Wasting syndrome due to HIV. (NYSDOH, 2007)

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

Numerator Options:

Potent antiretroviral therapy prescribed **AND**

History of nadir CD4+ cell count < 350 cells/mm³ OR

History of AIDS-defining condition

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

Potent antiretroviral therapy <u>not</u> prescribed, reason not specified <u>AND</u>

History of nadir CD4+ cell count < 350 cells/mm³ OR History of AIDS-defining condition

DENOMINATOR (REPORTING CRITERIA 1):

Patients aged 13 years or older with a diagnosis of HIV/AIDS who have a history of nadir CD4+ cell count below 350/mm³ or who have a history of an AIDS-defining condition, regardless of CD4+ cell count who had at least two medical visits during the measurement year, with at least 60 days between each visit

Denominator Criteria (Eligible Cases):

Patients aged ≥ 13 years on date of encounter <u>AND</u> Diagnosis for HIV/AIDS (line-item ICD-9-CM): 042, 079.53, V08 <u>AND</u> Patient encounters during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245

OR

REPORTING CRITERIA 2: For patients with HIV/AIDS who are pregnant NUMERATOR:

Patients who were prescribed potent antiretroviral therapy

Definition:

Potent Antiretroviral Therapy – Potent antiretroviral therapy is described as any antiretroviral therapy that has demonstrated optimal efficacy and results in durable suppression of HIV as shown by prior clinical trials. For potent antiretroviral therapy recommendations, refer to current DHHS guidelines available for download at the following address as of 11/3/08 - http://www.aids.gov.

Numerator Options:

Potent antiretroviral therapy prescribed

<u>OR</u>

Potent antiretroviral therapy not prescribed, reason not specified

DENOMINATOR (REPORTING CRITERIA 2):

Patients with a diagnosis of HIV/AIDS who are pregnant, regardless of CD4+ cell count or age who had at least two medical visits during the measurement year, with at least 60 days between each visit

Denominator Criteria (Eligible Cases):

Diagnosis for HIV/AIDS (line-item ICD-9-CM): 042, V08, 079.53 <u>AND</u> Diagnosis for pregnancy (line-item ICD-9-CM): V22.0, V22.1, V22.2, V23.0, V23.1,

V23.2, V23.3, V23.41, V23.49, V23.5, V23.7, V23.81, V23.82, V23.83, V23.84, V23.89, V23.9

<u>AND</u>

Patient encounter during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99242, 99243, 99244, 99245

RATIONALE:

Potent antiretroviral therapy slows disease progression, extends survival, and results in maintained quality of life by suppressing HIV RNA viral load.

CLINICAL RECOMMENDATION STATEMENTS:

Antiretroviral therapy should be initiated in patients with a history of an AIDS-defining illness (AI) or with a CD4 T-cell count < 350 cells/mm³. The data supporting this recommendation are stronger for those with a CD4 T-cell count < 200 cells/mm³ and with a history of AIDS (AI) than for those with CD4 T-cell counts between 200 and 350 cells/mm³ (AII). Antiretroviral therapy should also be initiated in the following groups of patients regardless of CD4 T-cell count: a) pregnant women (AI); b) patients with HIV-associated nephropathy (AI); and c) patients coinfected with HBV when treatment for HBV infection is indicated (BIII). (DHHS)

Clinicians should prescribe a HAART regimen that is best able to delay disease progression, prolong survival, and maintain quality of life through maximal viral suppression. (NYSDOH)

Initiation of HAART is recommended for patients who:

are symptomatic* from HIV, OR

have an AIDS-defining condition,** including those with CD4 counts < 200 cells/mm³, *or* are asymptomatic with two successive measurements of CD4 counts < 350 cells/mm³ and patient-related barriers to adherence are minimized.

*Signs and symptoms include but are not limited to oropharyngeal candidiasis (thrush); vulvovaginal candidiasis that is frequent or responds poorly to therapy; cervical dysplasia (moderate or severe)/cervical carcinoma *in situ*, HIV nephropathy in the setting of worsening serum creatinine; severe seborrheic dermatitis, constitutional symptoms, such as fever or diarrhea lasting >1 months; oral hairy leukoplakia; herpes zoster (shingles) involving at least two distinct episodes or more than one dermatome; thrombocytopenia; listeriosis; pelvic inflammatory disease, particularly if complicated by tubo-ovarian abscess; peripheral neuropathy; bacillary angiomatosis; or any conditions included in the CDC-defined AIDS definition.

**All HIV-infected persons with CD4+ T-lymphocyte counts of less than 200 cells/uL or a CD4+ percentage of less than 14. Conditions included in the 1993 AIDS surveillance case definition: Candidiasis of bronchi, trachea, or lungs; candidiasis, esophageal; cervical cancer, invasive; coccidiodomycosis, disseminated or extrapulmonary; cryptococcosis, extrapulmonary; crytosporidiosis, chronic intestinal (greater than 1 month's duration); cytomegalovirus disease (other than liver, spleen, or nodes); cytomegalovirus retinitis (with loss of vision); encephalopathy, HIV-related; herpes simplex: chronic ulcer(s) (greater than 1 month's duration); or bronchitis, pneumonitis, or esophagitis; histoplasmosis, disseminated or extrapulmonary; isosporiasis, chronic intestinal (greater than 1 month's duration); Kaposi's sarcoma; lymphoma, Burkitt's (or equivalent term); lymphoma, immunoblastic (or equivalent term); lymphoma, primary, of brain; mycobacterium avium complex or M. kansasii, disseminated or extrapulmonary; mycobacterium tuberculosis, any site (pulmonary or extrapulmonary); mycobacterium, other species or unidentified species, disseminated or extrapulmonary; pneumocystis carinii pneumonia; pneumonia, recurrent; progressive multifocal leukoencephalopathy; salmonella septicemia, recurrent; toxoplasmosis of brain; wasting syndrome due to HIV. (NYSDOH). Measure #162: HIV/AIDS: HIV RNA Control After Six Months of Potent Antiretroviral Therapy

2009 PQRI REPORTING OPTIONS: REGISTRY ONLY

DESCRIPTION:

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

INSTRUCTIONS:

This measure is to be reported a minimum of <u>once per reporting period</u> for patients with HIV/AIDS who are receiving potent antiretroviral therapy during the reporting period. Only patients who had at least two visits during the reporting period, with at least 60 days between each visit will be counted in the denominator for this measure. This measure is intended to reflect the quality of services provided for the primary management of patients with HIV/AIDS.

Measure Reporting via Registry Only:

ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure. Do not report this measure via claims.

NUMERATOR:

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

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

Definitions:

Potent Antiretroviral Therapy – Potent antiretroviral therapy is described as any antiretroviral therapy that has demonstrated optimal efficacy and results in durable suppression of HIV as shown by prior clinical trials. For potent antiretroviral therapy recommendations, refer to current DHHS guidelines available for download at the following address as of 11/3/08 - http://www.aids.gov.

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

Numerator Options:

HIV RNA viral load below limits of quantification <u>AND</u> Patient receiving potent antiretroviral therapy for 6 months or longer

OR

HIV RNA viral load not below limits of quantification

<u>AND</u>

HIV RNA control plan of care, documented

<u>and</u>

Patient receiving potent antiretroviral therapy for 6 months or longer

<u> 0R</u>

Patient receiving potent antiretroviral therapy for less than 6 months or not receiving potent antiretroviral therapy

Viral load <u>not</u> performed or documented, reason not specified <u>AND</u>

Patient receiving potent antiretroviral therapy for 6 months or longer

OR

Plan of care for viral load not below limits of quantification was <u>not</u> documented, reason not specified

AND

HIV RNA viral load not below limits of quantification

<u>AND</u>

Patient receiving potent antiretroviral therapy for 6 months or longer

DENOMINATOR:

All patients aged 13 years and older with a diagnosis of HIV/AIDS who had at least two medical visits during the measurement year, with at least 60 days between each visit, who have received potent antiretroviral therapy for at least 6 months

Denominator Criteria (Eligible Cases):

Patients aged \geq 13 years on date of encounter <u>AND</u> Diagnosis for HIV/AIDS (line-item ICD-9-CM): 042, 079.53, V08 <u>AND</u> Patient encounters during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245

RATIONALE:

The goal of potent antiretroviral therapy is to establish HIV RNA viral load below limits of quantification.

CLINICAL RECOMMENDATION STATEMENTS:

The goal of treatment for patients with prior drug exposure and drug resistance is to re-establish maximal virologic suppression, HIV RNA <50 copies/mL (AI). (DHHS)

Clinicians should prescribe a HAART regimen that is best able to delay disease progression, prolong survival, and maintain quality of life through maximal viral suppression. (NYSDOH)

Initiation of HAART is recommended for patients who: are symptomatic* from HIV, OR have an AIDS-defining condition,** including those with CD4 counts <200 cells/mm³, *or* are asymptomatic with two successive measurements of CD4 counts <350 cells/mm³ and patient-related barriers to adherence are minimized.

*Signs and symptoms include but are not limited to oropharyngeal candidiasis (thrush); vulvovaginal candidiasis that is frequent or responds poorly to therapy; cervical dysplasia (moderate or severe)/cervical carcinoma *in situ*, HIV nephropathy in the setting of worsening serum creatinine; severe seborrheic dermatitis, constitutional symptoms, such as fever or diarrhea lasting >1 months; oral hairy leukoplakia; herpes zoster (shingles) involving at least two distinct episodes or more than one dermatome; thrombocytopenia; listeriosis; pelvic inflammatory disease, particularly if complicated by tubo-ovarian abscess; peripheral neuropathy; bacillary angiomatosis; or any conditions included in the CDC-defined AIDS definition.

**All HIV-infected persons with CD4+ T-lymphocyte counts of less than 200 cells/uL or a CD4+ percentage of less than 14. Conditions included in the 1993 AIDS surveillance case definition: Candidiasis of bronchi, trachea, or lungs; candidiasis, esophageal; cervical cancer, invasive; coccidiodomycosis, disseminated or extrapulmonary; cryptococcosis, extrapulmonary; crytosporidiosis, chronic intestinal (greater than 1 month's duration); cytomegalovirus disease (other than liver, spleen, or nodes); cytomegalovirus retinitis (with loss of vision); encephalopathy, HIV-related; herpes simplex: chronic ulcer(s) (greater than 1 month's duration); or bronchitis, pneumonitis, or esophagitis; histoplasmosis, disseminated or extrapulmonary; isosporiasis, chronic intestinal (greater than 1 month's duration); Kaposi's sarcoma; lymphoma, Burkitt's (or equivalent term); lymphoma, immunoblastic (or equivalent term); lymphoma, primary, of brain; mycobacterium avium complex or M. kansasii, disseminated or extrapulmonary; mycobacterium tuberculosis, any site (pulmonary or extrapulmonary); mycobacterium, other species or unidentified species, disseminated or extrapulmonary; pneumocystis carinii pneumonia; pneumonia, recurrent; progressive multifocal leukoencephalopathy; salmonella septicemia, recurrent; toxoplasmosis of brain; wasting syndrome due to HIV. (NYSDOH)

Measure #163: Diabetes Mellitus: Foot Exam

2009 PQRI REPORTING OPTIONS: CLAIMS-BASED, REGISTRY, MEASURES GROUP

DESCRIPTION:

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

INSTRUCTIONS:

This measure is to be reported a minimum of <u>once per reporting period</u> for patients with diabetes mellitus seen during the reporting period. The performance period for this measure is 12 months. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

Measure Reporting via Claims:

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

When reporting the measure via claims, submit the listed ICD-9-CM diagnosis codes, CPT codes, G-codes, and the appropriate CPT Category II code **OR** the CPT Category II code **with** the modifier. The modifiers allowed for this measure are: 1P- medical reasons, 8P- reason not otherwise specified. All measure-specific coding should be reported ON THE SAME CLAIM.

NUMERATOR:

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

<u>Numerator Quality-Data Coding Options for Reporting Satisfactorily:</u> Foot Exam Performed

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

Foot Exam not Performed for Medical Reason

Append a modifier (**1P**) to CPT Category II code **2028F** to report documented circumstances that appropriately exclude patients from the denominator. **2028F** with **1P**: Documentation of medical reason for not performing foot exam (i.e., patient with bilateral foot/leg amputation)

Foot Exam not Performed, Reason not Specified

Append a reporting modifier (8P) to CPT Category II code 2028F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

2028F with 8P: Foot exam was not performed, reason not otherwise specified

DENOMINATOR:

Patients aged 18 through 75 years with a diagnosis of diabetes

Denominator Criteria (Eligible Cases):

Patients aged 18 through 75 years on date of encounter **AND**

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

<u>and</u>

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

RATIONALE:

The most common consequences of diabetic neuropathy are amputation and foot ulceration (ADA, 2006). In developed countries, up to five percent of diabetic patients have foot ulcers (IDF, 2005). One in every six diabetics will have an ulcer during their lifetime (IDF, 2005). Amputation and foot ulceration are also major causes of morbidity and mortality. One half to 80% of all amputations are diabetes-related (Mayfield, 1998; Reiber, 1995; ADA, 2001; Unwin, 2000). The risk of ulcers or amputations increases the longer someone has diabetes. Early recognition and management of risk factors can prevent or delay adverse outcomes (ADA, 2006).

CLINICAL RECOMMENDATION STATEMENTS:

American Association of Clinical Endocrinologists/American College of Endocrinology (AACE/ACE) and American Diabetes Association (ADA) recommend that a foot examination (visual inspection, sensory exam, and pulse exam) be performed during an initial assessment.

AACE/ACE (2002) recommends that a foot examination be a part of every follow-up assessment visit, which should occur quarterly.

ADA (2004) recommends that all individuals with diabetes should receive an annual foot examination to identify high-risk foot conditions. This examination should include assessment of protective sensation, foot structure and biomechanics, vascular status, and skin integrity.

The ADA (2004) recommends that people with one or more high-risk foot conditions should be evaluated more frequently for the development of additional risk factors. People with neuropathy should have a visual inspection of their feet at every contact with a health care professional.

Ω Measure #164: Coronary Artery Bypass Graft (CABG): Prolonged Intubation (Ventilation)

2009 PQRI REPORTING OPTIONS: REGISTRY ONLY

DESCRIPTION:

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

INSTRUCTIONS:

This measure is to be reported <u>each time</u> an isolated CABG procedure is performed during the reporting period. It is anticipated that <u>clinicians who provide services for isolated CABG</u> will submit this measure. This measure is intended to reflect the quality of the surgical services provided for isolated CABG patients. Isolated CABG refers to CABG using arterial and/or venous grafts only. This measure does not include patients undergoing repeat CABG procedures.

Measure Reporting via Registry Only:

CPT codes and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure. Do not report this measure via claims.

NUMERATOR:

Patients undergoing isolated CABG who require intubation > 24 hours

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

Numerator Options:

Prolonged intubation (> 24 hrs) required

<u> 0R</u>

Prolonged intubation (> 24 hrs) not required

DENOMINATOR:

All patients undergoing isolated CABG surgery

Denominator Criteria (Eligible Cases):

Patients aged \geq 18 years on date of encounter

<u>AND</u>

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

RATIONALE:

Based on the STS coronary artery bypass graft (CABG) study population, the morbidity rate associated with prolonged intubation following CABG is 5.96%. Also, prolonged ventilation (defined as >24 hours) was an independent predictor for readmission to the ICU following CABG surgery (OR=10.53; CI: 6.18 to 17.91). Shorter ventilation times are linked to high quality of care (i.e.,

reduced in-hospital and operative mortality, as well as better long-term outcomes as compared to prolonged ventilation).

CLINICAL RECOMMENDATION STATEMENTS:

Extubation greater than (>) 24 hours is considered a "pulmonary complication." Patients who were extubated after 24 hours had a longer duration of hospital stay and a greater incidence of postoperative complications.

 Ω Measure #165: Coronary Artery Bypass Graft (CABG): Deep Sternal Wound Infection Rate

2009 PQRI REPORTING OPTIONS: REGISTRY ONLY

DESCRIPTION:

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

INSTRUCTIONS:

This measure is to be reported <u>each time</u> an isolated CABG procedure is performed during the reporting period. It is anticipated that <u>clinicians who provide services for isolated CABG</u> will submit this measure. This measure is intended to reflect the quality of the surgical services provided for isolated CABG patients. Isolated CABG refers to CABG using arterial and/or venous grafts only. This measure does not include patients undergoing repeat CABG procedures.

Measure Reporting via Registry Only:

CPT codes and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure. Do not report this measure via claims.

NUMERATOR:

Patients who developed a deep sternal wound infection within 30 days postoperatively (must have ALL of the following conditions: wound opened with excision of tissue [incision and drainage] or reexploration of mediastinum, positive culture and treatment with antibiotics)

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

Numerator Options:

Development of deep sternal wound infection within 30 days postoperatively

<u> 0R</u>

No deep sternal wound infection

DENOMINATOR:

All patients undergoing isolated CABG surgery

Denominator Criteria (Eligible Cases):

All patients aged ≥ 18 years on date of encounter <u>AND</u> Patient encounter during the reporting period (CPT): 33510, 33511, 33512, 33513,

33514, 33516, 33517, 33518, 33519, 33521, 33522, 33523, 33533, 33534, 33535, 33536

RATIONALE:

The most serious hospital-acquired infection associated with coronary artery bypass graft (CABG) surgery is deep sternal wound or deep surgical site infection. The most common bacteria involved are *S. aureus* including increasingly more common methicillin resistant *Staph* (MRS). For CABG only outcomes 1997-1999 the STS dataset reported 0.63% deep sternal wound infection rate in 503,478 records. A report from an academic hospital reported 1.9% deep surgical site infections (Centers for Disease Control and Prevention National Nosocomial Infection Surveillance [CDC NNIS] criteria) in 1,980 patients undergoing isolated CABG or CABG+ procedures from 1996-1999. The Northern New England Cardiovascular Disease Study Group reported an incidence rate for mediastinitis of 1.25% and noted a marked increase in mortality during the first year post-CABG and a threefold increase during a 4-year follow-up period.

CLINICAL RECOMMENDATION STATEMENTS:

Several risk factors for sternal wound infection have been identified that can be optimized with good care practices: prophylactic antibiotics within 1 hour before incision time (odds ratio 5.3) [see antibiotic timing process measure] and avoiding elevated blood glucose levels (odds ratio 10.2). Surveillance for surgical site infections is a critical hospital function to monitor infection control practices and direct improvement activity.

 Ω Measure #166: Coronary Artery Bypass Graft (CABG): Stroke/Cerebrovascular Accident (CVA)

2009 PQRI REPORTING OPTIONS: REGISTRY ONLY

DESCRIPTION:

Percentage of patients aged 18 years and older undergoing isolated CABG surgery who had a stroke/CVA

INSTRUCTIONS:

This measure is to be reported <u>each time</u> an isolated CABG procedure is performed during the reporting period. It is anticipated that <u>clinicians who provide services for isolated CABG</u> will submit this measure. This measure is intended to reflect the quality of the surgical services provided for isolated CABG patients. Isolated CABG refers to CABG using arterial and/or venous grafts only. This measure does not include patients undergoing repeat CABG procedures.

Measure Reporting via Registry Only:

CPT codes and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure. Do not report this measure via claims.

NUMERATOR:

Patients who have a stroke/CVA

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

Numerator Options:

Stroke/CVA following isolated CABG surgery

<u> 0R</u>

No stroke/CVA following isolated CABG surgery

DENOMINATOR:

All patients undergoing isolated CABG surgery, excluding patients with a prior CVA

Denominator Criteria (Eligible Cases):

All patients aged \geq 18 years on date of encounter

<u>AND</u>

Patient encounter during the reporting period (CPT): 33510, 33511, 33512, 33513, 33514, 33516, 33517, 33518, 33519, 33521, 33522, 33523, 33533, 33534, 33535, 33536 <u>WITHOUT</u>

History of prior CVA

RATIONALE:

Stroke is a devastating complication after coronary bypass surgery. The 1999 American College of Cardiology/American Heart Association (ACC/AHA) guidelines indicate that adverse cerebral outcomes are observed in ~6% of patients after bypass surgery equally divided between 2 types: 1) associated with major, focal neurological defects, stupor or coma and 2) evidence of deterioration in intellectual function. Type 1 deficits occur in ~3% of patients and is responsible for 21% mortality.

Reports in the literature on postoperative stroke incidence are difficult to compare because the conditions included in the term "stroke" vary. A standardized definition of stoke will provide common language to compare stroke incidence and evaluate management strategies for reducing this devastating complication.

Reported rates of postoperative cerebral dysfunction range from 0.4% to 13.8% following coronary operations. Complications for patients undergoing emergent CABG or valve surgery were greater than the complication rate for patients undergoing elective CABG or valve surgery. As bypass times increased, so did the incidence of stroke. When bypass time was 90 to 113 minutes, OR=1.59, p=0.022 and when bypass time was >114 minutes, the OR was 2.59, p<0.001. Outcomes are better when patient age is younger and with beating-heart surgery rather than on-pump surgery.

CLINICAL RECOMMENDATION STATEMENTS:

The 1999 ACC/AHA guidelines describe strategies for reducing the risk of postoperative stroke such as an aggressive approach to the management of patients with severely diseased ascending aortas identified by intraoperative echocardiographic imaging, prevention or aggressive management of postoperative atrial fibrillation, delay of bypass surgery in the case of a left ventricular mural thrombus or a recent, preoperative CVA and preoperative carotid screening. Patients should carefully be screened for cerebrovascular disease to help prevent stroke and its associated morbidities.

Use of beta-adrenergic antagonists was associated with a lower incidence of stroke in patients undergoing elective CABG (OR=0.45; 95% CI 0.23 to 0.83; p=0.016). Use of antiplatelet agents within 48 hours of surgery is associated with a decreased risk of stroke (OR=0.51, p=0.01). Increased use of beating-heart surgery without cardiopulmonary bypass may lead to a lower prevalence of stroke following cardiac surgery and thus improve patient outcomes.

Ω Measure #167: Coronary Artery Bypass Graft (CABG): Postoperative Renal Insufficiency

2009 PQRI REPORTING OPTIONS: REGISTRY ONLY

DESCRIPTION:

Percentage of patients aged 18 years and older undergoing isolated CABG surgery who develop postoperative renal insufficiency or require dialysis

INSTRUCTIONS:

This measure is to be reported <u>each time</u> an isolated CABG procedure is performed during the reporting period. It is anticipated that <u>clinicians who provide services for isolated CABG</u> will submit this measure. This measure is intended to reflect the quality of the surgical services provided for isolated CABG patients. Isolated CABG refers to CABG using arterial and/or venous grafts only. This measure does not include patients undergoing repeat CABG procedures.

Measure Reporting via Registry Only:

CPT codes and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure. Do not report this measure via claims.

NUMERATOR:

Patients who develop postop renal insufficiency or require dialysis (indicate whether the patient had acute or worsening renal insufficiency resulting in one or more of the following: 1) increase of serum creatinine to > 2.0, and 2x most recent preoperative creatinine level; 2) a new requirement for dialysis postoperatively)

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

Numerator Options:

Developed postoperative renal insufficiency or required dialysis

No postoperative renal insufficiency/dialysis not required

DENOMINATOR:

All patients undergoing isolated CABG surgery, excluding patients with either a documented history of renal insufficiency or baseline serum creatinine > 2.0

Denominator Criteria (Eligible Cases):

All patients aged \geq 18 years on date of encounter **AND**

Patient encounter during the reporting period (CPT): 33510, 33511, 33512, 33513, 33514, 33516, 33517, 33518, 33519, 33521, 33522, 33523, 33533, 33534, 33535, 33536 <u>WITHOUT</u>

History of renal insufficiency or baseline serum creatinine > 2.0

RATIONALE:

In 2000, coronary artery bypass graft (CABG) surgery was performed on more than 350,000 patients at a cost of close to \$20 billion. Some degree of Acute Renal Dysfunction (ARD) occurs in about 8% of patients following CABG, and dialysis-dependent renal failure occurs in 0.7% to 3.5% of patients receiving CABG. The latter is associated with substantial increases in morbidity, length of stay, and mortality (odds ratios for mortality range from 15 to 27). ARD is associated with increased morbidity, mortality and length of stay in an ICU following surgery. In addition, Acute Renal Failure occurs in 1.5% of patients undergoing any type of cardiac surgery. There has been a substantial increase in postoperative morbidity, mortality, and cost associated with this relatively common complication, regardless of whether or not this incidence varies much between providers, and there are implications of even a modest decrease in its incidence.

CLINICAL RECOMMENDATION STATEMENTS:

Acute renal failure following CABG is an intermediate outcome measure for mortality since this complication is independently associated (OR=27) with early mortality following cardiac surgery, even after adjustment for comorbidity and postoperative complications.

12/08/2008

Ω Measure #168: Coronary Artery Bypass Graft (CABG): Surgical Re-exploration

2009 PQRI REPORTING OPTIONS: REGISTRY ONLY

DESCRIPTION:

Percentage of patients aged 18 years and older undergoing isolated CABG surgery who require a return to the operating room (OR) for mediastinal bleeding/tamponade, graft occlusion (due to acute closure, thrombosis, technical or embolic origin), or other cardiac reason

INSTRUCTIONS:

This measure is to be reported <u>each time</u> an isolated CABG procedure is performed during the reporting period. It is anticipated that <u>clinicians who provide services for isolated CABG</u> will submit this measure. This measure is intended to reflect the quality of the surgical services provided for isolated CABG patients. Isolated CABG refers to CABG using arterial and/or venous grafts only. This measure does not include patients undergoing repeat CABG procedures.

Measure Reporting via Registry Only:

CPT codes and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure. Do not report this measure via claims.

NUMERATOR:

Patients who require a return to the OR for bleeding/tamponade, graft occlusion, or other cardiac reason

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

Numerator Options:

Reoperation required due to bleeding/tamponade, graft occlusion or other cardiac reason

Reoperation not required due to bleeding/tamponade, graft occlusion or other cardiac reason

DENOMINATOR:

All patients undergoing isolated CABG surgery

Denominator Criteria (Eligible Cases):

All patients aged ≥ 18 years on date of encounter AND

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

RATIONALE:

In 2000, coronary artery bypass graft (CABG) surgery was performed on more than 350,000 patients at a cost of close to \$20 billion. Re-exploration after surgery is a serious complication that impacts length of stay, efficient use of resources, and increases risk for additional complications and death. As one of several major complications of cardiac surgery, repeat surgery is particularly worrisome for consumers and is an inefficient use of resources.

CLINICAL RECOMMENDATION STATEMENTS:

Re-exploration after surgery is a serious complication that impacts length of stay, efficient use of resources, and increases risk for additional complications and death. This measure is currently in use by approx. 65% of providers in the United States who perform cardiac surgery and report data to the STS National Database.

 Ω Measure #169: Coronary Artery Bypass Graft (CABG): Antiplatelet Medications at Discharge

2009 PQRI REPORTING OPTIONS: REGISTRY ONLY

DESCRIPTION:

Percentage of patients aged 18 years and older undergoing isolated CABG surgery who have antiplatelet medication at discharge

INSTRUCTIONS:

This measure is to be reported <u>each time</u> an isolated CABG procedure is performed during the reporting period. It is anticipated that <u>clinicians who provide services for isolated CABG</u> will submit this measure. This measure is intended to reflect the quality of the surgical services provided for isolated CABG patients. Isolated CABG refers to CABG using arterial and/or venous grafts only. This measure does not include patients undergoing repeat CABG procedures.

Measure reporting via Registry Only:

CPT codes and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure. Do not report this measure via claims.

NUMERATOR:

Patients who were discharged on antiplatelet medication

Numerator Options:

Antiplatelet medication at discharge

Antiplatelet medication contraindicated/not indicated

OR

No antiplatelet medication at discharge

DENOMINATOR:

All patients undergoing isolated CABG surgery, who did not have in-hospital mortality.

Denominator Criteria (Eligible Cases):

All patients aged \geq 18 years on date of encounter

AND

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

Patient not deceased prior to discharge

RATIONALE:

Use of aspirin soon after coronary artery bypass graft (CABG) is associated with reduced risk of death and ischemic complications involving the heart, brain, kidneys, and gastrointestinal tract.

High-risk patients now represent the majority of patients who undergo bypass surgery, giving rise to rates of 15% or higher for complications affecting heart, brain, kidneys, and intestines.

Guidelines from the American College of Chest Physicians recommend the administration of aspirin soon after CABG, specifically 325 mg per day starting six hours after surgery.

CLINICAL RECOMMENDATION STATEMENTS:

Evidence-based discharge therapies are underutilized in older patients who underwent CABG during hospitalization for AMI.

 Ω Measure #170: Coronary Artery Bypass Graft (CABG): Beta-Blockers Administered at Discharge

2009 PQRI REPORTING OPTIONS: REGISTRY ONLY

DESCRIPTION:

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

INSTRUCTIONS:

This measure is to be reported <u>each time</u> an isolated CABG procedure is performed during the reporting period. It is anticipated that <u>clinicians who provide services for isolated CABG</u> will submit this measure. This measure is intended to reflect the quality of the surgical services provided for isolated CABG patients. Isolated CABG refers to CABG using arterial and/or venous grafts only. This measure does not include patients undergoing repeat CABG procedures.

Measure Reporting via Registry Only:

CPT codes and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure. Do not report this measure via claims.

NUMERATOR:

Patients who were discharged on beta-blockers

Numerator Options:

Beta-blocker at discharge

Beta-blocker contraindicated/not indicated

OR

No beta-blocker at discharge

DENOMINATOR:

All patients undergoing isolated CABG surgery who did not have in-hospital mortality.

Denominator Criteria (Eligible Cases):

All patients aged \geq 18 years on date of encounter

<u>and</u>

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

Patient not deceased prior to discharge

RATIONALE:

Upwards of 70% of patients who undergo revascularization procedures have had a myocardial infarction (MI). Cumulative evidence and randomized trials indicate that patients with a previous MI live longer if they are on beta blockers. For many years, patients were taken off beta-blocker medications in preparations for surgery. Evidence from the STS National Database demonstrated that beta blocker use is safe and effective in many CABG patients previously thought to be at high risk for adverse events of beta blocker therapy (women, elderly, diabetes, congestive heart failure). The Society of Thoracic Surgeons National Database reported an increase in use of preoperative beta blockers during the time period 1996 (50% use) and 1999 (60% use).

CLINICAL RECOMMENDATION STATEMENTS:

Beta blockade reduces atrial fibrillation complications following CABG. At four to five years, survival was approximately 13% worse in patients who developed postoperative atrial fibrillation (p <0.001).

Ω Measure #171: Coronary Artery Bypass Graft (CABG): Lipid Management and Counseling

2009 PQRI REPORTING OPTIONS: REGISTRY ONLY

DESCRIPTION:

Percentage of patients aged 18 years and older undergoing isolated CABG surgery who have antilipid treatment at discharge

INSTRUCTIONS:

This measure is to be reported <u>each time</u> an isolated CABG procedure is performed during the reporting period. It is anticipated that <u>clinicians who provide services for isolated CABG</u> will submit this measure. This measure is intended to reflect the quality of the surgical services provided for isolated CABG patients. Isolated CABG refers to CABG using arterial and/or venous grafts only. This measure does not include patients undergoing repeat CABG procedures.

Measure Reporting via Registry Only:

CPT codes and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure. Do not report this measure via claims.

NUMERATOR:

Patients with an anti-lipid treatment at discharge

Numerator Options:

Anti-lipid treatment at discharge

Anti-lipid treatment contraindicated/not indicated

OR

No anti-lipid treatment at discharge

DENOMINATOR:

All patients undergoing isolated CABG surgery, who did not have in-hospital mortality

Denominator Criteria (Eligible Cases):

All patients aged \geq 18 years on date of encounter

AND

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

Patient not deceased prior to discharge

RATIONALE:

Atherosclerosis is a chronic disease. Events such as acute myocardial infarction (MI) and coronary artery bypass graft (CABG) surgery identify patients with the disease, but acute therapy is not sufficient for optimal long-term outcomes. In post-bypass patients, atherosclerosis continues to progress in the native circulation and develops at an accelerated rate in saphenous vein bypass grafts. Management of the chronic disease is critically important in patients with atherosclerosis, such as those undergoing CABG.

The advantages of adherence to the American College of Cardiology/American Heart Association "Get with the Guidelines" program are discussed in a recent article, which also demonstrates both variation in quality and opportunity for improvement (38% compliance with guidelines before program implementation, 98.4% compliance thereafter). The article also discusses educational and process measures used by a major medical center to achieve compliance.

CLINICAL RECOMMENDATION STATEMENTS:

Compliance rates for patients receiving personalized follow- up for lipid management over two years were significantly better than in the control group. Lipid lowering in coronary heart disease has been demonstrated distinctively through three trials (CLAS, post-CABG, and CARE) to delay the progression of atherosclerosis and/or reduce deaths, and non- fatal MI following bypass surgery. Aggressive (low-density lipoprotein [LDL]) cholesterol-lowering treatment (target <85 mg/d) was correlated to a slower rate of disease progression (31%) after 4-5 years in comparison to the control group, which was comprised of patients receiving moderate lipid- lowering treatment (target <130 to 140 mg/dl).

Measure #172: Hemodialysis Vascular Access Decision-Making by Surgeon to Maximize Placement of Autogenous Arterial Venous (AV) Fistula

2009 PQRI REPORTING OPTIONS: CLAIMS-BASED, REGISTRY

DESCRIPTION:

Percentage of patients aged 18 years and older with a diagnosis of advanced Chronic Kidney Disease (CKD) (stage 4 or 5) or End Stage Renal Disease (ESRD) requiring hemodialysis vascular access documented by surgeon to have received autogenous AV fistula

INSTRUCTIONS:

This measure is to be reported <u>each time</u> a procedure for hemodialysis access is performed during the reporting period. It is anticipated that <u>clinicians who perform the listed surgical procedures</u> as specified in the denominator coding will submit this measure.

Measure Reporting via Claims:

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

When reporting the measure via claims, submit the listed CPT codes, and the appropriate numerator G-code. All measure-specific coding should be reported ON THE SAME CLAIM.

NUMERATOR:

Patients diagnosed with advanced CKD or ESRD requiring hemodialysis vascular access as documented by the surgeon

Numerator Quality-Data Coding Options for Reporting Satisfactorily: Autogenous AV Fistula Performed G8530: Autogenous AV fistula received

Autogenous AV Fistula not Performed for Documented Reasons

G8531: Clinician documented that patient was not an eligible candidate for autogenous AV fistula

Autogenous AV Fistula not Performed, Reason not Specified

G8532: Clinician documented that patient received vascular access other than autogenous AV fistula, reason not specified

DENOMINATOR:

All patients with advanced CKD or ESRD who undergo open surgical placement of permanent hemodialysis access
Denominator Criteria (Eligible Cases):

Patients aged \geq 18 years on date of encounter

<u>and</u>

Diagnosis for stage 4 or 5 CKD or ESRD (line-item ICD-9-CM): 585.4, 585.5, 585.6, 996.73

<u>AND</u>

Patient encounter during the reporting period (CPT): 36818, 36819, 36820, 36821, 36825, 36830

RATIONALE:

AV access complications account for more than 15% of hospital admissions among hemodialysis patients. As the number of patients in need of chronic hemodialysis increases—estimated at 10% per year starting at a base population of 345,000 in 2000 – the cost to the health care system of dialysis access-related complications will increase proportionally.

CLINICAL RECOMMENDATION STATEMENTS:

For the surgeon, the most directly measurable performance parameter is the percentage of autogenous accesses placed as a proportion of the total number of accesses, (autogenous and prosthetic) placed by the particular surgeon.

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

2009 PQRI REPORTING OPTIONS: CLAIMS-BASED, REGISTRY

DESCRIPTION:

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

INSTRUCTIONS:

This measure is to be reported a minimum of <u>once per reporting period</u> for patients seen during the reporting period. This measure is intended to determine whether or not all patients aged 18 years and older were screened for unhealthy alcohol use during the reporting period. There is no diagnosis associated with this measure. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

Measure Reporting via Claims:

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

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

NUMERATOR:

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

Definition:

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

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Unhealthy Alcohol Use Screening Performed

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

Unhealthy Alcohol Use Screening <u>not</u> Performed, for Medical Reasons
Append a modifier (1P) to CPT Category II code 3016F to report documented circumstances that appropriately exclude patients from the denominator.
3016F with 1P: Documentation of medical reason(s) for not screening for unhealthy alcohol use (eg, limited life expectancy)

Unhealthy Alcohol Use Screening not Performed, Reason not Specified

Append a reporting modifier (8P) to CPT Category II code 3016F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

3016F *with* **8P:** Unhealthy alcohol use screening <u>not</u> performed, reason not otherwise specified

DENOMINATOR:

All patients aged 18 years and older

Denominator Criteria (Eligible Cases):

Patients aged \geq 18 years on date of encounter <u>AND</u>

Patient encounter during the reporting period (CPT or HCPCS): 90801, 90802, 90804, 90805, 90806, 90807, 90808, 90809, 90810, 90811, 90812, 90813, 90814, 90815, 90845, 90862, 96150, 96152, 97003, 97004, 97802, 97803, 97804, 98960, 98961, 98962, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, G0270, G0271

RATIONALE:

Screening for unhealthy alcohol use can identify patients can identify patients whose habits may put them at risk for adverse health outcomes due to their alcohol use. While this measure does not require counseling for those patients to be found at risk, brief counseling interventions for unhealthy alcohol use have shown to be effective in reducing alcohol use. It would be expected that if a provider found their patient to be at risk after screening that intervention would be provided. A systematic method of assessing for unhealthy alcohol use should be utilized. Please refer to the National Institute on Alcohol Abuse and Alcoholism publication: *Helping Patients Who Drink Too Much: A Clinician's Guide* for additional information regarding systematic screening methods., Available at: http://pubs.niaaa.nih.gov/publications/Practitioner/CliniciansGuide2005/guide.pdf.

CLINICAL RECOMMENDATION STATEMENTS:

The USPSTF strongly recommends screening and behavioral counseling interventions to reduce alcohol misuse by adults, including pregnant women, in primary care settings. (B Recommendation) (USPSTF, 2004)

During new patient encounters and at least annually, patients in general and mental healthcare settings should be screened for at-risk drinking, alcohol use problems and illnesses, and any tobacco use. (NQF, 2007)

All patients identified with alcohol use in excess of National Institute on Alcohol Abuse and Alcoholism guidelines and/or any tobacco use should receive brief motivational counseling intervention by a healthcare worker trained in this technique. (NQF, 2007)

A Measure #174: Pediatric End Stage Renal Disease (ESRD): Plan of Care for Inadequate Hemodialysis

2009 PQRI REPORTING OPTIONS: REGISTRY ONLY

DESCRIPTION:

Percentage of calendar months during the 12-month reporting period in which patients aged 17 years and younger with a diagnosis of ESRD receiving hemodialysis have a single-pool Kt/V \ge 1.2 or have a single-pool Kt/V < 1.2 with a documented plan of care for inadequate hemodialysis

INSTRUCTIONS:

This measure is to be reported <u>each calendar month</u> hemodialysis is performed on pediatric ESRD patients seen during the reporting period. It is anticipated that clinicians providing care for pediatric patients with ESRD will submit this measure.

Measure Reporting via Registry Only:

ICD-9-CM diagnosis codes, G-codes, and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure. Do not report this measure via claims.

NUMERATOR:

Number of patient calendar months during which patients have a single-pool Kt/V \ge 1.2 OR have a single-pool Kt/V < 1.2 with a documented plan of care for inadequate hemodialysis

Definition:

Documented Plan of Care – May include checking for adequacy of the AV access, increasing the blood flow, increasing the dialyzer size, increasing the time of dialysis sessions, increasing the number of days of dialysis, documenting residual renal function, documenting that patient has an inborn error of metabolism or is undergoing an alternate hemodialysis modality.

Numerator Options:

Kt/V \geq 1.2 (Clearance of urea (Kt)/ volume (V))

OR

Kt/V < 1.2 (Clearance of urea (Kt)/volume (V))

Hemodialysis plan of care documented

<u> 0R</u>

Kt/V not performed or documented, reason not specified.

Hemodialysis plan of care <u>not</u> documented, reason not specified <u>AND</u>

Kt/V < 1.2 (Clearance of urea (Kt)/Volume(V)

DENOMINATOR:

Calendar months for all patients aged 17 years and younger with a diagnosis of ESRD and receiving hemodialysis

Denominator Criteria (Eligible Cases):

Patients aged ≤ 17 years on date of encounter <u>AND</u> Diagnosis for ESRD (line-item ICD-9-CM): 585.6 <u>AND</u> Patient encounter during the reporting period (HCPCS): 90951, 90952, 90953, 90954, 90955, 90956, 90957, 90958, 90959

RATIONALE:

Patients receiving hemodialysis must be monitored (by assessing Kt/V) regularly to ensure that their dialysis dose is sufficient. A patient receiving thrice weekly hemodialysis whose Kt/V is less than 1.2 is not receiving adequate dialysis. This measure assesses whether the treating physician addressed a low Kt/V level. A plan of care (defined as checking for adequacy of the AV access, increasing the blood flow, increasing the dialyzer size, increasing the time of dialysis sessions, increasing the number of days of dialysis, documenting residual renal function, or documenting that patient has an inborn error of metabolism or is undergoing an alternate hemodialysis modality) should be documented by the physician for every time the Kt/V is less than 1.2.

CLINICAL RECOMMENDATION STATEMENTS:

Children should receive at least the delivered dialysis dose as recommended for the adult population. (NKF K/DOQI 2006) (Grade A Recommendation)

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 should be measured at regular intervals and no less than monthly. (NKF K/DOQI 2006) (Grade A Recommendation)

The minimally adequate dose of HD given three times per week with Kr less than 2 mL/min/1.73m² should be an spKt/V (excluding RKF) of 1.2 per dialysis. For treatment times less than 5 hours, an alternative minimum dose is a URR of 65%. (NKF K/DOQI 2006) (Grade A Recommendation)

A Measure #175: Pediatric End Stage Renal Disease (ESRD): Influenza Immunization

2009 PQRI REPORTING OPTIONS: CLAIMS-BASED, REGISTRY

DESCRIPTION:

Percentage of patients aged 6 months through 17 years with a diagnosis of ESRD and receiving dialysis seen for a visit between November 1 and February 15 who have documented administration of influenza immunization OR patient reported receipt of an influenza immunization from another provider

INSTRUCTIONS:

This measure is to be reported a minimum of <u>once for visits</u> occurring between January 1, 2009 and February 15, 2009 for the 2008-2009 influenza season **AND** a minimum of <u>once for visits</u> occurring between November 1, 2009 and December 31, 2009 for the 2009-2010 influenza season for ESRD patients receiving dialysis seen during the reporting period. This measure is intended to determine whether or not ESRD patients receiving dialysis received an influenza immunization during the flu season. It is anticipated that clinicians providing care for pediatric patients with ESRD will submit this measure.

Measure Reporting via Claims:

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

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

NUMERATOR:

Patients who have documented administration of an influenza immunization OR patient reported receipt of influenza immunization from another provider

NUMERATOR NOTE: Children with renal disease should receive the inactivated flu vaccine

<u>Numerator Quality-Data Coding Options for Reporting Satisfactorily:</u> Influenza Immunization Received

CPT II 4274F: Influenza immunization administered or previously received

<u> 0R</u>

Influenza Immunization <u>not</u> Received, for Medical, Patient or System Reasons Append a modifier (1P, 2P or 3P) to CPT Category II code 4274F to report documented circumstances that appropriately exclude patients from the denominator.

4274F *with* **1P:** Documentation of medical reason(s) for patient not receiving influenza immunization during the flu season (eg, patient allergy, other contraindication)

- **4274F** *with* **2P:** Documentation of patient reason(s) for patient not receiving influenza immunization during the flu season (eg, patient/caregiver declined)
- **4274F** *with* **3P:** Documentation of system reason(s) for patient not receiving influenza immunization during the flu season (eg, vaccine not available)

<u> 0R</u>

Influenza Immunization not Received, Reason not Specified

Append a reporting modifier (8P) to CPT Category II code 4274F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

4274F *with* **8P:** Influenza immunization <u>not</u> administered or previously received, reason not otherwise specified

DENOMINATOR:

All patients aged 6 months through 17 years with a diagnosis of ESRD and receiving dialysis seen for a visit between November 1 and February 15

Denominator Criteria (Eligible Cases):

Patients aged 6 months through 17 years on date of encounter <u>AND</u> Diagnosis for ESRD (line-item ICD-9-CM): 585.6 <u>AND</u> Patient encounter during the reporting period (HCPCS): 90951, 90952, 90953, 90954, 90955, 90956, 90957, 90958, 90959, 90963, 90964, 90965

RATIONALE:

Infectious disease is a common reason for hospitalization, morbidity, and mortality among pediatric end stage renal disease patients. All-cause hospital admission rates for pediatric end stage renal disease patients was 14% higher in 2005 when compared to all-cause hospital admission rates for adults. Hospitalizations for infections are also higher in children with end stage renal disease (46%) than in adults.

CLINICAL RECOMMENDATION STATEMENTS:

Vaccination of all children aged 6 months-18 years should begin before or during the 2008-09 influenza season if feasible, but no later than during the 2009-10 influenza season. Vaccination of all children aged 5-18 years is a new ACIP recommendation. (CDC/ACIP, 2008)

Children and adolescents at high risk for influenza complications should continue to be a focus of vaccination efforts as providers and programs transition to routinely vaccinating all children and adolescents. Recommendations for these children have not changed. Children and adolescents at higher risk for influenza complication are those:

• aged 6 months-4 years

- who have chronic pulmonary (including asthma), cardiovascular (except hypertension), renal, hepatic, hematological, or metabolic disorders (including diabetes mellitus)
- who are immunosupressed (including immunosupression caused by medication or by human immunodeficiency virus) (CDC/ACIP, 2008)

All children aged 6 months-8 years who have not received vaccination against influenza previously should receive 2 doses of the vaccine the first influenza season they are vaccinated. The second dose should be administered 4 or more weeks after the initial dose. (CDC/ACIP, 2008)

Heasure #176: Rheumatoid Arthritis (RA): Tuberculosis Screening

2009 PQRI REPORTING OPTIONS: CLAIMS-BASED, REGISTRY, MEASURES GROUP

DESCRIPTION:

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

INSTRUCTIONS:

This measure is to be reported a minimum of <u>once per reporting period</u> for <u>all</u> RA patients who are being considered or prescribed a first course of biologic disease-modifying anti-rheumatic drug therapy. It is anticipated that clinicians who provide care for patients with a diagnosis of RA will submit this measure.

Measure Reporting via Claims:

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

When reporting the measure via claims, submit the listed ICD-9-CM diagnosis codes, CPT codes, and the appropriate CPT Category II codes <u>**OR**</u> the CPT Category II code(s) <u>with</u> the modifier. The modifiers allowed for this measure are: 1P- medical reasons, 8P- reason not otherwise specified. There are no allowable performance exclusions for this measure. All measure-specific coding should be reported ON THE SAME CLAIM.

NUMERATOR:

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

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

Definition:

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

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

<u>Numerator Quality-Data Coding Options for Reporting Satisfactorily:</u> Tuberculosis Screening Performed and Results Interpreted

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

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

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

TB Screening not Performed or Results not Interpreted for Medical Reasons

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

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

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

<u>AND</u>

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

OR

If patient does not meet denominator inclusion because biologic DMARD prescription is Rituximab or this is not the first course of biologic DMARD therapy for RA, report:

(One CPT II code [4196F] is required on the claim form to submit this numerator option) CPT II 4196F: Patient not receiving first-time biologic disease modifying anti-rheumatic drug therapy for rheumatoid arthritis

<u> 0R</u>

TB Screening not Performed or Results not Interpreted, Reason not Specified

(Two CPT II codes [3455F-8P& 4195F] are required on the claim form to submit this numerator option)

Append a reporting modifier (8P) to CPT Category II code 3455F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

3455F *with* **8P:** TB screening <u>not</u> performed or results <u>not</u> interpreted, reason not otherwise specified

<u>AND</u>

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

DENOMINATOR:

All patients 18 years and older with a diagnosis of rheumatoid arthritis (RA) who are receiving a first course of therapy using a biologic DMARD

Denominator Criteria (Eligible Cases):

Patients aged \geq 18 years on date of encounter

AND

Diagnosis for rheumatoid arthritis (line-item ICD-9-CM): 714.0, 714.1, 714.2, 714.81 AND

Patient encounter during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, 99455, 99456

RATIONALE:

Before initiating biologic DMARDs for a patient with RA, it is essential to screen the patient for tuberculosis, as research has documented a higher incidence of TB after anti-TNF α therapy. All patients being considered for biologic DMARD should receive a tuberculin skin test, even if the patient has previously received the BCG vaccination. Test results, in addition to patient risk for TB and other tests, should be used to assess the patient's risk for latent TB infection. This is a patient safety measure.

CLINICAL RECOMMENDATION STATEMENTS:

The American College of Rheumatology's updated Recommendations for the use of nonbiologic and biologic therapies in RA recommend routine tuberculosis screening to identify latent TB infection (LTBI) in patients being considered for therapy with biologics. The evidence for TB testing is based on a documented higher incidence of TB following ant-TNFa therapy. To begin, clinicians should ask all RA patients being considered for biologic DMARDs about their potential risk factors for TB infection (see below) and, irrespective of prior Bacillus-Calmette-Guérin (BCG) vaccination, use a Tuberculin Skin Test (TST) as a diagnostic aid to assess their patient's probability of latent TB infection.

In addition to the ACR recommendations, guidelines from the British Society for Rheumatology have consistent recommendations. There have been a large number of cases of tuberculosis (TB) reported in association with the use of infliximab, and studies that demonstrate a significantly higher rate of TB in patients on this treatment compared with controls. Cases of TB have also been reported in association with etanercept and adalimumab. Reactivation of latent TB is highest in the first 12 months of treatment, so particular vigilance is required during this time. With infliximab, the majority of cases occurred within three cycles of treatment, with a median of 12 weeks after starting treatment, suggesting reactivation of latent TB as the main factor predisposing to TB in these cases. The following are the British Society for Rheumatology's recommended guidelines for patients with RA: Prior to commencing treatment with anti-TNF, all patients should be screened for TB in accordance with the British Thoracic Society (BTS) guidelines. Active TB needs to be adequately treated before anti-TNF therapy can be started; prior to commencing anti-TNF therapy, consideration of prophylactic anti-TB therapy (as directed by the BTS guidelines) should be given to patients with evidence of potential latent disease (past history of TB treatment or abnormal chest X-ray raising the possibility of TB) after consultation with a local TB specialist; all patients commenced on anti-TNF therapies need to be closely monitored for TB. This needs to continue for 6 months after discontinuing infliximab treatment due to the prolonged elimination phase of infliximab; patients on anti-TNF therapy who develop symptoms suggestive of TB should receive full anti-TB chemotherapy, but may continue with their anti-TNF therapy if it is clinically indicated;

anti-TNF therapy should only be resumed in accordance with the BTS guidelines and after agreement in collaboration with a TB specialist. (Level of Evidence C)

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

2009 PQRI REPORTING OPTIONS: CLAIMS-BASED, REGISTRY, MEASURES GROUP

DESCRIPTION:

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

INSTRUCTIONS:

This measure is to be reported a minimum of once per reporting period for patients with RA seen during the reporting period. While there are disease activity assessment tools and instruments used as examples in this measure, they are not required. The intent of this measure is to promote physician assessment of the level of RA disease activity to inform treatment decisions. It is anticipated that clinicians who provide care for patients with a diagnosis of RA will submit this measure.

Measure Reporting via Claims:

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

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

NUMERATOR:

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

Definition:

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

Numerator Quality-Data Coding Options for Reporting Satisfactorily: **Disease Activity Assessed and Classified** CPT II 3470F: Rheumatoid arthritis (RA) disease activity, low OR **CPT II 3471F:** Rheumatoid arthritis (RA) disease activity, moderate OR CPT II 3472F: Rheumatoid arthritis (RA) disease activity, high

12/08/2008

<u>OR</u>

Disease Activity not Assessed and Classified, Reason not Specified

Append a reporting modifier (8P) to CPT Category II code 3470F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

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

DENOMINATOR:

All patients 18 years and older with a diagnosis of rheumatoid arthritis (RA)

Denominator Criteria (Eligible Cases):

Patients aged ≥ 18 years on date of encounter <u>AND</u> Diagnosis for rheumatoid arthritis (line-item ICD-9-CM): 714.0, 714.1, 714.2, 714.81 <u>AND</u> Patient encounter during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, 99455, 99456

RATIONALE:

After establishing a diagnosis of RA, risk assessment is crucial for guiding optimal treatment. For the purposes of selecting therapies, physicians should consider the patient's disease activity at the time of the treatment decisions.

CLINICAL RECOMMENDATION STATEMENTS:

Several indices to measure RA disease activity have been developed each of which has advantages and disadvantages. Evidence-based guidelines require clear definitions of disease activity to make rational therapeutic choices, but it is not possible or appropriate to mandate use of a single disease activity score for the individual physician, and different studies have used different definitions. Therefore, the TFP was asked to consider a combined estimation of disease activity, which allowed reference to many past definitions. With these instruments as our guide, we rated RA disease activity in an ordinal manner as low, moderate, or high, as previously requested by the CEP.

BMeasure #178: Rheumatoid Arthritis (RA): Functional Status Assessment

2009 PQRI REPORTING OPTIONS: CLAIMS-BASED, REGISTRY, MEASURES GROUP

DESCRIPTION:

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

INSTRUCTIONS:

This measure is to be reported a minimum of <u>once per reporting period</u> for patients with RA seen during the reporting period. It is anticipated that clinicians who provide care for patients with a diagnosis of RA will submit this measure.

Measure Reporting via Claims:

Line-item ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. CPT Category II codes can be used to report the numerator of the measure.

When reporting the measure via claims, submit the listed ICD-9-CM diagnosis codes, CPT codes, and the appropriate CPT Category II codes <u>**OR**</u> the CPT Category II code(s) <u>with</u> the modifier. The reporting modifier allowed for this measure is: 8P- reason not otherwise specified. There are no allowable performance exclusions for this measure. All measure-specific coding should be reported ON THE SAME CLAIM.

NUMERATOR:

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

Definitions:

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

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

Numerator Quality-Data Coding Options for Reporting Satisfactorily: Functional Status Assessed

CPT II 1170F: Functional status assessed

Functional Status not Assessed, Reason not Specified

Append a reporting modifier (8P) to CPT Category II code 1170F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

1170F with 8P: Functional status not assessed, reason not otherwise specified

DENOMINATOR:

All patients 18 years and older with a diagnosis of rheumatoid arthritis (RA)

Denominator Criteria (Eligible Cases):

Patients aged ≥ 18 years on date of encounter <u>AND</u> Diagnosis for rheumatoid arthritis (line-item ICD-9-CM): 714.0, 714.1, 714.2, 714.81 <u>AND</u>

Patient encounter during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, 99455, 99456

RATIONALE:

Functional limitations are a significant and disruptive complication for patients living with RA. Assessments of functional limitations are used to assess prognosis and guide treatment and therapy decisions. Functional status should be assessed at the baseline and each follow-up visit, using questionnaires such as the ACR's Classification of Functional Status in RA or the Health Assessment Questionnaire or an assessment of activities of daily living. Regardless of the assessment tool used, it should indicate whether a functional decline is due to inflammation, mechanical damage, or both, as treatment strategies will vary accordingly.

CLINICAL RECOMMENDATION STATEMENTS:

The management of RA is an iterative process, and patients should be periodically reassessed for evidence of disease or limitation of function with significant alteration of joint anatomy. Baseline evaluation of disease activity and damage in patients with rheumatoid arthritis through evaluation of functional status or quality of life assessments using standardized questionnaires, a physician's global assessment of disease activity. The initial evaluation of the patient with RA should document symptoms of active disease (i.e., presence of joint pain, duration of morning stiffness, degree of fatigue), functional status, objective evidence of disease activity (i.e., synovitis, as assessed by tender and swollen joint counts, and the ESR or CRP level), mechanical joint problems, etc.

At each follow up visit, the physician must assess whether the disease is active or inactive. Symptoms of inflammatory (as contrasted with mechanical) joint disease, which include prolonged morning stiffness, duration of fatigue, and active synovitis on joint examination, indicate active disease and necessitate consideration of changing the treatment program. Occasionally, findings of the joint examination alone may not adequately reflect disease activity and structural damage; therefore, periodic measurements of the ESR or CRP level and functional status, as well as radiographic examinations of involved joints should be performed. It is important to determine whether a decline in function is the result of inflammation, mechanical damage, or both; treatment strategies will differ accordingly.

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

2009 PQRI REPORTING OPTIONS: CLAIMS-BASED, REGISTRY, MEASURES GROUP

DESCRIPTION:

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

INSTRUCTIONS:

This measure is to be reported a minimum of <u>once per reporting period</u> for patients with RA seen during the reporting period. It is anticipated that clinicians who provide care for patients with a diagnosis of RA will submit this measure.

Measure Reporting via Claims:

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

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

NUMERATOR:

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

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

Definitions:

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

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

<u>Numerator Quality-Data Coding Options for Reporting Satisfactorily:</u> Disease Prognosis Assessed and Classified

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

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

<u> 0R</u>

Disease Prognosis <u>not</u> Assessed and Classified, Reason not Specified

Append a reporting modifier (8P) to CPT Category II code 3475F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

3475F *with* **8P:** Disease prognosis for rheumatoid arthritis <u>not</u> assessed and classified, reason not otherwise specified

DENOMINATOR:

All patients 18 years and older with a diagnosis of rheumatoid arthritis (RA)

Denominator Criteria (Eligible Cases):

Patients aged ≥ 18 years on date of encounter

<u>AND</u>

Diagnosis for rheumatoid arthritis (line-item ICD-9-CM): 714.0, 714.1, 714.2, 714.81 AND

Patient encounter during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, 99455, 99456

RATIONALE:

After establishing a diagnosis of RA, risk assessment is crucial for guiding optimal treatment. For the purposes of selecting therapies, physicians should consider the presence of these prognostic factors at the time of the treatment decisions.

CLINICAL RECOMMENDATION STATEMENTS:

Important clinical markers of disease prognosis were reviewed by a recent expert panel convened by the American College of Rheumatology as part of an effort to update clinical recommendations. The American College of Rheumatology 2008 Recommendations for the Use of Nonbiologic and Biologic Therapies in Rheumatoid Arthritis were published in Arthritis & Rheumatism, June 2008.

Poor prognosis is suggested by earlier age at disease onset, high titer of RF, elevated ESR, and swelling of >20 joints. Extraarticular manifestations of RA, such as rheumatoid nodules, Sjogren's syndrome, episcleritis and scleritis, interstitial lung disease, pericardial involvement, systemic vasculitis, and Felty's syndrome, may also indicate a worse prognosis. Since studies have demonstrated that treatment with DMARDs may alter the disease course in patients with recent-onset RA, particularly those with unfavorable prognostic factors, aggressive treatment should be initiated as soon as the diagnosis has been established. (Level C evidence)

Assessment of prognosis should be performed at baseline, before starting medications, to assess organ dysfunction due to comorbid diseases. The literature agrees that a thorough assessment includes recording a complete blood cell count, electrolyte levels, creatinine levels, hepatic enzyme levels (AST – aspartate aminotransferase, ALT – alanine aminotransferase, and albumin), and performing a urinalysis and stool guaiac. If necessary prognosis at baseline should rule out other diseases; this may be repeated during disease flares to rule out septic arthritis through synovial fluid analysis. (Level C evidence)

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

2009 PQRI REPORTING OPTIONS: CLAIMS-BASED, REGISTRY, MEASURES GROUP

DESCRIPTION:

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

INSTRUCTIONS:

This measure is to be reported a minimum of <u>once per reporting period</u> for patients with RA seen during the reporting period. It is anticipated that clinicians who provide care for patients with a diagnosis of RA will submit this measure.

Measure Reporting via Claims:

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

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

NUMERATOR:

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

Definitions:

Prolonged Dose – Doses > 6 months in duration

Prednisone Equivalents – Determine using the following:

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

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

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

<u>Numerator Quality-Data Coding Options for Reporting Satisfactorily:</u> Glucocorticoid Use Assessed

(One CPT II code [419xF] is required on the claim form to submit this numerator option) CPT II 4192F: Patient not receiving glucocorticoid therapy

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

OR

Glucocorticoid Use Assessed and Management Plan Documented

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

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

<u>and</u>

CPT II 0540F: Glucocorticoid Management Plan documented

Glucocorticoid Plan not Documented for Medical Reasons

(*Two CPT II codes [0540F-1P and 4194F] are required on the claim form to submit this numerator option*)

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

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

AND

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

Glucocorticoid Dose not Documented, Reason not Specified

(One CPT II code [4194F-8P] is required on the claim form to submit this category) Append a reporting modifier (8P) to CPT Category II code 4194F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

4194F with 8P: Glucocorticoid dose was not documented, reason not otherwise specified

OR

Glucocorticoid Plan not Documented, Reason not Specified

(Two CPT II codes [0540F-8P and 4194F] are required on the claim form to submit this numerator option)

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

0540F *with* **8P:** Glucocorticoid plan <u>not</u> documented, reason not otherwise specified <u>AND</u>

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

DENOMINATOR:

All patients 18 years and older with a diagnosis of rheumatoid arthritis (RA)

Denominator Criteria (Eligible Cases):

Patients aged \geq 18 years on date of encounter <u>AND</u> Discussion for the encounter (in a item IOD a ON) - 714

Diagnosis for rheumatoid arthritis (line-item ICD-9-CM): 714.0, 714.1, 714.2, 714.81 AND

Patient encounter during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, 99455, 99456

RATIONALE:

Glucocorticoids are an important part of RA treatment as they inhibit inflammation and may control synovitis. However, long-term use of glucocorticoids, especially at high doses, should be avoided, due to the potential health complications. Monitoring length and dose of glucocorticoid treatment for patients with RA is integral to making other clinical decisions.

CLINICAL RECOMMENDATION STATEMENTS:

The 1993 American College of Rheumatology guidelines acknowledge the importance of the use and the tracking of glucocorticoid as a RA symptom reliever. The benefits of low-dose systemic glucocorticoids, however, should always be weighed against their adverse effects. The adverse effects of long-term oral glucocorticoids at low doses are protean and include osteoporosis, hypertension, weight gain, fluid retention, hyperglycemia, cataracts, and skin fragility, as well as the potential for premature atherosclerosis. These adverse effects should be considered and should be discussed in detail with the patient before glucocorticoid therapy is begun. For long term disease control, the glucocorticoid dosage should be kept to a minimum. For the majority of patients with RA, this means equal or less than 10 mg of prednisone per day.

Measure #181: Elder Maltreatment Screen and Follow-Up Plan

2009 PQRI REPORTING OPTIONS: CLAIMS-BASED, REGISTRY

DESCRIPTION:

Percentage of patients age 65 years and older with documentation of a screen for elder maltreatment AND documented follow-up plan

INSTRUCTIONS:

This measure is to be reported for <u>each initial patient evaluation</u> during the reporting period. When reporting CPT service code 96116, 97803, and G0270 the measure is to be reported each time the code is submitted. The not eligible code can be used to report if it is not an initial evaluation with screening for elder maltreatment. This measure may be reported by non-MD/DO clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

Measure Reporting via Claims:

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

When reporting the measure via claims, submit the listed CPT codes, HCPCS codes, and the appropriate numerator G-code. All measure-specific coding should be reported ON THE SAME CLAIM.

NUMERATOR:

Patients with a documented screen for elder maltreatment and follow-up plan

Definitions:

Documented – Evidenced in the clinical record. Such evidence can include narrative notes, a formal screen and/or an assessment and treatment plan tool/form, copy of a documented plan or referral request for further evaluation, etc.

Screen for Elder Maltreatment – The screen includes a review of the following components: (1) physical abuse, (2) emotional or psychological abuse, (3) neglect, (4) sexual abuse, (5) abandonment, (6) financial or material exploitation, (7) self-neglect, and (8) unwanted control. (Institute of Medicine 2002)

Physical Abuse – Infliction of physical injury by punching, beating, kicking, biting, burning, shaking or other actions that result in harm. (Institute of Medicine, 2002) **Emotional or Psychological Abuse** – Involves psychological abuse, verbal abuse, or mental injury and includes act or omissions by loved ones or caregivers that have caused or could cause serious behavioral, cognitive, emotional, or mental disorders.

Neglect – Involves attitudes of others or actions caused by others-such as family members, friends, or institutional caregivers-that have an extremely detrimental effect upon well-being. (Reyes-Ortiz 2001)

Active – Behavior that is willful, the caregiver intentionally withholds care or necessities. The neglect may be motivated by financial gain or reflect interpersonal conflicts. (NCPEA)

Passive – Situations where the caregiver is unable to fulfill his or her care giving responsibilities as a result of illness, disability, stress, ignorance, lack of maturity, or lack of resources. (NCPEA)

Sexual Abuse – Involves adults who are unable to fully comprehend and/or give informed consent in sexual activities that violate the taboos of society. (Institute of Medicine 2002)

Abandonment – Desertion of an elderly person by an individual who has assumed responsibility for providing care for an elder, or by a person with physical custody of an elder. (NCPEA)

Financial or Material Exploitation – Taking advantage of a person for monetary gain or profit. (Institute of Medicine 2002)

Self-Neglect – Self-imposed attitudes or actions that contribute to decline in the persons overall health and well being, may be associated with an inappropriate or nontraditional lifestyle. Other names used may include Diogenes syndrome (DS), aged reclusion, social breakdown, and squalor syndrome. (Reyes-Ortiz 2001) **Unwarranted Control** – Controlling a person's ability to make choices about living situations, household finances, and medical care. (Institute of Medicine 2002)

Follow-Up Plan – May include but is not limited to documentation of a referral or discussion with other providers, ongoing monitoring or assessment, and/or a direct intervention.

Not Eligible - A patient is not eligible if the following condition(s) exist:

- Patient refuses to participate.
- Patient is in an urgent or emergent situation where time is of the essence and to delay treatment would jeopardize the patient's health status.
- Patient elder maltreatment screen was negative and no further follow-up required.

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Elder Maltreatment Screen and Follow-Up Plan Documented

G8534: Documentation of an elder maltreatment screen and follow-up plan <u>OR</u>

Elder Maltreatment Screen Documented, Follow-Up Plan <u>not</u> Documented, Patient not Eligible

G8537: Elder maltreatment screen documented, follow-up plan not documented, patient not eligible

<u> 0R</u>

Elder Maltreatment Screen not Documented, Patient not Eligible

G8535: No documentation of an elder maltreatment screen, patient not eligible

<u> 0R</u>

Elder Maltreatment Screen not Documented, Reason not Specified

G8536: No documentation of an elder maltreatment screen, reason not specified <u>OR</u>

Elder Maltreatment Screen Documented, Follow-Up Plan <u>not</u> Documented, Reason not Specified

G8538: Elder maltreatment screen documented, follow-up plan not documented, reason not specified

DENOMINATOR:

All patients 65 years of age and older

Denominator Criteria (Eligible Cases):

Patients aged \geq 65 years on date of encounter <u>AND</u> Patient encounter during the reporting period (CPT or HCPCS): 90801, 90802, 96116*, 96150, 97003, 97802, 97803*, G0270*

Note: *When reporting CPT code 96116, 97803, and G0270, the measure is to be reported <u>each</u> time the code is submitted.

RATIONALE:

Elder abuse is the infliction of physical, emotional, or psychological harm on an older adult, but also can take the form of financial exploitation or intentional or unintentional neglect of an older adult by the caregiver. Over the past ten years there has been an increase in elder abuse, which is not being picked up and reported to appropriate authorities. The reasons for underreporting are two-fold: health care professionals don't ask patients if they are being abused and patients don't tell, for fear of retaliation by their caregivers. In the American Psychological Association's "Elder Abuse and Neglect: In Search of Solutions," found on their website, it is reported that every year an estimated 2.1 million older Americans are victims of physical, psychological, or other forms of abuse and neglect and that for every reported cases. Recent research suggests that elders who have been abused tend to die earlier than those who are not abused, even in the absence of chronic conditions or life threatening disease.

It is difficult to obtain accurate information on the extent of elder abuse and neglect in the United States. Studies often focus on reports of selected populations and many cases are unreported. Victims may be embarrassed, intimidated and overwhelmed by the situation. They may be fearful of reprisals or unaware of the availability of help. In some cases, victims may be unable to report maltreatment or do not realize that they are being maltreated. Finally, health professionals may ignore the signs and symptoms of elder maltreatment because they are unaware of the extent of the problem and uncomfortable with the responsibility of further assessment and action.

The extent to which elder maltreatment affects the health care system is largely unknown. Common clinical findings associated with maltreatment include bruises, lacerations, abrasions, head injury, fractures, dehydration, and malnutrition. These injuries commonly result in hospitalization. In one descriptive study that tracked the emergency department utilization of known elderly victims of physical abuse identified through adult protective services, 114 individuals had 628 emergency department visits during a 5-year window surrounding the referral; 30 percent of these visits resulted in hospital admission. (Institute of Medicine 2002) Studies do indicate that the effects of elder maltreatment increase the medical needs of victims. One longitudinal study of elderly victims of maltreatment documented a threefold increased risk of death in the 3-year period following maltreatment, after adjusting for comorbidity and other factors that predict death in older cohorts (Lachs 1998). In addition, maltreatment may exacerbate or interfere with the treatment of other medical and psychosocial conditions. For example, angina pectoris, emphysema, diabetes mellitus, and arthritis are much more challenging to treat in an abusive environment (Lachs 1997). No studies of the costs associated with these increased medical needs have been published. (Institute of Medicine 2002)

Website searches of the National Quality Measures Database (NQMC) using the keywords Elder Abuse and Elder Neglect resulted in 9 measures. The measures only pertain to intimate partner violence and not the broader topic of elder maltreatment. One measure was focused on preventive counseling on violence and abuse, which is not the measure focus.

CLINICAL RECOMMENDATION STATEMENTS:

Every clinical setting should have a protocol for the detection and assessment of elder maltreatment. This may be a narrative, a checklist, or some other type of standardized form that enables all providers in that practice setting to rapidly assess for elder maltreatment and document it in a way that allows clinicians to look at patterns over time. (Aravanis and Adelman 1993)

Measure #182: Functional Outcome Assessment in Chiropractic Care

2009 PQRI REPORTING OPTIONS: CLAIMS-BASED, REGISTRY

DESCRIPTION:

Percentage of patients age 18 years and older with documentation of a current functional outcome assessment using a standardized tool AND documentation of a care plan based on identified functional outcome deficiencies

INSTRUCTIONS:

This measure is to be reported <u>each visit</u> indicating the appropriate numerator code; however, the assessment is required to be current as defined for patients seen during the reporting period. This measure may be reported by non-MD/DO clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

Clarification:

The intent of the measure is for the functional outcome assessment tool to be utilized at a minimum of every 30 days but reporting is required each visit due to coding limitations. Therefore, for visits between each 30 day functional outcome assessment, the denominator exclusion code not documented/not eligible would be used for reporting purposes.

Measure Reporting via Claims:

CPT codes and patient demographics are used to identify patients that are included in the measure's denominator. G-codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed CPT codes, and the appropriate numerator G-code. All measure-specific coding should be reported ON THE SAME CLAIM.

NUMERATOR:

Patients with a documented current functional outcome assessment using a standardized tool AND a documented care plan

Definitions:

Standardized Tool – An assessment tool that has been appropriately normalized and validated for the population in which it is used. Examples of tools for functional outcome assessment include, but are not limited to, Oswestry Disability Index (ODI), Roland Morris Disability/Activity Questionnaire (RM), and Neck Disability Index (NDI).

Functional Outcome Assessment – Questionnaires designed to measure a patient's limitations in performing the usual human tasks of living. Functional questionnaires seek to quantify symptoms, functional and behavior directly, rather than to infer them from less relevant physiological tests. (Mercy guideline, pg. 143)

Current – A patient having a documented functional assessment within the previous 30 days.

Functional Outcome Deficiencies – Impairment or loss of physical function related to neuromusculoskeletal capacity, including but not limited to, restricted flexion, extension and rotation, back pain, neck pain, pain in the joints of the arms or legs, and headaches. **Care Plan** – A care plan is an ordered assembly of expected or planned activities, including observations goals, services, appointments and procedures, usually organized in phases or sessions, which have the objective of organizing and managing health care activity for the patient, often focused upon one or more of the patient's health care problems. Care plans may include order sets as actionable elements, usually supporting a single session or phase. Also known as Treatment Plan.

Not Eligible – A patient is not eligible if the following condition(s) exist:

- Patient refuses to participate.
- Patient unable to complete questionnaire.

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Current Functional Outcome Assessment and Care Plan Documented

G8539: Documentation of a current functional outcome assessment using a standardized tool AND care plan based on identified deficiencies

OR

Current Functional Assessment Documented, Care Plan <u>not</u> Documented, Patient not Eligible

G8542: Documentation of a current functional outcome assessment using a standardized tool; no documentation of a care plan, patient not eligible

Current Functional Outcome Assessment <u>not</u> Documented, Patient not Eligible G8540: Documentation that the patient is not eligible for a functional outcome assessment using a standardized tool

Current Functional Outcome Assessment not Documented, Reason not Specified

G8541: No documentation of a current functional outcome assessment using a standardized tool, reason not specified

Current Functional Assessment Documented, Care Plan <u>not</u> Documented, Reason not Specified

G8543: Documentation of a current functional outcome assessment using a standardized tool; no documentation of a care plan, reason not specified

DENOMINATOR:

All patients age 18 years and older

Denominator Criteria (Eligible Cases):

Patients aged ≥ 18 years on date of encounter <u>AND</u> Patient encounter during the reporting period (CPT): 98940, 98941, 98942

RATIONALE:

Researchers studying the efficacy of chiropractic care have long recognized that patient focused assessment is a critical component of the evaluation process. Chiropractors can utilize the standardized tools to help establish patient centered treatment goals and objective evaluation of achievement of treatment goals if done more frequently. The benefits are also cited by the American College of Physicians (Nelson and Wasson1994) such as: detecting, quantifying, and identifying the source(s) of decreased functional capacity; guiding management decisions; guiding the efficient use of resources; improving the prediction of the course of chronic disease; and improving patient outcomes: symptoms, mortality, satisfaction with care, function, and quality of life. Although the benefits of utilizing standardized functional assessment outcome tools are known, they are not typically utilized and instead information is gathered only by patient interview.

The use of outcome assessment is imperative for the practicing clinician as a means to document health status and improvement (van Hemert 1998). Goertz (1994) identified the importance of using a self-report questionnaire as a means of obtaining a functional health status assessment. Through use of a questionnaire, communication is increased between the physician and patient by focusing not only on location and severity of a specific condition but also on how the condition is affecting the patient's physical and emotional health status. Questionnaires, which measure pain level (visual analog scale), patient satisfaction, or functional assessment (Oswestry) take little time and are valid and reliable (Liebenson 1995). Use of a standardized tool to assess functional status provides a consistent approach in demonstrating the patient's status and response to treatment.

A recent unpublished review of the literature found more than 50 references to the use of functional health status assessment tools in evaluating chiropractic spinal manipulation. Among those most commonly identified were the Oswestry Pain Disability Index (ODI), Roland Morris Disability/Activity Questionnaire (RM), and Neck Disability Index (NDI). While there is a strong scientific basis for the use of outcome assessment in evaluating the impact of chiropractic manipulative procedures, these tools have not yet been widely incorporated into the clinical setting as a quality benchmark.

A review of the National Quality Measures Clearinghouse revealed no same or similar measures.

CLINICAL RECOMMENDATION STATEMENTS:

Functional questionnaires seek to quantify symptoms, function and behavior directly, rather than to infer them from less relevant physiological tests. Clinicians contemplating the use of functional instruments should be aware of differences between them and be able to choose the most appropriate assessment for their specific situation. (Haldeman, et al., 2005)

As a category, functional outcome assessments of everyday tasks are very suitable for evaluating treatment of dysfunctions of the neuromusculoskeletal system. Many questionnaires could be used; choice should depend upon the validity, reliability, responsiveness, and practicality demonstrated in the scientific literature. (Evidence Class: I, II, III, Consensus Level: 1) (Haldeman, et al., 2005)

Keep appropriate records of the patient's evaluation and case management. (The Council on Chiropractic Education, 2007)

Appropriately respond to changes in patient status, or failure of the patient to respond to care. (The Council on Chiropractic Education, 2007)

A Measure #183: Hepatitis C: Hepatitis A Vaccination in Patients with HCV

2009 PQRI REPORTING OPTIONS: CLAIMS-BASED, REGISTRY

If reporting Measure #183 - Hepatitis C: Hepatitis A Vaccination in Patients with HCV, also report Measure #184 - Hepatitis C: Hepatitis B Vaccination in Patients with HCV.

DESCRIPTION:

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

INSTRUCTIONS:

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

Measure Reporting via Claims:

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

When reporting the measure via claims, submit the listed ICD-9-CM diagnosis codes, CPT codes and the appropriate CPT Category II codes <u>**OR**</u> the CPT Category II codes <u>**with**</u> the modifier. The modifiers allowed for this measure are: 1P- medical reasons, 2P- patient reasons, 8P- reason not otherwise specified. All measure-specific coding should be reported ON THE SAME CLAIM.

NUMERATOR:

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

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

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

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

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

Hepatitis A Vaccine Injection <u>not</u> Received for Medical or Patient Reasons Append a modifier (**1P or 2P**) to CPT Category II code **4148F** to report documented circumstances that appropriately exclude patients from the denominator.

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

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

OR

Hepatitis A Vaccine Injection not Received, Reason not Specified

Append a reporting modifier (8P) to CPT Category II code 4148F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

4148F with 8P: Hepatitis A Vaccine not received, reason not otherwise specified

DENOMINATOR:

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

Denominator Criteria (Eligible Cases):

Patients aged \geq 18 years on date of encounter AND Diagnosis for hepatitis C (line-item ICD-9-CM): 070.51, 070.54, 070.70 AND Patient encounter during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215

RATIONALE:

Assure that hepatitis A vaccination is received except for cases of documented medical or patient reasons. This vaccination decreases the potential for a patient acquiring hepatitis A which would contribute to further liver damage.

CLINICAL RECOMMENDATION STATEMENTS:

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

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

12/08/2008

A Measure #184: Hepatitis C: Hepatitis B Vaccination in Patients with HCV

2009 PQRI REPORTING OPTIONS: CLAIMS-BASED, REGISTRY

If reporting Measure #184 - Hepatitis C: Hepatitis B Vaccination in Patients with HCV, also report Measure #183 - Hepatitis C: Hepatitis A Vaccination in Patients with HCV.

DESCRIPTION:

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

INSTRUCTIONS:

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

Measure Reporting via Claims:

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

When reporting the measure via claims, submit the listed ICD-9-CM diagnosis codes, CPT codes, and the appropriate CPT Category II codes <u>**OR**</u> the CPT Category II codes <u>**with**</u> the modifier. The modifiers allowed for this measure are: 1P- medical reasons, 2P- patient reasons, 8P- reason not otherwise specified. All measure-specific coding should be reported ON THE SAME CLAIM.

NUMERATOR:

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

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

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

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

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

Hepatitis B Vaccine Injection <u>not</u> Received for Medical or Patient Reasons Append a modifier (**1P or 2P**) to CPT Category II code **4149F** to report documented circumstances that appropriately exclude patients from the denominator.

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

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

<u>OR</u>

Hepatitis B Vaccine not Received, Reason not Specified

Append a reporting modifier (8P) to CPT Category II code 4149F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

4149F with 8P: Hepatitis B Vaccine not received, reason not otherwise specified

DENOMINATOR:

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

Denominator Criteria (Eligible Cases):

Patients aged ≥ 18 years on date of encounter <u>AND</u> Diagnosis for hepatitis C (line-item ICD-9-CM): 070.51, 070.54, 070.70 <u>AND</u> Patient encounter during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215

RATIONALE:

Assure that hepatitis B vaccination is received except for cases of documented medical or patient reasons. These vaccinations decrease the potential for a patient acquiring hepatitis B which would contribute to further liver damage.

CLINICAL RECOMMENDATION STATEMENTS:

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

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

B Measure #185: Endoscopy & Polyp Surveillance: Colonoscopy Interval for Patients with a History of Adenomatous Polyps – Avoidance of Inappropriate Use

2009 PQRI REPORTING OPTIONS: CLAIMS-BASED, REGISTRY

DESCRIPTION:

Percentage of patients aged 18 years and older receiving a surveillance colonoscopy and a history of colonic polyp(s) in a previous colonoscopy, who had a follow-up interval of 3 or more years since their last colonoscopy documented in the colonoscopy report

INSTRUCTIONS:

This measure is to be reported <u>each time</u> a surveillance colonoscopy is performed during the reporting period. It is anticipated the <u>clinician who performs the listed procedures</u>, as specified in the denominator coding, will report on this measure. Patients who have a coded colonoscopy procedure that has a modifier 52, 53, 73 or 74 will not qualify for inclusion into this measure.

Measure Reporting via Claims:

Line-item ICD-9-CM diagnosis codes, CPT code or G-codes, and patient demographics are used to identify patients who are included in the measure's denominator. CPT Category II codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed ICD-9-CM diagnosis codes, CPT codes, G-codes, and the appropriate CPT Category II codes <u>OR</u> the CPT Category II code(s) <u>with</u> the modifier. The modifiers allowed for this measure are: 1P- medical reasons, 3P- system reasons, 8P- reason not otherwise specified. All measure-specific coding should be reported ON THE SAME CLAIM.

NUMERATOR:

Patients who had an interval of 3 or more years since their last colonoscopy

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Interval of Three or More Years Since Patient's Last Colonoscopy CPT II 0529F: Interval of three or more years since patient's last colonoscopy, documented

Interval of <u>Less Than</u> Three Years Since Patient's Last Colonoscopy for Medical or System Reasons

Append a modifier (**1P or 3P**) to CPT Category II code **0529F** to report documented circumstances that appropriately exclude patients from the denominator.

0529F *with* **1P:** Documentation of medical reason(s) for an interval of less than three years since the last colonoscopy (eg, patients with high risk for colon cancer, last colonoscopy incomplete, last colonoscopy had inadequate prep, piecemeal removal of adenomas, or last colonoscopy found greater than 10 adenomas)

0529F *with* **3P:** Documentation of system reason(s) for an interval of less than three years since the last colonoscopy (eg, unable to locate previous colonoscopy report)

Interval of $\underline{\text{Less Than}}$ Three Years Since Patient's Last Colonoscopy, Reason not Specified

Append a reporting modifier (8P) to CPT Category II code 0529F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

0529F *with* **8P:** Interval of <u>less than</u> three years since patient's last colonoscopy, reason not otherwise specified

DENOMINATOR:

All patients aged 18 years and older receiving a surveillance colonoscopy with a history of colonic polyp(s) in a previous colonoscopy

Denominator Instruction: Clinicians who indicate that the colonoscopy procedure is incomplete or was discontinued should use the procedure number and the addition (as appropriate) of modifier 52, 53, 73, or 74. Patients who have a coded colonoscopy procedure that has a modifier 52, 53, 73, or 74 will <u>not</u> qualify for inclusion into this measure.

Denominator Criteria (Eligible Cases):

Patients aged ≥ 18 years on date of encounter <u>AND</u> Diagnosis for history of colonic polyp(s) (line-item ICD-9-CM): V12.72 <u>AND</u> Patient encounter during the reporting period (CPT or HCPCS): 44388, 44389, 44392, 44393, 44394, 45355, 45378, 45380, 45381, 45383, 45384, 45385, G0105 <u>WITHOUT</u> CPT Category I Modifiers: 52, 53, 73 or 74

RATIONALE:

Colonoscopy is the recommended method of surveillance after the removal of adenomatous polyps because it has been shown to significantly reduce subsequent Colorectal Cancer incidence. The timing of follow-up colonoscopy should be tailored to the number, size, and pathologic findings of the adenomatous polyps removed. The time interval for the development of malignant changes in adenomatous polyps is estimated at 5 to 25 years (ICSI, 2006). A randomized controlled trial of

699 patients showed that after newly diagnosed adenomatous polyps have been removed by colonoscopy, follow-up colonoscopy at three years detects important colonic lesions as effectively as follow-up colonoscopy at both one and three years. (ICSI, 2006)

Performing colonoscopy too often not only increases patients' exposure to procedural harm, but also drains limited resources that could be more effectively used to adequately screen those in need. Recent evidence from four surveys indicated that postpolypectomy surveillance colonoscopy in the United States is frequently performed at intervals that are shorter than those recommended in guidelines (Rex et al, 2006). Some endoscopists in these studies performed colonoscopy in patients with only small hyperplastic polyps or a single tubular adenoma at one year. These surveys underscore the importance of measuring intervals between examinations in continuous quality improvement programs.

CLINICAL RECOMMENDATION STATEMENTS:

Patients with one to two small (1 cm) tubular adenomas with only low-grade dysplasia should undergo follow-up colonoscopy no earlier than five years later. Patients with advanced adenomatous lesions or >3 adenomas should have repeat colonoscopy in three years as long as all visualized polyps were completely removed, the colonoscopy was completed up the cecum, and the colonic preparation was adequate. A shorter interval of follow-up is recommended in those patients with numerous adenomatous (>10) polyps and in those whom the colonoscopy was incomplete or the preparation was inadequate. After a surveillance colonoscopy has normal results, repeat examinations should be done at five-year intervals. Patients with large, sessile adenomatous lesions removed in a piecemeal fashion should have a repeat examination within two to six months to exclude and remove any remnant polypoid tissue. (Grade 1a) (Davila et al, 2006) **B** Measure #186: Wound Care: Use of Compression System in Patients with Venous Ulcers

2009 PQRI REPORTING OPTIONS: CLAIMS-BASED, REGISTRY

DESCRIPTION:

Percentage of patients aged 18 years and older with a diagnosis of venous ulcer who were prescribed compression therapy within the 12-month reporting period

INSTRUCTIONS:

This measure is to be reported a minimum of <u>once per reporting period</u> for patients with venous ulcer(s) seen during the reporting period. This measure is intended to reflect the quality of services provided for the primary management of patients with venous ulcers of the lower extremities.

Measure Reporting via Claims:

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

When reporting the measure via claims, submit the listed ICD-9-CM diagnosis codes, CPT codes, and the appropriate CPT Category II code <u>**OR**</u> the CPT Category II code <u>**with**</u> the modifier. The modifiers allowed for this measure are: 1P- medical reasons, 2P- patient reasons, 3P- system reasons, 8P- reason not otherwise specified. All measure-specific coding should be reported ON THE SAME CLAIM.

NUMERATOR:

Patients who were prescribed compression therapy within the 12 month reporting period

Numerator Quality-Data Coding Options for Reporting Satisfactorily: Compression Therapy Prescribed CPT II 4267F: Compression Therapy Prescribed

Compression Therapy <u>not</u> **Prescribed for Medical, Patient or System Reasons** Append a modifier (**1P, 2P or 3P**) to CPT Category II code **4267F** to report documented circumstances that appropriately exclude patients from the denominator.

4267F *with* **1P:** Documentation of medical reason(s) for not prescribing compression therapy (eg, severe arterial occlusive disease)

- **4267F** *with* **2P:** Documentation of patient reason(s) for not prescribing compression therapy
- **4267F** *with* **3P:** Documentation of system reason(s) for not prescribing compression therapy

Compression Therapy not Prescribed, Reason not Specified

Append a reporting modifier (8P) to CPT Category II code 4267F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

4267F with 8P: Compression therapy not prescribed, reason not otherwise specified

DENOMINATOR:

All patients aged 18 years and older with a diagnosis of venous ulcer

Denominator Criteria (Eligible Cases):

Patients aged \geq 18 years on date of encounter <u>AND</u> Diagnosis for venous ulcer (line-item ICD-9-CM): 459.31, 459.33, 459.81 <u>AND</u> Diagnosis for ulcer of lower limbs (line-item ICD-9-CM): 707.12, 707.13, 707.14, 707.15, 707.19 <u>AND</u> Patient encounter during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245

RATIONALE:

Compression therapy is fundamental to promote healing and prevent recurrence of ulcers in patients with venous abnormality. Although it has proven efficacy, research has shown that it is not universally used in the treatment of patients with venous ulcers. One study found that one third of patients did not receive compression of any sort and there was great variability in the level and type of compression therapy used. Graduated high compression (>30 mmHg) produces the best results. However, some compression is better than no compression.

CLINICAL RECOMMENDATION STATEMENTS:

For patients with venous hypertension or risk for venous insufficiency, consider graduated compression stockings. (Grade B) (ASPS, 2007)

The use of a Class 3 (most supportive) high-compression system (three layer, four layer, short stretch, paste-containing bandages, e.g., Unna's boot, Duke boot) is indicated in the treatment of venous ulcers. Although these modalities are similar in effectiveness, they can differ significantly in comfort and cost. The degree of compression must be modified when mixed venous/arterial disease is confirmed during the diagnostic work-up. Intermittent pneumatic pressure (IPC) can be used with or without compression dressings and can provide another option in patients who cannot or will not use an adequate compression dressing system. (Level I) (WHS, 2006)

Compression therapy heals more venous leg ulcers than no compression therapy as well as decreases the healing time. High compression is more effective than low compression, but there are no differences in the effectiveness of the different types of products available for high compression. (Level A) (WOCN, 2005)

Compression options:

- Elastic compression bandage heals more than inelastic compression (Grade A)
- Multi-layer (2, 3, or 4 layers) sustained, elastic high-compression bandage (Grade A)
- Elastic high-compression stockings to heal venous ulcers (Grade A)
- Elastic multiple-layer high-compression stockings to heal venous ulcers (Grade A)
- Duke Boot or Unna Boot + elastic compression (Grade A)
- Gradient compression better than uniform compression (Grade C)
- Short stretch bandage (Grade A)
- Unna boot zinc paste impregnated bandage (Grade A)
- Intermittent pneumatic compression (Grade A)
- Non-elastic compression with Circaid [or similar device] (Grade B)
- Sequential-gradient pneumatic compression (Grade C) (AAWC, 2005)

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